REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

COSMETIC HEALTH SERVICE COMPLAINTS IN NEW SOUTH WALES

At Macquarie Room, Parliament House, Sydney, on Wednesday 1 August 2018

The Committee met at 9:45 am

PRESENT

Mr Adam Crouch (Chair)

The Hon. Lou Amato
Mr Austin Evans
The Hon. Mark Pearson
The Hon. Walt Secord
Mr Mark Taylor
Ms Kate Washington

The CHAIR: Good morning and thank you for attending this public hearing this morning. We are hearing evidence today in the Committee's inquiry into cosmetic health service complaints in New South Wales. We will be examining a number of issues today including the roles and responsibilities of the Health Care Complaints Commission relative to the Commonwealth and other State agencies and whether there are opportunities for collaboration between agencies to improve outcomes for the public. We are also looking at the adequacy of the powers and functions of the commission to help the public in the cosmetic health services sector. I welcome you all here this morning.

SCOTT TURNER, Board representative, Australasian Society of Aesthetic Plastic Surgeons, sworn and examined

GAZI HUSSAIN, Vice President, Australian Society of Plastic Surgeons, affirmed and examined

MARK ASHTON, President, Australian Society of Plastic Surgeons, sworn and examined

KEN LOI, NSW State Committee Chair, Royal Australasian College of Surgeons, sworn and examined

POURIA MORADI, NSW State Committee Plastics Representative, Royal Australasian College of Surgeons, affirmed and examined

The CHAIR: Would you like to make a short opening statement before we begin with questioning this morning?

Professor ASHTON: My name is Mark Ashton. I am a professor of surgery at the University of Melbourne and for the last 16 years have been head of plastic surgery at the Royal Melbourne Hospital and recently have left to start a new professorial unit in Melbourne. I am also the President of the Australian Society of Plastic Surgeons. I would like to start by just telling you a brief story about an elderly diabetic, overweight gentleman who walks into a corner store and wants to buy a Mars bar. He walks in the front door, gets the Mars bar, takes it to the counter, goes to the store owner and says, "I would like to purchase this please". The store owner says, "Sure. Have you got the $5 to pay for it? He says, "Yes, I do". He gives him the $5, he gives him the Mars bar, the transaction is completed.

Later that afternoon the same overweight gentleman goes to see his endocrinologist. He walks into the office and he sees sitting on the desk is another Mars bar. He says to the endocrinologist, "Can I please purchase that Mars bar? I'm feeling a bit peckish and I wouldn't mind having that if I could", to which the endocrinologist says, "Whilst I would like to sell you the Mars bar I am not going to. I am not going to sell you the Mars bar because you're overweight and you're a diabetic and in your interests as a patient that is not the correct and right thing to do". The point of that story is simply this: Within this industry right now there are people who are service providers and there are people who are ethical, moral professionals, and that is what this is all about. The people who have Australian Medical Council [AMC] accredited training behind them spend a minimum of five years in supervised accredited training, which teaches them far more than just how to perform a procedure; it teaches them about ethics, about morality, about managing risk, about managing complications and about how to assess the patient as a whole rather than just how to do an individual procedure.

What we have at the moment is a multibillion-dollar industry which is engendering a lot of very bad behaviour. People out there are looking only at procedures and what procedure can be sold to an individual patient, what Mars bar they can sell to a community, rather than looking at the patient as the community as a whole and what is the right thing for them. At the moment in Australia we have a Federal Government which has created an independent, thoroughly investigative body called the Australian Medical Council, and they critically examine every single aspect of medical training and if a particular training organisation comes up to scratch, if they meet a set of very stringent criteria, they are awarded as being accredited by the AMC.

In surgery there are only three bodies who have passed that test and that test is repeated year on, year on, year on. They are the College of Ophthalmology, the Obstetricians and Gynaecologists and the Royal Australasian College of Surgeons, which is then broken down into nine separate parts. My group, the plastic and reconstructive surgery, is part of the Royal Australasian College, and before accepting people, which is a competitive process, we look at their ethics, we look at their morals, we look at their commitment to the community, we look at their capacity to research and to give back to the community, and then we train them for five years in a supervised, intensive training program which at the end of it has an exit exam which is amongst the most difficult in the world. To put that into perspective, the exit exam in plastic surgery has a pass rate for people who do not sit from within Australia—that is, they have their training elsewhere, even if they are trained in plastic surgery in Britain or America—of less than 50 per cent. Our exams and our standards are incredibly high and we make absolutely no apology for that.

Within Australia right now there are a group of people—let us call them the pretenders—who go out and they get a basic medical degree, which may or may not have involved any surgical training at all, they have had no hands-on experience, they then can go and do a one- or two-week course and can walk out and call themselves a cosmetic surgeon. Last year, 2017, the average age of a fellow from the Royal Australasian College of Surgeons graduating was 39—that is after entering medical school at 17 or 18. So they spent 21 years training, and what that training is about is about more than just learning how to do a procedure; it is about how to be a professional, how to be ethical, how to be moral and how to look after the patient in the first instance.

To give you one further example before we continue, just last week a 44-year-old mother of two came to see me. She had a harrowing story where she had been to see a cosmetic surgeon—and I can give you both her name and his name if you would like. She, after delivering two kids, was worried about a little bit of hanging underneath her arms and thought she might need to see a plastic surgeon about some liposuction. She saw two plastic surgeons, both of whom said, "Because you're only 65 kilograms we do not think there is a lot of fat that we can suck out, and whilst it is possible that we could sell this procedure to you, we don't think the risk benefit analysis is worthwhile" and they declined. They suggested that she should go to the gym.

She went and saw a cosmetic surgeon who is a member of the Australian College of Cosmetic Surgery and therefore is meant to be ethical and everything they say he is. She saw him in a palatial suite with marble and glass in Wattletree Road in Armadale in Melbourne. He convinced her not only to have liposuction of her arms but also to have liposuction of her abdomen, and then, one week after she paid her money, transferred the location of her surgery—she thought it was being done in Armadale—swapped it across to on top of a gym in Berwick in outer south-eastern Melbourne. She had it under conscious sedation and the operation went a bit longer than normal. She awoke in the middle of the afternoon after a morning procedure to find that she had excruciating pain, far worse than her two caesarean sections, and shoulder tip pain. Shoulder tip pain is really important because that is pathognomonic to anyone who has done any surgical training that you either have air or blood in your abdomen.

Despite this, both the staff at this day surgery and the cosmetic surgeon insisted she get in a taxi and go home. She said, "I'm not going home" and they had a stand-up fight, and that ended by her requesting to get her mobile phone from the nurses, which they gave her. She rang her husband and said, "Can you call me an ambulance". An ambulance arrived and assessed that she was grossly hypovolemic—that is, she had lost lots and lots and lots of blood—and she was critical and about to die. They raced her to Cabrini Hospital where she had an emergency laparotomy and had three litres of blood sucked out of her abdomen and multiple holes in her liver repaired. Had she not called the ambulance she would be dead.

The point of that story is that you can train anyone how to do a procedure, but that is not the point. The point here is that it is about looking after a patient as a whole and looking after a community. When something goes wrong, you must be in a position to fix the problem. If you simply learn how to do liposuction and you are not an Australian Medical Council [AMC] accredited surgeon you do not know how to do a laparotomy, so you send the patient away or to an emergency room, but you do not look after the patient.

So if we are talking about open, honest, transparent, informed consent, we would say that at a very minimum this committee should recommend that the term "cosmetic surgeon" be banned, because it does not give any indications as to the level of training, it is confusing for the public and it is being deliberately misused in a somewhat disingenuous and, I would say, somewhat sinister way to overstate and give the false impression of training that simply does not exist.

The CHAIR: Thank you very much, Professor Ashton. Just before we move onto questions, does anybody else want to add to Professor Ashton's opening statement?

Dr LOI: Yes, I would like to do that. As part of my background as current chair—I come from an upper GI background and I am doing a lot of bariatric surgery as well—I have a lot of dealings with different surgeons in terms of after weight-loss surgery. When I bring this issue to a council meeting they are very concerned about the word "surgeon" being used, but it has been going on for quite a long time.

New South Wales and Melbourne are the most affluent states and all these surgeries are being seen in every State, but New South Wales and Melbourne seem to be places where most of this is concentrated. Until critical events like this happen we need to review ourselves, but the college's position is that we say that AMC training is formally accredited at a college to be named Fellow of the Royal Australasian College of Surgeons [FRACS] as a surgeon. So as these surgeons we talk to all the different kind of specialties that may need to be protected. So adding towards this is that it is not easy to get to become a surgeon. So I think the college's viewpoint is that the "surgeon" title needs to be protected. Hopefully we can look into that. I am just here to support my colleague.

The CHAIR: I suppose the scope of this inquiry is also focusing on New South Wales and the Health Care Complaints Commission's [HCCC's] ability here in New South Wales with regard to these issues. My question to all of you to start with is how could the healthcare complaints system in New South Wales be improved, particularly in relation to the powers of the HCCC that I mentioned before, to deal with the cosmetic health services complaints that we are seeing?

Dr HUSSAIN: I would say, as an opening, that as a community, and perhaps as an entity, we need to clarify what is the distinction between a beauty treatment and a medical treatment. At the moment there is a real blurring of that. That is where, unfortunately, some practitioners are dwelling—and essentially going from what

might be considered beauty treatments to what we would consider medical treatments. That is where we are seeing a lot of issues in terms of harm to patients and poor outcomes.

I would also say that we believe that there is a significant underreporting to the HCCC, for a number of reasons. No. 1 would be awareness. I do not know that most patients are aware that they have that process. Some patients, as Mark has alluded to, sometimes feel a bit embarrassed if they get a complication. So if they have a cosmetic procedure and something goes wrong they feel a bit embarrassed and sometimes blame themselves in that they feel they should have known better and not gone to these practitioners.

What we would like to see is an improved methodology around reporting to the HCCC so that we can get a real idea of the scale of the problem. I do not think at the moment the HCCC sees what the true scale of this is. We have often had issues around what the punishments for breaches are, as well as the enforcement of those breaches. We have had cases where we have reported issues to HCCC, but also to AHPRA, and they simply do not have the resources, sometimes, to follow up on these and to investigate, and then, also, to punish appropriately. We know that NSW Health's report talked about the Therapeutic Goods Administration's [TGA's] abilities in terms of their punishments and how that has not kept up with time. We would say the same thing with regard to the HCCC in that we feel, if anything, that their punishments need to be beefed up. But we also need to be able to clearly show to the public and also to the practitioners who are doing the wrong thing that there are consequences and that these consequences will be enforced.

The CHAIR: Following up on your answers, I have two questions. Firstly, do you believe that there needs to be greater clarity about the terminology used with regards to a specialist?

Professor ASHTON: Yes, I could put it another way. If we said that a person can no longer call themselves a cosmetic surgeon unless they are a surgeon you might say, "Hang on, that is difficult and problematic because we have doctors who are also PhD students and we do not have any trouble discerning between a medical scientist and a medical practitioner." If we say, "You can only use the term 'surgeon' if you are part of an AMC accredited training program," that means that when those people are advertising they are unable to use the term "cosmetic surgeon". Talking about a public being educated and informed consent, that person is then required to say, "I am a general practitioner who has an interest in breast augmentation," or "I am an anaesthetist who has an interest in liposuction." The patient is then going say, "Hang on, I thought you were a surgeon." So it encourages a second question, which means that the patient then seeks out the training and credentialing of that particular individual to be able to do that procedure safely and manage any risk or any complications that may occur. So by removing the term "cosmetic surgeon" you are encouraging a much more transparent and a much more informed process of consent.

Dr HUSSAIN: We are not saying that you have to be a surgeon to do a procedure. We are not trying to say that this is a closed shop. We are saying that any doctor can do these procedures but they need to be up front about what their level of expertise is and what their scope of practice is. So you can say, "I am a general practitioner but I do cosmetic procedures."

Professor ASHTON: We already have that system within New South Wales and Victoria. If you are in the back of Bourke and you want to have a child, or you get appendicitis and you need to have your appendix out you are not going to get on a plane and fly to Sydney. There will be a GP there and a GP-anaesthetist there who will put you off to sleep and deliver your baby or take out your appendix. As a public member of that particular rural community you are completely aware of the level of training of that person. For example, you would not get him to do a huge Whipple's major bowel resection or something like that, but for an appendectomy or delivering a child and things like that you know what the risk is because it is very clear. We are not saying that the rural GP cannot do appendectomies or give anaesthetics. We are saying, "Just be open and transparent about your level of training," that is all.

The CHAIR: Dr Hussain you also mentioned clearer methodology for the HCCC. Can you elaborate on what sort of methodology you believe should be made clearer by the HCCC?

Dr HUSSAIN: I think around a greater public awareness of the HCCC. I am not sure about the ability to make anonymous complaints to the HCCC. A lot of patients might say, "I've had a poor outcome but I really don't want my breasts flashed across everyone's newspaper saying that I had a problem." Sometimes these patients may want to have the ability to make a complaint anonymously. There is also the issue around doctors and surgeons where we see patients who have had complications. The patient may not want to make a complaint but we would like to see a facility whereby a surgeon or a doctor treating a complication has an ability to raise this with an organisation like—

The CHAIR: As a third party you could effectively go to the HCCC to represent them.

Dr HUSSAIN: Yes.

Dr MORADI: Without any recourse, is what you are saying. You get that quite commonly. You get a complication. I have a patient who is under my care at Prince of Wales Hospital who has had a cosmetic procedure by someone on this street who is a cosmetic doctor. The care has been transferred to the public sector. So now it is my problem as the consultant surgeon. The patient—who happens to be a medical student, of all things!—does not want any complaints made about this practitioner. I feel that it is my role as a visiting medical officer at this hospital, who is now dealing with this complication, to make a complaint, but I do not have informed consent from this patient to make a complaint. So the audit process has broken down because we cannot make the complaint because my patient will not be very happy with me if I did make the complaint without her consent.

The CHAIR: You just mentioned that that particular person is a medical student. If it is at a point where a medical student who has had some training experience does not feel comfortable about giving evidence you can imagine how difficult it would be for the average person who has no medical experience.

Dr MORADI: Absolutely, it is frustrating. You say to them, "What do you want me to do? Your practitioner has transferred your care to the public sector." This patient came in over the weekend and is still an inpatient and is still getting multiple operations to correct this problem. That is a poor outcome. You think you would be very frustrated and very angry at the person who did it, but there is an element of embarrassment.

The CHAIR: Because it is cosmetic?

Dr MORADI: Correct.

The CHAIR: If you were treating a normal surgical procedure, that may not be an issue.

Dr MORADI: It would not be an issue.

Dr TURNER: I highlight that point. The thing we need to understand with cosmetic surgery, the referral practice and the way patients get to a doctor is very different to a medical practice. Your GP, your filtering practice or your emergency gets referred to a specialist and gets treated by a proper AMC surgeon. This highlights an example where a medical student went to a cosmetic surgeon and did not do research. The vast majority of patients that we see are vulnerable people who do not have the capacity to understand these distinctions and that is what a lot of these budget clinics are preying on. Unless we set the standards above that so that people are forced to be aware and make educated decisions, if you allow it to be based on cost price, there are going to be a lot of people who are preyed upon. They are not even medical students. They are vulnerable people in difficult stages of their life who should not have these surgeries at all.

Professor ASHTON: What we would all see is that there are two elements to that. Even if you are medically trained, it is a nightmare to work out exactly what is going on, what the level of training is. The people who are the cosmetic surgeons mirror—almost to the letter of the law—all the terminology, all the phrases. If someone is an association, they are called an association. If they are a college, they call themselves a college. They mirror the names. They make up names at the end, which are indecipherably separate from the true AMC accreditations. So they have all these letters after their name. They have palatial rooms. They appear to be spectacularly well trained. There is no transparency on training. Therefore, even if you are well skilled, you can still end up falling into the wrong hands.

When something goes wrong, everyone comes out of the woodwork and says, "Why did you go to him? He is not trained." There is a feeling of, "I thought I did the right thing. I bought myself a dud." It is a bit like buying a car and it is a lemon. You do not have self-pride, you say, "Goodness, I should have been smarter." To make a complaint, you then have to fess up to your community, which might be the mums at school, your cousins, your brothers and sisters, your mum and dad that you undertook something which they might have strong views about. Therefore, there are a lot of factors at play. Most of those can be fixed by making it much easier for the community, for the patient—because that is the most important person—to easily determine who has done the training and who is the pretender.

The Hon. MARK PEARSON: Dr Moradi, is your understanding ofthe HCCC that you cannot make an anonymous or confidential report to the HCCC—anonymous on behalf of the patient that you are treating—to at least flag that this surgeon or this clinic could be in question without necessarily breaching any confidentiality with your patient because he or she has not given consent?

Dr MORADI: Yes. I realise that through Australian Health Practitioner Regulation Agency [AHPRA] or through HCCC you can make a confidential complaint. I can complain about a practitioner if it is a worthy cause, but, to be honest, I have not looked into whether I can make the complaint as a proxy for a patient. Not that I have done it before, but if I see someone advertising in an unethical manner, whatever that may be, I know that I can go to AHPRA or the HCCC and make a confidential and anonymous complaint. I understand that. I am not aware, and nor have I looked into it, whether I can do it on half of a patient.

Professor ASHTON: The other thing, which is self-evident, is that if Dr Moradi was to make a complaint, the next avenue would be that the ACCC would ring that particular practitioner and inquire about that particular patient, who would be contacted. Then it becomes self-evident as to where the referral came from.

The Hon. MARK PEARSON: Would it mean that in our review of all this that the HCCC be given other investigative powers so that they do not have to divulge sources to protect people?

Professor ASHTON: Correct.

The Hon. MARK PEARSON: Unless it progresses to something much more.

Professor ASHTON: Yes, or unless there is a death or significant disability and things like that. Yes, that would be very helpful.

The Hon. MARK PEARSON: What is a basic medical degree?

Professor ASHTON: A basic medical degree is a six-year degree. In the old terms, it used to be a bachelor of medicine and a bachelor of surgery. It used to be the only degree that people would do and it would equip you to be a GP. With the increasing specialisation in medicine, we have worked out that even that is not enough to equip you to be a good GP. If you want to be a general practitioner in Australia, you need to do an extra degree in general practice, similarly with obstetrics, gynaecology, paediatrics, whatever you are doing.

The Hon. MARK PEARSON: General practice then becomes almost a specialty?

Dr HUSSAIN: Yes.

Professor ASHTON: Yes, because there is a recognition that the six years at university is insufficient. The other thing that has happened is that there has been a downgrading of anatomy and surgical skills in the basic medical degree to encompass many of the other things, such as psychosocial development and so forth. I think it would be universally accepted across Australia that the basic medical degree—that is the university degree that gives you an MB BS—does not equip you in any way for anything other than a stepping stone into what you then want to do. Historically, because you have a bachelor of surgery, you can then call yourself a surgeon, which is where these people who are cosmetic surgeons get around the loophole. It would be naive in the extreme to pretend that someone who has done a university degree is adequately skilled or equipped to do anything in surgery.

The Hon. MARK PEARSON: If a GP decides to have an interest in cosmetic surgery or these procedures, is there a requirement that that general practitioner must then do a course or obtain some sort of degree?

Professor ASHTON: No. That is a very, very good question. At the moment, there is no requirement. Again, this comes back to my point about learning to do a procedure and being an ethical, moral and professional human being who is looking after a patient. The GP who is in the back of Bourke who says, "I think I need to learn how to deliver a baby", and maybe needs to learn how to do a caesarean section, might come down to one of the women's hospitals and do an intensive course in how to do caesarean sections in case he gets caught in his GP practice. We would support and endorse that absolutely. But that person is then not going to Campbelltown and saying, "I am an obstetrician." That is exactly what is happening with cosmetic surgery. If a person in a rural community wants to do botox or fillers or some basic hand surgery or wants to learn how to do skin lesions properly, we would absolutely and thoroughly endorse them undertaking that extra training. That is what it is all about, but at least be honest and open and say, "I am not pretending I am someone with an AMC accredited training post. I am simply saying I am a general practitioner who has an interest in this particular graft and I am pretty good at it because I have done a couple of months of training and I can do the most basic things", but that is where it stops.

Where we are getting into trouble is you sometimes see submissions which state, "It is really hard, but what we are trying to do is manage a patient's expectations." That is a reflection on you. You have got a procedure and you are trying to make the patient fit the procedure. It is the wrong way around. You are meant to be looking after the patient and see whether that procedure fits that patient. As I said about the liposuction, the lady saw two plastic surgeons who both said that she did not need an operation because she is 42 and she is 65 kilograms; she needs to go to the gym. She is low risk. She goes to see someone who is selling a procedure, and that is when the trouble starts.

The Hon. WALT SECORD: Professor Ashton, thanks for your evidence. In your earlier oral statement you called for a ban on the use of the phrase "cosmetic surgeon". You said it was deliberately misused. I have been calling for this for three years and meeting considerable resistance to it. Why would a State Government decline or refuse to do this? I, as well as bodies such as yourself and across the table, have been calling for the

ban for three years. Who is resisting banning this phrase or allowing someone to call themselves a cosmetic surgeon when they are not?

Professor ASHTON: That is a spectacularly good question.

The Hon. WALT SECORD: Can you explain it to me?

Professor ASHTON: Yes, I can.

The Hon. WALT SECORD: I have hit a brick wall.

Professor ASHTON: I have spoken to Greg Hunt and to Brendan Murphy, both of whom are absolutely supportive of banning the term. Greg Hunt said, "It is a no brainer. It is in the best interests of our community. I do understand why we cannot get it through." Your Minister for Health, Brad Hazzard, has been spectacularly helpful. He has got on board right from the get-go.

The Hon. WALT SECORD: So why is it not happening?

Professor ASHTON: Then we went to Perth and met the senior health adviser in Perth, and he could not see that there was an issue. He said, "Hang on, we have just had another college here, who call themselves the College of Cosmetic Surgeons, and apparently they do all this extra training, and they are the only people who train cosmetic surgeons and they are the best in the business." I had to explain to them about what the AMC is and how wrong and misguided they were. These guys are incredibly—I do not want to be blunt here—manipulative. They do not tell the whole truth, they manipulate, and people are gullible. We cannot change the term "cosmetic surgery" federally unless we get the Australian Health Practitioner Regulation Agency to change it and that involves every State and every Territory seeing the value in what we are saying. We have been to Queensland a month ago: on board. We are trying our hardest but if you can help us that would be really helpful.

Dr HUSSAIN: It is basically a COAG issue and, as Professor Ashton says, we really need to get every State and Territory on board to enable this to happen. Brad Hazzard is supportive, he certainly has raised this with COAG. It was raised at COAG in October and it was handed off to AHPRA to investigate and it is still with AHPRA. Despite our efforts to try to find out where this is at, we have hit a brick wall.

The Hon. WALT SECORD: Is there any scope for a State to require proper identification? Can you go to New South Wales and say, "You cannot call yourself a cosmetic surgeon."?

Professor ASHTON: That would be spectacularly helpful.

The Hon. WALT SECORD: You can do it in New South Wales if you wanted to?

Professor ASHTON: If you can pass that through and say, "As a condition of your licensing within New South Wales we need you to call yourself by your AMC accreditation."

Dr LOI: Just to bring it down a notch, I guess. It is really great that my plastic colleagues are on fire with this. Hearing this, I give you an example of what we debate about in the college council about the excessive fee issues regarding what surgeons charge, et cetera. From the college standpoint, it is about education, advocacy, patient safety and transparency. I think our fellow colleagues are probably asking for help in terms of legislation that the Committee can help to make it transparent, to make the term "surgeon" sacred and make the people aware that surgeons are real surgeons not someone who has done all these courses and can be trained. The college has no mandate or cannot tell a surgeon how much they are charging but they now make patients fully aware of the financial engagement they are going into. It is about transparency, it is about making sure that the public is aware what it is getting. It is a similar issue to what we are dealing with, but this issue has been going on for quite a long time and has culminated in these events and hopefully we need the Committee's help in terms of guiding us how to proceed.

Dr MORADI: From my standpoint, I am a consultant plastic surgeon at Prince of Wales Hospital. With Dr Loi I am on the Royal Australasian College of Surgeons [RACS] committee in New South Wales. The other hat that I wear, I am part of the curriculum task force for rewriting the plastic surgical curriculum. There have been allegations that in the public hospital we do no cosmetic surgery and cosmetic surgery is not part of our curriculum. That could not be further from the truth. The curriculum has a whole module on cosmetic surgery. Do we perform cosmetic operations in the public sector? Yes. They are part of reconstructive surgery. For example, a patient has a rhinoplasty post trauma. That is a cosmetic operation. There is also a reconstructive operation. Can patients get breast reductions in the public sector? Under extreme situations in New South Wales, yes they can. Can a patient have breast augmentation in a public hospital, and do our trainees do it? Yes, they do. In what situation? In a situation where we have done breast reconstruction from cancer on one side, and we are doing an augmentation, which is yes, a cosmetic procedure, but it is a matching procedure. Do we do face lift operations in the public sector? Yes, we can do it in relation to patients who have facial nerve or Bell's palsy.

Do our trainees in their five years get exposed to cosmetic surgery? Yes, they do in the public sector, as described, and in New South Wales they spend minimum six, sometimes 12 months of their five-year tenure in a specific cosmetic hospital, for example, Macquarie Hospital, the San hospital, East Sydney Private Hospital, St Luke's Hospital and St Vincent's Hospital. Trainees go to these hospitals and get mentored and trained and become competent practitioners in cosmetic medicine, along with hand surgery and burn surgery and all the other endeavours. When other colleges say there is no cosmetic surgery being taught through RACS, that is total nonsense. It could not be any further from the truth. It is integral to every part of plastic surgery. I do not think there needs to be another training program, because under the auspices of RACS, the plastic society is taking care of cosmetic training because it is a very varied thing, it is not just one operation. Yes, labiaplasty is purely cosmetic or any pure face lift is cosmetic but aspects of that get done in reconstructive surgery.

The Hon. WALT SECORD: Dr Moradi, you practice at Prince of Wales Hospital?

Dr MORADI: Correct.

The Hon. WALT SECORD: Do you see the so-called handiwork of cowboys in the industry?

Dr MORADI: Absolutely. There are two issues.

The Hon. WALT SECORD: Is it increasing?

Dr MORADI: Is it increasing? I think it is pretty steady, to be honest. We got some of the patients from the famous clinic—I do not know if I am allowed to name names.

The Hon. WALT SECORD: You are under privilege here, you can.

Dr MORADI: The Cosmetic Institute had some complications. They came to our hospital. I mentioned this weekend when I was on call the patient that came in. We also had a patient under our care within the last month who had injector put in her nose and became blind as a result of it. That came into our hospital. If you work at a major teaching hospital, which some plastic surgeons do, you are going to see all these complications, whether it be from overseas tourism, whether it is going to be from other plastic surgeons, whether it is going to be from non-AMC accredited practitioners.

Dr HUSSAIN: I have some photographs. I do not know whether I am able to show them to you. These are photographs of patients who have had procedures done by non-plastic surgeons who have had complications and you can see firsthand what the potential complications are.

The CHAIR: They can be tabled.

Professor ASHTON: To follow up, the somewhat ironic thing about what we just discussed is that because when the cosmetic surgeon gets into trouble and cannot manage the complications, they are almost invariably sent to the public system, to the public hospitals, where most of the plastic surgery is being trained. So, if anything, our plastic surgery trainees, even our first and second-year trainees, are experts in the complications of cosmetic surgery because they deal with them on a daily basis. I can tell you that within Melbourne we would see them on a weekly basis.

The other thing is the comment that Dr Moradi made about changing workload is reflective of the general population in what we are seeing. That is, our hospitals are stretched, they are trying to do more with less money. If you have on your waiting list, say in Melbourne for example, we set up a breast reconstruction service for patients who had breast cancer. That was on the Monday morning and it involved a breast surgeon and two plastic surgeons, patients taking time off work. That list was the list which was under the most pressure because it was a Monday morning list, it was right after the weekend and patients who came in with hand lacerations and circular saw injuries, football injuries and so forth would be in the hospital on Friday, Saturday, Sunday night, in hospital three or four days. The hospital is saying, "We need to get these patients treated. You have an elective, semi-cosmetic operation that someone is going through." That is how they framed it.

Someone is going through a breast cancer mastectomy and reconstruction, we can take that list and we can give that to treat the fractured hands and the lacerations and so forth. Is there a pressure on the plastic surgery units within our public systems to make sure that the percentage of cosmetic surgery or reconstructive surgery is maintained? Yes, absolutely. But that just means we need to work harder at what we do. One of the ways in which we have done that is develop a series of off public hospital sites—specific hospitals or specific units. Just as there are in New South Wales, within Melbourne there are a number of hospitals which are away from the Royal Melbourne, away from the Alfred hospital, and away from St Vincent's where all they do is breast reconstruction, cosmetic surgery, and so forth. These people have protective beds. That means with breast reconstruction, they need six weeks off, so you need someone to look after your kids for six weeks. You need to give work notice.

You cannot have that operation cancelled at the last minute. Again, as I come back to, it is about putting the patient first, not learning how to do a procedure.

The CHAIR: Mr Secord, you have asked your question and I will come back to you.

The Hon. WALT SECORD: I want to put a follow-up question to Dr Moradi.

The CHAIR: I will come back to you because it is a 24 minutes past 10. I will go to Mr Taylor and I will try to get back to you so everyone gets a chance to ask a question.

The Hon. WALT SECORD: Try to get back to me.

Mr MARK TAYLOR: Professor, in your opening comments you mentioned regulating the terminology "surgeon". What about gaps in regulation of the place where these cosmetic procedures take place?

Professor ASHTON: That is part and parcel of what is going on. A person who does not have an Australian Medical Council [AMC] accredited training behind them will find it incredibly difficult to get an operating list and admitting rights to a private hospital. Therefore, they are, by necessity, forced out into places which are unregulated or unlicensed. That means that, as those rules are coming down—and it varies from State to State—if you are trying to do procedures which are part of the New South Wales code, you are being squashed into areas. Part and parcel is that there needs to be not only a tightening around the term "cosmetic surgeon" but an absolute enforcement and tightening around the facilities regulation about what procedures can be done.

For example, this girl who got into trouble with the liposuction, she had conscious sedation and under 2.5 litres of liposuction because she was only 65 kilograms. But she still got into strife. If you said, "Look, I am really sorry; you can't do liposuction", and drop it down even further, or "You can't use any sedation"—yes, it does need to be tightened. But the other thing too is that it needs to be enforced. One of the ways that you could look at maybe enforcing that is if you bumped up the penalties. That is going to give you more money, which is then going to allow you to fund better investigations and enforcement.

Dr TURNER: I was just going to say, as a follow-up to that, that they are all linked to each other: the title, the scope for practice, the facility and the indemnity. When one falls, they all fall. We have fought this battle for decades trying to ban cosmetic surgeons and the Australian Competition and Consumer Commission [ACCC] gets involved in restriction of trade. We come at it from a paternal approach: What is best for our patients? That is all we are looking at. We are not trying to restrict from a financial point of view. But there is no definition of "cosmetic surgery" and who fills that scope of practice. As a plastic surgeon, if I went to the local hospital and wanted to do a knee joint replacement, they would not let me do it, I would not be covered by my medical indemnity, and if I had a problem and I was allowed to do it somewhere, the Health Care Complaints Commission [HCCC] would come down on me like a ton of bricks.

The Hon. WALT SECORD: Dr Moradi—

The CHAIR: Just a minute. Mr Taylor has not finished questioning yet.

The Hon. WALT SECORD: I want to find out more about—

The CHAIR: Mr Secord, I will get back to you.

Mr MARK TAYLOR: I think Dr Turner is still going.

Dr TURNER: If we can get to the point where we can define which Royal Australasian College of Surgeons [RACS] members or AMC accredited surgeons within general surgery—ear, nose and throat [ENT] surgery, plastic surgery—or which procedures fall within their scope of practice, and each society is responsible for their members that can do those procedures under that scope of practice, that then limits the hospitals. A hospital will not let a doctor operate out of their scope of practice because they are liable if there is a complication. We can very quickly turn this around and restrict who does what procedures in what facilities by defining a scope for practice. Defining a scope for practice then makes your medical indemnity company come into line. It will not indemnify someone doing a procedure out of their scope for practice.

Restricting doctors to use their name, which is their AMC accredited name—so you are a general surgeon, you are a plastic surgeon, you are an ENT surgeon—defining which people from RACS, their syllabus that they can do within their specialty, defines. Then the private hospitals will restrict who can do what procedures in their facility. We have pushed for it, as your question is: If you are taking off a mole or you are doing a skin procedure, you can do it in the rooms: not a problem. If you are breaching fascia and going into a deep plane within a body cavity, that should be done in a private hospital where there is an anaesthetist and there are resuscitation facilities. The big perception in the community is that cosmetic surgery is simple and has a very low complication rate. Nothing is further from the truth.

Most of the cosmetic surgery procedures we do have some of the highest revision rates of any surgical or reconstructive procedures we do when you follow them up over five, 10, 15 or 20 years time. All our patients who have breast augmentation sign a contract. There is a 100 per cent revision rate in their lifetime. If you look at the core data from the big implant companies over seven years, it is 15 to 20 per cent revision rate. You have these clinics, like the Cosmetic Institute, that were quoting a less than 1 per cent revision rate. For $599, get your breast augmentation done. The people come back two, three or four years later still paying off that initial procedure and now it is a one-to-two-stage operation that takes three to four hours to fix. It cannot be done in the public sector. It costs these patients $15,000 to $20,000 by the time they do all these types of things. That clinic is now rebranded as Cosmetic Evolution are under a different entity and is doing exactly the same thing in Sydney.

Dr MORADI: There is one thing relating back to your question, Mr Taylor. In New South Wales, after the near misses that we had with this particular institute, conscious sedation has to be done in an accredited facility. I have visited the Cosmetic Institute theatres at Bondi Junction. I have walked in them and done the walk-around. It looks like a proper hospital. It looks exactly like any other hospital and they set it up like that because when they set it up, in fairness to them, there was no legislation to say that you cannot do this procedure. These near misses in New South Wales have been very good in terms of governance because now, any invasive procedure—whether it be liposuction or breast augmentation—has to be done in an accredited facility.

Dr TURNER: But that goes back to HCCC or the Australian Health Practitioner Regulation Agency [AHPRA], which need to be able to enforce these, and there needs to be penalties to enforce it. I know that Professor Mark Ashton did a lot of reviews for the class action with the Cosmetic Institute [TCI]. I did a lot of the initial reviews. One of the things was that they were accredited for light sedation. All their patients went to recovery with Guedels in their airways, so they had an unprotected airway. If you got all those patients' anaesthetic records and reviewed them by anaesthetists, they were all having deep to almost general anaesthetic procedures in an unlicensed facility.

Ms KATE WASHINGTON: I am wondering if the people you are seeing, particularly in terms of revisions of cosmetic surgery, are predominantly women.

Dr MORADI: They would be 95 per cent.

Ms KATE WASHINGTON: Going to your points about their reluctance to make complaints, am I also right in thinking that when you look at the people who are seeking cosmetic procedures, even before they come to that decision they are perhaps are a more vulnerable person, a more insecure person, even before they have made that decision?

Dr TURNER: The patients we deal with, the vast majority, we see patients of all demographics. But, you know, there would be at least a third of your patients who are cosmetic patients that come through your clinic who are vulnerable patients from a financial, social, and economic point of view. Not all of them should get an operation. It is difficult as a surgeon to say no to patients. We have all seen it where you have said no to someone and they have come back 12 months later with a complication from somewhere else. You feel like, had I done the original surgery and they got actually a good result, maybe they would not have got that. But then, if they had a problem, you are managing a bigger issue.

Dr MORADI: If you have a complication, you know how to deal with your own complication. You are not going to palm it off to somebody else.

Dr TURNER: No, and that is fine.

Dr HUSSAIN: But getting to your point—yes, these patients are vulnerable and it is about training in terms of knowing which patients you should operate on and which patient you should not operate on.

Ms KATE WASHINGTON: If I were to suggest that perhaps the political reluctance or professional reluctance to move on the use of title is perhaps a reflection of the people who predominantly are users or consumers being predominantly women. Do you have any views on that?

Professor ASHTON: That is an incisive question. There is absolutely no doubt that there is a gross under-estimation about the extent of cosmetic surgery and about the complications that arise from that. So that, for example, if you spoke to people and they said "What is the incidence of, say, botox injections within our community?" It is unbelievably high. You only have to look at our news readers on our television who are giving us information which is meant to be factual, unbiased and is meant to be setting a role model, and every single newsreader, except one, has botox. So the image and the standards which we are presenting to our young female population to our young kids is that these people have botox: they have a certain look. We see kids as young as 17 or 18 coming in to have botox. It comes back to my original question: That is called selling a Mars bar. And

what you need to do to them is say, "Yes, you might want to have botox but it is inappropriate for me as an ethical professional to do that."

Dr TURNER: I think this comes back to a point made about referral practices. Patients' safety net, whether it is cancer surgery or other medical issues, a lot of the time is their general practitioner who can give them advice, look after them and steer them in the right or wrong direction. These patients go on Instagram, social media and forums and there is no referral practice. They are direct to consumer. This area needs to be more regulated than general surgery as a whole, not less regulated, to protect those patients. I tell all my patients, "What you see on social media, Facebook or their websites is less than 1 per cent of that doctor's portfolio. It is their best 1 per cent not their worst 1 per cent.

Professor ASHTON: To follow up on your question, yes, there are two elements to that. One is that people do not recognise I think that there is a real need for increased action here until something dramatic happens, like Ms Huang dies, and that is when everybody jumps up, "Oh my goodness, we need to do something." And also, as we have talked about before, it is not straightforward. You would think it would be but it is not straightforward because there are lots of people there who are very, very good at talking and very persuasive and downplaying. They will come to you and say, "There is no difference between our training that goes for six, seven or eight months or a weekend and someone who goes into medical school at aged 18 and comes out, on average, at 39." Quite clearly there is, but when you listen to them they sound very persuasive.

Ms KATE WASHINGTON: We have got to somehow overcome the reluctance of reporting so people can understand the magnitude of what is actually happening?

Professor ASHTON: Because it is the young 19-, 20- or 21-year-old kids, the young girls, who are the most vulnerable.

Dr TURNER: The more we can regulate the entry into the cosmetic cycle, and not the outcome of the cosmetic cycle, the further we will get ahead. If we just focus on reporting and the end result we will be in this same position.

Dr MORADI: It is interesting we talk about reporting but as soon as the Cosmetic Institute had a couple of near misses and it became a class action its lawyers got inundated with other people that had similar problems. One person is not going to complain—very much like the—

The CHAIR: It takes the first person to make the call—

Dr MORADI: Correct. And then 200, 220 patients—the last I heard in the class action.

Mr AUSTIN EVANS: You talked about the banning of the phrase "cosmetic surgeon". I refer to the submission of the College of Plastic Surgeons that refers to the definition of "cosmetic surgery". Is the issue to get rid of that designation?

Professor ASHTON: It is. The problem is, again, the crafting of the language has been done so professionally that the terminology has been changed.

Mr AUSTIN EVANS: I am reading that correctly? That is a definition from the Medical Board of Australia.

Professor ASHTON: Correct. So the Medical Board has asked for a definition on "cosmetic surgery". They came to us and said, "Can you please define for us what cosmetic surgery is?" We provided them with a reference, as best we could. I would be much happier and I think it is much fairer on the 22-year-old kid who is trying to find their way through this mire of Internet and social media if the person who is not a surgeon calls himself a "cosmetic practitioner" or a "general practitioner with an interest in botox" or "an interest in breast augmentation". I think that that is a much more honest and transparent way which comes back to being ethical about being a professional.

Mr AUSTIN EVANS: From what I understand a general practitioner under that definition can still do cosmetic surgery but cannot be a cosmetic surgeon? I am confused.

Professor ASHTON: Yes. We would much rather take that term "surgery" out of it. We would much rather say doing thus "specific procedures".

Dr TURNER: This is the issue in discussions of this in the past decade or so, that as soon as you start trying to say "We want to ban GPs doing breast augmentations" then it comes down to ACCC and restriction of trade. We are saying "Let us restrict the title to your official title. Let us define 'cosmetic surgery' and which ANC surgeons can do what procedures." That then dictates which facilities you can do it in and that restricts indemnity companies nursing doctors doing procedures that they are not trained to do.

Dr MORADI: I have had patients say "My cosmetic surgeon says you are a plastic surgeon, you do not do cosmetic surgery and I am a cosmetic surgeon". So that is the sell, as Mark was saying before, "You don't want to go to a plastic surgeon. They are in the public hospital just doing cancer reconstructions and traumas where I am a specialist in cosmetic surgery." Now if you are an upper GI surgeon, you do your fellowship with the Royal Australian College of Surgeons. If you want to sub-specialise in upper GI surgery, you go away on a fellowship. I wanted to do sub-specialty in cosmetic surgery and micro surgery and I went to Sweden and England because I wanted to sub-specialise in that but my training was perfectly good to be a cosmetic plastic surgeon but I chose to sub-specialise just as Ken Loi sub-specialised in upper GI surgery. The sub speciality comes as part of your training not just because you do a one-year private—

Professor ASHTON: I was just going to say quickly, Austin, if you are finding it confusing, and you have us in front of you, and we are trying our best to explain it you can imagine what a 23-year old, walking into a room that is covered in marble with professional staff and white uniforms, they have no hope. They need you—collectively you—to make it clearer to them.

Dr LOI: If you call yourself a "cosmetic consultant" or a "practitioner" do not have the bang as a "cosmetic surgeon" because the moment you mention surgery your mindset is already having surgery. But being a consultant or a practitioner you are not necessarily having surgery by a surgeon.

Dr TURNER: This is why we think it needs to be more regulated than less because they do not have their GP to fall back on and give them advice. It is direct to consumer. As soon as it is direct to consumer and there is money and it is a low barrier to entry—you like at airline industry or any industry where it is completely, you know, the safety margins come out of it, the costs drive down and complications go up.

The Hon. LOU AMATO: Did the college receive complaints about surgeons or other practitioners? If so, what does it do with those complaints? Professor Ashton and Dr Hussain mentioned there should be harsher or stiffer penalties. Who adjudicates over that decision process when someone has done the wrong thing? How are those penalties imposed? How are they determined?

Professor ASHTON: Currently what happens is that it is referred through AHPRA and then if you even know where the AHPRA web site is, and know how to navigate your way around it, you can type in a particular surgeon who has done a misdemeanour and you can see that they are on a series of probationary measures which are dictated what is going through. But the actual original crime, what they have done, is never specified. What ends up happening at the moment is that we can, as a society, when one of our members—for example, we have had a member who we thought was acting unethically, acting immorally, and was not looking after his patients as the primary goal.

We asked him, we counselled him, we spent some time with him. We also asked him to sign an understanding, an ethical code of conduct, which he said he could not. So he was discharged from our society. We take that whole thing about ethical, moral professionalism very seriously indeed. The patient must come first. If they do not do that then all we can do is to stop them from our society—in the same way as the College of Surgeons, if someone is behaving badly, can discharge them from the College of Surgery—but it does not stop them practising.

The Hon. LOU AMATO: Although you have stopped them in your society, how do you let the community know that this person has done the wrong thing and they should not go to them? We are talking about ethics and morality here.

Professor ASHTON: Correct. That person is no longer able to call themselves a member of our society and if we are contacted by patients we will explain to them, "I am sorry but he was unable to sign our code of conduct". Again, we have to be very careful because these guys—remember we talked at the start—this is a multibillion dollar industry and these guys are really lawyered up. So if you go after them, try and restrict their trade, try and kick them out, they say, "You are taking away my livelihood." They were will then go you in the courts and you can chew through an enormous amount of funds very quickly. We would like to have the Attorney General have a situation where we can say, for example, "This particular individual has behaved unethically or immorally or did not meet our code of conduct and on those grounds we have dismissed that person." We then make that public and if that person goes us for defamation or loss of income we do not have a situation where at the moment it goes to court and costs are awarded evenly between two parties. So even if you do the right thing as a society and you get rid of the bad apple, they still sue you and you can still end up with—as we did—a $250,000 legal bill.

The Hon. LOU AMATO: Other industries have their own code of practices and if you trade or perform certain services in the community there are a set of rules and regulations determined by that body and if it comes

to attention that someone has breached those rules and regulations those penalties are imposed by that body. However, you are saying that you cannot impose those penalties and say, "This person is suspended."

Dr TURNER: AHPRA can.

Dr HUSSAIN: Exactly. Can I add to that? We have had a situation where we have referred some of our members as well as other practitioners to AHPRA, which is the governing national body. We have made representations to AHPRA and two, three years down the track they are still pending. My point is that, unfortunately, AHPRA does not have the resources to investigate these things and then to hand-out significant penalties. So these just sit in AHPRA with nothing happening to them.

The Hon. LOU AMATO: Earlier you mentioned harsher or stiffer penalties. Can you elucidate on the type of penalties you would impose?

Dr HUSSAIN: My understanding is that at the moment penalties might be around $5,000 or $10,000 but when you are talking about someone who is making hundreds and hundreds of thousands of dollars that is minimal. What we are saying is that we need stiffer penalties—make it $100,000. Then you will actually send a better message to these practitioners and to the community that there are sufficient issues here and there are significant penalties. But also—as Professor Ashton alluded to—it might actually give a funding stream to AHPRA to better enforce their own regulations.

The CHAIR: I note the time but I am happy to go over because the evidence given this morning has been incredibly beneficial.

The Hon. WALT SECORD: Dr Moradi, thank you for your earlier evidence. Unfortunately, I have highlighted problems at The Cosmetic Institute. They were relentless in threatening to sue me and tying me up but you are under parliamentary privilege so you are fine. I understand 220 cases have come forward involving the people who operate at Bondi Junction and Parramatta.

Dr MORADI: Yes.

The Hon. WALT SECORD: I think they are an absolute disgrace. How did you feel when you saw examples of people who were treated by them showing up in your hospital?

Dr MORADI: I can take it back a bit further than that to the genesis of the society. An Australasian Society of Aesthetic Plastic Surgeons [ASP] member was one of the medical directors and two businesspeople. By pure coincidence one of the businesspersons was a family friend of mine whom I have known since I was a child. He asked me to join right from the get-go. I said, "I do not like the model. I am not going to join." It was at my brother's wedding when he said, "Would you like to join?" and I said, "No." I have always had this connection with it from that point of view. He would always tell me about what they were doing, how well they were doing and blah, blah, blah, "We do not have any complications." But when all this started to happen he said to me, "I just thought everything was okay. I did not realise that we were doing anything bad. We outsourced all this to our medical director. We thought he was in charge of everything."

In the first year you do not see it, then it is all these complications and, as Dr Turner said, anybody can do a procedure but it is the longevity of that procedure. For them it was just doing one operation, one implant. So if you have a hammer, everything looks like a nail. So most of their complications came from poor decision-making, not realising what operation they should do—that was from an aesthetic complication. Now all the life-risking complications that came in, one to Westmead—where I used to be a consultant and I heard about it—and then this one, were all related to incorrect techniques in overdosing of local anaesthetic because they could not do proper full anaesthetics. How did that make me feel? It may be frustrated because it was not fair for the patients. All the patients were 18- to 25-year-olds. There were very few older patients.

The Hon. WALT SECORD: So they were young women?

Dr MORADI: Most of them were young women, correct. It is frustrating because I have seen it from the genesis of it and I have seen the complications of it at both public hospitals and in my private practice. My clinic—believe it or not, even with my family connection to that gentleman—got a legal letter from their lawyers, a defamation letter because on one of our social media posts we talked about twilight sedation and being aware of cheap cowboys. I got a letter from this lawyer saying, "We are going to sue you for defamation." I was like: Okay, that is a bit scary.

Dr HUSSAIN: It makes you angry because right from its establishment we knew the outcome, we knew there were going to be complications, yet you feel powerless to do anything about it. That is exactly what has happened.

The Hon. WALT SECORD: Two hundred and twenty young women?

Dr MORADI: Have taken action against them.

Dr TURNER: That 220 is probably less than 5 per cent of the real number to be honest.

The Hon. WALT SECORD: So this is just a little tip of the iceberg?

Dr MORADI: Yes.

The CHAIR: I am mindful of the time.

Dr TURNER: I just wanted to make one point. We have talked about the amount of money involved. After 18 months The Cosmetic Institute [TCI] was listed in *BRW*'s 20 fastest growing companies in Australia. After 18 months of setting up, that organisation was in the top 20 fastest growing companies in Australia. That shows you how much money is involved and when the college is trying to sue them it is really difficult. The other point we were making before about penalties and enforcement, there are numerous examples over the past decade where a number of surgeons have been restricted or removed from the public hospital system and then continued to operate for multiple years as a private entity unrestricted because as a private entity they are bringing in money. So the public patients are more likely to be protected from these so-called surgeons than private, full-fee paying patients who are just going direct to entry.

The CHAIR: I will ask the closing question. One of the statements made earlier today was about COAG and having a continuity of terminology.

Professor ASHTON: Yes.

The CHAIR: You mentioned that Queensland, New South Wales and I think Victoria are in agreement with that?

Professor ASHTON: Yes.

The CHAIR: Can you confirm which States were not in agreement?

Professor ASHTON: We have been to see Perth as of three months ago. I think they are reassessing and re-evaluating what is going on. South Australia, as you know, has recently undergone a change of government so we are in the process of going to meet them. Tasmania we have spoken to on many occasions. I am 99.9 per cent sure they would be in agreement but I have not got a formal sign-off from them. Perth was the one—it was one of the most unbelievable meetings. We sat down—like we are sitting here—and this language came back at us. Like we were talking about before, it is the language. These guys are professional, well instructed narrators and they twist the language.

I am going, "Hang on, what? The Australian Medical Council is not very good at what it does; they have got it all wrong. This particular body here is the best trained to perform this work?" It took me 15 minutes to try and explain. So we will be back in Perth and see what we can do. Look it comes back—we talked about TCI briefly but they were really effective at selling Mars bars. It had nothing to do with the patient; everyone got the same operation. Dr Turner and I see most of their patients–I have seen a lot of their patients. These are kids who just simply had the wrong operation and someone should have said no right at the get-go.

The CHAIR: Thank you all for appearing before the Committee today. The Committee may have some additional questions to put to you in writing. Your replies to those questions will form part of your evidence and will be made public. Would you be happy to provide a written reply to any of those further questions?

Professor ASHTON: Yes, we would.

Dr HUSSAIN: Absolutely. Some of the photos I have given will possibly need explanation. I am happy to do that.

The CHAIR: The Committee secretariat will write to you about that.

(The witnesses withdrew)

(Short adjournment)

SAXON SMITH, Chair of the NSW Faculty, Australasian College of Dermatologists, affirmed and examined

The CHAIR: Would you like to make an opening statement?

Dr SMITH: I am here representing the Australasian College of Dermatologists, where I am the Chair of the New South Wales faculty. We look after the whole of New South Wales. The Australasian College of Dermatologists is the sole medical college accredited by the Government—the Australian Medical Council—for the training and continuing professional development of medical practitioners in the specialty of dermatology. Dermatologists are specialists in the diagnosis, treatment and management of all skin conditions and skin diseases. Dermatologists' skills and expertise span medical, surgical and procedural areas of dermatology, including laser technology and injectable treatments which are also used for cosmetic purposes.

The CHAIR: This inquiry is looking at how unregistered cosmetic health service providers could be better regulated. From your perspective, how could the Government and the Health Care Complaints Commission better regulate those issues?

Dr SMITH: The two main issues are what regulation frameworks are in place and the visibility of what is happening out there in the community. Cosmetic services around Australia and the world have expanded almost exponentially over the last 10 to 15 years. It has come to such a point that people feel that it is something that you just do on a whim, without recognising that all these procedures are just that: medical-based procedures. Potential risks are associated with them.

In a regulation framework, because there is management to be made in a system that is not covered by Medicare, we have difficulty in having great visibility into how many procedures are performed and who performs them. At the moment in New South Wales, there is no regulation around who can own and operate laser and intense pulsed light-based devices. This is different than in Queensland and Western Australia which have at least that minimum standard of a laser safety officer certification. At this point in time in New South Wales potentially anyone could buy a laser and start using it for whatever reason.

When we look at injectables, we are governed by the Poisons and Therapeutic Goods Act in New South Wales because it is a Schedule 4 medication. The injectables include Botulinum toxin A and the various filler-based products which are injected into the dermaplane as collagen boosters and collagen replacements. Because they are governed by Schedule 4, they are to be prescribed only by doctors and dentists and are to be administered by doctors, dentists and nurses under direction or supervision. The issue is that the Poisons Act is decades old. The cosmetic services space has rapidly evolved recently. The Poisons Act is not keeping up with what we are looking for, what we need for protection and to ensure quality service and safety for the community.

The CHAIR: Previous evidence referred to the lack of national standardisation regarding terminology and accreditation. In your answer, you talked about legislation regarding laser devices in Queensland and Western Australia, but not in other States. Is this something that needs a national standard that can be rolled out across States to provide a consistent message and accreditation process?

Dr SMITH: I think we need a national framework. I know that this has been discussed at Council of Australian Governments previously. That is because people cross borders. Albury Wodonga used to be the example in New South Wales because only a few blades of grass across, suddenly it was a different State and a different jurisdiction. When the Medical Board of Australia was formed, we moved to a national registration process. Prior to that, if I was working in New South Wales and the Australian Capital Territory—which I did at one point in my career—I needed two registrations in two different States.

National frameworks are important because we are talking about the mobility of a population. People will seek services where they want, particularly in the cosmetic setting. Furthermore, we are talking about the corporatisation in a lot of areas of cosmetic services. Therefore, these would, by definition, cross State boundaries. When we have franchising processes and large corporate entities owning any clinic- and business-based operations around the country, we need a national framework.

The CHAIR: As part of this inquiry, the Committee is looking at the ability of HCCC to highlight to the public potential dangers for some providers if necessary and the services that people can complain to. What would you suggest that the HCCC could do more in your field to be able to provide those services? If you went to HCCC as a member of the public, what do you expect it to say?

Dr SMITH: A member of the public going to HCCC would expect to have their complaint listened to and some outcome from it. As we know, there are challenges about the powers within the HCCC. It has obvious powers. It investigates issues with any medical practitioner or registered practitioner which includes nurses and dentists in this setting. But when you move towards beauticians and laser operators without that framework of

regulation around them, it becomes increasingly difficult. More importantly, when you look at corporate responsibility and large corporate organisations owning many clinics in a State or across the country, where does that responsibility go and what powers does the HCCC have to prosecute them? At the moment, a disproportionate responsibility is placed on the practitioner—be it nurses, doctors or dentists—compared to corporate entities. Furthermore, we have to ensure that the HCCC has powers so that a corporate entity cannot just declare themselves bankrupt and move on and abdicate any responsibility for misadventure and adverse outcomes for their patients and clients that have seen them.

Mr AUSTIN EVANS: You mentioned the botox stuff, and that one has been mentioned already today as well as in a number of submissions. You are saying it is regulated but you did say the regulation was decades old and needs updating. You also made the comment in your submission about it being just flouted. What can we do in that space where we do have a regulation and it is being flouted? Is it just a question of throwing resources at it and enforcing it?

Dr SMITH: I think it is critical in this space to put resources into the HCCC to ensure that we can investigate, and that includes going into clinics to see practices that are happening.

Mr AUSTIN EVANS: And at a New South Wales level rather than at a national level? Where is the best place to target that?

Dr SMITH: New South Wales, I believe, leads the country in terms of our complaints in health care with the HCCC. We fought very hard to ensure that the HCCC retained its powers when we moved to the national board structure for health practitioners, and many States look towards us as one of those leaders in this field. I think it is really important that we acknowledge the work that the HCCC does and acknowledge the vision of maintaining the HCCC in New South Wales but resourcing it so that it can do its job in this particular space. We know in terms of the clinics that are around that this is happening.

There is an ethical discussion around the role of Skype or videoconferencing for medical consults versus a face-to-face. As you would see in our submission, as a college and being one of the two Federal Government accredited colleges in terms of qualifications for cosmetic services, we believe in face-to-face because it is the appropriate thing to ensure the best outcome for patients. Particularly when you look at teledermatology, you lose that 3D picture, and when you are talking about cosmetic services it is all about that 3D picture.

The Hon. LOU AMATO: In regard to laser removal, that also happens in the tattoo industry because a lot of people know that obviously they have made a bad choice and they do not like the tattoo. What sort of regulations are there in regard to the tattoo parlours and so forth?

Dr SMITH: My understanding is that at the moment—

The Hon. LOU AMATO: Do they have qualifications and so forth?

Dr SMITH: That is what I am about to answer. My understanding is that given there is no regulation in New South Wales there is no qualification for a tattoo parlour to have in one door the ability to put a tattoo on and in the other door to take a tattoo off.

The Hon. LOU AMATO: What sorts of things could the Government do to impose those regulations?

Dr SMITH: Clearly what we have is looking to Queensland and WA as a minimum standard where they have a laser safety officer certification prior to being able to own or operate a laser in that sort of pseudo health setting, and that is where we start to get some of that greyness around the edges where you start to move in this pseudo health setting. So that would be the minimum sort of requirements, I would expect. Certainly it is something that I as a dermatologist have done as well, being qualified within the public health setting. In New South Wales public hospitals, if you are a doctor and you are using lasers you have to have done a laser safety officer certificate, but that is a regulation, not within public hospitals only. But if you talk about the State, you would expect to have that as the minimum requirement.

The Hon. LOU AMATO: That means somebody who has not done a medical degree could just do tattoo removing.

Dr SMITH: Absolutely, and it happens. It is not "could"; it happens.

The Hon. LOU AMATO: Is there a course? Is there something out there that they are doing?

Dr SMITH: You are asking a question I cannot answer specifically in terms of there will be people who can buy a laser and start using it. I expect the companies that are selling the laser generally—and I know from experience because as a dermatologist I run laser systems—do training on their system because they want the best outcome possible for their product; they do not want bad outcomes and a bad reputation. But abdicating the

responsibility of education to the companies alone is not where we should be and we should have a regulation framework that is clear and reproducible and reliable so that we have at least a minimum trustworthiness in this situation so the public have safety and a measure of understanding what is going around.

The Hon. MARK PEARSON: Are you also representing the Australian Medical Association at this moment?

Dr SMITH: At this moment I am not; I represent them in the next session of evidence.

The Hon. MARK PEARSON: In relation to what you said about the Poisons Act needing to be reviewed and maybe brought up to speed with the recent developments in relation to cosmetic surgery, are you suggesting that there be rescheduling of certain drugs or a special schedule put in place for the types of substances or drugs that are being used in cosmetic surgery or another amendment to the Poisons Act?

Dr SMITH: When we look at the Poisons Act we are specifically dealing with injectables as opposed to surgical components. We would be looking at products within the botulinum toxins, toxin A in particular, and also the filler-based products. These are injectables which you penetrate their skin using a needle or a cannula, which is a plastic sort of delivery point. People may have had an IV cannula for infusions but we use that for fillers to give a better placement. So there is not a surgical cutting of the skin but there is still penetration of the skin with a needle—I think it is important to make that distinction. What we have at the moment is actually a strong legislation; the difficulty is in enforcing that legislation, and also terminology. The terminology specifically relates around the words "directional supervision" in terms of the nurses being able to do these injections.

If we extrapolate out from the rest of medicine—I work in a public hospital and I have done for decades—we have directional supervision around delivery of antibiotics through the hospital and the home programs; we have dialysis, we have chemotherapy delivered at home through nurses. You have a doctor who has done a full formal assessment of that patient as a face-to-face assessment, not over a Skype or a phone or a photograph, to then decide what is the best course of action for that patient, and the nurses who are appropriately trained and appropriately credentialed with their degrees and the medical board and the ongoing continuing professional development [CPD] deliver those services and a doctor does not have to be there for that service to be delivered.

Needing to define exactly what "directional" means in the Poisons Act with respect to these particular products, being the botulinum toxins and fillers, I think that is going to be an important step, but I think it is important to recognise that it does not mean you have to have a doctor over your shoulder to do it, because that would be contrary to how they do a lot of other health care. So we have to put it within that framework, but ensuring that it is representative of all framework because it is a medical procedure.

The Hon. MARK PEARSON: Do you think one safeguard—even though the practicableness of it might be in question, considering that we have learnt just recently that probably the highest proportion of people who seek cosmetic surgery are very young women—would it be appropriate for it to be a requirement and mandatory that there be a referral from a general practitioner after a face-to-face consultation with the client before any practitioner or surgeon or whoever or whatever can do anything?

Dr SMITH: That goes outside the scope of my submission in terms of dermatologists because whilst we do surgery—and I do a lot of surgery; my substantive role at Royal North Shore Hospital is a dermatologist surgeon in terms of skin cancer—we do do a lot of cosmetic procedures. We are not the ones doing the breast augmentations and the nose jobs et cetera, so I think that would be best directed to them. But in principle, what you would also have to recognise is that given this is not anything Medicare rebatable, then asking someone to go to a general practitioner to try and claim potentially a Medicare rebate for something that is not, by national legislation, rebatable would be a challenge. But I absolutely believe, and the college absolutely believes, in face-to-face consultation by the person providing the services to ensure the best outcome, the best consent, but, most importantly, that the patient has direct eyeball sight on who is responsible for their care.

I certainly have patients and clients who have come to my clinic having had misadventures and adverse outcomes from other facilities. They have gone back to those facilities to complain and ask for help to be told that the facility does not have responsibility for them because it is a corporate owned facility—it is a different beautician or nurse who has done the procedure. The particular scenario a week ago was a laser hair reduction procedure. I do not know what laser they were using. The patient received significant burns on their arms. It looked like disks all over their arms. She went to the head office of the corporate entity which owned the overarching clinics but was told that this is a franchised operation so the overarching corporate entity has no responsibility either. Unfortunately, the patient is left in a quandary about who they see and how they fix this. They have to seek alternative advice to try and fix a problem which is not always fixable.

The Hon. MARK PEARSON: How does the Australasian College of Dermatologists define an invasive procedure if there are procedures taking place on the skin or the subcutaneous tissue which do not require an incision?

Dr SMITH: I think there is very good regulation and definitions about that already in both State and Federal legislation and certainly under the governance of the medical boards. I think that is already covered, and I do not think we can give you a better definition than what is already out there.

Ms KATE WASHINGTON: Your submission talks about raising public awareness through a New South Wales Government led targeted education campaign. What would that look like, in your view?

Dr SMITH: I think it is really important because we have this advent where there is almost a normalisation of the process to go and have cosmetic based procedures ranging from things on the lower risk scale, such as laser hair reduction, through to the significant risk scale of breast augmentation and the like. This is a broad scope and it is a challenge for you as a committee, I recognise. But the normalisation of cosmetic procedures means that people do not realise that all of those procedures, from go to whoa, constitute a procedure. There are risks; there are adverse outcomes that can occur. It is important to have appropriately trained providers of those services. I think it is really important from a government point of view to raise awareness so that people have a consciousness around needing to ask for qualifications from who they are seeing and about the systems that they are using and being able to accept that they can say no, and not be talked into extra things that they do not need.

Unfortunately, some of the corporate entities run incentivised contracts for their staff members. It is like a "would you like fries with that" scenario, where the employee is paid more if they can talk them into having other procedures or having more of the same procedure, such as fillers. Having more filler injected makes more money for the corporate entity. I think that is really important as well and is something that is within the scope of this Committee that needs to be considered, and also the HCCC having powers around that. Incentivised contracts are not in the patients' or the public's interest, for obvious reasons. Rather than simply just reminding people, as we do—rather than relying on tragic and unfortunate events to raise awareness—we should be proactive.

The Hon. WALT SECORD: Earlier you mentioned that anyone can buy a laser and use it. Do you stand by that? Is that correct? Is there nothing to stop me from buying one tomorrow and hanging up a shingle and removing things?

Dr SMITH: That is largely correct, it is my understanding.

Mr AUSTIN EVANS: Up to a certain level.

Dr SMITH: Up to a certain level. You have grades of laser or laser equipment. There is one that you can buy and there is one that is restricted to medical practitioners, but there is a lot of bandwidth within that.

The Hon. WALT SECORD: You must see this in your practice and through your university work. What are people actually using the lasers to do? What are they removing? What are the kinds of procedures that they are undertaking?

Dr SMITH: There are a range of lasers that are available. This operates on the physics of it. It is something that is really fascinating; I enjoy it, but I will not bore you with the physics.

Mr AUSTIN EVANS: No, no, we are all riveted.

The CHAIR: Mr Secord wants to hang up a shingle!

Dr SMITH: I realise that. There are basically three targets within the skin when you look at lasers. A laser hits those three particular targets; they are called chromophores. Essentially, the red blood cells are one target. Colour, which is the melanin in the skin—it is produced by melanocytes—is the second target. Water is the third target. Different laser systems target those to different degrees. There are beautiful little graphs which you can get pictures of; they are probably in submissions somewhere. No one laser system targets everything precisely, but each would target one thing more than another.

Knowing that you want to treat the dark spot on your cheek we would choose a laser that targets melanin specifically or more so than any other target point. That is a different laser system than for treating your red blood vessels, which we all get as Caucasians in Australia across our faces. It is a combination of sun, ageing and rosacea. Then you have resurfacing targets, which is almost like a woodwork plane, where you shave off the skin or resurface the skin. That would be targeting water with things like CO2 lasers and the like. What can we do with lasers? There is a huge scope. I treat patients for laser hair reduction, which targets the melanin in the hair. If you have fairer skin and darker hair you get a better result than if you have dark skin and dark hair.

More importantly, if you are like me—you cannot tell because I have a short haircut—and you are going very grey, once the hair is grey you cannot target that. It is not the target point any more, and that is not the best outcome for you. Obviously, being a Caucasian I expect to get redness. So we use vascular based lasers. There are few different types of those to treat the redness and things from the blood vessels. There is a Medicare item for the severity of some of these legions—particular with blood vessels. It is 14100, within the Medicare online. There are other pigment things on people with birthmarks. There is a thing called a café au lait macule, "café" referring to coffee and "au lait" being the milk we put in it. It is a brown pigment macule which we can treat. Again, there are Medicare item numbers for that. There is another one called nevus of Ota, which is a dark pigmentation—a deep mole, I guess—on the face, which can be quite significantly disfiguring for patients. We can treat that.

The Hon. WALT SECORD: Do you find people engaging in these procedures without proper medical qualifications?

Dr SMITH: We find there are people engaging, particularly in laser hair removal. Rejuvenation is one of the other things you can do. That is promoting the collagen turnover to improve the quality of your skin. That is something that is done by non-medical practitioners. Obviously the items I have talked about, which have Medicare item numbers, are restricted to Medicare practitioners specifically. There are other devices which are not laser based which do skin tightening—anti-ageing and anti-wrinkling. There are lots of things you can do.

The CHAIR: I am mindful of the time and we have another witness coming in so I will conclude with a couple of quick questions. You mentioned public awareness and being able to message that. Do you have an example of how another jurisdiction may have done a public awareness program that could be emulated in New South Wales? If so, what would you suggest? The second part is, through the HCCC do you think there is something that can be done to promote the HCCC's ability to investigate and/or deal with people that are inappropriately using services in your field?

Dr SMITH: You first question was about raising public awareness through advertising and the likes. There is no jurisdiction in Australia that has done this well. Across the world we have struggled with it. So there is not a great pool to give you the best place to go. It is something that many of us are grappling with. As a nation we are grappling with this so each individual State government would be looking at something similar.

The CHAIR: Can I just interrupt you for a second? Do you think that it is a responsibility of government to run those sorts of programs. Do you think the industry should be heading it up or do you think it is something the HCCC should be doing?

Dr SMITH: I would expect that, given that this is a public health concern, and is to do with ensuring quality and safety for the general public, it would fall more on the onus of either the government or the HCCC.

The CHAIR: Your college expressed concerns, also, about the issue of a data gap in your submission, about cosmetic health services and collecting data. The HCCC obviously focuses on the data it collects and how it implements that. What more can be done to address that data gap in your own industry?

Dr SMITH: The data gap exists because we are talking about things that do not have a Medicare item number associated with them. We are not calling for Medicare item numbers for these things. There is nothing that has a tail on it so that you can process it. We have big data otherwise. We know what happens with the Medicare spend around the country. In healthcare dollar terms we know what is happening. We know how much the State Government spends and how much the Federal government spends, because there are numbers to it. When you talk purely about cosmetics there are none of those numbers; it happens in isolation. That is where the data gap exists. We truly do not know what the rate of growth in the cosmetics field is. We can run off surveys which give you some of the information, but it is not accurate. Therefore we do not have great oversight as to what percentage of people have complaints. We need to know those things.

The CHAIR: Thank you, Professor Smith for appearing before the committee today. We may send you some additional questions in writing with regard to the evidence you have given, which will form part of the evidence which will be made public. Would you be happy to provide a written reply to any further questions from the Committee with regard to that?

Dr SMITH: Yes, that is fine.

SAXON SMITH, Councillor, Australian Medical Association, on former oath

DANIELLE McMULLEN, Vice President, Australian Medical Association, affirmed and examined

The CHAIR: Dr McMullen, would you like to give a short opening statement before we begin our questions?

Dr McMULLEN: No, you have the submissions from Australian Medical Association [AMA] New South Wales.

The CHAIR: We have heard about data. Do you believe it would be beneficial to collect data on the number of types of cosmetic procedures being performed in the country? First, who would be best placed to collect that data? Secondly, how can regulators stay abreast of the emerging treatments and their associated risks?

Dr McMULLEN: Data is useful to us. As Dr Smith explained recently, it would be helpful to have an idea of how many of these procedures are happening, but the big question is how would we collect that data? At the moment the cosmetic industry is so widely spread, as we have heard from medical centres, and being done by doctors and other health professionals through to the pseudo health space in beauty clinics across the country, so I think it would be difficult to collect that data. I do not have a clear idea of how we would collect that.

Dr SMITH: The principle is that data is absolutely important; we know the value of data. The first question is: how do you go about collecting it across such a disparate source? That is the bigger challenge that needs to be faced as a State or a country. That needs to be solved first before you can look at what you can do with the data and what information you get from it.

The CHAIR: In addition to a question I asked before, Dr Smith, from the AMA's position, do you believe that there should be a centralised information source for consumers who want to undergo a procedure? We heard evidence earlier that it is effectively doctor shopping to some degree. While we cannot legislate about people not being happy with the answer they get from their first couple of sources, do you believe the Government or the HCCC can do something whereby we provide an easier way to access the information about the services that are provided, the accreditation those people have received, what you should expect and the questions you should be asking of those providers?

Dr SMITH: It is not just, as you were describing, doctor shopping to find the next doctor. It is actually clinic shopping. They will go to any provider who provides what they want and how they want it.

Dr McMULLEN: I think that would be very helpful. As we have heard in previous submissions, educating the public that procedures are procedures in an environment where there is more cosmetic work being done and it is being taken as go down the street and have your laser hair removal and then added on to that, "While you are here, see our nurse and talk about rejuvenation with this laser." Consumers are losing sight of the fact that these are health-related procedures, especially when they are being provided in that pseudo health space. Education to consumers about the fact that these procedures can have risks associated with them would be beneficial.

As you said, the information about what regulation exists, what mode of complaint there is, because consumers do not necessarily recognise that it is a health procedure, especially if it is not being done by a health provider, they then do not know that the HCCC is the appropriate complaints body. We feel we are seeing an underreporting of complaints or issues about complications. Also, as a doctor—I am a GP—providing information to patients about that, it would be helpful to know that there is a strong regulatory framework in place so that we could trust that providers performing procedures are being appropriately regulated.

The CHAIR: As a GP, do you find that predominantly most people are coming to you after they have had a procedure and there is an issue with it, rather than seeking your advice as a GP prior to having the treatment? Does Patient X come in and say, "I have this mole", whatever it might be, "what do you think I should do?" Or do you find they are coming to you after they have had the mole treated and there are side effects that they were not expecting or that were not explained to them?

Dr McMULLEN: In my personal experience I have not had someone come to me afterwards, but I have had people come to me before with a complication. That is probably just luck. I have had people come to me beforehand and say, "I have this cosmetic issue. What should I do about it?" That is where being able to trust the regulatory framework would be helpful. We encourage people to come and see us as GPs to talk about all aspects of their health care and having a strong regulatory framework in place so that we know we can trust where we are either referring them on to or encouraging them to seek help, as you said, that information base about what questions to ask, what regulations exist, what is the difference between having your laser done by a dermatologist versus having it done by a beautician.

Dr SMITH: While we are talking about that information and the need for trust so that people can get the right information, at the moment that information void is being filled through advertising both on social media and mainstream media. I will point out it is an uneven playing field. As a medical practitioner, I am highly regulated in what I can and cannot say in respect of promoting a service or practice. As a corporate entity, you are not under the same restrictions. I am not allowed to incentivise people to come and see me, but clearly if you have a coupon to get your treatment for X amount of dollars and they are able to upsell something else at the same time, it is a very different world. That is another reason that we, as the AMA, believe it is important to have that place to go to and why it is important to have that public awareness.

The Hon. MARK PEARSON: Has there been consideration that what these unregistered operators are doing in respect of the consumer could be considered to be misleading and deceptive conduct under the Australian Consumer and Competition Commission, considering the evidence that is coming in about how often things can go wrong or expectations are not fulfilled? Is it possible that there is a misleading and deceptive process in place by these operators or so-called surgeons and so-called practitioners?

Dr SMITH: I guess we would have to take that on notice. It is a bit of a challenging question. Because it is such a complex field, if someone purports to be a doctor and they are not a doctor, it is a criminal matter, as you would be aware. If someone purports that they can operate a laser but they are not a doctor, at the moment there is no regulatory framework to say that they have to say anything other than they can operate a laser. That is the breadth of what you are asking.

The Hon. MARK PEARSON: Partly, but, mainly, is the promise to deliver X, Y, and Z for the patient misleading? Is it misleading, considering everything we are looking at? We are here because this is getting out of control and a lot of people are suffering consequences and are being taken down a path which could be considered to be a misleading and deceptive process. It would be great if you could take it on notice. Your lawyers would probably want to turn their minds to the question.

Dr SMITH: Correct. One question, though, is in whose minds is it actually misleading? There could also be unrealistic expectations from the patient or client who is attending for whatever procedure or process that they are. That then comes down to the onus on being told the right information and going to the right sources. I think that misleading absolutely happens. Deceptive implies an extra negative connotation, which, as you can tell, we are struggling to answer because of that. We will take it on notice.

The CHAIR: We should refer to people as patients rather than clients, and that is also part of the issue, they are seeing themselves as clients of a service rather than patients because they are undergoing a procedure. Is the question to ascertain whether the expectations of the person walking in the door are being underestimated?

The Hon. MARK PEARSON: Yes, that is part of it.

The CHAIR: You can take the question on notice and come back to us after the hearing.

Dr SMITH: I can answer that in brief, but we will take it on notice. Essentially, one of the key things when you are dealing with the cosmetic space is ensuring you meet and discuss with that patient the value of that face to face consultation with the doctor. To be able to do that is critical because you are then able to marry expectation with what can be realistically achieved. You can talk about what it is that they want out of a procedure. Then the art to doing this properly is being able to say no. If you are in a situation as a doctor, we do that all the time. We are able to say no, and should be able to say no. If you are on an incentivised contract working from a different clinic, it is very difficult to say no.

The Hon. MARK PEARSON: And there's the rub.

Ms KATE WASHINGTON: In the AMA's submission you are suggesting that the Health Care Complaints Commission does not currently have the power to regulate the cosmetic service industry and that the public is not aware of the complaints process that exists. There is an awareness issue there. Do you have thoughts on how the HCCC could increase its awareness? It also suggests that there is little point because the HCCC does not have the regulatory authority to act. Is that what your intention is?

Dr SMITH: One of the key outcomes we would like to see, and one of our key points and recommendations within the AMA submission, is to ensure that the HCCC has the power to not only look after the health care practitioners who are under a regulation framework, but also the critical component here is the ones that are not under a regulation framework, and more importantly, the corporate component that is associated with that, so that a corporate entity cannot just declare themselves bankrupt, move on and take no responsibility for things that have happened. I think that is key. We also believe that the HCCC should be appropriately resourced to ensure that they can do that.

Ms KATE WASHINGTON: In terms of awareness, so that people know to go to the HCCC with a complaint, we need to address that and understand the enormity of the problem. How does the AMA see that being done?

Dr McMULLEN: That gets to that education campaign that we have been talking about, making consumers, patients, aware that the procedures they are having are health-related procedures and that therefore regardless of who is providing that procedure that the HCCC is the appropriate complaints body. I think there is a lack of awareness around that at the moment. Then, as Dr Smith said, once that complaint has been escalated more resourcing and powers to the HCCC to be able to follow through and investigate those complaints, both with regards to practitioners but also that corporate responsibility, which is an area lacking at the moment. Those two aspects, and the resourcing to be able to investigate potentially, in the absence even of a complaint. We have touched on it a little bit, better resourcing to patrol or to enforce the regulation that exists at the moment so that we are catching things before big errors happen.

Dr SMITH: Also, it is important to empower the community to know that there is that process to go to the HCCC. At the moment all too often patients think, "I knew I shouldn't have gone there" and they accept that it is their fault for having gone somewhere they knew they should not have gone to, therefore it perpetuates because nothing gets done about it.

Ms KATE WASHINGTON: So how do we overcome that?

Dr SMITH: By public awareness campaigns. We did talk before about are there ones around that we could borrow from. While we may not have one directly related to the cosmetic services industry per se, we have excellent resources within New South Wales and within the New South Wales Government. The Cancer Institute NSW have had a very successful campaign using social media for the skin cancer awareness campaign called Pretty Shady where they used social media targeting 18- to 30-year-olds in particular, and we know this is a key segment of the market. They went into the place where they interact with news and media. They do not buy a newspaper. They do not listen to the radio. They have got Spotify. They have their apps and they digest things in a different way, but they are on social media a lot and Pretty Shady was a very successful campaign for skin cancer awareness. That is something you could build upon and leverage off already existing experience with the New South Wales Government and within the framework around New South Wales.

The Hon. WALT SECORD: Dr McMullen, where does the AMA NSW stand on the current discussions about people calling themselves cosmetic surgeons when they do not have the qualifications to call themselves a cosmetic surgeon?

Dr McMULLEN: That is a complicated question around training and accreditation and we felt that is outside the scope of the questions pertaining to this inquiry. Our recommendations are around the regulatory framework, making sure that the consent processes for people undergoing procedures are appropriate and that the people providing procedures are appropriately trained and qualified. But the questions around nomenclature are complicated and outside scope for this.

The Hon. WALT SECORD: Would you have AMA members who would have medical training or would be calling themselves cosmetic surgeons?

Dr McMULLEN: I cannot answer that today. We can take that on notice.

The Hon. WALT SECORD: If you do, can you tell us how many there are?

Dr McMULLEN: We can attempt to. I can take that on notice and see if we can provide that information to you.

The Hon. WALT SECORD: Has it come to your attention? Are you aware of any members who have basic medical training, general practitioners [GPs], but would be engaging in activity in which they would call themselves cosmetic surgeons?

Dr McMULLEN: I would like to clarify that GPs have specialist medical training. I can take that on notice also.

The Hon. WALT SECORD: Are you aware of any members who have been brought to your attention who are concerned about engaging in that practice?

Dr McMULLEN: I am not aware at this stage.

The Hon. WALT SECORD: Can you take that on notice and have your executive director or senior management investigate that?

Dr SMITH: We may or may not be able to have that information because it comes down to what our member purports to them on their membership to be.

The CHAIR: It is up to them to report their qualifications.

Dr SMITH: It is up to them to self report what they feel their craft group is. We may not have that information, but we can certainly see if we do.

The Hon. WALT SECORD: Dr Smith, if your organisation could adhere to the general spirit of the question.

Dr SMITH: Absolutely.

Mr MARK TAYLOR: If someone does contact the AMA about a complaint, what is the procedure from there and what is your relationship with the HCCC then? How does that interconnect?

Dr SMITH: We have a very healthy relationship with the HCCC. As a past president of the AMA NSW I had regular meetings with the commissioner of the HCCC because we are all working to the same goal of quality health care and ensuring the best outcomes for the citizens of New South Wales. If a complaint comes in, it depends on the nature of that complaint. If it is a public person complaining about a doctor, we direct them to the HCCC because that is the appropriate complaint mechanism. If it is a member to member complaint, depends again on the nature of the complaint, but we do have within our structure an ethics committee to consider these and then we can direct whether it goes to HCCC or the medical board, which is the other appropriate source for complaints to go to as well. We work within the existing framework to ensure that the complaint and the issue goes to the right body. We do not police complaints ourselves, that is not our jurisdiction, we do not have regulation to do that, but we absolutely help to ensure it goes to the right place.

Mr AUSTIN EVANS: Short of kicking people out of the AMA.

Dr SMITH: That has happened before. If a member of the AMA does not conform to the ethics, code, beliefs and structure, then members could be asked to leave.

Mr AUSTIN EVANS: To follow on from the Hon. Walt Secord's question, does the AMA have a policy around members who call themselves surgeons who are not a member of one of the societies or colleges of surgeons?

Dr SMITH: We do not have a policy on that. People in those positions may have other qualifications and recognise themselves as such for those other qualifications.

Mr AUSTIN EVANS: That relates to previous societies and colleges who have asked for that term "cosmetic surgeon" to basically be banned. The AMA does not have a position on that one way or the other?

Dr SMITH: On our membership form, we do not have a box to tick if you think you are a cosmetic surgeon.

Mr AUSTIN EVANS: Not so much have people identified that through you, but if people are representing themselves and in line with what those colleges and societies are asking for, does the AMA have an opinion one way or the other on that—whether that should be banned as a title?

Dr SMITH: Again, it is a complex issue, as you can appreciate. We will have to take that on notice.

The Hon. LOU AMATO: Dr Smith, there has been mention of public awareness or an advertising campaign to make the public aware of the cosmetic industry. Does your organisation have any campaign, or have you done a campaign? You mentioned a good example of that by the Cancer Council with its Pretty Shady campaign.

Dr SMITH: It is the Cancer Institute of New South Wales.

The Hon. LOU AMATO: Yes. I thought that was quite good. Does your organisation have public campaigns, or are you aware of any other organisation that has public campaigns, to make the public aware that there could be unscrupulous cosmetic surgeons, so to speak?

Dr SMITH: At this point in time, like the Government, we have been reactive to unfortunate situations more than proactive. We do not have the budget to be proactive, to be honest. But it is something we would like to partner with the Government in, if we were going to move into that space because I think that is an appropriate thing. But it is not something that we could do off our own bat purely because we do not have that level of money to be able to do those sorts of things. We usually partner with other organisations, such as the road traffic campaign, which a former President, Brian Owler, was a part of. That was a partnership with the New South

Wales Government. It was highly effective in that road traffic campaign space. I think that is key—getting the right people around the same table and working together.

The Hon. LOU AMATO: Your organisation does not have the financial capability or capacity to do your own fundraising, although your members pay a fee to your organisation. It would be similar to other organisations and bodies whose members pay a fee and they have the capacity to do advertising for public awareness.

Dr SMITH: You are assuming we have a large substantial fee that covers running an organisation.

The Hon. LOU AMATO: No. If I may interject for a moment, is there any reason why? For example, the Motor Traders' Association [MTA] has members who are mechanics and pay a fee, but they advertise and promote to generate public awareness of different activities happening in the industry. I surmise that perhaps the AMA might have had that capacity as well.

Dr SMITH: We work on many issues, of which this is one. Perhaps a burning issue that is coming in the near future is the State election. We only have finite resources and we have to be able to look at all of those at any given time, but we often operate on a shoestring budget in that regard.

The Hon. LOU AMATO: Yes. It is quite obvious from the evidence that has been presented to this Committee and to our attention that it is imperative for the public to be made aware through some type of advertising campaign, which would be no different to skin cancer campaigns that have been going on for years. We definitely need public awareness.

Dr SMITH: I think that is going to be best delivered in partnerships.

Dr McMULLEN: The AMA does run some small-scale public awareness campaigns on various issues. We have to remember that our remit is wide. If we consider all public health issues, there would be a new issue every day, but we have found that those tend to have better reach and are more effective when in partnership. We would be happy to discuss that going forward.

The Hon. LOU AMATO: What about through your website? Do you have a website where you can list this, considering that more people are accessing websites these days? Do you have even a website outlining the concerns that could be raised out there?

Dr McMULLEN: Our website has links to our position statements on various topics and, as I said, when there is a public awareness campaign on various issues. It is there, yes.

The Hon. LOU AMATO: You do have something out there, which is good.

Dr McMULLEN: Yes, and we can run a Facebook campaign.

The Hon. LOU AMATO: Excellent. Thank you.

The CHAIR: Earlier you mentioned about your good relationship and working closely with the HCCC, which is very good. Do you believe that the HCCC should be given additional powers to cover the scope of your industry?

Dr SMITH: Yes.

The CHAIR: That was nice and easy.

Dr SMITH: And appropriate financing to ensure they can police it.

The CHAIR: The commissioner would be very pleased to hear that.

Dr SMITH: Yes.

The CHAIR: Would you support the HCCC being given the power to issue public warnings, naming specific health facilities or individual registered practitioners, following or during investigation into their practices?

Dr SMITH: That is a much more complex question to answer. I apologise for having to take that on notice, Chair, mainly because you then potentially are invading into questions of privacy and defamation. I think if we borrow from the experience of the ACCC currently, they do not name and shame when things are in the process of investigation. However, it is something that you have to look at.

The CHAIR: I suppose if the HCCC believed there was a definite public interest and public concern, would you be more likely to look favourably on that?

Dr SMITH: If there is a public concern and it is being appropriately investigated, I think that is in the public interest to be made aware.

The CHAIR: Also in your submission you note that there is not a register of adverse outcomes data at the moment. As we have said, there is a lack of data related to cosmetic services. Do you believe that there should be a register established for cosmetic health services, effectively, for a register of adverse outcomes?

Dr SMITH: The challenge with that is the definition of what an adverse outcome is.

The CHAIR: It is the definition of the ACCC.

Dr SMITH: An adverse outcome can be something that is truly adverse or it can be a perceived adverse outcome by the patient who has received it. One of the things we have noticed in this cosmetic industry is the impact from the selfie for things such as people who have rhinoplasty, which is a nose job that could be correcting septal defects for snoring, or something, but also could be for cosmetic purposes. The selfie now shows that if you have one millimetre change off what the patient expected, they could see that as an adverse outcome. That is very different to, say, having a significant local anaesthetic event that lands you in hospital, which we have seen publicised in the media for other issues, or large infections, or inappropriate procedures being performed. You are looking at having to have an appropriate grading of what you mean by an adverse outcome and have that appropriately vetted as to whether that is right or not. That is the power of the HCCC, and that is what they do with their committees and the structure that they have.

Mr AUSTIN EVANS: As far as education programs are concerned, are you aware of any jurisdictions throughout the world that do a good job in this cosmetic space beyond not just the education but also regulation?

Dr SMITH: I think this is something that the world is grappling with as a whole, particularly when you look at some of our comparable entities in the United Kingdom [UK], America, and the likes. Unfortunately, in many regards, our approach to regulation and frameworks, as is often the case for a lot of things, is behind what is happening in the real world. That is not unusual in some regards, but it is something that we have to actively address. That is what we are all part to be of today.

Mr AUSTIN EVANS: In your submission you list the top five procedures. With respect to those five procedures, do we currently regulate them enough? Some of it seems to be that you have that your injections, your fillers, your laser -related procedures and your breast surgery and liposuction stuff. Is it going beyond the existing regulation, or are our regulations not coming down to low-enough procedures?

Dr SMITH: At present, the existing regulation that has been formed in New South Wales is very good and captures what is important.

Mr AUSTIN EVANS: In all five areas?

Dr SMITH: We have clear definitions around what type of surgical procedures and the question earlier referred to what is a definition of a surgical procedure. That is in your regulation already about the level of anaesthetic that is required and the type of procedure performed. That is already listed within regulation in New South Wales and gone through Parliament. When we go that next layer down, procedures like anti-wrinkle injections and fillers and even lasers can be very safely performed in an outpatient setting. You do not need to be in a licensed facility, unlike a breast augmentation, a rhinoplasty, et cetera. That is to do with ensuring that the people who are performing those procedures are appropriately trained and credentialed. I think that is going to be the crux.

Mr AUSTIN EVANS: The gap.

Dr SMITH: And that is the gap. Anti-wrinkle injections are things that wear off and the same with the injectable from a fillers point of view, they wear off. Obviously lasers have potentially more issues, depending on what type of laser, as I described earlier, ensuring that the right laser is being used for the right problem in the rights hands. But the key bit for that element of the cosmetic services is ensuring that the equipment is in the right hands, appropriately trained, appropriately credentialed and having some degree of oversight to ensure that regulation is policed through the HCCC.

Mr AUSTIN EVANS: Are you comfortable with the sort of split between, I guess, medical practitioners and accredited people, it is just we need to do more work in that accredited space, in that non-medical—

Dr SMITH: We are comfortable with the split of things that do not need to be within a licensed medical facility. But these are predominantly health and medical procedures that need some degree of oversight. We already have regulations that are defined for injectables and also for botulinum toxin for anti-wrinkle injections who is allowed to do that, but that needs to be policed. There is regulation that is appropriate but it needs to be policed and needs to ensure that the ACCC has powers to police that and has the finances to do that.

The CHAIR: The Committee may send you some additional questions in writing. You have taken questions on notice today and you will have about two weeks to reply to the Committee to those. Your replies will obviously form part of your evidence and will be made public. Are you happy to provide any other written replies to any further questions?

Dr SMITH: Yes.

(The witnesses withdrew)

(Luncheon Adjournment)

TERENCE STERN, Principal, Stern Law, Law Society of New South Wales, affirmed and examined

NGAIRE WATSON, Spokesperson, Australian Lawyers Alliance, affirmed and examined

WILLIAM JAMES MADDEN, Spokesperson, Australian Lawyers Alliance, sworn and examined

The CHAIR: Welcome to the inquiry of the Committee on the Health Care Complaints Commission into cosmetic health service complaints in New South Wales. Before we proceed do any of you have any questions about today's hearing process?

Mr MADDEN: No.

The CHAIR: I note that the Committee has not received a submission from the Australian Lawyers Alliance. Would anyone like to make a brief opening statement before we proceed with questions?

Mr MADDEN: I am content to do that. I can indicate that Ngaire Watson and myself have been invited to speak on behalf of the Australian Lawyers Alliance, which some of you may know is a national association of lawyers, academics and other interested professionals. It primarily has an interest in promoting access to justice and equality before the law for individuals. There is a tendency to focus on outcomes for people who have suffered injury or loss through no fault of their own but the organisation has broader interests. We can, if the Committee wishes, make some preliminary comments that we have prepared about three of the four terms of reference or, if the Committee prefers, we are happy to simply answer questions.

The CHAIR: Please feel free to make your comments.

Mr MADDEN: I will pass over to Ngaire Watson for the first part of the comments dealing with term of reference (b) in this inquiry.

Ms WATSON: The Australian Lawyers Alliance notes in its submissions to this Committee that the Health Care Complaints Commission states under section 94A of the Health Care Complaints Act 1993 that the Commission may issue a public warning if following or during an investigation it is of a view that a particular treatment or health service poses a risk to public health or safety. A public warning may not be issued about a specifically named health facility or individual registered provider. The Australian Lawyers Alliance submits that in order to enhance public safety the powers of the Commission should be expanded so that a public warning may be issued about a specifically named health facility or individual registered provider.

The Australian Lawyers Alliance notes in its submissions to this Committee that the Commission states, and we support, that section 41AA to section 41D of the Health Care Complaints Act 1993 outlines the powers of the Commission in regard to interim and permanent prohibition orders and that these extend only to individual and non-registered practitioners; they are not able to be issued in regard to our facility. The Australian Lawyers Alliance submits that in order to enhance public safety the powers of the Commission should be expanded so that interim and permanent prohibition orders are able to be issued in regard to a health facility in addition to the current powers in respect of individual, non-registered practitioners.

Again in relation to terms of reference (b) and the powers and functions of the HCCC, submissions to this Committee have suggested that the Commission ought to be more proactive in its approach so as to enhance its public protection aim. With that in mind, the Australian Lawyers Alliance submits that the Health Care Complaints Act 1993 should be amended so as to require cosmetic health service providers to disclose to the Commission all matters in which a cosmetic health service provider or its insurer have agreed to refund or pay a cosmetic health service consumer an amount—and we offer a suggestion of $1,000—as redress for failure in respect of consent, of informed consent or of an adverse clinical outcome.

In relation to the functions of the Commission, while it is appreciated that the Commission may face workload resourcing constraints, it would be beneficial to members of the public who lodge an application or a complaint that findings be made in a more timely manner. It is noteworthy that the 2016-17 annual report of the Commission noted an increase in assessment time from 45 days to 60 days and that 72.4 per cent of complaints are finalised within 12 months, which suggests that almost 30 per cent of complaints remain unresolved after a year. We would like to see that figure improved.

Again in relation to the functions of the Commission, members of the Australian Lawyers Alliance see occasions where the same medical practitioner has repeatedly been the subject of compensation claims or has been the subject of multiple complaints. It appears that there are a small number of practitioners who may pose a proportionately high risk to public health. It is recommended that greater scrutiny be applied and proactive action be taken by the Commission to those medical practitioners who have already had prior adverse findings against them. Such an approach is consistent with the research results published by Dr Marie Bismark and others of the

University of Melbourne—for example, the authors Spittal, Bismark and Studdert, in the article "The PRONE score: an algorithm for predicting doctors' risks of formal complaints".

I turn now to term of reference (c). The Australian Lawyers Alliance submits that a key element in collaboration with other agencies, organisations and levels of government to improve outcomes for the public in the cosmetic health services sector should be nationally consistent in the titling of surgeons, which may well be suggested by the Australian Society of Plastic Surgeons, to require the elimination of the term "cosmetic surgeon" in order to reduce public confusion as to the credentials and skills of those offering cosmetic health services. The title "surgeon" should be protected for use by fellows of recognised organisations such as the Royal Australasian College of Surgeons or equivalent in other specialties as recognised by the Australian Medical Council. The Australian Lawyers Alliance recognises that this is a particularly complex topic that we have raised and, if requested, we will be happy to offer any further assistance the Committee may seek in this matter.

One source of complaint to the commission is patient dissatisfaction following cosmetic surgery due to apparently unrealistic expectations of what cosmetic surgery will achieve for patients. Australian Lawyers Alliance [ALA] submits that a key element of collaboration with other agencies, organisations and levels of government to improve outcomes for the public in cosmetic health services should be an agreement on legislative reform so as to require mandatory referral for counselling sessions with a clinical psychologist prior to major surgical procedures. This is intended for people of all age groups; not just minors.

Mr MADDEN: If the Committee would wish, I can deal with a few points relating to term of reference d. Members would appreciate that it is an "all other matters" category and seems to cast a fairly broad net. It seemed to us that although the focus of this Committee is on regulatory measures—which are vital—it may be useful for cosmetic health consumers to be able to take their own steps in circumstances of dissatisfaction with treatment outcomes for financial redress when they have been harmed by cosmetic surgical procedures due to adverse outcomes through some failure on part of the service provider. It seems to us that that would support the aims of the Committee more broadly in terms of the regulatory environment by having another mechanism in place which also would not impose a significant cost, if any cost, on the Government.

The capacity for cosmetic health service consumers to obtain redress at the moment is mostly governed by the Civil Liability Act in New South Wales, a statute that was introduced more than 15 years ago, now in the context of insurance concerns about insurance availability in various sectors, including the health sector. The legislation is complex but a key feature is the prevention of recovery of financial redress for non-economic loss—pain, suffering, emotional distress, scarring and so on—unless the severity of that non-economic loss is more than 15 per cent of a most extreme case. It seems to us that in a lot of cosmetic surgery treatment scenarios, there may be an adverse outcome but it can be quite difficult for the patient to get over that hurdle of saying that it is more than 15 per cent for a most extreme case.

Our proposal would be that in some circumstances it might be feasible, should the Parliament wish to do so, to amend that Act so as to remove its operation in relation to some aspects of cosmetic surgery which were performed contrary to law. By that I mean procedures that are prohibited outright by law, such as the female genital mutilation procedures; procedures that are prohibited for persons below a certain age; procedures that are carried out in unlicensed premises, contrary to regulation; or procedures that are carried out by unlicensed providers, contrary to regulation. It could also be a tool used in circumstances where procedures were carried out by providers without the necessary insurance cover, as might be required by regulations.

In relation to experimental procedures, where they are recognised as experimental—we can expand on an example if the Committee members wish—that same reform might be further assisted by looking at an approach which the State of Victoria has taken in relation to the claims which are sometimes brought by people following childhood sexual abuse, where there has been a reversal of the onus of proof. Normally, a patient complaining about a cosmetic procedure will need to be prove that it was performed without reasonable care. In Victoria, with regard to the sexual abuse scenario, the institutions are now required, in the event of an adverse outcome, to prove that they did, in fact, exercise reasonable care.

Although that is a slightly more complex position, it might be a useful tool, obviously not for all medical treatment and perhaps not for registered medical practitioners, but in some situations. We also agree with some submissions saying that a mandatory information document should be provided to patients. That might tie back in to the recommendation that we have just made about taking away the threshold. If the mandatory information document were not provided, then that 15 per cent threshold should not apply to that type of claim, just by way of an example. These are the primary suggestions we wish to make today. They are separate to Mr Stern's who is here on behalf of the Law Society, but I think there is some overlap between the two.

The CHAIR: Mr Stern, would you like to add to those comments?

Mr STERN: I will try not to repeat what has been said. I speak for the Law Society of NSW. I chair its injuries committee. I have gone over the material with the injuries committee which appeared here today. The substance of what I am saying expresses views which were shared by the members of the injuries committee, a number of whom are professionally interested in this area. I am professionally interested in this area having, during my career, come across many of the situations that before the Committee today in a medical negligence practice.

Generally, the Law Society considers that it is appropriate to regulate the activities of providers of cosmetic services, given the possibilities of adverse outcomes in unsafe and illegal procedures. Generally speaking, we are in agreement. We suggest that it should be remembered that the HCCC is not a regulator; it is an organisation which deals with complaints. It fulfils a very important role in investigating complaints and in making recommendations. We do not think that it ever should become a regulator, because that would take it away from the objective, independent role that it has and the very important purpose that it serves.

The area of cosmetic services is wide in its scope and we suggest that consideration be given to bringing into the ambit of this inquiry tattoo services, because problems with infection in the extreme case can lead to death, just as they can with injections of botox. The Law Society considers that it is worthwhile to pragmatically note that there is a massive number of botox procedures, a massive number of laser procedures for hair removal and so on, thousands of clinics in Sydney and procedures probably taking place every minute, with a minute number of problems actually arising.

The problems that do arise come to light because of the extreme cases. It is the concern to ensure that those extreme cases are properly dealt with, such as this sort of inquiry. But those pragmatic considerations of not overreacting, given the actual scope of the problem, should be kept in mind. We do consider that it is appropriate that people who provide services which are medically invasive—in the sense of injectables which must be prescribed or who provide services where significant injury can result—should be accredited and properly trained with a minimum level of training.

In relation to the issue and the divide between cosmetic surgeons and general surgeons, we do not necessarily share the view that there should be legislation specifying who can call themselves what, but if a person is not a surgeon by accreditation and training they should not be entitled to call themselves a surgeon. Merely having done a university course does not make a person a surgeon. If a person is holding themselves out as a cosmetic surgeon there should be full disclosure of what they actually are. If they are in fact not practising as a surgeon the patient should be told and be informed fully so as to be able to make an informed choice. We take the view that in any significant elective or cosmetic procedure there needs to be on a mandatory basis counselling and real risk warnings in plain English on every occasion and cooling-off periods. Finally, we consider there should be mandated public liability/professional negligence insurance.

The CHAIR: Thank you all. My first question is to all of you. In your opinion, obviously we are looking at the HCCC as a main component of this, do you believe that by the time people come to a lawyer that they were either aware of or knew of the HCCC and their options and their abilities to discuss their complaint with the HCCC or are you finding that they are not aware of the HCCC's ability?

Mr STERN: Most people that come to me are aware of the HCCC and many have already made a complaint.

The CHAIR: Their feedback effectively from that initial engagement with the HCCC, their responsiveness, are they satisfied or—

Mr STERN: It is varied.

The CHAIR: For patients who have suffered that adverse outcome, especially in cosmetic procedures, how do you believe, in addition to what you have already said, the Government could assist in preventing that happening? What more can we be doing at a government level, in addition to the HCCC, potentially to warn the public from a legal perspective?

Mr STERN: From my point of view, advertising and dishonest advertising is a real significant issue. It is absolutely prevalent. People do believe that there is minimal risk in these procedures and that at the drop of a hat they can alter their appearance and go on with their lives happily ever after. The before and after photos that the surgeons do at the roadshows really lead people along the path to surgery. The horror stories are rarely publicly advertised or become publicly known. I have seen some pretty horrible cases as a result of things going wrong and people if they knew what the downsides were would not dream of rushing into surgery. They would want to be well informed, they would want to be properly counselled and they would want to have considered the downsides before going ahead with it.

The CHAIR: Ms Watson, do you want to add to that?

Ms WATSON: Yes. If I may go to your original question about are people aware of the HCCC, my practice is entirely in the area of medical negligence litigation as a barrister and I have seen many occasions where people have gone to the HCCC and there has been no finding of any particular problem. A fairly short report gets produced—and I have read many of them—which does not really enlighten the person particularly and we have gone on to successfully litigate because it has been quite apparent that there has been a problem in the treatment provided.

The CHAIR: As a litigator in medical issues do you find that if it is outside the sphere of cosmetic surgery the HCCC's responses are more detailed and more informative versus with regard to a cosmetic surgery complaint?

Ms WATSON: I think that that could be a fair statement partly because I think cosmetic surgery is virtually a moving feast. The types of procedures that doctors and their patients are coming up with are changing constantly. We are being driven particularly from America. I presented at a conference earlier this year and it even surprised me to find out that now men are seeking botox treatment to their scrotums to remove the wrinkles from them. It would not be too difficult to imagine, with the nerve supply, the blood supply to that region of the anatomy, what could go wrong. I had not even come across that as a concept and in the process of my research I found all these rather strange and extreme, initially extreme that later become quite mainstream procedures that people are undertaking. So it is unsurprising that the HCCC if they are coming across novel, strange things may find that rather challenging.

The CHAIR: Do you think that the difficulty in those cases is also the fact that when a person is going to have a standard procedure they are meeting a surgeon or a specialist who explains what to expect, where, as we just heard before, there is an unreal expectation by some patients as to what the cosmetic service will provide them? Do you find that that could also be contributing to the problem for the HCCC?

Ms WATSON: Yes, definitely. On the AHPRA website you can find guidelines as to how doctors particularly are supposed to promote themselves and what they should and should not do, including having pictures that are unrealistic so that a person viewing these pictures may develop an unrealistic expectation of what their outcome would be. However, a simple scan of the internet of doctors practising in New South Wales will show that that guideline issued by AHPRA is basically rarely adhered to. So the expectations that people go in with leave them often very disappointed. I have seen many cases where a person would be very distressed about the outcome but, in terms of the Civil Liability Act, would not meet the thresholds; they were just simply distressed that they did not end up looking like what they thought they were going to look like according to the websites particularly.

The Hon. MARK PEARSON: I just wanted to tie a few things together and then ask a question, particularly on Mr Stern's evidence about the fact that the websites are showing all sorts of magical tricks that could be done or certainly promote the surgery to be able to achieve probably some fairly unrealistic outcomes for patients, and then the evidence we had from the last witnesses was the age group and vulnerability of most of the people who are seeking the cosmetic surgery. Has it ever been the situation where you have considered whether they need to be referred to the Australian Competition and Consumer Commission for misleading and deceptive conduct?

Mr STERN: Yes. I had a case where a practitioner in Bondi Junction was widely advertising in the local papers amazing results for penile enhancement surgery and the sort of people who were coming along as prospective patients were people who needed counselling; they came along with unrealistic expectations and, at least in the case of the people who came to me, they ended up with devastating results. I am pretty sure that they never had a full explanation, at least the particular case that I did, of what was actually involved, including carrying a weight for six months and ending up with scarring and huge problems with intercourse and no solution to any of the problems. That was the sort of case where there could well have been a complaint of misleading and deceptive conduct under other legislation. Certainly that could be something that would be always kept in mind.

The Hon. MARK PEARSON: Were you going to say something?

Mr MADDEN: I was just going to add that there have been a number—not a great number, a small number—of matters where the HCCC has become involved. I think that particular clinic was one of them. They tend to focus, though, on the larger businesses. The HCCC, in my experience at least, is unlikely to get involved in the smaller operations that might be dotted across the city.

The Hon. MARK PEARSON: Maybe it could be pitched that this is part of a larger picture of something that is happening across multiple companies. It is becoming clearer and clearer that one of the critical points of intervention is when the consumer sees the advertisement, becomes interested and then believes it could help

them, and then has the procedure done. Because a lot of these facilities are not registered the HACK has enormous amounts of limitation in what it can do to intervene or to investigate. What mechanism do you think we could put in place so that once a person or a company advertises this type of surgery or procedure in any way, in any forum, they are accountable to the community and to the legal system just as much as a registered person or facility?

Mr MADDEN: I might try to answer that in terms of a suggestion that I put at the close of the remarks earlier on. It seems to me that individuals who are unhappy with an outcome will generally try and find a remedy. In your scenario, if you are talking about those sorts of places, the remedy could well be for them to seek financial compensation because of the poor outcome. At the moment, the way that the legislative scheme for compensation is structured in New South Wales they cannot effectively do that.

I appreciate that the scheme is there for a reason and it works comfortably enough in most situations where we are dealing with registered medical practitioners—for example reputable health providers and hospitals—but in these organisations which do not fall into that category and which, as you say, may not be properly licensed and may not have appropriately skilled individuals there, it is not clear to me why they should have the benefit of that protection which, in effect, gives rise to a problem of all care and no financial responsibility. If they had a financial responsibility—if they were exposed to paying compensation to their clients or patients for poor outcomes—then that may have a practical hip-pocket-nerve effect on the way those practices operate their businesses.

The CHAIR: I am mindful of time.

The Hon. MARK PEARSON: I will just ask a quick question;. I will not ask any other questions. In terms of the vulnerability that has been raised I am wondering what kind of mechanism we could put in place, even for the unregistered facilities, so that when a person is intending to have a procedure done there would be—as you raised earlier—counselling or, as I suggested to the former witnesses, mandatory referral from a GP. Maybe we need to set in place some protective mechanism, financially, for that to happen. That would mean there was an opportunity to review and reconsider the matter with a person who has no interests in supporting the procedure but is purely supporting the patient.

Ms WATSON: There are some medical groups which are not in favour of that. Doctors believe that they are able to adequately assess the psychological state of a patient in terms of whether they are coming at it with realistic or unrealistic expectations, whether they have body dysmorphia or are depressed, or have a variety of problems. However, I think history has shown that there could be potential of interest there, where a doctor is seeing a patient who they may operate on, if they were then to advise them and say, "We think that you may not be particularly well and before we operate on you I think you need to go and see a psychologist." By making it mandatory, certainly for major operations—I am talking about things which require general anaesthesia and not just for people under 18 but for all age groups—they are potentially a particularly vulnerable cohort of patients that could be at risk of exploitation.

The CHAIR: We have to move on, if you do not mind.

Ms KATE WASHINGTON: Ms Watson, I have been digging into your submission. At the beginning you referenced expanded powers for the HCCC in relation to public warnings and the potential for interim orders. Can you flesh that out a little bit more?

Ms WATSON: With interim orders, where investigation is underway, at the moment it is very difficult for the public to be aware of problematic practitioners.

Ms KATE WASHINGTON: When this was raised earlier with the AMA they suggested that there might be some defamation concerns. I think it was the AMA that gave that evidence; I do not want to put that on them if it was not them.

The CHAIR: I think it was.

Ms KATE WASHINGTON: That was in terms of interim orders before a review is concluded by the HCCC. I am just wondering, at what point would that be feasible, in the view of Australian Lawyers Alliance?

Ms WATSON: I think it would be determined on the factual matrix of the case—the seriousness of it—to potentially identify some objective aspects that would need to be addressed before it maybe could reach a threshold whereby there would be an interim order. That is something that at ALA we would be happy to turn our minds to more if the committee sought advice or information. In my opinion it would have to be done on a one by one basis—I appreciate the issue of defamation—with a variety of people reviewing the case and then taking regard of the seriousness of the matter.

Mr MADDEN: Could I add two things to that, briefly. That power already exists in the HCCC, as I understand it, for non-registered practitioners. Although it is described as defamation, I suppose what you are really focusing on is the potential for some financial harm to be done to a provider who is unjustifiably criticised. That, to me, is a balance between the public's interests and the rights of the individual, and will be very much dependent on how thoroughly the commission investigates the matter. There should be no strict liability for defamation in carrying out a public duty or an obligation that exists. So it could be implemented provided that a proper balance was struck between the people who are obviously seeking to earn their living carrying out work in a competent fashion, but unfortunately there is a group of people who perhaps do not fall into that category.

Ms KATE WASHINGTON: Regarding people with adverse outcomes as a result of a cosmetic procedure having recourse to compensation or financial redress by a different means, you said that there might not be any cost attached to it. Is there an example of that in another field where redress is available or is there a scheme being implemented by governments?

Mr MADDEN: When I said "no cost attached to it", I meant in the sense that that would not be a cost borne by the Government. If I was a provider and I had treated a patient without due care, I would be financially liable to compensate that patient. It would not impose a cost on the State.

Ms KATE WASHINGTON: What structure do you envisage imposing that? Is it strict liability?

Mr MADDEN: No, I was not suggesting that. If it was possible for a patient to demonstrate a lack of reasonable care in the way they were treated, in those circumstances they should be entitled to obtain compensation. They are entitled now. If they get some disastrous outcome that is worth tens of thousands of dollars in compensation it can become economic for them to go down that path, but if they have had a relatively modest procedure and they have ended up with some scarring, perhaps, and some disfigurement, it may not be worth a great deal of money to them. Therefore, it may be uneconomic to go down the path, given the way the law is presently structured.

The Hon. WALT SECORD: Ms Watson, in an earlier answer you talked about the disparity between an HCCC ruling or decision being a very short matter and then you being successful pursuing court action on behalf of that person who made a complaint to the HCCC. What is the discrepancy, or why do you think that is the case?

Ms WATSON: I wish I could answer that fully because I find the HCCC process rather opaque in respect of what they do and how they do it, and quite literally the processes by which the investigation takes place. I will get the documentation and then because I will have been briefed in the matter, I will have the medical records. I will see quite different things and wonder how it arrived at a conclusion that there was no problem found by the HCCC. I find that the process is rather opaque and I do not really understand what kind of detailed, investigative process has taken place, by whom and what qualifications over what really has happened.

The Hon. WALT SECORD: Would I be safe to conclude that you feel that the court processes are actually more vigorous than the HCCC approach?

Ms WATSON: Absolutely.

The Hon. WALT SECORD: Do you find that the HCCC processes are tipped in favour of the medical practitioner who is in question rather than the person making the complaint?

Mr MADDEN: I might not be seeing a representative group to properly comment on it, because clearly there are cases that have come to me when the person has not been happy with what was found by the HCCC. They thought that the matter was maybe incorrectly decided or they still had questions that remained unanswered. I am seeing that group of people already. I could not really comment on whether it is tipped in favour of the doctors or the health practitioners or not.

The Hon. WALT SECORD: You must encounter patients or clients who are dissatisfied with the HCCC process but then are quite surprised when they receive a settlement in court that makes them not happy but is in their favour.

Ms WATSON: I do.

The Hon. WALT SECORD: They must find that very puzzling and very frustrating.

Ms WATSON: Yes, they do.

The Hon. WALT SECORD: Does that happen often?

Ms WATSON: I see it quite frequently.

The Hon. WALT SECORD: Is this in the area of cosmetic surgery or in all medical—

Ms WATSON: At this point I have to say I am speaking quite broadly, not just cosmetic surgery. I am talking about my entire practice. I qualify that by saying that I am not limiting that to cosmetic surgery.

The Hon. WALT SECORD: You must see themes and trends developing. What would be the remedy or what changes would you like to see to the HCCC? A lot of people are in fact not looking for financial compensation. They want to feel that justice has been done and they have been heard, that they have gone through the process and that other people will be impacted on by the way that they have been impacted on.

Ms WATSON: Correct, yes.

The Hon. WALT SECORD: Do you have any recommendations about that?

Ms WATSON: I would like to make recommendations if I actually knew more about their process. I am afraid to have to answer with a question, because to make a recommendation I would really need to know about what actually does happen.

Mr MARK TAYLOR: There are some anecdotal submissions about patients getting corrective surgery after an incident when they are asked to sign a waiver, or a deed of release for a fee. Do you find that asking for a deed of release is a common practice? Does it affect their legal outcomes and does it affect their complaint status?

Mr MADDEN: It is something that is raised on occasion. I must say I do not find it a particularly appealing concept. I am not convinced that it has much legal strength at the end of the day. Of course, whether that is another factor which might mean that people do not pursue compensation because they may have a belief that they have signed away their rights, as it were. If that was something that the Committee was finding as occurring frequently, it could be, perhaps, the subject of regulation to remove that from the medical treatment setting.

Mr MARK TAYLOR: Mr Stern?

Mr STERN: I would agree with Mr Madden on that.

Mr AUSTIN EVANS: Following on from Mr Taylor's questions, have you seen a successful overturning of those deeds of release?

Mr MADDEN: Yes.

Mr AUSTIN EVANS: You mentioned that they probably do not have much legal standing. Are you aware of cases in which a deed was signed but litigation was pursued successfully?

Mr MADDEN: There was a reported decision that came out of the Australian Capital Territory [ACT] fairly recently where a patient had been asked to sign a document essentially in favour of a hospital, stating, in effect: If something goes wrong, it is the doctor's fault. It is not our fault, we are just the hospital. Although it was an interlocutory decision, the court in the ACT said that that was not something which could automatically be accepted on face value. There are some protections in the Australian Consumer Law that create a framework that make it difficult to do away with everyone's rights in an absolute fashion.

Mr AUSTIN EVANS: But you have not seen that tested?

Mr MADDEN: It is not tested a lot, but, as I said, there is a recent ACT decision that went down that path.

The Hon. LOU AMATO: Are there any particular cosmetic procedures that are more likely than others to be the subject of litigation?

Ms WATSON: Yes.

The Hon. LOU AMATO: What particular area?

Ms WATSON: Breast augmentation, by far and away.

Mr STERN: And reduction. Infection cases are quite common.

The Hon. LOU AMATO: What percentage of your litigation work would you say that entails at the moment?

Ms WATSON: For breast augmentation, 80 per cent. I have to say, I have not had so many cases with breast reduction. In fact, it is quite small. For me, it is just the sheer volume of women seeking augmentation versus reduction. Proportionately, there is a lot more augmentation going on than reduction.

The Hon. LOU AMATO: Is it mainly undue care or negligence or do you find that someone's expectations have not been met?

Ms WATSON: I could say all of the above, but infection is a recurring problem—serious significant post-operative infection.

The Hon. WALT SECORD: Does the postoperative infection occur in the facility or at home? How does it occur?

The CHAIR: Are we talking immediately post treatment?

Ms WATSON: By the nature of the development of the infection, even if the person is infected in theatre, for example, that may not manifest until at least 72 hours by the time the wound is exposed to an organism. Typically the infection will develop over days to weeks after the person has left hospital. Then there may or may not be various attempts to treat the infection, which may or may not be successful. In some cases—and one I am thinking of in particular—the entire prosthesis needed to be removed, so that the woman had a prosthesis in one side and nothing in the other when the infection was treated. The only way was to take it out altogether.

The CHAIR: I thank all of you for appearing before the Committee today. We may send you some additional questions in writing as a result of today. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

Ms WATSON: Yes.

Mr MANSFIELD: Yes.

(The witnesses withdrew)

MARINA BUCHANAN-GREY, Executive Director Professional Division, Australian College of Nursing, sworn and examined

ROBIN CURRAN, member, Australian College of Nursing, sworn and examined

The CHAIR: Would either of you like to make a brief opening statement before we ask questions?

Ms BUCHANAN-GREY: No, happy for you to start.

The CHAIR: How does the Australian College of Nursing believe the Health Care Complaints Commission could raise its profile to members of the public seeking cosmetic health services?

Ms BUCHANAN-GREY: It is about raising awareness of who the HCCC actually are. I think there is limited understanding of the body as it stands, what their role and function is. The Australian College of Nursing would certainly welcome an opportunity to work more strongly with the HCCC in providing better knowledge and awareness in that space so that the consumers, the public, are aware of who they can turn to should there be an issue or incident they need to raise in the public domain.

The CHAIR: The Committee heard evidence earlier of the suggestion of a campaign that was run very publicly about awareness of skin cancer. Do you feel from your organisation's perspective that something along those lines would be beneficial to cosmetic surgeries and procedures, whether it be run by government or in conjunction with the HCCC or an organisation such as your own? What are your thoughts on that?

Ms BUCHANAN-GREY: I think it is about understanding where you feel the market value is in any sort of advertising campaign to raise awareness around a body. Something like that type of campaign would be effective in putting forward what the HCCC stands for, what their role and function is and how they can help and assist in the complaints system.

The CHAIR: Nurses are in the frontline. My wife is a nurse, so I completely understand the frontline services. Do you think from a nurse's perspective that there is a lack of understanding about the risks associated with cosmetic procedures and surgeries, and a lack of understanding about the difference between the two of them? Earlier we heard evidence of a health practitioner not realising some of the potential outcomes. From a nursing perspective do you believe that exists?

Ms BUCHANAN-GREY: I am not aware of any specific incidents but in that specialty field nurses are regulated to work to their scope of practice and are bound by national law in whichever State or Territory that they work and practice in. It is their responsibility to be fully conversant with the legislation and law that governs their practice as a nurse and that regulates them as a health practitioner. My answer would be that they should be aware. That is their legal requirement as a registered practitioner and part of their registration requirements every year with the Nursing and Midwifery Board of Australia.

The CHAIR: Ms Curran, do you have anything to add?

Ms CURRAN: I completely agree with Ms Buchanan-Grey. In all areas of nursing and medicine there are varying degrees of awareness and understanding. If something that came out of this inquiry was to standardise education and the requirements to enter, whether it is procedural or surgical, for nurses or whether it is for doctors, that there is a set standard of education that you need to be accredited in before you enter the area.

The CHAIR: The Committee has heard that doctors will often give consultative advice prior to a procedure but in some cases with cosmetic procedures nurses are the ones administering those procedures. If somebody has a treatment that is administered by a nurse, does that nurse have the necessary skill set and been given the training so they can advise of potential outcomes and adverse effects before administering that procedure?

Ms BUCHANAN-GREY: Yes, correct. Any nurse, male or female, providing a procedure in a clinical environment should be able to talk through any potential adverse outcomes, any benefits, with the patient prior to them consenting to undergo the procedure. That would be a requirement of part of the nursing assessment and process that they would go through with that patient at the time. The nurses themselves would need to be fully conversant with what that procedure was and understand what the risks involved were and also how to treat them.

Mr AUSTIN EVANS: The Committee has heard about some of the more corporate entities where nurses are pressured to upsell or make things happen and perhaps water down the potential consequences. How do you as a body help nurses in that situation who come to you? What is the way forward? They may be putting their job at risk and are being pressured.

Ms BUCHANAN-GREY: Absolutely, and they are putting their registration on the line, which is essentially their job and lifeline, should they do something which is against the national law and the regulation that they are governed by as a health practitioner with the Board. What we are doing with the Australian College of Nursing is looking to develop a graduate certificate in cosmetic nursing and dermatology. We are a registered training authority and have that ability to do so, because there is lack of credentialed programming in this space for nursing.

I believe there is limited in the medical space but if I talk purely from nursing, which is my realm of experience and expertise, there is really nothing outside of education and training that is provided by pharmacology companies. I am not here to discuss the benefits or not of what is on offer there, but that is really all that we have in terms of governance around education and training. We would look to strengthen that to provide the nursing profession, who wish to specialise in this area, an opportunity to be appropriately skilled and trained to undertake the work they do in this specialty space.

Mr AUSTIN EVANS: But that tension they are put under by supervisors, managers and doctors, how do you help them through that?

Ms BUCHANAN-GREY: We need to work with nurses in practice and raise awareness around knowing that you can speak up and speak out around what is wrong, and calling inappropriate and unprofessional practice. It goes without saying that we know that whistleblowing, for want of a better word, is a very difficult thing to enact. It is about how do we support the profession to ensure there is robust governance in this space? There is a lot of good work happening out there. It is the bad work that gets the bad press.

We would probably need to look at how we could work more closely with the Nursing and Midwifery Board of Australia to improve education and training in this space and the scope of practice around nursing in this specialty field, and work with nurses on a professional level around recognising their responsibilities as a registered practitioner, knowing what is right and wrong, knowing the issues that will come from doing the wrong thing, and the potential consequences that they will face, regardless of whether a medical practitioner has said, "I ask you to do X, Y and Z."

The Hon. LOU AMATO: Do you think there are any improvements to the way in which unregistered cosmetic health service providers can be regulated?

Ms BUCHANAN-GREY: They definitely should be regulated. I think this is the big issue—that in the unregulated workforce, there is no governance around what is happening, and yet in the nursing sphere they are a heavily regulated workforce that we would still call needs to be better supported. I think there needs to be some discussion around how we regulate an unregulated workforce currently. What minimum standards would we set to provide some governance around the procedures that they are undertaking or assisting with so that their knowledge and skill meet the purpose of what they are doing in their day-to-day employment?

The Hon. MARK PEARSON: In the training of nurses at the college, is it an ongoing issue or concern as to what actually in certain circumstances of procedures in certain clinics is supervision? This has come up in a few of the submissions. In some instances there is a lack of clarification in certain practices, whether they are registered or unregistered, as to what actually constitutes supervision if a nurse is being asked to do a procedure and the doctor or practitioner is not there but has given instructions, but then left the room, and then something goes wrong. In the training of the nurses, is supervision an area which is of the understanding and grappling with supervision? Is it an area of concern as to how clear that is?

Ms BUCHANAN-GREY: It is certainly something that needs to be clarified. Just to be clear for the record here today, the Australian College of Nursing, while it is an accredited registered training organisation, we do not provide the training currently in this specialty area. This is something that we are looking to develop as a graduate certificate—a postgraduate qualification—in. We are not the body that actually trains people to become nurses, either. That is all through the universities, of course.

The Hon. MARK PEARSON: Have there been incidences? Why has the college decided to address this specific training for nurses in cosmetic surgery? Have there been particular issues that have brought that about?

Ms BUCHANAN-GREY: The industry itself. The nurses working within the industry have come to us and spoken around concern that there is no regulated governance training in this space for registered nurses—enrolled nurses, registered nurses or nurse practitioners—who work in this industry. We have decided that it is something that needs to be addressed in order to support the profession in being able to provide safe and appropriate care to patients. At the end of the day, this is about patients' safety.

The Hon. MARK PEARSON: Of course.

Ms BUCHANAN-GREY: But coming back to your earlier point around supervision: It is something that probably needs to be more clearly defined. What does supervision look like? What does it entail? Is it indirect or direct, in person or via remote? I would put forward the position that there should be direct supervision, particularly in the training stages. Then it comes down to the whole governance and training framework around what is the real skill and competence of the practitioner delivering the service and how you have the evidence to support that they are truly accomplished in being able to deliver that appropriately and unsupervised by that point. I think there are a couple of elements that probably need to be worked through. What is the supervision required while they are undertaking appropriate extended training in this specialty field? Is there a requirement for any supervision, be it direct or indirect, ongoing and post some initial training?

The Hon. MARK PEARSON: Is there a relationship between the college and the New South Wales Nurses and Midwives' Association in relation to this new area where nurses can find themselves in situations of being directed or coerced to do procedures with or without appropriate supervision? I imagine once a nurse is trained, done the course and is working, it is really that the support mechanism for them is really the New South Wales nurses association, is it not? With this controversial question happening in nursing and in relation to these procedures, I am wondering if there is communication going on between yourselves and the New South Wales Nurses and Midwives' Association to assist nurses who have to deal with the possible situations of being coerced?

Ms BUCHANAN-GREY: We are not working with them directly. We work at the Federal level with the Australian Nursing and Midwifery Federation. We are not doing any direct work at the moment with the New South Wales nursing federation, which is an industrial body, but we would certainly look to ensure that the terms and conditions around the nurses working in this area were fair and reasonable and in line with legislation and law. We can certainly look to do some work with them specifically, but we liaise our relationship at the Federal level so that we look at what is happening across the country as a whole to ensure that there is consistency in approach across the different States and Territories with the legislation that is bound by each jurisdiction.

Ms CURRAN: I work and train on the coalface—nurses and doctors—and there is this issue of supervision, whether it should be direct or indirect. I agree with Ms Buchanan-Grey: It really depends on who is being supervised and by whom they are being supervised. The prescription that is given to a nurse to administer is for the patients. The authorisation is given to the nurse but the prescription actually belongs to the patient, which is a technicality. It is the medical officer giving the prescription to the person and then it is giving the authority to treat to the registered nurse. That registered nurse could have three days training or they could have 13 years experience and have actually trained the doctor that was giving them that prescription.

One rule does not suit all. We definitely need preceptorship. We need hours where both doctors and nurses have a traineeship wherein they work with experienced injectors, whether that is nurses or doctors. We have a saying in the industry that the syringe does not know who is at the other end of it. Doctors and nurses cause adverse events so it is about education, understanding facial anatomy, and it is about the applied science of actually doing the treatments. Supervision should happen within a structured course and for a certain number of hours—no less than 100 hours of supervised training—so that when people meet the marketplace, we know there is a minimum level of education and expertise.

Ms KATE WASHINGTON: In terms of making complaints to the HCCC, do nurses have an avenue? Given that you are at the coalface, you are seeing all sorts of things going on, and there is talk of potentially coercive situations and adverse outcomes, is there an avenue for nurses to make complaints to the HCCC?

Ms BUCHANAN-GREY: The first port of call for a nurse, if they were making a complaint in this scenario, would be through their regulatory body—the Australian Health Practitioner Regulation Agency—which helps to facilitate the regulation of nursing through the Nursing and Midwifery Board of Australia. That is where they would go, most likely, in the first instance. They may well then subsequently also make a parallel complaint through the HCCC. But usually, when it is about a registered practitioner, it would be through AHPRA.

Ms KATE WASHINGTON: When you say "they", are you saying AHPRA or the nurse?

Ms BUCHANAN-GREY: No, the nurse, sorry. If it was about another registered practitioner, be it a medical officer or another registered nurse, AHPRA would be their first port of call.

Ms KATE WASHINGTON: A lot of evidence has been given about the lack of understanding of the enormity of the problems in the sector. How can that be captured better if everyone was making sure that things were being called out? I appreciate that nurses would often be in a situation where their employment might be at risk and all sorts of difficult scenarios. I am trying to understand how we might be able to capture information.

Ms BUCHANAN-GREY: I think, to your point around your job may be at risk, there is certainly that air of caution around how your raise complaints and actually do the right thing and feel supported to do the right thing. As a registered nurse or as another registered practitioner—it may be a medical officer that makes the

complaint around a nurse and vice versa, or about their counterparts—there does not seem to be the same level of concern to raise that complaint through our regulating body through AHPRA. So I think in some instances for the regulated professions it is a little bit easier to raise a complaint. They know the process. You actually understand what the process is because you are part of the profession and internally have an understanding. I think the issue around the HCCC and the clarity around that process probably would not be front of mind for someone to say, "I am going to go to the HCCC and make a complaint. I would rather go to AHPRA because I know what that process is."

The Hon. WALT SECORD: In my discussions over the past three years of the cosmetic surgery sector and things like that I have come into contact and discussions with many nurses who find themselves in situations where they actually are fixing up, responding or trying to remedy mistakes of a person who is actually calling themselves a cosmetic surgeon. Do you get similar feedback? Does the ball get tossed to nurses, so to speak?

Ms BUCHANAN-GREY: Correct. I have heard anecdotal reporting around similar scenarios and our advice has always been that this needs to be reported through AHPRA to the Board.

The Hon. WALT SECORD: What do you advise nurses who find themselves in that situation? I will not give an example. What advice do you give those with whom you come into contact? Do they have more experience, knowledge or practical experience than the cosmetic surgeon?

Ms BUCHANAN-GREY: If there is an issue around fitness to practise in a particular space then we would certainly advise the nurse involved in that scenario to report the individual to the Board and allow that process to go through its natural course. Of course, we can only give strong advice that that is the direction that they should go, and if they choose not to for other circumstances that they are concerned about then I guess that is their choice. But we would certainly support them in making the right choice to take that further so that we are actually flushing out where there is poor practice or inappropriate practice be it through unskilled registered practitioners, not just unregulated practitioners.

Ms KATE WASHINGTON: Do you find that where a nurse is raising concern around the fitness to practise of a qualified doctor that less value is placed on a complaint made by a nurse when talking about a doctor because of the perceptions around different qualifications?

Ms BUCHANAN-GREY: No, I think we need to get past this sort of turf war of nurses and doctors, and the gender imbalance and bias that we associate with either of those labels.

The Hon. MARK PEARSON: Do you think we have?

Ms BUCHANAN-GREY: I am not sure that we have.

The Hon. MARK PEARSON: We are getting closer.

Ms BUCHANAN-GREY: We are getting better, we absolutely are. I think that certainly a professional respect across the boundaries around the nursing profession and the experience and expertise that nursing holds. Certainly to Robyn's point earlier around quite often the nurses will have been involved in the training of some of the medical practitioners that are undertaking some of these procedures. They are very different scopes of practice and very different regulatory bodies that govern that too. I would like to think that that was not something that influenced one way or the other how a complaint was managed, depending on who reported against whom.

Ms CURRAN: It is not so much nurses fixing up things from doctors, it is really about experience. It is inexperienced practitioners having their work fixed by experienced practitioners. So it would be regardless of whether they are doctors or nurses. With regard to coercion, one of the things I would like to say is that in some of the commercial organisations the nurses are on commission only. I think if that was looked at more seriously—

The Hon. WALT SECORD: Nurses are on commission?

Ms CURRAN: Commission, yes. So there are commission structures involved in—

The CHAIR: These are in non-registered—will you repeat that?

Ms CURRAN: Can you clarify what you mean by "non-registered"?

The CHAIR: Will you repeat what you just said about nurses working on commission?

Ms CURRAN: Commission, yes. There are commission structures, hence the reason for coercion.

Ms BUCHANAN-GREY: In private practice.

Ms CURRAN: In private practices in commercial entities.

The Hon. MARK PEARSON: Does that mean a nurse gets a commission if they convince the patient to have another type of procedure?

Ms CURRAN: I am surprised it is a surprise.

The CHAIR: We are talking about registered nurses working in a registered practitioner's—

Ms CURRAN: Working in shopping centres, in the medi-clinics throughout Australia—there are about 3,500 of them. Registered nurses and, in some cases, enrolled nurses will be taken on board for 12 months. They have varying structures so they can have structure where they earn to pay out their training. They work for a very low minimal hourly rate. So the legislative rates for nurses within registered organisations—hospitals—do not necessarily apply to commercial entities. You will see nurses working for a minimal hourly rate. They will be paying back their training over 12 months and they will be on a commission structure.

The Hon. MARK PEARSON: What do you see is the commission structure?

The Hon. WALT SECORD: This is a new area for me, I am sorry.

Ms CURRAN: I can only talk to—

The Hon. MARK PEARSON: Just give the Committee an example.

Ms CURRAN: For an example, you would have a target to meet a certain amount of treatments for a day, let us say, for $3,000 and out of that you might earn $300, so 10 per cent.

The Hon. WALT SECORD: Are they able to do that legally in New South Wales?

Ms CURRAN: I am sorry, I cannot answer that question. I can answer the ethical questions.

The Hon. MARK PEARSON: If 10 procedures were done rather than nine they would get an extra $300?

The Hon. WALT SECORD: I want to hear the answer to my question.

Ms CURRAN: I am talking to non-invasive medical aesthetics as well. So I am talking about dermal fillers and neuro modulators—

The CHAIR: They are not surgical procedures, effectively.

Ms CURRAN: Right.

The CHAIR: We are talking about cosmetic procedures that may not necessarily be surgical?

The Hon. WALT SECORD: But still a registered nurse is being told that she has to meet a certain target because she does not paid.

Ms CURRAN: Yes.

The Hon. MARK PEARSON: It is probably not so open directly.

The CHAIR: We may well seek additional information from you. You stated on page three of your submission that the HCCC powers have reached being optimised. In the limited time remaining, will you provide an example from your perspective of what sort of optimisation the HCCC could benefit from?

Ms BUCHANAN-GREY: This is really about being able to enact assessment and investigation into a complaint more quickly than is currently the outlined process by the HCCC. It should not really be a catastrophic event or death that triggers a significant incident inquiry by the HCCC in a quick manner. Any complaint around patient safety or a practise that could enact issues of patient safety down the track if a practitioner is still able to practise whilst undergoing investigation. Patient safety is really paramount and so we would seek to say that the HCCC should be able to have greater reach and power in how it officiates its role and function as a complaints body.

The CHAIR: The Committee may send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Are you happy to provide written replies to any further questions?

Ms BUCHANAN-GREY: Yes.

Ms CURRAN: Yes.

(**The witnesses withdrew)**

NICOLE MONTGOMERY, Creative Director, Trusted Surgeons, affirmed and examined

The CHAIR: Before we proceed I note that it was unanimously agreed in the brief deliberative meeting the Committee just had that following the evidence of Ms Montgomery an additional witness will be giving evidence in-camera. Ms Montgomery, do you have any questions regarding today's proceeding process?

Ms MONTGOMERY: No, thank you.

The CHAIR: Would you like to make a brief opening statement before we proceed with questions?

Ms MONTGOMERY: No. That will give the Committee more time for questions.

The CHAIR: Firstly, do you believe that the people who have contacted you in the past have been aware of their rights and the relevant standards that should be met in the cosmetic health sector? Secondly, how do you think the State Government and the Health Care Complaints Commission [HCCC] could improve on that?

Ms MONTGOMERY: For the first part of the question, no, definitely not—the majority of the people I have dealt with have been from my previous employment, not through Trusted Surgeons—because of the sheer volume. We are talking about 15,000 patients who went through and had breast augmentation. I was the senior post-operative nurse from the moment I started and when I say "senior" I was the only post-operative nurse when I started. When I left there were about 14. All of those people felt there was a huge injustice to them and that they were grossly let down by the Government and the regulations. They had an inherent trust that anybody who was a medical professional or a doctor would do no harm.

So when they initially went to have a consultation with a cosmetic surgeon they were of the opinion that this person was actually a surgeon. None of the surgeons I worked with were actually surgeons until closer to the end when we had a Fellow of the Royal Australasian College of Surgeons [FRACS] surgeon who was a cardiothoracic surgeon—so no experience in cosmetic surgery or training for that matter. The patients obviously believed that they were being looked after by somebody who was qualified and specialised in breast augmentation but postoperatively when something went wrong, which it did—most frequent were infections and the whole list of things I have put in my submission—they very quickly realised that it was not actually a surgeon and that this person did not have the scope of practice to resolve their issue. This is where we came to.

Basically option A was to sign a deed of release, get your money back and hope that you can save up and eventually have surgery with a specialist plastic surgeon or take a punt and believe in the doctor, take them at face value and go under another revision—that is why so many patients ended up having multiple revisions. No, they had no idea. They also had a fear that if they complained to the HCCC or to any other body then that would automatically destroy the therapeutic relationship, they would never have the option of secondary surgery or the offer of a deed of release and getting the money back was off the table. So it was handled very cautiously because these are people of low socio-economic status who do not understand their rights or what is available to them and for the ones who did complain there was no recourse because technically the surgeons are not doing anything illegal, the facility is not doing anything illegal, so they were still left high and dry. What was the second part of your question?

The CHAIR: How do you think the State Government and the HCCC could improve on providing information services to those patients of whom you were aware?

Ms MONTGOMERY: From a government level two of the surgeons I worked with did not trade under their name on the Australian Health Practitioners Regulation Agency [AHPRA]. For instance, in the public it is often mentioned to search for the person to find out whether or not they are qualified, to do your homework, but you cannot find these people. Something my colleague mentioned to me that is actually a good idea is to have the photograph of the practitioner on AHPRA. For instance, if you are talking about an Asian person with either the name Lee or Chang then you might have 20 doctors with that same name. We also had a doctor who came from another State so you could not even find him in Sydney, it was nearly impossible. That is provided you have a patient with the know-how to navigate and get to AHPRA. If they did, I myself cannot find half the surgeons because they are not trading. Actually we had three—I lied—surgeons who used different names to their registered name on AHPRA, which makes it extremely difficult. That is just one way that AHPRA on a federal level could help improve by helping patients to find surgeons who are actually qualified or even just what their qualifications are.

Apart from that, obviously the psychological impact is huge. That is all I deal with every da—all Trusted Surgeons does is deal with the psychological aspect. Screening people prior to surgery would make a significant difference because you are not taking on patients with body dysmorphia. We had a victim who had been raped a week before and in recovery the patient got really upset when we tried to dress her. I thought, "Oh my goodness,

this had never happened before. Why is this patient so violent?" She said, "A week ago I was raped and then I decided to get a breast augmentation to make myself feel better." Jaw dropping. But this is not screened because this is a commercial business, the volume is what gets them money through the door so it is all about converting. Obviously as nurses we did not have a commission structure but the front of house staff did, the consultants did, and there were incentives to convert people—whether it be over the phone or in person.

The CHAIR: Were those front-of-house staff who were working on a commission licensed practitioners or registered nurses?

Ms MONTGOMERY: No.

The CHAIR: They had no formal qualifications at all?

Ms MONTGOMERY: No, they were receptionists.

The CHAIR: Do you believe there was no explanation for the people coming in of the procedure they were about to undergo? Do you also believe there was no caution to them about potential side effects and potential follow-up issues that could happen with those services?

Ms MONTGOMERY: I think it has grossly minimalised. It is like the 1970s when people smoked cigarettes thinking that they were so cool because they were cowboys with Marlboros. That is when it is: it has been trivialised that patients see high-volume clinics like that is like that and think, "They do hundreds of them. Yes, there might be a few odd ones that do not turn out okay, but that is just the odd few. The majority of them are okay." It is the same with patients going to Thailand. That is all it takes: You see the reviews and before-and-after pictures online—which, half the time, may or may not be real. I know from my previous employer that we would only put up photos that were good. So out of 100 patients, you might only get five from that surgeon that would actually go online and were boosted.

The CHAIR: From your experience in your employment, did you see failure to notify those patients of the potential risks and side effects of the treatment that they could be having?

Ms MONTGOMERY: Yes, they had a checklist on the consultation form that had to be filled out. They went "tick, tick, tick" on all the issues in a very short, 30- to 45-minute consultation. The patients did not know what the issue was. If I said, "A side effect might be symmastia", the patient would say, "Yes, no worries."

The CHAIR: There was no explanation as to what that meant.

Ms MONTGOMERY: Exactly. When I created a PowerPoint—something I have mentioned in my submission—to show people what the side effects were, it was shut down very quickly because no-one would go through and have surgery.

The CHAIR: If you had to generalise, of all the people that you saw treated, would you say that a majority of them did not receive that information and advice prior to treatment?

Ms MONTGOMERY: They received the information about potential side effects, but I do not believe that they actually understood what the side effect was, because when I saw them post-operatively, I had to explain to them what "dehiscence" meant. It was told to them. It was given to them, but it was given to them in a language that they did not understand. That is the vast majority. These were people from a low socio-economic group who were taking a loan for $20 a week and getting a boob job "for the cost of a coffee a day". That was how it was advertised.

The CHAIR: The Committee has heard evidence today about what we believe to be misleading advertising which did not outline the concerns, the risks or managed customer expectations. Effectively, all of those things took place.

Ms MONTGOMERY: Yes, one hundred per cent. Earlier, I heard evidence regarding nurses. Last weekend, just by chance, I went out with about nine of the nurses that are used to work with. All of them said that there was no way that I would speak. I have children, a mortgage to pay and that I would not speak to the media, the HCCC or anybody, out of fear of retribution from not only the clinic that I worked at but also the industry itself. I get a lot of negative attention—I do not want to say bullying—from people within the industry just from having worked there. That tarnish for being a whistleblower will continue for the rest of my career. Potentially, it would prevent me from working in the industry.

The Hon. WALT SECORD: Ms Montgomery, I am the shadow Minister for Health. I thank you for coming forward. What you have said is explosive. I have had dealings with The Cosmetic Institute [TCI] of Bondi Junction. It has attempted repeatedly to sue me for exposing its efforts, so I understand that today has not been easy. I thank you for that. It is something that is very brave and principled.

Ms MONTGOMERY: Thank you.

The Hon. WALT SECORD: During your time there, of the 15,000 patients you referred to, how many would you say would have had an adverse impact on their life?

Ms MONTGOMERY: A lot of them have. That number will increase, especially with the awareness about anaplastic large-cell lymphoma and the surgical practice not being in line with the 14-Point Plan. The number would increase whenever we got a new surgeon—they had no experience or background. You are talking two days of training.

The Hon. WALT SECORD: You would have had more experience than them.

Ms MONTGOMERY: No, I do not operate.

The Hon. WALT SECORD: I mean in-patient care and things like that.

Ms MONTGOMERY: In postoperative care, I had quite a lot of experience. I mentioned before about a cardiothoracic surgeon. Every time he came in for one of his dehisced wounds, even when an implant was showing through the incision, he asked, "What would you do?"

The Hon. WALT SECORD: Would he ask for advice from you?

Ms MONTGOMERY: All the time. Because I was a bit more experienced and had been there for quite some time, I took it upon myself to alert another surgeon and to do what needed to be done. He had no understanding of wound care management. He had no understanding that there were a number of pseudomonas cases in a very short period of time, so, may be alarm bells should be ringing and that we should be looking at our practice because somewhere, something was not right because one surgeon had a very high ratio of pseudomonas cases in a short period of time. There was no accountability. They were working within their scope of practice and I was just the annoying voice in the background saying, "There are a lot of infections on my end. What's going on?"

The Hon. WALT SECORD: Would you stand by the description that this was the McDonald's—the fast food outlet—of cosmetic surgery?

Ms MONTGOMERY: A hundred per cent. Everything was commercialised and driven to increase revenue. It was a business. The board of directors were four businessmen. One of those happened to be a specialised plastic surgeon who did not work with the facility. He did two days of training on real patients paying full price with no understanding that that surgeon was operating for the very first time.

The Hon. WALT SECORD: What did you feel when you walked into the facility? I have been to the facility when it was The Cosmetic Institute. It was full of beautifully young, healthy and vibrant women under the age of 25 who had been talked into procedures that they did not need. How did you feel when you walked in?

Ms MONTGOMERY: The women believed that they needed it and that they wanted it. This gave them hope. Some of the earlier patients who spoke out against TCI got bullied and had to take down profiles online because they got bullied so badly by other TCI patients. The front-of-house staff, which is unregistered practitioners, treated these patients so well, they promised them the world. We had a couple of receptionists who used to show their breasts and say, "Look how good mine are. I got mine done by Dr such and such", and that would be reassuring; they think, "Oh my goodness, this is amazing. I could love this. I can't believe this." When they came in they were thankful that TCI existed; they were excited that their loan got approved and they could not wait to get on the table. I think even if you had said to them, "It's not above board. The surgeon down the street who is $5,000 or $10,000 dearer is a qualified plastic surgeon," they would have found some sort of argument because TCI had a script for everything so there was an answer.

The Hon. WALT SECORD: They workshopped every possible scenario?

Ms MONTGOMERY: Yes, absolutely.

The Hon. WALT SECORD: What if a young woman had second thoughts or was reconsidering or wavering, what would they do?

Ms MONTGOMERY: That was fine; they were busy enough that it did not matter. You would get a refund and away you could go, it was not the end of the world, but let us not forget that huge amounts of money were going into Google AdWords, social media—you are talking a minimum of $2 million a month.

The Hon. WALT SECORD: In advertising to attract people in?

Ms MONTGOMERY: Yes. That is just in AdWords, yes.

The Hon. WALT SECORD: Two million dollars a month in AdWords?

Ms MONTGOMERY: Yes.[1]

The Hon. WALT SECORD: How long did you last at the facility? How long did you work there?

Ms MONTGOMERY: I worked there for three years. When I first started working there I did not know that they were not surgeons.

The Hon. WALT SECORD: When did you find out?

Ms MONTGOMERY: The first time I did a weekend that training was on and I thought this is really odd—they are learning how to suture. Again, if you are a surgeon you would know how to suture.

The Hon. WALT SECORD: So what did you do? Did you think "My god, what am I doing here?"

Ms MONTGOMERY: I did and I tried to leave numerous times and literally could not get a job anywhere. As soon as I said where I worked and what my experience was I was treated very, very poorly by any surgeon that I approached. The only reason I ended up getting a job was because I knew the practice manager personally from prior to TCI. I have four children, my husband is a tradesman, I still have to work. It is easy to say "You could have just left. You're unethical for staying there", but whilst I was there all I did was fight. By the time I left I was exhausted from fighting; I constantly fought for patients to either get a refund, to go to the HCCC, to seek a second opinion, and just to support them because the blame was constantly passed to them.

The Hon. WALT SECORD: What do you mean the blame was passed to the patient?

Ms MONTGOMERY: "It is your pre-op anatomy", "You didn't follow the post-operative instructions" or "This was explained in the consult. I told you you were borderline". That was very frequent. So many patients who required a lift were pushed through the system and had an augmentation and it ended up being a very deformed look and horrible and these patients said, "I had children and I was deflated and I did this to boost my confidence"—or they might be just recently divorced—"and it has actually done the opposite. Now I can't even look at myself naked," and they said, "Yes, but I told you you were borderline. You've signed this form." They would pull the form out and say, "Look, this is where you signed. You acknowledged that you were borderline lift. You should have had a lift. That's not my fault. I don't do lifts, I only do breast augmentations."

If the patient complained to the HCCC, which I know of patients who have, a letter would come out to TCI, TCI would have a very experienced corporate lawyer do a response and then the whole matter would be done. The only option for that patient is to try and go through legal channels, and I can tell you I have not spoken to one patient who has happily gone down the path of trying to claim some sort of compensation, not for themselves but for a revision surgery.

Mr AUSTIN EVANS: With the benefit of hindsight, what are the things that you would put in place to stop this happening again?

Ms MONTGOMERY: There is no balance. You have got every surgeon and doctor out there throwing money into advertising, into social media, into marketing. Everybody is fighting for more work and that is predominantly what the problem is; it is a very lucrative industry and everybody is greed driven. You need to educate patients of the real risks. No-one is brave enough to do that because everybody is scared that you will turn people off having surgery. If you turn people off having surgery there is no work, then there is no business, you are not getting an income. I am not sure if you have googled it but quite a lot of surgeons live a very lucrative lifestyle, whether they are cosmetic surgeons, plastic surgeons or whatever. The practice is effectively a business. You have some that are more ethical than others but all of them in this day and age have to have marketing, they have to have websites, they have to invest in whatnot. But being a government organisation, investing on the other side to try and bring some sort of balance in regards to what the real risks are so it is not so trivial and that there are real people who are going to suffer real side effects. Nobody is transparent about their complication rate.

Mr AUSTIN EVANS: Do you think, probably not 100 per cent but that that would have made a difference to a large number of the patients?

Ms MONTGOMERY: Yes. I had a couple of friends who went through TCI and both of them I tried to discourage–one of them actually moved the surgery to a different surgeon—and both of them still persisted to go through because in both instances they had multiple children, they had a mortgage, they were either stay-at-home or part-time mums, and it was $4,000 or $5,000 cheaper and looking online and everything else was reassuring. So me being one person telling them "No, I don't think you should," even though I worked there, did

[1] Note following the hearing, Ms Montgomery advised the Committee that she had incorrectly stated the Cosmetic Institute spent 2 million dollars per month in AdWords. The correct figure was $200,000 per month.

not carry enough weight for them to change their mind. Had there been a public campaign, an awareness, there would be a little bit more doubt.

The Hon. LOU AMATO: You mentioned that people with low socio-economic backgrounds are particularly vulnerable. Is that because they are informed differently or the procedure is different or because of their lack of understanding of the procedures?

Ms MONTGOMERY: Because they are driven by money, because they are very price conscious because they cannot afford it. If you, for instance, are going out to dinner and you have got the family in tow and you walk past a restaurant you stop and have a look at what is on the menu and how much it is. I know personally if I walk past and I look at the menu and there are no prices I cannot afford it—I am not even going to continue looking. I am not going to go to the waitress and say, "Excuse me, how much is your kids menu?" and that is the perception of these people.

The Hon. LOU AMATO: I understand the price is what attracted them to get that procedure done but what I am asking is how is that procedure different to something you are going to pay more for? What is the difference in the procedure? Is it the implant is different?

Ms MONTGOMERY: There are a number of answers to that question. The implants were cheaper because they were buying in huge bulk compared to another surgeon.

The Hon. LOU AMATO: Was the quality different?

Ms MONTGOMERY: No. They were also using a limited range of implants. There were a lot of things done differently, which Alfie would be able to answer because he worked on that commercial side of the business; I did not so this is quite beyond what I did and what I was privy to, but I know from the patients' perspective when they saw an ad that "For a cup of coffee a day" or "All of our surgeons are very trustworthy; they are all registered with AHPRA" and things like that, if they were university graduates who had gone on and done something exciting and were very wealthy they would be going to the best surgeon and they would not settle on anything less than the best surgeon—

The Hon. LOU AMATO: It is you get what you pay for.

Ms MONTGOMERY: Yes it is, but that is the prime reason why you do not see more horror stories in the media. There was a lady who came out and spoke on *The Project* about her experience which is horrible, and within two minutes of her story ending one of the comedians said, "Yes, well I go to a plastic surgeon in Melbourne. He is the best in Melbourne. You get what you pay for, you know. You can get a qualified surgeon", which immediately discredited her whole story, made her feel like crap and she is still having therapy for that. She will not come out and speak publicly again and anybody else who is considering speaking publicly after seeing that certainly would not. So it is that perception that you get what you pay for that prevents people from coming out and speaking.

The Hon. LOU AMATO: They kind of feel embarrassed about it all.

Ms MONTGOMERY: Absolutely, yes. If I was to go car shopping I am not going to go and walk into Mercedes; I would be going to the Kia shop, and that is what it is.

The Hon. LOU AMATO: You mentioned that the HCCC only corresponds by electronic communications—no onsite investigation or interviews occur. That sounds like it would be rather frustrating and difficult for a lot of people because you are only going by an electronic rather than a face-to-face conversation.

Ms MONTGOMERY: Yes. If you walk into an aged care facility you see signs everywhere with a number where you can report issues. For violence against the elderly there is a proper reporting process. It is very transparent. If there are reports or complaints of elderly people being abused or whatnot it is thoroughly investigated with a fine-tooth comb. In the cosmetic sector it is not. I do not know why. Despite multiple complaints and despite multiple infections it is dealt with by the solicitor of the surgeon, doctor or clinic, and away it goes. Even if you did a tour and you decided that everything was unethical, if you spoke to people off the record so that it did not affect their employment, you do not have the ability to enforce a strong reprimand and show that surgeon or that person up. If you go and eat at a dodgy restaurant all of a sudden the health department would close them down and put a sign on the door. You do not do that in a cosmetic clinic. So without the HCCC having more power I am not sure what difference it would make.

The Hon. MARK PEARSON: I want to thank you for coming and for exercising the courage to do so. It is noted and respected. Did you feel any coercion by the "surgeons" or the clinic to undertake practices which you knew that you, with your skills, should not have been asked to do?

Ms MONTGOMERY: I did at times, yes.

The Hon. MARK PEARSON: Was that because the "surgeon" was clearly not capable of doing it and it was looking like a fairly serious situation developing?

Ms MONTGOMERY: Yes.

The Hon. MARK PEARSON: Did the "surgeon" or practitioner come and assess any situation where it was clear there was a requirement for follow-up or corrective surgery? Is it called "revision surgery" or "revision intervention"?

Ms MONTGOMERY: Yes.

The Hon. MARK PEARSON: Did they participate in the professional way that they should have in assessing and undertaking that work?

Ms MONTGOMERY: No. We had one particular case in Queensland. I saw the complaint to the Queensland Heath Ombudsman. The woman who came in had an implant showing. You could see the implant. It was leaking everywhere. She actually had a sanitary pad on it—a maxi pad. The surgeon said, "If it falls out, it falls out. It is too close to Christmas; I am not adding another case to my list." We—the other nurses and I—knew that this needed a wash-out. It needed to be addressed. The surgeon who would normally take that on—we would manoeuvre and weave to make what was needed happen for that patient—had left because it was days before Christmas.

The poor patient did end up in hospital. She did end up having to have explant surgery and did end up with a specialist plastic surgeon through Queensland Health. Of course, that plastic surgeon wrote to the Health Ombudsman and then that letter came to us: "This is rubbish. This is just a turf war. He is against me because I'm a cosmetic surgeon. I'm above him anyway because I am thoracic-cardio; I have saved lives. He is just a plastic surgeon; he is beneath me." That was the attitude and it just went away. Nothing ever happened. He was never reprimanded. He continued to practice. He continued to have infections.

The Hon. MARK PEARSON: Despite those situations being referred to the HCCC?

Ms MONTGOMERY: I know it was referred to the Health Ombudsman of Queensland.

The Hon. MARK PEARSON: If such a situation was referred to the HCCC that is actually unlawful. So the HCCC would have had the capacity to investigate that. Would you agree with that? Not supervising a corrective procedure because it is invasive or whatever—

Ms MONTGOMERY: But if you had investigated it, what would you have done? What can the HCCC do to stop this person operating?

The Hon. MARK PEARSON: That is what our job is. That is why we are teasing out these—

Ms MONTGOMERY: Have any cosmetic surgeons been stopped to date?

The CHAIR: Mr Pearson, that surgery was conducted in Queensland, is that correct?

Ms MONTGOMERY: Yes.

The CHAIR: It was carried out outside of New South Wales. The HCCC does not have jurisdiction outside New South Wales.

Ms MONTGOMERY: That was one example. He did operate in Sydney before going to Queensland and had over 150 patients on the concerns register before going to Queensland.

The Hon. MARK PEARSON: Were you ever offered a commission to speed up the number of patients that were going to be treated? Let's say there were eight listed and the surgeon wanted to do get 10 through, were you ever offered a commission on top of your salary?

Ms MONTGOMERY: No. I did not sell anything.

The Hon. MARK PEARSON: No, I mean a commission to say, "If we can get 10 through today you'll get $300 for the last two."

Ms MONTGOMERY: I never worked in theatre; I only worked post-operative. I worked for free half the time, out of hours, because there were too many patients that needed hand-holding. They needed to vent and needed to be heard. They need to be validated—that they were not going crazy and it is not them. There definitely was a commission structure. It was like a car dealership—you know, out the back where you have the names on a list and how many have been sold, and what your gift voucher is going to be at the end of the month. That definitely happened but I was not part of that because I was on a base wage. I was on a salary; that was it.

The CHAIR: Can I just clarify? Did that commission structure you just mentioned refer to the people at the front of house who were unqualified? It was only them?

Ms MONTGOMERY: Yes. Correct.

The Hon. MARK PEARSON: Last question. How many former patients are you an advocate for at this moment?

Ms MONTGOMERY: I received a cease-and-desist letter from The Cosmetic Institute [TCI] very soon after commencing Trusted Surgeons in regard to, "This is conflicting with your past employment and you are not allowed to work in the same industry et cetera." So I have made a conscious effort not to have anything to do with any TCI patients. If they contact me I refer them back to TCI. In saying that, I have spoken with Turner Freeman Lawyers. I am supportive of their case and whatever I can do to help I am happy to do so.

As far as Trusted Surgeons go, and all of the patients mentioned in my submission—no, I have intentionally tried to leave them out. My submission would be like an encyclopaedia if I wrote some of the stories about the pneumothoraxes, the constant symmastia cases, the dehiscence of incisions. We had surgeons where every single patient for the first month after they started had an infection—every single patient!—until they learnt to suture. Then all of a sudden it would be okay and they would be good. We had delayed seromas and lots of haematomas.

The Hon. MARK PEARSON: What is a seroma?

Ms MONTGOMERY: A delayed seroma is when, maybe a year or two years later, the patient wakes up one day and their breast is like a bowling ball. It is extremely painful from the pressure because there is so much fluid. Again, this is beyond my scope of practice. There are different ways to manage it. Some surgeons managed it quite well. They went into theatre and a sample was sent off to pathology to see if they had anaplastic large cell lymphoma [ALCL] or whatnot. From other surgeons these people had drainage via ultrasound with a pathology under Medicare four or five times before anything was done. So four or five times they had something going in where there is a foreign body and withdrawing fluid.

The CHAIR: Draining it.

Ms MONTGOMERY: Exactly. We had numerous patients, especially over Christmas, who would end up in the public health system. The psychological impact, apart from the infections and Medicare and whatnot, was huge. We even had a couple of patients who had deep vein thrombosis [DVT], who were in the public system.

The Hon. MARK PEARSON: Thank you very much.

The CHAIR: Of the people who have come to you with post-operative issues, how many have you referred on to the HCCC at this stage?

Ms MONTGOMERY: All of them—every single one.

The CHAIR: All of them. Do you have a rough idea of how many that would be?

Ms MONTGOMERY: I do not know how many actually do. There are only some that I have helped—

The CHAIR: What would be the number who have been referred on to the HCCC, approximately?

Ms MONTGOMERY: Well over 50. There are more who are in law suits. They are not interested to going to the HCCC. What is the point? They need money to get a revision, at the end of the day. You are talking over 50 in that category. But any of the patients who have contacted us have not had any real fundamental help. We are only providing support. We are only pointing in a direction. We are only telling them of who the Victorian Civil and Administrative Tribunal [VCAT] is or—

The CHAIR: Their options?

Ms MONTGOMERY: Exactly. What they really need is education prior. Prevention is better than a cure.

The Hon. WALT SECORD: Ms Montgomery, I do not know if you would be aware, but this Committee has made repeated efforts to contact the people who are involved in The Cosmetic Institute [TCI], Eddy Dona, and they are refusing to participate, refusing to come. They say, "We do not exist anymore. Why are you bothering us?" Does that surprise you?

Ms MONTGOMERY: No, that does not surprise me at all. I did not have a lot to do with Dr Dona. He was a business investor. Again, from a patient's perspective, seeing an elite—

The CHAIR: Before you proceed with answering that question, I recommend that we now go in camera. I recommend that we clear the gallery.

The Hon. WALT SECORD: We should give the option to Ms Montgomery.

Ms MONTGOMERY: I am happy to go in camera.

The CHAIR: With the witness's permission, we will now go in camera. I ask that the gallery be cleared at this time.

(**Evidence in camera proceeded**)

(**The Committee adjourned at 16:24)**