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Submission to ACSQHC public consultation re:

NATIONAL SAFETY AND QUALITY COSMETIC SURGERY STANDARDS

The Royal Australasian College of Surgeons (RACS) welcomes the development of *National Safety and Quality Cosmetic Surgery Standards*. RACS thanks ACSQHC for providing the opportunity to comment in relation to the draft.

Given the nature of the cosmetic surgery sector, national consistency in its regulatory framework - uniformity across all jurisdictions so that all states and territories function under the same standards and expectations - is absolutely essential. RACS thus welcomes the establishment of these standards.

Given that there have been numerous concurrent consultations in relation to cosmetic surgery and other matters relevant to surgery, more time than was given would have been valuable in order to provide a more considered response, as this consultation is an important one.

With this disclaimer, RACS Health Policy & Advocacy Committee (HPAC) provides the remarks and recommendations which follow.

RACS HPAC's overall impression is that these standards put significant responsibilities on the 'service provider' (facility), and appear to reduce the burden on the regulator and the individual practitioner's responsibilities. Clarity regarding the role of the facility versus the regulators would be beneficial.

Independent oversight of scope of practice

A fundamental issue with the cosmetic surgery sector has been that practitioners have been able to work outside of their scope of practice and with insufficient care due to lax oversight. Often the reason they have been able to do this is because they conduct surgery in small unregulated facilities, often owned by the practitioners themselves. There has thus been insufficient independent oversight by medical directors or other methods. In RACS HPAC's view cosmetic surgery should only be practiced in properly licenced facilities which meet these standards of appropriate and robust clinical governance. It is RACS HPAC's understanding that this will be the case once the *National Licensing Framework for Cosmetic Surgery* is implemented by the various jurisdictions. If this will not be the case RACS HPAC recommends that this be remedied.

RACS HPAC also recommends that there should be independent surgical representation on the Medical Advisory Committee of any facility where cosmetic surgery is conducted, so as to better ensure

practitioners performing cosmetic procedures remain within their scope. The representative should be a specialist surgeon, not someone with an endorsement in cosmetic surgery. It is unclear whether this would be a requirement under these standards as proposed. If it will not be a requirement RACS HPAC recommends that this be remedied.

If and when a basic endorsement for cosmetic surgery is established, there will likely be shortfalls in training for some procedures, for example; rhinoplasty; browlift; facelift; revision breast augmentation; revision of anything; two-surgeon operations etc. The credentialling process will need to clarify what procedures are valid for the individual practitioner, and not simply rely only on the fact that they hold an endorsement for 'cosmetic surgery'.

The current standards as suggested by AHPRA indicate that the practitioner has a responsibility to work within their scope of practice without indicating what that scope actually is. In a two-tiered system of fellowship trained surgeons, and endorsed cosmetic proceduralists it is critical for independent oversight to have clarity around the normal scope of practice of each of these groups.

Nationally consistent outcome data collection

Having a standardised set of outcome data that should be collected by all facilities would be helpful, especially where that data can be collected independently by data managers to improve transparency and accuracy.

Ideally, at the same time as these standards are published a predetermined list of data to collect should be provided to facilities, including demographics, procedure, length of stay, complications, return to theatre, readmissions, hospital transfers, mortality etc. That way institutions can be monitored and benchmarked against each other to ensure adequate quality is acheived.

Monitoring compliance by clinicians

Many of the standards relate to matters which are primarily the responsibility of the clinician, rather than the facility, for example; informed consent, shared decisions and planning care, suitability for surgery, screening and assessment, etc. RACS suggests that rather than putting the burden for these matters on the facility, facilities should be required to put in place a means of monitoring whether practitioners have fulfilled their responsibilities in these areas. This could be achieved through a patient survey and/or other ways of collecting outcome data such as a random audit. There should be clear guidance developed by regulators as to when breaches identified by facilities need to be reported to regulators as opposed to providing feedback initially to the clinicians.

Advertising

Enforcing advertising standards should be the responsibility of the regulator, though reporting guidelines need to be developed should other clinicians or facilities identify clear breaches of the advertising standards.

Conclusion

A cosmetic surgery facility should maintain:

1. Independent oversight of scope of practice by a medical director, with specialist surgeons sitting on any medical advisory committees.

2. Mechanisms to collect common quality control and benchmarking data which is comparable across the country.

3. Mechanisms to ensure the practitioner has fulfilled their requirements in areas such as informed consent, shared decisions and planning care, suitability for surgery, screening and assessment, etc. There should be clear guidelines developed by regulators for facilities regarding management of breaches of standards.

4. Finally, facilities must provide clarity to patients regarding the handling of complaints.

RACS Health Policy & Advocacy Committee