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Mr Jason Warnock
Chair, Podiatry Board of Australia
c/o Level 8, 111 Bourke Street
Melbourne VIC 3000

22nd November 2010

Dear Jason

**Re: Podiatry Board of Australia - Consultation paper on:
Guidelines for endorsement for Scheduled Medicines. 5 November 2010.**

The Podiatry Board of Australia's (*the Board*) Guidelines for Endorsement for Scheduled Medicines (*the Guidelines*) for podiatrists and podiatric surgeons provides a welcomed, potential increased scope of practice for qualified practitioners in Western Australia.

The Guidelines, however, appear little more than a reprint of that issued by the former Podiatry Board of Victoria, designed to facilitate prescribing endorsement for Fellows and trainees of the ACPS, and fail to reflect the unique situation that exists in WA with regards to the profession's history of scheduled medicines use and high educational standards.

A positive finding of the revised Guidelines is that there is a slight increase in the range of necessary scheduled medicines on the drug list, including one or two antibiotics and an appropriate S8 postoperative analgesic - oral oxycodone for use by podiatric surgeons.

However, the Guidelines for endorsement are strongly biased to satisfy the Victorian practitioner and have little relevance or applicability to UWA podiatric medicine graduates or to existing 'Authorised Podiatrists' in WA who already have access to a range of Schedule 4 medicines. Specifically:

(i) The Board has failed to recognise four WA academic qualifications in their list of 'approved programs of study' – Master of Science (Podiatry) (*Curtin*), Bachelor of Podiatric Medicine (*UWA*), Master of Podiatric Medicine (*UWA*), Doctor of Podiatry (*UWA*), and Doctor of Clinical Podiatry (*UWA*) (see Appendix B, pg 27).

The Board must be reminded that the WA Department of Health presently recognise earlier relevant Curtin Master's degrees and present undergraduate and postgraduate degrees from The University of Western Australia as fulfilling their requirement to become an 'Authorised Podiatrist' to access Schedule 4 medicines in WA. Furthermore, that the current UWA BPodM course shares 40% of its curriculum with the MBBS and BDSc programs, including the important units in biomedical sciences, clinical pathology, pharmacology, general medicine, general surgery and anaesthesia. Dental graduates of UWA require no further training, assessment or patient co-management protocols and may prescribe an expansive range of scheduled medicines, well in advance of the National Drug List for podiatrists.

(ii) The requirements to complete either 'Pathway 1' or 'Pathway 2' may well be acceptable and appropriate for Victorian podiatrists/podiatric surgeons who until last year had no history of using

scheduled medicines. This is not the case in WA where 'Authorised Podiatrists' have had the right to use a range of Schedule 4 medications for the past 18 years.

(iii). The mechanisms described in 'Pathway 1' or 'Pathway 2' are disjointed, unnecessarily prolonged and virtually impossible for individuals to achieve.

The Board has defined two pathways for endorsement to prescribe drugs. Both pathways are inappropriate for WA podiatrists/podiatric surgeons.

Problems with 'Pathway 1'

The Board does not include any UWA undergraduate or postgraduate qualification in podiatry or the Master of Science degree from Curtin as an 'approved program of study'. I can only assume this was an oversight.

The 'Information Package' supplied by the Board defines the requirement to obtain two references from a medical practitioner (or endorsed podiatrist) certifying that an applicant has worked for a period of seven years in a clinical setting where drugs have been prescribed. Furthermore, that the applicant has been actively involved in managing patients with a variety of conditions requiring drugs and has demonstrated that he or she is "work ready" to begin prescribing drugs themselves (see pg 6).

Firstly, the period of time required (7 years) is extraordinarily excessive. Is there any other profession in Australia that requires seven years of mentoring before being authorised to prescribe drugs?

Secondly, assessment of the applicant is to be made by two individuals. This raises questions about the validity of their assessment (their training, experience and methods used to assess students) and of potential conflicts of interests. For example, it is likely that a podiatric surgeon may seek references from two practitioners with whom he or she has a symbiotic financial relationship. Examples of this scenario would be of a podiatric surgeon seeking a reference from two anaesthetists, or a podiatrist leasing rooms from a group of general practitioners.

Thirdly, the referee would seem to require seven years of a continuous working relationship with the applicant – this would raise significant difficulties for the applicant as individuals (applicants and referees) often change employment or place of residence over that period of time.

The objectivity in measuring the experiential value of spending seven years working (full-time/part-time?) in a 'prescribing environment' must be questioned. In short, this requirement has not been adequately considered and fails on many practical and pedagogical levels.

Problems with 'Pathway 2'

The Board does not include any UWA undergraduate or postgraduate qualification in podiatry or the Master of Science degree from Curtin as an 'approved program of study'.

The Board requires the applicant to successfully complete 15 approved web-based case studies and 40 Log Sheets as part of a clinical experience in association with a Supervisor (see pg 7).

While the completion of 15 approved web-based case studies is quite reasonable, this could quite easily be embedded within all of the existing undergraduate/postgraduate podiatry courses in Australia. This would ensure that all future podiatry graduates have completed this requirement within their university studies, relieving the Board of dealing with this requirement.

The completion of 160 hours of additional supervised clinical practice is however problematic. The Guidelines requires podiatrists seeking endorsement to have attended a "variety of placements such as: high risk foot clinics, teaching clinics, emergency departments, the operating room, rheumatology clinics, endocrinology clinics, general medical practice and aged care facilities", with a multitude of clinical supervisors (see pg16 of 'Information Package'). Respectfully, the Board must be more realistic.

In practice, without the full cooperation of State Health Departments and the various medical departments within government teaching hospitals, this requirement would be virtually impossible to achieve for each and every podiatrist in Australia seeking endorsement.

The Board also states “All podiatrists who have been granted endorsement for scheduled medicines are encouraged to enter into a mentor agreement with a prescriber for a two-year period” (see pg 7). This would seem to be a further example of unnecessary extreme conservatism. If a practitioner is adequately qualified to prescribe a range of scheduled medicines then he or she should be permitted to do so without further mentoring. This requirement implies that Pathways 1 or 2 are not *quite good enough*, and to be safe, every endorsed practitioner should have their hand held for a further two years. I note that this would seem to be a recommendation and not a requirement.

The clinical training of students at UWA includes clinical exposure to scheduled medicines being used over three years of clinical practice, by three podiatric surgeons who are presently ‘Authorised Podiatrists’ in WA. In this sense, WA students are unique in that they are the only podiatry students in Australia to be exposed to the practical aspects of supplying and administering drugs to patients in the clinical setting. Prescribing drugs via the use of computer-base prescribing software (MIMS) is practiced during clinical sessions. Accordingly, UWA graduates at least, should be treated differently to graduates of other universities where prescribing, supplying and administering drugs, other than local anaesthetics, is not yet conducted.

The National Drug List

In general, the list of drugs proposed by the Board is quite suitable for the safe practice of podiatry. The Podiatrists Registration Board of WA submitted a similar list of medicines to the WA Department of Health in 2007 for use by Authorised Podiatrists in WA. No action was taken by the Health Department at that time as a new WA Poisons Act and the introduction of the National Health Practitioners Act was deemed imminent.

Problems with the National Drug List

Endorsement for scheduled medicine: Practice guidelines (see Appendix A, pg 10-22) details the list of drugs and restrictions relating to their use by podiatrists and podiatric surgeons; limitations on the length of therapy; and the need for shared-care arrangements with a medical practitioner.

At a recent WA Health Department Podiatry Reference Group meeting on 21 July 2010, it was unanimously agreed by all podiatrists present, including representatives of the Podiatrists Registration Board of WA, The Australian Podiatry Association (WA), The Australasian College of Podiatric Surgeons, The Podiatric Medicine Unit of the UWA School of Surgery and a number of podiatrists employed by the WA Department of Health, that:

- (i) The National Drug List was appropriate for use by appropriately qualified WA podiatrists
- (ii) There should be no delineation between ‘podiatrist’ and ‘podiatric surgeon’
- (iii) The word ‘Restriction’ be replaced with the word “Recommendation”
- (iv) WA podiatrists should be authorised to access scheduled medicines by virtue of their formal academic qualifications and not be required to undertake additional Pathway 1 or 2 training as described in the Board’s Guidelines

The revised National Drug List (5 November 2010) varies only slightly from that proposed in July 2010. The only significant addition is the inclusion of oral oxycodone (for use by podiatric surgeons only, 5mg with maximum of 10 doses). This is a very sensible inclusion that was included in the Queensland drug list in 2009. It provides podiatric surgeons with a Schedule 8 narcotic analgesic that is suitable for use in patients experiencing or likely to experience moderate to severe postoperative pain of a temporary nature.

A noticeable omission to the National Drug List is the lack of antiemetic medication, other than a variety of oral antihistamines. The Podiatrists Registration Board of WA in 2007 recommended that

the antiemetic drugs prochlorperazine (oral or suppository) and metoclopramide (oral or by injection) be made available to podiatrists.

The inclusion of IV adrenaline (for podiatric surgeons only) is unnecessary when the standard management of an acute anaphylactic drug reaction is generally the administration of IM adrenaline. Intra-muscular administration is said to be much easier in an emergency situation and offers the ability to deliver a more reliable dose without the need to perform a venipuncture.

The requirement for shared-care arrangements with medical practitioners is flawed in many respects. Firstly, it assumes that endorsed podiatrists are inadequately educated in the first instance and must rely upon the advice (or instruction) of a medical practitioner to safely prescribe or administer scheduled medicines. Is it a requirement for dentists to seek the sanction of a medical practitioner before prescribing or injecting a drug into their patient?

Insistence on a protocol of share-cared patient management assumes that each patient has a medical practitioner and that the medical practitioner in question is both available and amenable for immediate consultation. This may be suitable for podiatrists working within a hospital environment but is hardly satisfactory for podiatrists working in private practice. The Victorian AMA has already highlighted the medico-legal ramifications for medical practitioners authorising podiatrists to prescribe drugs over-the-phone. The Board has not adequately considered the various problems associated with this requirement.

Clearly, it is desirable for podiatrists to maintain good levels of communication between other health care providers, including medical practitioners and pharmacists, but it should not be an absolute requirement to do so. Proper standard of patient care will determine when a consultation is required between a podiatrist and the patient's medical practitioner. To make this a mandatory requirement is both unnecessary and professionally demeaning for adequately educated primary care practitioners.

The Board should reflect on the 18 years of experience in WA, where to the best of my knowledge, there has been no reported serious adverse outcome in any patient from podiatrists supplying or injecting scheduled medicines without the need for a medical practitioner's prior consent or co-management of the patient.

Implications for current 'Authorised Podiatrists' in WA

Presently, the WA Department of Health approves certain WA based university qualifications for access to a range of scheduled medications by podiatrists. With the passage of the new Poisons Act and the acceptance of the Podiatry Board of Australia's National Drug List, Authorised Podiatrists in WA should be permitted to prescribe, supply and administer an increased range of medications. This will require current practitioners to attend a Board approved Therapeutics Update Course and to adhere to the requirements of the Board to attend relevant Continuing Professional Development (CPD) programs.

Undertaking an appropriate Therapeutics Update Course is in keeping with the recommendations of the Podiatrists Registration Board of WA's 2007 submission to the WA Department of Health. In that submission The UWA undertook to provide an appropriate CPD course for local Authorised Podiatrists to update their knowledge of any medication on a revised list. The University stands ready to provide a suitable course, approved by the Board for this purpose, giving podiatrists the option of undertaking either the La Trobe program in Melbourne or attending a similar course in Perth at UWA.

Recommendations

1. The National Drug List proposed by the Podiatry Board of Australia is appropriate for use by appropriately qualified Australian podiatrists.
 - a. The drugs prochlorperazine and metoclopramide should be included as antiemetic agents.
 - b. Consideration should be given to deleting the IV route of administration of adrenaline.
2. There should be no distinction between 'podiatrist' and 'podiatric surgeon', for any drug or route of administration, other than to restrict the use of oxycodone to podiatric surgeons.
3. The term "Restriction" as it applies to the National Drug List should be changed to the term "Recommendation". Specifically, the absolute requirement for medical consultation and patient co-management should be removed.
4. Present 'Authorised Podiatrists' in WA, including BPodM graduates who completed their course in 2009 or 2010, should only be required to attend a Board approved Therapeutics Update Course at either La Trobe or UWA before becoming eligible to prescribe, supply or administer the extended range of scheduled medicines on the National Drug List.
5. There should be no requirement for graduates from 2011 of the UWA BPodM, MPodM, DPod, DClinPod programs, or the graduate entry DPM course due to commence in 2013, to undertake any further requirements as outlined in Pathways 1 or 2, beyond successful completion of their degree, to access drugs on the National Drug List.
6. Universities providing undergraduate and postgraduate podiatry programs should be encouraged to include sufficient subject content in the areas of general medicine, clinical pathology, pharmacology and clinical podiatric therapeutics, including the 15 Board approved web-based case studies, such that graduates should not be required to participate in any further requirements as outlined in Pathways 1 or 2, beyond successful completion of their degree, to access drugs on the National Drug List.



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22nd November 2010