Less than two months ago, the newly elected FIP Board met face-to-face for its first board meeting. One of our top priorities of the board meeting was reviewing the FIP committees and commissions with the goal of repopulating them and making them active again. While we discussed all of the committees, our two key immediate priorities were the Articles and Bylaws Committee and the World Foot Health Awareness Month Committee.

The Articles and Bylaws Committee is reviewing the FIP’s current documents and taking into account the discussions and issues that occurred in Iceland. The FIP Board looks forward to the work of this committee and sharing the outcomes at the 2015 FIP Annual General Meeting (AGM).

The FIP WFHAM Committee is also busy preparing the various materials for the 2015 campaign. The committee is hoping to complete it’s work by the end of this year, so that the campaign material can be posted on the FIP website at the start of the new year.

In addition to the above two committees, the FIP is still looking for a few more volunteers. If you are interested in being involved, please contact me at carine.haemels@skynet.be

The FIP fall board meeting was scheduled to coincide with the annual scientific conference of the Spanish Podiatry associations. This allowed us to also meet with the board of the Colegio, and have a look at their scientific program and exhibition hall.

This fall, I was honoured to meet Dr. Tim Shriver, President of Special Olympics. He and I signed a new Memorandum of Understanding between our two organizations. More information about this is provided on page (to be inserted).

The FIP is once again busy with the initial preparations for the 2016 World Congress of Podiatry. The space has been confirmed, the conference organizers have been hired and even the FIP headquarters hotel for the congress has been secured.

As has already been announced, the dates for the 2015 FIP spring meetings in Athens, Greece are: Friday May 22 – FIP delegate session in the afternoon; Saturday May 23 – ECP AGM, FIP AGM and President’s dinner.

I look forward to seeing you in Athens.

Carine Haemels
MchS - MSc. Podiatry and Education & BSc. occupational Therapy

PS. You may have noticed that this issue of Footsteps is larger than many previous issues. There was so much news to share that we decided to join the fall and winter issues. The next issue will be the Spring 2015 issue, which will be out late February/early March. If you have suggestions for topics you’d like to see in the magazine or information you want included in the next issue, please email it to Jayne Jeneroux at jj@fip-ifp.org
This isn’t just a sandal.
It’s a Spenco® TOTAL Support® Sandal

**FOOTBED**
- Lightweight compression molded EVA footbed with Spenco’s proven Total Support™ Contour.
- Treated with Ultra-Fresh® Antimicrobial to help reduce odor.

**OUTSOLE**
- Lightweight compression-molded EVA and rubber.
- Unique forefoot and heel tread pattern for improved traction and grip.
- Molded details in the arch add support and structure.

**SPENCO® ARCH SUPPORT**
- Orthotic-grade arch support conforms to every foot shape

**DEEP HEEL CUPPING**
- Cradles the heel and aligns the foot

**METATARSAL SUPPORT**
- Offloads pressure from the ball-of-foot to help relieve forefoot pain

**SOFT LINING & TOE POST**
- Comfortable feel with no chafing or hotspots

**COMPRESSION OVERSTRAP**
- Keeps foot in full contact with orthotic-grade footbed

Based on the design of Total Support® Insoles, each sandal incorporates a cushioned heel, deep heel cupping, orthotic arch support, metatarsal dome, and a cushioned forefoot. Drawing on over 45 years of insole design and manufacture, combined with the best medically-driven research and development, each of these bio-mechanical attributes have been carefully designed and engineered to provide “Full-Contact Comfort™” to the widest possible cross-section of foot types and shapes. And unlike other sandals that claim orthotic benefits, Spenco® Footwear is easy to wear: The initial soft feel and incredible comfort are unmatched. It’s the combination of all these features that create The Shape That Feels Great™ — only Spenco® Footwear with Total Support® Technology has it, and it makes for the best sandal for after-sport recovery and helping to ease the symptoms of most common foot ailments.
Australia

The Australasian College of Podiatric Surgeons (ACPS) is the peak representative and training body of podiatric surgeons in Australia. 2014 is the second year the ACPS has run one-day seminars in each capital city across Australia. This year the seminar has been entitled “The difficult ankle and rearfoot”. These have been well attended and received by the podiatric community largely due to the quality of presentations. The College’s one-day seminars are designed to provide attendees with clinical information and skills that can be used by podiatrists when they are consulting in their offices.

Over the past two years, the ACPS has focused considerable resources on a submission to the Federal government to obtain public (Medicare) funding for podiatric surgery. Successfully achieving this objective will see podiatric surgery funded in the same way as all other providers of foot and ankle surgery. The outcome of this process is expected in 2015. Concurrently, the ACPS is undergoing its second accreditation cycle overseen by the Australian New Zealand Podiatry Accreditation Council (ANZPAC). The College is confident that accreditation of its training program will be successfully achieved in 2015. For more information visit www.acps.edu.au

Rob Hermann, President ACPS

Belgium

On 25/09/2014 the BVP/ABP held an Extraordinary General Assemble in order to renew the board of the association, in preparation for an active progressing future.

Young podiatrists will join the board with fresh ideas and together with the senior podiatrists create an association where everybody will find a place to express themselves in a democratic way and decide what the future will be in accordance with the FIP and ECP. We understand what the importance of the EU is, and the impact it has on the development of our profession in Belgium by the EU directives.

The board is aware of difficulties that lie ahead in a country with three official languages, and therefore we will renew our “reglements d’ordre intérieur” to adapt to the next generation.

Antwerp, Belgium also organized the Special Olympics European Summer Games with the collaboration of the university colleges that teach Podiatry and with the help of the local podiatry professionals. During the six days of the event, 1,459 athletes were screened and 1,407 pairs of Nike shoes were distributed to Special Olympics athletes. The Belgian Healthy Athletes Program managed to screen 84% of all the participating athletes.

Belgium is also very proud to be the place where the Memorandum of Understanding (MOU) was signed between the Federation Internationale des Podologues (FIP) and Special Olympics International (SOI). The CEO of SOI, Dr. Tim Shriver, and FIP President Carine Haemels jointly signed the MOU during the 2014 European Summer Games in Antwerp.

Finland

Greetings from Finland!

The Finnish Podiatry Association organized on November 6, 2014 a national conference day with a theme: “Footwear and work well-being”. There were interesting lectures about footwear properties and how a podiatrist can relax and alleviate stress with mindfulness techniques. The conference day was targeted to all professionals interested about foot health. On the same day the annual general meeting of the Association was held.

Minna Stolt, Vice President and international co-ordinator Finnish Podiatry Association (SJ JL ry), Finland

France

LIVRE BLANC DE LA PROFESSION : Suite aux Assises qui se sont déroulées en mars 2014 et qui ont réuni tous les responsables nationaux de la profession, la FNP a décidé de produire un LIVRE BLANC de la profession qui définit les orientations de la pratique professionnelle à l’horizon 2025. Ce livre blanc sera destiné à tous les acteurs de la profession et aux institutionnels (ministères, sécurité sociale …).
Le projet de la Fédération Nationale des Podologues est de faire reconnaître notre profession comme une profession médicale à compétences définies.

Serge Coimbra, Président FNP

United Kingdom

As autumn approaches we started looking forward to the annual College of Podiatry conference, which this year took place at the Bournemouth International Centre on 13-15 November.

The theme of this year’s conference was “Making Connections”, whether re-establishing old ones or making new ones. The keynote speakers include Dr. Phil Hammond, a general practitioner and media personality in the UK; Dr Scott Wearing, associate professor from the University of Technology, Australia; and Professor Keith Rome from Auckland University of Technology.

The conference included over 50 specialist concurrent sessions and the largest podiatry trade exhibition in Europe.

There was also a special stand commemorating the First World War, as we are fortunate to have a number of historic items in our archives. These included the notebook of James Kelsey, a “surgeon chiropodist”, which records treatments given to wounded soldiers in hospital in Brighton throughout the war. We also have the letters of Ernest Runting, one of the founders of the SCP, who was responsible for ensuring that chiropody was available for soldiers at the front, and also a copy of his manual entitled “Battalion Chiropody”. Many soldiers who were trained in chiropody went into the profession full time after the war.

The SCP ran a very successful media campaign in June. Research was commissioned to establish the impact of increasing weight and wearing ill-fitting shoes on foot health. To our surprise, the research revealed that British feet have on average increased by two sizes in both men and women since 1970. This was the aspect that the media latched on to, with national newspaper headlines such as “Bigfoot Britain” and “Getting too big for your boots?”, and coverage on daytime radio and television.

We were delighted to be able to promote important messages about foot health in a light-hearted and accessible way.

USA

The American Podiatric Medical Association (APMA) held a very successful Annual Scientific Meeting in July in Honolulu, Hawai. Attendees enjoyed an outstanding scientific program including world-renowned speakers, cutting-edge science and unparalleled networking, all set against the backdrop of beautiful Oahu.

The APMA gratefully acknowledges its sponsors and exhibitors for their generous support of the program. For full coverage of the meeting, read the September issue of APMA News, or visit www.apma.org/thenational for access to on-site daily papers, social media around the meeting, and a news feed.

Next year’s meeting takes places July 23–26, 2015, in Orlando, Florida. Visit www.apma.org/thenational to register.

APMA Advocating for Podiatrists Serving American Veterans

The APMA is actively lobbying the US Congress to resolve ongoing pay disparity for podiatrists employed by the US Department of Veterans Affairs (VA). Podiatrists in the VA are not classified as physicians, despite providing vital care for American veterans, especially those suffering from diabetes, lower extremity trauma, and peripheral neuropathy due to exposure to chemical agents. Many podiatrists are forced to leave the VA due to the disparity in compensation. Given the dramatic advancement in the education and training of podiatrists in the United States, the APMA is strongly advocating for a change in VA guidelines that would establish pay parity for podiatric physicians serving our veterans.

New Buyers’ Guide

The APMA is pleased to introduce the newly redesigned APMA Buyers’ Guide. The Guide is still a 24/7, one-stop shop for all podiatry product and service needs. Bookmark the new URL, http://apma.officialbuyersguide.net/, and start shopping today!

APMA Educational Foundation Awards More than $200,000 in Scholarships

The APMA Educational Foundation 2014 Annual Giving Campaign raised more than $200,000 and awarded 223 American podiatric medical students a scholarship. To make a donation to support the next generation of podiatrists, visit www.apma.org/donate.
ECP update

By the ECP Committee

Dear Colleagues,

The Board of the ECP met in Brussels in October to push forward with the programme of work contained within our strategic plan which we agreed in Reykjavik. Following this meeting it is necessary to update this strategic document and we will hopefully be able to send out the updated strategic plan before the end of the year.

The board met with the secretariat of CEPLIS to discuss how to further develop the work of the common platform document on podiatry practice within the European legislature. Many of you will remember this work which was completed and presented at the 2007 AGM. If anyone would like a copy of this please let me know and I can arrange for a soft copy to be emailed to you. Interestingly the common platform of practice documents are no longer permissible under the current legislation. We are not the only profession within CEPLIS in this situation. Osteopaths and biomedical scientists are also in the same position. If you remember when we spoke to you at Reykjavik we discussed that there were two issues that we needed to focus our programme of work on. The first was the common platform document and the second was the threshold qualification document in accordance with the Bologna declaration. The good news is that under the current legislation these two documents are joined and called a common training framework.

As you are no doubt aware the European Commission changed on the 1st November and we do not know whether these common training frameworks will be the will of the new commission. This is something we surely see within our own governments when there is a change of leadership! It is imperative that we lobby our own governments and MEPs to raise the awareness of podiatry so that when the document is ready it is well received. Time is short to prepare the document and there is significant work involved.

The largest challenge for us as members of FIP is that the European legislature

From left to right: Peter Boelens, Dr. Koutroubas, Neil Simmonite and Pauline Wilson

Provided below are links to videos that will give you a better understanding of how the EU legislature operates.

https://www.youtube.com/watch?v=nWpg01EPO_Y

https://www.youtube.com/watch?v=8A02zjkKpF8
The largest challenge is the European legislature does not recognize member organizations

does not recognise member organisations and as such any document submitted must be representative of 80% of all practising professionals across all member states. This is irrelevant of whether they are members of ECP, CEPLIS or FIP! This is a real challenge for us as members as to move forward with this document we need to engage with podiatrists who are not part of our group.

The important thing to remember is that to push forward with any document within Europe, we must engage with other groups that we have not engaged with in the past. Quite simply any document that we present to the European houses of legislature that is not representative of at least 80% of practising podiatrists will not be considered. Even when the document is representative of 80% of practising podiatrists, the European legislature will present the document to the other 20% of practitioners to see if they agree with the document before it is considered. It is in our interests to ensure that we can have our documents as representative as possible to ensure a smooth passage within the legislature.

The board of the ECP and FIP can only do so much. Our aim is to target member states who are not currently members of ECP/FIP for their support along with other stakeholders including patient groups and other professional groups who are sympathetic to pushing forward the role of podiatry and podiatrists within the European legislature. It is up to you and your members to work with your national governments and ME’s as well as with any other member organisations within your state to promote unity amongst the profession in Europe.

We will support you wherever possible with draft letters and documents over the coming months but without complete collaboration any document will not make progress within Europe.

We are still collecting details of member organisations by the means of the communication trees. If you haven’t completed one of these please do so as soon as possible. Without this information we won’t be able to contact you with the necessary documentation. If you have any details of organisations or MEPs who are sympathetic to our cause please let us know so that we can write to them on your behalf to push forward with this piece of work.

This is a challenging yet exciting time for Europe. Let’s all pull together to get this work done and our professional skills given the recognition they deserve with our European Legislators.

Next time we shall write about the implications of not having a common training framework in place.

Thank you for your ongoing support.

Save the date

2016 World Congress of Podiatry

May 26–28, 2016 | Montreal, Quebec
Offloading the diabetic foot: Effects of obesity

By Andrew J. Meyr, DPM, FACFAS; Kelly Pirozzi, DPM, AACFAS; and Matthew R. Wagoner, DPM

Obesity has been deemed a “global epidemic” by the World Health Organization and all evidence points to this problem getting worse before it gets better.1 An interesting investigation on the topic studied two “high risk” elementary schools in Houston, TX.2 The intervention school implemented a yearlong intensive program of daily nutrition education, behavior modification, exercise, and healthy lifestyle counseling for both students and parents, while the control school received no specific obesity-targeted interventions. At the end of the year, the intervention school actually had statistically increased incidences of obesity, weight, and body mass index (BMI) z-scores among students. The authors concluded that “implementation of any school-based obesity intervention programs requires careful planning.” That seems like an understatement.

From a big-picture standpoint, most recent evidence has pointed to a negative effect of obesity on the development, treatment, and outcome of lower extremity pathology. Obese patients are more likely than normal-weight patients to develop symptomatic lower extremity deformity, arthrosis, tendinosis, and other chronic musculoskeletal pathologies.3-10 They are also more likely than their normal-weight counterparts to suffer from fractures of the lower extremity11-13 and experience an increased incidence of postoperative complications when surgery is performed.14-27

The situation becomes increasingly foreboding when considering patients with neuropathy and diabetes. A study by Vela et al28 demonstrated an association between increased weight and increased plantar pressures in the setting of a “normal” foot. They studied the effect of increasing weight in healthy individuals without peripheral neuropathy by loading the front and back pockets of workout vests worn by participants with 9.1 kg and 18.2 kg weights; plantar foot pressures increased 5% and 19% in men and 9% and 25% in women, respectively. These findings were consistent for the various plantar regions (first metatarsal, lesser metatarsal, midfoot, and heel). The authors concluded that reduction in weight could reduce plantar foot pressures and, potentially, the development of ulceration in neuropathic patients.

Table 1: World Health Organization Obesity Weight Classes

<table>
<thead>
<tr>
<th>Weight Class</th>
<th>BMI*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt;18.4</td>
</tr>
<tr>
<td>Normal</td>
<td>18.5-24.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>25-29.9</td>
</tr>
<tr>
<td>Obese</td>
<td>30-39.9</td>
</tr>
<tr>
<td>Morbidly obese</td>
<td>&gt;40</td>
</tr>
</tbody>
</table>

Increasing body mass index is associated with significantly increased peak plantar pressures regardless of the type of off-loading device used. However, it is possible to decrease plantar pressures in some regions of the foot with the use of offloading devices.

Source: Courtesy of Lower Extremity Review
Sohn et al also studied the relationship between BMI and diabetic foot ulcers.29 The authors described a J-shaped association between body mass and the development of diabetic foot ulcerations, with obese patients having significantly higher risk for ulceration than normal-weight individuals. Compared with patients with a BMI between 25 and 29.9 kg/m², the five-year risk of developing a diabetic foot ulcer was 1.4 times higher in those with a BMI between 40 and 44, and 2.1 times higher in those with a BMI of 45 or higher.

Finally, Stuck et al found obesity to be significantly associated with the development of Charcot neuroarthropathy in US Department of Veterans Affairs patients with diabetes, independent of other factors.30 Compared with nonobese patients who did not have neuropathy, those who were obese but did not have neuropathy were 59% more likely to develop Charcot neuroarthropathy.

From an individual practice standpoint, the treatment of lower extremity pathology in the setting of obesity can be a challenging and often frustrating endeavor. The first author of this manuscript has been in private practice for five years in the urban setting of downtown and North Philadelphia. His group’s data indicate that patients presenting to the clinic have a mean BMI of 29.3, meaning that about half of the patients are categorized as “obese” assuming a normally distributed population (Table 1).31 When a patient who is 100 pounds overweight presents to the clinic with a chief complaint of generalized heel pain, it’s not surprising their feet hurt. And when clinicians treat a patient with a plantar diabetic foot wound who is morbidly obese, they often have serious reservations about whether a standard surgical shoe can effectively offload that much extra mass.

We don’t mean to suggest that such clinicians are acting without empathy or sympathy. On the contrary, these are realistic issues we all should be addressing to determine whether we are doing everything we can to appropriately and effectively treat our patients.

It is with this in mind that the first author’s group at the Temple University School of Podiatric Medicine has recently undertaken a series of observational investigations studying obesity and the foot. We have made some interesting observations that have changed the way we evaluate and treat obese patients.

**Evaluation of patient BMI**

One of our first hypotheses was that physicians in the US could be at risk for a concept or phenomenon that we termed “relative obesity.”32 Although the patients in the first author’s clinic have a mean BMI of 29.3, this doesn’t indicate that a BMI of 29.3 is “normal.” It means that the average patient encountered is overweight and nearly obese. But, because this is the case, it’s possible that clinicians’ perception of what is obese may be skewed accordingly. We may see a patient with a BMI of 41 and think to ourselves that the patient is subjectively and relatively “not that big,” when in fact they are objectively categorized as “morbidly obese.” We suspected this was the case for other clinicians as well.

To test this hypothesis, we had physicians across several levels of clinical experience (student, resident, and practicing physician) provide a visual estimation of a given patient’s BMI without actual knowledge of the patient’s height or weight. We did this across three different clinical situations in which physicians commonly see patients (walking down a hallway, sitting...
in a treatment chair, and lying in a hospital bed). In our study, the physicians’ visual estimates of patient BMI were inaccurate twice as often as they were correct (77.9% vs 22.1% of the time), and the most common error was to underestimate BMI (48.3% of the time). Assessments were most likely to be underestimated when patients were actually obese or morbidly obese, when they were sitting in a treatment chair, and when they were lying in a hospital bed.

Based on these results, we concluded that physicians are likely to be influenced by the concept of relative obesity if they solely rely on a visual estimation, and that they should be performing an actual calculation of BMI during the patient examination and medical-decision making processes. We believe if clinicians are unconsciously underestimating patient BMI, they also may be unconsciously underestimating the risks inherent to the treatment of obese patients.

The BOOT data
We have also sought to evaluate whether increasing body mass has an effect on the efficacy of offloading devices that are commonly used in the treatment of acute foot and ankle injuries, postoperatively following elective or traumatic reconstructions, and in the treatment of diabetic foot wounds. In other words, does a CAM (controlled ankle motion) walker have the same level of efficacy in someone who is 5’10”, wears a size 11 shoe, and has a BMI of 22 versus someone of the same height and shoe size who has a BMI of 42?

We have completed the initial portion of our planned series of investigations, which we have termed the “Body mass and Obesity Offloading Trials” (BOOT).33,34

To test our initial hypothesis we replicated the basic structure of a previously published study design investigating the effects of increasing weight on peak plantar pressures,28 making modifications in participant footwear and the amount of added weight. Our participants ambulated down a 12-m hallway in a pair of their own sneakers, a surgical shoe, a CAM walker, and a total contact cast (TCC) with cast shoe. All of our volunteers had normal-range BMIs, which we increased to overweight, obese, and morbidly obese levels by asking them to don military backpacks with adjustable shoulder, chest, and waist straps and loaded with weight evenly that was distributed anteriorly and posteriorly about the trunk for each of the test conditions (Figure 1). For our outcome analysis, we measured mean peak plantar pressures under the heel, midfoot, forefoot, and first metatarsal with an in-shoe pressure measurement system. Comparisons involved foot segments, BMI weight class, and footwear conditions.

Although this, like any investigation, was not without methodological limitations, we think there were some interesting findings worthy of attention and future investigation. First, we found that increasing BMI did lead to significantly increased peak plantar foot pressures across all plantar foot segments regardless of which, if any, offloading device was used. We also found that
it was possible to decrease plantar foot pressures with the use of offloading devices, though this occurred in a manner proportional to body mass. For example, plantar pressure under the first metatarsal for the obese BMI condition was higher for the surgical shoe than the CAM walker, but first metatarsal pressure in the CAM walker was still higher for the obese BMI condition than for the normal BMI condition.

However, this did not occur across the entire plantar surface of the foot in the same manner. We found that the heel was incredibly challenging to offload; none of the offloading devices was associated with a statistically significant difference in heel pressure compared with the sneaker for any BMI category. The offloading devices in all BMI classes were, however, associated with lower midfoot and forefoot pressures than the sneaker, particularly when the ankle was immobilized. Finally, of the offloading conditions in all BMI groups, we found the TCC decreased pressures by the greatest margin, which is consistent with previous studies suggesting that it is the gold standard for offloading.35-46

Future trials in the BOOT series will aim to evaluate the efficacy of offloading devices in individuals whose actual BMI falls within each of the categories, as well the effects of diabetes and peripheral neuropathy on plantar pressures and offloading outcomes.

**Scaling theory**

Perhaps the most provocative thing we've investigated has been the concept of “scaling theory” as it relates to obesity and the diabetic foot. This is a recognized theory within the field of animal biology that proposes, first, that tissue systems of organisms cannot maintain constant morphology as body mass increases, and second, that constraints of locomotion and support differ between large and small organisms. This theory has been primarily applied to evolutionary morphologic changes that have occurred over centuries in the so-called graviportal animals (elephants, rhinoceroses, hippopotami, etc), but we have studied the potential for applying the same concepts to the human foot.47-50 Our supposition is that the musculoskeletal anatomy, physiology, and biomechanics of the lower extremity of an active and healthy patient with a BMI of 22 are not, and probably should not, be the same as the musculoskeletal anatomy, physiology, and biomechanics of the lower extremity of a neuropathic diabetic patient with a BMI greater than 40.

We identified three unique anatomic differences in graviportal animals that may have application to diabetic foot disease in obese patients. The first is differences in the plantar soft tissue structure, specifically the rearfoot, which contains a highly structured network of adipose tissue organized into compartments and reinforced with collagen, retinculin, elastic fibers, and even a cartilaginous rod which has been termed the “sixth ray” or “prehallux” to add support during heel strike. The second is differences in the osseous structure with metatarsal orientation in a thickened and more horizontal tripod configuration. The third is differences in graviportal tendon structure with muscle tendon thicknesses and insertions that appear to be moving away from pronation and supination function and are more consistent with strictly flexion and extension.

At the very least we have found information that correlates with some of the clinical problems that frequently occur with the obese diabetic foot. These include differences in soft tissue structure such as the calcaneal fat pad, osseous structure such as the tripod foot type, and tendinous structures such as the Achilles tendon and equinus. Although we are certainly not comparing our obese patients to these animals studied by others, it is interesting to see how their evolutionary adaptations to increased mass may have potential application to reconstructive surgery of the Charcot foot.

**Conclusion**

From a big picture standpoint, all of these findings have changed to some degree the way we evaluate and treat obese patients, particularly in the setting of peripheral neuropathy and diabetes. First, we attempt to be very active in the recognition of obesity, as well as patient education. We will specifically discuss with our patients their BMI weight class, the known lower extremity complications of obesity, and how much weight loss is needed to transition into a different BMI weight class. We refer specifically to weight in our discussions of offloading, particularly of plantar foot wounds, and believe that weight loss may have as much of an effect as a specific surgical shoe or offloading boot.

It is also fair to say that we are more likely to immobilize the ankle during offloading in obese patients. Based primarily on the BOOT data, we feel that ankle immobilization may have a significant effect on plantar foot pressures when compared with something like a surgical shoe that does not immobilize the ankle. And
finally, we have come to view Charcot as an “anatomic failure.” What we mean by this is that the patient’s normal anatomy has essentially failed them to some degree. We approach a Charcot reconstruction not as an attempt to give the patient back a “normal” foot and ankle structure, but rather one that can withstand the stresses that caused the problem in the first place. This is a matter of expectations, and we believe physician expectations may be just as important as patient expectations.

Andrew J. Meyr, DPM FACP, is an associate professor in the Department of Podiatric Surgery at Temple University School of Podiatric Medicine in Philadelphia, PA. Kelly Pirozzi, DPM, AACFAS, is in private practice with Valley Foot Surgeons in Scottsdale, AZ. Matthew R. Wagoner, DPM, is chief resident in the Temple University Hospital Podiatric Surgical Residency Program at Temple University Hospital in Philadelphia.

REFERENCES

By all accounts, the 2013 FIP World Congress of Podiatry was a great success. But rather than take our word for it, the charts below highlight the key components of the event.

These charts and figures, which were created by Aldo Palomino, provide a quick glance of the scope and variety provided at the world congress. They also serve as a foundation on which to build the 2016 World Congress of Podiatry.
SAVE THE DATE

Montreal, Canada 2016

WORLD CONGRESS OF PODIATRY

MAY 26-28, 2016

www.fipworldcongress.org
The FIP/IFP has a number of working committees that carry out a variety of activities related to the work of the FI. All committee members are appointed to each committee by the executive board and all committees are governed by the FIP Terms and Conditions document, which is posted on the FIP website. The only exception to this process is the European Council of Podiatrists (ECP). The ECP consists of all FIP country members of the European Union (EU). The ECP will internally elect its own chairperson as this committee is solely responsible for issues that affect FIP EU country members.

If you are interested in being involved with one of the FIP committees, please contact Christian Jerome, FIP Member at Large. He can be reached at Christian.jerome@noos.fr

2013 FIP-IFP Humanitarian Award

Did you know that the FIP-IFP presents an FIP-IFP Humanitarian Award each year to a special individual whose selfless work in the field of podiatry has made a difference in the lives of others? And did you know that you can nominate one of your colleagues for this award?

If you know of someone who has gone above and beyond to provide podiatry-related care or assistance to others in need, please take a few moments to fill out a nomination form on their behalf. Perhaps you know a fellow colleague who has contributed to disaster relief, enhanced podiatry education in developing countries or has made a unique sacrifice to help others. If so, the FIP-IFP wants to hear about it and encourages you to nominate this person for the 2015 FIP-IFP Humanitarian award.

Awarded annually to a nominated FIP-IFP member after careful evaluation by the FIP-IFP Board, the 2015 Humanitarian award will be announced at the 2015 Annual General meeting in Athens, Greece on May 23, 2015.

Award criteria and nomination forms are available on the FIP website (www.fip-ifp.org) so take a moment to consider someone you think is deserving of this honour.

FIP COMMITTEES

The FIP/IFP has a number of working committees that carry out a variety of activities related to the work of the FI. All committee members are appointed to each committee by the executive board and all committees are governed by the FIP Terms and Conditions document, which is posted on the FIP website.

The only exception to this process is the European Council of Podiatrists (ECP). The ECP consists of all FIP country members of the European Union (EU). The ECP will internally elect its own chairperson as this committee is solely responsible for issues that affect FIP EU country members.

Provided is a list of the current FIP committees.

- Articles of Association Committee (AAC)
- Budget and Finance Committee (B&FC)
- Economic Development Committee (EDC)
- Corporate Development Committee (CDC)
- European Council of Podiatrists (ECP)
- International Academy of Podiatric Medical Educators (IAPME)
- International Recruitment Committee (IRC)
- Special Olympics International Committee (SOI)
- Website Committee (WSC)
- World Foot Health Awareness Month Committee (WFHAM)
Instant relief and visible improvement in a few days only!

PROVEN EFFICACY IN 3 CLINICAL STUDIES!

FISSURES AND CRACKS
HANDS & FEET

Effective on cracked heels as well as hands. Easy to apply thanks to canule tube.

With Silk Lipesters®
(ASEPTA PATENT)

ACTIVE INGREDIENTS:
Silk lipesters®, vitamin B5 & E,
Centella asiatica, beeswax.
Paraben free

SERVICING FOOT PROFESSIONALS WORLDWIDE FOR OVER 50 YEARS

www.asepta.com
Your new FIP board has been quite actively promoting the FIP and the importance of podiatry.

The FIP has received several invitations to meet with the board of member association countries and when possible the FIP President attends in person. However, when circumstances or conflicting dates make it impossible to attend, your FIP President Carine Haemels videos a personal message so that she can accept the invitation electronically. Two examples of this are Germany and Mexico. Recently she attended the FNP annual conference and has accepted invitations to attend meetings with Great Britain and the United States next spring.

Carine appreciates the opportunity to meet with as many FIP members as possible so she can share information about the FIP and its activities and also to hear from members about issues that are important to them.

Recently, the FIP has also been asked for interviews with several media outlets. For example, this month Carine did a radio interview with French-speaking radio station RTBF, where she spoke about the FIP and also about Special Olympics. She was also interviewed for an article in Podosofia magazine. And FIP Vice President Dr. Matt Garoufalis was interviewed for an article with Reader’s Digest International.

A key component of the FIP is communication to and about podiatrists and podiatry. By seizing opportunities like these interviews, the FIP is able to reach broader audiences.

Resource materials for FIP members

As a member of the FIP, you have access to a variety of podiatry related materials. For example, all 80 lectures from the 2013 World Congress of Podiatry are posted on the FIP website for members to view. Similarly, there is a virtual exhibit hall on the website, with videos from some of the companies that exhibited at the 2013 WC.

There is also information about World Foot Health Awareness Month, including documents and posters from previous issues.

As well, you have access to the FIP’s quarterly magazine, Footsteps. Each issue provides information about podiatry updates from different countries, listings of podiatry conferences around the world as well as clinical articles and practice-related advice.

These are just a few of the many items available to you and most of them can be easily accessed through the FIP website – www.fip-ifp.org

As winter arrives in many of the locations where FIP members live, take some time to check out the FIP website and see what’s available.

NOTE: FIP members are also entitled to preferred rates for the World Congress and the “The Foot” journal.
Putting the spotlight on Special Olympics International

On September 13, 2014 FIP President Carine Haemels and Special Olympics International (SOI) Chairman Tim Shriver officially renewed the Memorandum of Understanding (MOU) between the FIP and SOI. This memorandum was signed in the presence of media, corporates and the public at the European Summer Games of Special Olympics, in Antwerp, Belgium, where 1459 athletes had their feet screened and 1400 (84%) of the participants were provided with a free pair of running shoes thanks to Nike. The signing of the MOU solidified the ongoing relationship that exists between both organizations that was originally formalized in 2011.

In recognition of this momentous event, Footsteps is doing a special feature on Special Olympics and the FIP’s involvement.

The FIP first got involved with SOI through podiatrists in countries around the world volunteering to help out at local SOI games and events. Many podiatrists also took part in the SOI’s train-the-trainer program. Involvement with SOI reached a new level when the FIP Board of Directors visited the global office of Special Olympics International in Washington D.C. on March 18, 2011. During this historic meeting, FIP President Janet McInnes signed a Memorandum of Understanding (MOU) with the Director of Special Olympics. Previously, Special Olympics had only signed such an agreement once before, which was with the Peace Corp. The signed agreement between the FIP and SOI solidified the working relationship of the two organizations and opened the door for ongoing collaboration.

A key component of the FIP’s involvement with SOI is the Fit Feet program, which is a component of the Healthy Athletes initiative.

Fit Feet helps Special Olympics athletes step lively on the playing field, and in everyday life. Many athletes suffer from foot and ankle pain, or deformities that impair their performance. In fact, up to 50 percent of Special Olympics athletes experience one or more preventable or treatable foot conditions that can affect their sports participation. Often, these individuals are not fitted with the best shoes and socks for their particular sport. To alleviate these problems, volunteer podiatrists work with athletes to evaluate problems of the feet, ankles and lower extremity biomechanics.
About Special Olympics

Special Olympics is a global movement that unleashes the human spirit through the transformative power and joy of sports, every day around the world. We empower people with intellectual disabilities to become accepted and valued members of their communities, which leads to a more respectful and inclusive society for us all. Using sports as a catalyst and programming around health and education, Special Olympics is fighting inactivity, injustice and intolerance. Founded in 1968 by Eunice Kennedy Shriver, the Special Olympic movement has grown to more than 4.4 million athletes in 170 countries.

With the support of more than 1.3 million coaches and volunteers, Special Olympics delivers 32 Olympic-type sports and more than 81,000 games and competitions throughout the year. Special Olympics is supported by individuals, foundations and partners, including the Christmas Records Trust, the Law Enforcement Torch Run for Special Olympics, the Coca-Cola Company, the Walt Disney Company and ESPN, Lions Clubs International, Mattel, P&G, Bank of America, Essilor Vision Foundation, the B. Thomas Golisano Foundation, Finish Line, the Safeway Foundation, and Safilo Group. Visit special olympics at www.specialolympics.org.

For more information about Special Olympics and how to get involved, visit www.specialolympics.org

QUICK FACTS

› The 2015 Special Olympics World Summer Games open on 25 July 2015 in Los Angeles, California.

› The 2015 Games will feature competitions in aquatics, gymnastics, track and field, basketball, football (soccer) and many other summer sports involving 7,000 athletes with intellectual disabilities from around the world.

› The 2015 Games will be the 14th Special Olympics World Summer Games.

› LA 2015 will mark the first World Summer Games held in the U.S. in 16 years.

› The LA2015 website is at www.LA2015.org
Podiatrists Making a Difference

Often, we read a news item about the positive effects that podiatrists have had on people’s lives. As stated in a news release from Special Olympics International a few weeks ago, a routine Healthy Athletes check up of Special Olympics athletes as part of the Special Olympics European Summer Games taking place in Antwerp, Belgium from September 13th – 20th may have saved the life of one of the athletes.

During a routine check-up that athletes receive as part of their Games experience, an infection caused by a toenail growing into one athlete’s flesh was detected. The condition had already created a very bad inflammation that could have caused death if not cured properly in due time.

“We discovered a necrosis. Untreated, the blood of the athlete could have been poisoned within three days, which could cause death” says Carine Haemels, President of the International Federation of Specialists in Podiatry and Regional Advisor to the Fit Feet Program of the Special Olympics European Summer Games 2014. “We immediately referred the athlete to a specialist and in this way her life was probably saved. In many cases people with an intellectual disability have a different sensibility to pain and as conditions develop may not feel the pain any more. So it can often happen that health problems are not revealed in time. A case like this proves that our work and the work of Special Olympics Healthy athletes is vital.”

Athlete Evy Ploegaerts:

How were you involved in Special Olympic?
As an athlete I participated since 2001 at the Special Olympics National Games in Belgium. If I cannot participate as a sportswoman I’m involved as a volunteer. Then I accompany other athletes or help with the lunchbox distribution during the Games. I was also a member of the Belgian team in 2007 during the Special Olympics World Summer Games in China and in 2013 I did snowshoeing during the World Winter Games in South-Korea. Of course I participated at the fantastic Special Olympics European Summer Games 2014 in Antwerp.

What was/is the impact of this involvement in your daily life/ practice?
Special Olympics changed my life. Sport is important but Special Olympics is more than sports. It also supports athletes to speak in public and to speak for themselves. Special Olympics helped me to accept my disability and to gain more self-confidence.

What is your message?
I think there should be more publicity about Special Olympics, everybody should know the movement. Attention should be raised by the media so that everybody can support us and come and watch our game.

Continued next page
PODIATRISTS MAKING A DIFFERENCE

Gerbrand Van Uytvanck, volunteer photographer

How were you involved in Special Olympic?
I responded to a volunteers call issued by Special Olympics in 2013 to become a volunteer during the National Games. It was such a great experience that I participated at many other events organized by Special Olympics.

What was/is the impact of this involvement in your daily life/ practice?
The impact it has on my life is that I learned to put things in perspective. It is fantastic to be a photographer for such great people. They bring the joy of life to me.

What is your message?
My message would be ‘Keep on going’. I send it out to athletes, to Special Olympics and to all the volunteers. They gave Special Olympics a chance in their lives, and they are grateful.

Nicolas Clercx, Volunteer podiatrist

How were you involved in Special Olympic?
Since 2004 I have worked each year as a voluntary podiatrist on the Fit Feet Program, first as a student, then as a professional, and as from the next game, I’ll be Manager of the Fit Feet Program Belgium.

My contribution was to screen the athletes (as well biomechanical analysis as skin and nails check) and to brief them on the results and provide advice on care and follow-up actions.

What was/is the impact of this involvement in your daily life/ practice?
This brings me each time an enormous satisfaction because offering my time and professional skills to people who need it is very worthfull. Also I was able to improve my skills and increased my knowledge about the needs and approach of this specific group. This had an impact in my daily practice and on top of this, my patients are always very impressed when they hear about this.

What is your message?
I would encourage the podiatrists to take part to this program, at least one time. The atmosphere during the Special Olympics Games is really particular and engaging, but you can only feel it if you live it!

About Special Olympics

The new MOU between the FIP and SOI includes the following FIP actions:

- Promote volunteer opportunities and encourage our members to volunteer for Fit Feet screenings held in member locations (state, province or country).
- Help facilitate the recruitment of Fit Feet Clinical Directors from the FIP provider network.
- Provide input and suggestions on the Fit Feet Manual and assist SOI with the preparation of educational materials for the Fit Feet Program.

Assign to SOI all rights FIP may have to any materials related to the Fit Feet program.

This means that the FIP will help build the manual with all the expertise we have and input from around the world to help SOI create educational materials.

With the support of more than 1.3 million coaches and volunteers, Special Olympics delivers 32 Olympic-type sports and more than 81,000 games and competitions throughout the year.

When I am called into podiatry offices, I usually spend a good amount of time focusing on ways to bump things up to the next level; you know, the old “work smarter, not harder” theory. Typically, the first thing we’re faced with is how many doctors insist on doing all patient care tasks themselves. When I see a physician leave a treatment room to get a DME product out of the lab or spend an excessive amount of time either fitting a patient with a night splint or explaining stretching exercises for example, I know they are not using their staff in the best possible way.

I’d love to see every doctor focus on tasks that best utilizes their “productive” time (defined as time in which they perform those tasks that only they, as doctors, are licensed to do) but that’s not always the case. So whenever I see productivity compromised or patient logjam, I have to ask: “Why don’t you delegate more hands on patient care to your staff!” prompting a number of responses:

by: Lynn Homisak, SOS Healthcare & Management Solutions, LLC - www.soshms.com

1. “My staff is not trained to do that.”
That actually is not so much a problem as it is an opportunity! Having a trained staff is a major plus if training is properly done. Training means teaching, explaining and showing them how...not just telling them. While training does cost precious time up front; it is more than recovered down the road as staff become more proficient. By allowing them to take the lesser tasks off your plate, you can focus more on the “productive” ones that generate additional revenue.

2. “My patients only want me to take care of them in the treatment room; not my staff!”
Although some patients may resist staff intervention in the beginning; their acceptance will ultimately depend on the doctor’s presentation. It all comes down to trust. If doctors truly trust their staffs’ competence and abilities, they’ll find it easy to communicate a professional “care team” concept to their patients and delegate with confidence. Likewise, if the patient TRUSTS their doctor, they, in turn, will have faith in whatever decision he or she makes. Conversely, if the doctor demonstrates the least bit of apprehensiveness, the patients will detect it; triggering their rejection.

3. “I can do it quicker and better.”
No doubt...excellence comes with experience and time. Just as you trained to become an excellent podiatric physician, staff must train to become excellent podiatric assistants. Consider giving them a chance to grow and meet that challenge. In time and under your direct guidance and supervision, they can be taught to replicate certain non-invasive services to your (and your patients’) satisfaction.

4. “What’s the big deal? It only takes me a minute to get the night splint, draw the injection, or demonstrate the exercises, etc.”
If you calculated what your time is worth, you might feel differently. You might even realize how eliminating one minute of wasted time from each patient encounter can equate to scheduling a couple more patients a day. By delegating more patient care duties to their capable staff, in addition to increasing volume, doctors can reduce their effort AND capture lost revenue. Those captured minutes turn into dollars and over one year’s time that can become very significant.
5. “It’s not always about the money! The extra time I spend with my patient is important to them…and to me.”
Correct. It’s NOT always about the money. Saving those minutes may equate instead to finishing early and having extra time to spend with loved ones, or pursue hobbies. It’s all about trade-offs and choices. You get to choose how to best manage your minutes. Would you like to use them to increase revenue or time... or would you prefer to escort patients to the front office, for example, because giving that personalized attention is more important to you? There’s no wrong answer. I think the bigger point is not to confuse quantity of time spent with your patient with quality of time. If patients sense they are being “turfed off” to someone who they perceive is less qualified, they WILL understandably be apprehensive; even resentful. If however, patients feel that their overall experience in your office (by you and your staff) was first rate, they will walk away feeling completely satisfied. That feeling comes from the combined efforts of a TEAM…and in the end, a good reflection on you!

Ms. Homisak, President of SOS Healthcare Management Solutions, has a Certificate in Human Resource Studies from Cornell University School of Industry and Labor Relations. She is the 2010 recipient of Podiatry Management’s Lifetime Achievement Award and recently inducted into the PM Hall of Fame. Lynn is also an Editorial Advisor for Podiatry Management Magazine and recognized nationwide as a speaker, writer and expert in staff and human resource management.
Proven Results
Hand Held Laser
No Consumable Expense
Fast Return on Investment
FOX Diode Laser 1064 nm

A SUCCESS STORY:
More than 7,000 FOX laser installations – worldwide.

THE SOLUTION IS A SIMPLE FOX-LASER TREATMENT

- Proven Results
- Hand Held Laser
- No Consumable Expense
- Fast Return on Investment
- FOX Diode Laser 1064 nm

An inexpensive laser shows reliable results within a few months – Simply with a Beam of Light.

A.R.C. Laser GmbH
Bossemerstraße 14
D-90411 Nürnberg
Germany

+49 (0) 911 217 79 -0
+49 (0) 911 217 79 99
info@arclaser.com
www.arclaser.com

LASER CLEAR
and no more Nail Fungus.