What the world needs now... is co-operation and research

Matthew Young

Hal David thought that love was the only thing in the world that there was just too little of. Unfortunately, when it comes to diabetic feet we are short of a few other things. The recent Fourth International Congress on the Diabetic Foot in Holland highlighted that there are still significant areas of practice where the management of diabetic foot disorders is largely opinion and not evidence based. The committee (which includes some of the senior opinion leaders in worldwide foot care) tried to decide on management of infection and research classification of ulcers, but could only come up with draft guidelines. A wider representation from up and coming practitioners, and more speakers from podiatry and nursing (like at *The Diabetic Foot Journal* conferences) might help.

Diabetic foot care and its needs

We need a universally accepted system for primary and secondary screening for at-risk patients. No healthcare system has unlimited resources or total equity of access. Implicit and explicit rationing is a fact of life, even in the US where equality of access to high technology care is denied to many. Accurate identification of at-risk patients can be achieved by simple means using established evidence based methods. However, they are not universally accepted or employed. Paul Scuffman's article on page 62 describes diabetic neuropathy. However, foot ulcer risk and neuropathy are not the same thing. A third of patients can be described as neuropathic, but at any one time only a fifth of these have ever had a foot ulcer. If we knew what the missing links were it might enable us to focus care.

Priorities

At-risk patients need priority access to preventive care and emergency care if problems arise. Podiatry is not recognised as a speciality in many countries. In the UK it has not been afforded the status it deserves. Like nursing, with notable exceptions, it appears that advancement in career terms can only come about through moves into management or teaching. NHS modernisation may help this. The role of non-doctor healthcare professionals needs to be advanced worldwide. These professionals can then set priorities for service delivery, and hopefully avoid much of the social podiatry provision and use their specialist skills on more at-risk care.

The management of ulcerated feet is a completely opinion and experience based process. The evidence is for multiprofessional integrated teams but these are a minority of the care models in the world. In Britain there are few examples of the multidiscipliary model in its truest sense. Perhaps this might explain the variations in amputation rates described by Ronan Canavan on page 82. We cannot even agree on what constitutes an appropriate level of amputation. For example, I feel that most mid-foot amputations do not work but my colleagues in the surgery departments still perform them. When should non-healing or severe deformity suggest that the foot be removed to enable a person to get on with their life? Simon Parvin's article on page 90 describes the positive amputation and I believe that not every amputation is a failure of care. However, it is still a brave person who says this out loud.

Infection and antibiotic therapy await a big trial to finally determine the most appropriate type, timing and duration of antibiotic therapy for diabetic foot ulceration and infection (if we can ever decide what infection actually is).

Brave new world

So, what the world needs now is more talking to each other, more co-operation and more research to bring all the care in the world up to the level of the best centres. Although that does not scan into lyrics as tidily as 'love sweet love' it might be easier to achieve! ■

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