To whom it may concern,

I write to you regarding the Podiatriasts who advertise/promote themselves as surgeons review. I believe it to be unsafe in many ways, and misleading in almost every way, that Podiatrists who practice surgical techniques, often with poor outcomes, are allowed to use the term "Surgeon".

Much like cosmetic surgery, Podiatrists should not be allowed to advertise/use the term "Podiatric Surgeon" or "Foot Surgeon"

Thank you for reading

Matthew Alexander
Orthopaedic Surgeon
Austin Health
MBBS, BMedSci, FRACS (Ortho), FAOrthA

[redacted]

Dear Professor Paterson

Question A.
I complete this submission on behalf of myself, Murray Blythe.
[redacted]

Question B.
I am an Orthopaedic Surgeon who has undertaken international fellowship subspecialty training in foot and ankle surgery. I have been working as a consultant (VMO) for 10 years. I was the inaugural secretary of the Western Australian Orthopaedic Foot and Ankle Society (WAOFAS) and am currently the treasurer thereof.

Question C.
Publish my submission with my name.

1. I take umbrage at the term "podiatric surgeon". They are podiatrists who operate. Consumers are entirely **un**informed as to their training or competence. Patients are consistently surprised to hear that the person who operated, or is planning to operate, on them is not medically qualified. The recent legislation to protect the title "Surgeon" is ridiculous as it only limits medical health professionals from using the term. This conveniently allows podiatrists who operate to continue to inappropriately use "Surgeon". The failure of the legislation was to not cover ALL health professionals under AHPRA.

As an example, Ms DC was in her 30s at the time of her procedure by a podiatrist who operates. When I contacted her recently, 8 years later, to see if she would "go on the record" with a reporter from the SMH, DC said she remained furious that she had no idea the podiatrist who operated was not medically trained and would be happy to do so. I refer to DC's case as members of WAOFAS have found it difficult to find patients of podiatrists who operate to "go on the record" as usually they are involved in litigation or preparing for this. We have found that while the patient is usually very motivated to prevent others from having similar experiences their legal advice is inevitably to not have any involvement.

DC continues to have pain in the toes and so "would do anything to save another person going through the same thing". Accordingly I suspect DC would be motivated to speak to your Review if requested. DC reported at the time of my initially seeing her in an emergency department 8 years ago, and when I spoke to her on the phone recently, that she would never have accepted surgery from a podiatrist had she known they were not medically trained.

2. They are NOT podiatric surgeons, they are "Podiatrists who operate". Protecting the title "Surgeon" relative to ALL health professionals would help to reduce the confusion.

3. I refer you to the attached AOA and AOFAS submission on podiatrists who operate.

4. I refer you to the attached AOA and AOFAS submission on podiatrists who operate.

5. DC developed an infection in her wounds at one week. This is not remarkable. She was prescribed antibiotics although the letter from the podiatrist implied this was by the GP the practice. A Surgeon should be able to manage simple complications. The letter reported that at two weeks that the toes were looking much better but then the podiatrist went on to debride and resuture the wounds. In active infection this was inappropriate. DC reported that a wound was resutured on several occasions and subsequently glued as it dehisced although the letter reports only one such event. The "dehiscence" was gapping of the epidermis and so was never going to "heal".

DC was identified as a carrier of a minor immunity deficiency as her child had been diagnosed with the

condition. The podiatrist discussed and referred DC to an Immunologist “who felt she may need assessment by plastics or infectious disease…” Surely referral to ID directly would have been most appropriate, if any? This demonstrated no understanding of medical subspecialties and their roles.

The podiatrist’s letter then went on “She was reassured and advised to seek further examination and opinion from yourself”. In fact DC was sent in to the Emergency Department by a different GP. I just happened to be the consultant orthopaedic (general) surgeon on call that day. I took a swab, continued the antibiotics and stopped playing with the wounds. They then healed by secondary intention.

DC’s case demonstrates podiatrists failure (or inexperience) to manage simple (common) complications (every surgeon will have them) and the interaction of surgery with medical systems and processes.

10. A great deal of my time as a foot and ankle orthopaedic surgeon is spent assessing and counselling patients with simple foot conditions and then referring to podiatrists, physiotherapists or orthotists. In an audit of referrals to myself over a two year period less than 25% of patients referred for foot or ankle conditions came to an operation within two years. In comparison, approximately 50% of patients referred for a hip or knee condition came to surgery within two years. Given the cost to Medicare (and patients who pay a gap for each consultation) surely an Orthopaedic Surgeon's time and skillset would be better used seeing patients who likely need surgery rather than organising non-operative management? Given a podiatrist's primary training and skillset, wouldn’t they be most useful to the community focusing on that non-operative management, rather than trying to identify and manage the small proportion who will require surgery?

Regards

Dr Murray Blythe

[redacted]

AOA SUBMISSION

Assessment of foot and ankle services by podiatric surgeons

24 March 2014

Introduction

The Australian Orthopaedic Association (AOA) and the Australian Orthopaedic Foot and Ankle Association (AOFAS) welcome the opportunity to respond to application 1344 for the Application for access to the Medical Benefits Schedule by Podiatric Surgeons.

AUSTRALIAN ORTHOPAEDIC ASSOCIATION

AOA represents Orthopaedic Surgeons and AOFAS represents Orthopaedic surgeons with specific interests and additional clinical training and education in Foot and Ankle surgery.

AOA and AOFAS are the peak bodies for both Orthopaedics and Foot and Ankle surgery in Australia.

The Australian Orthopaedic Association is the peak professional body for orthopaedic surgeons in Australia. AOA provides high quality specialist education, training and continuing professional development. AOA is committed to ensuring the highest possible standard of orthopaedic care and is the leading authority in the provision of orthopaedic information to the community.

AOA members provide advice to Government by way of membership on many health technology related committees and working groups both within the Department of Health and the Therapeutic Goods Administration. Therefore AOA is well placed to provide comment on the review of orthopaedic related MSAC issues.

Preamble

In principle the AOA and the AOFS has no problems with appropriately trained surgeons, having access to the Medical Benefits Schedule. In this situation we object to the granting of access to operating podiatrists because of the inadequate educational standard of the Australian operating podiatrist.

Our objections to this particular application are not derived from any concerns regarding the concept of appropriately trained individuals in Podiatry performing surgery. The AOA and AOFAS object to the granting of access based on the inadequate standard to which the Australian Podiatric Surgical Fraternity has been educated.

It is vital to note, that granting access to the MBS, will be construed by consumers as the Government endorsing the standard of surgery supplied by members of the Australian College of Podiatric Surgeons (ACPS) and later by those trained under the University of Western Australia standards; standards that have never been independently inspected or assessed as being adequate or fit for purpose.

The situation is not the same for medical practitioners and surgeons whose training is assessed and approved by the Australian Medical Council (AMC) a Federal Government body. Nor is it the same as the Oral/ Faciomaxillary surgeons who have set up a training protocol which is the minimum model we accept for surgery on the public.

Numerous concessions by the various levels of Government have been obtained by ACPS, but in almost every case each level of Government has specifically stated that it has not inspected the educational standard[1], and has left it to another entity to undertake this task. Consequently the task has never been done.

As in previous and multiple submissions to Government AOA and AOFAS believe it is an absolute requirement for CPME certification of the Podiatric Training Program to be the educational standard for podiatric surgery in Australia. Although it is often quoted that Australian operating podiatrists are ‘on par’ or ‘equivalent’ to American podiatric surgeons this is not factually correct.

It cannot be emphasized enough that the Training Program must be CPME and AMC standard, and the training program inspected and audited. It is not adequate to have individuals who may have the qualification teach, it is the actual entire course that must be accredited.

The key question for public funding is:

1. **Are the services provided by operating podiatrists as safe and effective as those provided by orthopaedic surgeons?**

It is imperative that MSAC comprehensively researches and satisfies itself that the ACPS and UWA courses meet the same standard as that set and assessed by Australian Medical Council (AMC) for all other health professionals that operate on humans in Australia before issuing advice to the Minister.

MSAC will quickly discover that operating podiatrists are the only surgical group operating on humans without AMC sanction. Therefore MSAC will be unable to define whether "*foot and ankle surgery performed by podiatric surgeons (is) at least as safe and effective as foot and ankle surgery performed by orthopaedic surgeons"*

AOA and AOFAS believe it is imperative that such research is done so that a comprehensive and impartial assessment of the Standard of podiatric training is undertaken.

The AOA and AOFAS objections are based on the following issues:

1.1 Non Equality of Australian Operating podiatrists and US Podiatric Surgeons or Australian Orthopedic Surgeons

In the submissions that will be provided to MSAC by ACPS, it is to be recognised that Surgical Podiatrists in Australia will claim an equivalent training to those of America.

This is absolutely incorrect.

American Model (CPME)

Podiatric Surgeons in the USA undergo a basic medical training and an examination known as the MCAT examination. This is the same basic sciences program which is untaken by Osteopaths and Medical Practitioners.

It is after obtaining the MCAT that specific training is then directed towards Medicine, Podiatry or Osteopathy.

After being trained, the Podiatrists will spend 5 - 6 years in a Podiatry school in the USA to be graduated with a Doctor of Podiatric Medicine. This is not the same degree as is confirmed by the University of Western Australia.

After this, if a person wishes to become a Podiatric Surgeon in the USA, this training will be within a specific recognised registrar training program also known as a residency in the USA. It will include a significant amount of hands-on clinical training where the registrar actually operates on patients. This is NOT the case in Australia.

All of these steps, the MCAT, the Podiatric Medical school training and registrar training are supervised by the Council of Podiatric Medical Education known also as

the CPME. This institution (the CPME) has, for many years, overseen podiatry training and has brought it to a very high standard.

This assertion is more than the opinion of the AOA and AOFAS; it is also reflected in the practice and opinion of the Podiatric Medical Authorities in the United States.

- No Australian trained podiatrist or Podiatric Surgeon has the equivalent training to the base level of MCAT education.

- No Australian trained Podiatrist or Podiatric Surgeon can go to America and gain entry into a CPME certified Podiatry School to begin education to obtain a DPM.

- No podiatrist or Podiatric Surgeon in Australian would be eligible to sit the MCAT without further education.

- No Australian Podiatrist or Podiatric Surgeon can be trained as a Podiatric Surgeon or registered as either a Podiatrist or Podiatric Surgeon in America.

- No Australian Podiatrist or Podiatric Surgeon can be registered to practice, or has ever been registered based on their Australian Credentials to practice in the United States.

Any claims of equivalency with the USA are absolutely false.

Australian Model (ACPS)

An investigation into the training of Operating podiatrists, and their claims to equivalent training to Orthopaedic Surgeons, was undertaken by the Price Waterhouse Cooper group for the Department of Queensland Health [2].

In this they stated that Operating podiatrists in Australia are “trained to undertake a range of procedures to the foot, but these skills are not as extensive as the skills attained by medical practitioners, especially those medical practitioners who have qualified in one of the surgical ‘specialties’ “ [2]

Thus the Australian Operating podiatrists are must be considered as being far less well trained than a general practitioner in issues regarding surgery.

The assessment of the level of training has already been done and has been found to be woefully inadequate.

Furthermore, whilst the ACPS will supply a number of training programs, the ACPS have been shown in the Royal Australasian College of Surgeons submission to the AHMWC [3] to have been highly arbitrary in conferring their fellowship, that individuals who failed examinations were permitted to pass without re-sitting the examinations, that individuals that did not even sit examinations were permitted to pass and granted the fellowship without convening the Court of Examiners.

Individuals who do not qualify to sit the examination have been allowed to sit the examination.

The ACPS have allowed individuals who have not received the Masters degree to sit the examination despite this being an absolute requirement of their training program.

The training program is not in any way equivalent to that of an Australian Orthopaedic Surgeon.

Far from adhering to the stated goal of National Registration, "that all suppliers of a service would do so to the same standards" the ACPS has acted not as an independent education provider, but as a "old boys club" gifting its Fellowship, or withholding it, apparently on whim and personal preferences.

Whilst the ACPS claim a temporal equivalency (i.e. the same number of years in training), it can be seen that an Orthopaedic Surgeon Registrar in Australia will be a full time doctor undertaking full time training in Orthopaedic Surgery, every day, being on call and operating daily in outpatients, fracture clinics and in operating theatres under the supervision of Orthopaedic Surgeons.

A registrar of the ACPS is none of these.

The ACPS assert their trainees are "full time registrars", but this deliberately misleads the reader, as it fails to say what they are doing "full time". These "registrars" will simultaneously be a "full time podiatrist", earning an income to support themselves, and simultaneously a "full time Masters student" completing the required Masters Degree, whilst also asserting to be "full time surgical podiatric registrars".

It is simply impossible for an individual to claim to be able to do these three full time courses simultaneously.

In what Australian hospitals are the podiatric surgery registrars operating on patients and under whose supervision? – There are no such positions.

1.2 Irregularities in Adoption of Current Standards

The ACPS training program has never been inspected nor has it been ratified by any independent organisation.

The ACPS has had its educational standard recognised by a number of State Podiatry Boards including the Queensland Podiatry Board, and it is very instructive to reflect on how this standard has been accepted.

In 1996 the Queensland Podiatry Board reviewed the question as the "minimum training and qualifications of the practice of podiatric surgery "to determine the standard required to operate on the Public in this State".

Instead of the Queensland Podiatry Board inspecting the ACPS facilities and training program and assessing whether the education was appropriate and being appropriately and reliably provided, and without seeking the council of individuals learned in Surgery (as none of the members of the Board in attendance were Surgically Trained). The Board simply heard from one of its members regarding whether or not the Podiatry Board should accept this standard above all alternative Standards which might have been adopted.

The advice was provided and on the same day, the Queensland Podiatry Board passed the policy accepting the ACPS standard of education without inspecting the Association, never inspecting its training facility, never inspecting its registrars[6].

The individual proving the advice failed to disclose that he was a registrar in the ACPS and he would benefit from this being accepted as the standard of training.

This is not the only instance in which the ACPS have used members of Boards to gain advantage.

Review of Training

ANZPAC was tasked to define the minimum standards of training with the funds for the study; the Victorian Podiatry Board [12] provided substantial funds to pay for a member of ANZPAC to decide what would the appropriate standard of education required for Podiatric Surgery would be.

Dr (non-medical) Susan Owen, the individual, who undertook the assessment of the training programs in Podiatric Surgery, was a consumer member of the Podiatry Board [5] , and by definition had no training or understanding of Podiatry. Ms Owen also has neither training in medicine, nor in surgery.

There are also no individuals with a background in education involved in either assessing the training programs, assessment of individual podiatrists or indeed actually training podiatrists.

The Terms of Reference requested that the AMC was involved in the production of the document, and this collaboration never occurred (page 2 paragraph 3.)

At the same time, the University of Western Australia was not accepted in the preliminary report, and remarkably the marked lack of separation of the assessor and assessed was evident on page 28 where it is stated in Pathways Forward:

- ANZPAC in conjunction with ACPS and relevant others, considers the accreditation standards proposed in this draft report, identifies amendments and upon endorsement, commences formal processes for the recognition of podiatry specialities if this future is granted by the Podiatry Board of Australia.

Following communications from the Western Australian Podiatry Board, complaining about the UWA not being accepted the University of Western Australia Podiatric education for operating podiatrists, was accepted by ANZPAC, without ANZPAC adhering to its own required standards to inspect this group, with no investigation of the actual education that would be provided, in a purely political activity, the UWA standard was accepted.

As of 2010 only one student had enrolled in the UWA course, and it has yet to produce a single Podiatric Surgeon. UWA was advertising the course as a route to surgical qualifications without having been accredited. UWA it has been accredited now, without ANZPAC having physically inspected the site.

In this document, the writer is so confused about the duties she has been given, that on page 12 she writes “To date there has not been agreement reached between the ACPS and the University of Western Australia in terms of the Doctor of Clinical Podiatry program of study being accepted for Fellowship purposes. …… The academically-focused UWA Masters program has previously been accepted by the ACPS but the concern seems to be around the practical clinical training aspects of the doctoral program for which no agreements have been reached by the various parties (ACPS, 2009b). “The author seems unaware that the standards of surgery are not set by either of these two groups.

So far, no rigorous independent appropriately educated group has inspected either of these institutions.

It is not acceptable for podiatrists, who have never been trained in medicine, never had any education in surgery, to be given the onerous task of deciding what standard of education is required for surgery that they have never done and cannot therefore hope to appropriately administer.

ANZPAC has also inappropriately accepted the ACPS and UWA standard.

Under its own Accreditation Standards for Procedures for Podiatry Programs for Australia and New Zealand (page 22), ANZPAC requires 64 months before a program can be approved.

As it undertook these studies in 2010, it cannot have adhered to its own criteria in assessing these programs.

Other questions and considerations for public funding include:

2. **Would patients be offered different surgical procedures (for the same condition) by podiatric surgeons as compared to orthopaedic surgeons?**

ANZPAC Bound To International Standards.

ANZPAC has given commitments to the government in the lead up to National Registration 13 that it would "The Ministerial Council request the agency (ANZPAC) consider the following matters in developing accreditation standards …. (c) the need to align standards with relevant international standards and clearly indicate the international standards on which these standards are based when presenting them to the boards for consideration" (d) the need to ensure that accreditation assessment panels provide sufficient public accountability and independence"

To which ANZPAC wrote "agree".

It has failed to be independent of the existing standards and failed to seek the international standard.

AHWMC directed the Podiatry Board to develop guidelines in consultation with the AMC but our information suggests that they did not engage in any meaningful consultation and involve the AMC in the development of any educational standards despite the suggestion they did (page 2)
http://www.podiatryboard.gov.au/Accreditation.aspx>.

The evidence outlined thus far in this submission indicates that it would be impossible to ascertain whether or not patients would be offered different surgical procedures for the same condition as compared to orthopaedic surgeons.

Orthopaedic surgical training and education is acknowledged as first class by independent standards as recently assessed by an independent expert in medical education. In particular the clinical experience of orthopaedic surgery registrars is superior to most in the Western world.

Orthopaedic surgical training is a well-established robust program which is assessed and accredited as part of the overall Royal Australasian College of Surgeons training programs. The orthopaedic training program is robust and transparent. Procedures are taught in a systematic and consistent manner by supervisors who are trained to do so.

As the operating podiatrists have no such system and no emphasis on hands on clinical training it would be impossible to compare surgical procedures/techniques.

3. **Would patient management by a podiatric surgeon result in the utilisation of fewer MBS items as compared to management by an orthopaedic surgeon for management of the same condition?**

This would be extremely difficult to determine.

We note that there is a list of some 40 MBS Items that operating podiatrists are requesting to access apart from the routine minor procedures the remainder are procedures for which no meaningful utilisation data exists and due to the issues outlined in the response to Question 2 (above) there is no way of identifying potential utilisation.

In the absence of other evidence, anecdotal evidence would suggest that when health professionals other than medical officers have been given access to MBS item numbers the utilisation of those item numbers has increased well beyond any predictions.

4. **Are the surgical techniques performed by podiatric surgeons comparable, in terms of complexity and for the same level of disease and dysfunction, as those performed by orthopaedic surgeons?**

Unable to be determined. See Question 2 above.

Other more specific issues; at the present time they do not wish to engage in ankle replacement or malignant tumours. They have no training in arthroplasty or tumours. How are they to know that what they think is a benign lesion is not a malignant tumour. There is adequate documentation that poor initial surgery on a malignancy decreases the chances of a positive outcome. It is important that here be sufficient training to assess and manage pathology at all levels and not “cherry pick” cases.

5. **Are foot and ankle surgery services by podiatric surgeons provided at the same line of treatment as orthopaedic surgeons?**

Unable to determine, there is no Australian data or evidence available.

Other more specific issues; at the present time operating podiatrists do not wish to engage in ankle replacement or treatment of malignant tumours. They have no training in arthroplasty or tumours. How are they to know that what they think is a benign lesion is not a malignant tumor? There is adequate documentation that poor initial surgery on a malignancy decreases the chances of a positive outcome.

6. **How is pre and post-operative risk dealt with by podiatric surgeons compared to orthopaedic surgeons?**

7. **What undergraduate and postgraduate training are undertaken by podiatric surgeons, including curricula, compared to orthopaedic surgeons?**

As outlined in Question 1 (1.1 & 1.2) there is NO independently assessed and independently credentialed educational pathways for operating podiatrists. (See Attachment 1)

In 2010 the ACPS claimed " International Affiliate Status" with the American College of Foot and Ankle Surgery.

Canadians, English and NZ Podiatric Surgical societies were all approached by to ascertain their position on the ACPS and the Australian operating podiatrist's qualifications. The results follow:

USA:
ACFAS international affiliate status does not, in any way, endorse or designate surgical competency of the physician. Affiliate status is intended only to provide access to ACFAS services. We do not accredit or credential any surgeon. .
If you have any questions, please contact me.
J.C. (Chris) Mahaffey, MS, CAE, Executive Director
American College of Foot and Ankle Surgeons
8725 West Higgins Road, Suite 555, Chicago, IL 60631 USA
P 773-693-9300, Ext. 1305 F 773-693-9304
mahaffey@acfas.org Visit www.ACFAS.org or www.FootHealthFacts.org

UK :
Basically would allow them to operate, but only because the Podiatry Degree is recognised, NOT because the "Advanced Training" is recognised.

The term Podiatric Surgeon is in fact a protected title under our new Health Professions Act. Applicants trained under the Australian model would not qualify for membership in any region where the DPM/Residency is the minimum entry to practice (4 of the 6).

Canada:
Has real DPM Podiatrists - not equal, but also a sub-class of Chiropodist.
In two regions, the regulatory bodies allow a different "levels" of podiatrist. The majority of these practitioners are in fact chiropodists with minimal training and certainly no surgical experience. These regions consider the term "Podiatrist" to be more modern and widely accepted in Canada and so even though their diploma may say chiropodist, their regulatory bodies allow them to be called podiatrists. In these two provinces, a podiatrist trained in Australia may gain membership but would certainly not be considered a "surgeon". Their practice would be limited to routine foot care and non-invasive biomechanical treatment.
In the non-regulated regions, an Australian trained "podiatrist" could conceivably set up a practice but any claims of being a doctor or surgeon would not be looked upon kindly by the provincial College of Physicians and Surgeons (regulatory body for MD's). Any attempt to put knife to skin in these regions would be considered assault.

NZ
The President of the College stated (in march 2014) as there is no recognition of the ACPS Fellowship by NZ as the training programs are different, so therefore he would

be denied the scope of Podiatric Surgery (see below). All these documents are on the public record at:
https://www.surgeons.org/media/301623/attachment_part_2.pdf

So in Summary the ACPS qualification does not give Australian operating podiatrists the right to operate in American, Canada, United Kingdom or New Zealand.

Conversely, Australian Orthopaedic surgeons have no such issues as the FRACS is recognised worldwide.

8. **How are patients referred to podiatric surgeons from other health practitioners?**
   Patients can be directly referred from General podiatrists, Physiotherapists , GPs, Sports trainers and even shoe-fitters**.**

9. **What arrangements exist for podiatric surgeons to refer to other health practitioners and specialists?**

10. **How do podiatric surgeons provide multidisciplinary patient care, particularly with other podiatrists, medical practitioners, physiotherapists and occupational therapists?**

11. **What arrangements exist for podiatric surgeons to prescribe medications?**

Operating podiatrists in some jurisdictions are permitted limited prescription rights. In other jurisdictions they are not permitted as enabling legislation have not been passed through state parliaments and so they cannot supply prescriptions

12. **What arrangements exist for podiatric surgeons to request pathology testing or diagnostic imaging?**

13. **What care planning is undertaken by podiatric surgeons regarding surgical options and postoperative rehabilitation?**

14. **How do podiatric surgeons manage intraoperative complications, such as cardiac arrest?**

Operating podiatrists are not trained in Advanced Life Support and cannot administer cardiac medications and cannot administer DC cardioversion. If there were a cardiac arrest in theatre while there was no anesthetist (local anesthetic procedure) the patient's survival would depend on there being a qualified anesthetist in a nearby operating theatre.

15. **How do podiatric surgeons manage postoperative medical problems, such as venous thromboembolic disease, myocardial infarction or pneumonia?**

Unknown.
Operating podiatrists cannot prescribe venous thromboembolism (VTE) prophylaxis – presumably their patients would be required to see their general practitioner for this to be prescribed – an additional cost for the patient and Medicare.

The podiatrist is intending to be the primary health professional responsible for the patient's care around the time of surgery. This also requires knowledge of potential problems and the management of them not related directly to the patient's foot problem. Orthopaedic surgeons general medical degree allows them to understand patient's conditions that are not necessarily related to their foot that may impact upon the assessment and management of the patient.

As noted in the submission to MSAC many patients have diabetes, most of these also have other comorbidities such as ischaemic heart disease and lung disease, etc. The operating podiatrists lack of a general medical knowledge would make it difficult to them to adequately assess the appropriateness of surgical candidates and obviously manage any perioperative problems associated with these comorbidities.

It may be necessary to manage the patient's comorbidities while the patient is in hospital. The only option for the operating podiatrists would be to engage either the patient's general practitioner or a medical specialist to assess and manage the problems. This is neither practical or in some cases possible. This will also add to the cost of patient care as all these doctors will be billing through Medicare for undertaking what is normally part of the surgeon's post-operative care.

The fact that the operating podiatrists are not actually providers as defined by Medicare means that if a specialist physician is involved the patient will need to go back to the general practitioner to get a referral for this service.

16. **How do podiatric surgeons approach the prevention and management of postoperative infection?**

17. **How do podiatric surgeons follow up and monitor their patients?**

In a study of ACPS surgical cases in Australia, Bennett's PHD showed loss to follow-up for his study of 20% at one month. As PhD is a significant study, and efforts to follow up would be extensive, the implications are that there can be a major and important loss to follow up.

18. **What are the anticipated costs or savings to Government and consumers should this application be approved?**

The main issues here seem to be that the operating podiatrists are not only seeking to gain access to Medicare rebates but do so at the level of a specialist. This would put them above the general practitioners and sports physicians we work with who could easily claim to have postgraduate qualifications superior to those of the podiatrists.

The claim was made by the Operating podiatrists that they can provide cheaper services based on a report supplied via Access Economics [9] .

This particular Access Economics report was in fact, a report paid for by the Operating podiatrists.

In it, a comparison is made between the care supplied by public orthopaedic surgeons, and private Operating podiatrists claiming a significant improvement in the throughput when comparing public with private (page 8). This is of course completely inappropriate, and Access Economics did not compare Private Orthopaedic Surgeons with Private Operating podiatrists waiting times.

The Access Economics report states that all orthopaedic surgeons will be charging at AMA rates. (page 20) an assertion not substantiated at all.

What is remarkable, is that even though this was a study paid for by the Operating podiatrists, and was prepared with the assistance of Operating podiatrists and their advocates (see Acknowledgements of the report) Access Economics did not have access to the Operating podiatrists charging schedule. In this report, the Operating podiatrists fees are arbitrarily placed at 12% lower than an orthopaedic surgeons fees, with not one single piece of documentary evidence that this is the case.

Furthermore in the Analysis of conditions, there is a listing for Clubfoot and congenital vertical talus. Access economics were so poorly advised that they attempt to use a condition, in which 95% of the surgery occurs in infants and toddlers, as having a significant economic impact on the absenteeism and loss of productivity of the patient, causing a loss in the taxable revenue of the patient.

What has been shown however in trials conducted both in Australia and overseas, is the woefully poor productivity of podiatrists when compared to Orthopaedic Surgeons.

In the Queensland Clinical Podiatry trial [10] podiatrists saw one new patient per hour and two return patients per hour.

This is stunningly poorer than an Orthopaedic Surgeon would see in their clinics.

The flow-on effects of this extraordinarily slow work ethic can be reflected in the publications of Kilmartin [11], after a clinic of Podiatric Surgery was established in the United Kingdom. Within four years of its establishment, the time taken to be seen was 28 weeks, and a waiting period for surgery to occur of 71 weeks.

Thus the Public Waiting time to surgery was almost 2 years! Such data was available to Access Economics but not modeled as it did not serve the purposes of their paymaster.

The costs of Podiatric Surgery is higher and their work ethic are far below those of an average Orthopaedic Surgeon.

A number of quotes have been obtained by the AOA for surgery offered by Operating podiatrists. The fees of the Podiatric Surgeon in general represent one and a half times more expensive than an orthopaedic surgeon charging the AMA rate.

The claims of more efficiency and cheapness by the Operating podiatrists are simply assertions with no documentary evidence to support it.

There is a potential for overseas non- resident visiting Podiatric surgeons to access the MBS schedule as there are some already on the Accredited list of practitioners.

In Summary

The AOA and the AOFAS is absolutely comfortable with the concept of a CPME certified educated Podiatric Surgeon residing in Australia, performing surgery and having access to the MBS schedule.

We would also be comfortable with an AMC supervised training program, providing that this program was ***actively supervised by the AMC*** and also that the training regime had been inspected prior to individuals undertaking this training program.

The AOFAS and the AOA are implacably opposed to individuals who are inappropriately trained, such as the ACPS operating podiatrists, or the UWA standard of podiatrists, operating and being given access to the MBS schedule.

It is important to note that the objections are not based on Podiatric Surgery as such.

AOA as the standard bearer of the education of surgery to bones and joints would be implacably opposed to *any allied health professionals* operating on patients, not having achieved the standard of education that is required for this to be done safely.

It was a fundamental tenet of the national registration of Health Practitioners scheme under which APHRA was established that all suppliers of a service would do so to the same standard.

It is completely at odds with the stated goals of this legislation that a number of different standards have evolved and for these to all be enshrined using the MBS schedule would be completely inappropriate.

Similarly, were physiotherapists to want to perform knee arthroscopy, or hand therapists wishing to perform carpel tunnel surgery, the generic answer would be precisely the same.

Providing these individuals have been appropriately trained to an internationally acceptable standard, or an Australian defined and administered Nationwide and multi-disciplinary wide accepted standard, then we would be comfortable with such changes.

However, Boards, constituted with no medical or surgically trained individual, establishing ad hoc through a similarly constituted Accreditation Body, any standard that they deem to be appropriate is in opposition to both the intent of the legislation and the chartered responsibility of those Boards to primarily protect the citizens of this country.

We therefore submit that this application is rejected, and that notice be served to the UWA and the ACPS members that the application will not be re-visited until such time as these institutions are inspected and their training programs accredited and recognized by either the AMC, or the CPME.

It should be noted AOA and AOFAS do not believe that MSAC is the appropriate and lawful arena to evaluate the competency and standards of training for podiatrists.

1. Tony Abbott letter https://www.surgeons.org/media/301623/attachment_part_2.pdf
2. Review of Restrictions on the Practice of Chiropractic,Osteopathy,Medician,Occupational Therapy,Optometry,Pharmacy,Physiotherapy,Podiatry,Psychology and Speech Pathology Queensland Health November 2000 page iv
3. https://www.surgeons.org/media/301623/attachment_part_2.pdf
4. http://www.surgeons.org/media/302088/sbm_2010-05-20_ahwmc.pdf
5. ANZPAC public release 28 August 2009
6. Minutes of Queensland Podiatry Board 30 April, 1996
7. PODIATRIC SURGERY ACCREDITATION STANDARDS PROJECT S Owen 2011
8. Podiatry PODIATRY SPECIALISATIONS EDUCATION AND TRAINING ACCREDITATION STANDARDS PROJECT S Owen 2010
9. 9 Access Economics The economic Impact of podiatric surgery 2008
10. Orthopaedic Podiatry Triage Clinic Project Completion Report 2010
11. T.E. Kilmartin Podiatric Surgery in a Community Trust: The Foot (2002) 11, 218-227
12. ANZPAC Public Release . Operational Meeting 28 August 2009
13. ANZPAC 16 December 2008 Practitioner Regulation Sub-Committee Consultation Paper Proposed arrangements for accreditiation. Page 5 Section 3.10

To whom it may concern,

I am an Orthopaedic foot and ankle specialist in Melbourme.

My comments regarding podiatric surgeons are as follows.

I have had many patients present to my practice after seeing an operating podiatrist.
Uniformly they are shocked to hear that the practitioner is not a doctor and has not undertaken the training that we as orthopaedic surgeons have undertaken.
They report that at no time has the operating podiatrist informed them of this.

The majority of patients have only found out that the podiatric surgeons cannot claim medicare after they are booked for surgery.

It is my opinion that the term surgeon applied to this group is misleading to the public and the information provided to the patients is below what would be expected as reasonable.

Regards
Hamish Curry

[redacted]

Dr Meghan Dares

Joint Vision Orthopaedic Group

16th November, 2023

Dear Professor Ron Paterson

Independent Reviewer

Independent review of the regulation of podiatric surgery

c/o Ahpra

GPO Box 9958

Subject: Submission to the Inquiry into Podiatric Surgeons in Australia

Melbourne VIC 3001

I am writing to submit valuable insights and recommendations regarding the regulation and practices of podiatric surgeons in Australia. The following talking points highlight critical issues that warrant attention and remedial actions:

Notification Discrepancies

Podiatric surgeons exhibit a notification rate at least eight times higher than that of general podiatrists. This alarming statistic is compounded by the exclusion of notifications in New South Wales (NSW) and Queensland (QLD) not involving the Australian Health Practitioner Regulation Agency (AHPRA). Litigations against podiatric surgeons may not be adequately captured by AHPRA's notification system, raising concerns about the accuracy of reported data.

Failure in Professional Standards

Currently, five out of 32 Australasian College of Podiatric Surgeons (ACPS) fellows operate under practice restrictions, indicating potential shortcomings in their training, maintenance of professional standards, and Continuing Professional Development (CPD). This underscores the necessity for a robust review of the training and oversight mechanisms in place.

Terminology and Public Perception

The protection of the term "Podiatric Surgeon" was originally intended to distinguish practitioners who were allowed to operate before AHPRA's existence. However, it inadvertently creates confusion for the public, akin to the challenges associated with the term "Cosmetic Surgeon." The recommendation is to use the term "Operative Podiatrist" to enhance clarity.

Training Program Standards

Current training programs for podiatric surgeons fall short of both national and international accreditation standards. AHPRA should withhold endorsement until these programs meet the required benchmarks. Those accredited under inadequate standards should restrict their practice to that of a general podiatrist until they meet the appropriate surgical standards.

Re-accreditation and Expertise: Re-accreditation of training programs should involve individuals with expertise in surgical training education. The current lack of representation in the PBA accreditation

committee necessitates the inclusion of external experts, ensuring a comprehensive evaluation of surgical training programs.

Oversight Challenges

The private nature of podiatric surgery and training introduces challenges related to oversight, audit, and quality assurance. This calls for the establishment of robust mechanisms, including Medical Advisory Committees (MAC) and comprehensive morbidity and mortality reviews.

I am writing to provide additional context to my submission on the regulation and practices of podiatric surgeons in Australia, drawing from my personal experiences in the field. My involvement in the treatment of several patients has revealed concerning patterns that necessitate urgent attention and reform within the podiatric surgery landscape.

1) Complications Ignored Due to Lack of Expertise: In my professional capacity, I have encountered instances where complications were effectively ignored by podiatric surgeons. These cases often involved delays in diagnosis attributed to a lack of expertise. The practitioners in question displayed an unwillingness to order appropriate investigations, such as blood tests, ultrasound, and x-rays, which are critical for accurate and timely diagnosis.
2) Inappropriate Treatment Approaches: In several instances, podiatric surgeons opted for suboptimal treatment approaches, such as treating deep infections with oral antibiotics when a washout and drainage were urgently required. These decisions were made without adhering to the established standards of care for similar conditions. The consequences of these inappropriate treatments have been severe and have resulted in unnecessary suffering for the patients involved.
3) Failure to Notify Authorities: Another concerning trend that emerged from these cases was the failure of podiatric surgeons to notify nearby medical authorities of complications. Timely communication and collaboration with other healthcare professionals are critical in managing complex cases effectively. The lack of notification further exacerbated the delays in appropriate interventions, leading to adverse outcomes.
4) Partial Amputations Resulting from Delays: Regrettably, the aforementioned delays and suboptimal care have, in some instances, resulted in the need for partial amputations of the affected foot. This outcome is not only emotionally devastating for the patients but also indicative of systemic failures in the current regulatory and training frameworks for podiatric surgeons.

In addition to the concerns outlined in my previous submission regarding the regulation and practices of podiatric surgeons in Australia, I would like to draw the committee's attention to specific instances involving a [redacted] podiatric surgeon whose practices have raised serious ethical and patient safety concerns.

Unsubstantiated Use of Low-Powered Laser Therapy: It has come to my attention that a [redacted] podiatric surgeon is offering low-powered laser therapy at a considerable charge of $3000 for a series of treatments. However, there is a conspicuous absence of credible evidence supporting the efficacy of this therapy for the conditions being treated. The lack of scientific basis for such interventions raises ethical questions about informed consent and the appropriateness of charging patients for treatments that lack substantiated efficacy.

Unsafe Injections without Ultrasound Guidance: Furthermore, this podiatric surgeon has been performing injections on vulnerable chronic pain patients without the use of ultrasound guidance.

This practice is highly concerning, as the absence of proper guidance increases the risk of incorrect injection placement and potential complications. I have been made aware of at least one instance where such an injection has resulted in a significant exacerbation of complex regional pain symptoms in a patient, underscoring the need for immediate attention to these unsafe practices.

Audit Standards

The current audit system fails to distinguish between the number of procedures and operations, leading to inflated numbers. Particularly the scope of practice could be called into question as currently many of those procedures are minor eg ingrown toenail etc but they are effectively accredited to do major surgery including the possibility of ankle replacements. An effective audit should focus solely on operations performed exclusively by podiatric surgeons, excluding procedures that can be undertaken by general podiatrists.

Volume Standards

Establishing minimum standards for the volume of operations during training and ongoing practice is essential to ensure the currency and maintenance of skills among podiatric surgeons.

Advertising Standards: Advertising by podiatric surgeons should refrain from misleading terms such as "surgeon," "registered specialist," and "Commonwealth Accredited Podiatric Surgeon." Clear disclosures must inform the public that these practitioners are not medical practitioners and have not completed accredited specialist surgical training.

In conclusion, addressing these issues is crucial to safeguarding public safety, ensuring the highest professional standards, and mitigating confusion among healthcare consumers. I appreciate the opportunity to contribute to this important inquiry and look forward to positive changes in the regulation and oversight of podiatric surgeons in Australia.

Sincerely,

Dr Meghan Dares

[redacted]

[redacted]

Response template for submissions to the *Independent review of the regulation of podiatric surgeons*

You are invited to have your say about the regulation of podiatric surgeons by making a submission to this independent review. The consultation questions from the consultation paper are outlined below.

Submissions can address some or all of these questions, and you can include any evidence or examples that you think are relevant.

You can email your submission electronically to:

Professor Ron Paterson
Independent reviewer
podiatricsurgeryreview@ahpra.gov.au

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Independent Reviewer
Independent review of the regulation of podiatric surgery
c/o Ahpra
GPO Box 9958
Melbourne VIC 3001

The closing date for submissions is 5.00pm AEDT 16 November 2023

Publication of submissions

At the end of the consultation period, submissions (other than those made in confidence) will be published on the Ahpra website to encourage discussion and inform the community and stakeholders about consultation responses.

The review will accept submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the *Freedom of Information Act 1982 (Cth)*, which has provisions designed to protect personal information and information given in confidence. **Please let us know if you do not want us to publish your submission or want us to treat all or part of it as confidential.**

We will not place on the website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation. Before publication, we may remove identifying information from submissions, including contact details.

The views expressed in the submissions are those of the individuals or organisations who submit them, and their publication does not imply any acceptance of, or agreement with, these views by the review.

Published submissions will include the names of the individuals and/or the organisations that made the submission, unless confidentiality is requested. If you do not wish for your name and/or organisation's name to be published, please use the words **'Confidential submission'** in the subject title when emailing your submission.

Initial questions

To help us better understand your situation and the context of your feedback please provide us with some details about you. These details will not be published in any summary of the collated feedback from this consultation.

Question A

Are you completing this submission on behalf of an organisation or as an individual?

Your answer:

☐ Organisation

Name of organisation: Click or tap here to enter text.

Contact email: Click or tap here to enter text.

☒ Myself

Name: Catherina Anna Doyle

Contact email: [redacted]

Question B

If you are completing this submission as an individual, are you:

☐ A registered health practitioner?

Profession: Click or tap here to enter text.

☒ A member of the public?

☐ Other: Click or tap here to enter text.

Question C

Would you like your submission to be published?

☒ Yes, publish my submission **with** my name/organisation name

☐ Yes, publish my submission **without** my name/ organisation name

☐ No – **do not** publish my submission

Your responses to the consultation questions

1. Do you think the way podiatric surgeons are currently regulated in Australia ensures consumers are well informed and receive appropriate care from podiatric surgeons who are suitably trained and qualified to practise in a safe, competent and ethical manner?

Absolutely not.

I was referred to someone who called himself “Doctor” and “Surgeon” and I wrongly assumed he had the qualifications to use these titles. As a result of my lack of knowledge and understanding I allowed an operation to be performed on my feet that has now left me with permanent damage, disfigurement and pain.

If it had of been transparent that this person was neither a doctor or a surgeon I would never have let him operate on my feet.

2. Do you have any suggestions to improve the current system for regulating podiatric surgeons?

Podiatrists should not be allowed to use the titles doctor and surgeon as the use of these titles is misleading and gives patients a false sense of confidence.

The system needs to have very strict guideline when allowing the use of titles as it would appear it is way too easy for unqualified practitioners to call themselves by whatever title they want.

Registration

3. Do you have any concerns about the registration requirements for podiatric surgeons? Are any changes needed, and why?

As a person who has been left with permanent damage, disfigurement and pain due to putting my trust in a practitioner who called himself a doctor and a surgeon I am greatly concerned that the registration requirements allow people to practice under these titles.

To find out that he was neither a fully qualified doctor or a surgeon only after the procedure is alarming as I believed he had the qualifications and training to call himself a doctor and a surgeon.

Standards, codes and guidelines

4. Do the Podiatry Board's current standards, codes and guidelines adequately help ensure podiatric surgeons perform podiatric surgery safely?
From my personal experience it would appear the current standards, codes and guidelines are not adequate due to situation I now find myself in. There needs to be transparency regarding podiatrist's using titles so easily so that patients can make an informed decision prior to agreeing to any surgery that a person who is not a qualified medical doctor or surgeon is proposing to perform on them.
5. Do the current professional capabilities for podiatric surgeons appropriately describe the knowledge and skills and knowledge required of podiatric surgeons for safe practice?
I believe not. Once again, I think the use of the titles "Doctor" and "Surgeon' is misleading.
6. Are any changes to the standards, codes and guidelines needed? If so, why? What additional areas should the standards, codes and guidelines address to ensure safe practice?
I believe to ensure safe practice there is a need for clear and concise descriptions when it comes to a practitioner's qualifications and training so that patients are not misled into thinking they are allowing procedures to be performed by qualified doctors and surgeons when this is not the case.

Education, training and qualifications

7. Do you have any concerns about education and training for podiatric surgeons? Are any changes needed, and why?
I have concerns as a result of my personal situation as surgery performed on my feet was unnecessary and not what I was originally referred for. I was referred for an issue I had with recurring corns on the 4th and 5th toes on both my right and left feet and during the initial consultation the podiatric surgeon suggested another procedure he "specialised" in. I f these practitioners are allowed to continue to operate they need to be made accountable and transparent when it comes to their credentials. Education and training in any arena is important, and no one should be allowed to perform surgery that in my case has let me with permanent damage, disfigurement and pain that I now have to live with and manage for the rest of my life.

Management of notifications

8. Do you have any concerns about the approach used by Ahpra and the Podiatry Board to manage notifications about podiatric surgeons, including the risk assessment process?
In my personal line of employment any notifications need to show they have been read and any updates to procedures and safety need to be adhered to otherwise there are consequences. I am not familiar with how Ahpra manages theirs but I believe it's important that there is a clear record of practitioners responding to notifications to acknowledge they have been received.

Advertising restrictions

9. Do you have any concerns about advertising by podiatric surgeons and the management of advertising offences?

I most certainly do.

The use of a titles such as doctor and surgeon used so freely by podiatric surgeons is misleading and confusing to the general public.

Further comments or suggestions

10. Do you have any further comments or suggestions relevant to Ahpra's and the Podiatry Board's regulation of podiatric surgeons?

I would like to thank you for taking the time to read my comments and I can only hope that by completing this submission I may prevent some other individual experiencing the same outcome as myself due to my lack of knowledge and misunderstanding of the credentials the practitioner I allowed to operate on me actual had.

Dr Richard Freihaut

BSc(Med), MBBS, FRACS(Orth), FAOrthA

Orthopaedic Surgeon

Surgery of the Hip, Knee, Foot and Ankle

44 Hunter Street
Lismore NSW 2480

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Monday, 30th October 2023

Professor Ron Paterson
Independent Reviewer
Independent review of the regulation of podiatric surgery
℅ Ahpra
GPO Box 9958
Melbourne VIC 3001

Dear Professor Paterson,

Please accept this letter as a submission to the independent review of the regulation of podiatry surgeons. This submission includes a clinical case I was involved in which helps to address the first consultation question:

"1. Do you think the way podiatric surgeons are currently regulated in Australia ensures consumers are well informed and receive appropriate care from podiatric surgeons who are suitably trained and qualified to practise in a safe, competent and ethical manner?".

A 48 year old developmentally delayed man with a history of polio and muscular dystrophy underwent tibiotalocalcaneal fusion on [redacted] *in a* [redacted] *by an operating podiatrist or "podiatric surgeon". The patient himself was incapable of making informed decisions and relied on his sister as his guardian.*

The patient was admitted to [redacted] *on* [redacted] *with a deep post-operative infection of the right ankle (surgical site).*

Prior to surgery the patient had initially been seen by a local podiatrist whom the patient had seen for foot and ankle problems. The local podiatrist referred the patient to the operating podiatrist who would travel from [redacted] *to consult. He would then book the patients for surgery on the* [redacted]*. The local podiatrist at the time was a budding operating podiatrist and has gone on to operate* [redacted]*. At no time prior to surgery was the patient's GP or other medical practitioner involved in, or aware of, the decision making.*

Following discharge after the initial surgery the patient and family represented to the local podiatrist (as the operating podiatrist had [redacted]*) worried there was a problem. The local podiatrist took a look at the wound and advised them they'd need to go to the nearest emergency department for treatment.*

On presentation at [redacted] *severe infection was apparent and obvious. X Rays revealed the podiatrist had attempted a tibiotalocalcaneal fusion which is a major operation even for a trained orthopaedic surgeon. The skin incisions and internal fixation used were atypical, inappropriate and inadequate for this procedure.*

Treatment consisted of intravenous antibiotics and 7 visits to the operating theatre in our centre for hardware removal, wound debridement and joint washout. Amputation was discussed with the patient's family in the event of inability to control the infection. Temporary external fixation was required to stabilise the limb. The patient was subsequently transferred to a tertiary hospital in [redacted] *where limb salvage surgery was carried out in the form of revision fusion and plastics reconstruction for wound coverage.*

Prior to admission to [redacted] *the patient and family were unaware the podiatrist who carried out the surgery was not medically trained. They were shocked to discover the operating podiatrist was not a doctor.*

The above case illustrates the fact that consumers are ill-informed with respect to the qualifications of operating podiatrists. The patient and family were under the impression the "surgeon" was a medically trained doctor. To subject a patient to such a major procedure without informing them that this is not the case displays a complete lack of ethics. The fact the patient himself was developmentally delayed and incapable to make his own decisions adds another layer to the lack of ethical judgement displayed.

The way the surgery was performed illustrates a lack of knowledge of safe soft tissue handling and approaches to the ankle and hind foot. The internal fixation used was completely inadequate for the task required and displayed a lack of training, experience and knowledge of contemporary techniques. The way in which the operation was performed was unsafe and led directly to the severe complications the patient suffered.

In summary, this case illustrates the way podiatry surgeons are currently regulated in Australia does not ensure consumers are well informed and allows inappropriate care from podiatric surgeons who are not suitably trained and qualified to practise in a safe, competent and ethical manner.

Kind regards,

[redacted]

Dr Richard Freihaut
Reviewed & Electronically Signed

Hi

I am currently a trainee in Orthopaedic surgery based in WA. In our clinics, we frequently encounter patients facing two key issues:

1. 1) Lack of disclosure by podiatry surgeons regarding their non-medical training.
2.
3. 2) Limited awareness of the option for gap-free surgery provided by orthopaedic surgeons.

Patients who have consulted podiatrist surgeons often assume they are consulting a medical doctor due to the title "surgeon." The revelation that they have received treatment from someone without a medical degree is met with surprise.

Moreover, patients are astonished to discover that gap-free surgery is an option when consulting orthopaedic surgeons. In addition to these concerns, we observe cases where podiatrist surgeons have provided incorrect diagnoses or failed to consider the patient comprehensively.

This discrepancy is attributed to the narrower training of podiatrist surgeons compared to the extensive educational path of orthopaedic surgeons, involving medical school, years of unaccredited work, an orthopaedic surgery training program, and a fellowship.

In light of these observations, I advocate for a reconsideration of the use of the title "surgeon" by podiatrists to avoid confusion among patients.

Thank you kindly

GDR Gunaratne (MED0001669618)

Dr Kevin Ho
ACPS Foundation Stage Podiatric Surgical Registrar (WA)

Independent review of the regulation of podiatric surgeons: Consultation Question Responses

Initial questions

To help us better understand your situation and the context of your feedback please provide us with some details about you. These details will not be published in any summary of the collated feedback from this consultation.

Question A

Are you completing this submission on behalf of an organisation or as an individual?

Your answer:

☒ Myself

Name: Dr Kevin Ho *BSc DPM (UWA)*

Contact email: [redacted]

Question B

If you are completing this submission as an individual, are you:

☒ A registered health practitioner?

Profession: Endorsed Podiatrist & Stage 1 Podiatric Surgical Registrar (ACPS)

☐ A member of the public?

☐ Other: Click or tap here to enter text.

Question C

Would you like your submission to be published?

☒ Yes, publish my submission **with** my name/organisation name

☐ Yes, publish my submission **without** my name/ organisation name

☐ No – **do not** publish my submission

Dr Kevin Ho
ACPS Foundation Stage Podiatric Surgical Registrar (WA)

1. Do you think the way podiatric surgeons are currently regulated in Australia ensures consumers are well informed and receive appropriate care from podiatric surgeons who are suitably trained and qualified to practice in a safe, competent and ethical manner?

Podiatric surgeons in Australia prioritize patient safety and the delivery of quality care, ensuring consumers receive appropriate treatment. This commitment is evident in their meticulous adherence to strict regulatory standards, encompassing compliance with the Health Practitioner National Law, Commonwealth, State, and Territory legislation, negligence and civil liability laws, and rigorous national safety and quality standards. They also actively comply with Australian Consumer Law, TGA regulations, and licensing requirements for private hospitals, consistently meeting reporting obligations to AHPRA. Both Australian Podiatric surgeons and Orthopaedic surgeons are obligated to comparable regulatory compliance, with both specialities being held to high clinical standards, necessitating adherence to professional codes of conduct and ethical guidelines. Their differences predominantly lie in the focus and structure of their surgical training and scope of practice.

Integral to podiatric surgery's dedication is the implementation of a national compulsory audit for each procedure performed, reinforcing the paramount importance of ensuring consumers receive safe and effective care. Recent research, derived from the ACPS national audit data covering 20,000 admissions between 2012 and 2022, highlights a remarkable low hospital readmission rate of 0.3%. Additionally, an impressive 97% of all podiatric surgery cases are conducted as day surgeries. These statistics not only affirm the rigorous standards upheld by podiatric surgeons but also emphasize the significance of prioritizing consumer well-being and satisfaction in podiatric surgery.

2. Do you have any suggestions to improve the current system for regulating podiatric surgeons?

To enhance the regulation of Podiatric Surgeons in Australia it must be normalised within healthcare. There are two vital recommendations proposed that will normalise podiatric surgery and thereby improve its regulation:

<u>Valid Referral System:</u>

- Establish a valid referral system allowing Podiatric surgeons to refer patients for necessary medical and specialist care during podiatric surgical episodes, ensuring informed collaboration with general practitioners and relevant specialists (e.g., Infectious Disease, Vascular Surgery), and ensuring patients have access to prompt specialised care within the peri-operative period.

<u>Access to Discrete MBS Codes:</u>

- There is no MBS item number for Podiatric surgery or the associated services such as anaesthetics and pathology. Podiatric surgeons are the only registered specialist surgeons with accredited training who are excluded from accessing the MBS for procedures which they are already safely and effectively conducting in the private setting.
- Recognition of this specialty through MBS codes ensures accurate billing, facilitates systematic data collection, and provides a standardized framework for documenting and categorizing podiatric surgical interventions.
- MBS codes promote transparency, enable convenient comparison of outcomes, and reinforce professional recognition of podiatric surgery within the healthcare system.

Dr Kevin Ho
ACPS Foundation Stage Podiatric Surgical Registrar (WA)

Furthermore, the inclusion of Australian Podiatric Surgeons in the public healthcare sector would diversify expertise, broaden access to specialized services, and enhance oversight and collaboration within the larger healthcare system. This integration facilitates systematic data collection, interdisciplinary collaboration, and improved training and research opportunities, contributing to a more comprehensive and patient-centric healthcare environment.

3. Do you have any concerns about the registration requirements for Podiatric Surgeons? Are there any changes needed, and why?

The current registration requirements for Podiatric Surgeons in Australia are robust and contribute to maintaining high standards in the profession, which meet international standards, providing patients with the highest quality of care.

4. Do the Podiatry Board's Current standards, codes and guidelines help ensure podiatric surgeons perform podiatric surgery safely?

Yes, the Podiatry Board's current standards, codes, and guidelines play a crucial role in ensuring the safe performance of podiatric surgery. These comprehensive guidelines cover areas such as clinical competence, infection control, ethical conduct, and ongoing professional development, collectively contributing to a framework that prioritizes patient safety and quality care in podiatric surgery. This is consistent with international standards and comparative specialities (e.g. Orthopaedic Surgeons).

5. Do the current professional capabilities for Podiatric surgeons appropriately describe the knowledge and skills required of podiatric surgeons for safe practice?

Yes, the current professional capabilities for Podiatric surgeons aptly describe the necessary knowledge and skills for safe practice. These capabilities encompass the specialized expertise, clinical proficiency, and ethical conduct required in podiatric surgery, ensuring practitioners are well-equipped to provide safe and effective care to patients.

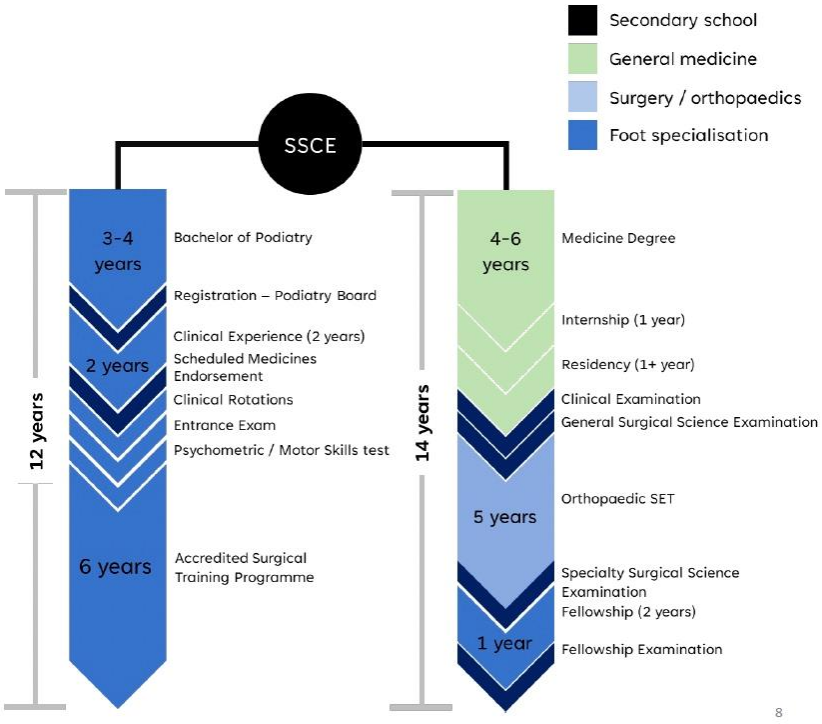
6. Do you have any concerns about education and training for Podiatric Surgeons? Are any changes needed, and why?

No, the education and training requirements for registration as a Podiatric Surgeon in Australia is rigorous, comprehensive and demanding to ensure the delivery of safe and effective patient care.

For example, in my personal experience (consistent with the standards of registrations of podiatric surgeons in Australia), after completing a bachelor of physiology/pharmacology and post-graduate doctor of podiatric medicine (DPM) degree (total of 6 years) obtaining registration as a general podiatrist, and accumulating a minimum of two years of prevocational experience as a general podiatrist, applicants undergo a competitive selection process to obtain a fellowship surgical training position. This included completing the ACPS Basic Surgical Skills Education and Training (BSSET) course, obtaining endorsements to prescribe scheduled medicines, clinical and surgical rotations, and passing various examinations (e.g. entrance examination, Psychometric and motor skills examination) and a selection interview panel. Once obtaining a position as a podiatric surgical registrar (ACPS), trainees undergo a six-year accredited foot and ankle surgical training program,

logging a minimum of 1970 teaching foot and ankle procedures, with most registrars having participated in excess of 3000 procedures (e.g. 1 bunionectomy is logged as 1 procedure). I am currently in my first stage of surgical training (2nd year) and have logged in excess of 1000 procedures in private hospital facilities.

Additionally, they complete various examinations, courses, continuous assessments, publish in peer-reviewed journals, and participate in interstate and international surgical (UK & USA) and medical rotations (e.g. Infectious Disease, Vascular Surgery, Radiologist etc.). The entire training process spans 14 years, ensuring comprehensive training and education in foot and ankle-specific surgery, including peri-operative medicine, before achieving registration as a qualified specialist Podiatric Surgeon. This stringent process ensures that Podiatric Surgeons are well-prepared and qualified to deliver safe and effective patient care. I am exceptionally pleased with the rigorous and supportive training provided by the college program; it has been both challenging and rewarding. I am confident that the skills and knowledge acquired will contribute significantly to my role as a highly trained foot and ankle surgeon, making a valuable impact on the Australian Healthcare System. I am willing to offer insights into my daily surgical training and provide evidence of my logbooks upon request.



7. **a**

PODIATRIC SURGEON TRAINING (ACPS PROGRAM)
3-years undergraduate university degree (e.g. biomedical sciences)
3-years post-graduate degree (e.g. Doctor of Podiatric Medicine)
Minimum 2 years prevocational training and portfolio development
6 years accredited surgical training program (ACPS)
Total: 14 years

ists).

The higher rate of notifications for Podiatric Surgeons compared to general podiatrists is simply attributable to the fundamental differences in their scope of practice. Podiatric Surgeons, as

specialist foot and ankle surgeons are involved in more complex and invasive procedures, inherently carrying a higher risk profile than the general podiatrists who focus on non-surgical interventions.

Foot and ankle surgery often involve complex interventions, delicate structures, and proximity to critical anatomical components, leading to a higher inherent risk of complications. Additionally, the weight-bearing function of the feet and the intricacies of gait patterns pose unique challenges in achieving optimal surgical outcomes. This is consistent with the existing orthopaedic literature.

A more appropriate comparison of notification rates for Podiatric Surgeons would be to that of similar surgical disciplines (e.g. orthopaedic surgeons). This would provide a more relevant benchmark within comparable surgical specialties.

8. Do you have any further comments or suggestions relevant to AHPRA's and the Podiatry Board's regulation of podiatric surgeons?

I appreciate the opportunity to provide feedback on AHPRA's and the Podiatry Board's regulation of podiatric surgeons. One significant concern revolves around the reported instances of anti-competitive bullying from the [redacted]. Examples include blocking podiatric surgeons/registrars from attending international workshops, spreading misinformation about our profession and training program to other health care professionals and the general public, encouraging litigation from patients against podiatric surgeons, and collaborating to impede the accreditation of Podiatric Surgeons in hospital facilities. It's deeply concerning to note instances where podiatric surgery operating lists are directly cancelled due to baseless bullying from [redacted]. Such actions not only disrupt planned procedures but also have a direct impact on the quality of life and care for patients. This behaviour underscores the need for a collaborative and patient-centred approach within the healthcare system, emphasizing the importance of fair and unbiased treatment for all qualified healthcare professionals. Addressing and rectifying such incidents is crucial to ensuring the well-being and timely care of patients. Historically, this behaviour has been swept under the rug, but needs to be brought to the attention of stakeholders and members of the public. A comprehensive compilation of evidence documenting instances of anti-competitive behaviour and bullying by the [redacted] have been collated and is available upon request.

Such behaviour not only constitutes professional slander but most importantly, interferes with patient care. I suggest addressing these concerns through open communication and collaboration, fostering an environment that prioritizes patient well-being over professional rivalry and turf wars.

Response template for submissions to the *Independent review of the regulation of podiatric surgeons*

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Question A

Are you completing this submission on behalf of an organisation or as an individual?

Your answer:

☐ Organisation

Name of organisation: Click or tap here to enter text.

Contact email: Click or tap here to enter text.

☒ Myself

Name: Dr Matthew Hope

Contact email: [redacted]

Question B

If you are completing this submission as an individual, are you:

☒ A registered health practitioner?

Profession: Orthopaedic Surgeon

☐ A member of the public?

☐ Other: Click or tap here to enter text.

Question C

Would you like your submission to be published?

☒ Yes, publish my submission **with** my name/organisation name

☐ Yes, publish my submission **without** my name/ organisation name

☐ No – **do not** publish my submission

Your responses to the consultation questions

1. Do you think the way podiatric surgeons are currently regulated in Australia ensures consumers are well informed and receive appropriate care from podiatric surgeons who are suitably trained and qualified to practise in a safe, competent and ethical manner?
Podiatry Surgeons may be regulated by AHPRA, but this does not translate into the consumer being aware that a podiatric 'surgeon' has not undergone a medical training. Pateints will present to me who have been operated on by a Podiatric Surgeon following a complication and it is only after the event that they realise that these individuals have had limited surgical training and do not hold a medical degree.
2. Do you have any suggestions to improve the current system for regulating podiatric surgeons?
A mandatory requirement that the 'podiatric surgeon' declareto the patinet, prior to engaging with a patient that they do not hold a medical degree or have completed surgical training from the Royal Australasian College of Surgeons.

Registration

3. Do you have any concerns about the registration requirements for podiatric surgeons? Are any changes needed, and why?
I do not believe that Podiatric Surgeons, within the AHPRA have sufficient knowledge and expertise to regulate Podiatric Surgeons (ie themselves). If this were appropriate then we would not be seeing the complications and concerns with regard professional conduct.

Standards, codes and guidelines

4. Do the Podiatry Board's current standards, codes and guidelines adequately help ensure podiatric surgeons perform podiatric surgery safely?
See above

5. Do the current professional capabilities for podiatric surgeons appropriately describe the knowledge and skills and knowledge required of podiatric surgeons for safe practice?

I have significant concerns that the limited surgical training for a Podiatric Surgeon results in over confidence and that the podiatric surgeon has not passed the step of 'you don't know what you don't know'. This is a critical step to pass in surgical training and is set out in the training program of the Australian Orthopaedic Association 2021.

Surgical training involves development of insight as to one's limitations and ability to seek outside opinion. These are critical steps that are assessed as part being recognised as a fellow of RACS.

6. Are any changes to the standards, codes and guidelines needed? If so, why? What additional areas should the standards, codes and guidelines address to ensure safe practice?

The limited training does allow the podiatric surgeon to know when not to operate. The desire to operate and demonstrate capability in podiatric surgery results in a surgical group that is isolated and will not seek counsel or advice from orthopaedic foot and ankle surgeons who have medical, orthopaedic and foot and ankle training.

This situation requires to be resolved. Podiatric Surgeons will continue to pose a significant risk to the public. The knowledge that this is continuing to occur and can be prevented is hard to account for.

Education, training and qualifications

7. Do you have any concerns about education and training for podiatric surgeons? Are any changes needed, and why?

I am concerned that the training of a Podiatric Surgeon does not thoroughly prepare the individual for practice. I have witnessed numerous examples of a patient being uninformed, surgery that has been inappropriate and poor professionalism. For example, a podiatric surgeon flying interstate to operate and leaving the follow up to a podiatric colleague.

A review of the Podiatric Surgical training requires review with regard to scope of practice and professionalism.

Management of notifications

8. Do you have any concerns about the approach used by Ahpra and the Podiatry Board to manage notifications about podiatric surgeons, including the risk assessment process?

The processes are cumbersome and not utilised frequently. We have been encouraged to ask patients to complain rather than ourselves as Orthopaedic Surgeons as we will be seen as merely attempting to protect our practice. The difficulty with this however is that patients are reluctant to complain for fear of instigating a lengthy legal process with poor outcomes for all. I believe this has led to severe under-reporting of the problem.

Advertising restrictions

9. Do you have any concerns about advertising by podiatric surgeons and the management of advertising offences?

Orthopaedic surgeons are not allowed to advertise and the AOA has a committee that specifically deals with this matter.

Podiatric surgeons should have the same.

Further comments or suggestions

10. Do you have any further comments or suggestions relevant to Ahpra's and the Podiatry Board's regulation of podiatric surgeons?

I would like to site an example of a case that came to me of a lady in her 50's who had medial foot pain and saw a podiatrist. The podiatrist attempted to help with insoles. This did not work and so the podiatrist referred the lady to a 'surgical colleague' – a podiatric surgeon. This lady had a painful accessory navicular bone. This bone has a significant tendon attached (tibialis posterior) and the tendon must be repaired and the foot protected to prevent rupture. The patient was not aware that the podiatric surgeon did not hold a medical degree or RACS fellowship.

She underwent surgery with the podiatric surgeon who removed the accessory navicular. There was not repair of the tendon. The item codes and operation note from the podiatric surgeon confirm no tendon repair.

The patient presented to me with a flat painful foot. Her MRI confirmed a rupture of the tendon which causes the flat foot, which she did not have previously. She will require further surgery to correct including a tendon transfer and calcaneal osteotomy (cutting the heel bone with internal fixation).

Podiatric surgeons may be seen as the 'cheap' alternatives and orthopaedic surgeons as 'over charging', but this example demonstrates that the podiatric surgeon may be able to complete some limited operations, such as removeing a bone as above, but the limited training does not allow them to fully understand the implications of such action and that as practitioners we must seek to deal with the whole problem and minimise surgical complications. The current Podiatry surgical training and regulation does not support this.

Dr Matthew Hope

Director of Orthopaedic Surgery PA Hospital, Brisbane

Member of Court of Examiners, Royal Australasian College of Surgeons

Chair of RACS Trauma Committee

Orthopaedic Surgeon (Foot and Ankle)

Response template for submissions to the *Independent review of the regulation of podiatric surgeons*

You are invited to have your say about the regulation of podiatric surgeons by making a submission to this independent review. The consultation questions from the consultation paper are outlined below.

Submissions can address some or all of these questions, and you can include any evidence or examples that you think are relevant.

You can email your submission electronically to:

Professor Ron Paterson
Independent reviewer
podiatricsurgeryreview@ahpra.gov.au

If you are unable to provide your submission via email, please send your written submission to:

Professor Ron Paterson
Independent Reviewer
Independent review of the regulation of podiatric surgery
c/o Ahpra
GPO Box 9958
Melbourne VIC 3001

The closing date for submissions is 5.00pm AEDT 29th November 2023

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Are you completing this submission on behalf of an organisation or as an individual?

Your answer:

☐ Organisation

Name of organisation: Click or tap here to enter text.

Contact email: Click or tap here to enter text.

☐ Myself

Name: Sharyn King

Contact email: [redacted]

Question B

If you are completing this submission as an individual, are you:

☐ A registered health practitioner?

Profession: Click or tap here to enter text.

☐ A member of the public?

☐ Other: Click or tap here to enter text.

Question C

Would you like your submission to be published?

☐ Yes, publish my submission **with** my name/organisation name

☐ Yes, publish my submission **without** my name/ organisation name

☐ No – **do not** publish my submission

Your responses to the consultation questions

1. Do you think the way podiatric surgeons are currently regulated in Australia ensures consumers are well informed and receive appropriate care from podiatric surgeons who are suitably trained and qualified to practise in a safe, competent and ethical manner?
Yes
2. Do you have any suggestions to improve the current system for regulating podiatric surgeons?
No

Registration

3. Do you have any concerns about the registration requirements for podiatric surgeons? Are any changes needed, and why?
No

Standards, codes and guidelines

4. Do the Podiatry Board's current standards, codes and guidelines adequately help ensure podiatric surgeons perform podiatric surgery safely?
Yes

5.	Do the current professional capabilities for podiatric surgeons appropriately describe the knowledge and skills and knowledge required of podiatric surgeons for safe practice?
Yes	

6.	Are any changes to the standards, codes and guidelines needed? If so, why? What additional areas should the standards, codes and guidelines address to ensure safe practice?
No	

Education, training and qualifications

7.	Do you have any concerns about education and training for podiatric surgeons? Are any changes needed, and why?
No	

Management of notifications

8.	Do you have any concerns about the approach used by Ahpra and the Podiatry Board to manage notifications about podiatric surgeons, including the risk assessment process?
No	

Advertising restrictions

9. Do you have any concerns about advertising by podiatric surgeons and the management of advertising offences?
No

Further comments or suggestions

10. Do you have any further comments or suggestions relevant to Ahpra's and the Podiatry Board's regulation of podiatric surgeons?
My surgeon [redacted] was amazing, explained everything to me from pre op to post op. He was kind, caring and very knowledgeable. I would recommend him 100%.

11 Nov 2023

Use of the title “surgeon” by medical practitioners in the Health Practitioner Regulation National Law Consultation- Regulation Impact Statement

I am an Orthopaedic Surgeon specialising in Foot & Ankle surgery and have been practicing for the past 20 years. The most common foot and ankle surgery that I perform is bunion and forefoot correction. I estimate that I have performed thousands of these procedures.

On a routine basis, I will consult with patients who have seen ‘Podiatric Surgeons’ requesting second opinions. In each of these cases, the patient was referred to the ‘Podiatric Surgeon’ by their Podiatrist, bypassing their General Practitioner. In every case, it is when we discuss surgical options and health fund arrangements, that the patient discovers that the ‘Podiatric Surgeon’ they had seen is not a ‘doctor’ and are genuinely surprised. The most repeated quote is ‘but I thought they were a Doctor’.

I have unfortunately reviewed dozens of patients with poor outcomes following surgery by ‘Podiatric Surgeons’, seeking salvage or repeat surgery due in most instances to poorly performed surgeries or surgeries that were inappropriate for the presenting condition. In fact, I have seen 3 patients who required amputation of the first ray after bunion surgery performed by a “Podiatric Surgeon” due to missed and finally, uncontrolled infection. The third patient ultimately underwent a midfoot amputation secondary to undiagnosed gangrene. All of these patients were horrified and distressed to find out that ‘Podiatric Surgeons’ were not medical practitioners.

All of my patients that have previously seen a ‘Podiatric Surgeon’ have indicated to me that they believed them to equate to a Foot and Ankle Orthopaedic Surgeon. This indicates to me a systemic lack of informed consent for patients. There are not proactive measures in place to inform the patient of the qualifications, experience and standing of the individual treating them – specifically when they bypass their General Practitioner – instead the system relies on the patient to have the level of understanding to ask specifically if the Podiatrist was a ‘medical practitioner. This is not ‘informed consent’.

This lack of informed consent is enabled by the lack of protection of the title ‘surgeon’, and as result, patients assume that the person they’ve been referred to is held to the same professional and technical standards as those trained and endorsed by the Royal Australasian College of Surgeons and the AMC.

I believe it would be remiss of the Australian Government, APHRA and the Podiatry Board not to regard patient welfare and safety as its highest priority. I fully endorse the submission made on behalf of the AOA and the AOFAS,

Yours sincerely,

Dr Nicole Leeks MBBS FRACS(Ortho)
State Chair WA AOA Executive Committee
Federal AOA Board Member

To whom it may concern

I am currently a trainee in Orthopaedic surgery based in WA. In our clinics, we frequently encounter patients facing two key issues:

1) Lack of disclosure by podiatry surgeons regarding their non-medical training.

2) Limited awareness of the option for gap-free surgery provided by orthopaedic surgeons. Patients who have consulted podiatrist surgeons often assume they are consulting a medical doctor due to the title "surgeon." The revelation that they have received treatment from someone without a medical degree is met with surprise.

Moreover, patients are astonished to discover that gap-free surgery is an option when consulting orthopaedic surgeons. In addition to these concerns, we observe cases where podiatrist surgeons have provided incorrect diagnoses or failed to consider the patient comprehensively.

This discrepancy is attributed to the narrower training of podiatrist surgeons compared to the extensive educational path of orthopaedic surgeons, involving medical school, years of unaccredited work, an orthopaedic surgery training program, and a fellowship.

In light of these observations, I advocate for a reconsideration of the use of the title "surgeon" by podiatrists to avoid confusion among patients.

Dr. Christopher Lim
MBBS, BMSc (Hons), MSurg
Orthopaedic Registrar: [redacted]
AHPRA Number MED1992332
[redacted]

To whom it may concern

I would like to express my views by email as I am unable to join in the virtual forum due to work commitments. I would like to talk about the experience I had not once, but twice, with podiatric surgeon [redacted]

Both operations were done in hospital to improve my quality of life to fix my hammertoes on both feet as follows: Left third toe distal interphalangeal joint arthroplasty in 2019; and Right third toe distal interphalangeal joint arthroplasty in 2020.

I had a consultation with a podiatric surgeon [redacted], after receiving the quote for the cost of the operation I made contact with my health fund to find out my out of pocket expenses. I was astounded to find out I wouldn't be covered for the surgery and would only get the hospital stay and the theatre fees covered. [redacted]'s fee would not be covered. At this point I had top hospital and extras cover for over 20 years.

Due to being unable to afford this surgery with [redacted] I had the operation performed by an orthopaedic surgeon and had limited out of pocket expenses. The surgery was unsuccessful and a couple of years later I had restorative surgery performed by [redacted] and had to pay the full amount for the surgery. This caused financial stress for my family.

I then chose to have other surgery completed by [redacted] successfully and I was very happy with the results. I felt unhappy by the expenses I had to pay and unsupported by my health fund who suggested I could have surgery done again by a general surgeon. This is unfair and inequitable. My choice caused financial strain for my family again, however the leading issue was it was important to have my quality of life back and to be able to have my toes fixed.

This causes financial barriers to having the choice to have qualified surgeons to perform operations on our feet

I also have the correspondence to support these operations and the blatant disregard I received from the health funds about covering costs.

Kind regards"

Lisa Mills
[redacted]

[redacted]

Dear, Sir.

In my practice, I have seen a number of patients who have been assessed by podiatrists and surgical treatment recommended. Quite often, the surgical treatment recommended is excessive or quite inappropriate and associated with quotes that are approximately four times the amount of money that I would charge as an orthopaedic surgeon. The patients often only come to see me after they become aware of the fact that the podiatrist is not a registered surgeon and that they are faced with substantial out-of-pocket expenses.

Please note also that I have been involved in providing expert evidence for [redacted] legal cases in recent times both of these after failed surgical treatment by a podiatrist. The outcomes have been particularly poor with major ongoing complications. They have required further treatment by foot and ankle surgeons, but because of the mischief created by the poorly directed surgery in the first instance, the final outcome has been a compromise to say the least.. Apart from the fact that the surgery was not performed in a professional fashion, one of the real problems has been the inability of the podiatrist to manage the patient post-operatively. As they have no ability to keep a patient in hospital for intravenous antibiotics, dressing management and so on, the patients are usually treated in a sub optimal fashion if issues arise,. This leads to a delayed recovery presentation to the public hospital system. It would seem that these individuals are unable to provide adequate management if there are post-operative complications.

You will note that I perform a great deal of foot and ankle surgery and, if there are any perioperative complications, my nurse takes phone calls directly from the patient, communicates with me and, if we have any concerns, the patient is seen immediately, and if necessary, admitted to hospital. This does not occur with the podiatrists [redacted] where I practice. Treatment is often suboptimal, usually delayed and leads to significant complications.

I have significant concerns with these practitioners claiming to be surgeons. Podiatrists are not trained surgeons. Allow me to provide you with an anecdote:

When I first went into practice in [redacted], having already been an orthopaedic surgeon for about 10 years, I was approached by a podiatrist who said that he would like to watch me perform surgery. It became apparent to me after about two or three cases that this person was undergoing “podiatric surgical training.” I enquired of him as to the level of experience that he had. He paused, considered the issue carefully, and told me that, once when he was in the United Kingdom, he was allowed to put a couple of stitches in the capsule of a great toe fusion. It was apparently the case that he had done some time in the United Kingdom looking to gain experience. Remarkably, he had no other direct surgical experience, either at a basic level or in terms of ongoing significant training.

Astonished as I was that he had not actually done any surgery, I asked him whether he was concerned that a lack of surgical training would have some impact on his ability to perform surgery. After all, I indicated to him, surgery is a difficult specialty, requiring a great deal of experience, and is to be regarded as a form of apprenticeship.

We had an interesting discussion, and I suggested to him that at my stage of training, I had probably done 15,000 operations.

He did not seem concerned at all that he had not done any surgery, and yet would be very soon completing his “training”

The real issue that I have in relation to podiatrists representing themselves as surgeons especially where their clinical experience is so limited. They are not doctors and have no experience in the management of complicated medical issues which can occur after any type of surgery. They do not have the ability to prescribe antibiotics and they do not have the ability to admit patients to hospital. Surely this is more than sufficient to indicate that they should not be providing surgical services. They should also not be using the term “surgeon” as it is inappropriately applied to them just as it is to those who are doing cosmetic surgery and who are no more than General Practitioners.

There is a real tendency in our society for people to look at complex matters, such as surgery, believe that it is really quite simple because we make it look simple, and then regard themselves as fit to provide those services. It is an unfortunate reality that the sophistication of surgical treatment in general terms has allowed it to look to be a reasonably straightforward process to the general community. It is not a

straightforward process. It is an extremely highly trained and skilled profession that is associated with large levels of responsibility. It is not undertaken lightly.

I would urge you to look carefully at these matters. My experience, having seen multiple complications from podiatrists is that surgical procedures should not be their province. If they believe that surgery is needed, then the surgery should be performed by an experienced foot and ankle surgeon who is trained and whose expertise has been confirmed by the Australian Orthopaedic Association. Independent review should be performed of the outcomes of surgery; this takes place in our hospitals. I feel very strongly about this issue, and I am grateful for the opportunity to put forth my point of view

Should you deem it appropriate, I would be happy to discuss the matter with you personally. I am not at liberty to divulge the information relating to the cases that I have referred to above for privacy reasons. However, there is much to discuss.

Paul Miniter
Orthopaedic surgeon

I am currently a trainee in Orthopaedic surgery based in WA. In our clinics, we frequently encounter patients facing two key issues:

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This discrepancy is attributed to the narrower training of podiatrist surgeons compared to the extensive educational path of orthopaedic surgeons, involving medical school, years of unaccredited work, an orthopaedic surgery training program, and a fellowship.

In light of these observations, I advocate for a reconsideration of the use of the title "surgeon" by podiatrists to avoid confusion among patients.

Warm Regards,
Sheldon Moniz | Orthopaedics | [redacted] | M +61 [redacted] | E [redacted]

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Professor Ron Paterson
Independent reviewer
podiatricsurgeryreview@ahpra.gov.au

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Professor Ron Paterson
Independent Reviewer
Independent review of the regulation of podiatric surgery
c/o Ahpra
GPO Box 9958
Melbourne VIC 3001

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Your answer:

☐ Organisation

Name of organisation: Click or tap here to enter text.

Contact email: Click or tap here to enter text.

☒ Myself

Name: BRIANNA LEIGH MURPHY

Contact email: [redacted]

Question B

If you are completing this submission as an individual, are you:

☒ A registered health practitioner?

Profession: CLINICAL NURSE – (**ALSO** PATIENT WITH PAST EXPERIENCE TO RECEIVING CARE FROM BOTH ORTHOPAEDIC + PODIATRIC SURGERY)

☒ A member of the public? PREVIOUS/CURRENT PATIENT

☐ Other: Click or tap here to enter text.

Question C

Would you like your submission to be published?

☒ Yes, publish my submission **with** my name/organisation name

☐ Yes, publish my submission **without** my name/ organisation name

☐ No – **do not** publish my submission

Your responses to the consultation questions

1. Do you think the way podiatric surgeons are currently regulated in Australia ensures consumers are well informed and receive appropriate care from podiatric surgeons who are suitably trained and qualified to practise in a safe, competent and ethical manner?
Yes, I do believe that podiatric surgeons are well regulated and provide scientifically proven effective care. Podiatric surgeons make up part of the multi-disciplinary team in managing complex (and in my personal case) chronic foot and ankle problems. They are highly specialised, as unlike orthopaedic surgeons who provide primarily a surgical approach with minimal other intervention, podiatric surgeons can provide non (or less invasive) procedures to alleviate pain and suffering in people with feet concerns.
2. Do you have any suggestions to improve the current system for regulating podiatric surgeons?
Providing podiatric surgeons with greater access to providing medicare supported services (expanding on item numbers with re-imbursement to patients requiring their services. This would increase accessibility and equitability to their specialised services to the greater community.

Registration

3. Do you have any concerns about the registration requirements for podiatric surgeons? Are any changes needed, and why?
No – I believe they go through a well supported and specialised practical model of training.

Standards, codes and guidelines

4. Do the Podiatry Board's current standards, codes and guidelines adequately help ensure podiatric surgeons perform podiatric surgery safely?
In my brief review of the current accreditation standards of practice – I believe they are current, relevant and structured. As a fellow health care professional (and patient with prior experience in receiving care from a podiatric surgeon) I understand the importance of guidelines – but also the importance of practical training and fellowship. The care I have received is evident of a high level of expertise and training with intense specialisation in the management of foot and ankle problems.
5. Do the current professional capabilities for podiatric surgeons appropriately describe the knowledge and skills and knowledge required of podiatric surgeons for safe practice?
Yes they do
6. Are any changes to the standards, codes and guidelines needed? If so, why? What additional areas should the standards, codes and guidelines address to ensure safe practice?
No changes I see relevant at this time.

Education, training and qualifications

7. Do you have any concerns about education and training for podiatric surgeons? Are any changes needed, and why?
No concerns.

Management of notifications

8. Do you have any concerns about the approach used by Ahpra and the Podiatry Board to manage notifications about podiatric surgeons, including the risk assessment process?
The main concern I have is that notifications being made, predominantly from the Orthopaedic Association, come from a place of bias rather than fact / actual safety concern. I appreciate that AHPRA manage all notifications accordingly, but feel patient opinion should play a factor in the decision whether changes should be made to regulation of podiatric surgeons.

Advertising restrictions

9. Do you have any concerns about advertising by podiatric surgeons and the management of advertising offences?
Not really. I feel their services should be better understood by the wider public. I ended up finding such services through research of my own after prior failed input from orthopaedic surgery, leaving me in a worse position then I first started in. If I had of been aware (or my GP/service provider) than referral could have been made sooner.

Further comments or suggestions

10. Do you have any further comments or suggestions relevant to Ahpra's and the Podiatry Board's regulation of podiatric surgeons?
Overall; I would like to provide insight into why I am passionate about increasing podiatric surgery access to medicare and have no concerns that would initiate the need for review of regulation. I have received numerous surgeries from both specialities (Orthopaedic + Podiatry). This was attributable to multiple stress fractures requiring open reduction and internal fixation, as with lengthy conservative treatments (immobilisation etc.) the fractures were not healing and caused significant pain, swelling and disability. Firstly, I was referred to an Orthopaedic surgeon for the initial management of this issue. The initial consult was very short, expensive and I was rushed away with little or no concern. As the issue persisted despite non-invasive treatments and immobilisation, I returned later for further review to then be booked in for surgery. The surgery itself appeared to go well, but I had very poor after care resulting in an infection, and 12 months later, had the fixation screws relocate themselves into the neighbouring metatarsal. I understand all surgeries come with a risk and this was just one experience, but when comparing my experiences with both care providers, the surgical and pre/post care I received from a podiatric surgeon was far superior. The discussion and referral to other members of the MDT, along with the eventual need to do further surgery (partially as a result from prior mentioned surgery from an orthopaedic surgeon), has made my experience with a podiatric surgeon very positive. I can say whole-heartedly, I would not be in the position I am today physically, and subsequently, professionally, if it was not for the services I receive, and continue to receive, from a podiatric surgeon. I was provided with thorough, efficient, safe and informed care through the whole process. This included, referral to other providers to investigate the cause of my concern, regular follow up

and thorough communication to my primary GP allowing continuity of care. As a Clinical Nurse, doing long and very physically demanding shifts has only been possible now that my feet are in good health from the management received prior to my qualification and studies. I spent years in my young adult hood seeking help from GP/Orthos ending up with no benefit.

Anecdotally, surgery on metatarsals (and the feet in general) is something most orthopaedic surgeons seem so steer away from, and understandably due to needs/demands, have other limbs / areas they specialise in. Podiatric surgeons deal with surgical and non-surgical approaches to managing specifically foot and ankle which I believe Is a very important attribute and why access should be improved by allowing greated item cover for services through medicare as well as surgery performed within public hospital services.