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Submission to the New Zealand Podiatrist's Board on the Draft Submission to the New Prescribers Advisory Committee for Restricted Prescribing Rights

The National Council of Women of New Zealand (NCWNZ) is an umbrella organisation representing 41 nationally organised societies. It has 33 branches throughout the country attended by representatives of those societies and some 150 other societies. The Council's function is to serve women, the family and the community at local, national and international levels through research, study, discussion and action. NCWNZ has a longstanding history of encouraging the promotion of social and health issues, particularly as they affect women.

Members of the Health Standing Committee, and other interested parties were asked for their input into this document. The following is a summary of their comments.

General Comments

Most respondents were most concerned about the attempt by yet another group to take over the role of GP's as primary care givers. In "Patient Choice", 6.14 the statement is made that, "Podiatrists are frequently the provider of first choice because they *specialise* in the lower limb and foot." In reality, what presents is a whole person and therefore should be looked at holistically. If anything should go wrong that affects the whole person then it will likely not be the podiatrist who will have to deal with the problem but the person's actual primary care giver, who will in most instances be their GP.

NCWNZ is particularly concerned that here is yet another group of health professionals wanting rights to prescribe. It would appear that it is hard enough to control the effects of the over prescribing of antibiotics, steroids, for example, especially as there are already substantial recorded problems caused by their overuse.

Respondents had concerns about prescribing rights, in general. It was noted that many patients could be on numerous medications, have had previous adverse drug reactions and that information would not necessarily be available to the podiatrist. There may be other medical conditions that the podiatrist is not informed about and prescribing without consultation with the GP in some cases would be potentially risky. The full clinical notes about a patient would not be accessible. Serious risk of harm must be considered together with the benefits of easier access for patients to receive correct medication.

Many patients using podiatry services are elderly with a range of health problems such as diabetes, kidney and/or heart disease. Often these patients are unable to accurately list the drugs they are taking or the amounts. In the field of geriatric assessment and rehabilitation it is a reasonably frequent occurrence for patients to be taken off all prescribed medication before their current needs could be accurately assessed. There would also be a need to educate all people as at present this could be seen as a confidentiality issue as podiatrists are not expected to be prescribing drugs.

Specific Comments

5 Indicative Medicines List

Respondents expressed concerns about the prescription of drugs listed in Appendix C. Particular concern was expressed about the over prescribing of antibiotics in general. It was noted that antidepressants may already have been prescribed for the patient and therefore the use of Diazepam might be inappropriate. Codeine in high doses may present risks, particularly to older patients. The use of SAIDs and NSAIDs caused particular concern. Some NSAIDs e.g. Diclofenac can cause gastric problems and when a podiatrist is not aware that there is a pre existing condition the patient will need to be referred back to the GP for remedial treatment. NCWNZ regard it as vital to the wellbeing of patients that when a podiatrist wishes to prescribe any drug that there must be consultation with the GP to ensure that the potential for harm is minimised. Clear quality standards must be available prior to this being considered.

6 Justification

Respondents had some empathy for the rationale presented in this document for drug prescription and thought it was justified and reasonable in intent.

Although it was stated that podiatrists receive their pharmacology training with midwives who already have prescribing rights this was not seen by members as adequate justification to extend prescribing rights of podiatrists.

NCWNZ is concerned that consumers may be confused over the role of various professionals who can prescribe for them. It is essential that anyone prescribing drugs should be aware of the complete medical history of the patient. This is necessary to avoid problems e.g. over prescribing, drug interactions and the possible side effects perhaps relating to a non-podiatry condition present at the same time.

It is not made clear as to who will hold the complete health picture. Podiatrists should be required to notify the GP (lead medical carer) of their prescription, for the record. Ideally, all patients would carry personal health records with them to whichever professional they consult in the same way that all of a child's health records are meant to be recorded in the well-baby record book. However, this is not currently the practice.

Although there may be some delay in treatment respondents regarded patient safety as paramount. At the very least the Podiatrist must discuss treatment with the patient's GP to ensure that the outcomes are favourable.

7 Competencies and Education

NCWNZ acknowledges, as written in Competencies and Education, that podiatrists who wish to become "designated prescribers" must:

(a) have obtained a postgraduate pharmacology qualification from within New Zealand which is accredited by the Podiatrists Board; or
(b) having become eligible through having graduated from a course of study undertaken overseas that is recognised as meeting the quality criteria by the New Zealand Podiatrists Board; and
(c) be able to demonstrate that they have a minimum of three year's post basic clinical experience."

It appears practical for a podiatrist to be able to prescribe within their scope of practice, providing that adequate pharmacology training is given and those granted prescribing rights qualify as set out above.

Respondents did not, however, consider that a minimum of 3 years post basic training was enough clinical exposure for the practitioner to be able to identify and diagnose those patients who have significant medical issues, e.g. brittle diabetes. The practitioner must be able to demonstrate that they have the knowledge to ensure that what they want to prescribe will not interact adversely with the patient's existing medication, or have a detrimental effect on any pre-existing condition.

It was noted that Podiatrists may be able to assess general good health and they may be able to identify some conditions e.g. diabetes, heart failure etc. However, there are many conditions they will not be able to diagnose and for this reason respondents felt it vital that the Podiatrist discuss treatment options with the patient's GP.

8 Ongoing Competence

NCWNZ is concerned to read (p12 8.3) that the processes for assessment and on going monitoring of practitioner competence has not yet been fully developed. NCWNZ would note that this assessment and monitoring should have been an integral part of this submission, to prove how the process would be managed, and by whom.

Concern was also expressed that there is no mention of how frequent educational updates should be, once a practitioner has been granted prescribing rights.

9 Risks and Benefits/Costs Utilisation

NCWNZ applauds the idea of reducing costs to the patient and of the point made elsewhere about the break in time between consultations when there is a need for the control of infection. However, costs must not be reduced at the expense of patient safety or privacy. Likewise convenience, should podiatrists prescribe medication, must not be allowed to impact on patient safety or privacy.

NCWNZ would like to thank you for this opportunity to comment on these discussion documents which were clear, well set out and apart from those areas where we have made comment, thorough. We look forward to the final outcome.

Beryl Anderson
National President

Catherine Gurnsey
Convener, Health Standing Committee.