No time to wait for diabetic foot care in the developing world

Sirs,

Two recent articles in *The Diabetic Foot Journal* – *Diabetic foot care training in the absence of podiatrists* (McInnes and Baird, 2009) and *Reflections on a visit to India: Diabetic foot care in the developing world* (Braid and Stuart, 2009) – highlight the dilemma in diabetic foot care in the developing world; the former suggests how it ought to be, the latter show us how it is.

In the Spring issue of *The Diabetic Foot Journal*, we presented the Diabetic Foot Care Education Programme (DFCEP; Tulley et al, 2008; 2009). The programme aims to train diabetic foot care assistants in the developing world and is a work in progress, with various areas of delivery yet to be confirmed. The fundamental idea is to bring the best of already established courses (e.g. Step by Step) together, under one banner.

McInnes and Baird (2009) reminded us in their subsequent editorial that the multidisciplinary team (MDT) model provides the best level of diabetic foot care (Morbach, 2006; Apelqvist, 2007). In the same issue, Braid and Stuart (2009) related their experience in an Indian hospital with "no dedicated space ... available for the treatment of foot problems ... [or] the co-ordination of care across related disciplines (i.e. the multidisciplinary foot care team)". While India does have a number of dedicated foot clinics – albeit no podiatrists – the number of clinics falls well short of that necessary to adequately serve India's 1 billion population. Similar examples of near, or complete, absence of diabetic foot care are common throughout the developing world.

We concur with McInnes and Baird (2009) that the MDT is the ideal care setting for the management of diabetic foot disease. However, our experiences in the developing world suggest that the provision of diabetic foot care that sits between the far-from-being-achieved MDT ideal and the current situation – where podiatry is an unknown discipline and amputation is the norm – needs to be made available.

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Money for care

"It would be an unhappy situation if true MDT diabetic foot care is only ever available in the wealthier nations of the world", say McInnes and Baird (2009). The DFCEP's Chair, Susan Tulley, has provided podiatric care in the Middle East for the past 18 years. Some 33% of people in the Middle East have diabetes (International Diabetes Federation, 2007), although there are few named diabetes clinics. MDT diabetic foot care is a long way from being achieved in the countries of the Middle East; Susan sees an average of 17 people with high-risk feet per day, and has worked for stretches with no dedicated clinic space, queuing for rooms between people attending for vaccinations, cancer drug administration and so on.

The nations of the Middle East are some of the wealthiest in the developing world; if a MDT system is not available there, what hope for Bangladesh or the Sudan? Added to this, wealthy countries do not necessarily invest in podiatrists or in podiatry education – as Glasgow Caledonian and Edinburgh Universities have discovered, their plans to introduce podiatry courses in the Middle East are, as far as we know, yet to be realised.

The profession of podiatry

The DFCEP will not be offered in countries where tertiary podiatry courses exist. While we wait for podiatry educators to sell their diabetic foot care courses to universities in countries currently lacking the profession of podiatry, healthcare professionals in the developing world struggle daily with ever more cases of diabetic foot disease.

Susan Tulley is often asked by physicians and nurses for information on how to treat diabetic foot problems, and she is in the process of establishing the DFCEP for medical and nursing staff in the United Arab Emirates, where two podiatrists serve a population of 1.75 million. She will primarily be introducing foot screening

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for people with diabetes and training healthcare professionals already involved in wound care in how to treat the diabetic foot at first presentation, and in dressing changes. This training will be key in the management of those with foot problems who may be located some 150 km away from the podiatrist's clinic.

Investment in locally trained podiatrists

McInnes and Baird (2009) raised the concern that developing countries may not invest in podiatry education programmes if the DFCEP's Advanced Course (see Tulley et al, 2008) reduces foot ulceration and amputation. Our view is that anyone, with any system, who can reduce diabetes-related amputation should be supported.

The ultimate introduction of degree-level podiatry in all countries is, of course, the ideal, and a move that we would fully support. There is understandable frustration among those in podiatry education in the UK who have not been able to get tertiary courses introduced in the developing world to train local people. However, we hold that the provision of diabetic foot care cannot be delayed to those who need it while we wait for podiatry courses to be approved and local people to become qualified.

A member of the DFCEP Working Group, Vilma Urbančič-Rovan, is a physician and Associate Professor of Medicine in Slovenia. Slovenia has no podiatrists and is a good example of a country where they are trying to formalise podiatry in her school of nursing, but in the meantime provide care for those with diabetic foot disease as best they can. Vilma has been attempting to establish a diabetic foot care assistant programme in her school of nursing and is going through the many stages before acceptance. Against this background, she runs a diabetic foot clinic and teaches diabetic foot care on an *ad hoc* basis. The situation in the Czech Republic is similar and, as this issue goes to press, Professor Alexandra Jirkowska will be introducing the country's first diabetic foot care course for nurses, based on the Advanced Course of the DFCEP curriculum.

General podiatry

McInnes and Baird (2009) pose the question: Why diabetic foot care rather than general podiatry? It is diabetes-related foot problems that primarily demand our attention in the developing world, far more so than in the UK. If we had undertaken to develop a course aimed at providing comprehensive foot care, we would expect McInnes and Baird to be even more alarmed at the prospect of Western-style university courses being undermined.

For the future

We are encouraged to hear that some countries without podiatry education have adopted the curriculum of the DFCEP Advanced Course as a model for planned university programmes. This might be seen as an interphase to the development of mature podiatry education in the future. It is expected that more countries will follow.

We would encourage all podiatrists to dedicate some time to teaching the DFCEP in the developing world each year. This would be of immediate benefit to communities who have no foot care, of long-term benefit to the people whom the podiatrists would instruct, and be a rewarding experience for the podiatrists themselves. A twinning system between a podiatry unit in the UK and a clinic in the developing world would be one way to achieve this.

Conclusion

The DFCEP Working Group know how enormous the task of trying to deliver this programme will be, but we feel compelled to try. In the meantime, those podiatrists who care for the diabetic foot in the developing world advertise the importants of the profession, as well as making a material improvement to the lives of those with diabetic foot disease. In the same way, we feel that the reputation of the profession of podiatry will be enhanced, not reduced, by the DFCEP.

Yours sincerely,

The Diabetic Foot Care Education Working Group

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