Australian Society *of* Plastic Surgeons

Feedback on ACSQHC National Safety and Quality Cosmetic Surgery Standards

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ASPS welcomes the introduction of specific standards for improving safety and quality in cosmetic surgery and thanks the ACSQHC for the opportunity to give feedback. In general ASPS has two areas of mild concern.

The ACSQHC standards as applied to public hospitals have an assumption that the hospital usually has an employment relationship with its doctors and has oversight over the whole of the patient journey in terms of pre-operative, operative and post-operative care. This assumption mostly holds true for this environment and the ACSQHC model works well in setting, monitoring and enforcing standards in domains such as Comprehensive Care and Partnering with Consumers. It seems that from this consultation document that the ACSQHC has not fully recognised that the model in cosmetic surgery is often very different. The primary "home" of patient care is the surgeon's rooms and it is here, rather than in the facility where the surgery is performed, that much of the patient education, partnering with consumers and comprehensive care takes place. Insisting on duplication of processes once the patient has arrived in the facility where the surgery takes place is not necessarily good medicine. ASPS is cognisant that it is neither possible nor desirable for the ACSHC to have a presence in every surgeon's rooms and it is important to recognise that qualified surgeons have factors other than the requirements of the ACSQHC that determine their behaviour in terms of ethical behaviour, patient selection and consent. These are intrinsic parts of the training leading up to the award of the FRACS and are taken seriously by all qualified surgeons as a normal part of their practice. Ensuring that facilities only take on qualified surgeons to operate there would help and would obviate the need for facilities to take on the monitoring of this element of surgeon behaviour.

Secondly, it is important to realise that private hospitals have an ability, to some extent to pick and choose the surgeons they host. If the cost and difficulty of seeking cosmetic surgery accreditation is too great, the private hospitals will simply refuse to host surgeons performing cosmetic surgery. It is therefore extremely important to have clarification on whether this set of standards for cosmetic surgery will be a straight forward "bolt on" module for private hospitals or a more complex separate process. The last thing we want is for private hospitals to start turning away cosmetic surgery work, as this will further push patients to travel overseas for these operations or to "hidden" facilities within the community.

INTRODUCTION

The introduction is clear.

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LANGUAGE

The language is mostly clear. We would urge the ASCQHC to change the term "service provider" to something else. It is very confusing and linguistically problematic. There is already an established meaning to the term service "provider" in Medicare. It is the individual doctor or other health practitioner who provides the service. In this document it seems to be being used as the "business" or "service". Which is the right term to use is difficult, because in fact, often there is no unified "service" or "business". The system is really a collection of individual businesses using a facility, with the facility being its own business / service entity. The concepts are of a "service facilitation business" (e.g. a private hospital) and a "service provision business" (eg. a group of surgeons running a cosmetic surgery business who may use one or several private hospitals).

As a first step, just removing the word "provider" would be much clearer. Leaving the language as it is will cause great confusion amongst doctors and the community.

APPROPRIATENESS

Governance, leadership and Culture

1.04 The service provider has processes to assure itself that clinicians conducting cosmetic surgery;
a) Comply with MBA requirements for assessment of patients for suitability for the planned surgery

- Facilities do not have oversight on patient selection
- Practitioners generally have a VMO relationship with facilities and bring patients to the facility – how are facilities expected to ensure provider complies with the guidelines for patient assessment? It is overreach of the ACHSQH to be trying to monitor what happens in the private rooms of surgeons and in their relationship with their patients in those rooms.

b) Allow sufficient time for informed consent processes to occur

- As above – facilities are not privy to consultation records of patients. The only thing they will be able to check is the date the consent form was signed. Even this can be problematic as sometimes patients have signed a consent for a procedure at a different facility and the patient changes lists to a different facility. The new facility consent form and date may not reflect when the patient actually consented to the procedure. As has been discussed elsewhere the concept of a specific date of consent is problematic and does not reflect the consent process.

c) *Ensure advertising of cosmetic surgery that they commission or are referenced in complies with legislation etc*

This is fair enough for advertising the facility commissions but may be difficult to police advertising they are referenced in.

CLARIFICATION

Please see under "Language". Rewording is needed. "Service provider" is both conceptually flawed and confusing due to its established meaning in Medicare.

GAPS AND DUPLICATION

There is no obvious duplication. The main gaps are the lack of understanding that this is not a situation where there is a single "service provider" and the lack of information on the mechanics of implementation and the likely burden to private hospitals.

OTHER FEEDBACK

The rigor of the standards of the ACSQHC will no doubt assist in ensuring improved patient safety in the field of cosmetic surgery. However, it is important that enforcement of standards is not used as a substitute for surgical training and qualifications. The Royal Australasian College of Surgeons is the entity which ensures surgeons are fully trained in patient education, consent, perioperative care and ethics and this cannot be replaced by bureaucratic processes.

End
Dated; 26 May 2023