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Diabetes specialist podiatrists: time for recognition

In the mid-1980s, the emergence of podiatric specialists in diabetes and, at the same time, the publication of papers such as Improved survival of the diabetic foot: the role of the specialised foot clinic (Edmonds et al, 1986) paved the way for the development of the hospital podiatrist in diabetes. Since then this role has developed significantly, the podiatrist now being an established, respected and pivotal member of the hospital diabetic foot care team.

Podiatry in the community

Within the community, however, the role of the podiatrist in diabetes is less well established. Although clinical sessions dedicated to the care of diabetic feet are common, the activities and resources available in community clinics can be highly variable and the level of skill and expertise very diverse, ranging from excellent to basic.

An increasing number of practitioners in the community are adopting the term 'diabetes specialist' and sometimes this has been self-appointed or adopted with little merit. In contrast, in the hospital setting it is now usual for practitioners to be interviewed for designated posts and selected on their qualifications and merit. We suggest that a system should be employed within the community where those who wish to specialise in the diabetic foot should have the opportunity to distinguish themselves by further qualification.

It is clear that many podiatrists are highly motivated and would welcome this suggestion, having already endeavoured to further their knowledge by attending a variety of courses and conferences, often self-funded. If we are to achieve an effective seamless, high quality diabetic foot service, it is essential that funding be made available for individuals to attend and graduate from recognised training programmes. Furthermore, those who have specialised in this area should be provided with the necessary resources to develop the service.

Patients with diabetes often present with multiple pathologies and symptoms that need to be understood and fully appreciated in order to offset potential foot problems. It is therefore imperative that practitioners in hospital and community services dealing with diabetic feet are competent to identify and manage such patients.

In view of this, it is our opinion that only those who are recognised to be competent should be able to treat the diabetic patient with an at-risk foot. It may be argued that the three years of undergraduate training leading to state registration adequately equips podiatrists to deal with patients with diabetes, but this may not always be the case as exposure at an undergraduate level can be very varied, with some having seen many patients with diabetes and others very few. Thus, although well educated in general foot assessment techniques, the lack of exposure of students to the more subtle complexities of the diabetic foot may lead to misinterpretation or lack of full appreciation of the potential significance of their clinical findings.

Honing graduate skills

At present, training relies principally on attendance at courses, study days or conferences. The main courses available for podiatrists are the diabetic foot modules run by the Hospital Chiropodist Group, or the diabetic foot modules run as part of MSc degrees in podiatry, accredited by the Society of Chiropodists and Podiatrists. Although excellent, these are always over-subscribed and are not mandatory for podiatrists wishing to work in this field. Study days are currently available for specific topic areas or may be dedicated to one facet of diabetic foot management.

Conferences on the diabetic foot are similarly designed, varying in length from one to four days. Although stimulating and informative, they do not always address the practical requirements necessary for a clinician to develop the specialist skills, expertise and research evidence base that are fundamental in the management of the at-risk diabetic foot. We feel that there is a need for practitioners to be able to learn these clinical skills in a structured and practical way and

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suggest that perhaps there should be two levels of training: one for those working in the community and another for those in a specialised hospital foot clinic. Each would comprise both theory and practical components. The training for the hospital specialist would comprise multiple modules similar to surgical podiatric training and a pupillage system to meet the practical component. The training of the community specialist could use the existing diabetic foot module run by the Hospital Chiropodist Group, made available nationally, with the addition of a practical component. The latter could be developed through a placement system with recognised centres.

Ensuring standards

How should we ensure that, in a given geographical area, practitioners dealing with diabetic feet are sufficiently skilled? Perhaps the community podiatric services should follow the example of the Diabetic Retinal Screening Services set up in many districts in the UK. In such services, optometrists wishing to be involved in these schemes are required to be trained to a given standard before they can be registered. Those registered are expected to participate in annual audit and annual clinical updates to remain on the district register. Such a scheme for podiatric services, together with nationally agreed standards, would ensure that only appropriately educated and developed staff would be involved in diabetic foot care; and would enable identification of appropriate state registered practitioners in both the public and private sectors.

Conclusions

The time is right, with the advent of clinical governance and continued professional development, to establish a structured and recognised postgraduate education and training programme nationally for all those who wish to be involved in the management of the at-risk diabetic foot. Such programmes would lead to an increase in the number of state registered diabetes specialist podiatrists able to deal with diabetic foot complications. This career pathway will help to acknowledge and reward those who have invested into specialising in this area, and most importantly will help ensure that nationally, high-quality care is focused on this at-risk group. ■

Edmonds ME, Blundell MP, Morris HE et al (1986) Improved survival of the diabetic foot: the role of the specialised foot clinic. *Quarterly Journal of Medicine* **60**: 763–71