RECOGNITION OF COSMETIC MEDICAL PRACTICE AS A MEDICAL SPECIALTY

Introduction

The Royal Australasian College of Surgeons (RACS) has been invited to make submissions on the application to the Australian Medical Council (AMC) by the Australasian College of Cosmetic Surgery (ACCS) for recognition of Cosmetic Medical Practice as a medical specialty.

This submission is in two parts. PART 1 addresses specific claims made by the ACCS in their application. PART 2 responds to the four criteria set out by the AMC for recognition of a new medical specialty.

Please note that RACS supports the Australian Society of Plastic Surgeons (ASPS) submissions and where possible has avoided repeating that content in this submission.

PART 1

The ACCS makes the following claims:

A. Cosmetic Medical Practice is a well defined and unique medical specialty (Criteria 1 and 3);
B. A change of name – from Cosmetic Surgery to Cosmetic Medical Practice – better reflects the province of the specialty (Criterion 1);
C. Sufficient and appropriate training is not provided by any other specialty (Criteria 1 and 3);
D. Their training and practice will raise the standard of patient care and safety (Criteria 2 and 3);
E. Recognition by the AMC will ensure that training, qualifications and professional development in the area will meet Australian standards (Criteria 1 and 3); and
F. Several irrelevant and extraneous matters not relevant to the application.

A. Cosmetic Medicine as a unique specialty

The ACCS attempts to characterise cosmetic medicine as a stand alone and distinct specialty, asserts that cosmetic medicine lacks recognition within formal and accredited training, and portrays itself – the ACCS – as an acceptable body to represent and advance this area of clinical practice.

The ACCS (p.18) defines Cosmetic Medical Practice as "a specialty of medicine and surgery that uniquely restricts itself to the enhancement of appearance through medical and surgical techniques", claiming 'patient satisfaction' as both a criteria for success and a marker of difference from other specialties. RACS argue that:

- the ACCS is not unique in its involvement in the enhancement of appearance through medical and surgical techniques;
- a client’s motivation does not significantly change the underlying medical skills, techniques and treatments in those fields of practice, however it may mean that training needs to be more focused on the broader medical competencies which are not evident in the ACCS application (see Part 1 section C in this submission); and
- the subjective measure of patient satisfaction and the patient’s expectations do not help to define the specialty.
The ACCS also claims another point of ‘difference’ is a requirement for ‘post-residency’ specialised training and experience which is not available in the public hospital system. As the submission from ASPS points out, neither of these claims is justified. The manner of learning and locations where procedures are conducted are not unusual and are therefore not significant.

Another point of ‘difference’ claimed by the ACCS is that it draws together a “wide array of cosmetic medical and surgical procedures” into a “well defined field of medical practice”. However, beyond the simple act of listing of those techniques and procedures, RACS found it very difficult to identify in the application exactly what it is that unifies them into a medical field.

Further, the proposed definition of the medical specialty does not take into account the educational and professional standing of RACS and the Australian Society of Plastic Surgeons in relation to surgery. Equally, the ACCS does not adequately consider the presence of other AMC accredited training bodies including the Australasian College of Dermatologists in relation to dermatology and the Royal Australian College of General Practitioners in relation to general practice. The application does not identify and discuss the overlap between cosmetic medical practice and these existing generalist and specialist areas in an even handed manner.

RACS does not consider cosmetic medicine is a stand alone and distinct specialty.

B. Change of name to Cosmetic Medical Practice

RACS notes with concern the change in the specialty for which recognition is sought. In the preliminary application before the AMC, the ACCS applied for Cosmetic Surgery to be recognised. Now, under the pretext of preventing confusion, the specialty has been changed to Cosmetic Medical Practice so that it is “inclusive of both surgical and non-surgical procedures and practitioners” (page 8 of the ACCS application) with the footnote that “medical” needs to be differentiated from “medicine”. This provides a strong indication that the area is not well defined, distinct and legitimate.

The ACCS now defines Cosmetic Medical Practice as the “operations, procedures and treatments that revise or change the appearance, colour, texture, structure or position of normal bodily features with the sole intention of improving the patient’s appearance or self-esteem”. However, RACS questions the claimed focus on Cosmetic Medicine when the ACCS is called the ‘Australasian College of Cosmetic Surgery’ and continues to maintain the award of ‘Fellowship of Faculty of Surgery (FACCS)’ as its primary qualification (and not “cosmetic surgery” or “cosmetic medical practice”).

RACS would contend that in an attempt to develop a clearer area of clinical practice the ACCS has confused the boundaries between the formal medical practice of a number of already recognised and accredited areas and the typical activities of the beautician industry. In the course of wide consultation within RACS and its nine specialty groups, there has been considerable surprise at the idea of recognising an area of practice aimed solely at the modification of “normal bodily features”. That is not to dispute that many areas of medical practice are at the interface of normal and abnormal bodily features and function. Most are, and the training required to become a medical practitioner and a medical professional reflects the understanding of this interface. However, if recognised, Cosmetic Medical Practice would be the first specialty not based on the fundamental philosophy of “healing the sick” which underpins the whole of the medical profession.

RACS also notes that the application by the ACCS does not appear to be endorsed by the Cosmetic Physicians Society of Australasia whose members practice in “Cosmetic Medicine”. If Cosmetic Medical Practice is a well defined area, it is reasonable to expect that the ACCS would develop its application in conjunction with that society. While the ACCS application refers to having diplomas in certain sub-specialty areas, there is a significant lack of clarity as to the how the auspicing agents will act, their purpose and the extent of their support.

RACS does not support recognition of Cosmetic Medical Practice as a specialty nor its proposed name. RACS also raises concerns over the roles of various auspicing bodies associated with the submission.
C. Training in the areas of cosmetic surgery

The main theme of the ACCS application is the distinct nature of the practice of cosmetic medicine and the assertion that no currently recognised group provides training of a sufficient or sustained nature in all aspects of this area. RACS categorically rejects these ideas.

RACS provides training in nine different Fellowships. These are Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology and Vascular Surgery. Most of these specialties have an interface with work that is regarded as cosmetic. All surgical work is performed with a view to leaving the patient with the best cosmetic as well as functional outcome. This is an intrinsic part of surgical training and a key consideration of the competent surgeon. The specialty where cosmetic or aesthetic surgery is a substantial component of the training program is Plastic and Reconstructive Surgery (PRS). This specialty is already accredited by the Australian Medical Council through RACS accreditation.

The RACS application for re-accreditation in 2007 addressed all the criteria that are required by the AMC and gave full access to all documentation in support of our nine programs. In an attached copy of the application that was made in 2007, it is clear that one of these specialties, namely Plastic and Reconstructive Surgery, includes the field that is described by the ACCS as Cosmetic Surgery.

The key difference is that, although a substantial proportion of their procedures include an aesthetic component, PRS covers fields in addition to cosmetic surgery, be it for example the repair of cleft palates or the treatment of severe burns. It is absurd to suggest that because some Plastic and Reconstructive Surgeons can perform surgery of extraordinary complexity and social importance, they are somehow untrained in, or incapable of, purely aesthetic work.

Some of the other surgical specialties also include an aesthetic component in their work. These include training and examination of trainees in Paediatric Surgery and Otolaryngology Head and Neck Surgery to address problems of patients with congenital, developmental and/or acquired abnormalities.

All the supporting material can be made available to the AMC should it require details of training in the clinical area of aesthetic/cosmetic surgery. In particular RACS draws attention to the breadth of our competencies based on the CanMEDS model. It appears that the ACCS application is misleading on this issue. It focuses on a limited number of procedures within the technical competency area that is deemed to constitute cosmetic surgery and ignores the broader range of competencies expected of a medical professional.

RACS delivers its training program through nine training boards whose function is supported by the appropriate Specialty Society. In the case of PRS this is through the Australian Society of Plastic Surgeons and the New Zealand Association of Plastic Surgeons. The RACS is aware that ASPS has made a separate submission on this matter. However, as it provides the detail of the College training program delivered by ASPS, that document is also attached. RACS draws particular attention to the sections on curriculum, which clearly outline the areas covered. The submission by ASPS also speaks fully to the ongoing exposure of PRS trainees to cosmetic surgery in public hospitals, the increased availability of training positions in the private sector and the high volume and percentage of cases undertaken by trainees that are cosmetic/aesthetic.

Each year PRS Trainees and Fellows have access to a variety of seminars, master classes and conferences which provide current information and training in both reconstructive and cosmetic surgery. PRS Fellows have the highest participation rate (98%) in CPD across the nine surgical specialties.

The number of PRS surgeons and trainees is closely monitored and this data is compiled in the RACS Activities Report that is distributed to all governments and Departments of Health within Australia and New Zealand. A copy of the latest annual report is attached for the information of the AMC. Interpreting the various indicators of workforce sufficiency is complex. Although there may be a slight undersupply of PRS surgeons, the key factors relate to distribution. The College and ASPS and NZAPS fully occupy the training positions identified and funded by the various governments. And the PRS training program is fully engaged with Commonwealth Government initiatives to enhance training availability in the private sector.
RACS rejects comments made in the ACCS application that training is not provided within the clinical areas described as cosmetic medicine and cosmetic surgery. RACS and ASPS already provide a critical mass of Surgeons and Surgeons-in-training across Australia and New Zealand.

D. Raising the standard of patient care and safety

One of the more problematic components of recognising cosmetic medical practice is its narrow scope of practice. Although the definition used by the ACCS in describing Cosmetic Medical Practice is broad, to the point where it risks being too vague and equally applicable to the beautician industry, the actual detail of clinical work covered is limited. The more detailed listings referred to within the ACCS application are closely aligned to the Cosmetic Surgery Report: Report to the NSW Minister for Health in 1999. These are:

- Abdominoplasty;
- Augmentation phalloplasty;
- BOTOX therapy;
- Breast Reduction;
- Breast Augmentation;
- Chemical Peel;
- Collagen injection;
- Dermabrasion;
- Facelift;
- Laser resurfacing;
- Liposuction;
- Otoplasty;
- Rhinoplasty; and
- Sclerotherapy.

RACS is concerned that the ACCS training programs are focused on specific procedural areas where high volume of procedures can be generated. The ACCS has also established advertising guidelines, currently before the Australian Competition and Consumer Commission (ACCC) solely to consider competition law concerns regarding their Code of Conduct where there is a persistent failure to differentiate between quality of results and number of procedures. The number of times a procedure was performed:

- does not adequately describe a practitioner’s experience;
- encourages consumers to rely on this number as a measure of a practitioner’s experience; and
- encourages practitioners in other areas to market their experience where it may be inappropriate.

The ACCS training programs reveal limited evidence of the broad understanding of medical practice which is the hallmark of the competent clinician. In particular, there is no emphasis on the clinician’s responsibility to reflect on the interventions that are requested by patients. Indeed given the language and approach of the application (e.g. on pages 13 and 14), one is reminded that it is undesirable to treat patients as consumers or customers. Such an approach can give rise to training programs that do not provide the necessary surgical experience and background to deal with the potential, and sometimes life threatening, complications of surgery.

The drive towards specific procedures moves the profession towards a “beautician industry” approach, something which the AMC – through insistence on a broad competency model and application of CanMEDS into Australian and New Zealand medical and specialty training – has been concerned about for more than a decade.

RACS has great concerns with training programs of limited scope, focused on volume rather than quality, which may lead to inferior training, an incomplete understanding of medical practice, a failure to reflect appropriately on the needs of the patient and an inability to manage surgical complications that do arise.
E. Accreditation Standards for Specialist Medical Education and Training

Within the AMC Accreditation of Specialist Medical Education and Training and Professional Development Programs there is emphasis on producing medical specialists who have demonstrated the requisite knowledge, skills and professional attributes for independent practice through a broad range of clinical experiences and training in the relevant specialty. Specialists also need to be able to practice unsupervised in the relevant medical specialty, providing comprehensive, safe and high quality medical care, including in the general roles and multifaceted competencies inherent in all medical practice. And at all times they must practice in accordance with the ethical standards of the profession and the community they serve.

It is on these issues that RACS has serious concerns about the structures and approach of the ACCS. The consultative process undertaken by RACS in preparing this submission drew very strong responses from many who believe this area of clinical practice needs to be regulated more clearly and rigorously. There is a perception that inappropriate clinical practices exist and that the approach of some practitioners to medical care may not be of the required standard. Indeed the ACCS application places great weight on the need to regulate the area, claiming that AMC recognition will meet that need. However, RACS has substantial concerns as to the acceptance of required standards by individuals represented by the ACCS. These concerns are based on the lack of:

- separation between the procedures listed (see above under D) by the ACCS and those carried out by beauticians and other non-medical practitioners;
- recognition or acknowledgement within the ACCS application of expertise of existing medically accredited providers; and
- focus on the substantial depth and breadth of medical responsibility in current training.

It is because of these concerns – regarding standards, accountability and commitment to education as something more than a marketing tool – that the question whether the AMC should recognise cosmetic medical practice is an issue of such importance.

The AMC documentation addresses the Standards for Specialist Medical Education within the following broad parameters:

1. **The Context of Education and Training**
   - Governance
   - Program Management
   - Education Expertise and Exchange
   - Interaction with the Health Sector
   - Continuous Renewal

2. **The Outcomes of the Training Program**
   - Purpose of the Training Organisation
   - Graduate Outcomes

3. **The Education and Training Program – curriculum content**
   - Curriculum Framework
   - Curriculum Structure, Composition and Duration
   - Research in the Training Program
   - Flexible Training
   - The Continuum of Learning

4. **The Training Program – Teaching and Learning**
   a. **The Curriculum – Assessment of Learning**
      - Assessment Approach
      - Feedback and Performance
      - Assessment Quality
      - Assessment of Specialists Trained Overseas
   b. **The Curriculum – monitoring and evaluation**
      - Ongoing monitoring
      - Outcome Evaluation
c. Implementing the curriculum – trainees
Admission Policy and Selection
Trainee Participation in Training Organisation Governance
Communication with Trainees
Resolution of Training Problems and disputes

d. Implementing the Training Program – delivery of educational resources
Supervisors, assessors, trainers and mentors
Clinical and other educational resources

5. Continuing Professional Development
Continuing professional development program

RACS with our thirteen Specialty Societies and Associations has been accredited for surgical education and training in nine Fellowships for Australia and New Zealand. RACS is highly aware of the organisational sophistication and critical mass that is now necessary to achieve the requirements in these areas. It is substantial. As post graduate medical training continues to evolve, the benefit of allowing increased subspecialisation with a requirement for separate educational resources and commitment appears inappropriate. The ACCS application clearly demonstrates that that organisation considers the RACS training programs to be appropriate as it identifies experience in them as prerequisites in many areas. Indeed there is greater detail provided on the RACS components of its program than there is on many of their own.

Although the parameters as defined above would need to be formally addressed at the stage of education and training program accreditation, it is our contention that they should at least be reflected on in the context of an application for specialty recognition. The ACCS and its associated bodies have not demonstrated the educational capacity to appropriately train independently practising specialists in cosmetic medical practice.

RACS queries whether the necessary organisational sophistication or educational commitment is present to create an ongoing training program from the ACCS application.

F. Irrelevant and extraneous matters

The RACS is disappointed that a significant amount of the ACCS application and supporting documentation does not focus on the merits for and against the recognition of a medical specialty. It sympathises with other medical colleges, government and regulatory authorities that have reviewed a substantial amount of extraneous and irrelevant material in order to prepare submissions to the AMC.

The compilation of previous submissions made by the ACCS to various governmental and regulatory agencies has limited relevance to the AMC’s assessment. They simply represent the ACCS views which do not provide a balanced perspective.

Nor do those submissions demonstrate that the ACCS has contributed to substantial improvements in the quality and safety of healthcare (Criterion 2) nor any substantial improvements in the standards of medical practice (Criterion 3). For example, recent submissions by and on behalf of RACS to the Australian Competition and Consumer Commission (and available on the ACCC web-site) in relation to the ACCS’ code of conduct (which amounts to policy development “on the run”) show that there are substantive and procedural flaws in the ACCS approach to improving standards.

Further, the inclusion and reliance on anecdotal evidence and personal perspectives is largely irrelevant as it fails to focus on the merits for and against the recognition of a medical specialty.

RACS notes that substantial components of the ACCS application are irrelevant to recognition of a medical specialty.
PART 2

Criteria for the Recognition of Medical Specialties

The AMC have established criteria for the assessment of applications for recognition of a medical specialty.

Criterion 1

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<th>That the proposed specialty is a well defined, distinct and legitimate area of medical practice with a sustainable base in the medical profession.</th>
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<td>a. That the proposed specialty is a well-defined and distinct field of medicine.</td>
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<td>b. That the proposed specialty is based on substantiated and major concepts in medical science and health care delivery.</td>
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<td>c. That the proposed specialty represents a widely accepted field of medical practice, for example, as indicated by comprehensive and developing body of international research and scholarly literature, significant representation within academic medicine and formal recognition in comparable countries.</td>
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<td>d. That the medical specialty has a demonstrable and sustainable base in the medical profession as indicated by sufficient number of practitioners with the capacity to meet existing clinical need, who possess the knowledge and skills to practise in the specialty and who practise predominantly in the specialty and sustain activities such as vocational training and assessment and continuing professional development.</td>
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As detailed above, the proposed ‘specialty’ is already covered fully by training programs within RACS and in particular the Plastic and Reconstructive Surgery training program provided across Australia and New Zealand. The singling out of the cosmetic areas of practice has been broadly driven by the beautician industry, which portrays some of the human body’s normal processes as undesirable and proposes progressively more aggressive interventions to offset them. The best place to understand this field of medical practice is at the interface between the healthy and not healthy, which is precisely where some of the programs provided by RACS focus. To artificially divide this field of medical practice, and focus solely on the “healthy”, is a dangerous concept.

Although there is a base within the literature now developing that is more focused on cosmetic work, the advances to which this literature refers are routinely developed and carried out within surgical and medical areas that are already accredited with substantial educational programs. Once proven and acknowledged in these areas, they are then transferred to the cosmetic area.

RACS, in association with ASPS and NZAPS, is training the required cohort of Plastic and Reconstructive Surgeons to meet workforce demands. All endeavours are made by RACS to work with government funding bodies to increase the number of clinical training posts in both the public and private sectors, and all posts are fully utilised.

Cosmetic Medical Practice does not satisfy Criteria 1a, 1b, 1c, 1d.

Criterion 2

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<th>That specialisation in this area of medicine is demonstrably contributing to substantial improvements in the quality and safety of health care.</th>
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<td>a. The dimensions to be addressed include effectiveness, appropriateness and safety.</td>
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<td>b. That specialisation is not adversely affecting the quality of healthcare in Australia and will not in the future by promoting unnecessary fragmentation of medical knowledge and skills, unnecessary fragmentation of medical care, unnecessary deskilling of other medical practitioners.</td>
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<td>c. That where the specialist medical services are already provided that provision of these services by this new specialty enhances the quality of health care and/or efficiency of healthcare.</td>
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During the consultation process undertaken by RACS it has become apparent that there is a pressing need for much better regulation of this area of practice. It is bringing the medical profession into disrepute, a fact borne out by the regularity with which it is the recent focus of the attention of regulatory and complaints bodies. There is no doubt that the issue must be properly addressed, as various attempts over the past fifteen years have not succeeded.

However, recognising the area of Cosmetic Medical Practice as a specialty is unlikely to address this problem. There are already recognised educational, training, assessment and ongoing professional development programs that fully cover this area and are conducted within accredited medical colleges including RACS, the Australasian College of Dermatologists and the Royal Australian College of General Practitioners. There already exist groups that provide ongoing professional development in a number of multi-disciplinary areas.

The path forward is clear to improve effectiveness, appropriateness and safety. Ensure all medical practitioners who undertake cosmetic medicine or cosmetic surgical practice have Fellowships of one of these Colleges. That will mean they have undertaken an accredited training course and developed advanced surgical skills.

The ACCS is clearly a special interest group that is to be respected for its effectiveness in promoting the interests of its members. It is not, however, primarily an educational body.

**Cosmetic Medical Practice does not satisfy Criteria 2a, 2b, 2c.**

**Criterion 3**

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<th>That specialisation in this area of medicine is demonstrably contributing to substantial improvements in the standards of medical practice.</th>
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<td>a. There is a professional body that is responsible, has the capacity of ensuring high quality health care, has guidelines for Foundation members and has appropriate processes for determining the standards.</td>
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<td>b. Specific body of knowledge and skills is sufficiently complex or extensive to require a comprehensive and distinct training program.</td>
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<td>c. There is a program of education, training and assessment that will enable practitioners to be independent and safe practitioners in the specialty, demonstrate requisite skills and attributes through a broad range of clinical experiences, provide leadership and demonstrate knowledge associated with safe and high quality cost effective care.</td>
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<td>d. There is a program of continuing professional development.</td>
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<td>e. The professional body has experience in health policy development, health promotion and research facilitation.</td>
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While the ACCS appears to have undertaken significant marketing and lobbying, it is not clear that the ACCS has contributed to substantial improvements in standards of medical practice.

As detailed above, the knowledge and skills required in cosmetic medical practice are already covered in the educational and training activities of a number of accredited medical colleges. Although the body of knowledge is specific, there is no compelling reason why that particular combination of knowledge requires a distinct training program. Indeed, quite the opposite is true, given the program outlined within the ACCS application does not include detail as to how independent and safe practitioners will be assured. The extent of active trainee involvement in a structured training program is not documented, and anecdotal evidence of “training positions” is such that concerns must be raised.

The RACS notes the presence of an ACCS continuing professional development program but does not have the detail to fully comment.

**Cosmetic Medical Practice does not satisfy Criterion 3a, 3b, 3c.**
Criterion 4

That recognition of the specialty would be a wise use of resources on the criteria.

a. There is public health significance as defined by the burden of disease parameters coupled with a demonstrated capacity of members of the proposed specialty to influence this with evidence of community support.

b. That the resource utilisation for both public and private health care sector providers and consumers is justified on the basis of the benefits to the community through recognition of the specialty.

RACS does not believe the recognition of the specialty would be a wise use of resources. As cosmetic medical practice is, by the ACCS’ own admission, premised on providing procedures to the “healthy”, there can be no ability, or even intention, to lessen the “burden of disease”. On the strength of this criterion alone, the ACCS application should be rejected.

The Galaxy Survey that was undertaken to demonstrate community support for cosmetic surgery as a specialty was poorly constructed and contained confusing or misleading questions. The economic analysis in appendix 1 of the ACCS application is fundamentally flawed, as without a burden of disease as the basis and measure of economic advantage to the community, the opportunity cost represented by inappropriate use of scarce resources can never be overcome.

These statements notwithstanding, there is obviously a community desire for cosmetic surgery. This is amplified by the media and movie industry. This should not, however, be confused with “wise use of resources”. As an act of individual choice, a member of the community can decide to employ the services of a beautician or a practitioner of cosmetic medicine. That should not, however, be at a cost to the broader health system. In a world of increasingly difficult economic decisions, the health system needs to focus on improving community health with the wisest possible use of resources – not on undertaking procedures on the healthy.

Benefit to the community would flow not from recognition of cosmetic medicine as a specialty but by more robust regulation of the area. As highlighted above, regulation has become a matter of pressing importance.

The area is already covered by recognised educational providers that are accredited by the AMC. They are supported by a number of professional bodies of increasing sophistication that are already fully integrated into Australia’s health system and actively involved in the sector’s broadest initiatives.

**Cosmetic Medical Practice does not satisfy Criterion 4a, 4b.**

**Conclusion**

The Royal Australasian College of Surgeons thanks the AMC for the opportunity to comment on whether to recognise Cosmetic Medical Practice as a medical specialty. In summary, the RACS does not support recognition of cosmetic medical practice as a new medical specialty.

RACS strongly believes the components of cosmetic medical practice needs to be addressed through better regulation and the more determined use of approaches to quality and standards that already exist in our health system. However, recognition of these areas as proposed by the ACCS will not resolve this issue.

RACS does not perceive benefit to the community or the health sector by collecting some of the existing activities of a number of recognised specialties into another new specialty. Training, education, professional standards and ongoing professional development in those areas are already provided by bodies of international renown.

The RACS acknowledge the significant efforts of the AMC in assessing the ACCS application. Many of the senior members of the RACS hope that the application does not detract from other critical activities that the AMC needs to undertake to improve standards of healthcare.