AOA SUBMISSION

Consultation paper: Draft proposed professional capabilities and accreditation standards for podiatry and podiatric surgery

12 March 2021

AUSTRALIAN ORTHOPAEDIC ASSOCIATION

Introduction

The Australian Orthopaedic Association (AOA) and the Australian Orthopaedic Foot and Ankle Society (AOFAS) welcome the opportunity to submit a response regarding the Consultation paper: *Draft proposed professional capabilities and accreditation standards for podiatry and podiatric surgery*. However, it is noted that we were not invited to contribute to the previous review consultation round as mentioned in the documents, despite having made multiple contributions to podiatry consultations in the past.

Executive summary and recommendations

AOA and AOFAS are pleased that the Podiatry Board of Australia (PBA) is reviewing the Standards for podiatry and podiatric surgery, and we take this opportunity to bring to the Board's attention a number problems in the development of the previous Standards in the expectation that the Board might reflect on these problems and amend the previous process.

Further, our contribution is made with the goals of:

- ensuring public safety;
- ensuring parity of surgical training with all other surgical specialities operating on members of the Australian public;
- ensuring that accreditation courses to educate podiatrists who operate on the public are held to the same standard as that required by the Australian Medical Council; and
- Ensuring that the surgical training of podiatrists is accredited by an independent accrediting body with experience in the field of surgical training programs - such as the AMC.

It should be noted that the AOA and AOFAS have not resiled from our previous position on the inadequacy of Podiatric Surgical training.

Recommendations

AOA and AOFAS believes that the PBA must have the goal of ensuring that the intent of the National Legislation is brought to fruition by:

- Engaging in consultation, undertaking investigation and analysis of the current surgical education available nationally for podiatric surgeons;
- Developing appropriate surgical educational standards and requirements as well as clinical supervision nationally to ensure there is a consistent level of education and clinical supervision across all jurisdictions;
- Ensuring that National Registration Legislation enacted for the protection of patients should be a single national standard of care, consistent across all states and territories.
- This means there must be a single national standard of training and accreditation for all podiatric surgeons across Australia.

- The standard of care for foot and ankle surgery was established in 1936 with the formation of the Australian Orthopaedic Association. The PBA must ensure their training and accreditation is equal to the current orthopaedic surgical training level.

Background Information - Professional capabilities for podiatric surgeons

The PBA in the negotiations leading up to the National Legislation gave undertakings that any new standards set would be to international standards.

Regrettably this has proven not to have been the case in the field of operative podiatry.

The previous Standard development process (managed via ANZPAC) did not refer to the globally accepted gold standard i.e: the CPME as a standard against which the education providers should be assessed to ensure local Australian standards were appropriate and in line with global surgical best practice.

The Report was authored by a person not trained in podiatry, medicine or surgery and was partly funded by one of the education providers within the scope of the review.

The resulting standards were voted on by ANZPAC. One of the members of the voting group who was actively involved in the promotion of the standards was himself a member of the educational groups being assessed.

He did not recuse himself from considerations and voting, despite there being an obvious conflict of interest.

Importantly under the current Accreditation Committee terms of reference the PBA Section 11 (Membership) states that there will be 2 Podiatric Surgeons on the committee. AOA/AOFAS have significant concerns that future potential conflicts of interest will not be appropriately managed.

There should be transparency around the measures the PBA has undertaken to ensure that conflict of interests will not occur in the formation and implementation these new standards.

It is for these reasons that AOA is firmly of the opinion that all surgical standards and accreditation must be formally aligned with a body independent of podiatry, such as the AMC.

Podiatry surgery is currently an outlier in the field of surgical interventions undertaken on the Australian public.

The initial report tendered to ANZPAC did not accept the UWA standard of education as the program was transitioning to a Doctorate of Clinical Podiatry Program. UWA was added in the later versions and was not based on data supplied, nor a review of the program, but on argument.

Indeed, the chair of the WA Podiatry Board stated "*The current consultation process has a closing date of 24.11.2009 however, it is noted that prior to this closing date,*

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the consultation paper has extensive input from Australian College of Podiatric Surgeons (ACPS) as one organization currently training podiatric surgeons, including referencing its documentation. The consultation paper has failed to fully consider the current situation in WA."

And "*In conclusion, it would seem that this circulated consultation paper has many shortcomings, highlights a serious lack of prior consultation and shows an untenable bias towards the Podiatrist Registration Board of Victoria and the ACPS*."

The PBA, and ANZPAC did not inspect the education of the Fellows of the ACPS, and so do not have a comprehensive knowledge of the actual training the Fellows receive. Indeed, ANZPAC did not inspect the ACPS training program for 5 years after the ACPS were accepted as educational providers, so two entire cohorts of Podiatric surgeons could potentially have had an inadequate training programme, and the Assessors be none the wiser, or properly informed.

Furthermore, ANZPAC accredited the ACPS with conditions.

"Australasian College of Podiatric Surgeons (Fellowship Training Program) (site visit undertaken November 2014) Application for accreditation – accredited with conditions until 26 February 2020" and afterwards accepted self-assessment rather than reinspection.

The PBA accepted the Standards of the ACPS and the UWA, without defining a standard and assessing the UWA and ACPS against them.

In this Draft Proposed Accreditation standards for podiatric surgery program the PBA has still not done so.

Indeed, if asked in a court of law, what the formal pharmacological teaching received by the ACPS Fellows (whom the PBA accepts into its Specialist Register), the PBA would not be in a position to answer the question with any authority, and so the PBA is not in a position to execute its duties to protect the public.

AOA also points out that the Inspection process to ensure adequacy of the Training Program has not been done impartially and not to a standard in which the Board can have confidence.

AOA/AOFAS has significant concerns about practices such as the allowing of Fellowships to individuals who had not obtained Masters degrees (as required by the published training programs) before the sitting their Fellowship exam.

AOA/AOFAS understands that there are significant numbers of podiatric surgeons who have never done any formal tertiary education in pharmacology and yet have been given the right to prescribe, and who under the Board's Pathway B are currently mentoring others to prescribe – and drawing fees for this service.

With respect to the issue of podiatric surgeons prescribing medications, it is timely to remind the PBA of the circumstances of the Board advocating for the right to prescribe being given to podiatric surgeons.

At the time the PBA extended to podiatric surgeons the right to prescribe, the ACPS claimed its members had formal education in prescribing. They stated their members did a pharmacology course at Curtin University (Pod Pharmacology 651).

When AOA contacted the co-ordinator of the course (Max Page) he stated "*I would not regard The Pod Pharmacol 651 as equivalent to a medical pharmacology course, mainly because it covers only a few selected areas. As external units they also lack the face-to-face tutorial experience and interaction with teachers and mentors which would be in any medical course.*" He also stated that the course itself was not sufficient to qualify someone to prescribe.

He was able to supply a list of those who had done the course, and almost 60% of ACPS Podiatric Surgeons had not done the course, and so had no formal advanced tertiary education in Pharmacology other than their undergraduate diploma level pharmacology.

Furthermore, the PBA is mistaken when it suggests a pharmacology course qualifies someone to prescribe. Prescription comes at the end of an extensive process of history taking, examination, investigations and imaging studies, understanding the pathology and then instituting treatment. None of these competencies was assessed before the podiatric surgeons were given the right to prescribe.

The question must be asked – how could the PBA (whose primary duty is to protect the Australian public) have permitted and advocated this change, and how can it do so now?

The current Pathway B is not knowledge-based, and relies on mentors of unknown quality supplying ad hoc information, based on uncertain contact times with non-uniform outcomes of education, and yet the PBA is granting to individuals participating in this very poorly-defined pathway the right to prescribe.

The above suggests that this is an extremely heterogenous group with no defined standards being mandated, and the standards that are in place are being very inconsistently applied.

Key Capabilities

It is pleasing to note that the PBA and APHRA in Key Capabilities 1.1 e. have noted that there is a need to have a basic standard of Anatomical, Biochemical, Physiological, Pathological and Pharmacological knowledge to underpin surgical training, but AOA laments the fact that the current guidelines do not establish the standards, and so fail the basic tenet of the National Legislation: that all providers of **a service will do so to the same set of standards.**

In the proposed changes, it is noted that the PBA intends to charge TEQSA to execute the role of the AMC in ensuring the Standards are met. The AOA endorses the use of an independent Auditor, but recognises that TEQSA will require the establishment of robust standards so that consistent assessments can be made.

We also note that TEQSA has the capacity to allow providers to "self-assess" and request the PBA specifically instruct them not to allow this in the case of surgical training.

AOA submits that this proposal to "self-assess" is completely unacceptable.

AOA finds it curious that an assessment-based program responsible for ensuring clinical and surgical standards are met would be conducted by any regulatory body

other than the AMC, which performs this function for **all** other surgical training programs.

Indeed, it is with disquiet that AOA and AOFAS read that in reviewing standards of education, the draft documents accept a "Letter from the specialist college president or university vice chancellor (or delegate) confirming ongoing support for the quality and resourcing of each unit/subject."

AOA and AOAFAS point out that podiatry courses available in Australia do not aim to produce surgeons and so the Undergraduate Background Knowledge cannot be itself the knowledge base for prescribing and surgery.

We suggest that the PBA, in order to meet its obligation under the National Legislation, defines for TEQSA that the education providers need to supply knowledge and examination to the standard of a Bachelor's Degree course in Biochemistry, Physiology, Pharmacodynamics, and Pharmacology, and Masters in Pathology, Anatomy and Surgical Anatomy and microbiology. This must be the baseline standard for all surgical specialities in Australia to ensure adherence to the National Legislation.

The following medical courses should be undertaken at the level of a Bachelor's Degree:

- Immunology;
- Rheumatology;
- Anaesthetics; and
- Paediatrics.

It is important to note, that none of the undergraduate courses reviewed by AOA and AOFAS actually provides a meaningful section on paediatrics, despite endorsed podiatrists being authorised to prescribe to children.

Surgical Training

With respect to the actual surgical training, there needs to be much clearer definitions of the actual training standard.

The ACPS speak in nebulous terms about "rotations in medicine and radiology", but AOA and AOFAS has not been able to find any institution or group who state they are conducting this education.

It follows therefore that there is no assurance as to precisely who is responsible for provision of these teaching activities in these rotations and so the quality of the education gained by the trainees who attend these rotations is completely unknown and unassessed.

An independent formal review of the actual training experience of current and past Registrars doing these rotations must be undertaken in order to understand the actual educational experience. This is vital as the PBA, in the draft standards document, acknowledges that the surgeon needs to have a good understanding of the past medical history of the patient, and so the quality of the training that underpins this understanding must be independently reviewed and assessed.

It is insufficient for the surgical podiatrists to claim that will involve physicians to manage the medical components of the patient care.

This is unsatisfactory for a number of reasons:

Firstly, this will be an added expense for the patient.,

Secondly, physicians are not surgeons, and will not necessarily have the depth of understanding required to manage all the potential problems that may arise during the perioperative care of the patient.

An appropriately qualified surgeon is the best person to perform this role as they have a sound understanding of both the medical and surgical aspects of the procedure and subsequent recovery period.

Surgical experience of a varied nature is essential in producing good surgeons, and there needs to be diligent supervision of the trainees on a training program. In this respect there is no defined reliable training or contact with the trainees in the training documents.

The third iteration of the ACPS Training document stated: “The ACPS is responsible for assessment of Registrars (trainees). The ACPS provides guidance and structure in respect of practical training. *No guarantee is provided by the ACPS that practical training will be* ***provided****”* (our bold and italics).

AOA and AOFAS submit that this is an extraordinary proposition for a purported training body to propose – they are stating tin effect that they cannot necessarily provide supervised, hands-on surgical experience for their trainees. This stands in marked contradistinction to AOA’s registrar training program, where this hands-on experience is explicitly provided, reviewed and recorded via the AOA21 training app.

The ACPS quotes its trainees as performing 2000 procedures within their period of training. It is clear from the ACPS’s own documents published on the internet, that they do not have the patient numbers to provide registrars with this level of training.

If a trainee closes a wound, they are not performing a procedure, and it should not be listed as such. The unbundling of a single operation into 15 “procedures” which can be recorded as such in a trainee’s logbook is inappropriate and gives a false impression of surgical experience. This practice is banned for all surgeons when using MBS item numbers.

ACPS publishes audits on its website, and the following is the list of total cases done by all podiatric surgeons in this group for the following calendar years:

2014 - 2106 cases;

2015 - 2266 cases,

2016 - 2080 cases

2017 - 2185 cases

Thus, the trainees would need to have performed every case to attain the numbers of cases that being are quoted.

Training in comparison with orthopaedic registrars

AOA/AOFAS takes this opportunity to point out that the "full time podiatric surgical registrars" are supposedly full-time registrars of the ACPS (and are unpaid), whilst supposedly undertaking a "full time Master's Degree" (which is a requirement of training since 1993) and are also working as podiatrists to earn an income to fund this "training".

This is to be contrasted to orthopaedic registrars who are doctors and who are in paid employment doing nothing but orthopaedic cases for a minimum of five years, with high hours of clinical contact and weekly educational meetings (on site in the hospital) and weekly bone school contact, and generally with other orthopaedic trainees at the same site for additional support and training. All of which is inspected and accredited by AOA to ensure the training and meetings provided for orthopaedic registrars are of a high standard.

Registrars in orthopaedic surgical training have constant daily contact with Specialist Orthopaedic surgeons with all sessions supervised initially, and as they progress through their training and being granted gradually increases in their surgical autonomy and decision making, there is always be a supervising surgeon to whom they will communicate treatment plans and surgical decisions.

This is to be compared to the ACPS who recommend - D2. Supervisors responsibility include "maintain regular contact with the Registrar, normally weekly".

It is important the PBA is aware of the limited training achieved by podiatric surgical registrars. In the 2004 training document regarding practical component of training the statement is made "The ACPS Registrars are required to keep logs and are required to observe 50% of their cases, assist 30% and perform under supervision 20% of cases.

If we recognise that an ACPS surgeon performs 110 cases (on average 2014 data) per year, and 29.2% are toenail surgery which the PBA would be aware normal podiatrists are able to perform, this invites the assumption that a podiatry registrar will experience a total of surgical 78 cases per year.

In ideal circumstances, they will observe 50% (39), assist in 30% (23) and perform 20% (15). So, the registrar will actually perform 60 cases in a 4-year training program. The 2000 cases the ACPS states a registrar performs would take 25 years to acquire, unless the ACPS is counting individual procedure items rather than cases - which would artificially but substantially increase the numbers quoted above.

An orthopaedic registrar will typically perform more surgeries in a 2-month period than the ACPS trainee will in their entire training program. Coupled with this, orthopaedic surgeons who specialise in foot and ankle surgery generally then undertake a twelve-month fellowship, most often at an international centre of excellence before practicing as a foot and ankle surgery.

ACPS will quote procedures in their reports and the reports of their trainees. This is very misleading to the casual reader as the procedure is "unbundled". For example, a bunion operation might be broken down into its individual steps: an incision, capsulotomy of joint, bunionectomy, metatarsal osteotomy, fixation of osteotomy, joint plication, and closure of incision (laceration) and then have each step claimed as a stand-alone procedure.

Thus, the registrar can claim 7 procedures for a single case.

This is not representative of the activity and would be counted as a single case by an orthopaedic registrar.

This practice should concern PBA, and it should require the Standards to have strict definitions of what constitutes a surgical procedure, with the practice of unbundling being excluded.

Duty of care – private patients

The draft document has not addressed the issue of privately insured patients paying a podiatric surgeon to perform their surgery but are then being operated on, without consent, by another individual who is not as experienced as the person the patient retained to do the surgery.

This is very concerning as it represents a major breach of the contract of patient care. AOA and AOFAS believes this practice occurs in the training of podiatric trainees, and has not been addressed by the PBA.

Informed consent needs to be comprehensive, and the standards should insist that patients be aware that the person who they have contracted to undertake an operation, may not in fact be the operating surgeon.

A comparison of this situation to the public system might be helpful. Patients in the public system are given documentation on admission stating they will be reviewed by medical students, interns, residents etc. Not unusually, consent forms for public hospitals state surgery may not be performed by a particular surgeon and may be done by a training surgeon. There is also a multidisciplinary, multi-level layer of supervision in the public system with clear escalation processes and clinical governance, including x-ray meetings, clinical audits and the similar educational events.

AOA has been advised that this level of clinical oversight is not seen as valuable by podiatric surgeons.

An important part of surgery is the aftercare of the patient and outcome analysis, which the trainees are denied as they do not attend the outpatient care of the patient.

It would be difficult to ascertain how a podiatric surgeon trainee would be experienced with the normal post-operative care of a surgical patient if they have never been involved nor exposed to this part of the patient journey. How do they know the infection rate? The non-union rate? The success rates of the surgery?

Furthermore, how can they obtain informed consent from a patient in the absence of such knowledge? How do they choose which bunion operation is the one they feel most reliable, when they have no idea of the success of the operations that they have seen/ assisted in/ or performed?

ACPS document states mentor contact in the order of once a week compared to the multiple times daily that an orthopaedic registrar will have contact with a fully qualified orthopaedic surgeon

The proposed standard for contact time should be daily, and the trainees should be in attendance at the patient's post-operative visit to ensure the adequacy of post-operative outcomes, pathology review, and to allow the trainee to learn the normal post-operative care pathway and experience the ways to identify complications and how to deal with them.

Whilst the proposed document on Surgical Training has some good intentions, it is entirely inadequate on specific training requirements and needs to be re-drafted with a view to defining the basic medical science and standards needed to begin surgical training, and then to define the minimum surgical training requirements that TESQA can then apply to surgical education providers to ensure the protection of the Australian public.

In conclusion

AOA's position is:

1. We are not interested in training Podiatric surgeons, but in ensuring adequate surgical standards.
2. We are firmly resolved that the PBA needs predetermined educational requirements against which providers are assessed by an impartial and qualified assessor. AOA/AOFAS is firmly of the view that the AMC (and no other) is the appropriate body to complete this role
3. AOA/AOFAS is prepared to participate in crafting a comprehensive and complete definition of the education required, and defining educational standards of these courses, if we could be confident in the independent and unwavering administration of these standards.
4. We require that a review of the education and credentials of existing podiatric surgeons be performed to ensure adequacy of the training of the mentors; and
5. We require that any participation from AOA/AOFAS is not misrepresented as an endorsement of podiatric surgery, and is done only to ensure an improvement in patient safety.

Thank you.

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