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Surgical Assistant Working Group
Medicare Benefits Schedule Review Advisory Committee

Email: MBSContinuousReview@health.gov.au

Dear Surgical Assistant Working Group,

RE: Medicare Benefits Schedule Review Advisory Committee (MRAC) - Surgical Assistant Working Group Draft Report

The Royal Australasian College of Surgeons (RACS) welcomes the opportunity to provide comment on the Surgical Assistant Working Group Draft Final Report. The below comments are further to the invited RACS presentation led by Associate Professor Kerin Fielding, RACS Councillor and Chair, RACS Rural Health Equity Steering Committee. In summary:

- Surgeons are best placed to determine who can surgically assist with reference on the complexity of the procedure, the assistant's level of competence and available local workforce.
- RACS recommends that non-medical surgical assistants, with the appropriate training and experience, can be utilised in settings where there is a limited pool of medically trained surgical assistants, especially in the rural, regional and remote settings. Non-medical surgical assistants refer to registered nurses, perioperative nurse surgical assistants and nurse practitioners, that have appropriate training and experience in surgical assisting.
- Expanding MBS eligibility to non-medical surgical assistants, with the appropriate training and experience is important to equity for rural patients and rural surgeons' financial sustainability.
- Current highly experienced, rural, non-medical surgical assistants can be recognised by a legacy clause as part of the MBS eligibility. Any formal Masters' qualification should not be onerous for rural health services to support their nurses through.
- RACS is best placed to define what constitutes adequate past experience and adequate training for a nurse surgical assistant. This should be determined prior to implementation of any MBS changes.
- RACS can play a significant role in developing training, accreditation and credentialing of non-medical surgical assistance education programs with funding from government.

RACS provides its in principle support for the use of appropriately trained registered nurses, perioperative nurse surgical assistants and nurse practitioners as surgical assistants, where medically trained surgical assistants are unavailable, as highlighted in our position paper[1]. As a leading advocate for surgical standards, professionalism and surgical education in Australia and Aotearoa New Zealand, RACS is best positioned to ensure appropriate levels of training and safe surgical service delivery (both for surgeons and surgical assistants) meet the needs of the community.

The acute need to use non-medically trained surgical assistants is mostly, if not totally, experienced in rural, regional and remote settings, where there is often a lack of medically trained surgical assistant workforce. Expanding the pool of available surgical assistants to include appropriately trained registered nurses, perioperative nurse surgical assistants and nurse practitioners would allow more procedures to be provided closer to home with the focus on the patient

benefiting from continuity of care, while reducing the propensity for surgical lists to be cancelled, due to the lack of medically trained surgical assistants.

In urban settings, surgeons can largely rely on medically trained surgical assistants, who are often specialist surgeons, senior surgeons, general practitioners, surgical trainees, or prevocational doctors. This pool of medically trained surgical assistants should be utilised in settings for complex surgical procedures. Many complex operative cases may be performed in secondary and tertiary referral hospitals, and there is a need for a highly skilled surgical assistant to ensure patient safety. This task is often undertaken by fully trained specialist surgeons, assisting their colleagues, and should be formally recognised and remunerated commensurate with the complexity of the case and the skill and experience of the surgically trained medical assistant. Patient safety should not be compromised by utilising surgical assistants (medical or non-medical) with competency levels below that required to complete the operative case safely.

Surgeons are best placed to determine if non-medically trained surgical assistants should be used in the operating theatre, with informed consent obtained from patients. RACS fellows, particularly those in rural, regional and remote areas, have anecdotally reported relying on non-medical surgical assistants for several years, with patient satisfaction surveys gathered by members reportedly indicating great support from patients, other theatre nurses and surgeons for this role.

RACS recognises that nurses are essential members of the surgical team, as they can and do provide competent surgical assistance under supervision. As with many health professions, the nursing workforce has faced challenges in recruitment and retention, especially as the COVID-19 pandemic has exacerbated burnout, resulting in high attrition rates and poor job satisfaction. By acknowledging and valuing their role as non-medical surgical assistants, the nursing workforce is more likely to be retained within healthcare. However, there is a risk that this may dilute the nursing workforce further, by shifting nurses trained in operative and perioperative nursing out of those essential roles and into non-medical surgical assistance roles.

Billing arrangements and MBS eligibility of non-medical surgical assistants

RACS reiterates the importance of continued separate billing of patients by surgeons and surgical assistants. It is important this arrangement be extended to non-medical surgical assistants in the rural setting, where billing should be consistent with appropriate training and experience for minor procedures. Furthermore, consideration should be given to differential funding for complex cases, where that assistance is provided by a trained qualified surgeon.

Currently, the financial sustainability of rural surgeons is impacted, as they must cover the costs for services of the non-medical surgical assistants. The lack of MBS rebates has meant that the primary surgeon bears the financial cost of non-medical surgical assistance services, so that additional out-of-pocket expense are not incurred by the patient. Expanding the MBS item for nurses who provide surgical assistance would reduce the cost to the rural patients and surgeons. While RACS endorses the report's recommendation for non-medical surgical assistants to have access to the MBS, the following should be considered:

- Provider numbers tied to location of surgery and remoteness as classified by the Monash Modified Model (MM2-7) would enable nurse surgical assistants in rural and remote areas access to the MBS. This could prevent MBS claims by non-medical surgical assistants in areas already well serviced by medical surgical assistants (such as in urban settings MM1).
- A tiered schedule of MBS items for surgical assisting recognising the complexity of the surgical procedure and restricted to qualified surgeons only.

Qualifications and credentialling

The report proposes that eligibility to claim assistance for nurses and nurse practitioners, will require completion of the perioperative nurse surgical assistant postgraduate qualification that has been recognised for Medicare provider number eligibility. The SAWG consider that this qualification requires a minimum of 116 hours of study. This implies that assistance fees would only benefit a small number of nurse practitioners, but may not help perioperative surgical nurse assistants and experienced senior registered nurse surgical assistants. RACS emphasises that undertaking these

additional qualifications must not be onerous and nor a barrier for rural health services to support their nurses through. It is a concern that the requirement for a formal qualification may exclude current highly experienced rural non-medical surgical assistants. Whilst the postgraduate training is very rigorous and the training lengthy, expensive and city-centric, the impact is disproportionately on those in the rural settings.

RACS requests the SAWG considers expanding MBS eligibility to include a legacy clause applicable to current highly experienced senior nurse surgical assistants who have working in that capacity for some time. As part of a historically demonstrated surgical assistance competency, these nurses could demonstrate competence through workplace-based assessment. It would be feasible for RACS and its members to define what constitutes adequate past experience, and what constitutes adequate training for a nurse surgical assistant prior to implementation of any MBS changes.

RACS does not have the authority to mandate training requirements and scope of practice of nurses as this responsibility lies with Nursing and Midwifery Board of Australia (NMBA). Similarly, RACS recognises that nurses are required to practise within their scope of practice and emphasises that nurses only undertake surgical assistant roles if appropriately trained, credentialled and indemnified as specified in the Australian College of Perioperative Nurses (ACORN) Standards[2] and NMBA Registered nurse standards of practice[3] (in particular standard 6, point 6.2). However, the report notes that there is lack of clear governance and regulatory oversight of education pathways for perioperative surgical assistance programs. Should the government require a professional/training organisation to oversee the credentialling of non-medical surgical assistants, RACS can play a significant role in developing training, accreditation and credentialing of these surgical assistance programs with funding from government. It is imperative that there is clarity regarding these processes before implementation of any changes to the MBS schedule.

RACS is willing to make recommendations for agreed guidelines on the extended scope of practice of nurses and training standards in relation to their specialty. These recommendations would also apply to the legacy clause as described above. RACS could also support networking with surgical mentors, who are an integral part of working under supervision. AHPRA with NMBA would then be best placed to formally recognise qualifications. RACS welcomes the opportunity to support the NMBA, AHPRA and the relevant nursing colleges and professional bodies (such as the Australian College of Perioperative Nurses, Australian Association of Nurse Surgical Assistants and Cranaplus) in developing and implementing regulations and guidelines for perioperative surgical assistance, including the Continuing Professional Development framework.

RACS is always open to discuss our comments in detail if a request were made to do so by MRAC.

Yours sincerely,

Dr Sally Langley
President, RACS

Assoc Prof Kerin Fielding
Chair, Rural Health Equity Steering Committee

Prof Mark Frydenberg
Chair, Health Policy and Advocacy Committee

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[1] Royal Australasian College of Surgeons. (2015). *Surgical Assistants*. https://www.surgeons.org/about-racs/position-papers/surgical-assistants

[2] Australian College of Perioperative Nurses Ltd (ACORN). (2020). Standards for Perioperative Nursing in Australia – Professional Standards. (16th ed., Vol. 2).

[3] Nursing and Midwifery Board of Australia. (2016). Registered nurse standards for practice. https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx