QUEENSLAND CIVIL AND ADMINISTRATIVE TRIBUNAL

CITATION:	*Rosenbaum v Medical Board of Australia* [2022] QCAT 141
PARTIES:	**SIMON ROSENBAUM** (applicant) **v** **MEDICAL BOARD OF AUSTRALIA** (respondent)
APPLICATION NO/S:	OCR015-21
MATTER TYPE:	Occupational regulation matters
DELIVERED ON:	9 May 2022
HEARING DATE:	23 September 2021 and 13 October 2021
HEARD AT:	Brisbane
DECISION OF:	Judicial Member D J McGill SC, Assisted by: Dr P Baker, Dr D Khursandi, Ms M Ridley.
ORDERS:	**The appeal of the applicant is dismissed, and the decision of the respondent of 3 December 2020 is confirmed.**
CATCHWORDS:	PROFESSIONS AND TRADES – HEALTH CARE PROFESSIONALS – MEDICAL PRACTITIONERS – DISCIPLINARY PROCEEDINGS – OTHER MATTERS – immediate registration action – appeal to Tribunal – persistent breaches of conditions of registration – apparent poor post-operative care of patients – cosmetic surgeon – whether serious risk to persons – whether necessary to take any and what action to protect the health and safety of the public – whether immediate action in the public interest Health Practitioner Regulation National Law (Qld) s 156, s 199(1)(h) *Health Ombudsman v Harirchian* [2021] QCA 141 *LCK v Health Ombudsman* [2020] QCAT 316 *Liddell v Medical Board of Australia* [2012] WASAT 120 *Loney v Nursing and Midwifery Board of Australia* [2020] QCAT 486 *Oglesby v Nursing and Midwifery Board if Australia* [2014] QCAT 701

Rao v Medical Board of Australia [2021] QCAT 145
Ting v Medical Board of Australia [2021] QCAT 53

APPEARANCES & REPRESENTATION:

Applicant:	R De Luchi, instructed by Gardiner Legal and Regulatory Pty Ltd
Respondent:	S Marsh, instructed by Clayton Utz solicitors

REASONS FOR DECISION

[1] On 3 December 2020 the respondent suspended the registration of the applicant as a medical practitioner, acting under the Health Practitioner Regulation National Law (Qld) ("the National Law") s 156, which provides for the respondent to take immediate action extending to suspension in certain circumstances. By this proceeding the applicant appeals from that decision to the Tribunal, as he is entitled to do under the National Law s 199(1)(h). This is a merits appeal, and although the Tribunal may have regard to the decision of the respondent, the Tribunal decides the matter for itself.[1] In accordance with the *Health Ombudsman Act* 2013 s 126, I am assisted by assessors Dr P Baker, Dr D Khursandi, and Ms M Ridley.[2]

Background

[2] The applicant is a registered medical practitioner and has specialist registration as a general practitioner. For some time he has been practicing as a cosmetic surgeon, from premises in Brisbane and Melbourne.[3] In 2010 the former Medical Board of Queensland commenced disciplinary proceedings against him in relation to the post-operative care of a patient, as a result of which, on 29 November 2013 the Tribunal found he had engaged in unsatisfactory professional conduct, and imposed a condition on his registration, that he implement and maintain a referral plan for post-operative care.[4]

[3] After September 2015 the respondent received ten notifications relating to the applicant's clinical performance of cosmetic surgery by late 2016, most of which were complaints from patients. These were:

(a) N302434: Complaint about inadequate information about implant surgery, and visible scarring afterwards, with the implants too big and sitting too high. The applicant said that matters had been discussed comprehensively with the patient before surgery, including alternative procedures. There was a significant difference between the two versions of the pre-operative

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1 The National Law s 202; *Newcombe v Medical Board of Australia* [2013] SAHPT 2 at [2]; *Rao v Medical Board of Australia* [2021] QCAT 145.

2 For their function see the *Health Ombudsman Act* s 127.

3 In oral evidence he said he trained in cosmetic surgery in the US around 1990: p 1-8. He practised initially in Melbourne, but began to practise in Brisbane in 2002, and on the Gold Coast after 2010: p 1-45, 46. After Covid he practised only in Queensland.

4 [2013] QCAT 722. That decision was based on a joint submission from the parties, attached to the decision, which set out details of the event, including that the applicant placed the patient at risk by delaying for eight hours her transfer to hospital. An assessment of the applicant's sedation skills on 22 July 2013 concluded that he was competent and safe: Hearing Book p 584.

consultation, and there was a lack of adequate documentation. An independent opinion was critical of the notes of the first consultation, and said that the consent procedure was deficient, noting that one complication, occurring in 5% of cases, had not been mentioned. As well, the procedure was not performed in an orthodox way, but in a way which predisposed the patient to deformities. Another independent opinion was that the implants used were too large. The applicant disagreed with the independent reports.

(b) N311328: Complaint that the applicant was supposed to do a breast lift, slight reduction and implants, and all he did was insert the implants. The applicant conceded that he changed the procedure during surgery, having formed the opinion that the procedure performed would carry less risk of complications and be more beneficial to the patient. The respondent regarded the consent form as inadequate and unclear, and that the procedure performed was technically not covered by it.

(c) N319949: Complaint about not being given relevant information until just before surgery, and that the procedure performed was not the procedure consented to. This was denied by the applicant, who said that her skin had stretched several weeks after surgery which was not his fault. He said his notes indicated that the patient was given the procedure she requested. The respondent noted that there were conflicting versions before it, and that the applicant had misunderstood her concerns. There was also a complaint of inadequate post-operative care, and a recovery time much longer than estimated. The applicant said there were three follow-up appointments with an enrolled nurse, which indicated no infection or inflammation

(d) N324823: Complaint about the effectiveness of liposuction, asserting that the wrong method was used. The applicant said that this was explained to the patient before the surgery, including the method which was different from one he had been told by another practitioner. This explanation was not documented in records, and the only consent was on the day of surgery.

(e) N328072: Complaint that the unqualified practice manager was being used for nursing duties, including assisting at surgery. The applicant said that the person was not a nurse, but did things including changing dressings and dispensing oral medication. The respondent considered that he had provided inconsistent accounts as to what medication would be handled by her.

(f) N331047: Complaint that in a procedure in February 2016 the applicant had failed to repair a hernia, had performed an abdominoplasty inadequately, and had misaligned her navel. This was said to be supported by medical opinion. She also complained that the procedures performed were not the procedures consented to, and that post-operative care was inadequate. She developed an infection, but was told not to worry. After pus escaped from her navel, she attempted to telephone the applicant, without success. She then went to a hospital where the doctor she saw telephoned the applicant, and said he was interstate and had no practitioner covering his Brisbane practice. The patient was found to be quite unwell, and required extensive treatment. The applicant denied that different procedures were performed, and said that the hernia was repaired and the other procedures performed properly. The applicant said that after the surgery she was assessed by a nurse employed by the hospital, and later by his staff nurse, by telephone, and a few days later he saw her with a

nurse when her dressings were changed. He had returned her call on the day she went to hospital, albeit several hours later.

(g) N334889: Complaint that pain persisted for six months after surgery when a chin implant was replaced. As well there was no post-operative consultation, and emails had not been answered. The applicant said that there were no complications and the notifier had been pleased with the result, but after pain persisted, which was not uncommon, he removed the implant. He blamed his staff for the failure to respond to emails.

(h) N338189: Complaint that she had not been warned of problems associated with implants, or an explanation of test results. The applicant said he provided normal information and documents referring to risks and complications.

(i) N339080: Complaint that the applicant was allowing his practice manager to do consultations, and provide pre- and post-operative advice to patients. This was the practice manager who was at the time the de facto spouse of the applicant, and that relationship had since ended. The applicant blamed this person for a lot of the practice management complaints that had been received.

(j) N339119: Mandatory notification by a doctor, that a patient of the applicant had been unable to contact him when complications arose, and the notifier also had difficulty contacting him. The patient was not treated properly until she presented to a hospital, and the notifier regarded the monitoring and treatment of the patient after the procedure as inadequate. An independent opinion obtained by the respondent agreed with this assessment, as did a committee of the respondent.[5] (This involved the same patient as N331047.)

[4] In response to notification N311328, the respondent obtained a performance assessment report on the applicant by two doctors on 13 September 2016, which identified deficiencies with his performance. There was said to be a paucity of documentation of pre-operative assessment, and of discussion of risks and complications of procedures, with patients being able to elect to receive the bare minimum of information. Two procedures were seen, and in each case the process of consenting the patient occurred just before the surgery, and some of the risks appeared to be understated. The applicant said that he had previously gone through these matters with the patients, but the respondent was concerned about a lack of documentation to demonstrate this. As well, the applicant claimed he had since improved his record keeping, and used more detailed consent forms.

[5] The two procedures involved breast implants, and in each case the patient was anaesthetised and surgery commenced before the implants arrived at the facility. The assessors considered that it was fundamental that the implants be present and checked by the practitioner before anaesthetising the patient. One patient was under anaesthetic for an additional fifteen minutes, and the other, an additional fifty-five minutes. The assessors said the applicant did not seem to recognise how serious this was. The procedure was carried out skilfully, but this was seen as a lack of insight into the importance of patient safety. In his affidavit of 10 August 2021 the applicant said that it was unclear how condition 14(b), which required him to confirm the presence of the implants at the facility, related to patient safety, as it

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5 Hearing Book p 81.

would only be an inconvenience if the patient attended and the implants were not there. It appears that his lack of insight continues.

[6] The assessors also commented that the contact details provided to patients for post-operative care involved the applicant, his practice manager and another practitioner who worked in loose cooperation with the applicant, which was seen as unsatisfactory where the applicant (and his practice manager) were often interstate. At this time the practice manager was his de facto spouse, and the applicant said that that situation had since changed.

[7] Having considered that report, and other material, the respondent decided on 8 December 2016 to impose conditions on the registration of the applicant, and to investigate the applicant. Following negotiations, the respondent revoked those conditions, and on 5 April 2017 imposed different conditions on the registration of the applicant, although the differences were not great.

[8] A report of the investigation into the applicant initiated in December 2016 was considered by the respondent on 4 October 2017. Having considered that report, and other material, the respondent decided on 13 December 2017 to impose different conditions on the registration of the applicant.

[9] During 2018 and 2019, as a result of information obtained by the respondent, on five occasions it cautioned the applicant about various instances of non-compliance with those conditions.

November 2018 Audit

[10] An audit by a particular doctor nominated by AHPRA of 23 patients at the applicant's Melbourne practice was conducted on 9 November 2018, and a report was provided to the respondent on 6 June 2019. The auditor considered that overall the conditions on the applicant's registration were being met, but expressed concern about limited documentation of pre-operative and post-operative assessments, with notes not showing that all the requirements for the item claimed on the Medicare schedule had been present. He also considered that the patients were being routinely ordered extensive pre-operative investigations which did not appear to have been followed up, and mentioned a couple of specific cases. He also said he had difficulty making contact with the applicant to arrange the audit, and difficulty getting paid for it.

[11] A second audit ought to have occurred by 31 March 2019 in accordance with the conditions, but no audit took place in 2019. On three occasions during 2018 and 2019 the respondent cautioned the applicant about failures to comply with the condition for audits of his practice.

[12] In response to this report, the respondent on 16 October 2019 referred the applicant to the Health Ombudsman about seven patients covered by the auditor's report, for three of whom it expressed concern that the care provided was or may be below the standard reasonably to be expected. These patients, the basis for the concern, and the response of the applicant[6] were as follows:

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[6] In a letter to AHPRA of 27 August 2020, Hearing Book p 267. This dealt only with the patients about whom concern had been expressed.

(a) Patient AA: This patient underwent liposuction although she weighed only 45 kg, and was at the time being treated with anti-depressants. The Respondent was concerned about a generalised liposuction on such a person. The applicant said that the liposuction was not generalised but confined to her abdomen and flanks, where there was a mild excess of fat, and removal would produce a desired shape improvement; the patient was a medical practitioner, consented and was happy with the result: p 1-15. She was rational and sensible, and the anti-depressants did not preclude the procedure.

(b) Patient BB: The report of the pre-operative breast ultrasound recommended further investigations into two areas, but there was no documentary evidence of follow up with the patient, who had no treating general practitioner. The applicant said that the patient had a general practitioner, and that investigation results are always reviewed with the patient and if necessary the patient is advised to follow up with their general practitioner; he could not recall this particular patient. The absence of evidence of this, and a failure to advise a general practitioner of the ultrasound report, were not disputed.

(c) Patient CC: The report of a pre-operative investigation revealed possible renal impairment, but there was no evidence this has been followed up with the patient or any general practitioner. The applicant said that blood tests showed normal renal function, and the indication in the other tests were consistent with the high protein diet of the patient, an active gym participant. He said this was discussed with the patient, but did not dispute that any such discussion was undocumented.

(d) Patient DD: A pre-operative chest wall ultrasound revealed prominent lymph nodes, but there was no evidence of examination of this, or following up the result with the patient or any general practitioner.

(e) Patient EE: The patient was a bodybuilder but was not asked about steroid use, or a hormone assessment. In evidence the applicant said he did ask and was told steroids were not being used (p 1-15), but evidently this was not documented.

(f) Patient FF: This patient had to be taken to theatre ten days after surgery to drain a haematoma, but the applicant had denied that there had been any emergency admissions. The auditor agreed with the treatment, but considered that that was an emergency admission. In evidence the applicant said that it was not an emergency because there was no urgency as to the day on which it was done, and described it as an elective procedure: p 1-18, p 1-40.

(g) Patient GG: A claim on medicare was made for item 30177, an abdominoplasty, although the responses to the patient questionnaire indicated that the Medicare requirements for that item had not been met by the patient.

[13] In December 2019 the respondent referred the applicant to a Performance and Professional Standards Penal. On 8 June 2020 the Panel reported that the applicant had breached two requirements of the conditions on his registration, relating to the requirement for an audit of his practice, apart from the breaches for which he had been previously cautioned. This was characterised as unprofessional conduct, and the applicant was reprimanded. The Panel noted that these breaches were not disputed by the applicant, who had provided details of his difficult personal and financial circumstances during the relevant period, and in its decision it stated:

> It is important to note that the Panel felt a great deal of sympathy for the difficult personal circumstances that the [applicant] has faced since the imposition of conditions on his registration. The Panel was of the view that the [applicant] was genuine when he told them that he suffers "overwhelming anxiety" when dealing with AHPRA and this has adversely affected his compliance with the condition. The Panel considered that the [applicant] had appropriately accepted responsibility for his failure to comply with the conditions.[7]

Second audit

[14] In the meantime, in early March 2020 a different auditor, a general surgeon, conducted an audit of twenty patient files from the applicant's Brisbane practice, and provided a report of 6 March 2020.[8] The auditor produced a table listing the various conditions or parts of conditions, and whether they had been complied with for each patient, as appeared from the file, a process which really assessed the documentation of compliance with the conditions. This identified breaches of a number of conditions. The auditor also expressed concern that the applicant may have practiced outside his scope of practice, and had failed to implement a Plan B for a patient.

[15] Of the twenty-nine specific things assessed, the auditor found compliance every time for only five, although for a further seventeen there was compliance with 16 or more of the twenty patients. Condition 2(d)(iii), part of the informed consent condition, requiring the patient to be advised of a right to take time to consider the consent forms before signing, was said to be complied with for only six patients. Condition 3 requiring full documentation of patient consultations, was said not be complied with for eleven patients. Condition 14(b), applicable where implants were to be used, requiring documentation of confirmation in the morning of the surgery that the implants were present at the hospital, was complied with on two out of the sixteen patients where it was relevant.[9] Condition 16, requiring documentation of the confirmation of the availability of the alternative medical practitioner to be identified to the patient as a person to be called if the applicant was not available (as set out in the post-operative care plan), had been complied with only once. Condition 17, requiring the recording of the post-operative consultation of the patient with the practitioner, had been complied with for only twelve patients. Condition 19, requiring the absence of post-operative complications to be noted on the patient record, had been complied with for only nine patients. There was no case where Condition 18, requiring the formulation of a treatment plan in the event of a post-operative complication (broadly defined) in consultation with and with the approval of the supervisor and the plan to be kept on the patient's record, had been complied with.[10] In two cases where there were recorded complications there was no complication treatment plan, and no recorded supervisor involvement; in a

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7 Decision of the Panel, 8 June 2020, paragraph 11.6, Hearing Book p 290.

8 This date was before the appearance before the Panel, which was before the applicant had seen this report. It may be that the report was not actually provided to the respondent until later, in June 2020 after the auditor was paid: see Hearing Book p 631.

9 In evidence the applicant said that no hospital would allow surgery to proceed if the implants were not there: p 1-12. But that occurred during the performance assessment report, discussed above.

10 In evidence the applicant said that he had had to contact his supervisor about complications two or three times: p 1-11.

number of cases there were no such complications, but there were six patients who had no recorded post-operative information.

[16] The auditor was also concerned about umbilical hernias being repaired by the applicant. This was on the basis that such an operation involved penetrating a major body cavity, not something generally done by cosmetic surgeons. This occurred with two of these patients, and with only one was the supervisor informed of and approved this procedure.[11] He said that this amounted to a laparotomy, which gave rise to a range of potential issues for which specialist training was needed. In oral evidence, the applicant said that this involved only very small hernias, which could be conveniently repaired during the surgery.[12] In the solicitor's letter, he denied that this amounted to a laparotomy, as he did not enter the peritoneal cavity, and said there was no evidence that either repair had ever given rise to any problems.[13] The appropriateness of this approach was supported by the evidence of the supervisor of the applicant, who said that it was good practice to repair a minor hernia discovered during abdominoplasty, to prevent it from deteriorating.[14]

[17] With one patient, the procedure involved inserting an implant which had not been inserted in earlier surgery because of the presence of an infection, since resolved. The action taken was appropriate, but the auditor was concerned that further approval of the supervisor, and further consents, were not obtained.[15] With another patient, replacement implants were inserted in a staged procedure, as approved. Later a suspected infection resulted in the patient being sent to a public hospital, the plan for post-operative complications was not actioned, and there was no further supervisor involvement.

[18] In response to this report, the respondent decided to start an investigation.[16] The respondent obtained the patient records for ten patients identified in the audit report. It emerged that one patient suffered a poor outcome following a facelift,[17] and one suffered a poor outcome following a breast augmentation.[18] In one case the approval of the supervisor was not obtained until after the operation,[19] and did not cover approval for a hernia repair. There was also a failure to provide post-operative referral plans for eight patients from November 2019 to August 2020 (as well as for

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11 He also had concerns about whether one patient had been fully informed about matters relevant to this procedure before consenting.

12 Transcript p 1-19. He did not do repairs involving placing of mesh: p 1-20. See also affidavit of applicant of 10 August 2021, paragraphs 26 – 30.

13 But notification N331047 was apparently a case where there were problems with a hernia repair.

14 Affidavit paragraph 22, annexures AR-1, AR-2.

15 The applicant disputed that they were necessary, as the infection was not a complication but was pre-existing: Hearing Book p 633. He maintained in oral evidence that this was covered by the approval and Plan B for the earlier procedure: p 1-20, 21. I do not agree with his analysis.

16 Letter from respondent to applicant 29 July 2020, Hearing Book p 303.

17 In evidence the applicant said that a small haematoma in the face after the surgery pressed on a nerve, a known risk of facial surgery. He paid for her to see a neurologist and for medication to treat the nerve damage, and that she has since been seen by a colleague and is much improved: p 1-27.

18 The applicant said that the asymmetry was mild, and did not qualify as a complication: p 1-27. These were recognized risks of the relevant surgery which had been explained to the patients and acknowledged in their consent forms, and that there was no evidence of a failure to provide reasonable care in either case: Hearing Book p 635.

19 The applicant said that sometimes verbal approval was given before surgery, and written confirmation followed: Hearing Book p 637.

the patient referred to below), and a failure to schedule, or to record notes of, post-operative consultations for eight patients, as well as the patient referred to below.

Inadequate Post-operative Care

[19] In August 2020 the respondent received a notification from a doctor, and the following month a complaint was received from the mother of the patient, relating to inadequate post-operative care of that patient. On 20 August 2020 the applicant performed breast reduction surgery on a particular patient.[20] The patient complained that one nipple began to go black one or two days after surgery and one breast swelled, and arranged an appointment to see the applicant the next day. She saw a general practitioner, who said she should see the applicant. He saw her on the third day, attempted unsuccessfully to locate a haematoma with a needle without imaging, and referred her to radiology who located and drained 100 - 150 mls of haematoma. The applicant told her to see her general practitioner to release more blood from the nipple, which she did several times, but when the general practitioner tried to telephone the applicant he was not available. The applicant told her to tell the general practitioner to score the skin to let it bleed, which was done but did not help, and he then said a scalpel should have been used.

[20] By 31 August the general practitioner was very concerned about the nipple, and she made contact with the applicant with difficulty who said he would arrange for her to see a wound clinic, but no such arrangement was made. The next day her breast became swollen. She went to a public hospital on 3 September 2020[21] and required emergency surgery to evacuate a breast haematoma, and deal with necrosis of the nipple.[22] A Doctor at the hospital made a notification about this to the Office of the Health Ombudsman, and it also received advice that while in the hospital the applicant persisted in trying to telephone the patient, to an extent that she felt harassed. In his affidavit the applicant said that he managed this complication appropriately.[23]

[21] In evidence the applicant claimed that on the day after the procedure, he used an ultrasound machine to search for a haematoma which was clinically present, but was not able to locate it: p 1-25. He was unable to locate it with a needle, and arranged for it to be drained by a radiologist the next day. He denied that the nipple had turned black, describing it as "dusky", and said that her condition appeared to be improving until the Sunday, when he suggested she go to the local hospital. He telephoned the registrar there, and said she required immediate surgery: p 1-26. He claimed that he was in daily contact with her, that her management or her outcome would have been no different if he had been seeing her personally,[24] and that if the original surgery had interfered with the blood supply to the nipple, nothing could be done anyway. He suggested that the blood supply to the nipple had been diminished

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20 Details taken from the version in the notification – Hearing Book p 522 - and from information provided in a complaint by a relative of the patient, Hearing Book p 525. They are not always consistent.

21 The applicant claimed that he told her on 3 September to attend the hospital: Hearing Book p 636.

22 It is not clear when this surgery occurred. The applicant asserted it was the next day, but the date and time do not appear in the material, although there is a reference to the patient giving a version at a post-operative ward round on 4 September: Hearing Book p 522.

23 Affidavit of applicant of 10 August 2021 paragraph 37. In oral evidence he confirmed the affidavit: p 1-10.

24 That evidence is certainly believable.

by the surgery, a known complication of the procedure, and that when the haematoma developed that worsened the situation. In that case, if he was in daily contact with her, she should have been sent to hospital on 1 September.

[22] The supervisor in oral evidence confirmed that a haematoma following breast surgery is something that can occur, and that nipple necrosis is also a known complication. The larger the reduction in size, the greater the risk. He also confirmed that a haematoma would increase pressure within the breast which would tend to cut off the blood supply to the nipple, and said that the longer the pressure continued the more threatened it became. Once the blood has coagulated, it needs to be drained by opening the breast. If the haematoma is relatively small, it may not need to be drained. Observation of what is going on is very important, and it is not necessarily important to operate quickly; it depends on what is happening.

[23] In the context of this incident, it is relevant to note that the supervisor did not do breast reduction surgery himself. When questioned about this incident, he appeared reluctant to criticise the applicant, but I consider that some of his evidence supports the view that the applicant mishandled the post-operative care of this patient. The applicant's proposition that the appearance of the nipple appeared to be improving was inconsistent with the increasing concern of the patient and her general practitioner, and the increasingly aggressive treatment the applicant was ordering. I consider the patient should have been referred to a specialist surgeon, or to a public hospital, at a much earlier stage, and regard this as apparently a case of seriously deficient post-operative care.

Third audit

[24] On 28 August 2020 another audit was undertaken by the doctor who undertook the second audit, who checked the records of twenty patients of the Queensland practice. Overall the rate of compliance with the conditions was better, but by no means complete. There were nine conditions or part conditions which were always complied with, and a further four where there was non-compliance for only one patient, in each case the same patient.[25] There were two other patients for whom the three parts of condition 15 were not complied with, three patients for whom condition 19 was not complied with, and three patients for whom condition 17 was not complied with. Condition 18 was applicable for only four patients, and complied with only twice. Of the fourteen patients for whom condition 14(b) applied, it was complied with only three times, and condition 16 was complied with only once. The auditor complained of the absence of a clear document trail, which impaired the efficiency of the audit. The audit report was provided to the respondent only in October 2020.

Pre-suspension submissions

[25] In November 2020 the respondent gave notice of proposed immediate action, in the form of suspension, and invited a submission from the applicant. It does not appear that the audit conducted in August 2020 was taken into account in deciding to give this notice, which otherwise referred to all the matters set out above, and outlined the respondent's concerns. On 2 December 2020 lawyers for the applicant provided a submission, asserting that he did not pose a serious risk to persons, that it was not

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[25] Conditions 2(d)(i), (ii), (iii), (e). Condition 4 was also not complied with for this patient, and for one other.

necessary to take immediate action to protect public health or safety, and that suspension was not warranted, and was disproportionate in the circumstances.[26] Overall the letter seeks to minimise the extent and seriousness of the various problems.

[26] For example, the letter acknowledged that there had been "occasions" on which he had been "somewhat tardy" in compliance with the requirements for audits.[27] Given that there were supposed to be quarterly audits from December 2017 and only three were ever performed, this was an absurd response. Auditing his patient files seems to have been a very time consuming process, which would not have been the case if they had been properly kept, and he was then reluctant to pay the cost. It is no excuse to blame deficiencies on administrative staff; when a practitioner is under conditions requiring certain documentation to be kept and providing for audits, it is the responsibility of the practitioner to ensure the records are in order, and a failure to do so suggests an indifference to the importance of proper records, and a failure to take seriously the obligation to comply with conditions.

[27] At another point the letter suggested that "purported" non-compliance occurred only if the condition or part condition was not complied with more than 50 percent of the time.[28] As far as I am concerned, a failure to comply with a condition for *one* patient is an instance of non-compliance with that condition. Submissions like these do not encourage confidence in the rest of the latter.

[28] It was submitted that the applicant's complication rate was quite low, well below the national average for cosmetic surgeons.[29] The letter claimed only one complication in 2020, presumably a reference to the August operation discussed above, but in January 2021 there was a complaint from another patient (discussed below) about surgery in June 2020, which resulted in the procedure having to be repeated twice by the applicant, which was evidently not disclosed in this count. In these circumstances no reliance can be placed on the claims of low complication rates.

[29] With the submission was a letter from the supervisor who confirmed that he had given verbal approval by telephone, with written confirmation later, that he was not aware of any unapproved surgery, that he had never denied approval, and that he considered approval for an abdominal procedure impliedly included repair of abdominal wall defects, including hernias. On 3 December 2020 the respondent, after considering the applicant's submissions, suspended his registration by way of immediate action.

Another complaint

[30] Subsequently a further complaint was received on 20 January 2021 from a patient, about problems with a replacement of breast implants undertaken by the applicant in June 2020, and re-done by him in early September 2020.[30] The patient said that after surgery one breast became swollen and painful. The applicant saw her urgently (although at a shopping centre) and told her she needed urgent surgery, which was undertaken late the following day, when that implant was replaced and a drain

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26 Hearing Book p 628. In evidence the applicant confirmed he gave instructions for this letter: p 1-41.
27 Hearing Book p 629.
28 Hearing Book p 631.
29 Hearing Book p 638. See also affidavit of applicant of 10 August 2021, paragraph 34, which gave a total consistent with the numbers in the latter.
30 Hearing Book p 678.

inserted, although there was some difficulty contacting the applicant to get it removed. Some weeks later she contacted him again, as the other breast was also sore, and it felt as though the implant was turning over. The applicant told her that she needed further surgery for this, and when this was undertaken she was asked to sign the consent form only just before surgery. Shortly after that however both implants turned over again, and she had consulted someone else. This complaint was not the subject of evidence from the applicant. It is not included in the list of matters relied on in the supplementary submissions of the respondent as showing a serious risk to the public, and I do not rely on it for that purpose,[31] but I consider that it is relevant in the assessment of the reliability of the applicant's evidence.

Applicant's material

[31] The affidavit of the applicant[32] spoke of the financial hardship to him as a result of the suspension. The applicant explained that he used three different systems for storing records of patients, an approach likely to complicate the audit process. He explained the system he had in place to ensure that he or another cosmetic surgeon was available to deal with complications, although this does not explain the complaints of difficulty in contacting him some patients have experienced. He claimed a low complication rate, and very high rates of patient satisfaction. He asked to return to practise, if necessary with a condition that he not perform significant surgical procedures.

[32] In oral evidence he said the procedures involving a general anaesthetic were done in day surgeries, but minor procedures such as skin cancer or eyelid lifting surgery, and occasionally small liposuctions, were carried out in his rooms: p 1-9, 10. A lot of his practice was revision surgery, some of it from his own procedures but many were from other practitioners: p 1-10. The approvals from the supervisor were always received prior to surgery, although on occasions it was verbal approval, with an email following: p 1-11; p 1-13. He was inclined to blame his staff for breaches of the conditions requiring things to be documented. He said he had two staff making sure of compliance (p 1-12), and later claimed that in effect everyone was handling compliance: p 1-35. He referred to a practice manager, who was said to be more involved in sales than compliance, but said that compliance was her job: p 1-35. She ceased to be practice manager in mid 2020, and was replaced by someone who almost immediately left for family reasons, but he said that she had been responsible for compliance from 2017: p 1-36. Overall his evidence about how compliance was ensured was unclear and apparently inconsistent, but it appears clear that he devoted very little of his own attention to ensuring compliance with the conditions.

[33] The applicant claimed that any non-compliance was due to clerical issues, not flouting the conditions,[33] but many of the deficiencies identified on audit related to documentation of his interactions with patients, which could only have been documented by him. For example, he claimed he always telephoned the patients on the evening after their surgery, or sent a text if the call was not answered: p 1-24. He saw patients the day after any surgery, unless they had travelled away, in which

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31 The document concerning the complaint was however in the Hearing Book, and this complaint was not expressly excluded as not relied on by counsel for the respondent on the second day, when other, later notifications and other material were.

32 Made 10 August 2021.

33 Transcript p 1-37; 1-51.

case this consultation could be done by telephone. Any deficiencies in the documentation of these would also be his responsibility.

[34] The applicant said that if something was picked up on the pre-procedure tests it would be flagged to him by the staff, and the issue would be referred back to the primary care giver: p 1-15. He said this was not always documented, although he conceded that if there was a letter to a general practitioner, a copy should be on his files: p 1-45. If there was no regular general practitioner, the patient would be told that the issue should be investigated. The results of the tests would be discussed with the patient prior to the day of the procedure (by a nurse) and by him on the day of the procedure, but this may not be documented: p 1-43. He said his statistics are probably ten times better than some colleagues in terms of revisions and complications: p 1-32.

[35] The applicant was asked about the surgery which gave rise to the earlier proceedings in the Tribunal, which occurred on 5 October 2006. He said that he went to see the patient in her hotel room with a full medical bag, and took her blood pressure while there: p 1-47. He also said that after she was admitted to hospital 150 mls of blood were drained from a haematoma: p 1-48. Both of these propositions were inconsistent with agreed facts set out in the joint submissions to the Tribunal in 2013, signed by his then lawyers. Paragraph 15(c) said he went without any medical equipment, and did not take the patient's blood pressure, and paragraph 12(p)(3) said that 500 mls of blood were drained from the haematoma. It is possible that in 2013 he accepted these facts to avoid a contested hearing, but these were matters of some significance, and this also gives me concern about the reliability of his evidence. In view of this, the incorrect figure for complications in 2020, verified on oath, other matters I have referred to, and my general impression that he was always trying in his evidence to minimise the significance of what had occurred, I do not regard him as a witness whose evidence is reliable. Given that so much of his explanation for breaches of conditions found in audits was that they represented failures of documentation rather than failures in procedure, which depended solely on his evidence that the right thing had always been done even if sometimes it was not documented, this is a significant matter, since the applicant cannot dispel in this way concern about the adequacy of his procedures.

[36] The applicant also relied on an affidavit and oral evidence by the cosmetic surgeon who has been supervising him for over two and a half years. That doctor said that the applicant would email to him a request for surgery if he decided that surgery was appropriate, identifying the procedure to be performed, the patient history, clinical photographs and relevant investigations: para 14. No patients were referred to him for approval that the supervisor considered were not suitable for the proposed procedures, and as a result all requests were approved: para 17. Occasionally, because he was busy, he would only have time to give verbal approval, but this was always followed up in writing: para 27. On the basis of the information provided by the applicant about complications, his complication rate was no higher and probably lower than other surgeons performing similar procedures: para 19. He did not see complications which suggested that the applicant was not performing the procedures appropriately: para 20. The approval process used standardised documentation,[34] so the documents were very similar in each case: para 26. If any information was

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[34] Which the supervisor said he formulated himself.

missing, we would contact the applicant to obtain it: para 25. From the documents he saw, the supervisor had no routine issues that caused him concern: para 24.

[37] The supervisor expressed the opinion that there was no need for the applicant to be suspended, or for that matter to be supervised: paras 29, 30. These conclusions were apparently formed on the basis of information provided to him by the applicant. In oral evidence the supervisor spoke about complication and revision rates for breast implant surgery, and spoke about issues which can arise. He suggested that there is a higher incidence of patient dissatisfaction with cosmetic surgery that with other surgery, caused in part by the expectations of the patients.

Respondent's submissions

[38] The respondent submitted that there have been concerns about the way the applicant was practising for a long time, and that the concerns have continued despite the imposition from time to time of various conditions. There has been some persistence in concern about inadequate post-operative care, and a persistent failure to comply with conditions imposed by the respondent. The applicant was reprimanded by the Tribunal over an example of inadequate post-operative care in 2006, after 2010 there was a further instance of apparently inadequate post-operative care,[35] the second audit identified a case where there were post-operative complications which had resulted in the patient being sent to a public hospital, and the instance in August 2020 discussed above, and other notifications made in 2020. There had been instances of apparently unsatisfactory performance of procedures, and there had been a persistent failure to comply with conditions.

[39] The respondent relied in particular, as a matter putting the health and safety of the public at risk, on the instances of apparent inadequate post-operative care. In relation to the breaches of conditions, the respondent also advanced an argument that these could be seen as providing a basis for immediate action in the public interest.

[40] The respondent submitted that the Tribunal could give weight to the assessment of the Board in relation to the extent of the risk to the public, in view of the fact that the Board is made up of practitioners who are particularly well placed to be able to assess the significance of particular risks, and the risk profile of registered practitioners generally.[36] The applicant submitted that the Tribunal must have regard to the reasons of the respondent, which I think is putting the position too highly, in view of the fact that this is a consideration afresh of the issue under s 156. The Tribunal has to make up its own mind, on the material before it, but is entitled to have regard to the reasons of the respondent, and give them such weight as it thinks fit.

[41] The respondent submitted that the adverse consequences of the suspension, which are to be expected, are not of great relevance, because the exercise of the power under s 156 is entirely protective. Reference was made to *Rao v Medical Board of Australia* [2021] QCAT 145 at [28], and to *Health Ombudsman v Harirchian* [2021] QCA 141 at [11]. I respectfully agree with what was said by the then Deputy

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35 This was the instance (or instances) referred to in notifications N331047 and N339119, discussed above.

36 Citing *Psychology Board of Australia v White* [2020] VCAT 123 at [66]; *Macedon Ranges Shire v Romsey Hotel* (2008) 19 VR 422 at [53].

President, Allen DCJ, in *Rao* at [28], which I regard as consistent with the statements in the Court of Appeal decision.

[42] The respondent submitted that it was not necessary to arrive at any final conclusions about the various incidents, but the fact that the various complaints had been made meant that there were reasonable grounds to suspect that there was a serious risk to the health and safety of the public. It was submitted that there was at least prima facie evidence of actual patient harm, suffered despite the conditions imposed by the respondent, and in those circumstances it was a small step to concluding that there was a likelihood of further harm to future patients if the applicant were allowed to resume practice.

Applicant's submissions

[43] The applicant's submissions focused on the proposition that any deficiencies were in documentation rather than in procedural matters which would relate to patient safety. For example, it was said that the condition about confirming the presence of implants at the facility, and documenting this, was said not to relate to patient safety, but this was imposed after an incident when two patients were anaesthetised, and surgery commenced, before the implants were present at the facility, with the result that the period of anaesthesia was longer than necessary. That increased the risk from the anaesthesia, albeit the risk would have been small in view of the time involved, and it is not an appropriate practice. Hence condition 14(b). The applicant submitted that in each case there was an alternative practitioner available to deal with issues arising after the procedure, because of his standing arrangements, but in view of the number of complaints from patients of difficulty in contacting the applicant after a procedure, condition 16 performed an important function, related to the proper treatment of post-operative complications. That the applicant is complaining about these matters suggests a lack of insight into the underlying justification for these conditions, and a lack of respect for the authority of the respondent in imposing them.

[44] The submissions also sought to minimise the significance of the low rate of compliance with condition 18, which was said not to have given rise to any patient harm. But it must be remembered that there has not been an audit of all the applicant's patients, only of samples of about twenty. My attitude here is similar to non-compliance with condition 14(b).

[45] It was submitted that there was no evidence of sub-standard surgical skills, or that the complication rate was significant in context. There have been examples of notifications which on the face of it suggest some possible problems with surgical skills, but the focus of the respondent's concern was on post-operative care, which has given rise to the matters which appear to be of the most serious concern. The issue is not that complications arise, which can occur with any surgery, but with the way the applicant managed them.

[46] The applicant complained about aspects of the decision of the respondent, but this is not a procedure for review of that decision. Some of the submissions are relevant to the question of what decision the Tribunal should make; others, such as the complaint about delay by the respondent, are not. The applicant submitted that matters dealt with by the Panel in June 2020 had been dealt with, and should not be considered at this time. I do not accept that submission. The whole history of the

applicant is relevant, particularly if it reveals a pattern of behaviour showing a long term failure to comply comprehensively with conditions imposed on his registration.

[47] It was submitted that speculation by the second auditor that a procedure had been carried out outside a registered facility was denied and not supported by any evidence, and should be disregarded. It was also submitted that the concern of the auditor about hernia repairs was not justified, and that all that the applicant had done was stitch up minor hernias discovered in the course of surgery, which was an appropriate practice.[37] I accept that neither of these matters contributes to a reasonable belief that the applicant poses a serious risk to people.

[48] The same does not apply however to deficiencies in the documentation of Plan B for patients, in view of the history of issues in relation to post-operative care. These matters are of concern in the context of patient safety. Indeed, as a general proposition I do not accept that deficiencies in documentation are not issues affecting patient care, since I do not accept that deficiencies in documentation do not reflect deficiencies in procedure. I have previously rejected the proposition that it is only non-compliance in the case of more than fifty percent of the files audited that is relevant to non-compliance with conditions.

[49] I also reject the submission that it is necessary to establish that there has been a complication, rather than to consider matters where there is good reason to believe that there may have been a complication. It is not necessary to make positive findings in considering the operation of s 156, and all that is required is a reasonable belief. I will deal with the law below, but it must be stressed that this is an aspect of the precautionary approach appropriate in a context where the health and safety of the public are paramount.[38] There is also the consideration that the Tribunal knows about only those complications which gave rise to notifications or complaints, or which were exposed by the very limited audits of the applicant's records. Because as I have shown the applicant's figures for complication numbers are wrong, no reliance can be placed on them. I do not accept that, as submitted for the applicant, it is incumbent for the respondent to show at this stage how the applicant caused the complications, and how this results in a risk to people. The rest of the submissions for the applicant are largely repetitive.

[50] It is not a matter of assuming that every complication is the applicant's fault. The concern in this matter is more how well the applicant manages those complications which do occur. In addition, there is a protective element in the requirements for documentation, which the applicant clearly does not recognise. The conditions requiring documentation of precautions were imposed because the respondent did not trust the applicant to do the right thing, and that has not been recognised by the applicant either.

The Law

[51] Under s 156 the respondent, and in this proceeding the Tribunal, can take immediate action if it reasonably believes, relevantly, that because of the practitioner's conduct or performance, he poses a serious risk to persons, and that it is necessary to take immediate action to protect public health or safety. Immediate action can also be

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37 The appropriateness of this was supported by the evidence of the supervisor: Affidavit paragraph 22, annexures AR-1, AR-2.

38 The National Law s 3A.

taken if the Tribunal reasonably believes the action is in the public interest. As the then Deputy President of the Tribunal said in *Loney v Nursing and Midwifery Board of Australia* [2020] QCAT 486 at [5]:

> The Tribunal approaches the matter on the basis that an immediate action order does not entail a detailed enquiry by the Board or by this Tribunal. It requires action on an urgent basis because of the need to protect the public. That does not mean that the material available to the decision-maker should not be carefully scrutinised in order to determine the weight to be attached to it.

[52] In *Oglesby v Nursing and Midwifery Board of Australia* [2014] QCAT 701 at [20] the then Deputy President said:

> I am not of the view that it is necessary to be satisfied that certain conduct will be engaged in by a registered health practitioner before the reasonable belief can be held that the practitioner poses a risk to persons. In my view, it is not even necessary to be satisfied that it is more probable than not that the practitioner will engage in some conduct in the future. In my view, a reasonable belief may be held that a practitioner poses a serious risk to persons if, based upon evidence of past conduct, there is a real possibility that the practitioner will engage in conduct which could be harmful to persons.

[53] I respectfully agree with those propositions. The section is an application of the precautionary principle embodied in the National Law s 3A. Immediately action might be based on complaints or allegations which have not been substantiated, although they should be examined to assess the weight to be given them.[39] The term "serious risk" is not defined, and takes its ordinary meaning. As was said in *Loney* (*supra*) at [10], "In assessing whether a person poses a serious risk to persons it is helpful to consider the nature of the risk, the likelihood of its eventuating and the seriousness of the consequences if the risk does eventuate." As well, it has been said a number of times that the immediate action taken should be the least onerous necessary to respond adequately to the risk or the public interest considerations.[40]

[54] The reference in s 156 to the public interest is as a result of an amendment, and the parameters of this provision have not yet been clearly settled. The example given suggests that one matter of concern to the legislature was a desire to ensure that immediate action could be taken where there was doubt about the character of a practitioner, and the effect of criminal offending on public confidence in the profession, even though there was no reason to doubt the professional competence of the practitioner. The concept of the public interest is, at least potentially, very wide,[41] and it has previously occurred to me that an example of it is ensuring that a practitioner complies with any conditions imposed on his or her registration.

[55] In the past, a persistent failure to comply with a condition has been seen in disciplinary proceedings as a basis to cancel the registration of a practitioner.[42] I have previously expressed the view that it can also be seen as in the public interest to enforce compliance with conditions imposed on the registration of a practitioner by way of immediate action.[43] A failure to comply with conditions imposed on the

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39 *Liddell v Medical Board of Australia* [2012] WASAT 120.
40 See *LCK v Health Ombudsman* [2020] QCAT 316 at [43], and decisions there cited.
41 *CJE v Medical Board of Australia* [2019] VCAT 178 at [65].
42 *HCCC v Townsend* [2014] NSWCAT 65, esp at [33].
43 *Ting v Medical Board of Australia* [2021] QCAT 53 at [65].

registration of the practitioner can also harm the confidence of the public in the profession.

[56] In submissions the respondent adopted this approach, and submitted that the persistent failure to comply with conditions in the present case means that it was applicable here. The applicant in submissions did not challenge the basic proposition that such a failure could engage public interest considerations, but submitted that the breaches in the present case were not sufficiently serious to justify taken action in the form of suspension, given that they had been explained as failures of documentation only, and they did not amount to defiance of the conditions imposed. A comparison was made with the seriousness of the conduct in other cases where the public interest factor has, or has not, led to suspension of registration by way of immediate action, to show that suspension was not justified in these circumstances.

Consideration

[57] I consider that a persistent failure to comply with conditions imposed on the registration of a practitioner can support the application of the public interest ground in s 156(1)(e). Indeed, the failure would not have to be persistent if there was evidence that it did amount to defiance of the authority of the Board, but that is not this case. I am not impressed by the submission that the failures are mere deficiencies of documentation which do not impact on patient safety. First, I am not prepared to rely on the evidence of the applicant that the failures are only in documentation, and not in procedure. Second, the applicant had some years to do what is necessary to comply with the conditions, and although there was some improvement, there remained too many breaches, which suggests that the applicant has never taken compliance with the conditions as seriously as it should be taken. This has been despite having been reprimanded by the Panel, and having been cautioned eight times by the respondent, for failing to comply with the conditions on his registration. Third, the persistent failure to have the required audits is particularly concerning, because when audits have occurred, they have revealed breaches. The proposition that the audits are too expensive is unconvincing, and appears to be due to a lack of cooperation with the audit process, and the way in which the applicant keeps records for particular patients in different places, which makes correlating them more difficult. Fourth, the applicant appears to continue to regard these conditions as just a punitive burden, and to lack insight into the importance of them, and more generally of proper documentation, in protecting the health and safety of the public.

[58] It must be remembered that conditions were first imposed in 2013 on the registration of the respondent following a finding of unsatisfactory professional conduct, relating to inadequate post-operative care of a patient. They have been subsequently strengthened following a number of notifications, including about post-operative care and other clinical matters. When a performance assessment was undertaken in 2016 it revealed an inappropriate practice and other criticism. The audits that have occurred have led to further investigations, and there have been further complaints and notifications, including about the surgery in August 2020 which appears to have been a further example of seriously inadequate post-operative care, leading to real harm to that patient. In view of this history, it must be reasonable to be concerned about the applicant's willingness properly to comply with any conditions imposed on his registration.

[59] The other aspect of the matter is the applicant's history of problems with post-operative care. This has already been touched on. One aspect of this is that a number of patients (and others) have complained about difficulty in making contact with the applicant if they have concerns after a procedure. At least three patients have suffered actual harm, one of them permanent harm, as a result, or apparently as a result, of poor post-operative care,[44] and there is material leading me to suspect that other patients may have suffered actual harm. The fact that most of this occurred at a time when the registration of the respondent was subject to conditions designed to minimise the risk of poor post-operative care on his part is worrying, particularly when the applicant also has a history of not complying with conditions.

[60] In terms of s 156(1)(a), there is the applicant's history of poor post-operative care, a number of notifications which suggest that there may be some grounds for concern about his processes, and the persistent failure properly to comply with conditions imposed by the Tribunal or the Respondent designed to prevent the risk of harm to patients. That the applicant does not appear to recognise the relevance of these conditions in preventing harm to patients shows a concerning lack of insight. All of these factors taken together causes me to believe that the applicant's conduct or performance poses a serious risk to persons, or at least did so prior to the suspension of his registration by the respondent. In arriving at this conclusion, I have applied the tests referred to earlier, and taken into account all of the matters discussed in these reasons. I also conclude that immediate action is necessary to protect public health and safety, essentially because of the applicant's history.

[61] I accept that the applicant has considerable experience in cosmetic surgery, and may well generally perform procedures skilfully and without adverse consequences. The problems seem to arise when something goes wrong. Inevitably things will go wrong on occasions, and it is not the mere fact that the applicant has complications which is the problem. It is the fact that he has not, or at least not always, managed them properly, that contributes in particular to the serious risk of harm.

[62] I am also concerned about a tendency on his part to blame other people for the deficiencies. Problems with documentation were always said to be the fault of his staff. The failure to arrange the audits was blamed on the auditors, for charging too much. Even the harm following the surgery in August 2020 was blamed on the few hours before the surgery was performed in the public hospital. Apart from anything else, it was quite unrealistic for him to expect that a public hospital was going to leap into instant action as soon as he telephoned them. This is part of a more general lack of insight and reluctance to take responsibility on the part of the applicant. Overall, he did not impress me as someone who could be trusted to do the right thing if left to his own devices.

[63] On the question of whether the appropriate response is suspension, I am conscious of two additional considerations. One is that action under s 156 is clearly intended to be temporary, while matters are investigated and any appropriate disciplinary action is taken. The applicant's registration has now been suspended for going on for eighteen months, which is a long time. If possible a situation where he runs into difficulties with renewing his registration because of recency of practice issues should be avoided. An extended suspension under s 156 should not be seen as an

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[44] That is, the patient the subject of the Tribunal proceeding in 2013, the patient in notification N331047 in February 2016 and the patient in August 2020.

alternative to pursuing promptly any disciplinary proceeding against the applicant. I am concerned about this, and would be more concerned if the matter dragged on for any significant time.

[64] There is also the consideration that the most concerning aspects of the applicant's conduct in the past have been associated with actual surgery. The applicant did seek, in the alternative to the removal of the suspension and (presumably) a return to the prior conditions, that the suspension be removed with a new condition, prohibiting him from undertaking any major cosmetic medical or surgical procedure. The submission defined this as anything requiring admission to a day hospital and the administration of general anaesthesia, but a condition which was even more restrictive would be possible, for example excluding any procedure involving anaesthesia or sedation,[45] or any procedure involving the cutting of the true skin. That would cover any surgical procedure which would be likely to present a risk of serious complications, while enabling him to carry out more basic procedures. It would provide a more clear division between the matters excluded by the condition and the matters not excluded, which should simplify compliance, and reduce the risk that the applicant would test the boundary of the condition by performing procedures under sedation which would be better carried out under general anaesthesia.

[65] Such a condition could be seen to minimise the risk of complications which would require specialised post-operative care, and in that way limit the risk to persons. It would also be an application of the principle that the action taken under s 156 should be the least restrictive consistent with the proper protection of public health and safety. There are however two difficulties with this analysis. The first is that it appears that in the past major cosmetic procedures have been a large part of the practice of the applicant, and this is likely to have affected the nature of the problems which have arisen as a result. Removing surgical procedures from his work would certainly avoid the risk of harm as a result of surgical procedures, but problems can still arise from other cosmetic procedures, or indeed from anything that a general practitioner would do in the course of a general practice.

[66] The other difficulty is one of trust. The applicant has a long history of breaching conditions imposed on his registration, so that it is difficult for the Tribunal to conclude that, if a condition allowing him to practise without performing surgery were imposed, he would comply with it. As explained earlier, the applicant presented at the hearing as defensive, quick to blame others for issues that had arisen, unreliable, lacking in insight and generally not as someone who could be trusted to do the right thing. In these circumstances, the Tribunal cannot be sufficiently confident that, if the applicant is allowed to practise with conditions, those conditions will be complied with by him. In those circumstances, the imposition of conditions is not an adequate means by which to avoid the serious risk to persons, bearing in mind that the paramount consideration in a matter under s 156 is the health and safety of the public.

[67] I acknowledge the assistance provided by the assessors in this matter. For the reasons given above, the appeal of the applicant is dismissed, and the decision of the respondent of 3 December 2020 is confirmed.

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[45] He has previously drawn a distinction between sedation and anaesthesia, in a submission to the respondent on 26 June 2018: Hearing Book p 100.