The diabetic foot at the crossroads — vanguard or oblivion?

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For many readers of this journal the diabetic foot is a mystical organ, which continues to intrigue, amaze and enthral. Unfortunately, the attraction is not immediately apparent to *all* members of the healthcare community:

> ***'Diabetes is easy to diagnose and can be managed with negligent ease by those inclined to do so. It causes progressive and crippling disabilities affecting unromantic organs such as the foot and is prevalent among the old and the fat.'***
>
> ***Robert Tattersall and Edwin Gale***

Having an interest in the diabetic foot is considered by many to be on a par with train-spotting, anorak-wearing and an ability to memorise all the capital cities of the world. Moreover, admitting an interest in the diabetic foot is unlikely to generate invitations to dinner or make one the centre of attention at parties or other social gatherings.

Image problem

Enthusiasts of the diabetic foot ('footees') have a public relations problem. As relative newcomers to the world of the diabetic foot, we find it remarkable how often presentations and articles begin with statements such as, 'Diabetic foot ulcers are costly, in terms of morbidity, mortality and financially, to the NHS…', while there is an embarrassing lack of good-quality, prospective trial data taking this forward (Connor, 1999). Colleagues with less enthusiasm for the subject regularly express surprise that members of the footee community are still struggling with basic questions such as:

- How does one diagnose neuropathy?
- How often should feet be examined and which methods of assessment are preferable?
- What is the most beneficial system for preventing ulceration in the first place?

Research funding

At this journal's recent Edinburgh (March 2000) and London (June 2000) conferences, there was a great deal of discussion on the thorny issue of raising funds for research within our speciality. At present, the political currencies within the NHS are waiting lists and waiting times. Neither of these is usually relevant, as any footee worth his or her salt should already be ensuring that patients with active ulceration have rapid access to specialist services. There was consensus among conference delegates that successful grant applications are nearly impossible to achieve and when awarded are often targeted at high-profile units which are already productive — *plus ça change*…

Put simply, it is difficult to start from scratch as a virgin footee. While there is nothing intrinsically wrong with the great and the good being recognised financially, this can evoke feelings of nepotism and may demoralise troops on the ground who deliver patient care on an everyday basis.

Overall, this is an unhealthy situation. There are, however, three potential ways of helping to raise the profile of the diabetic foot and the footee community:

- Thinking laterally for fundraising
- Increasing collaborative efforts
- Modifying professional roles.

Lateral thinking

There is a need to think laterally when it comes to the question of resources. Basic principles are that this is a wealthy country and that pharmaceutical companies rarely (if ever) go bust; they just go on expanding. A foot ulcer in a person with diabetes is the result of a disordered metabolism and an unhealthy dose of fate. Fortunately, metabolism can be altered by a number of factors, including the use of pharmacological agents. Thus it may be possible to obtain resources from private industry to support local initiatives (including pilot projects) such as macrovascular disease risk factor reduction, and the use of novel hypoglycaemic agents in patients with, or at risk of, foot ulceration.

In addition, there is likely to be an expansion of prescribing by nurses (and,

'Is there any reason why podiatrists should not measure and treat hypertension, alter insulin doses and teach patients home blood glucose monitoring, and carbohydrate counting?'

potentially, podiatrists) requiring formal assessment and evaluation. This could be resourced in partnership with the private sector.

Shroud waving and warnings about the threat of litigation (since, it could be claimed that in theory, at least, all ulcers are preventable) are rarely persuasive and not recommended because of the risk of long-term fallout. Rightly or wrongly in today's world, the politics of health are directed by focus and single issue or pressure groups and, importantly, by the media. A good press matters. Thus, it would appear to be opportune to positively engage these groups and perhaps encourage a local high-profile 'champion' who can influence those who hold the purse strings. A note of caution though: the media can turn in any direction.

Collaboration not competition

The diabetic foot community needs to engage in co-ordination, co-operation and collaboration, with less competition between individuals and centres. It does not make sense to us to leave foot care to market forces. Rather than individual submissions, perhaps through agencies such as *The Diabetic Foot*, it would be possible to put together simple questions, which could be answered through a multicentred, multi-disciplinary approach. Such an approach may be difficult to engineer because of the foibles of human nature but grant-giving bodies are likely to be impressed by this approach. Suggestions for the composition of the governing 'central committee' are welcome!

The role of podiatrists

Most importantly, the role of podiatrists should be expanded. With proper training and support, they could develop into generic workers taking on roles previously considered to be the exclusive domain of diabetes specialist nurses or doctors. Is there any reason why podiatrists should not measure and treat hypertension, alter insulin doses and teach patients home blood glucose monitoring, and carbohydrate counting? If podiatrists develop this 'above-knee approach' the level of remuneration would have to change, but it may be possible to offset these costs against the reduction in rates of ulceration (and all its gruesome consequences).

Conclusion

The diabetic foot community needs to adapt and evolve, avoiding therapeutic and professional nihilism. Otherwise, it will remain a minority interest with only modest support from the diabetes community.

Lateral thinking and thinking the unthinkable — co-operation and collaboration between individuals, professions and communities — will produce benefit to patients. After all, aren't we all supposed to be in this for the same reason? ■

Connor H (1999) Diabetic foot disease — where is the evidence? *Diabetic Medicine* **16**: 799-800

Tattersall R and Gale E (1990) *Diabetes: Clinical Management.* Churchill Livingstone, Edinburgh

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