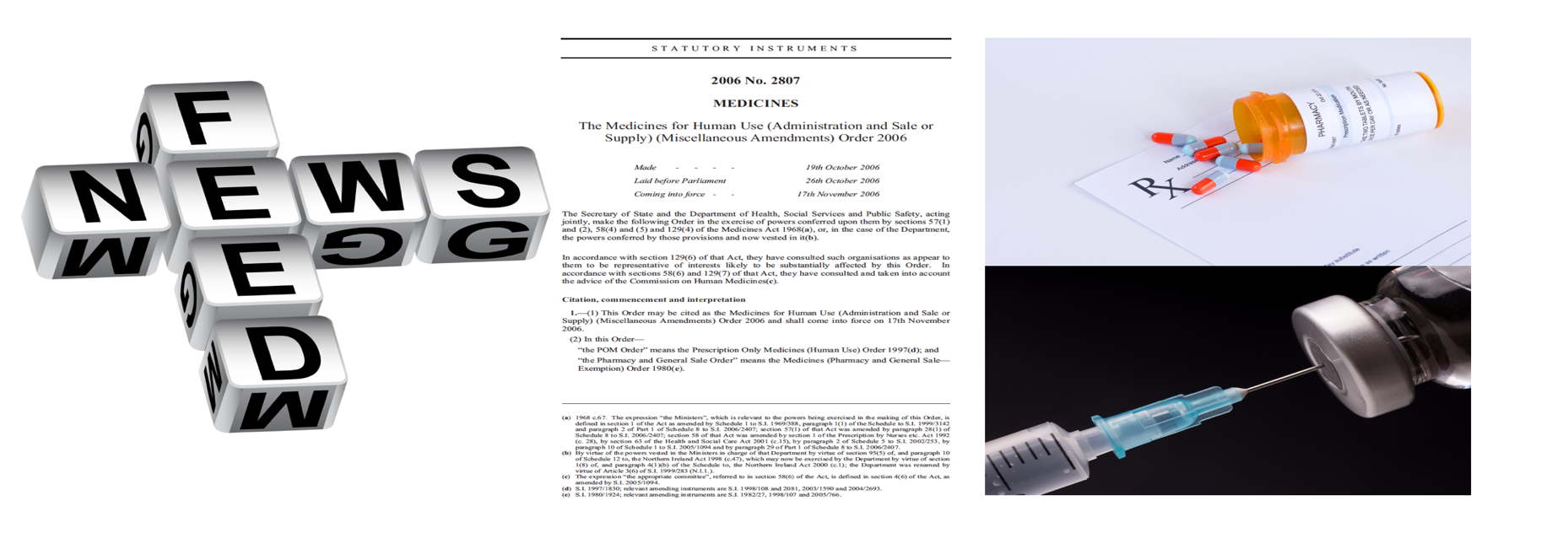
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**The Dawning of the PGD**

**** David R Tollafield

**A passion to learn about our past remains of interest to most podiatrists and so the theme associated with delving into those shadows from the past continues. Hopefully this will provide those interested in the subject of professional scope and development within podiatry with a different perspective on past events. While last month’s tale of local anaesthetic hit the right note, the story behind steroids and other key drug acquisition became a feature of podiatric practice as we crossed into the millennium. Inevitably this is a personal perspective but should not be considered an isolated effort. By 2006 I had been practising surgery for 20 years without the right to prescribe…something had to change, but the story starts around 1996.**

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**W**hile the acquisition of local anaesthetic was hard fought, podiatry found itself lagging behind access to key medicines. We seemed to be left with products called medicaments that had now become difficult to order with most disappearing. The old texts produced by PJ Read and John Le Rossignol would become historical pieces of interest but now had limited value and Neale and Merriman formed the mainstay references. By 1996 differences amongst ourselves focused on amalgamation of interests in foot surgery, management and education. Podiatrists sought alternative routes for access to drugs where prescription medicines

were required, or they relied on local pharmacy (P) medications to deal with pain. As scope expanded so did the gravity behind treatment, not least surgery and management of indolent tissue problems in the higher risk foot and limb, associated with peripheral vascular disease.

By 1994 I was involved in two Midland podiatry centres and found myself confronted by a supercilious pharmacist at one centre where I had recently set up a new podiatric surgery service. The pharmacist suggested he would allow nurses to issue two paracetamols if required, but, as a podiatrist I could forget it. A year later (1995) Gooch published a paper following her undergraduate work at Northampton (now Northampton University but formerly Nene College). Students were involved with the surgery unit and many undertook studies parallel with podiatric surgery. At the time efforts to attain necessary drugs for podiatry were being presented by many in the profession, but earlier efforts and studies are not as well known as the final elements that brought greater progress. Quinn (1995) corresponded making the profession aware of ‘standing orders’ that existed to acquire prescription drugs.

**‘my other centre unlocked the pharmacy cupboard’**

It became clear I could buy the drug over the counter (OTC) but I could not legally supply this for my patients. The idea of prescribing was out of the question and so the term ‘access to medicines’ was the only route to patient provision through what became known as Patient Group Protocols. In time these PGDs will be forgotten, but for expanding services, the need for baseline drugs was paramount for patient safeguarding and remained the only method pre- 2006. The PGD sewed the dawning of the evidence we needed to make access come alive.

In contrast, my other centre unlocked the pharmacy cupboard after a departmental debate at top level during 1996. Top level meant our Director of Medicine in the community looking at my list and saying,

*‘Well I have no problem here and some of these drugs I haven’t a clue about but they seem reasonable so go ahead.’* And he signed off the pre-requisite order. As a psychiatrist he was willing to entrust what he considered fairly basic drugs to a podiatrist.

After my own medical director supported the push for a PGD I needed support from other key areas. On account of the hostility from the orthopaedic department to our service I approached a general surgeon. Unfortunately, one of the general surgeons declined my support to provide a list I could draw from, although he was tacit in his support and understood my dilemma. Next I required the support of the Hospital Pharmacist Manager. All my hopes hung on a good meeting. After a period of time which seemed tense with anticipation, his only argument was which brand name of codeine provided an economical incentive to deliver 30mg strength! I looked at Taffy with his tight curly red hair and diminutive stature that held such power and said, *‘Erm well I could go with either,’* whilst trying to prevent my eyes from appearing as if I was suffering from thyrotoxicosis! We went with *Kapake* TM at the time.

Further discussion arose around another analgesic as a break away drug for pain management. The problem with any drug is the fact that it does not suit every patient, or work as effectively. This was the reason why wider access to Independent Prescribing would create an important magnet for change. Galloway, Milns and Milsom (1997) concluded *‘…Prescription only Medicines, may well have the potential to save on the present drug bill of the NHS*.’ A PGD, if well structured would at least fill the gap. Taffy did not like one so we ended up with a second. I now had antibiotics, anti-inflammatories, analgesics at a range of strengths but curiously was allowed another drug, which surprised me. This was no accident. I had spent a rotation at Fifth Avenue Hospital in 1991, part of which involved working with anaesthetists supporting some 60 attending podiatrists (Brammall, 1995). This introduction to anaesthesia was to change the direction of my life as a practising podiatric surgeon. Versed (U.S) was the drug of choice to help anxiety. In the UK this was known as Hypnovel TM but most know this as midazolam, a benzodiazepine which ended up on the [drugs register](https://www.chemistanddruggist.co.uk/content/change-status-midazolam-1-january-2008) in January 2008.

I began cannulating patients as access gave me these IV drugs where I was not using IM delivery. I wrote a letter for the Association’s Journal which caused some debate amongst colleagues. I think the general consensus was,

*“this man is totally mad; why do podiatrists need to cannulate patients; it’s only local anaesthetic we use!”*

Although Trevor Prior, the then editor for the main newsletter and journal of the Podiatry Association gave a balanced opinion over cannulation. We ran the first all podiatry Advanced Life Support course in Northampton and everyone passed to great celebrations. Another first. Wilkinson (1995) published a report for the course *‘the whole weekend proved to be both stimulating and entertaining and more difficult than many anticipated!’*

We were on the rung of another ladder as a body of people not an individual, and of course IV cannulation was very much part of this process. I will confess to one of my early attempts at cannulation during a visit by a colleague from London. It does not pay to show off! I cannulated the patient smoothly but could not fathom out, for a short period at any rate why my leg was warm*… a little blood goes a long way, especially if the cap is not secure*.

If the early eighties allowed licensing of local anaesthetic use, it took until 1998 to acquire access to local anaesthetics with adrenaline and codydramol for the profession. Requests for antibiotics amongst the three big names - analgesics-antibiotic-anti-inflammatories were rejected, but we had one analgesic of worth at a higher strength than the usual O.T.C at 8mg strength. Acquisition of anything more potent led us to lean on the patient’s GP. This had both its strengths and weakness. Deidre, a local GP who had been supportive, questioned who was responsible for the drugs once issued to the patient? This slight spanner was actually the catalyst that led to Taffy agreeing to a generous list of drugs which included IV midazolam. I went on to write a paper covering my use of midazolam over an 18-year period and the effect of the drug on blood pressure and pulse rate. Three journals rejected the multi-authored paper which represented an anaesthetist, a professor, reader at PhD level who carried out our statistics and one of my trainees. It was eventually published in a [Spanish journal](http://www.consultingfootpain.co.uk/downloads/articulo-5-2.pdf) in 2014. A healthy dose of suspicion lay in the direction that prevention of publication would help the antagonists to our cause.

I decided I needed to find a course to undertake IV sedation and Chris Ratcliffe, a dental surgeon who lived on the edge of Dartmoor threw himself into the project with eagerness. Some may recall his contribution to what was known as the Fellows Weekend at the time; this one was held in Oxford. Chris worked with the sedation group at the British Dental Association called [SAAD](https://www.saad.org.uk/index.php/courses-for-dentists) and so I found myself on a 2 ½ day course in London only to be asked to assist the lead lecturer (an anaesthetist) with cannulation. This time I remembered to put the cap back on. Armed with new knowledge, confidence and a certificate, our anaesthetic department was more than happy to let me use sedation and we increased the offer of sedation reducing the number of referrals to orthopaedics from 4% to 2% where general anaesthetic was the mainstay method.

**‘I remained diplomatically quiet but had to agree with orthopaedics’**

This reflected a big saving and patients appreciated the additional benefit.

It was only once I started to use sedation that I realised that there were disadvantages in providing unaided local anaesthetic. Unintentionally a small number of patients suffered agony where local anaesthetic degraded quickly with ‘burn off’, while others suffered [needle phobia](http://www.needlephobia.com/).

However, the lack of access to general anaesthetic was another criticism of podiatric surgery from orthopaedics. I remained diplomatically quiet but had to agree with orthopaedics as my experience with midazolam grew and my networking with anaesthetists rose and included building professional relationships. Efforts to persuade colleagues to use general anaesthetists was slow to take off and remains the case in stand alone day units today, but not through lack of desire. Realising a greater need for patient choice led to another big push to acquire support for general anaesthetic, therein lies another tale. One of the major problems was a change in legislation after the Poswillo Report which raised awareness of critical locations where sedation should or could be performed. The community was less ideal when viewed from the safety of a general hospital.

While sedation became a personal crusade, steroid application had more pressing needs. My senior trainee worked with me to produce the first paper on steroid usage for podiatry which she presented at a conference in our home region. The publication was printed in the Journal of British Podiatric Medicine, the forerunner to our associationship with JFAR, the joint Anglo-Australian Podiatry Journal after the journal ‘The Foot’ was dropped as the prima fasciae publication.

**A major turning point**

By 2006, some eight years later than the update on local anaesthetics and codydramol, and ten years after our steroid paper, success came in the form of a new statutory instrument No. 2807 entitled;

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**MEDICINE**

**The Medicines for Human Use (Administration and Sale or Supply) (Miscellaneous Amendments) Order 2006.**

**Made - - - - 19th October 2006**

**Laid before Parliament 26th October 2006**

**Coming into force - - 17th November 2006**

**Amendment of Schedule 5 to the POM order.**

The signatory for the Minister of State, Department of Health, was Andy Burnham

It was now in black and white, amongst Levobupivacaine and Ropivacaine, **‘methylprednisolone’.** One of the most important groups of medicines required to undertake MSK work. Of course there was more. Three antibiotics were added, one macrolide and two penicillins.

I could not find my original paper, which for me ‘is’ unusual as I keep a lot of junk in my library, but there was something about that old paper that haunted me. *What was it?* I had written about the longevity of the drug and its effectiveness. Having trawled many papers, mostly written into the millennium I realised our paper, although far from having optimum scientific rigour, was original, prospective and had a cohort of 66 patients. Perhaps a touch of conceit came over me but in reality I reminded myself of my own mantra.

“If you do not write something of merit down, it does not exist. If we fail to publish something of merit, no-one will ever know. A profession that fails in this regard will forever remain in obscurity.”

An e-mail to Clare Richards at The College of Podiatry bore fruit and she and Tina Davies kindly found the paper and made copies. While later Podiatry Now articles have been electronically archived some material is left in storage. It behoves us all not to lose valuable materials and of course access to this is important. Further enquiries revealed that as a result of changing website providers much of the old material that was accessible and had been uploaded is no longer accessible. For those of us with a passion for the past, or the past where impact was made, loss of material should be a concern. *If we forget the past, we are doomed to make the same mistakes!*

Today I urge all podiatrists to UPSKILL because progress is better where larger cohorts are involved. Steroid is not the remit of any one specialist group and provided that training includes the known drug boundaries around unsafe practice, problems are rare. Of course an excellent case history from Barber (2018) illustrates the very point about recording our experiences, but also sharing those events that would be otherwise embarrassing. The case was associated not with a podiatrist but a qualified medical doctor. The impression given was the GP did not recognise the gravitas of the breakdown. Not all problems arise due to negligence, but it is the management of problems for a patient that counts. The case reminds us that steroid is an excellent drug but does reduce the body’s immunity (Tollafield & Williams 1996).

It would not be unreasonable to ask what type of numbers the profession records. Methyl prednisolone (Depomedrone TM) outranks betamethasone, dexamethasone and triamcinolone. On 4th June for the period 1/5/10 to date we have 3796 (*or 3835 for data collected under trial runs before May 2010)*. This data was collected amongst 159,000 prescription medicines but only reflects those entered so we do not know how many remained unrecorded.

Methylprednisolone accounts for 2.4% of the drugs and ranks 11th. *Guess what comes top?*

Ibuprofen (20.9%) 1st paracetamol (18.3%) 2nd Flucloxacillin (7.5%) 4th

Data June 2018. Source PASCOM-10

PASCOM-10 data, amongst other surveys conducted by Alan Bothwick and Matt Fitzpatrick contributed to the evidence that finally allowed Independent Prescribing to take off. While Borthwick and Fitzpatrick must be credited with successfully bringing the final tier of the cake home, there were other colleagues who contributed over the years toward efforts to see the use of prescription only medicines for podiatry. In signing the amendment, Andy Burnham at least provided better legislation for protecting our patients.

There is some disappointment however that given changes in podiatry education, steroid therapy is not currently part of the main stream undergraduate course.

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I am indebted to Professor Alan Borthwick of Southampton University for providing additional information for this article.

*After local anaesthetic was legalised, the profession developed Part A and Part B courses to upskill those left outside of training. Today the gap between Independent Prescribing and Access to steroid injection can be achieved. Please see one of the courses below.*

Note that the Br. J. Pod. Med & Surg. was registered with the British lending library but there is no electronic capture of newsletters and journals from 1975-1987. It would be useful to consider identifying members who hold any old journals or newsletters, or early documents, so we could consider how best to preserve such material for future generations.

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If members have any other anecdotal stories covering their own efforts to use POMs please write to me through [Busypencilcase\_rcb@yahoo.com](mailto:Busypencilcase_rcb@yahoo.com).

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**Next article July 2018**

Reproduction of the original steroid paper*; the use of two injectable corticosteroid preparations* for Reflective Podiatric Practice.

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