CHIROPODY - THE WAY AHEAD

Report of a conference on 15 November 1978

King's Fund Centre

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"CHIROPODY - THE WAY AHEAD"

A report on a Colloquium arranged by the King's Fund Centre in association with the Society of Chiropodists held at the Royal Institute of British Architects, 66 Portland Place, London W1 on 15th November 1978.

CHAIRMAN: SIR ALAN MARRE KCB

The colloquium was arranged in three sections. The first included some of the less well-known aspects of chiropody which the Society of Chiropodists believes should be developed both because they are of benefit to patients and cost-effective in various ways. The second was directed at possible ways of improving efficiency in the existing service to the community. The final sections examined the relationship between the service requirements of the NHS and professional education.

OPENER

Mr. EricDeakins M.P. Parliamentary Under-Secretary of State (Health and Social Security), Department of Health and Social Security.

In his opening address Mr. Deakins referred to the national responsibility of the Department for the development of the chiropody service and the inadequacy of the present service to meet the needs of those who looked to it for help. In its consideration for future manpower planning policies the Department took into account the shortage of manpower with the requisite skills in various specialities. There was an insufficient number of state registered chiropodists altogether. Over 8,000 chiropodists were required to meet the needs of the elderly for chiropody. It was therefore necessary for many more state registered chiropodists to be trained, and the Department was supporting an expansion in the training programme. (The full text of Mr. Deakins address was published in the January 1979 issue of "The Chiropodist" and is attached as Appendix I).

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(1) Improving and Extending Chiropody Services.

Hospital Chiropody Dr T.D.R. Hockaday F.R.C.P. Consultant Physician, The Radcliffe Infirmary, Oxford, drew a distinction between patients with disease affecting the feet, who were the concern of the physician and chiropodist together, and patients with disease of the feet who were mainly the concern of the chiropody profession. Patients who suffered from severe infection in and deformities of the feet required the attention of chiropodists.

Patients with general disease, such as diabetes or peripheral vascular deficiencies, also required the intervention of the chiropodist in providing foot care as a part of total health care. The chiropodist was also able to offer preventive care, particularly in the manufacture and prescription of orthopaedic footwear and appliances, preventing further deterioration in the foot.

Because such specialised chiropody care could be concentrated in the hospital situation, it was essential that the present chiropody

services in hospitals should be maintained, in spite of the overall shortage of chiropodists and the demands of the community service. In the hospital a specialised, centralised service could be provided, with professional interraction with the services of other medical and paramedical services. To maintain a hospital chiropody service, good morale was required which depended upon a proper status and adequate reward for hospital chiropodists, which in turn depended upon an appropriate grading and career structure.

Dr Hockaday also spoke about the possibility of the chiropody services being developed in co-operation with other facets of health care e.g. in association with G.P. clinics for diabetes. He also looked to closer liaison with and co-operation between the hospital and community chiropodists because of the need for hospital patients to return to the community whenever possible. He also spoke about the development in chiropodial treatment and techniques which would arise from the availability of new materials, especially for footwear and appliances, and from the use of local analgesia by state registered chiropodists.

Miss G.J. French M.Ch.S. Senior Chiropodist, Greenwich District Hospital, felt that few people were aware of what the chiropodist could contribute as part of the hospital team. Because the emphasis in recent years had been on the provision of chiropody in the community for the "priority classes" the public image of chiropody was primarily as a service for the elderly. In hospitals, however, care was provided for patients of all ages in medical need on referral from a hospital consultant. It was the severity of their symptoms which brought patients to hospital and the hospital chiropodist was able to concentrate on the treatment of those symptoms as reflected in the condition of the feet as well as the regular surveillance of feet at risk because of underlying systemic disease. This relieved consultant staff from this responsibility. Hospital chiropodists were involved with out-patients as much as in-patients and a large part of their job was to try and keep those patients out of hospitals thus avoiding expensive hospital bed occupancy. They worked in co-operation with the various medical teams in providing essential treatments for a variety of patients. The types of cases seen included diabetics, rheumatoids, circulatory disorders, neurological diseases and other conditions which gave rise to potentially serious complications in the feet. The advantage of hospital based treatment for such cases was that the chiropodist, because of the concentration of severe cases in hospitals, was able to develop specialised skills and knowledge and in the event of any

sudden or serious complications could arrange for immediate referral to the appropriate medical team with no delay. Chiropodists were concerned not only to relieve pain and discomfort but also to maintain existing tissue as far as possible. This meant their aims were to control infection, to heal ulcers, to arrest gangrene and to prevent amputation of limbs. Their cost effectiveness in carrying out such work in the treatment of severe disease affecting the foot more than justified their appointment in the hospital service. At the same time certain "hospital" patients could be just as well treated in the community clinics if the interpretation of the "priority groups" were to be extended to include those in medical need. Two such patients had been referred to the chiropody department at Greenwich; one from the consultant psychiatrist after an attempted suicide in which his painful feet had been a contributory factor and the other a social misfit who had developed skin troubles as a result of living rough but who was totally unable to work because of the condition of his feet. These patients had been treated successfully and were both living and working in the community but had been kept on at the hospital for chiropody because they did not qualify for treatment in the community clinics under the present interpretation. There were numerous other examples which could have been given.

In speaking of the specialization which was possible in the hospital service it was also necessary to point out that many geriatric patients attended hospital clinics because they were acutely ill and that they frequently required specialised chiropody as part of their general treatment. Such patients represented a fair proportion even of those actually in geriatric "long-stay" units, but of course hospital chiropodists also undertook treatment of routine cases when patients were in hospital.

A re-definition of the priority classes for chiropody might enable some hospital patients to be seen in the community clinics and this might make life both easier for them and more interesting for the community based chiropodist. Nonetheless it was essential that the provision of the hospital-based specialist service should not be overlooked or neglected in any further expansion of chiropody in the NHS.

The Provision of Appliances Mr R.H.C. Robins F.R.C.S. Consultant Orthopaedic Surgeon, Royal Cornwall Hospital, Truro, referred to the decline in the quality of the service provided by the traditional surgical

last and shoe maker. Because of poor pay prospects, there was a lack of suitable apprentices. The cost of the materials used was also increasing rapidly. In dealing with the deformed, but painless foot, it was primarily a matter of engineering. The painful foot presented different problems requiring the attention of the chiropodist who was capable of producing appliances suitable for the treatment of many correctable deformities. Structural deformities might, or might not, require surgical intervention, depending largely upon the level of liaison which existed between the chiropodist and the surgeon.

Because the chiropodist understood the structure and functions of the foot he had a valuable part to play in rheumatological and orthopaedic clinics in the provision of appliances. These could often be provided instantly by the chiropodist, they were adaptable, and could if necessary be modified on a week to week basis as the condition of the foot changed. There were also distinct financial advantages to the health service. A pair of surgical boots or shoes manufactured by the traditional process now cost over £90. Modern materials and methods used by the chiropodist were much cheaper, yet obtained the same if not better relief of painful symptoms. The chiropodist could also act as a professional adviser in relation to the work of the traditional appliance maker.

Mr L.W. Matthews M.Ch.S. Chiropodist to the Cornwall Area Health Authority, referred to the range and scope of appliance work in the Schools of Chiropody and in professional practice, and illustrated a number of alternatives to the surgical boot, including appliances made for patients suffering from rheumatoid arthritis and ulcerations. There were also lower cost alternatives to the surgical boot, including "Footline" boots and shoes, desert boots such as those from Marks and Spencer and felt boots or shoes such as those made by Remploy, which could be specially made at the request of the chiropodist. It was also possible to adapt soft top leather boots or shoes for use with simple appliances.

On joining the Royal Cornwall Infirmary in 1962 Mr Matthews was asked if he could undertake the provision of special footwear and appliances, and had been able to set up a joint workshop/chiropody clinic there, which resulted in close co-operation between the consultants, the chiropodist and the workshop. Similar appliance laboratories had been or were being set up in Schools of Chiropody and by Area Health Authorities for their community patients but which also provided scope for integration with the hospital service. The basic requirements for appliance making were small, particularly in financial terms. What was also required was skill, knowledge

and experience. The chiropodist was not competing with the appliance maker, but was providing a complimentary service, ranging from the simple to the more elaborate appliance. Sometimes more sophisticated techniques were required as when extra durability was called for to enable the appliance to stand up to hard wear or adverse conditions such as excessive sweating. A moccasin type appliance might be made for an orthopaedically reconstructed foot which could give protection and check the formation of painful corns and callosities. All chiropodists were also concerned however, with the treatment of people who were not particularly liable to ulceration or disabled in any spectacular way. There was a silent majority whose foot troubles were due to all sorts of common causes who came to the chiropodist for the relief which he was able to give them to get on with their jobs. Provision of appliances by the chiropodist had grown naturally out of this need to give good service in relief of pain and disability in the foot without delay and without prohibitive cost.

Prevention and Foot Health Education Mr J.D. Idris-Evans M.Ch.S. Area Chiropodist, Buckinghamshire Area Health Authority, said that disorders and disfunctions of the feet could be attributed to many factors. Some of these might be beyond the individual's control such as injury, infection or physical handicap. However, there could be no doubt that one of the main causes of abnormalities of the forefoot in particular was within the individual's control and that cause was ill-fitting footwear - shoes and hosiery. In listing such abnormalities we might think immediately of bunions, over-riding toes, hammer toes, claw toes, etc., which could all lead to painful and incapacitating corns and callosities.

Those involved in the provision of chiropody services knew that painful feet lead to many older people becoming immobilised. They knew only too well, that the day the shoe was given up in favour of the slipper, was a "major indicator" in the life of the elderly with an immediate restriction in normal social and domestic activities and resultant loss of motivation. This, insidiously, resulted in more isolation with all its physical and mental problems. Greater demands were then made on more expensive health care and social service facilities with eventual costly residential or hospital care.

Over the last few years various documents had drawn attention to the importance of maintaining mobility in the elderly, of developing chiropody services, and emphasizing the importance of foot health

education; documents such as the Monro Report in 1972 and the Priorities for Health and Personal Social Services in England in 1976. Yet the NHS generally, the chiropody profession, and the Health Education Council had taken little notice of these warnings and the recent lean years of financial constraints in the NHS had done little to help.

Chiropody services were unable to cope with the demands placed upon them now, let alone able to cope with the rapidly increasing demands in the years to come. The situation was now critical. Many aspects needed immediate attention, for example, the number of chiropody students being trained and the number of Training Schools were both far too few. Health Authorities and the profession should act quickly together before the point of no return was reached. However there were certain courses of action which could be taken immediately. By promoting a positive caring attitude towards healthy feet many unnecessary deformities in middle age and later life could be prevented.

Foot Health Education should aim to involve the general public in three basic ways:- firstly, the parent in caring for the child's foot; secondly, the individual in caring for his or her own feet and thirdly, those people who may be involved in caring for other people's feet which would include health visitors, doctors, nurses and also the shop assistants responsible for foot fitting.

The professional approach to foot health education might be:- firstly prevention and the young. A child's foot was soft and malleable. Up to the age of eight years or so much of what people thought of as bone was more like gristle and could be easily distorted. Indeed, growth and development of the foot continued up to the age of sixteen or eighteen. Because the foot, up to this age, was malleable, it could often tolerate pressures from ill-fitting footwear and the child did not complain of pain. Good foot fitting was therefore of paramount importance, not only on the day the shoe was purchased but also as the foot grew. The importance of developing strong feet with straight toes could not be overstressed as these were more likely to withstand the stresses of adult life.

In the early years foot health education needed to be directed towards the parent but as the child grew older, he or she should become involved too. Occasional talks by chiropodists or others to parent groups or in schools were not enough. Foot health education should be an on-going subject involving not only the parents and the child

but also teachers, family doctors, school medical officers, health educators, health visitors and nurses. Education Authorities should be advised about suitable footwear and they, in turn, should give positive support and encouragement to parents and teachers alike to promote good foot health. Indeed, perhaps a return to school uniform shoes would do much to prevent deformities in the feet of the coming generation.

The second area was the role of manufacturers and retailers. To date, there had been comparatively little foot health education input or output from them. The responsibility on the manufacturer and retailer for foot health was considerable. Yet sadly it seemed that, apart from the few firms, their only interest was the ringing bell of the cash register. The health of the nation's feet was so dependent upon good footfitting, yet only a handful of manufacturers made multi-width fitting shoes for children let alone adults.

In a Government sponsored survey published in 1969 it was suggested that 2% of the working population had time off work because of foot trouble and he had already stressed earlier the importance of mobility in the elderly. The expense to the nation in provision of health care and social service facilities could be reduced by promoting good foot health.

Many organisations involved in health had suggested approved standards of manufacture, particularly for children's footwear but there had been little impact. This subject was such an important one and needed to be taken seriously at all levels, including by Her Majesty's Government. Indeed, he would go as far as suggesting - quite seriously - that any shoe not conforming to basic approved standards should carry a "GOVERNMENT HEALTH WARNING" in the same way as cigarette packets.

Shoe firms should be "encouraged" in inverted commas (as only the Government knows how) to take active measures to promote good foot health and so improve the nation's feet. It was recently suggested that part of the profit on shoes should go towards promoting foot health education. Equally, the retailer should be encouraged to provide trained staff. This was not as difficult as it sounded. Education Authorities and Health Authorities should be encouraged to promote training schemes locally. However, there would be little incentive for the retailer to do this until the public was educated to demand such a service in the shops.

The third and last area was foot health education and the elderly. Chiropody Services in the NHS were not able to meet the treatment demands placed upon them now, let alone cope with the requirements of the rapidly increasing elderly population. Obviously the development of foot care assistants within the NHS would go some way towards helping with simple foot care and hygiene but other avenues should be explored too, and one of these should be foot health education.

In that case, foot health education would not be aimed at prevention but would take on a slightly different role in that it should be directed towards teaching the elderly how best to live with the deformities and disfunctions of their feet that they have acquired over the years. In many of these cases there might not be a cure. There might be no operation to solve the problem. Part of the solution might be found in the provision of adequate footwear. Shoes with plenty of depth for clawed-up toes, shoes with plenty of width to accommodate bunions, etc., shoes that older people could put on and take off with ease. There could even be a case for an appropriate subsidy or grant for approved shoes that would accommodate distorted elderly feet. The provision of such footwear could improve mobility and relieve demands on other costly services. The elderly would need to be educated and advised to use such footwear but then there would be no point in explaining to an elderly arthritic patient that she needed to change her shoes unless she could be told what to get, where to get it and how much it would cost. All those involved in caring for the elderly would need to know much more about the subject.

The chiropody profession and Health Authorities had an ever increasing role to play in the field of foot health education. There would have to be even more co-operation between those involved in health care to promote the concept of healthy feet.

Mr J. Kendall Dip.H.Ed M.E.H.A. M.I.H.E. Area Education Officer, Buckinghamshire Area Health Authority, said that the Report of the Munro Committee on Children's Footwear, 1973, pointed out that well designed shoes, and shops with good fitting services were already available, and parents who cared about foot health and wanted their children to have shoes that fitted properly could buy them. The problem, the Report went on, was to educate all parents and children to want such footwear. The Government considered it best to proceed by influencing the development of consumer demand for well designed

footwear. Five years later, those observations and attitudes were still valid. Manufacturers eventually provided what the customers demanded but it was doubtful if customers, even to-day, did put much pressure on them in the way of design for foot health - fashion was probably far more important.

Most of us were either ignorant or indifferent about our feet - they were down there, hidden away in our boots and shoes - and as long as they were no trouble to us we did not bother a great deal about them. We cared far more for our eyes and teeth - they were more obvious and more immediately linked with our appearance. This indifference was confirmed by past surveys which had shown high proportions of children being wrongly shod - in the region of 75% and more - leading to high numbers of teenagers already having serious foot conditions. It was not only individuals who seemed to give foot health a low priority; it was not easy to find references to foot health in the many publications since PREVENTION became the 'in thing'.

These were significant pointers - feet were not particularly exciting, and did not command the attention they deserved - and this meant that those in the health field, whose concern was with feet, had an added responsibility. Far more than workers in other health spheres, they had to go out of their way to stimulate interest and enthuse others to generate far more foot health education.

OLD PEOPLE. This was a problem situation - foot troubles were already there in great numbers, and services were not keeping up with the demand. A team approach was needed to tackle such a massive endeavour. Chiropodists and Health Education Officers needed to get together to decide what information and guidance old people required in order to help themselves as far as possible. Together they should be able to devise a health education rationale, and supporting teaching material.

For the next step, the dissemination, a wider team would have to be recruited, such people as Health Visitors, Social Workers, Voluntary Organisations (such as Help The Aged) and Community Health Councils, in order to reach a wide range of people, not just the ones who attended Clubs.

CHILDREN. Here we were in a field of PREVENTION, and we should concentrate our energies on educating young children, children of primary school age. This was for several reasons. We could reach them in schools, where they were in a learning situation. Children of this age were already having a large say in what type of shoes THEY wanted. We wanted them to value their feet as part of a healthy, happy body,

as early in their lives as possible. If we could motivate the children, they in their turn would motivate their parents, a far more difficult group to make contact with. Such education should be part of an on-going programme taking the whole of healthy living into consideration, not isolated talks or campaigns.

This was where his second practical suggestions came in. For the past few years the Schools Council had been working on a project to provide a progressive rationale for health education, continuing right through a child's school career. The first two programmes for the age range 5 - 8 years (ALL ABOUT ME), and 9 - 13 years (THINK WELL) were already available, and this was splendid because these were the very ages for our concern, and foot health education was included.

He did not envisage chiropodists giving lessons in schools, unless they had a particular urge, but they should encourage and advise teachers in this respect. They should link up, once again, with their Health Education Officers, find out which schools were already using this material, or help introduce it to those that were not. They could be encouraging individual teachers, or holding in-service training sessions with groups of teachers, to make sure that the foot health parts of the projects were fully implemented. More and more schools were using this Schools Council material and this was a golden opportunity for chiropodists, and others, to achieve a great deal, with an economic use of their time.

Surely Community Health Councils had a role here too, by focussing attention on these projects in any of their activities, especially aiming at parents. The media, too, should be involved, the local press, radio, and T.V., and greater use made of poster displays in places where the public congregates.

Advanced Techniques in Chiropody Mr F.A. Schiess F.R.C.S. Consultant Orthopaedic Surgeon, Macclesfield Hospital, Macclesfield, referred to the more wide spread adoption of advanced techniques by chiropodists which were of benefit to their patients and also of benefit to orthopaedic surgeons, by relieving them of the minor surgical procedures involved. These included procedures on ingrowing toenails with the use of local analgesia, the complete or partial avulsion of nail plates, the cauterisation of verrucae and the removal of benign skin growths.

Waiting lists for minor operations in the NHS were up to a year in his Area and could be more. This delay could be avoided if the procedures he had listed were undertaken by chiropodists and there

would be a financial saving to the NHS. He had no doubt in his own mind as to the feasibility and safety of such techniques being undertaken by state registered chiropodists who had received appropriate training. Where more advanced operations were concerned, however, proper hospital operating conditions were required, with the use of antibiotics and stronger solutions of analgesic by registered medical practitioners, together with the ready availability of pathological services in case of malignancy.

Mr L.A. Smidt F.Ch.S. Principal, London Foot Hospital said that since the advent of the introduction of injected local analgesia by chiropodists and the perfection of techniques, the contribution which had been made by chiropody in the field of nail surgery was enormous. Many hundreds of patients had been successfully treated for nail pathologies, whether of an acute infected nature such as the true ingrowing toe nail, or of a chronic on-going type such as the painful involuted nail. The techniques used were either partial or total nail avulsions with sterilisation of the nail matrix (either partial or total).

These techniques, which varied quite a lot from individual to individual, were basically very simple. The nail removal procedure was carried out under local analgesia in a sterile primary field. The matrix was sterilised with either strong caustics, for example phenol, or by negative galvanic currents. All cases could be treated as out-patient procedures. Improvements to nail surgery had become possible because of the histological work carried out by Mr V.R. Rayner F.Ch.S. who described the pathology of nail hypertrophy.

VERRUCAE. Although the time honoured chiropodial methods of treatment were still the most widely used and their success rate was without question, in modern chiropody electro-coagulators were available. Although the use of such apparatus was fairly radical, the success rates were excellent and the only criterion of any importance when deciding whether to use this method or not, was patient selection. That meant that one would not choose to inflict an injection of local analgesic into the sole of the foot of a young child. Cryosurgical procedures were now also commonly used by chiropodists, particularly in the school health service. This method of treatment for verrucae pedis was both efficient, quick and relatively painless and was a good treatment of choice for the very young or the very nervous.

In the area of more conservative chiropody, the increasing use of therapeutic ultrasound was proving to be most valuable. In the work done by Mr M.F. Whiting F.Ch.S. there was fairly conclusive evidence to show when treating very painful enthesopathic junctional lesions in patients suffering from osteoarthritis of the heel the rate of relief produced was very encouraging. Currently, similar lesions of a less localised type were being treated with sub-aqua ultrasound and again the results were encouraging. For example, in the case of hallux rigidus it would be difficult to couple an ultrasound probe to such a prominence and there sub-aqua techniques were used.

SILICONES. For some years Mr Ian Coates M.Ch.S. and others, had been working on the chiropodial application of silicone rubbers and had now fairly well perfected the techniques of ortho-digital appliances.

Conservative physical methods of therapy had been the stock-in-trade of chiropodists for several generations. The redistribution of weight from one area to another using padding, strapping and appliances; the cushioning of painfull excrescences by spongy materials - all these were now taking on a new meaning because of the work being done with quantative measuring devices which were being used to assess load bearing areas on the foot. Such aids could also be used to evaluate our therapeutic physical methods of treating feet. The study of biomechanics in the feet was a veryimportant issue which could change the face of conservative, palliative chiropody in the future.

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(2) Chiropody in the Community

Mrs. A.M. Yorston M.Ch.S. District Chiropodist, West Berkshire Health District, spoke on a method of referral and assessment in a District Chiropody Service.

Mrs. Yorston said that her talk had been given the title of "A System of Referral" because there could be many successful systems within the National Health Service. Not all District needs were the same. A service developed according to the needs and resources within the District.

To understand how the system worked in West Berkshire, it would be necessary to know something of the District itself. The two-District Area was very long and narrow with the M4 Motorway passing East and West. The two Districts were very dissimilar in size, the West District occupying by far the greater part of the Area. West Berkshire was one of the largest Districts in the country, with about half its population contained in the four main towns, and the remainder spread very thinly through the rural areas. In addition to the approximately 400,000 people living in it, the District supplied Medical Services to another 48,000 people living in the overlap area of South Oxfordshire. The catchment area also extended to parts of North Hampshire. The population was increasing mainly due to London overspill development. In addition, of the 17 hospitals administered by the District, 5 lay in the overlap area or beyond.

Any extension of the service was bound to have revenue consequences in the shape of travelling time and expense. Although communications were easy East to West, there were considerable difficulties in travelling North to South with limited public transport, narrow country roads and toll bridges. A visit from Reading to outlying clinics could result in a slow round trip of up to 100 miles. There were three Sectors based on geographical divisions, and a fourth Sector for the Psychiatric Services. This latter had a catchment area much larger than that of the District and 50% of the in-patients were from outside the Berkshire Area. On appointment as District Chiropodist in 1975, the clinics which were inherited were unevenly distributed and communications were poor.

The problem of the waiting lists was one matter of concern. Not only were patients in some parts of the district without treatment altogether, but even where clinics were in existence, patients on the waiting list seemed to be waiting months or even years to be seen. Treatment had been given on a 'first come - first served' basis and there was no system of giving priority to those who would benefit most from treatment. Vacancies seemed only to arise where a patient died or left the District.

A second matter of concern was the statistics. The annual statistics collected by the D.H.S.S. deal with the total number of patients treated and not with the number of new patients seen. No distinction is made between a District where, say, all the patients might be cured and new patients seen each year, and another District where palliative treatment only might be given to the same patients year after year. In addition waiting lists mean nothing if patients stop being referred because it is known that no treatment will be available.

When any new system is contemplated there is a need to consult those involved. In addition to the staff and the Community Health Council, who could hardly have been expected to endorse a system whereby patients previously receiving treatment for years might be discharged, representatives from the Community Nursing Service, G.P.'s, Age Concern and others also had to be consulted.

Under the re-organised system patients could apply directly for treatment or were referred by relatives, medical advisors, social services departments and others concerned with their welfare. All referrals were recorded and acknowledged by letter. This made clear that only one appointment might be given, but that it would be given soon, and that future needs (if any) would be decided then. The appointment would be at a 'suitable' clinic, i.e. one that was best suited to the patient's requirements as indicated at the original referral. Not all clinics had identical facilities, and some staff had specialist skills.

Time was taken at the first appointment to give all the advice necessary for the prevention of future foot problems. The patient was then given either no further appointment, a long term appointment to see how they had been able to carry out the advice, or an early appointment to see what improvement a period of intensive treatment could achieve. The patient's doctor was notified and the date of the assessment recorded together with the name of the clinic and the chiropodist concerned. A comparison of the date of the original referral with the date of the assessment gave a good guide to the running of a particular clinic.

The assessment recorded the medical/social factors i.e. medical history to exclude those diseases affecting the feet, blood and nerve supply to the lower limb, previous X-rays, operations, injuries, medication, allergies, the problem bothering the patient, as compared with the actual problem on the foot (these may not be the same), weight, footwear, hygiene, and the most important of all: Who or What was required

to effect a cure (if possible), or at least to effect the maximum reduction of symptoms. This last item caused problems. Chiropodists were trained to be self-sufficient and it was sometimes difficult to persuade them to ask for equipment or help which they did not at present see available. Even the finest chiropody treatment would not help a patient whose problems were mainly due to carrying the weight of two people on a pair of feet meant for one. The Dietitians scales stop at twenty stones. Patients over this weight were weighed at the stores!

There were many ways in which different professions could combine their efforts. The stroke patient with speech problems could be encouraged to talk to the speech therapist about his foot problems. The combination of the remedial gymnast and the chiropodist could lead to general improvement in posture and muscle tone, giving rise to a more efficient use of the feet. The occupational therapist not only issued aids already developed but would help to devise aids for patients' particular problems.

Elderly and handicapped patients usually had one commodity in plenty, i.e. time. Many did not realise how much they could continue to look after their feet if they took their time. Relatives were more willing to help where such help was reduced to one simple action. Some problems were ridiculously simple; for instance one man had been sent a considerable distance by ambulance. His main problem was that because his shoes were too big he wore them on the wrong feet! Health visitors and community nurses found it easier to reinforce advice where it had been clearly given. The use of local workshops meant that simple shoe adaptations could be undertaken without delay. Most G.P.s seemed pleased to know not only that their patients were having necessary treatment, but also where further help was needed. Because they knew that any patient with an urgent problem could be seen within 24 hou . somewhere in the district, they were more appreciative of the problems where the patient was not helping himself.

Social factors included who took care of the patient when he was ill, whether he could use public transport (and if there was any) and whether he visited any of the District's Hospitals either as a patient or as a visitor. In either case he could have treatment there.

Treatment groups fall into three categories.

1. No treatment needed if the advice given were followed.
2. Treatment within the competence of a chiropodist and
   a) the patient was eligible for such treatment,
   b) the patient was not eligible for such treatment.

3. Other advice/treatment needed.
e.g. orthopaedic surgeon, physiotherapist, health visitor.

It was realised that not all doctors were aware of the scope of the modern trained chiropodist and a survey was undertaken of all foot problems in a large group practice. It was a mistake to believe that all patients who were not eligible for chiropody treatment under the National Health Service necessarily went to a private chiropodist. Some patients, particularly those with family comitments and a low wage, insisted upon their medical treatment being free. They might wait many weeks to see a consultant and then further weeks for treatment. Consultants might undertake work which was pure chiropody or which would not have been required if a chiropodist had seen the patient first. One gas-fitter had dropped a pile of gas pipes on his foot, injuring his nail. He had been off work on full pay for six weeks whilst waiting to see an orthopaedic surgeon. Following referral by the surgeon to the hospital chiropodist, he was back at work next day.

The system had tried to ensure the more equitable distribution of scarce resources. Patients were given priority according to medical need. It enabled an emergency service to be established throughout the District. Patients future requirements were known and each patient as shown what to do to help himself. It was more interesting for the chiropodist who could see his treatments achieve maximum benefit, and could refer to his colleagues special skills.

The assessment gave not only details of the problems brought to the chiropodist but also an insight into the chiropodist's attitude to his treatment. The curative aspects of our profession had been much neglected. The use of modern techniques meant a greater number of patients cured or at least made symptom-free on a long term basis. This meant that a greater number of new patients could be seen.

Mr J.A. Clarke M.Ch.S. Area Chiropodist, Leicestershire Area Health Authority, spoke on the use of part-time and contractual services on a long term basis. He saw the way ahead for the next ten years filled with obstacles to the point of stagnation unless some people had a change of mind or heart. There were about 5000 chiropodists on the State Register. Of these there were about 1800 whole time equivalents employed by the NHS. At least 1000 did no work for the NHS at all. And that number was growing daily. Either they chose not to, for the situation was very uncertain, or they were not allowed to for whatever reason. Many chiropodists did not want full-time work within the NHS and could not get part-time work because sessional and contractual work was expensive (or so it was said). That theory was doubtful. If the 1000 who did no work whatsoever for the NHS were given 10 patients each a week for a treatment cycle of 8 weeks i.e. 80 patients in all, that would take off 80,000 names from the working lists and give the very sick looking annual figures an increase of around ½ million extra treatments without any effort, without any capital outlay, without any extra drugs and dressings being bought and with only minimal administrative costs. Ah, but at what cost to the Health Service, in terms of cash outlay? The answer, assuming they were treated in a surgery, was £1,105,000. What a lot of money! It could be done by one of your full-time staff or two of your part-time staff, so much cheaper. Well, could it really? ½ million treatments was equivalent to an employment of 178.57, at least, whole time equivalents. That would cost the NHS £842,850, in salaries alone, and National Insurance stamps if the chiropodist were a Senior II. No allowance for leave had been included, nor any other overheads. If you added on the cost of dressings it brought the figure up to £967,850, only £147,150 short of the contractual figure. Then add on to the full timers' cost such little items as visiting cases £70 each, instruments, another £50+. Equipment for the clinic at £2000 per clinic, heat, light and telephones, clerical support, the Area Chiropodist's expenses, capital building costs etc., and the end figures did not bear comparison. BUT you have to find 178.57 whole time eqivalent chiropodists. Where on earth could you find that many chiropodists from? Of course, the Schools! But you do not. 250 may qualify each year, yet the number of state registered chiropodists only increased by 10 or so. A large number

obviously left the profession for retirements, babies, emigrated or found another career. So the newly qualified were not going to solve the problem. The point was that there are chiropodists already available. Of 5000 state registered chiropodists, only 1200 were in full-time employment and of these 150 were managers. There were therefore 3,800 chiropodists who could and were willing in many cases to help the NHS out. It was said in answer to a Parliamentary Question by Mrs Wise 24.10.78, services would only improve when "there are sufficient chiropodists available for NHS employment". There were numbers of chiropodists available to give immediate relief right now; if this administration allowed.

As to the availability of state registered chiropodists in full or part time National Health Service employment, which was mentioned in the same answer, the Department recently wrote to the Society of Chiropodists asking what could be done to encourage married women who no longer practice back into the profession to help the chronic shortage of community chiropodists. Whatever the official Society answer might be to the question, it was already busy trying to protect the contractual chiropodists from being thrown out of the service. It was trying to ensure that patients continue to receive treatment. The question that should have been asked was what was the Department doing to ensure that those chiropodists who were contractually employed were given some sort of protection and thus protect the <u>patient</u>. The patient was the one who suffered not the DHSS, the AHA or the Society of Chiropodists. Who cared whether state registered chiropodists were in full or part-time employment within the NHS. The Area Chiropodist's job was to co-ordinate services and provide chiropodists to treat patients. It was not to take action against the contractor because it was alleged that he was earning too much. If we looked at two Areas predominantly run by contractors, Leicester and Somerset, there were 150,000 treatments last year and 33,000 patients treated. Somerset had no waiting lists, and Leicestershire's had dropped from 2,500 to an almost negligible amount in 9 months. In contrast, another Area had patients being taken off the contractor and given to full time staff who had not even started. The advertisements were just out. Who was to say there would be any replies or any takers? Meanwhile there was a three year waiting list; three years, yet none in Somerset. Another District had stopped domiciliary visiting. All patients had to go to a clinic or mobile clinic by ambulance or special transport. Three men needed where one used to go. Send

two men out to push an old lady up the ambulance steps, transport her at a cost of 70p per mile or more, take her to a mobile clinic or health centre where we were employing a clerk/driver and a chiropodist. How much more did this cost than sending out a contractor at £3.69p plus mileage? It was not the fault of the ambulance department, but problems did arise in taking patients to clinics and if an emergency arose long delays might be expected in getting chiropody patients to a clinic. The sheer cost prohibited this method of transport.

Why would stagnation occur for about 10 years? We were phasing out the contractors in the hope of putting a full time chiropodist in his place. Full time staff of course were not renowned for staying in one place. He had had four posts in five years himself with 3 Authorities and knew of one chiropodist who had ten posts in nine years. If a member of staff left it could take months, even years, to replace him. In the health service there were a large number of older chiropodists and a large number of young chiropodists. It was estimated that 1000 chiropodists would retire in the next 10 years. Some of them were, of course, in private practice. Of the younger ones, many would have families and leave for a few years. The numbers leaving the schools as qualified chiropodists was not high. 250 per year was not going very far to replace those who left or those who were forced out by having their NHS contractual patients taken from them. In many cases the AHA could not supply a stable service based only on full-time staff and the old people drifted back and were forced to pay for private treatment. It was funny really that the Health Service would not use all the chiropodial manpower available to provide free treatment, and already forced old people to pay for chiropody treatment. Many, of course, went to unregistered chiropodists, or had one visit them at home because often they were cheaper.

There were three resources: men, money and machines. For machines, read chiropody surgeries. We had a plentiful supply of raw materials, but we had limited money. However, give him the men and the machines and he would finish the job by using the contractor more, and waiting lists would come down in size.

Supporting Services in the Role of Helpers Miss M.R. Witting F.Ch.S. Chairman of Council, the Society of Chiropodists, referred to the recent introduction of foot care assistants into the NHS Chiropody Service, which had unfortunately led to a number of

conflicting views within the profession. Many members were opposed to their introduction and to their undertaking foot care at all.

The Society accepted that the chiropody services were understaffed, and foot care assistants had only been introduced after extensive consultation with the profession. The view of the Society was that no objection could be raised to their employment provided that they worked under the supervision of State Registered Chiropodists in multi-chair clinics. They should not be employed on domiciliary visits. Their foot care tasks should be restricted to those that a normal fit adult could be expected to undertake for him or her-self.

Too often chiropody was regarded as a "social service" when toe-nail cutting only was required. The Society would not object to a toe-nail cutting service as such being provided by persons other than chiropodists if this would help to ease the pressure on the time of trained staff. However, how many patients in the priority classes required toe nail cutting only? How many multi-chair clinics were in operation? With the need for initial screening of patients by State Registered Chiropodists, it would seem from the point of view of making the best use of available resources that there would be little advantage to the NHS to be gained from the wider employment of foot care assistants.

Coupled with this was the very real risk of foot care assistants increasingly impinging on "fringe" chiropody without the background knowledge to recognise and be aware of the possible medical complications which might be involved, particularly in the case of high risk and priority groups of patients. There would be nothing to prevent foot care assistants, with very limited NHS experience of foot care, subsequently setting up in private practice as "chiropodists", which could lead to further dilution of the profession and place the public at increased risk of treatment by personnel without any professional qualifications.

The NHS patient was entitled to treatment by fully-trained and registered chiropodists especially since the feet of the elderly were frequently"at risk". Of far greater use in the NHS would be a helper who could relieve the State Registered Chiropodist of non-chiropodial duties such as helping patients with their footwear, arranging appointments and maintaining stocks of drugs and dressings.

The Society had an approved job description for such a "chiropodial attendant" who would act as a helper to the chiropodist and whose duties might be integrated with those of the foot care assistant. Such a person could provide immediate help to the chiropodist employed in the NHS without putting the patient at risk.

Mr. C. Freebairn M.Ch.S. Chairman of the Chiropodists Board of the Council for Professions Supplementary to Medicine, referred to the expansion in the scope of practice of chiropodists which had occured during the 30 years since the inception of the National Health Service. The profession of chiropody was now faced with the need for a proper structure to meet the demands on it for patient care in a re-organised National Health Service. Because of the overall shortage of existing chiropodial manpower in the NHS it was also essential to use the existing resources to maximum effect.

As chiropody in the NHS moved from a palliative to a curative service, the breadth of technological expertise of the modern fully-trained state registered chiropodist should be used for screening, appliance making and prescribing, and the more advanced techniques already referred to, whereas an enrolled grade could be introduced to undertake routine chiropodial care. The proposals of the Society to introduce such a grade by amending the Professions Supplementary to Medicine Act 1960 to close the profession were supported by the Chiropodists Board and, in principle, by the Council for Professions Supplementary to Medicine, by the Institute of Chiropodists and other chiropodial organisations. Subject to their having acquired the necessary experience and competence, all persons currently practising chiropody as their livelihood would be entitled to be enrolled and become eligible for NHS employment. By subsequent in-service training, continuous assessment and examination they could become eligible for state registration. Their employment in the National Health Service would provide a second-tier for the profession. A third-tier, the base of the pyramid, could be provided by the employment of chiropodial appliance technicians, Foot Care Assistants and chiropodial attendants, thus providing the supporting services needed to expand and improve the chiropodial manpower situation within the NHS.

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(3) Education and Manpower : Planning for the Future Service Requirements Mr. P.A. Shenton M.Ch.S. Senior Teacher, London Foot Hospital and School of Chiropody, referred to the future employment of chiropodial manpower as seen from the point of view of a training school. At present some 90% of students on qualifying chose NHS employment on either a whole- or part-time basis. Unfortunately they were often then faced with the lack of opportunity to use to the full their diagnostic and therapeutic skills due to the lack of facilities available and the chronic manpower shortage, which led to an emphasis on statistical returns based on repetitive and palliative treatments. There were few prospects for professional improvement, and disillusionment led to movement from one Authority to another, partly in the hope of promotion in the administrative structure because of a lack of adequate remuneration and job satisfaction in the clinical grades.

The newly qualified NHS chiropodist was faced with a series of competing demands. There was the ever increasing demand on the service by the increasing proportion of the elderly in the population leading to the demand for greater output often at the expense of those in real chiropodial need. On the other hand there were demands for abilities beyond the immediate competence of the newly qualified made worse from having to work single handed in isolated situations. There was the professional urge to become involved in minor surgical techniques, but a lack of appropriate facilities being made available in the NHS. In addition, there was the drain on chiropodial manpower made by the demands of chiropodial management of the services, and although a phased increase of students in training at the existing and new Schools of Chiropody was being pursued, this itself meant that there was a further need to attract trained chiropodists away from the clinical service to teaching.

Private practice was still an alternative for the newly qualified chiropodist. If the deterrent of finding the initial financial backing could be overcome, this could provide an attractive alternative, with its measure of self-determination and the ability to make a profit and take decisions. It was the self-employed private practitioner who was still responsible for providing chiropodial services for the great majority of the population and until recently, many private practitioners were able to serve the NHS by part-time work although it appeared that part-time and contractual work was being phased out. It was important to remember that a large number of the newly qualified were young women.

The Educational Response Mr P.J. Read F.Ch.S., Dip.F.E. Head of Chelsea School of Chiropody and Chairman of the Society of Chiropodists' Education and Examinations Committee, commenced by reiterating the philosophy of the education of chiropodists, which was that we are producing practitioners who were in primary contact with their patients. His second observation was that while the discussion had been mainly in the context of the National Health Service, in the schools they were concerned with the training of all varieties of practitioner and they catered for private practice in all its forms, industrial practice in all its manifestations as well as practitioners who would man the National Health Service. It should be remembered that the treatment of all but the priority classes was the responsibility of the private practitioner. Thus there was a vast amount of chiropody treatment which was not catered for by the NHS but which was left to the private sector.

The history of the development of chiropody education had been very firmly based on the premise that chiropodists needed to distinguish between lesions of local origin and foot troubles arising from systemic causes and, secondly, on co-operation with the medical profession. 1978 was the 40th anniversary of an important agreement with the medical profession to the effect that examiners in medical subjects, including medicine and surgery in the Final Examination, should be approved by the Royal Colleges of Surgeons of England and Physicians of London. Quite recently the Registrar of one of the Colleges had written to the Society saying they had been approving examinations for some time, and what were the Society's standards and how were they determined. He had been more than satisfied with the reply that the role of the external examiners in medicine and surgery was to ensure that students were ready to practice their profession given that they received their patients without referral from a medical service.

The practitioner they produced however, was not working in isolation all the time or in all circumstances. They had to produce a member of the medical team who was responsible for example for the care of the diabetic patient or the care of the rheumatoid

arthritic patient. They were concerned to train students to fulfill their role in team treatment. More than that, frequently in his role of primary contact, the chiropodist was referring patients to their family doctors for further investigation or treatment. Because they were a captive audience in a white coat, and because they had received an all-round medical training, chiropodists not infrequently pointed patients in the direction of the doctor's consulting room as a result of what they had heard the patient say during their treatment.

Chiropody had tended to become too much concerned with repetitive treatments, and the philosophy of the education of chiropodists lay stress on cure. "Cure" in some cases might be limited to a considerable reduction in the number of treatments required, but the philosophy of treatment was positive. It was a great pity that in the service administrative pressure meant that return periods were determined in many cases before treatment was even commenced and depended on availability rather than on need. It was also regrettable that patients tended to demand so many treatments per annum as a right, and perhaps one of the most difficult things to teach students was how far they should go in being firm with a patient and resisting their blandishments for particular forms of treatment without on the one hand upsetting the patient, or on the other exposing themselves to charges of negligence. Prevention naturally was better than cure, so that students had to be taught a counselling and health education role. This consisted essentially of two parts; how to counsel and what advice to give during counselling.

The education of chiropodists had tended to follow the pattern of medical schools rather than the pattern of nursing apprenticeship. The course linked the vocational and academic training with practical and professional skills and the course took place in schools established for the purpose of chiropody education. There was an important by-product of the courses held in Schools of Chiropody, in the form of a very substantial number of patient treatments per annum. Naturally this was a great advantage to those Areas in which the Schools of Chiropody were situated, but it was essentially a "by-product". In certain areas of paramedical training the work of students, or more correctly apprentices, was an essential factor in maintaining the service (even if when they were fully trained there were no jobs for them). Nevertheless this by-product of treatment needed to be put to the best use within the area within which it occurred. But even

in this case, care had to be exercised as to the nature of the work which had been undertaken. The difficulty lay in the nature of the priority classes. Experience had shown that student services were particularly welcome in the context of treating priority classes, especially the elderly. In trying to look outwards into the community links had been established between his own School and the community services in the area. Since that had been done, the proportion of priority class patients treated by students had risen from 50%, a level which had been maintained for more than a decade, during which patients had been accepted as it were at random, to 66% over the past few years. The Department of Health and Social Security was publically committed to the concept of a comprehensive service and in order to train students to fulfill that concept, a comprehensive patient service would have to be retained within the training schools.

Currently the intake into schools was extremely buoyant. This was a recent phenomenon and up until last year comparatively few potential students had been turned away. Even in this year's intake, there had been room for a number of mature students and students changing their careers. Only students with the very highest qualifications would gain places in the 1979 intake. However, since awards in England, Wales and Northern Ireland were discretionary and not mandatory, and students had to get into the queue for discretionary grants, it was not always possible to wait until A-level results were available before accepting a student. While the clamour for more chiropodists was loud, the the suggestion that chiropody students should receive mandatory awards had had a distinctly sotto voce reception. Hence the Schools had to exercise their judgement, and filling courses with an exact number of students was an art rather than a science, but one in which Heads of Schools were becoming ever more adept.

The three-year course is a very full one. Moreover, because of the better quality of intake that might be expected for the next few years, before experiencing the result of the decline from the birthrate fourteen or fifteen years ago, there was some levelling up required in the topping-up of the science subjects. Pressure of new material requiring to be taught in the course to cope with new techniques had to be answered by increased efficiency in teaching. Inevitably, in any course where there was a significant practical element, especially one involving the treatment of human beings, there was bound to be pressure. A student might well be

better able to cope with lectures and tutorials following a three-hour practical chemistry period, than he would following a three-hour clinical period.

However there was no rigidity in implementing the three-year course. Chiropody was changing, and with the increased availability of teacher training and the participation of chiropody teachers in that training, Open University and other University Courses, new ideas in patient methods and new concepts in teaching methods were the subject of enthusiastic experimentation.

In looking at any increase in the amount of chiropody places available in schools, and in looking to the opening up of new schools, the scarcest commodity was experienced teachers. Experienced teachers could not be produced overnight. Experience was required in teaching chiropdy: mere pedagogic training was not enough. Teachers had to have the material to teach and it was in the field of chiropody both academic and clinical that experience was required. An appreciable number of middle-range teachers had been lost to overseas schools in recent years, and the Society was concerned that all students should come into contact with a reasonable range of experienced staff. This meant that it was not possible to open up an indefinite number of new schools because these could not attract experienced staff. Clearly the established schools had a job to do in the immediate future in training new teachers, thereby possibly increasing their own output, but at the present time there was certainly no rush of suitable candidates wishing to come into full time teaching. Advertisements for full time teachers met with a very poor response.

Teachers of chiropody had to consider change and adaptability. They had to educate their students to make progress in their own profession both in the sense of personal development and in the evolution of new and improved techniques. A picture of a developing profession had been presented in earlier papers, and students had to be educated and given a sufficient background in order to make progress, rather than just to be trained in existing techniques.

In the final analysis, the most important factor in attracting people into the chiropody service, and maintaining them as happy and fruitful chiropodists, was motivation, and motivation was the result of job satisfaction. Schools of Chiropody looked to producing lively, skilful, well-motivated and happy chiropodists.

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Discussion The following is a summary of the points made during the discussion.

It might be preferable to refer to "handicapped" rather than to "physically handicapped" as one of the priority classes for treatment in the community service. There was an obvious need for the selection for treatment on grounds of "biological" as opposed to "chronological" age (Mr P.R. Threlfall M.Ch.S. Chiropodist, Wellington).

Vinyl shoes were not unsuitable for elderly feet, although they might require ventilation (response to an enquiry from Mrs M. Cooper, South Lincolnshire C.H.C.).

It was difficult to relate the costing of individual treatments to the costing of a full-time service which was "already there" (Mr D. Walker, Area Chiropodist, Doncaster A.H.A.).

There was no objection to a voluntary organisation undertaking a nail cutting service in the community, providing there was adequate supervision to ensure that the patients treated were not at risk (response by Miss Witting to an enquiry from Mrs M.E. Thomas, Bromley Red Cross).

It would not be desirable to encourage school leavers to seek work as a Foot Care Assistant before training as a chiropodist (response to enquiry of Miss C.M. Link, Crawley C.H.C.).

A recent survey on health education in Schools contained nothing on treatment of the feet (Mr J. Carter, Kettering, C.H.C.).

The letter by Mr Clarke published in the April 1978, issue of "The Chiropodist" had indicated that it was 4% more expensive to engage contractual chiropodists. Current costing indicated that sessional and contractual services were 25% more expensive. Payment of contractors' fees was a commercial system, based on piece work (Mr S.J. Hammett, Area Chiropodist, Oxfordshire A.H.A.).

It was necessary for comparative costs to be worked out very carefully. It could well vary considerably from one Authority to another. There was little argument between the Department and the Society over the role of Foot Care Assistants, and there was general agreement on the employment of chiropodial attendants (Mr E.H.W. Luxton, D.H.S.S.).

Discussions were taking place between the Department and the Footwear Industry as a result of the Munro Report, but no conclusions had been reached. The answer lay largely with educating the public to insist on the supply of better designed shoes (Mr A.G. Saville, D.H.S.S.).

Quite apart from the question of costing contractual work compared with full-time work it was also necessary to maintain the private practice sector to meet the demands of the working population for chiropody. It was also essential to use the private practitioner if a comprehensive service was to be provided (Mr P.R. Threlfall).

Were mobile units used in chiropody? (Dr M. Stewart, Assistant Physician, Geriatric Department, Edgware Hospital). There were definite advantages in their use. It meant that a fully-equipped surgery could be taken out to the patient, and it was possible to reduce the number of individual domiciliary visits. The patient would receive the full standards of treatment. The use of mobile clinics was more efficient than domiciliary treatments (Mr J.F. Webster, Area Chiropodist, Nottinghamshire A.H.A.).

The present position was scandalous. A large number of the elderly were receiving no chiropodial treatment at all and as a result they were suffering from physical deterioration in their condition. It was essential that there should be greater co-operation between the differing health care professions to ensure that such patients did receive treatment. The provision of an adequate chiropody service should be a matter of highest priority (Mr K.A. Gigg, Chairman, Hillingdon A.H.A.).

Exhibition An exhibition of modern chiropodial equipment was held in conjunction with the Colloquium. This was designed to represent mock-ups of three rooms. The first, a surgery for routine chiropody work. The second a surgery for advanced chiropodial techniques. The third, an appliance workroom. Among the firms who contributed to the display were:

FOOTMAN & CO LIMITED
HINDERS-LESLIES LIMITED
JOHN WEISS & SON LIMITED
GREATWEST ELECTRICAL GROUP LIMITED
HEATRAE - SADIA HEATING LIMITED
WANDSWORTH ELECTRICAL MANUFACTURING CO LIMITED
WHITFIELD WYLIE LIMITED

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APPENDIX 1

Opening Address by Mr Eric Deakins, MP, Parliamentary Under-Secretary of State (Health and Social Security)

Mr Chairman,

It is sometimes suggested that the word 'chiropodist' is a misnomer, since it derives from two Greek words meaning 'hand' and 'foot', but I would counter this by saying that we can equally well translate it in modern idiom as meaning 'someone who is handy with feet'. That is what chiropodists are and those with foot complaints know it and they are grateful that there are such people. Their only regret is that there are insufficient numbers of them and that the chiropody services of the National Health Service are inadequate to meet the need of those who look to them for help and treatment.

I am therefore gratified that the King's Fund Centre and the Society of Chiropodists have arranged this Colloquium so that this problem may be discussed, and I am most appreciative of their gesture in inviting me to open it. I am quite sure that what is said here today, especially if it is being recorded, will prove of great benefit not only to the participants in the Colloquium but also to the officials in my Department and of the Department of Education and Science who are involved in seeking a solution to the problems of the chiropody service.

I do not wish to anticipate what other speakers may wish to say, but nevertheless I think, Mr Chairman, that you will wish me to say what the policy of my Department for the chiropody services is and how we see the problems which beset us in seeking to meet our objectives.

The policy is quite clear. The Secretary of State for Social Services and the health authorities, which are his agents, have a duty in law to continue the promotion in England of a comprehensive health service designed to secure improvement in the physical and mental health of the people and in the prevention, diagnosis and treatment of illness. The care of people's feet is no less part of that obligation than the care of any other parts of their bodies. There are however limitations on what the overall health services can provide at any time. These are imposed in part by the sum total of the financial resources which Parliament by the appropriarion provides for expenditure on the health services and which are themselves determined by what the taxpayers can legitimately be called upon to pay. But lack of money is not the only limitation - and in real terms what has been spent annually in the NHS has increased during the tenure of office of the present Government. Shortage of manpower with requisite skills in various specialities contributes as much as does shortage of money to certain deficiences in the services the NHS can provide.

In determining priorities and commending these to health authorities my Department has to take into consideration not only what is desirable but also what is possible. In the Health and Personal Social Services priorities document published in 1976, Barbara Castle called for a 3% per annum expansion in the chiropody services, and in'The Way Forward', published in 1977, David Ennals suggested that the rate of expansion must exceed this if the chiropodial needs, particularly of the elderly, were to be met adequately. Available statistics are always out-of-date and at present we are working on 1976 figures, but I am satisfied that most health authorities

have sought to achieve the expansion in their community chiropody services which the priorities documents recommended. Any issue of 'The Chiropodist', with its advertisements for vacancies, is ample evidence of vigorous attempts being made to achieve recruitment of additional staff. It is unfortunately also evidence of the fact that vacancies are not easily filled and that staff shortages are the principal impediment to improved services.

There are of course a variety of reasons why vacancies are not filled. Not all chiropodists want to work for the NHS and for so long as the NHS Chiropody service is limited to the treatment of the priority groups of the elderly, the handicapped, expectant mothers and school children, it is not reasonable to expect that all of them should. At the same time, it cannot be said that the NHS chiropody services are deficient for no other reason than that most State Registered Chiropodists do not want to work for them.

Let us look at a few figures. They will have to be for 1976, but more recent figures would, I suspect, make the points even more strongly. In 1976 there were 2297 State Registered Chiropodists (1394 whole-time equivalents) working in the NHS community chiropody services as either whole-time employees of the NHS, part-time salaried employees of the NHS, or in undertaking sessions for the NHS on a fee per session basis. 892 of these were whole-time employees, but they count as 848 whole-time equivalent employees since those with managerial and supervisory and other duties did not spend all their time on giving treatment. In addition there were private chiropodists undertaking domiciliary treatments and treatments in their own surgeries for the NHS on a fee per treatment basis. We cannot determine the total numbers of these, but in whole-time equivalent terms there were around 500 of them. In addition there were 589 chiropodists (216.6 whole-time equivalents) employed in hospitals and 123 (43.7 whole-time equivalents) working in schools and school clinics. This gives us a total equivalent of 2154.3 chiropodists working in the NHS in 1976, but in terms of actual human beings we estimate that some 3000 State Registered Chiropodists were working, in whole or in part, for health authorities in 1976, and in addition those teaching in chiropody schools were also providing a service to the community. Since our count of the Chiropodists' Register for 1976 suggests that there were only 3772 State Registered Chiropodists resident in England in that year, it is abundantly clear that the NHS was beholden for their help to the great majority of State Registered Chiropodists. It need not then be said that the unfilled vacancies advertised by health authorities indicate a reluctance by chiropodists to serve in the public sector. What can be said is, quite simply, that there are not sufficient State Registered Chiropodists altogether.

This established, it is obviously incumbent on us, Government and clinicians alike, to try to calculate how many chiropodists the country needs. Certainly we cannot plan for their training, at a rate ultimately commensurate with our anticipated resources for their employment, unless we do. This requires us to examine some more figures. The total population of England in 1976 was 46,418,000. The total number of State Registered Chiropodists was, as I have said, 3772, which works out at one chiropodists for slightly less than 12,306 people. We must now ask how many people out of the total population require the services of a chiropodist if, as I am sure is right, our ultimate objective is to provide treatment for all the population on the

basis of clinical need, and next decide how many of these each chiropodist can be expected to look after in a year. The first question is almost impossible to answer, since demand never reveals itself completely until it can be fully met, so let us put this aside for the moment and try to answer the second question. 'The Chiropodist' of August of this year reported that representatives of the Association of Chief Chiropody Officers, the Health Services Chiropodists Association, the Hospital Chiropodist Group, the Institute of Chiropodists and the Society of Chiropodists had recommended, as a new broad guideline in assessing future workload norms, that one chiropodist could treat 16 patients a day or 80 a week or 480 a year on a 6-weekly cycle. If, on average, each chiropodist was to spend one day of the working week on other tasks than treatment, school work, health education, appliance making, administration, etc, then the 480 patients must be reduced to 384, at best say 400 a year. On this basis the total number of State Registered Chiropodists would have been able to treat only in around 30 of their potential patients from the population at large. Now to revert to the first question, how many of the 30 would be likely to need treatment? At least 50% of the elderly according to the same persons who worked out the norms. Shall we say 10% of the population at large?

Since obviously we have no hope of producing another 7500 or so additional State Registered Chiropodists in the very near future, let us now set our sights lower and examine the requirements of the elderly, the group which has the greatest need for chiropody and for which the NHS has a primary responsibility. In 1976 there were 6,649,000 persons in England aged 65 and over. If we take the lower estimate of need, half of these, 3,324,000, required chiropody treatment on a regular basis. Using the same norm of 400 patients per chiropodist, a fully adequate chiropody service to meet their needs would require 8310 chiropodists. The NHS, which has responsibility for this group, has only 2154.3 whole-time equivalent chiropodists. Without any allowance being made for the handicapped, expectant mothers, and school children, the NHS requires almost 4 times as many whole-time equivalent chiropodists as it has got to look after those aged 65 and over. The multiplication factor is even greater if we include women pensioners between the ages of 60 and 65. In 1986 it will be even higher, since the population of elderly will have increased then by 5% from what it was in 1976.

This would suggest that in both the public and the private sectors we need just about three times as many State Registered Chiropodists as we have, in terms of the 1976 figures, say 11,316. Is it surprising therefore that last year Government felt unable to introduce legislation as it was asked to do to close the profession of chiropody to future entry only by State Registered Chiropodists? The 2,000 or so non-State Registered Chiropodists in Great Britain (I do not know how many of them are in England) obviously meet a need for those who do not at present qualify for NHS chiropody treatment or cannot obtain it from a State Registered Chiropodist.

Enough of figures I think. We know what the problem is. We can come somewhere fairly close to quantifying it. What are we doing to solve it? The 4 schools of chiropody in England up to 1975, Chelsea, Salford, Birmingham and the NHS-managed London Foot Hospital, were barely able to produce sufficient graduates to keep up with the natural wastage in the profession from retirements and deaths. A new school was opened in Durham in 1975, another in Huddersfield this year, and once they have intakes for each year of their full courses, their outputs will of

course help to raise the total of new State Registered Chiropodists. I sincerely hope that the Chiropodists Board, when it meets in a few days time, will feel able to give the go-ahead for the joint local education authority/Devon Area Health Authority-financed school in Plymouth to open next year. I hope that ways will be found round the problems which so far have deterred further long term planning for the increase of trained student output. My Department, the Department of Education and Science, the Council for Professions Supplementary to Medicine, the Chiropodists Board and the chiropodists themselves inevitably look at these problems from different angles. All are seeking to get their various views in focus and to agree on what should be done next. Meanwhile I am optimistic that the expansion there has already been in the training programme and the expansion which promises will go a long way towards solving the problem of chiropodist numbers. I am equally optimistic that present discussions between the interested parties will be productive.

I am sorry that I cannot remain here for the rest of the day, but I am leaving behind officials who will, I am sure, be happy to contribute to your discussions should this, Mr Chairman, be your wish. You have my best wishes for an interesting and well-spent day.

Evidence

The Colloquium was designed as a follow-on from the Final Evidence of the Society of Chiropodists to the Royal Commission on the National Health Service in the light of the DHSS Consultation Document on Priorities in the Health and Social Services, "The Way Forward", (1977). The following documents are available on application to the Society of Chiropodists, 8 Wimpole Street, London W1M 8BX:

Chiropody in the Re-organised National Health Service.
A memorandum setting out the recommendations of the Society of Chiropodists

The Final Evidence submitted by the Society of Chiropodists to the Royal Commission on the National Health Service