9th Dec 2016

**Submission to the Podiatry Board of Australia**

**RE: Public consultation paper**

**• Registration standard: Endorsement for scheduled medicines**

**• Guidelines: Endorsement for scheduled medicines**

Anthony Short *MPod BAppSc(Pod) FFPM RCPS(Glasg)*

(content redacted)

To the Chair,

I appreciate the opportunity to provide some brief comments and feedback to the Podiatry Board of Australia regarding it proposed changes the registration standard and guidelines surrounding the activities associated with endorsement in scheduled medicines. This is a timely and long anticipated development for our profession since the first introduction of the endorsement process by the Board. My apologies for providing the comment outside of the recommended template the Board has developed, however they include some very specific suggestions and feedback.

I would be grateful if the Board could consider these comments found below in the following table:

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| --- | --- | --- | --- |
| **Consultation Paper Reference** | **Issue highlighted** | **Comments** | **Suggested improvements** |
| Page 7 | *“removal of some medicines from the list (for example: felypressin, procaine, mepivacaine and temazepam) because they are not available in the form specified in the current list or the product specified in the current list is not registered for podiatric use”* | The removal of temazepam from the National Medicines List reduces the therapeutic options for podiatrists to provide pre-procedural anxiety relief. No alternative has been proposed to replace this, and no explanation provided. Although the TGA indication for temazepam is to induce sleep, the only alternative benzodiazepine is lorazepam which has a longer duration of action, and greater potential for adverse effects over a longer period of time | 1. Retain temazepam within the National Medicines List, or, 2. **Replace with an alternative shorter acting benzodiazepine, such as oxazepam** |
| Page 22 | *“Methoxyflurane…should only be used where appropriate resuscitation facilities are available”* | The Board has not determined what “appropriate” resuscitation facilities are or would be, and why this would be indicated | 1. Do not include this statement, or 2. Define what is ‘appropriate’, bearing in mind the widespread use of methoxyflurane by other persons such as ski instructors and surf lifesavers |
| Page 24 | *“IM and IV routes are restricted to use by podiatric surgeons only and must only be used in association with a hospital admission (including a registered day surgery facility)”* | Does this mean that treatment of a post-operative infection with IM penicillin would need to occur in a hospital or day surgery facility? This would be incongruous with similar antibiotic care provided by GPs in the community setting.  More broadly, IM and IV routes or administration should also be available to general podiatry registrants, particularly those that co-manage infections in public and private hospitals (eg diabetic foot clinics, etc), where this is often widely indicated. | 1. Better define or remove this stipulation, or 2. Restrict this to just IV therapy 3. Allow general podiatrists to also access these routes of administration |
| Page 25 | *“When oral therapy using antifungal agents is initiated by a podiatrist or podiatric surgeon with endorsement for scheduled medicines, the prescriber must inform, request and ensure agreement from a medical practitioner with regard to who takes responsibility for monitoring the systemic status of the patient in line with the principles of Quality Use of Medicines (QUM).”* | Although desirable, the explicit requirement to “ensure agreement” from a medical practitioner to monitor the systemic treatment of the patient is not consistent with real world practice. This is, in practice, very difficult to achieve, and may be negated by a range of political, financial and practical considerations. | 1. Remove or modify this statement to make this a ‘desirable’ requirement, but not absolutely essential. The general principles of shared care management which underpin all podiatric prescribing will still apply to oral antifungals, as they do to all other therapeutic interventions. |
| Page 25 | *References to the word ‘skin’* | This appears redundant, as we are talking about topical preparations used for podiatric conditions. This is unnecessarily complicating the issue. | 1. Remove references to ‘skin’, and consider just continuing with a focus on the route of administration (topical) |
| Page 27 – injectable corticosteroids | *“Injection limited to injection in the foot for local effect”* | This is a very troubling statement. It is defining and restricting podiatric scope of practice to just the ‘foot’. For example, there are many ankle conditions that require treatment with injectable corticosteroids. What about treatment of a condition in the lower leg?  This statement is the first time the Board has ever defined an anatomical restriction to the practice of podiatry, and may lead to a perception that podiatric medicine is limited to just “foot conditions”. This could impact regulatory, legal and insurance related matters in the future. | 1. Remove reference to a limitation on practice to the foot only, or 2. Consider replacing with a term such as “*for podiatric conditions*” |
| Various sections | *150 hours supervised practice* | Should include guidance to the mentor on what would constitute quality supervised practice (eg mixture of public hospital, private sector, medical, specialist and podiatric prescribing environments) | More clarification on where supervised practice should occur |

Many thanks for the opportunity to submit these comments.

Yours sincerely,

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Podiatrist