

**A Study to Compare the Attitudes of Chiropodists towards the
Provision of Routine Chiropody Care for the Elderly within the
National Health Service**

Author: Anne Walker

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Abstract

With their increasing scope of practice, the modern day chiropodist is capable of carrying out a broad range of procedures. While routine chiropody care remains a valuable service for the elderly population, there is a belief within the profession that this care does not utilise their full potential. This study was designed to investigate and compare attitudes among state-registered chiropodists towards the provision of routine chiropody care for the elderly within the NHS.

Questionnaires were sent to 110 chiropodists working within the NHS in the UK. The response rate was 56%.

The main conclusions were that routine chiropody care for the elderly continues to form the majority of the chiropodists workload. While most of the respondents agreed that chiropodists should be the major providers of this care, approximately half of the respondents felt that state-registered chiropodists were over-qualified to perform these routine tasks. There was a strong consensus among the respondents that there is a role for other healthcare personnel in the provision of routine chiropody care for the elderly within the NHS.

Suggestions have been made which may help the schools of podiatry and podiatry managers to prepare newly qualified state-registered chiropodists for the working practice within the NHS. Also strategies have been recommended which may ensure that, where there is a need, the elderly will continue to receive routine chiropody care.

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Introduction

Education is playing an ever-larger part in the day-to-day practice of chiropody (Berry, 1989). With their knowledge of such subjects as anatomy, physiology, medicine, pharmacology, and their expertise in diabetic management, biomechanical examinations and minor surgical procedures, to name a few, the modern-day chiropodist is capable of tackling a broad range of procedures which is far removed from the widely held view that chiropody is mainly simple nail cutting and the removal of corns and callus. The increased scope of practice and modern techniques has brought with it an increase in clinical responsibility and of academic competence. Research is being carried out more and more and once qualified there are openings for the chiropodist for further and higher educational qualifications.

Although patients can range from the very young to the very old, in the National Health Service (NHS) it is the elderly who comprise the majority of the chiropodists' client base (Redfern, 1986¹). According to Age Concern (1998) two thirds of chiropody patients are over the age of 65. The numbers of people living to an older age is increasing rapidly (Heath, Schofield, 1999¹) and the NHS chiropody service cannot continue to supply an adequate service for the demand within the community (Powrie, 1992). A new strategy to accommodate the increasing chiropody requirements of the older client groups may have to be developed (Powrie, 1992).

A Department of Health report (1994) stated that 'a significant proportion of those who are trained in chiropody enter the private sector'. Other studies (Borthwick, 1992, The Chiropodist, 1986) have shown that many NHS chiropodists are disillusioned by the working practice within the NHS and, as a result, many leave to set up in private practice. Newly qualified chiropodists have high expectations of their chosen career and some of them are not prepared for the routine chiropody which is the reality within the NHS (Marsh, 1987).

Previous studies have identified problems of recruitment and retention of NHS chiropody staff, and high rates of resignation within the first two or three years of

employment (The Chiropodist, 1986). In a study by the Society of Chiropodists of practitioners in the NHS (1986), many stated that they were unable to use their fully trained potential, and had little opportunity to use their skills. Many commented that NHS chiropody was, basically, treating the elderly, and so there was less chance to practice to their full capability.

The chiropody service has traditionally been one of the most widely provided community services for older people within the NHS but due to economic pressures being placed on the NHS chiropody service, chiropodists and their managers are having to review their client base (Borthwick, 1992). Reduced funding means that many health authorities are now implementing a 'needs based' chiropody service, with the aim of being more cost effective and, as a result, many elderly patients are now considered ineligible for the chiropody care which they have received in the past.

Although foot hygiene and basic chiropody care is usually the responsibility of the individual, there are many problems, such as poor eyesight or arthritic disease, which can impair an elderly person's ability to cope with such basic care. Usually these aspects of care fall within the scope of practice of the chiropodist, but some of this routine care could be carried out by other healthcare personnel such as footcare assistants, district or community nurses or nurses working in old people's homes. (Heath, Schofield, 1999²).

In view of the perceived professional dissatisfaction of chiropodists' working within the National Health Service, this study was designed to investigate the attitudes of NHS chiropodists towards the provision of routine chiropody care for the elderly within the NHS. This may be one area of discontent upon which chiropodists may have differing views. The particular areas of investigation include chiropodists' attitudes toward their role and the possible role of other healthcare personnel in the provision of routine chiropody care and, in view of the increasingly academic content of the podiatry course, their attitudes towards being 'over-qualified' to carry out this care. Further areas of investigation include determining whether the age of the chiropodist, length of time since state registration or place of training are factors influencing their attitudes. Additionally it was thought relevant to investigate if

chiropractors consider routine chiropody care to be cost effective or if they consider charges for such a service within the NHS to be appropriate.

If areas of discontent could be identified, perhaps the reasons for the chiropractors' dissatisfaction could be addressed by the schools of podiatry and chiropody managers, then chiropractors may find working in the NHS more gratifying.

Aims and Objectives

The specific aims of the study were

- To investigate whether there is a consensus among chiropodists that they should be the major providers of routine chiropody care for the elderly within the NHS.
- To investigate whether there is a consensus among chiropodists that there is a role for other healthcare workers in the provision of routine chiropody care for the elderly within the NHS.
- To investigate whether there is a consensus among chiropodists that they consider themselves 'over-qualified' to carry out routine chiropody care.

General aims of the research were

- To investigate whether routine chiropody care for the elderly forms the majority of the NHS chiropodists' workload.
- To determine whether chiropodists regard the provision of routine chiropody care for the elderly to be cost effective.
- To determine whether chiropodists consider that charging the elderly for routine chiropody care within the NHS is appropriate.

If any responses demonstrated that there was not a consensus among chiropodists, a further aim was to investigate if there was a consensus among those of similar age. Also, among those who had been qualified for a similar length of time and among those who had trained at the same school of podiatry.

Rationale

The rationale for this study is to investigate whether and to what extent there is a conflict within the chiropody profession with regard to the provision of routine chiropody care for the elderly within the NHS. Also, if a conflict exists within the profession to suggest reasons why this may be the case. It is also the intention to make suggestions which will assist schools of podiatry and chiropody managers to ensure that newly qualified state registered chiropodists are more prepared for the working practice within the National Health Service and to recommend strategies which will ensure that, where there is a need, the elderly will continue to receive routine chiropody care.

Definitions

Routine Chiropody Care

Routine chiropody care refers to minor procedures, such as toenail trimming and/or the treatment of superficial skin lesions, such as callus and corns. The treatments are carried out at regular intervals due to the failure of conservative management, such as a change of footwear or mechanical therapies, to bring about a cure. The procedures generally give the patient short-term comfort only. The following definition of routine chiropody care appeared on all the questionnaires:

‘Regular care of non-pathological nails and/or regular care of superficial skin lesions which have not responded to long-term conservative management.’

Elderly

Most texts refer to those who are of state pensionable age as elderly (i.e. women over the age of 60 and men over the age of 65). For the purpose of this study the author used the above-mentioned criteria.

Terminology

Podiatry or Chiropody?

The terms ‘podiatry’ and ‘podiatrist’ are increasingly being used within the profession and parts of the NHS in preference to the older and more familiar ‘chiropody’ and ‘chiropodist’. For the purpose of this study, the author has chosen, solely on the basis of simplicity, to use the terms ‘chiropody’ and ‘chiropodist’ (which refers only to those chiropodists who hold state registration).

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Literature Review

The Chiropodist within the National Health Service

Chiropody is a specialist, but wide ranging profession (Otter, 1996) and chiropodists see themselves as experts in the fields of foot health and foot care. However, they often feel frustrated by what they see as the ignorance and lack of understanding on the part of the public and other health professionals as to the chiropodists' role and scope of practice. Chiropodists continue to strive for recognition and public acceptance of their professional status. Unfortunately many members of the public are unaware of the development of chiropody/podiatry and fail to appreciate or understand its place within the health care system (Skipper, Hughes, 1983).

Education is playing an ever-larger part in the day-to-day practice of the profession (Berry, 1989a). The earliest formal chiropodial education in the UK was in the early part of the twentieth century and consisted of a six-month course of study. By the mid 1920s the course had become one year full-time and by the 1940s these courses had mostly become two years full-time. By 1945 the Society of Chiropodists had been formed and there was a common educational bond across the UK. The full-time, three year course was developed in the 1950s and by the late 1980s, degrees in chiropody were becoming an established part of the profession (Berry, 1989a).

The Society of Chiropodists and Podiatrists (whose members are all state registered or studying for a degree), state that the profession of chiropody offers a wide range of career opportunity in the NHS or private sector for those who complete the degree course. However, they also acknowledge that the profession has an image problem (Mahoney, 1999). A contributory factor to this image problem may be the fact that UK laws allow anyone to set themselves up as a chiropodist after a few weeks training. Although practitioners cannot use the term 'state registered', many style themselves 'qualified chiropodists' (Mahoney, 1999).

Regulations to control either the training of private chiropodists or the use of titles such as 'chiropodist' may be long overdue, but to extend the requirement of state

registration to private practice would only restrict the availability of chiropody treatment, as there are not enough state registered chiropodists (White, Mulley, 1989).

The status of the chiropody profession and lack of appreciation by the public and other health professionals are recurrent themes in research and chiropodial journals (Marsh, 1987, Kemp, Winkler, 1983).

Research by Gallup (Berry, 1992) concluded that while 93% of GPs were aware that only state registered chiropodists are allowed to practise in the NHS chiropody service, only 24% were aware of the extent of chiropodial education for the registered sector. In 1983 Winkler and Paley carried out a survey of family practitioners, the results of which were very discouraging for the chiropody profession. Compared with other health care professionals, chiropodists were accorded the lowest status and the providers of a 'not terribly essential' service. A later study, which investigated GPs' perspectives on the NHS chiropody service, was carried out by Otter (1996). While GPs agreed that chiropodists should be the major providers of footcare, they indicated a role for other health care professionals in the fields of diabetic footcare, ulcer management, biomechanical evaluations and orthotic prescription.

Marsh (1987) found that many chiropody students appear to agree with the generally held view that the status of the chiropody profession is too low, and appreciate this position even prior to their qualification and commencement of employment. When asked to rank professionals according to their status, the students ranked chiropodists below general practitioners, dentists, physiotherapists, district nurses, hospital nurses and radiographers but higher than health visitors and occupational therapists.

It would appear that many students are entering the chiropody profession fully aware of their perceived relatively low status. However in the same study of 186 third year students from 10 schools of chiropody in the UK (Marsh, 1987), the majority of students (63%) said that chiropody had not been their first choice of profession. The most popular choice of profession had been medicine, followed by physiotherapy, dentistry, pharmacy, nursing and teaching.

This indicates that many chiropody students may be embarking upon a career which to them is 'second best', and as such this may be considered a prime reason for discontentment within the profession.

There are 14 schools of podiatry in the UK (Jan 2000). The podiatry course offers clinical practice in subjects such as podiatric orthopaedics, the 'at-risk' foot, podopaediatrics, sports injuries, and general clinic, as well as biomechanical work including the manufacture of orthoses. The course content also includes soft tissue and bone surgery theory. The 186 third year students in Marsh's 1987 study completed a questionnaire designed to investigate aspects of their training and their attitudes and expectations for the future, with particular reference to the NHS chiropody service. The students were asked what aspects of work they would find most attractive if they were looking for a full-time post in the NHS. In order of popularity, the opportunity to perform surgical procedures was by far the most attractive (81%), followed by biomechanical and orthotic work (54%) and opportunity for promotion (51%). Working with the elderly (17%) and domicilliary work (11%) were the least attractive areas.

It could be argued that the content of the podiatry courses throughout the UK is partly responsible for giving students high expectations of their chosen career and that students are not prepared for the routine chiropody, which is the reality within the NHS. It is possible that the value of routine chiropody care is inadequately emphasised within the curriculum. Currently, the theory behind invasive surgical techniques is taught in the schools of chiropody, however this knowledge may not be a major requirement demanded by health service managers (Powrie, 1992). At present the state-registered chiropodist is not qualified to perform such procedures and further study is required if the chiropodist wants to specialise in this area.

A study was carried out by Borthwick (1992) to investigate the attitudes of chiropody managers towards newly qualified chiropodists. The question was asked whether managers felt that newly qualified chiropodists were suitable for NHS practice in respect of attitude, knowledge or skills and the responses were revealing. 45% of managers agreed that chiropodists were inadequate in terms of knowledge. 33% agreed that they were inadequate in the instance of skills and 51% stated that

chiropractors were inadequate in terms of attitude. Comments such as “dreadful attitude to elderly”, “lack empathy with the elderly” and “have a know-it-all attitude” were explanatory reasons for their responses. Further reasons were that newly qualified chiropractors had “excessively high expectations” and were “unprepared for the repetitive/tedious work of the NHS”.

It may be that newly qualified chiropractors, like any other graduates, have much drive and ambition and are eager to utilise their many skills, but become disillusioned very quickly due to the routine nature of chiropractic care within the NHS.

Chiropody Provision for the Elderly Within the National Health Service

Since the turn of the twentieth century, census data has shown that the general population is ageing. In developed countries there has been a dramatic rise in the number of people aged 60 and over. Although population numbers, as a whole, are declining, in developing countries the number of people living to an older age is increasing rapidly. Consequently, the largest sector of society seeking health care are the elderly and they also comprise the majority of the chiropodists' client base (Redfern, 1986²).

It is difficult to define old age; most texts refer to those of state pensionable age as elderly (i.e. women over the age of 60 and men over the age of 65). The ageing process is slow and variable in its effects upon each individual and while most people aged 65 and over are quite independent and able to perform tasks of daily living, some have varying degrees of difficulty (Farquhar *et al*, 1993). The conditions most likely to limit functional ability among older people are heart problems, arthritis and related conditions affecting the back and joints, and sight defects. The General Household Survey (1987) stated that 63% of males and 67% of females aged 65 and over living at home, reported a long-standing illness, disability or infirmity, and these proportions increase with age (Farquhar, *et al*, 1993). The risk of diabetes increases with age, and older people represent almost half of the diabetic population (Heath, Schofield, 1999³). In people over the age of 65, the prevalence may be as high as 15%, about 90% of older diabetics have non-insulin dependent diabetes mellitus (NIDDM) and many older people will have had diabetes for up to 10 years before diagnosis. Complication such as blindness, foot ulceration or gangrene of the lower limb are not uncommon (Heath, Schofield, 1999⁴).

Although foot hygiene and routine nail care are usually the responsibility of each individual, there are many problems which can impair a person's ability to cope with such basic care, however, these problems are usually more prevalent in the elderly person. The most common problems are poor eyesight and arthritic disease which affects the ability of patients to reach their feet or affects grip strength and dexterity of

their hands. Neurological conditions and muscular weakness, hypertension, cardiac and pulmonary disorders may also prevent older people from bending down to reach their feet. Other significant factors are hand tremors and obesity (Heath, Schofield, 1999⁵).

Toenail trimming, although a minor aspect of care, is important for the elderly persons' mobility (Love, 1995). Difficulty in cutting toenails is one of the most common foot problems reported by older people (Cartwright, Henderson, 1986). If toenails are not cut on a regular basis, a range of problems may result. Long toenails may pierce the skin, causing a portal of entry which may result in infection and ulceration. Subungual ulceration may result from pressure caused by footwear on to long or thickened nails (Tollafield, Merriman, 1997).

As well as the inability to manage toenail cutting, other common foot problems which older people are more prone to are corns and calluses. They occur as a result of a combination of excessive friction, shear and pressure on the skin and are a normal reaction to these stresses. Older people are more susceptible to corns and calluses due to the loss of elasticity of the skin and the thinning of the fibrous fatty padding. Continued pressure causes pain and may interfere with the older person's ability to walk comfortably and wear shoes. Patients may adopt a different gait to avoid the painful area. These changes in gait may precipitate complications such as knee or lower back pain. So, although corns and calluses are relatively minor conditions, the effects they have may be quite extensive. Because corns and callus occur as a normal reaction to excessive stresses, removal of the hard skin is not always indicated and treatment is usually directed toward removing the mechanical stress (Scranton, 1982). However, they can become painful and other treatments such as filing or debriding with a scalpel blade may be performed. These procedures usually need to be carried out at regular intervals as they generally give the patient short-term comfort only. Without proper care and treatment, abnormalities may occur leading to discomfort and pain which then becomes disabling and mobility becomes affected (Heath, Schofield, 1999⁶).

Mobility is of prime importance to the elderly and remains a significant means of personal contact and independence. Mobility can be severely restricted by relatively

simple foot problems (Cartwright and Henderson, 1986). Limitations of mobility affect all aspects of daily living and may result in the elderly person becoming sedentary which leads to joint and muscle stiffness and inability to shop, undernutrition and reduced social contact.

A longitudinal study of 250 elderly people was carried out by Farquhar *et al* (1993) which explored the health, functional ability, service use and needs among very elderly people. The study was aimed at assessing the health and needs of those people aged 85 and over and how their health and needs changed over a two and a half year period between 1987 and 1990. The most commonly reported physical health problems were those with eyesight and feet.

Tasks of daily living were assessed and categorised according to type. Mobility tasks such as walking about indoors and walking outdoors, personal care tasks such as washing and dressing, and domestic tasks such as cooking and laundry were assessed over the two and a half year period. Deterioration in functional ability was most severe for tasks involving mobility. A high proportion of the elderly people reported difficulty with tasks of daily living and stated that they required more help with such tasks.

The study concluded that more frequent interventions from health services such as chiropody and occupational therapy might help prevent some of the negative consequences of disability, such as the untimely deterioration of ability, as well as improving the emotional well-being of the elderly person.

National surveys have confirmed that one of the greatest unmet needs of elderly people is chiropody. According to Age Concern (1998), two thirds of chiropody patients are over 65 with more than 10 per cent over 85 and the most frequent complaints of the elderly are the loss of nailcutting services, extended treatment intervals for chiropody care and loss of those services due to changed eligibility criteria. Cartwright and Henderson (1986) found that 86% of a randomly selected group of elderly people reported some form of foot problem and the General Household Survey of 1985 reported that people over the age of 75 are frequently unable to manage toenail cutting (Heath, Schofield, 1999⁷).

According to Age Concern (1999), there is evidence that the NHS discriminates against older people at all levels of the health service: from the refusal of kidney dialysis or transplants, to delays in hip replacements and the withdrawal of chiropody services. Failure to provide adequate services means that less is being achieved for many elderly people than is possible. For example, the poor mobility, fear of falling and resulting social isolation, which is experienced by many older people, could often be improved simply by better foot care and chiropody services (Henwood, 1990).

Many older people who can ill afford private care are having to choose between finding the funds to pay for chiropody care or suffering pain and discomfort. Age Concern state that the withdrawal or rationing of the chiropody service may be harmful to older people's health and may lead to some elderly people becoming housebound and will cost the NHS more in the long term.

Providing and paying for long-term care for Britain's ageing population is an immediate issue (Richards, 1998). Resources are a key reason but the overall decision of how much of the taxpayers money goes into our health service is a political one (Greengross, 1997). The need to ration health resources may be a fact of life for the National Health Service (Henwood, 1990), however many clinical decisions involve short-term savings that cost the NHS more in the long-term (Greengross, 1997).

Financial stringency in the NHS today is such that all health professionals must constantly consider the economic aspects of the services they provide (Merriman, Tollafield, 1997). Economists must make rational choices between different ways of spending resources. They must compare activities in terms of two different variables: the costs and the benefits (Whitaker, 1991). In the field of health care, the cost of treatment can be expressed relatively successfully in monetary terms, but the benefits of changes in health are more difficult to quantify.

Routine chiropody care for the elderly may be considered by some to be a minor issue, but according to Bryan *et al* (1991), it is also a potential cost-effective use of NHS resources. However, there is no reliable data at present regarding the efficacy of

chiropractic interventions for low risk conditions. Age Concern (1998) has called for more research on the effectiveness in maintaining older people's health, mobility and independence, as well as the effects of service withdrawal and on the resulting costs to the NHS.

Resources are the primary issue in the health care of the elderly and because of reduced funding, NHS chiropody may only be available to people who have a medical condition which puts the foot 'at risk' and who need the specialist clinical skills of an experienced state registered chiropodist.

Some health authorities have introduced an assessment scheme with a view to discharging 'low risk' patients. An example of this is the 'Risk Assessment Model' which has been introduced by Cambridge (1998), Northampton (1999) and Huntingdon (1999) health authorities. All patients in those authorities have been re-assessed by chiropodists and only those patients judged to be in the 'high-risk' category (conditions threatening to life or limb) receive long-term treatment and monitoring. 'Low risk' patients (perceived to be able to self-care) are discharged and 'medium risk' patients (significant pain/loss of mobility responding to short-term care and discharge) receive short and intensive treatment plans. New cases are accepted on referral only from a GP or hospital consultant (Graham, 1999).

Unfortunately the risk assessment model, which is based on vascular and neurological tests, does not take into account the fact that the elderly are a group whose medical status can change very quickly over a very short period of time. Furthermore, the patients' physical ability, social and economic status are not considered within this model. Many of the discharged patients had chronic foot conditions which needed regular care, but were otherwise healthy (Graham, 1999).

The introduction of the risk assessment model has not been smooth. In a 'yet to be published' study by Lifespan NHS Trust (1998-99), it is reported that the scheme generated some 3000 complaints to the health authority. Furthermore, 10% of patients returned to NHS chiropody care within six months of discharge, 6% of patients changed to the high risk category within six months and 12% of patients changed to the medium risk category within six months. One patient sustained a

serious hip dislocation whilst attempting to bend to care for her own feet and required a long hospital stay and rehabilitation. The cost (in monetary terms) to former patients is unknown, but it is reported that private practice fees are now higher than previously (Graham, 1999).

Although routine chiropody care may not be available from most NHS chiropodists, some health authorities have recognised that there are some people who have difficulty in looking after their feet themselves. Dorset Health Authority (1999), for example, is offering training in basic footcare, such as toenail cutting, to voluntary organisations. Volunteers are also given advice to enable them to recognise any signs or symptoms which might mean that more specialist care is needed. The voluntary organisations may then charge a small fee for this service. Other health authorities, such as Huntingdon, have introduced a payment scheme for routine footcare for those patients who no longer qualify for (free) treatment after being assessed.

In a study by Otter (1996), opinions were mixed when respondents were asked whether patients should be made to pay for NHS chiropody treatment. Although the study related to chiropody services in general, rather than solely routine chiropody care for the elderly, 60% of chiropodists were of the opinion that charges may be appropriate for certain groups of patients and 21% indicated that no charge whatsoever should be made for NHS chiropody treatment.

With increasing pressures being placed on the NHS as a whole, chiropodists may feel that charging patients for routine chiropody is justified and that by introducing charges, routine chiropody care for the elderly remains available. However, it may prove to be a dilemma for some chiropodists who may not feel comfortable taking money from their elderly patients whom they may have treated for many years and whom they know can ill afford the cost of such treatment.

Many studies have concluded that NHS chiropody budgets have to be increased to meet the predicted increase in demand (Cartwright, Henderson, 1986, Bryan *et al*, 1991). The study by Cartwright and Henderson (1986) recommended a doubling of current facilities, a screening service for the over 65s and a footcare clinic at health centres employing better trained footcare assistants. A 1994 Government report

recommended that NHS Trusts increase their chiropody budgets to meet the predicted increase in demand and that they work with social services and the voluntary sector to ensure that older people's needs are met. However, because existing funds are stretched to the limit it is unlikely that most of these services will be implemented, therefore other means may have to be identified to ensure that older people's needs are met.

Foot Care Assistants and other Healthcare Personnel in the Provision of Routine Chiropody Care

'The chiropody care received by many of the elderly patients within the NHS does not require the highly skilled training of a state-registered chiropodist.'
(White, Mulley, 1989, p.277).

The idea of 'health care assistants' is not an entirely new concept. The term applies to staff who, whilst not qualified in one of the recognised health care professions, provide direct support for one or more professions either in the provision of patient care or in other ways (Berry, 1991).

Some health authorities employ footcare assistants (FCAs) to support chiropodists and to carry out basic foot care. The Whitley Council (Berry, 1991) defines FCAs as:

'A footcare assistant who is working under the direct clinical supervision of a state-registered chiropodist may be employed on the following types of duties:

Patient preparation, surgery preparation and other related routine duties; foot hygiene, and the cutting of normal toenails under the direction of and following assessment by the state registered chiropodist.'

Some chiropodists hold feelings of strong aversion to the training of footcare assistants. One of their concerns, reported by Berry (1989b), but with no literature to back up the report, seems to be that FCAs who, having built up a level of dexterity, then set themselves up as 'chiropodists' in the private sector. Unfortunately there are no laws at present to prevent unregistered practitioners advertising themselves as 'chiropodists' within the private sector. Some chiropodists feel that FCAs are not sufficiently trained in chiropodial skills and, more importantly, they are not trained to recognise problems which need skilled help. Other chiropodists, however, believe that there is a role for FCAs in the provision of basic footcare and that by employing FCAs, chiropodists are then able to carry out more complex tasks which fall within their increasing scope of practice (Berry, 1989b).

A Department of Health report (1994) recommended that the basic foot care needs of the elderly should be met by a wide variety of different helpers, for example, relatives, home carers, district nurses and carers in residential care homes and nursing homes. This, they stated, would reduce the number of elderly patients receiving routine, long-term follow-up care. The report also suggested that the initial and continuing training of carers in basic foot care provision should be undertaken by state registered chiropodists. In Borthwicks study (1992) 50% of chiropody managers favoured the idea of footcare assistants being trained at schools of podiatry, this they said, would ensure that qualifying chiropodists would then be able to manage assistants, monitor their performance and ensure quality in care delivery both cheaply and effectively. At present, those health authorities which employ footcare assistants train them 'in-house', which may be more economical and appropriate to their needs.

A study by Otter (1996) which looked at the roles, or potential roles, of other health professionals in the provision of footcare, concluded that 'strategies for the implementation of alternative sources of manpower (other than chiropodists) able to undertake routine chiropody care, would be desirable'.

It seems that nurses are reluctant to carry out basic foot care. Many nurses have strong negative reactions to feet and health care records suggest that nurses do not consider the care of feet to be a priority and that care of the feet is not a part of nursing practice (Heath, Schofield, 1999⁸). In a study by Love (1995), it was found that more than 50% of the nurses questioned were reluctant to carry out toenail trimming. Although some nurses (45%) would consider trimming a patients' toenails if the need arose, most considered this aspect of care to be the responsibility of the chiropodist, rather than the nurse. The nurses' reasons for not carrying out this procedure were 'fear of damaging patients' feet', 'not feeling confident of the technique' and 'toenail trimming not within the scope of practice'. This reaction seems surprising as Love's study was limited to orthopaedic nurses and one of the principles of orthopaedic care is the promotion of pain-free mobility (Love, 1995). Love concluded the report by stating that if basic care of the feet such as toenail trimming is to become a nursing function, provision for its instruction must be

included within the formal curriculum of nurse education. At present it is the duty of the chiropody service to be adequate to service demand.

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Methodology

Research Method Used

It was considered that the best way to investigate the chiropodists' attitudes was to carry out a self-administered survey, which is a questionnaire filled out by participants in the absence of an investigator (Polit, Hyngler, 1997)

The self-administered survey was chosen for various reasons. They are easily distributed to a large number of people and they are relatively inexpensive to conduct. They allow anonymity which may be important to ensure the answers given genuinely reflect the respondents' opinions. Unfortunately self-administered surveys often have a low response rate. It was considered that a response rate of 50% could be achieved and would give a satisfactory basis upon which to analyse the data.

Design of Questionnaire

The questionnaire (appendix 1) comprised five demographic questions and seven attitude statements with a five-point scale. The demographic questions were used to find a basis upon which the attitude statements could be compared. The demographic questions covered the following areas:

- Age range of respondent
- Gender
- Number of years since state registration as a chiropodist
- School where trained
- Place of work (NHS or both NHS/private practice)

The seven attitude statements were designed in the Likert-style with a five-point scale, which was labelled as follows:

- Strongly agree
- Agree
- Neither
- Disagree
- Strongly disagree

Population

The population for this study is defined as all state registered chiropodists who are employed within the National Health Service.

Inclusion/Exclusion Criteria

All chiropodists currently employed within the NHS were eligible for inclusion in the study including those who also work part-time in private practice, although it is acknowledged that their responses may be influenced to some extent by their private practice interests.

Chiropodists who work solely in private practice were excluded from the study. It was considered that their attitudes toward routine chiropody care for the elderly within the NHS could have been influenced by their possible reliance on elderly patients as a source of income.

Selection of Sample

Due to time and cost constraints, it was considered that the most satisfactory method of obtaining a sample of the target population was to contact chiropody managers from a random sample of health authorities within the UK and to request their assistance in distributing questionnaires to all state-registered chiropodists employed within their health authority. The names of six health authorities were randomly selected from a list of addresses and contact numbers for district chiropodists/podiatry

managers in the UK. Each of the district chiropodists/podiatry managers was contacted by telephone and permission was sought to send questionnaires for distribution to all chiropodists employed within that health authority.

Ethical Committee Approval

The approval of the Ethical Committee was not a requirement of this study.

Pilot Study

A pilot study was carried out in November 1999. Six questionnaires were given to fellow third year students who were given instructions to pass them on to their placement supervisor. All six questionnaires were returned. Comments from the pilot study highlighted one ambiguous statement and as a result this statement was rephrased accordingly.

Distribution of the Questionnaire

The questionnaires (110 in total) were sent to the six managers, who had agreed to distribute them to each of the chiropodists, at the beginning of December 1999. Each questionnaire included a covering letter (appendix 2) on University College Northampton headed notepaper explaining the general aim of the study and acknowledging their assistance in the study. To ensure confidentiality a pre-paid return envelope was included with each questionnaire.

Although all six managers assured co-operation with the distribution of the questionnaires, the identities of the chiropodists who received the questionnaires and those who actually responded were not known. Therefore follow-up reminders were considered impractical.

Response

A period of two months was thought reasonable for the return of the questionnaires. The responses were counted at the beginning of February 2000. The return rate was 62 or 56%. See appendix 3 for the raw data.

Data Analysis

As the statements were not designed to measure the same variable, a summated score could not be produced for each respondent, therefore each of the attitude statements were analysed separately. The demographic questions were used to group the data according to age-band and length of time since qualifying as a state-registered chiropodist of the respondents. The data was converted to percentages to allow comparisons to be made between the different groups. Similarities and differences were graphically displayed by means of charts and tables.

Inferential statistics were not used in this study, as a hypothesis was not formulated.

Chapter Four

Results

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Results

The return rate for the questionnaire was 56% (n=62). 29% (n=18) of the respondents were male and 71% (n=44) were female. At the time of the study 73% (n=45) worked in the NHS and 27% (n=17) worked both in the NHS and private practice.

Demographic questions

Table 1 shows the gender, age range and length of time since qualifying as a state-registered chiropodist of those who responded to the questionnaire.

Age Band	Male	Female	All	Length of time since qualification		
				Minimum for age band	Maximum for age band	Mean for age band
20-24	2	4	6	6mths	4yrs 6mths	1yr 10mths
25-29	2	8	10	1yr 6mths	7yrs	3yrs 5mths
30-34	3	11	14	6mths	12yrs	7yrs 6mths
35-39	7	10	17	2yrs	18yrs	10yrs
40-44	3	7	10	6mths	19yrs	10yrs
45-49	0	0	0	-	-	-
50-54	1	2	3	25yrs	32yrs	29yrs 4mths
55-59	0	1	1	38yrs	-	38yrs
60-64	0	1	1	45yrs	-	45yrs
	N=18	N=44	N=62			

Table 1

The length of time since qualifying as a state-registered chiropodist varied greatly, from 6 months to 45 years. 48% (n=30) of the sample had been qualified for less than five years and 39% (n=24) had been qualified for more than 10 years. Figure 1 shows a graphical representation of the age range of the respondents.

Age Range of Respondents

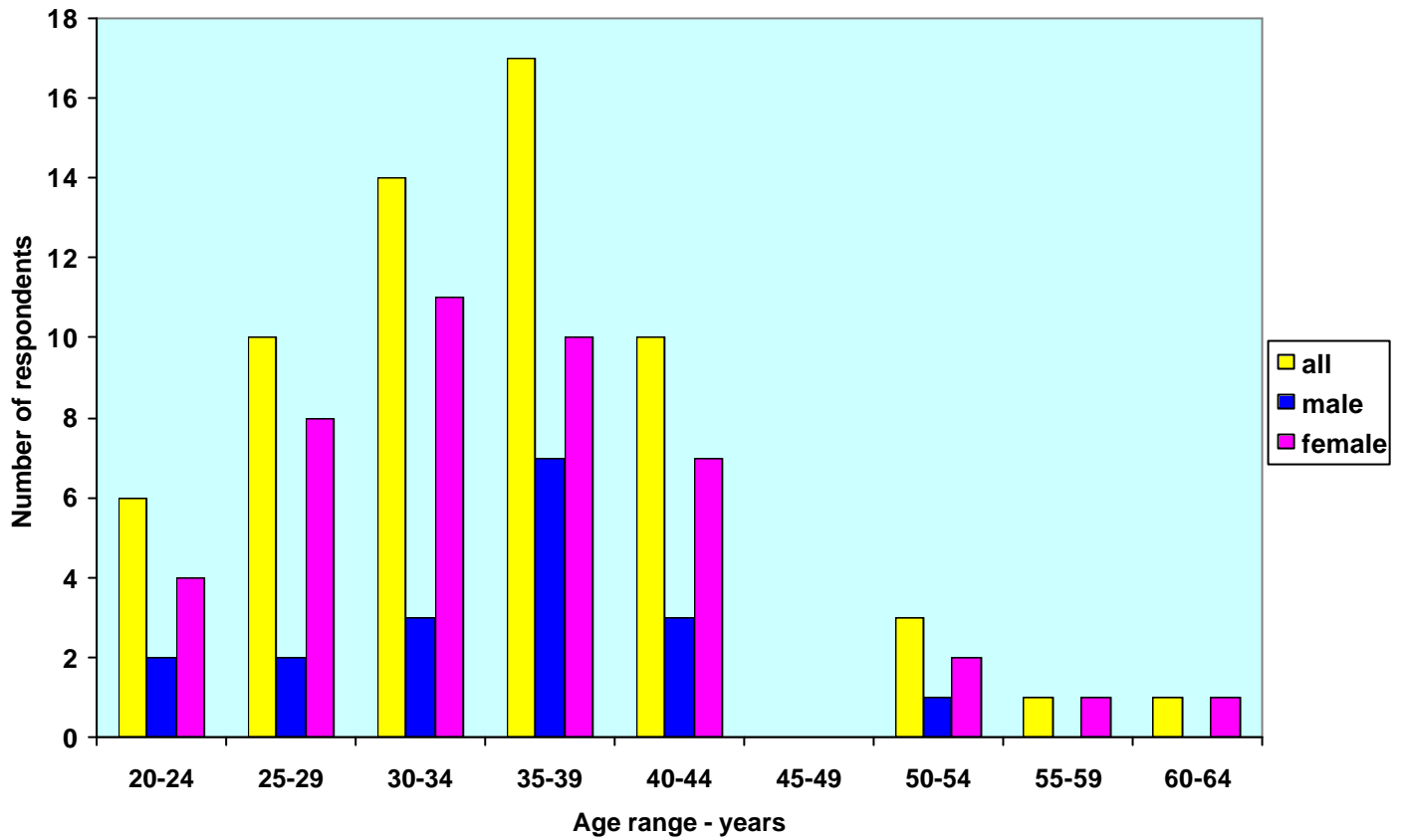


Figure 1

At the time of the study there were 14 schools of podiatry in the UK. Apart from the Podiatry School, Queen Margaret College, Edinburgh, all schools were represented within the study. In addition the Chelsea school of chiropody, which is now closed, had 12 representatives.

Figure 2 shows the place of training of the respondents.

School of Training of Respondents

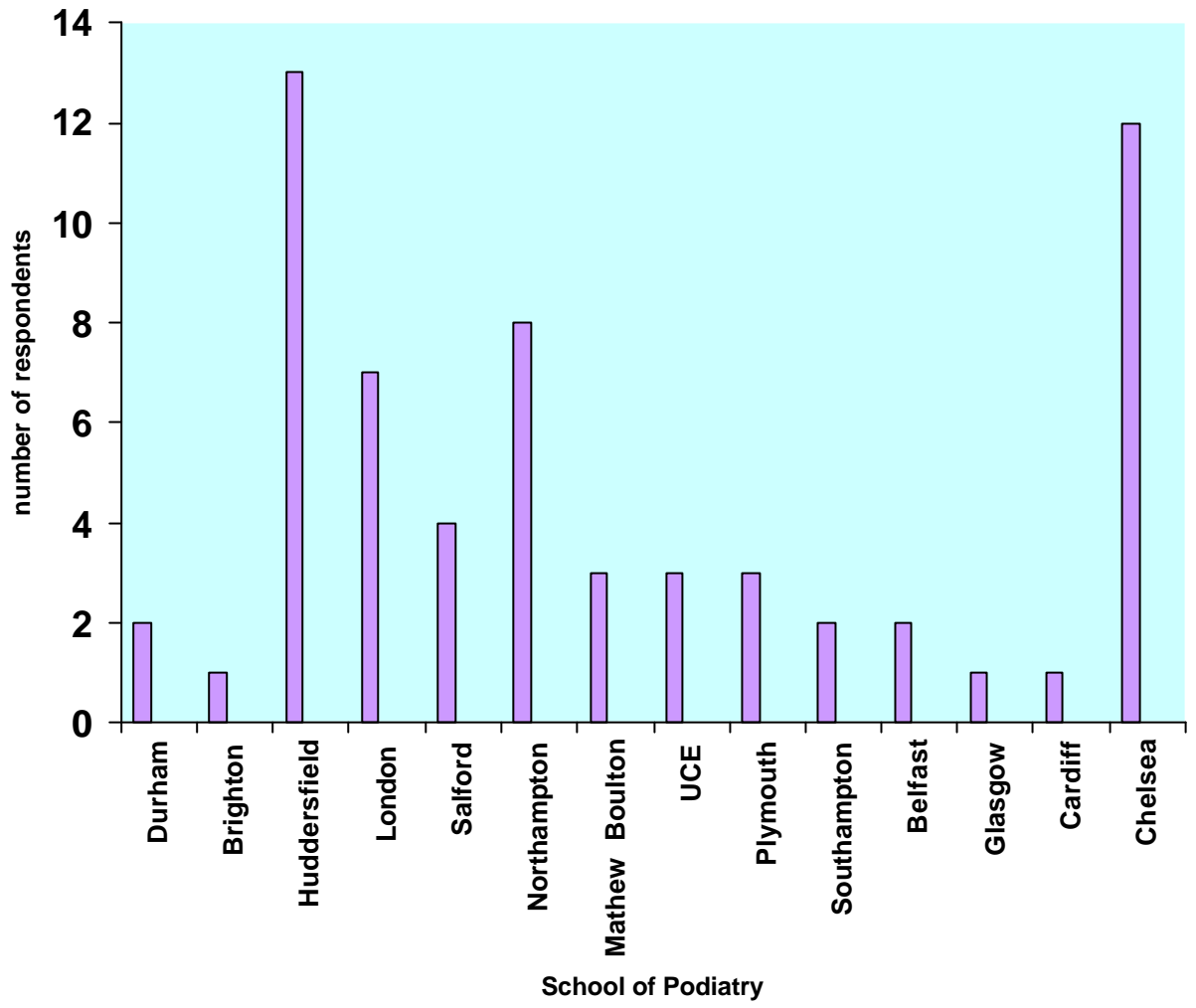


Figure 2

Attitude Statements

Although the statements had a five-point scale, for the purpose of data analysis, they were combined into a three-point scale (i.e. strongly agree/agree, neither, disagree/strongly disagree).

From table 1 it can be seen that the age bands were not equally represented, therefore to determine if age was an influencing factor towards attitudes, the sample was arranged into four groups. The age bands utilised within the questionnaires were combined to give broader age band categories of varying widths containing approximately equal numbers of respondents. Comparisons could then be made between the age categories. Table 2 shows how the respondents were sub-divided according to age.

Age Band	Number (n) of respondents
20-29	16
30-34	14
35-39	17
40-64	15
	N=62

Table 2

Also, to determine if chiropodial experience was an indicator of attitudes, the respondents were arranged into two categories based on length of time since qualifying as a state-registered chiropodist. These two categories covered the majority of the respondents (87%) and consisted of those who had been qualified for less than five years (48%, n=30 of sample) and those who had been qualified for more than 10 years (39%, n=24 of the sample).

Although all the schools of podiatry (except Edinburgh) had a representative within the study, the numbers of respondents from each of the schools were not considered substantial enough to enable comparisons between schools to be made.

Statement – Routine chiropody forms the major part of the chiropodists workload.

There was a general consensus among the respondents that this care formed a large part of their workload, with only 14% (n=9) of respondents disagreeing that routine chiropody care formed the major component of their workload.

Statement – Chiropodists (as opposed to other healthcare workers) should be the major providers of routine chiropody care for the elderly.

68% (n=42) of the sample strongly agreed/ agreed with this statement whereas 26% (n=16) disagreed/strongly disagreed with this statement.

Figure 3 shows the percentage breakdown of responses for each of the age band categories. Figure 4 shows the percentage breakdown of responses for each of the length of time since qualifying categories.

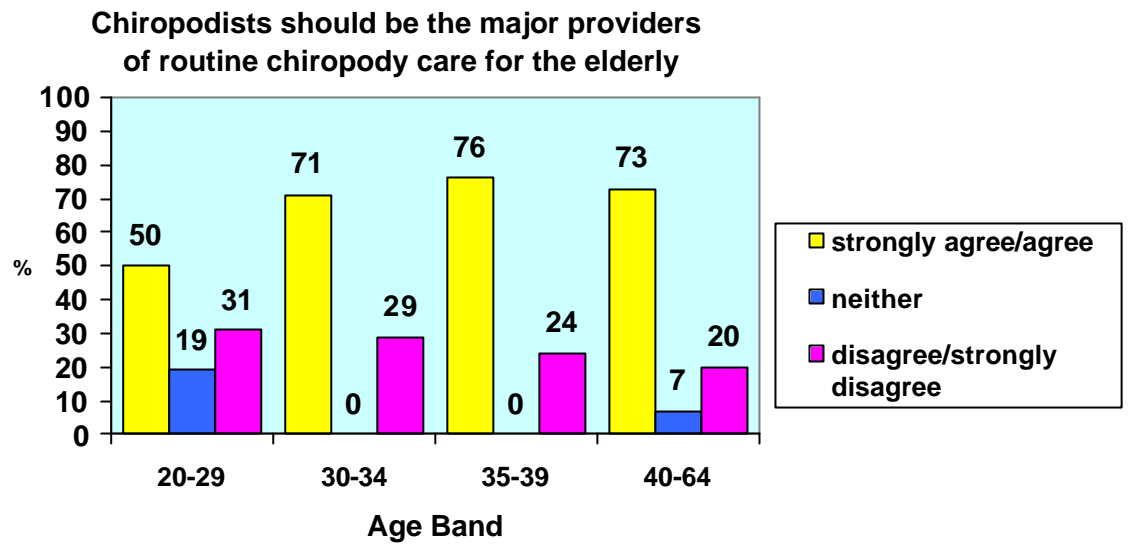


Figure 3

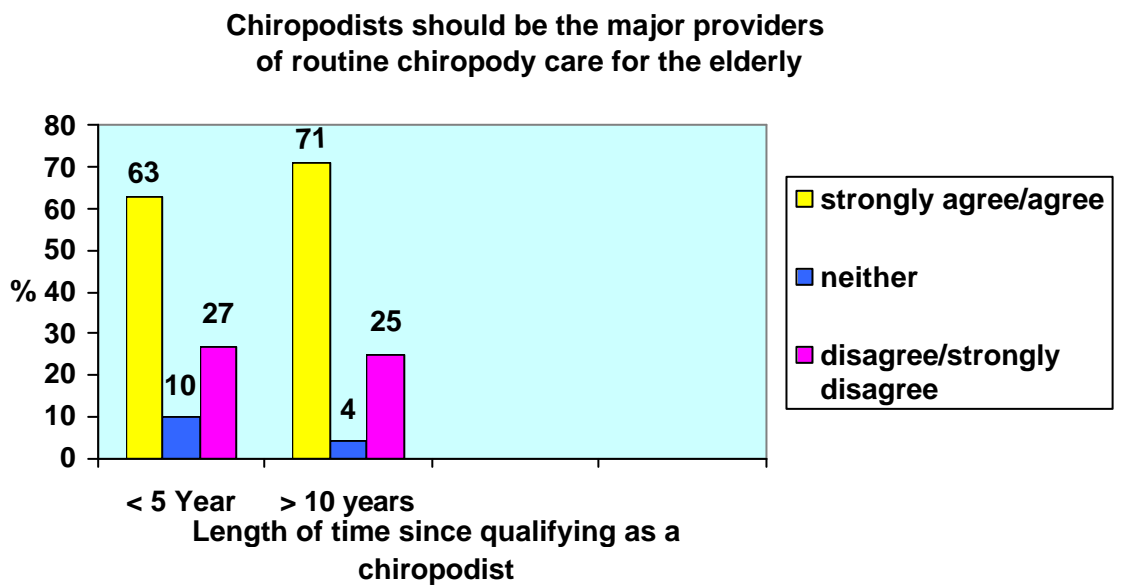


Figure 4

Respondents in the older age bands were more likely to agree that chiropodists should be the major providers of routine chiropody care for the elderly. Over 70% of the respondents in each of the age bands over 30, either strongly agreed or agreed with the statement, yet in the below 30 age band, this reduced to 50%. The length of time since qualifying was not an indicator of attitude towards this statement with 63% of respondents with less than 5 years since qualification and 70% of respondents with more than 10 years since qualification agreeing with the statement.

Statement – There is a role for other healthcare workers in the provision of routine chiropody care for the elderly within the NHS.

45% (n=28) of the respondents strongly agreed and 53% (n=33) agreed with this statement. There is clearly a consensus among the respondents (98%) that there is a role for other healthcare workers in the provision of routine chiropody care for the elderly.

Statement Chiropodists are over-qualified to carry out routine chiropody care.

This statement showed differing attitudes between the respondents. 42% (n=26) strongly agreed/agreed that chiropodists are over-qualified to carry out routine chiropody care, while 47% (n=29) disagreed/strongly disagreed with this statement. This is shown graphically in figure 5. Figure 6 shows the percentage breakdown of responses within each of the age band categories and figure 7 shows the percentage breakdown of responses from respondents in the two length of time since qualifying categories.

Chiropodists are over-qualified to carry out routine chiropody care (all respondents)

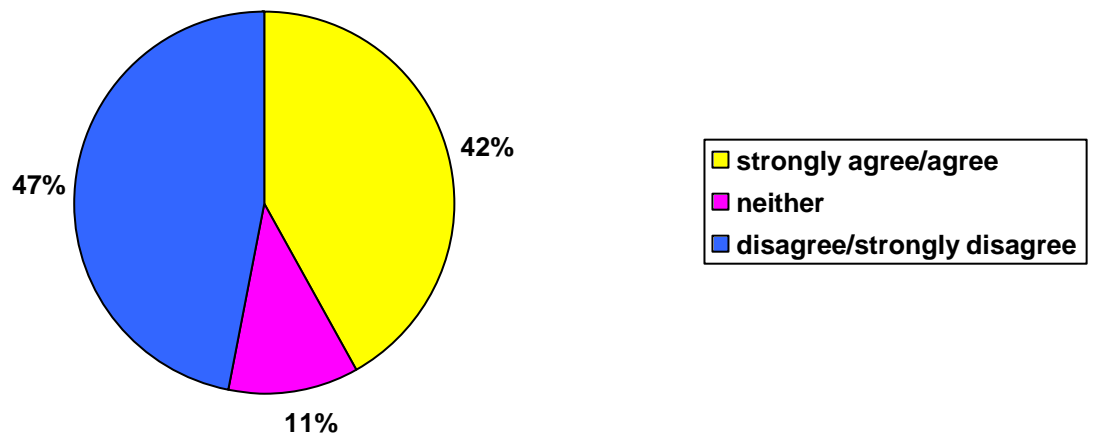


Figure 5

Chiropodists are over-qualified to carry out routine chiropody care

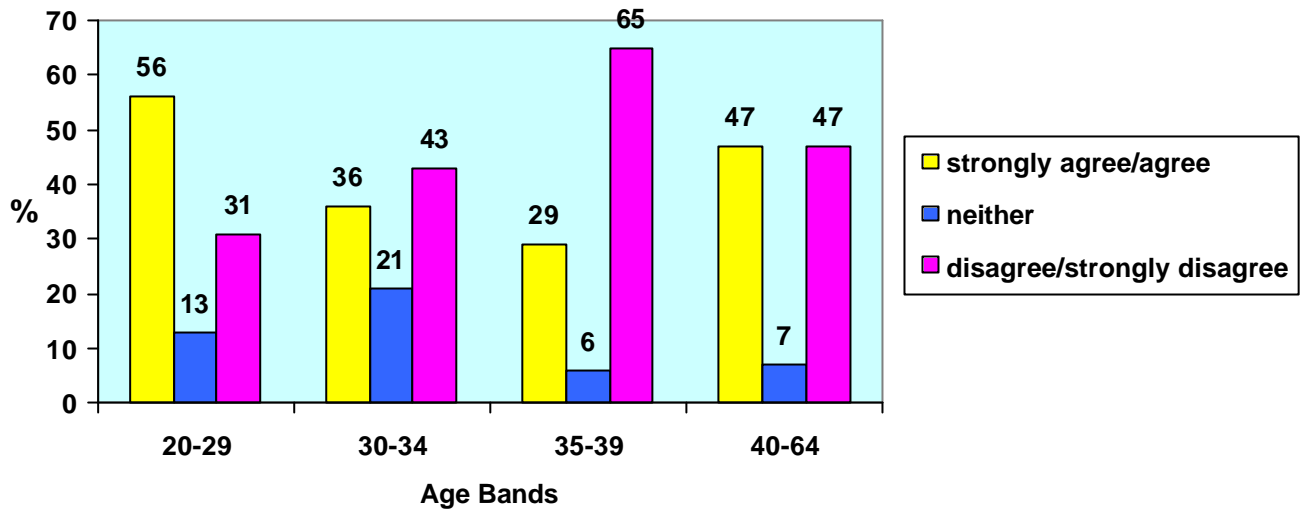


Figure 6

Chiropodists are over-qualified to carry out routine chiropody care

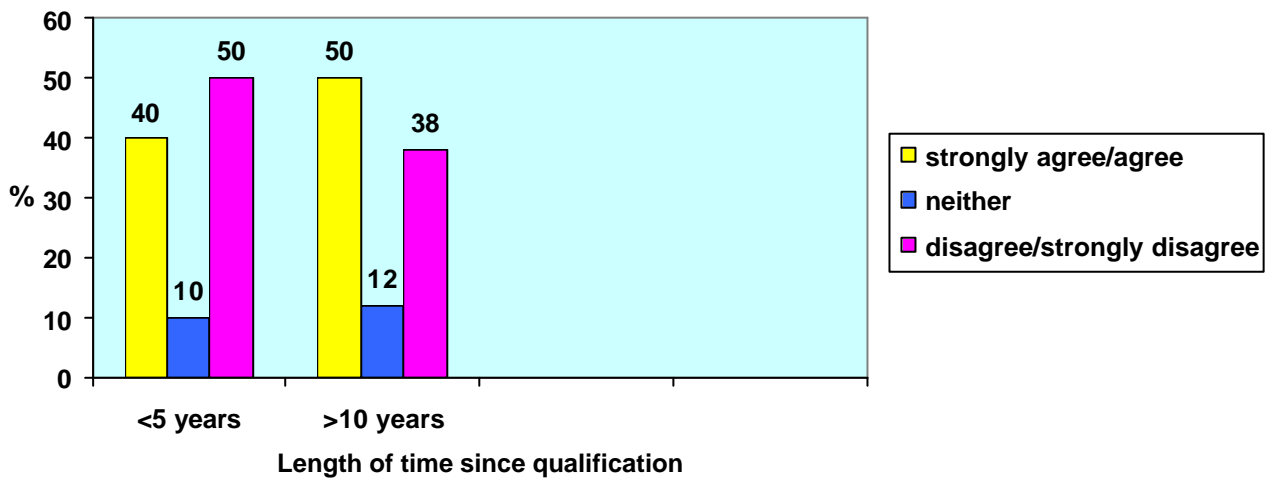


Figure 7

Respondents within the 20-29 age band were more likely to strongly agree/agree with the statement (56%, n=9) and those in the 35-39 age band were more likely to disagree/strongly disagree (65%, n=11). However there appears to be no consensus of opinion within the age bands. Similarly among those who have been qualified less than five years, 40% (n=12) strongly agreed/agreed that chiropodists are over-

qualified to carry out routine chiropody care and 50% (n=15) disagreed/strongly disagreed with the statement. Of those qualified for more than 10 years, 50% (n=12) strongly agreed/agreed with the statement and 38% (n=9) disagreed/strongly disagreed with the statement. Again, there is no common attitude among those respondents who have been qualified a similar length of time.

Statement - Routine chiropody care for the elderly is cost effective.

50% (n=31) of all respondents strongly agreed/agreed that routine chiropody care for the elderly is cost effective and 31% (n=19) disagreed/strongly disagreed with this statement. 19% (n=12) of the respondents stated neither.

There was generally no common attitude within the age bands, however, within the 35-39 age band, the majority (71%, n=12) strongly agreed/agreed that routine chiropody care is cost effective. 50% (n=15) of respondents who have been qualified for less than five years and 50% (n=12) of those who have been qualified for more than 10 years strongly agree/agree with this statement. This demonstrates again that there is no common attitude among the respondents with regard to this statement.

Figure 8 shows the percentage breakdown of the responses within the age band categories.

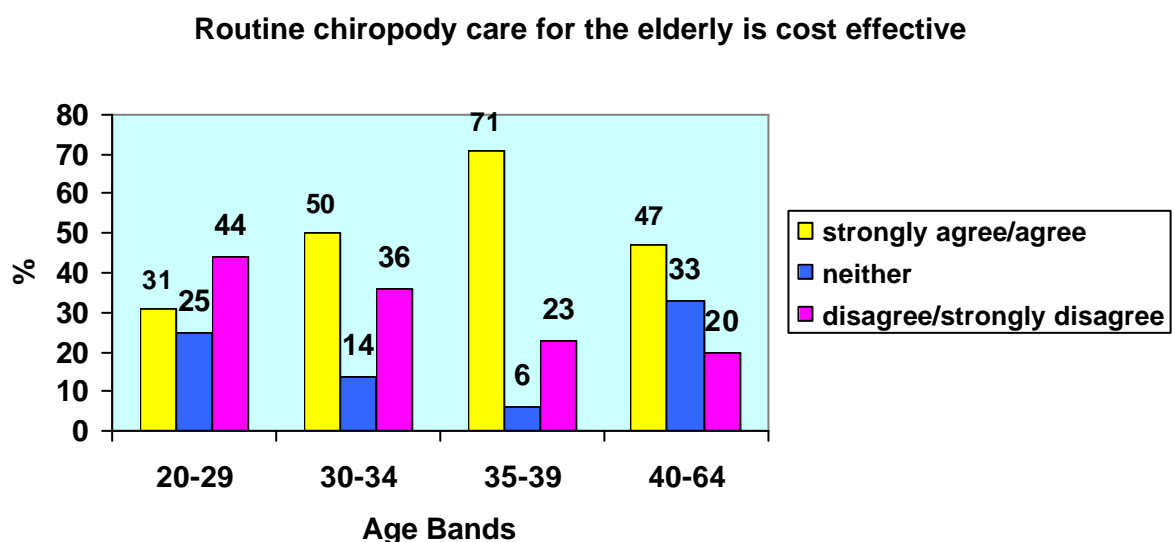


Figure 8

Statement - Patients should be charged for routine chiropody care

50% (n=31) of the respondents disagreed/strongly disagreed that patients should have to pay for routine chiropody care within the NHS. While 29% (n=18) strongly agreed/agreed that charges should be made, 21% (n=13) neither agreed nor disagreed with the statement.

Respondents in the 20-29 age band were the most likely to agree that charging for routine chiropody care is appropriate with 43% (n=7) agreeing with this statement. 28% (n=4) of respondents in the 30-34 age band, 18% (n=3) in the 35-39 age band and 26% (n=4) in the 40-64 age band strongly agreed/agreed with the statement. Again, there is no common attitude among respondents that patients should be charged for routine chiropody care.

Chapter Five

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Discussion

Demographic questions

The questionnaire return rate of 56% was approximately as anticipated as self-administered surveys are known to have a low return rate (Mitchell & Jolley, 1992). The statistical balance between gender and age of the respondents compares reasonably well with that found in previous studies. For example, Powrie (1992) stated that of all chiropodists employed within the NHS (1988-89), 49.5% were between the ages of 21 and 25, there was a numerical dominance of 4:1 ratio of female to male and that chiropodists were showing an increasing tendency to leave the NHS. Similar to Powrie's study, this study shows a notable female to male ratio of 2.4:1, although this is a smaller ratio than Powrie's 4:1. The age categories within this study were arranged differently and only 10% of the respondents were under 25. However, 76% of respondents within this study were below the age of 40.

If length of experience, rather than age is considered, 48% of the respondents had been qualified for less than five years. This would suggest that since Powrie carried out his study there has been a substantial increase in the number of mature graduates entering the chiropody profession. This is also illustrated in this study by the fact that 29% of the respondents were between the ages of 25-44 and had been qualified for less than three years.

There are a number of reasons why the profession of chiropody is attractive to the mature person. As the Society of Chiropodists and Podiatrists state, upon completion of the degree course the newly qualified state-registered chiropodist has the option of employment within the NHS or the private sector. Private practice allows the practitioner flexibility and this may be an important factor for the mature person who decides to pursue a career in chiropody. It could be argued that those wishing to practice in the private sector could do so much quicker by undertaking a course of study promoted by one of the institutions that does not confer state-registration. However, many of the people who investigate the options prior to a course of study are able to understand and appreciate the differences between the 'non state-registered' chiropodist and the 'state-registered' chiropodist.

Attitude statements

85% of the respondents strongly agreed/agreed that routine chiropody care forms the major part of their workload. This figure seems high, however in view of the fact that approximately two thirds of all chiropody patients are over 65 years (Age Concern, 1998) this may be a fair representation. Elderly people are more likely to require routine chiropody care than any other patient group. Conditions that make it difficult to cope with basic footcare, such as arthritis and poor eyesight, can affect younger age groups, as can diabetes or peripheral vascular disease. However, these conditions are more prevalent in the older age groups and when routine footcare, such as the trimming of normal toenails, becomes difficult, it is the elderly who are more likely to seek the help of a chiropodist.

Marsh's study (1987) highlighted that working with the elderly was one of the least attractive aspects of work within the NHS, yet it is clear from other studies (Powrie, 1992, Age Concern, 1998) that the elderly comprise the majority of the chiropodists client base. Routine chiropody care will continue to be a requirement for many elderly people, especially for those with conditions such as impaired circulation or diabetes for example. The value of this care should not be underestimated. The 3rd year students in Marsh's study stated that the opportunity to perform surgical procedures was the most attractive aspect of work within the NHS. The term 'surgical procedures' was not defined within the study and perhaps it refers to nail surgery which is within the scope of practice of the state-registered chiropodist, however, any other surgical procedures are not within the scope of practice of the state-registered chiropodist and they are taught in theory only. The schools of Podiatry in the UK seem to encourage students to expect that in practice there will be scope for specialist work within the NHS. Perhaps more emphasis should be placed on routine chiropody care and its value. As previously stated, many elderly people require appropriate footcare if they are to remain mobile, and maintain independence.

While the majority of respondents (68%) agreed that routine chiropody care for the elderly should be carried out by chiropodists, an overwhelming majority (98%) of the respondents agreed that there is a role for other healthcare workers in the provision of

this care. This result compares favourably with Borthwick's study (1992), Otter's study (1986), and a Department of Health Report (1994) which all stated that the basic footcare needs of the elderly should be met by a variety of different helpers from relatives and home carers to nurses and footcare assistants. Berry's study (1991) which reported that chiropodists hold feeling of strong aversion to footcare assistants is unsupported by this study.

Routine chiropody care undoubtedly forms a substantial proportion of the chiropodists' workload and while some of the elderly patients within the NHS receiving this care require the highly skilled training of a state-registered chiropodist, many do not. The palliative treatment of the elderly may have to change to educating the public on self-care and better health education. Also, it would be beneficial for chiropodists to work closely with GPs and other healthcare professionals so that appropriate foot health education and training can be made available to all.

The statement 'chiropodists are over-qualified to carry out routine chiropody care' demonstrated a clear division among the respondents, with the numbers of respondents who agreed with the statement almost equating with the numbers who disagreed with it. There was no consensus among those of a similar age or among those who had been qualified a similar length of time. It was notable that 50% of respondents who had been qualified for more than 10 years agreed that they are over-qualified to carry out routine chiropody care. However, respondents were not asked to state their grade within the NHS, therefore it is not possible to determine whether their relative seniority has any bearing on their responses.

Many of the students (63%) surveyed in Marsh's study (1987) were embarking on a career in chiropody despite it not being their first choice of profession. Whilst the respondents career choices were not addressed within this study, if the findings of Marsh's study are representative of all 3^d year podiatry students, then it is possible that many newly qualified state-registered chiropodists become disillusioned because of their perception that they have entered a lower status profession than they would have liked.

At present the cost-effectiveness of routine chiropody care for the elderly is difficult to ascertain, as there is a lack of literature relating to this subject. Groups such as Age Concern are calling for more research to be carried out into the cost-effectiveness of such a service for the elderly.

Although respondents were asked their opinions relating to the cost-effectiveness of routine chiropody care, the results are a point of interest only as there are no comparative studies. Notably, 19% of the respondents neither agreed nor disagreed with this statement which may be a reflection of the lack of published research into the cost-effectiveness of routine chiropodial interventions.

In contrast to Otter's study (1996), which found that 60% of chiropodists were of the opinion that charges for some chiropody services may be appropriate, this study found that only 29% agreed that charging for routine chiropody care is appropriate. With the increasing economic pressures being placed on the NHS service, some form of charge for routine chiropody care may become necessary, but this remains a contentious and politically sensitive issue, as people generally assume that all NHS treatments will be free at the point of delivery.

Recommendations

- Chiropodists to promote, facilitate and encourage improved health and mobility for all sections of the population. Chiropodists to implement new strategies, such as teaching of self-care, and education of carers of the elderly.
- Foot hygiene and routine chiropody tasks to be carried out by other healthcare personnel. Chiropodists should also work more closely with social services and voluntary organisations to ensure the foot health of the elderly.
- State-registered chiropodists are the best people to teach the skills of basic footcare to those who care for the elderly
- The present curriculum should raise the profile and promote the value of routine chiropody care.
- Issues relating to the NHS should assume a higher profile in educational programmes than is currently evident.

Areas for further research

During the compilation of this study a number of areas which warranted further investigation were identified.

There is very little published research into the cost effectiveness of routine chiropody care for the elderly. Further research in this field would undoubtedly be beneficial to Health Service Managers.

There is currently a move by certain Health Authorities towards discharging patients who no longer meet strict eligibility criteria, but have previously benefited from routine chiropody care. A survey of the discharged patients could be carried out to monitor and determine the effects the withdrawal of routine care has on their general foot health over the following months and years.

Marsh's study is now over 12 years old. It would be interesting to carry out a similar study of current third year podiatry students to determine their expectations for the future, with particular reference to the NHS. The questions asked could be modified to take account of the changes in the curriculum. For example, how many are considering a career in podiatric surgery which, although a relatively new discipline, has much emphasis placed upon it within the present curriculum?

The proportion of mature graduates qualifying as chiropodists would appear to be increasing. A survey of their expectations and aspirations, perhaps compared to those of the typical graduate who qualifies in their early twenties would be very interesting. A survey principally aimed at mature graduates could also seek to determine whether the flexibility a career in chiropody can offer is an important issue. For example, are mature graduates more likely to enter into private practice?

Criticism of Methodology

To produce a sample that could have been more representative of the target population, a listing may have been generated by using the current directory of state-registered chiropodists. The directory lists the names and addresses of all state-registered chiropodists within the UK and is published by the Society of Chiropodists and Podiatrists.

As in any study of this kind a larger sample would have produced more definitive results. The six health authorities surveyed may not be representative of all health authorities within the UK. For example, the proportion of older people within the general population in locations around the UK varies. In some areas, less than 10% of the population is over pensionable age, while other areas are popular in retirement and people of pensionable age or over comprise up to 35% of the population (Heath, Schofield, 1999⁹). Populations of the elderly should be taken into account when the necessary provision for services, such as chiropody, are being decided by Health Service Managers. As the provision of chiropodial care varies throughout the country, it may be that the health authorities in this study do not give a truly representative sample of the elderly population. Therefore, the results from this study cannot be generalised to the target population as a whole.

The results of the survey may also be influenced by other secondary factors. For example, there is no way of knowing whether the respondents are correctly interpreting the questions. Also, the respondent's answers may not fully reflect their true opinions.

Conclusion

At present chiropody is not a united profession. The issue of closure of the chiropody profession is a contentious one and has been so since the 1940s, yet little has been done to address it. This issue is of considerable concern to most state-registered chiropodists who generally feel that some form of closure needs to be achieved before greater professional development can be acquired. However, as chiropody is diversifying into new areas of specialisation and academic orientation, the profession may become further fragmented. The teaching of specialist new fields such as podiatric surgery are very important, however, it has already been put forward by Horwood (1998), that if everyone trains to be a specialist in chiropody, the routine chiropody care such as nail care, lesion debridement skills, padding and strapping, which remains the majority of the chiropodists' workload, will become a chore to those who feel they are capable of more specialist work.

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Appendix 3

Raw Data

						Statement number						
	Gender	Age band	school	Qual YR-MTH	practice	1	2	3	4	5	6	7
1	M	20-24	N	6	B	D	A	N	SD	SD	A	N
2	F	20-24	H	3 6	NHS	A	A	A	N	SA	SA	N
3	M	20-24	BI	1 5	B	D	N	D	D	SA	SA	SA
4	F	20-24	P	6	NHS	D	A	D	D	D	SA	SA
5	F	20-24	D	4 6	NHS	D	D	N	A	A	A	A
6	F	20-24	SA	6	NHS	A	SD	D	A	SA	SA	N
7	F	25-29	BI	2	NHS	D	A	A	A	A	A	A
8	F	25-29	P	3	NHS	D	D	A	A	A	SA	A
9	F	25-29	H	3	NHS	A	N	N	D	A	SA	N
10	F	25-29	H	1 6	NHS	A	D	D	SA	SA	A	D
11	F	25-29	CH	1 6	NHS	N	N	D	SA	SA	A	N
12	F	25-29	N	2	NHS	D	A	A	A	A	SA	A
13	F	25-29	BI	4 6	B	SA	A	D	D	A	SA	D
14	M	25-29	SA	3	B	D	A	N	N	A	SA	D
15	F	25-29	LFH	7	NHS	D	D	D	A	A	A	A
16	M	25-29	G	7	B	SA	SA	SA	A	A	A	D
17	M	30-34	CH	8	NHS	D	D	SD	N	A	SA	N
18	M	30-34	N	6	B	D	SA	A	D	D	A	A
19	F	30-34	H	10	B	SA	A	N	SA	SA	SA	SD
20	F	30-34	N	9 6	B	A	SA	A	D	A	A	N
21	F	30-34	H	10	NHS	A	A	SA	D	D	SA	SD
22	F	30-34	D	11	NHS	D	A	N	N	A	SA	SD
23	F	30-34	W	12	NHS	D	D	D	A	A	A	A
24	F	30-34	BR	12	NHS	A	D	D	A	A	SA	D
25	M	30-34	W	10 6	B	D	A	D	SA	SA	SA	A
26	F	30-34	CH	3 6	NHS	D	D	D	A	A	SA	A
27	F	30-34	BI	4	NHS	A	A	A	D	A	A	D
28	F	30-34	CH	2 6	B	A	SA	A	D	SA	A	D
29	F	30-34	LFH	6	NHS	N	SA	A	N	A	A	D
30	F	30-34	N	3	NHS	A	A	A	D	A	SA	D
31	F	35-39	H	17	NHS	A	A	A	N	SA	SA	SD
32	F	35-39	H	17	NHS	A	A	SA	D	A	A	N
33	F	35-39	H	15	NHS	SA	A	SA	D	A	SA	D
34	F	35-39	SA	14	NHS	A	SA	A	D	A	A	A
35	F	35-39	CH	11	NHS	D	A	SA	SA	SA	SA	D
36	F	35-39	CH	18	NHS	SA	SA	SA	SD	SA	A	N
37	M	35-39	H	14	B	SA	SA	SA	D	A	A	D
38	M	35-39	CH	15	B	D	D	D	A	A	SA	D
39	M	35-39	P	13	NHS	D	D	SD	SA	A	SA	A
40	M	35-39	CH	17	NHS	D	D	D	A	D	A	D
41	F	35-39	BI	2	B	SA	SA	SA	SD	A	SA	SD
42	F	35-39	N	4	B	A	A	A	D	A	A	D
43	F	35-39	CH	2 6	NHS	SA	SA	SA	SD	SA	SA	SD
44	F	35-39	N	2	NHS	SA	SA	A	SD	A	A	D
45	M	35-39	CA	2	NHS	A	A	SA	D	A	A	N
46	M	35-39	H	4 6	NHS	A	A	N	SA	A	A	N
47	M	35-39	BE	3	NHS	SA	D	A	SD	SA	SA	A
48	F	40-44	H	2	NHS	A	D	D	D	D	A	A
49	F	40-44	CH	1 6	NHS	A	SA	A	D	A	A	D
50	F	40-44	N	5 6	NHS	A	A	N	A	A	N	A
51	F	40-44	LFH	6	NHS	A	SA	A	D	A	A	D
52	F	40-44	H	4	NHS	A	D	N	A	D	A	D

53	F	40-44	LFH	19	NHS	N	N	N	A	A	SA	N
54	F	40-44	CH	17	NHS	SD	A	D	D	A	SA	SD
55	M	40-44	CH	17	B	D	A	N	A	A	A	D
56	M	40-44	BE	15	NHS	N	SA	A	D	D	A	D
57	M	40-44	H	19	NHS	SA	A	SA	N	SA	A	N
58	F	50-54	LFH	31	B	D	A	A	A	D	A	D
59	F	50-54	LFH	32	NHS	D	D	N	A	SA	SA	SD
60	M	50-54	BI	25	NHS	D	A	A	D	A	A	A
61	F	55-59	LFH	38	B	A	SA	D	D	A	A	D
62	F	60-64	SA	45	NHS	SA	A	A	A	A	A	A

Key to table

School of Podiatry

N	University College Northampton
H	Huddersfield
BI	Birmingham (UCE & Matthew Boulton)
P	Plymouth
D	Durham
SA	Salford
CH	Chelsea School of Chiropody (University of Westminster)
G	Glasgow
W	Wessex Centre for Podiatric Studies (Southampton University)
BR	Brighton
LFH	London Foot Hospital (University College London)
CA	Cardiff
BE	Belfast

- Statement 1 The elderly should be entitled to routine chiropody care within the NHS.
- Statement 2 Chiropodists (as opposed to other healthcare workers) should be the major providers of routine chiropody care for the elderly.
- Statement 3 Routine chiropody care for the elderly is cost effective.
- Statement 4 Chiropodists are over-qualified to carry out routine chiropody care.
- Statement 5 Routine chiropody forms the major part of the chiropodists workload.
- Statement 6 There is a role for other healthcare workers (i.e. footcare assistants) in the provision of routine chiropody care for the elderly.
- Statement 7 Patients should be charged for routine chiropody care within the NHS.

SA – strongly agree

N – neither

SD – strongly disagree

A - agree

D - disagree

