14 November, 2023

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

Dear Professor Paterson,

Independent review of the regulation of podiatric surgeons

On behalf of the Western Australian Orthopaedic Foot & Ankle Society (WAOFAS), we make the following submission to the current enquiry looking at the regulation of podiatric surgeons.

The WAOFAS is a sub-specialty medical society comprising an experienced group of Western Australian orthopaedic surgeons with a dedicated focus on the care of foot and ankle conditions.

For many years, WAOFAS along with the Australian Orthopaedic Association, the Australian Orthopaedic Foot & Ankle Society, the Royal Australasian College of Surgeons and the Australian Medical Association have had serious concerns about the training, standard of care, governance and rate of complications of 'podiatric surgeons'. The general public are not aware that 'podiatric surgeons' are not medical doctors, and that they are the ***only*** group of practitioners in Australia who perform invasive procedures on humans who have not undergone advanced surgical training in an Australian Medical Council (AMC) accredited program.

Unfortunately, sequential regulatory failures by AHPRA and the Podiatry Board of Australia over many years have resulted in the insidious establishment of this small cohort of poorly trained individuals who do not have the surgical education and training the Australian public would expect of a surgeon. Given that the majority of podiatric surgeons in Australia work in Western Australia, we unfortunately have extensive experience in managing the complications regularly caused by podiatric surgeons, who undertake both routine procedures poorly, or attempt more complex surgeries they have no training or experience in performing. In both cases, they invariably are unable to manage their complications, which get left to our public hospital emergency departments and orthopaedic surgeons to treat.

Please see our submission to the enquiry below, utilising your template questions as requested.

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?**

No, the current regulation of podiatric surgeons does not ensure that patients are well informed, and we would argue that overall podiatric surgeons are not suitably trained or qualified to practise safely and competently.

It is well understood by members of the orthopaedic surgery profession that podiatric surgeons are not regulated in the same way, or indeed to the same standard, as any other specialist surgeons in Australia.

Podiatric surgeons are the only practitioners performing invasive procedures on patients who are NOT regulated by the Medical Board of Australia.

Podiatric surgeons are regulated by the Podiatry Board of Australia, which was never designed or required to regulate surgeons. The Podiatry Board does not contain a position for a medical practitioner or orthopaedic surgeon and the Board does not have expertise in surgical outcomes, except for the current 41 podiatric surgeons it oversees.

Whilst the Podiatry Board has expertise in supervising Podiatrists, it is not equipped to understand the implications of surgical practice or independently assess outcomes in an informed way. It does not engage with the Royal Australasian College of Surgeons, and does not define standards of surgical care equivalent to those of the Australian Medical Council.

The general public are unaware that podiatric surgeons are not held accountable to the same clinical governance standards as a medically trained orthopaedic surgeon.

Whilst orthopaedic surgeons understand the difference between podiatric surgeons in comparison to orthopaedic/plastic/vascular/general surgeons etc, unfortunately this distinction is not at all clear to members of the public.

The average patient assumes that anyone calling themselves a surgeon must be trained to an advanced level in a first world, highly regulated health system like Australia. Almost universally, the patients that our orthopaedic surgeon members have treated for complications caused by a podiatric surgeon have reported that they thought the podiatric surgeon was a medical doctor because they called themselves a 'surgeon'.

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

Yes – we believe the term 'surgeon' should be restricted to those individuals with the requisite medical training provided by a specialist surgical college, whose training and standards are accepted and accredited independently by the Australian Medical Council.

Protection of the title 'surgeon' has been in contention for some time, leading to the recent NRAS review into "Use of the title 'surgeon' by medical practitioners in the Health Practitioner Regulation National Law". The outcome of this was to restrict those who can call themselves a surgeon to specific practitioners with AMC-accredited surgical training. The problem with this outcome was that it applies *only* to those under the umbrella of the Medical Board of Australia (i.e. medical practitioners), and not to all practitioners registered with AHPRA. This has resulted in appropriate restriction of some medical practitioners calling themselves a surgeon (such as cosmetic 'surgeons'), yet there are no restrictions on any practitioner of podiatry, physiotherapy, chiropractic, Chinese medicine etc from calling themselves a 'surgeon'.

The term 'podiatric surgeon' is misleading to the general public as there is no indication that such a health practitioner is not medically trained. As it stands, podiatric surgeons are also the only people performing surgery on Australians without their training being overseen by the external independent body, the Australian Medical Council. They are internally accredited *by their own Board*, so there is no transparency, accountability or a governance structure free from conflicts of interest (as there is with the AMC independently accrediting every single other specialist college).

The fact that there are multiple podiatric surgery training pathways within Australia, and that none of them have been accredited against an independently defined international or AMC standard, has resulted in the fundamentally inadequate surgical education that is leading to significant rates of complications and notifications to AHPRA.

The current training programs for podiatric surgeons have never met the standards required for accreditation internationally by the Council on Podiatric Medical Education (the USA accreditation body for podiatric surgeons) or in Australia by the AMC, and as such should not be endorsed by the Podiatry Board of Australia until they do.

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

In our view, if a person wishes to be a 'surgeon' in Australia, then they *should* be embarking on advanced studies and surgical training.

Having talked to some podiatrists about the current situation with podiatric surgeons, many of them have commented that their friends or colleagues wished they could be a surgeon, and that doing so with podiatric surgery 'training' is the *easy* way.

A podiatric surgeon undertakes a basic podiatry degree, followed by *part-time* 'surgical training' at the UWA Podiatry clinic, which is not hospital-based experiential training, has relatively low caseloads and minimal contact hours. A podiatric surgeon will be involved with a few hundred cases during their training at best, most of which is observational. This can all be achieved in **6 years**.

In comparison, to become an orthopaedic surgeon one:

- must complete an undergraduate medical degree (6 years),

- work as a junior doctor (intern/resident) for a *minimum* of 3 years prior to becoming eligible to apply to the orthopaedic training program (full-time, 50-80 hours per week),

- work as an unaccredited/service registrar for 1-5 years (full-time, 50-80 hours per week),

- complete the 5-year orthopaedic surgery training program, during which a trainee will participate in around 3000 operations (full-time, 50-80 hours per week);

- followed by a further 1-3 years of sub-specialty fellowship training domestically or overseas.

This is between 16-22 years of training after leaving high school, compared with just 6 to be a 'podiatric surgeon'.

Additionally, the orthopaedic training program is so competitive that less than 20% of applicants each year are selected on to the training program. Many junior doctors never get selected on to the training program despite years of unaccredited training and multiple applications.

The sequential failures of regulation over the last decade are outlined in detail in the Australian Orthopaedic Foot & Ankle Society and Australian Orthopaedic Association submissions to this enquiry. As a result of these regulatory failures, with the relative ease of granting specialist titles and despite poor evidence of whether podiatric surgery in Australia is safe, there are now a large increase in notifications of podiatric surgery in Australia.

The high number of podiatric surgeons who currently have or have had restrictions placed on their practise speaks volumes about these regulatory failures. A review of the AHPRA register of practitioners has demonstrated that five out of 32 podiatric surgeons who are fellows of the Australasian College of Podiatric Surgery currently have their practice restricted ([redacted], [redacted], [redacted], [redacted] and [redacted]). Currently, 15.6% of podiatric surgeons who are active fellows of the ACPS, the very organisation that states on their website that its primary objective "is to advance knowledge in podiatric surgery and uphold the highest standards of foot and ankle care provided by podiatric surgeons to patients and the community" are under supervised and/or restricted practice despite being granted their fellowship in podiatric surgery.

This suggests that podiatric surgeons in Australia are not suitably trained and qualified, and are not currently practising in a safe, competent, and ethical manner.

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

The PBA's current standards are inadequate as they are not founded on either an accepted International Standard, nor Australian AMC accredited standards. The sub-standard education that podiatric surgeons receive in Australia has unfortunately resulted in a group who are simply unable to perform the vast majority of foot and ankle surgery safely, because they were never given the training, education and experience to do so.

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

Every single orthopaedic surgeon member of the Western Australian Orthopaedic Foot & Ankle Society has independently seen complications resulting in harm to patients due to podiatric surgeons.

There have been multiple court and legal proceedings (both past and currently ongoing) in Western Australia with patients litigating against podiatric surgeons. Most of these have *not* been reported to AHPRA or the PBA (as advised by patients to their treating orthopaedic surgeon).

Complex case discussion meetings of our Society occur 4-5 times a year, and at virtually every meeting **at least** one complication of a podiatric surgeon is presented for discussion. These cases range from what should be straightforward surgeries being done without adequate skill or pre-operative work-up, through to the wrong operations being performed due to misdiagnosis, overt lack of knowledge and skill, or the podiatrist simply only have one operative solution to presentations requiring a much broader surgical skill set (e.g. continual implantation of sinus tarsi arthroereisis screws as the only surgical procedure for flatfeet, even in cases where it is completely contra-indicated such as rigid flatfeet, tarsal coalitions or severe arthritis).

With no Medicare rebates and many health fund policies not providing rebates, these podiatric surgeons are charging patients egregious fees for operations leading to terrible outcomes (often $10,000-$15,000). One country patient presented with a painful flatfoot to a podiatric surgeon in a regional centre – he apparently repaired a tendon and fused a midfoot joint. The deformity and pain was unsurprisingly not fixed, as it related to her extreme hindfoot arthritis and deformity. She works in a roadhouse earning minimum wage, and in order to pay for this operation, she had to take money out of her superannuation. She reports paying in the order of $15,000-$20,000, for the wrong operation done poorly. She was never referred on to the local orthopaedic surgeon in the public hospital for free, where she would have got the right treatment given by the appropriately trained orthopaedic surgeons, at no cost.

Another country patient was seen by the [redacted] orthopaedic team recently, having had 5 operations performed by a podiatrist on her Charcot foot. Charcot neuroarthropathy is when the bones and joints can disintegrate due to a lack of protective sensation and is most often seen in diabetics. It is considered an extremely high-risk foot presentation, and one which even a general orthopaedic surgeon would refer on to a foot and ankle sub-specialist orthopaedic surgeon. This particular patient had multiple poorly performed operations on her foot by the podiatrist, and with no private health insurance, she reports paying approximately **$85,000** out of pocket, an obscene amount which she used her superannuation to cover.

She was shocked to hear from the [redacted] team that the podiatrist was not a medical doctor, was not qualified to carry out her procedures, that he carried out her procedures outside of his accredited scope of practice at the hospital, and sadly that most of the procedures were not what was indicated for her foot, and that had she been appropriately referred to the public hospital orthopaedic department, she would have been treated correctly, for free. The patient reports the podiatrist told her that he "was the best foot and ankle surgeon in [redacted]", and she believed him to the tune of $85,000. Informed financial consent was clearly not given to this patient by the podiatrist.

Another recent complication seen was of a young woman who had attempted bilateral bunion surgery, involving an osteotomy (bone cut) of the 1st metatarsal. Post-operative x-rays demonstrated that the single screw inserted into each foot had completely failed to enter the metatarsal on either side of the osteotomy, and the screws were sitting in the plantar soft tissues. This in and of itself is complete and utter negligence, and it is inconceivable to us as orthopaedic surgeons that a screw could be inserted and it not be known that it wasn't in bone (and this happened on each foot). This particular podiatrist has an x-ray machine in his rooms, which is deliberately done in order to avoid having x-rays taken independently at a radiology practice and the images reported on by a radiologist. In this case though, the patient had external x-rays and the radiologist reported that the screws were not at all in the bones and were not providing any fixation of the osteotomies (see report below). The patient reports that when she raised this with the podiatrist, his reply was that the radiologist "sits in a dark room all day and he wouldn't have any idea what happened at the time of surgery", but that he was there and so the radiologist is wrong. It sadly took her more than 9 months before she saw an orthopaedic surgeon to remove the screws she'd been walking on for all that time, and she even tried to commit suicide during that period as her complication had not been managed. She has now been left with chronic pain which likely cannot be salvaged. This is not an isolated case of a podiatric surgeon either failing to correctly diagnose a complication, or otherwise recognising it but not providing open disclosure to the patient.

Radiology Report

XRAY BILATERAL FEET

[redacted]

Patient details redacted

Referrer [redacted]

Date [redacted]

Clinic [redacted]

[redacted]

X-RAY BOTH FEET

Clinical Details: Two weeks post-op bilateral hallux valgus correction. For evaluation.

Findings: Comparison study [redacted]
Bilaterally there are distal 1st metatarsal osteotomies for correction of hallux valgus.
Bilaterally there are headless screws located in the soft tissues plantar to the distal half of the 1st metatarsals that have their tips within the inter-sesamoid interval. The screws are not seated in the 1st metatarsals and and do not traverse the osteotomies.
Reporting Doctor: [redacted]

There have been cases in [redacted] where podiatric surgeons' complications have directly resulted in the need for amputation of toes. Earlier in 2021, one of the company reps who supplies equipment (plates/screws) to the podiatric surgeons observed a horrendous case when the podiatrist couldn't figure out how to fix a bone cut (osteotomy) made during a bunion correction, and the female patient in her 20s ended up waking up with the great toe fused – something that is generally done in older people for arthritis. This example is absolutely egregious, and is but one example of the lack of appropriate training, no review of complications by an accredited hospital medical advisory committee, and no self-insight into the abilities of the actual podiatric surgeon.

Another company rep, who has a great deal of previous experience in the UK with orthopaedic foot & ankle surgery, says she finds it deeply distressing to watch these podiatric surgeons operate, as it's abundantly clear they simply do not have the requisite knowledge and skills to undertake most of their surgery properly.

These are just a few of the multiple complications of podiatric surgery that our members have seen time and again over many years. Specific cases can be sourced and further information provided if required.

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?

As outlined already, the only way that the integrity of any podiatric surgery training in Australia could be achieved is by having an independently accredited pre-defined standard of training created by the Australian Medical Council, and applied absolutely to any training provider in Australia. The Australian Orthopaedic Association and Australian Orthopaedic Foot and Ankle Society have repeatedly called for this in the past, and presumably the reason that an AMC defined standard has not been adopted is because the current podiatric surgery training would fail to meet this bar.

Any podiatric surgeons who are currently registered should have to demonstrate competency by the newly defined standard, with appropriate independent audit of their surgical activity. Allowing any podiatric surgeons to continue to practise without being accountable to this much higher standard would likely result in ongoing poor outcomes, high complication rates and further AHPRA notifications. There are currently a large number of podiatric surgeons who have had repeated restrictions placed on their practice, with a cycle of restrictions which get applied and then removed, only to have further restrictions applied again. We question the Podiatry Board of Australia as to how it is that 'repeat offenders' are allowed to continue to operate, despite repeated evidence of harm to the community.

In addition, podiatrists should be restricted from using the term 'surgeon', as it implies to the average member of the public that they are medically trained and have advanced surgical training and experience. A Galaxy Poll previously reported that 96% of the general population think that if someone calls themselves 'surgeon', then that individual is medically trained and has completed a basic medical degree followed by specialist training in surgery. As it stands, the vast majority of patients that our members see with podiatric surgery complications were completely unaware that the 'surgeon' was not a medical practitioner, and did not have the same level of training as all other surgeons in Australia.

A further suggestion for change is with regard to referrals. As it stands, every surgeon in Australia treating a patient must be referred that patient by their general practitioner or another medical practitioner – with the sole exception of podiatric surgeons. Having the patient referred by their primary care physician is appropriate for multiple reasons, most importantly for continuity of care in managing the patient's overall health, as well in overseeing any specialist interventions the patient requires.

It is the experience of many of our patients with podiatric surgery complications that they bypass their GP either through directly responding to the ubiquitous advertising of podiatric surgeons or they are sent by their regular podiatrist – who, like much of the general public, are unaware of the differences in training between podiatric surgeons and every other surgeon.

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

Our multiple concerns about podiatric surgery education and training are outlined in detail both above, and in the comprehensive submission to this enquiry by the Australian Orthopaedic Association (AOA) and Australian Orthopaedic Foot and Ankle Society (AOFAS).

At the heart of this, it has been the experience of orthopaedic foot & ankle sub-specialist surgeons in Western Australia that the rate of complications and patient harm is much higher than for other areas of medical and surgical practice.

As has been quoted in the joint AOA and AOFAS submission to this enquiry, the Podiatry Board receives a disproportionate number of AHPRA notifications about podiatric surgeons in comparison to general podiatrists – in some years, up to a 28 times higher rate. This is an extraordinary rate of notifications, and is well above the number of notifications recorded by AHPRA for medically-trained surgeons in any specialty.

We would also point out that this vastly understates the true rate of complications, as the majority of patients with podiatric complications seen by our members reported that they had *not* put in a complaint to AHPRA.

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?

Firstly, the fact that this enquiry has come about with the recognition that the number of notifications about podiatric surgeons is alarmingly high on a year-to-year basis should be a clear indicator that the current management of notifications is inadequate. As should apply to AHPRA notifications made about any health practitioner, the clear aims of response should be to protect the community and reduce the risk of harm from the practitioner about which the notification is made. Given that the rate at which notifications are made about podiatric surgeons is not declining, it is clear that the actions taken by the PBA are not addressing the root causes on either an individual or cohort basis.

Secondly, the fact that many podiatric surgeons have had repeated cyclical restrictions placed on their practice is also evidence that the PBA is not appropriately clamping down on these practitioners and mitigating harm to the community. Whatever the restrictions being imposed on some individuals, the fact that they continue to operate and create more complications would suggest that the approach by the PBA needs to fundamentally change. We question how practitioners who have restrictions applied are receiving any truly independent supervision, when it appears that the supervisors are often close professional associates, or even colleagues in the same podiatry practice, for which there is an obvious financial conflict of interest.

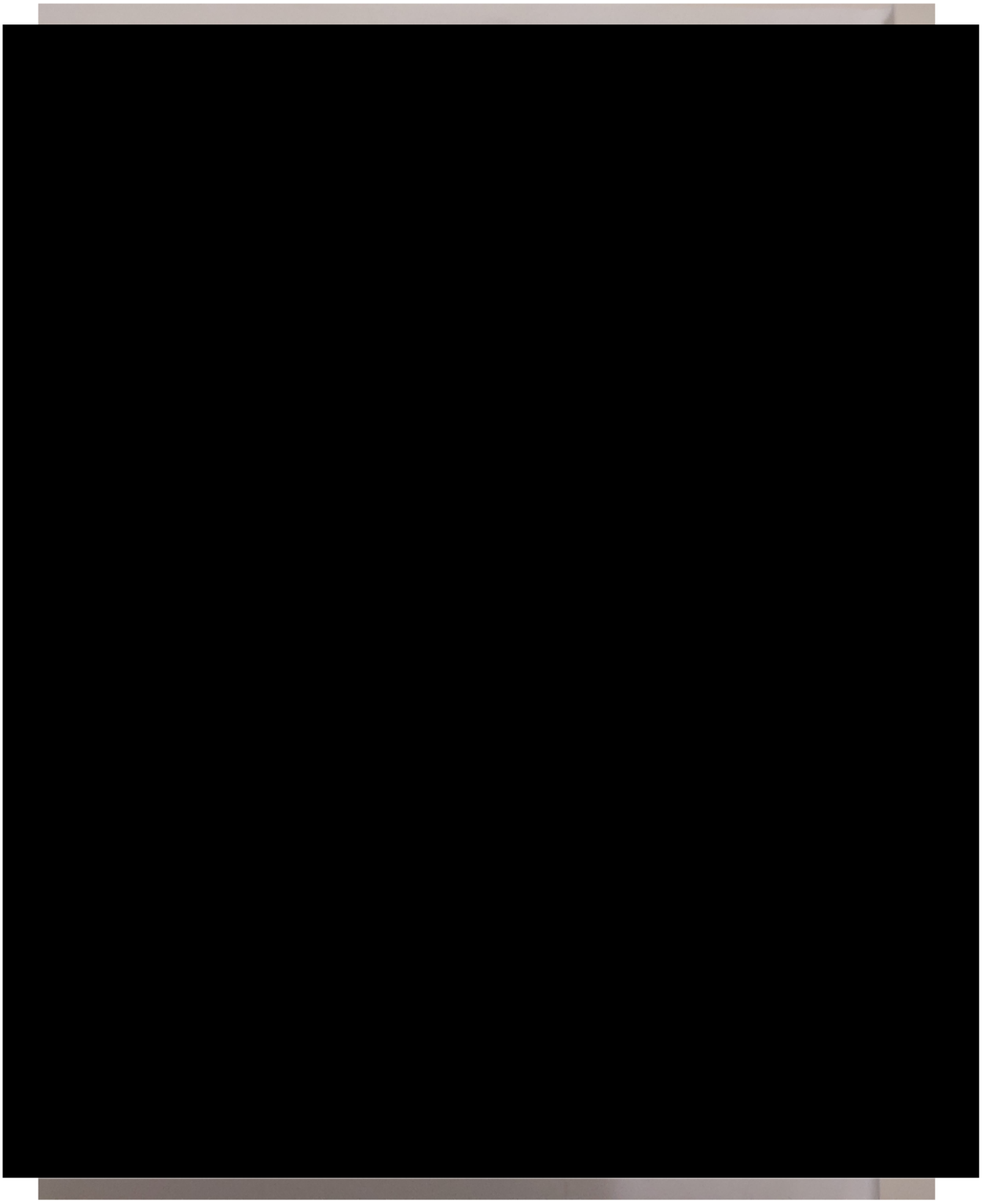
Thirdly, there are numerous cases that we are aware of where patients have reached confidential legal settlements with podiatric surgeons, *without* an AHPRA notification being made. Given the concern about the high complication rates of podiatric surgeons, we suggest that the PBA mandate that all legal settlements be disclosed to the Board as a condition of annual registration renewal. This is likely to already require disclosure to the podiatrists' indemnity insurance companies (as it is for medical practitioners), and would provide greater transparency and opportunity to identify practitioners who require additional scrutiny.

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

Unethical and misleading advertising is rife within the podiatric surgery community. Given that podiatric surgeons do not require GP referrals, many patients have reported they responded to direct advertising online by podiatric surgeons. Some examples follow:

Podiatric surgeon [redacted] provides the following document to patients, purporting himself to be "one of the most highly qualified foot specialists in Australia", a claim which is not permitted under the AHPRA advertising guidelines. [redacted]

The language used by [redacted] in this profile document exaggerates and embellishes his training, and has misled multiple patients who have subsequently presented to orthopaedic surgeons for management of complications. It is also interesting to note that he was an [redacted] at [redacted] at the same time he was a student of the podiatric surgery training program. If this is correct, it would certainly raise questions about the basis on which such titles are being conveyed and would be another example of concern about the quality of the training program.



Previous notifications have also been made to AHPRA about [redacted] advertising, including the use of testimonials on public forums such as FaceBook, advertising unrealistic expectations of treatment (such as a "Pain-Free Experience"), soliciting public forum reviews from patients, and offering financial incentives for referrals, all of which are illegal under the National Law. Examples are seen below:

[redacted]

[redacted] notes on her website profile [redacted]) that [redacted] is a "(reconstructive foot surgeon) who completed [redacted] undergraduate and postgraduate Doctorate in foot surgery through the Faculty of Medicine, School of Surgery at the University of Western Australia (UWA)" (see screenshot below).

The UWA podiatric surgery program is actually run by the UWA School of Allied Health (https://www.uwa.edu.au/schools/allied-health), which is different to the School of Medicine which produces medical practitioners, but [redacted]'s advertising claim that [redacted] completed surgery training through the 'Faculty of Medicine' misleads the general public to believe that [redacted] is a medically-trained doctor and surgeon.

Murch of the remaining language used about [redacted] training, such as doing "one on one training" at the "leading foot surgery training facility in the world" is again the kind of language seen on many of the podiatric surgeons' websites amping up their training experiences to make them sound much more impressive to the average potential patient on the street.

[redacted]

[redacted], a podiatric surgeon in [redacted] holds [redacted] out to be [redacted] despite not being a medical practitioner or having a doctorate degree. Multiple patients in [redacted] who have suffered complications and presented to orthopaedic surgeons report being shocked to find out that [redacted] is not in fact a medical doctor or medically-trained orthopaedic surgeon, and that as patients they were under the impression that a 'surgeon' calling themselves 'Doctor' would surely hold a medical degree qualification and appropriate surgical training (see screenshot below).

Similarly, [redacted] podiatric surgeon [redacted] also holds [redacted] out as '[redacted]', despite not having a doctorate degree or medical degree, which again has led multiple patients to mistake [redacted] for being a medical doctor (see screenshot below).

[redacted], a podiatric surgeon based in [redacted], advertises on [redacted] website that [redacted] treats *posterior heel spurs, plantar fasciopathy/heel pain, Achilles tendinopathy, adult acquired flat foot, recurrent ankle sprains, subtalar joint pathology, ankle arthropathy, ankle impingement syndromes, and spring ligament injuries* (see screenshot below), which are all hindfoot pathologies. This is despite the fact that [redacted] is *not* accredited to perform any hindfoot surgery within his scope of practice at the facility that [redacted] operates at, [redacted] (confirmed by [redacted], current Chair of the hospital's Medical Advisory Committee). Advertising a broader scope of practice than he is permitted to carry out misleads patients to believe that he has a much greater skill set and is more qualified than he is.

[redacted]

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

We concur with the recommendations made to this enquiry by the AOA, AOFAS, AMA and RACS.

We agree that the term 'podiatric surgeon' be abolished and that podiatrists not be permitted to use the title 'surgeon'. In the interest of public safety and informed patient decision making, we advocate that the term 'operative podiatrist' replaces the term 'podiatric surgeon'. This offers the government a universal solution to all health professionals who wish to offer surgical services, but whose Colleges or Associations are not accredited by the AMC.

If the status quo of the current sub-standard podiatric surgery training remains, we believe that the term 'operative' (with a profession specific descriptor) may safely be used by podiatric practitioners, and other groups in future, in order to clearly indicate to the public that whilst the 'operative' technician may have undergone further training, there is a recognised difference between that training and an AMC certified surgeon.

We would be happy to provide any further information to the enquiry if desired.

[redacted]

Dr Simon Zilko
Orthopaedic Surgeon
Chair, WAOFAS

[redacted]

Dr Robert Story
Orthopaedic Surgeon
Secretary, WAOFAS

[redacted]

Dr Andrej Nikoloski
Orthopaedic Surgeon
Treasurer, WAOFAS

ADDENDUM

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