Fall 2011 is going to be a very busy time for the FIP, especially in terms of organizational details for the 2013 World Congress of Podiatry. As I write this, the FIP board is getting ready for its fall board meeting, which takes place in Rome. This location was chosen to enable the FIP Board and the Italian Podiatry Association to have site visits and face-to-face discussions about the many aspects of the world congress – site location, scientific conference, exhibit hall, to name just a few.

We are very excited about the 2013 World Congress, and collectively we are all working hard to make it the best world congress yet.

But that’s not all the FIP is working on these days. We are also working on a number of initiatives that directly benefit our members around the world. The resources for the 2012 World Foot Health Awareness Month program are nearing completion and will be sent out to member associations in the near future. And we’re working on the details for establishing a podiatry registry, which will enable FIP members to know about areas around the world looking for podiatrists – be it for a career change, a working vacation or a specific event or program.

We are also looking at some of our internal initiatives to make them more accessible for our members to get involved with the FIP. That includes the nomination forms for the FIP Humanitarian Aid Commission and the terms of reference for committee involvement.

As well, we continue to explore ways to increase our communication efforts. This magazine is a tremendous way for us to share information with members, and for members to share information with their colleagues around the world. It is also a way to remind members about our corporate partners and the significant part they play in the FIP’s success. We’re also working on a Facebook page to enable even greater communication opportunities for everyone. Communication is a very critical aspect of the FIP because it sets the stage for sharing information, creating networking opportunities and keeping everyone apprised of what’s happening in the world of podiatry. I encourage you to share your information, ideas and events with us.

Janet McInnes
FIP President
GETTING THE WORD OUT...

To kick start the FIP’s promotional efforts about the 2013 World Congress of Podiatry in Rome, Italy, the FIP secured a booth at one of North America’s largest podiatry conferences – the American Podiatric Medical Association’s (APMA) Annual Scientific Conference, which was held in Boston, Massachusetts this year. Incidentally, this is the same city where the FIP held its 2004 World Congress of Podiatry.

The APMA is a member association of the FIP, and we were warmly greeted by many association members who were very interested in knowing more about the world congress. Some had attended a previous FIP World Congress and others had heard positive comments about them and were interested in attending one themselves.

Dr. Robert Chelin, Immediate Past President of the FIP, and Jayne Jeneroux, FIP Director of Corporate Development and Communication, staffed the booth and mingled with exhibitors, delegates and speakers. Professor Mauro Montesi, President of the Italian Podiatry Association, also attend the conference and spent time with Dr. Chelin and Mrs. Jeneroux and walked around the exhibit hall.

The Andre Boticelli music from the Rome Tourism DVD playing at the booth was also an effective drawing card.

Jayne Jeneroux and Dr. Robert Chelin at the FIP booth in Boston

Join us on Facebook

Today, online communication is one of the primary ways of connecting with others and, since its creation in 2004, Facebook has become a key communication tool. According to statistics, Facebook now hosts over 800 million users, and the site has been translated into over 70 languages. Created to make the web more ‘open and social’, Facebook not only allows friends and co-workers to connect instantly online, but it can also be used to advertise and spread information at a speedy rate. But what does this mean for podiatrists and organizations like the FIP? It means that information and awareness about the profession can be shared online via Facebook, and that this information can be instantly accessed by people all around the world.

There are many different ways that Facebook can be used by podiatrists. A general podiatry page could be created and filled with important foot-health tips accompanied by pictures and videos. A page could also be created specifically to spread awareness about proper diabetic foot health. For podiatry professionals, a page could be created informing podiatrists from around the world about events and updates in the podiatry community.

Also, because Facebook is relatively easy to navigate, new information can be added constantly. If an important podiatry event comes up, details can be posted on the Facebook page and if there are new photos or videos to be shared from a recent conference, they can quickly be posted and easily viewed. By creating a Facebook page, and continually adding to it, current information will always be available to anybody with a link to the page.

Once Facebook pages are up and running, they will start being shared and ‘liked’ among users. With over 800 million users, and the average user being connected to 80 community pages, groups or events, Facebook has become a mode of communication that is hard to ignore. By displaying ‘Join us on Facebook’ signs at conferences, in the office or on websites, podiatry information becomes just a click away. When one person chooses to ‘like’ a site, a link is created. From there, others can view the page, receive the information and perhaps choose to ‘like’ the page as well.

Because of the astounding global popularity of Facebook, it is a form of online communication that podiatrists and podiatry organizations should take advantage of. By sharing information, creating links and viewing other pages, podiatrists from around the world can make global connections, and keep on top of what is new in podiatry.
Representatives from more than 40 professional organisation-members of CEPLIS from all over Europe gathered in the premises of the European Parliament on Wednesday (07/09) in Brussels, in order to discuss the European Commission’s Green Paper “Modernising the Professional Qualifications Directive” with the Head of Unit for “Professional Qualifications” of DG MARKT, Mr. Jürgen Tiedje, whose team drafted the document.

The event was launched by Ms. Bernadette Vergnaud, MEP, expected to become the Parliament’s rapporteur on the legislative proposal the Commission is now preparing in replacement of 2005/36. A long-time friend of CEPLIS, Ms. Vergnaud reaffirmed the House’s interest in the liberal professions, underlining that they constitute a key sector for the growth of the European economy. The Euro-parliamentarian stressed the fact that modernising of the Professional Qualification Directive is a priority for the European Parliament and that MEPs from all sides of the political scene are attaching special attention notably on European Professional Cards and Professional Insurance.

Taking the floor after Ms. Vergnaud, Jürgen Tiedje centred his intervention on three key questions:

Who is the addressee of the policies proposed by the Green Paper?

The Head of Unit insisted on the fact that the regulated professions are not the only ones concerned by the “Mutual Recognition” Directive. According to him, it is important to be aware that the scope of the Directive in question is broader: it embraces the partially-qualified professions as well as the non-regulated ones.

Why has the Euro Commission decided to act now?

For Jürgen Tiedje the main reasons that led DG MARKT to push forward the modernization of 2005/36 are the need to increase confidence in what the Single Market actually does, and the need to increase growth in Europe. The free movement of persons is in fact a major contribution to growth because when people move, creativity and ideas move too! As the speaker pointed out: “Growth is coming also from people, not only from capital”.

Where does the Commission want to go?

A new challenge for the Commission is to give a European dimension to the recognition of professional qualifications using the means of the 21st century. In this context, a European Professional Card could be a major improvement of
the current recognition process. Such a Card could in fact not only accelerate the procedure in question but enable at the same time the professionals to get more ownership of the system by getting the country of origin directly involved.

For Jürgen Tiedje, the Internal Market Information System (IMI) could play the role of “back office” for cooperation between Member States but it should not be considered as an “alternative” to the Card: IMI is in fact confidential and therefore not accessible to clients and patients. The Head of Unit also made it clear that the Commission is not intending to impose European professional cards to professions that are, for their own reasons, not interested in it.

On the issue of the Common Platforms, Mr. Tiedje underlined that bringing the minimum required number to only nine Member-States constitutes a radical improvement. Reminding the difficulties the professions concerned by the platforms have faced in the past, the speaker strongly advised the professions to secure the Member-States’ agreement before coming to the Commission with their proposal.

On Language Requirements, the Head of Unit repeated that the Commission is in favour of some controls but cannot allow the issue to become a barrier for the movement of professionals.

Another sensitive topic addressed by Jürgen Tiedje was the Alert Mechanism. For the European Commission, a professional who decides to move needs to demonstrate his/her legal status. Both the professional and the citizen must have an easy access on information relating to who is the competent authority in each country and what are the documents required for the recognition of qualifications by the host State.

Still many important questions remain unanswered such as for example: the necessity or not to immediately alert when a professional has a legal procedure still pending on him.

Taking the floor after Jürgen Tiedje, Jacques Reignault, the President of CEPLIS, thanked the Commission for having conducted the process of consultation with an open mind and for having taken into consideration a non-negligible number of CEPLIS’ remarks. Jacques Reignault expressed confidence that this positive climate will prevail both at the level of the coming two meetings of the Steering Group on Professional Cards and at the drafting of the legislative proposal that will follow the Green Paper.

“Europe is not here to solve all problems”

The possibility was afterwards given to the representatives of CEPLIS Members to discuss their specific questions with Mr. Tiedje. Many among them took this opportunity to ask clarifications on several issues such as the possibility of associating common platforms and the future professional card (Mr. Tiedje excluded this possibility since, in such cases the consent of all 27 Member States would be needed instead of that of 9), or who would be the issuer of the Professional Card (Jürgen Tiedje insisted on the fact that the card should be issued only by competent authorities, the latter being defined by the Member States). The importance of CPD and the difficulty of making it mandatory was also tackled by CEPLIS Members. According to Mr. Tiedje, a lobby on this issue is also needed at the Member States’ level.

“Europe is not here to solve all problems” Tiedje said.

Ms. Bernadette Vergnaud added that the European Parliament is currently having a positive collaboration with Mr. Tiedje’s Unit on the issue.

Forthcoming European Commission conference the 7th of November;

At the end of the meeting, Mr. Tiedje took this opportunity to announce that the European Commission will organise a conference the 7th of November with the participation of the Commissioner Barnier in order to present its analysis of the answers of stakeholders to the Green Paper. The meeting closed on a positive note, many members had afterwards the opportunity to interact with our guests about issues and preoccupations proper to their professions.

Meeting in EP with Mister Jürgen Tiedje

Ms. Vergnaud (MEP), Mr. Reignault, Mr. Tiedje
The world took a huge step forward when the United Nations held its first high-level summit on non-communicable diseases on September 19-20, 2011, at the UN headquarters in New York. As FIP members already know, non-communicable diseases (NCDs) like diabetes and cancers have become worldwide epidemics, and when the resolution calling for the summit was unanimously passed on May, 13, 2010, it was clear that the world was ready to take a serious stand against NCDs.

Resolution 64/265, passed in May 2010, stated that the high-level summit would revolve around the four major NCDs:
- cardiovascular diseases
- cancers
- chronic respiratory diseases
- diabetes

These diseases continue to gain strength and, in 2009, claimed more lives than communicable diseases like malaria and cholera. Fighting through the devastation left behind by these diseases, the 2011 summit was held to bring global attention to NCDs in the hopes that people will be helped and lives potentially saved.

Ready to take action, the UN members agreed to an ‘action-oriented outcome document’ which is considered the strongest possible agreement. By agreeing to the outcome document, global leaders were committing to the cause and agreeing to take the necessary steps to make a difference. With the ultimate goal being to reverse the epidemic of NCDs, governments will contribute by increasing access to quality medicines and technologies, providing better diagnostic services, and working towards diabetes prevention by promoting healthy diets and physical activity.

Although the summit was a monumental occasion in the battle against NCDs, it is only the beginning, as these diseases will not dissolve overnight. Yet it is inspiring to know that the world is ready and willing to take a stand and work towards a brighter and healthier future.

Sources: www.ncdalliance.org/summitfaq
www.idf.org/un-summit-and-beyond-new-era-diabetes

Good news … the FIP’s Academy of Podiatric Medical Educators is making good progress in re-invigorating the academy on a number of fronts.

One of the key initiatives is expanding the current database to include all eligible podiatry institutions around the world and ensuring that the data collected is accurate and complete. To accomplish this, the Academy recently sent out an email requesting registration and contact information.

Academy President Dr. Vince Hetherington has also hired Donna Perzeski, a librarian with the Ohio College of Podiatric Medicine, to assist the Academy with its activities.

The Academy is proceeding with plans for a comprehensive presence on the FIP website in the near future. And, they are getting geared up to work with the scientific committee of the Italian Podiatry Association regarding the lecture program for the next World Congress of Podiatry that will take place in Rome, Italy on October 17-19, 2013.
Several prominent FIP people were invited to the Awards ceremony and luncheon of the Society of Chiropodists and Podiatrist (SCP) that was held at the House of Lords in London, England on September 21, 2011. In attendance was The Right Honourable Lord Morris of Manchester, AO QSO, who is the President of the Society of Chiropodists and Podiatrists. SCP Chairman Professor Stuart Baird gave a warm welcoming speech and introduced Lord Morris, who presented several awards to SCP members.

More than 100 guests from across the United Kingdom were in attendance, including FIP President Janet McInnes (who is also the immediate Past Chairman of the SCP), FIP Corporate Partner Chairman Hans Bakker and SCP Past Chairman Ralph Graham.

Help us celebrate successes!

If you know of recent appointments or achievements of podiatry colleagues, please send the information to Jayne Jeneroux, FIP Director of Communication and Corporate Development, so we can include it in this column. Email the information (and photos too, if possible) to jjeneroux@xplornet.com.
The world is changing, and with each passing day the gender inequalities that plagued the past are fortunately moving further away. Jobs that were once considered ‘male’ professions are now being held by women as well, proof that the working world is no longer a reflection of society’s gender roles, but of a person’s hard work and dedication.

More and more women are entering the world of podiatry ready to do their part to push the somewhat misunderstood profession to new limits. In fact, according to 2010 statistics, podiatry schools in the United States were split nearly 50/50 between male and female students; in Canada, at the University of Quebec at Trois Rivieres, the enrollment was also split 50/50, and in Europe, more than 50% of SOCAP members were women. Along with practicing podiatry, many of these women are stepping into the spotlight to take on important roles for the good of the global podiatry community.
Janet McInnes, the current President of the Federation Internationale des Podologues, has been working in the podiatry field for over 30 years, and is a shining example of the impact that women are making on the profession. After graduating from the Glasgow School of Chiropody in the early 1970s, Janet began work for the National Health Services, but then made a switch from practicing podiatric medicine to teaching it. Holding a teaching post in Glasgow until 1980, where she also served as secretary to the Association of Chiropody Teachers in the UK, Janet made a switch, and moved on to join her husband in private practice. Along with holding the title of FIP President, until recently Janet was also the Head of the Division of Podiatry and Deputy Head of the School of Health Professions at the University of Brighton in the United Kingdom. With so many years working in podiatry under her belt, and by having held positions in everything from general podiatry to higher education, Janet McInnes is a woman who lives and breathes the profession in hopes that awareness will continue to spread around the world.

Unlike Janet McInnes, who immediately pursued podiatry, Dr. Kathleen Stone, current immediate Past President of the American Podiatric Medical Association, began her professional life in nursing. A prime example of how gender roles have shifted over the years, Dr. Stone grew up in a time when women were encouraged to pursue traditional ‘female’ careers like teaching and nursing. But after three years of working as a nurse, Dr. Stone realized that it just wasn’t for her, and at 35 decided to follow her own ambition, and went back to study podiatry. Now, in her own practice with another podiatrist in Glendale, Arizona, she is in the profession meant for her. And although Dr. Stone is proud to be a woman working in podiatry, she does not want to be recognized for her gender. In fact, she encourages women to always keep things gender neutral; that way people will recognize and remember their work and personality, not the fact that they were female.

Of course Janet McInnes and Dr. Kathleen Stone are only a small example of how women are making a difference in podiatry. Holding positions on the FIP executive board along with Janet McInnes are Heidi Corcoran—Secretary General, and Diamanto Maliotou-Papasavva—Treasurer, making the FIP executive board a 50/50 split between male and female members. And at the 2011 FIP Annual General Meeting, Joanna Brown, Chief Executive Officer for SOCAP, along with Dr. Kathleen Stone, presented for the delegate session on advocacy.

The professional world is no longer male dominated, and with women like Janet McInnes and Dr. Kathleen Stone doing such extraordinary work for podiatry, the way has been paved, and with each graduating class, more and more women will continue to enter the profession. But thankfully, in our modern society, this is not considered unusual, for people, and more specifically podiatrists, are now being recognized for their special skills and hard work, not for their gender.

Acknowledging past contributions by FIP women

Two other FIP-connected prominent women that stand out are Gwen French (from England) and Jose Roofthooft (from Belgium).

Gwen French’s involvement with the FIP began when she and Paul Shenton (FIP President from 2005-2007) attended an annual meeting of the FIP as observers in 1985. Gwen French was elected as FIP President in 1997.

Jose Roofthooft’s FIP involvement and contributions began in 1987 with her insistence that the Group de Reflection be created as a commission of the FIP. She became its first President and Gwen French was among the first active members. Jose Roofthooft eventually replaced Gwen French as FIP President in 1999. Over the years, both women have contributed greatly to the growth and professionalism of the FIP.
ABP-BVP/Belgium

by Marc Bourgeois, ABP-BVP Chairman

The institutional problems which we were meeting for more than one year let the country suck in the healthcare field. The lack of a federal government froze many steps in the general medical field and in podiatry in particular.

However, despite this difficult period, the ABP–BVP (Association Belge des Podologue) is working hard about two features: diabetes and education.

Concerning diabetes, two pluri-disciplinary organizations, a French speaking one (Association Belge du Diabète) and a Flemish speaking one (vlaamse diabetische vereniging), are aware about the chronic lack of podiatrists (200 recognized podiatrists for 350,000 diabetic people!) and are looking for solutions to cover the public healthcare requirements regarding the diabetic foot. On the other hand, the important number of chiropodists could support the podiatrist to treat the patients. For that, it is necessary to create a specialization called "feet specialists" issued from the chiropodists' community trained enough to help all the actors in the place including podiatrists. Consequently, the ABP-BVP has been working in synergy with the diabetes associations in order to set up the field of these "feet specialists". No doubt that at the end, ABP-BVP will open the doors to those specialists to manage the grade 0 and 1 diabetic patients. Matter to follow so.

Regarding education, the landscape of the country is different from the Flemish and from the French part. For the French speaking Belgium, the highest authorities being charged of the education curriculum are only open to the executives of the paramedical professions. The professional trade unions have no access to the decision power to change or re-engineer the curriculum. The ABP-BVP association is lucky, in this context, as through his Chairman who is attending the High Paramedical Council of the High School, where negotiations are done for any modification of the curriculum, we have been able to propose two important reforms:

- The re-engineering of the courses upon the skills profile
- The basic curriculum of the Master in Podiatry, in order to open university to podiatrists

On the other hand, regarding continuous training and knowledge updating, the ABP-BVP is associated to the High Schools who are sole able to deliver the official educating curriculum in this field. The way chosen by our association to work together the High Schools allows us to guaranty true quality curriculum for the continuous training. Of course, it is less blatant that professional congresses as others organized them, but so more profitable to the practitioners with quality updating done by podiatrists and medical doctors of high scientific and professional level. In this matter, ABP-BVP remains faithful to its policy: offering the best to all the podiatrists of the Kingdom in order to guaranty quality healthcare to the patients.

Lasf/Denmark

By Tina Rønhøj

After six year of uncertainty…

June 1 2011, the Danish podiatrists waved goodbye to six years without an agreement with the National Health Service in Denmark and entered into a new phase.

The new agreement has brought with it a lot of change as every body who is working for the state had to invest in electronic equipment for their clinics to be able to live up to the demands. It has been hard work for our organisation as well as our members for about a year, however, things are falling into place now and we seem to have conquered the challenges.

One of the major changes is that every patient with diabetes has to undergo a full examination of their feet the first time they enter a clinic. The result of the examination shows which state their feet are in and determines how much subsidised podiatry they are entitled to. The examination will be repeated once a year.

The day of the foot

In Denmark, we have announced the 22 September as the day of the foot. On that day, the Danish podiatrists will be visible in the streets and shopping centres all over Denmark. They will inform people about their feet and give them a quick check-up. It is our hope that this day will make more people aware of their feet and the problems they may have and encourage them to seek help if they need it. The day of the foot will be announced in Danish magazines and hopefully on radio stations and in the television.
Free magazine
For about a year and a half, we have published our own free magazines which primarily are handed out in the clinics of podiatry. The magazine is published four times a year. The articles in the magazine concern feet in one way or the other, it puts the spotlight on the foot and helps our members promote their values.

FNP/France
by Louis OLIE, FNP President

Image of the profession
We have developed the image of the profession getting offices in the board of national organizations such as UNPS (National Union of the Healthcare Professions) and CNPS (National Council of the Healthcare Professions). We have also got an office in the national commission working on the infectious risks in the podiatry offices.

Agreement with a Hospital
We have just signed an agreement with the CHU LYON to proceed to the diagnosis of the onychomycosis which was, until now, reserved to the medical doctors in the aim to extend our skills.

VDP/Germany
by Volker Pfersich, President Verband Deutscher Podologen (VDP) e.V.

The Institute for Body-Related Therapies at the Steinbeis-University Berlin has inaugurated the course of study ‘Bachelor of Science (B.Sc.) in Complementary Medicine and Management with a specialization in podiatry, starting in the winter term 2011/2012.

The clearly structured course of study (Bologna process) according to scientific criteria will set up new standards in education for podiatrists in Germany.

The design of the study course for a Bachelor of Science degree in podiatry (BSc Podiatry), which runs on a part-time, extra-occupational basis over three academic years, was set up by a cooperating group of physicians, scientists, experts and the German Association of Podology ‘Verband Deutscher Podologen’ (VDP).

The course is aimed at podologists/podiatrists already at work and to medical doctors. The course primarily aims to a skilled and sustainable provision of diagnostic and treatment skills as well as the relevant expertise in the field of podology, manual medicine in general and in particular of podiatry.

The comprehensible quality of the study courses and associated dynamics in the fields of research and teaching will also contribute in the medium term, to give the profession of podology/podiatry a legitimate recognition from legal, political and social perspectives.

Further information can be found under www.koerperbezogene-therapien.de and www.verband-deutscher-podologen.de

Best greetings from Germany.

SOCAPI/Ireland
By Carmel Devine

The Society of Chiropodists and Podiatrists of Ireland (SOCAPI) hosted their annual conference on the 1st and 2nd October 2011 in the Lyrath Estate Hotel and Conference Centre, Kilkenny. It was addressed by Dr. James Reilly, TD Minister for Health and Children, also a General Practitioner (GP). Dr Diarmuid Smith, Consultant Endocrinologist and National Lead for the National Diabetes Programme of which footcare is a major part. Reflecting the developments in Diabetes, other international speakers included Dr. David Armstrong, Dr. Caroline McIntosh and Martin Fox. In addition there was an extensive musculoskeletal track, all of which promised a most informative weekend.

As part of the National Diabetes Programme we are on course to recruit 16 Podiatrists for the major hospitals in the country. This is recognised as an important first step in reducing the burden of ulceration and amputation, and much work is being undertaken to develop integrated diabetes care. Those screened and identified at low risk of developing foot complications will be managed by the GP and Practice Nurse and those with active foot disease will be managed by the Hospital Specialist Footcare team.

The first cohort of Podiatry students enter their 4th and final year at NUI Galway and will be ready to supplement the podiatry workforce in June 2012. Meanwhile, the profession continues to make progress towards State Registration and Ginny Hanrahan, CEO and Registrar of CORU will also address the Conference.
AIP/Italy
by Mauro Montesi

In the quarter under review, the engagement of AIP has focused on two issues of great importance for Italian podiatry. The first concerns the organization of the World Congress to be held in Rome from 17 to 19 October 2013. We first selected some large companies that organize congresses, which gave the necessary guarantees of experience and reliability. After choosing a company, we have compiled a draft contract that shows the performance by the event organizer.

We then solicited the assistance of the City of Rome, which has made available a few copies of a DVD “Tribute to Rome,” useful to promote the city at the European Associations and beyond.

We have also done an operational plan aimed at informing the highest Italian authorities about the important event (President of the Republic, Prime Minister, Minister of Health, the Mayor of Rome, Dean of the Faculty of Medicine, etc.).

In late July, the President of AIP, Prof. Mauro Montesi, attended the APMA conference in Boston, U.S.A, which, with the screening of the DVD, presented the first organizational steps to locate the seat of Congress (“Palazzo dei Congressi” EUR-District).

The second issue is the 16th AIP National Congress, which was held in Marina of Grosseto 15 to 18 May 2011. This year it was organized with a different formula, giving more space to workshops and limiting to one half-day the Congress in the plenary hall. The latter dealt with the topic “General medicine and podiatry. What is collaboration?” with various speakers, including Senator Mariapia Garavaglia and Senator Cesare Cursi, calling for a closer relationship between the physician and podiatrist in the interest of the patient.

The workshops addressed the topic of “Innovative therapies for the treatment of diseases breach.” All the workshops were a great success at the scientific level and on the presence of more numerous. The topics covered the major diseases and treatments primarily to address them.

In addition to these two issues, we need to highlight the numerous initiatives for the enhancement of the profession, through contacts with the highest legislative bodies (Parliament) and executive (government) in order to remove some constraints that exist in Italy, such as, for example, that the professional profile must also be updated to take account of the studies and training of podiatrists Italian (Degree, Master vocational, etc ...).

There was also intensive participation in major conferences, which primarily addressed the issue of the role of the chiropodist in diabetes, highlighting the contribution that our profession can make in the presence of diabetic foot complications.

Sveriges Fotterapeuter/Sweden
By Stella Tommos, chiropodist, member of Sveriges Fotterapeuter and unbiased observer

The Swedish National Board of Health and Welfare:
New national guidelines for the care of the diabetic foot

Ulcers
The National Health Service shall:

• Offer regular screening to detect sensory loss due to diabetes, palpation of foot pulse and inspection of feet in order to detect biomechanical problems. (Priority 2)

• Offer preventive foot care when, based on screening, the risk of foot ulcers is great.

• Offer orthopedic treatment with shoes and/or insertions for individuals who are high risk patients when coming to developing ulcers due to biomechanical faults. (Priority 2)

Multi-disciplinary foot team

• A multi-disciplinary strategy for treatment of severe problems due to established injuries shall lead to fewer amputations.

• Members of a foot team: diabetologue (coordinator), diabetes nurse, vascular surgeon, infection specialist, orthopedist, chiropodist, orthopedic engineer, radiologist and clinical physiologist.

• The multi-disciplinary foot team set high demands on organization and structure. Access to different specialists can be difficult to achieve outside the county council.

• A quick handling of referrals and improvement of cooperation between the multi-disciplinary foot team and primary health care are vital components in safe care.

• The National Health Service shall offer treatment and diagnostics of serious foot problems, such as slow healing ulcers and/or infections and foot deformity, at a multi-disciplinary foot team. (Priority 1)

• Specialist care, primary health care and home nursing shall co-operate.
Society of Chiropodists and Podiatrists/UK

By Joanna Brown

The summer has passed by all too quickly and we are now preparing for a busy autumn.

The Health and Social Care Bill, which will make major changes to the National Health Service in England, is likely to be approved finally by Parliament after much controversy. The Bill will enable independent and voluntary sector healthcare organisations to be approved to provide NHS services. There is still much uncertainty about how this will work in practice, but podiatry will be one of the first services to be included in the new arrangements.

Another major change is that General Practitioners will be responsible for deciding which services will be commissioned in their area. They will be obliged to seek advice and input from other clinicians, but podiatrists and other Allied Health Professionals will not have a guaranteed seat on the commissioning boards and may struggle to have influence.

These changes will present major challenges for the Society, and we are running road shows throughout England to make sure that members understand the implications and are equipped to engage with commissioners and the public in their local areas.

Because of the economic situation, the NHS in all parts of the UK is making cuts, which is leading to podiatrists being made redundant and vacant posts not being filled. This is creating a particularly difficult situation for new graduates who are being driven into the private sector whether or not that is their preferred option, or in some cases taking podiatry jobs abroad. This is especially frustrating when there is so much need for highly skilled podiatrists who can prevent limb loss and other complications, which will save the NHS money in the long run. The Society is working hard to broadcast this message and convince officials that their policies are short sighted. We are working with the major diabetes charity in this country, Diabetes UK, which is planning a campaign on the diabetic foot in 2012.

The Society conference, with the theme of “Keeping you on your feet” will take place in the lovely spa town of Harrogate on 24-26 November. As we build up to the London Olympic Games our keynote speakers will include the Chief Medical Officer for Paralympics GB and Baroness Tanni Grey-Thompson, who won 11 Gold Medals for Great Britain in Paralympic wheelchair events. We hope that some of our friends from FIP will come to the conference, and take advantage of some Christmas shopping into the bargain!

AUPA/Uruguay

By Liliana Bello, APU President and Gisela Fiorella, AUPA Secretary

Podiatry in Uruguay is progressing.

We grouped in an association called “Association of Podiatrists Uruguyan University” (AUPU) which is working hard to achieve Podiatric Medical Degree.

A.U.P.U. Podiatrists represents graduates of the School of Medical Technology, Faculty of Medicine, which now is a University Degree of 3 years’ duration, so when we reach the Degree will be 4 years.

Our work in the community is independent or dependent. On Public or Private Hospitals our work is dependent, but is only for people with diabetes.

We have succeeded in entering the Wage Board in our country.

The Podiatrists also reached Government Programs, such as “Goal for the Future” by the Ministry of Tourism and Sports for young football players.

The main function of Podiatrists in Uruguay, wherever you work, is the education of the patient about the health care of their feet. This is essential in the prevention of any disease. We’re teaching in schools, high schools, sports clubs, old care institutions, etc.

Also we are teaching society and the health teams about the importance of our role, because there is much ignorance about our function.
Giving back to those in need can be a rewarding experience, and although donating money is often the first thing we think of when it comes to helping others, one of the most effective ways to give back is to volunteer your time and skills.

Dr. Shazia Malik, a podiatrist working out of Montreal, Quebec, first decided that she wanted to give back when she learned about the devastation caused by a tsunami in Indonesia. Her first response was to make a generous donation to what she felt was a very worthy cause. Unfortunately things did not go as she had hoped.

“I pledged a lot of money to the cause, but got discouraged when I found out that bureaucracy was interfering with people getting the help they needed,” says Dr. Malik about her donation.

The less than ideal situation didn’t hinder her, though. Instead, it inspired her to begin donating her time and personal skills as a podiatrist and health-care professional to help people in need.

Born and raised in Toronto, Ontario, Dr. Malik attended the University of Toronto, then headed to the New York College of Podiatric Medicine where she obtained her DPM. After completing her residency in Brooklyn, New York, Dr. Malik opened her own practice in Montreal, Quebec in 1998. She was the first podiatrist in Quebec to obtain Diplomat status, the highest recognition given by the American Board of Orthopaedics and Primary Podiatry Medicine.

Dr. Malik went on her first volunteer mission in 2005. Ready to donate her time and skills, she traveled alone to Pakistan to help deal with the aftermath of a violent earthquake. Upon arriving, she connected with the Italian Red Cross, a group she found to be very well organized and well equipped with a lot of good supplies. Dr. Malik remained working in Pakistan for four weeks before returning home to Canada.

Next, she focused her efforts on the people of Haiti, where she completed two, seven-day missions through the University of Miami medical school, another very organized group. In Haiti, Dr. Malik found that her skills were put to good use, for most of the work she did was on ‘the foot’. There were many open wounds and a lot of diabetic people that needed tending too. She performed many surgeries and found the whole experience to be a lot like working as an ER doctor.

Dr. Malik decided to join up with Islamic Relief Canada after a recommendation from her brother, who told her that they were a very well-organized and safety-focused group. Going purely on her brother’s contact, Dr. Malik went on a 10-day mission to Somalia. On this, her most recent mission, she was one of only three medical personnel on site. Unfortunately, when she arrived, Somalia wasn’t prepared for them and supplies were few. Dr. Malik immediately began seeing patients and coordinating efforts with other relief organizations. Together they selected a hospital in desperate need of help, and started establishing protocols to ensure that the work and help that had been started would continue even after they departed the country. About her time in Somalia Dr. Malik stated, ‘It was very different, and very challenging, but a great experience.’

“I pledged a lot of money to the cause, but got discouraged when I found out that bureaucracy was interfering with people getting the help they needed,”
If you haven’t yet registered on the FIP site www.fipnet.org take a moment to do so now. If you have already registered, be sure to check back often for updates, contest announcements and more.

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When asked how she manages to juggle her volunteer missions along with running her private practice, she says, “I am fortunate to have patients that are loyal and healthy.” They realize that she has a strong desire to help others, and now presume she will go wherever disaster strikes.

“When the earthquake happened in Japan, my patients were all asking ‘Dr. Malik, when will you be going to Japan?’”

It is apparent that volunteering has become an important part of Dr. Malik’s life, and is something that she is determined to make a priority.

After participating in so many successful missions, Dr. Malik is now being asked by local fundraising organizations to provide presentations about her involvement and experiences. After years of donating her time and skills to worthy causes, Dr. Malik is excited to share her expertise.

There is nothing more rewarding than helping those in need, and Dr. Malik lives this truth every day. By donating her money, time, skills and now expertise and experiences, she has become a volunteering veteran, and in a relatively short period of time. When asked what her advice is on where to start volunteering, Dr. Malik recommended that people look for organizations that are well-organized and that simply do good work. Everyone can volunteer and help others by taking their skills and sharing them with those in need, whether it is in Somalia, or in their own community.
Diabetes has become a worldwide epidemic, and the facts are shocking, to say the least. In 2009, more people died as a result of non-communicable diseases (NCDs) than of communicable diseases like malaria and cholera, and by 2030, it is estimated that $47 trillion will have been spent battling NCDs like diabetes.

Because of the severity of diabetes, it is crucial that awareness be spread and people around the world properly educated. In response to these staggering numbers, the FIP has formed the Diabetic Foot Commission, including a public relations committee ready to join the global fight against diabetes. Comprised of members from all corners of the world, the committee is one of four committees, based on the four key strategies of the Diabetic Foot Commission.

To keep their energies focused, the committee has designated themes to raise awareness and education about all the different, and equally important, aspects of diabetes. The theme for November 2011 is Podiatrists Fighting Amputations Worldwide. For many diabetic patients, amputation is a harsh reality, but by dedicating the month of November to education and awareness about amputation, the committee is making sure that people become more aware of ways to alleviate amputations from occurring.

The energy and time that the committee members are dedicating to this commission will help the FIP become the global source for information concerning diabetes. The committee has been working on a number of educational materials, such as true and false quizzes, healthy lifestyle information and exercise/running tips to ensure that important diabetes-related information is readily accessible to everyone. Making FIP members aware of and encouraging them to share this information with their patients will help grow the awareness about diabetes and hopefully lead to reduced incidences of amputation.

Podiatrists can rest assured that the FIP will be there to provide them with all the tools necessary regarding diabetes education to aid them in teaching people about diabetes and what they can do to fight back and live a happy and healthy life.

### FIP Diabetic Foot Commission Objectives

As presented at the 2011 FIP AGM in Geneva, Switzerland last May, the FIP Diabetic Foot Commission is comprised of four key objectives. Strategies for each objective were also identified, as outlined below:

#### Four Key Strategies

**Objective #1 – Educate the public on the pedal effects of DM**

*Strategies include:*

- creating an annual public DM campaign
- developing and providing PowerPoint presentations for member use
- offering patient/public contests

**Objective #2 – Be the educational resource on DM and its pedal complications for our members**

*Strategies include:*

- creating a DM page on the website, which includes statistics, links, meetings and a lecture series

**Objective #3 – Educate other health professionals on the podiatrists’ role in the care and prevention of the diabetic foot**

*Strategies include:*

- FIP members participating in world conferences
- establishing PowerPoint presentations for use
- FIP member involvement in their DM associations

**Objective #4 – Develop strategic alliances with other organizations**

*Strategies include:*

- establishing a summit on amputation rates around the world
- identifying the prominent associations
- collaborating with associations in our campaign
Alice Peterson was a teenage tennis prodigy, before being struck down with rheumatoid arthritis aged 18. Consequently Alice has had considerable experience of multidisciplinary care, having been on the receiving end of a wide range of health care interventions. In recent years, health policy has recognised the concepts of patient-centredness and the key role of expert patients to improve the delivery of various aspects of health care. The concept of the expert patient was defined in 2001: 'Research has shown that today’s patients with chronic diseases need not be mere recipients of care. They can become key decision makers in the treatment process. By ensuring that knowledge of their condition is developed to a point where they are empowered to take some responsibility for its management and work in partnership with their health and social care providers, patients can be given greater control over their lives.'

Several reports and policy documents from successive Governments have recognized the concept of patient-centredness and the key role of expert patients to improve the delivery of various aspects of health care. The concept of the expert patient was defined in 2001: 'Research has shown that today’s patients with chronic diseases need not be mere recipients of care. They can become key decision makers in the treatment process. By ensuring that knowledge of their condition is developed to a point where they are empowered to take some responsibility for its management and work in partnership with their health and social care providers, patients can be given greater control over their lives.'

The latest Government White paper advocates ‘putting patients at the heart of the NHS, through an information revolution and greater choice and control’. In the following moving and absorbing account from a patient’s perspective we highlight the role of the expert patient, identifying what their insights can offer podiatry and how these reflections can inform our Continuing Professional Development.

BACKGROUND
Alice was diagnosed with rheumatoid arthritis (RA) when she was 18. Now 36, she has lived with this condition for half her life. During those 18 years the illness has been aggressive and unrelenting. Alice has tried every anti-rheumatic drug and has undergone 11 major joint replacement operations. Alice describes what it means to live with RA from a patient’s perspective, and what it feels like to go from a very active teenager, to someone living with a chronic long-term disease, focusing on the impact of pain on both a physical and emotional level as well as the role of podiatric care.

ALICE’S STORY
To show you the true impact RA has had on me, I need to illustrate what life was like before. Life was pretty good – although of course I didn’t appreciate it then. At the age of 12 I started to play tennis competitively; my heroine was Chris Evert. Every weekend was taken up with training or tournaments; Tim Henman was in my regional training squad. I was playing competitively across the country and abroad, travelling to America, Germany, France and Spain. At 16 I was one of the top ranking juniors in the UK. By 17 I had secured a tennis scholarship at an American University.

Aged 18, while in the finals of a tennis tournament I said, ‘Mum, my thumb hurts’ and I could not grip the handle of my racket. I poked and prodded my hand; nothing looked wrong, but annoyingly I had to concede the match. I went to casualty, my wrist was bandaged and I was given a painkiller. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt. The next day it felt fine again, so all was OK……until a week later when I couldn’t serve over arm because my shoulder hurt.

Continued next page
'With all the symptoms you describe it could be galloping arthritis,' my GP said, pricking me with the sharp needle and drawing out more blood.

'No way,' I dismissed. 'Only old people get that.'

Six weeks later, after yet more blood tests, a final diagnosis of RA was made and I was referred to a rheumatologist immediately.

I can remember the day I visited my rheumatologist vividly. Mum and I walked down an airy corridor, the smell of stale cabbage drifting from the kitchens. We passed porters pushing frail people in wheelchairs, doctors in white coats, nurses and visitors. Mum tells me she was fighting back the tears and thinking, 'why my Alice?' I, on the other hand, had a spring to my step; I wanted to be seen quickly. Thank goodness I have RA, I thought to myself. I'm not a fraud. I can take a pill and make it better. I was sitting in the hospital filling in questionnaires. 'Can you lift a cup to your mouth?'. 'Can you open a new box of soap powder?'. This is stupid, I told Mum. Of course I can lift a cup to my mouth. I ticked 'With no difficulty' for all the questions.

My doctor called me into his office. He was Canadian. We talked initially about my tennis. Next he was scribbling down a picture of joints and how they worked. He's attractive, I was thinking, at least my doctor is good looking! I wasn't listening to his medical jargon. 'As long as it clears up so I can go to America, that's fine,' I said. 'I am due to sign the contract this weekend,' I informed him. Nothing, surely, could get in the way of my ambition to go to America? I can remember him being quiet then, not looking me in the eye. 'Alice, there are no guarantees' he said. He wanted me to defer a year. I couldn't believe this RA could affect me for a year? That was impossible.

'You have to get me better by the autumn... you can, can't you?', I persevered.

He was silent. 'Can you get me better at all?', I gasped.

'Alice, I'm afraid there is no cure,' he said.

I prayed so hard my doctor had got it wrong, but when I was admitted into hospital and having every single joint drained of fluid, great thick test tubes of liquid collecting at the bottom, I realised my life had changed, overnight. My diagnosis was at a crunch time because A levels were six weeks away. My first doctor got me through this period. He would sit at the end of my bed and test me on my (very bad) French. He talked and explained things to me. He was kind, and saw me not only as his patient, but as 'ALICE'. At the time I didn't realise how unusual this was, and that I would receive very different levels of care in the future.

Pain is hard to describe. I shall always remember this drawing a young child did for an arthritis magazine (Figure 1). Without the need for words this image conveys the intense, hammering hot pain I experienced from my head right down to my toes. On more practical levels I couldn't do the most basic of tasks because pain prevented me. My mother sometimes had to help me eat; my father once held the telephone to my ear so I could talk to my friend – pain reduced me to a life of existence. Pain affects you on every single kind of level – it's not just about what you can or can't do. I chose three words to describe how I feel about pain: Pain is:

Torture – there were times when I couldn't even bear anyone touching me because the slightest pressure on my body hurt. All I wanted to do was curl up into a ball, covered in hot water bottles and never wake up again.

Suffering – and it's not only me. It is one of the worst things watching someone you love suffer my father tells me. That pain affects others is one of the most important lessons I have learnt.

Grief – many ignore the mental side of pain but it is just as overwhelming as the physical. It's a grief of losing a part of you. I missed my tennis, a sadness that shall always be with me. Over and over again I asked that soul-searching question, Why me?

'WHY ME?' is a destructive question that I knew I had to stop asking – but how can you not be tormented by that question? I would look at the photograph of me in Miami after winning the 'Miami Shores' tournament. My tennis days now seemed little more than a dream. 'Dear God, give me my old life back, please,' I prayed every day.

In the 18 years that I have had RA the time when it truly affected me was a year after the diagnosis, when I was at Bristol University. I still hadn't accepted I had RA, and if I was unable to accept it, how could I tell other students? It was so embarrassing, so unglamorous. I still believed that RA was an old person's disease. At this stage the pain was worst in my feet. I had managed to pick the hilliest of university cities, so how was I going to get to lectures? An extract from my autobiography illustrates how the pain got in the way of being a normal student:

'At the end of a typical week my feet felt as if they have been fighting – under protest – in a major war. When I took my socks off, the toes were battered soldiers, squashed up and blistered. Two of my toes are in love – and it's not only me. It is one of the worst things watching someone you love suffer my father tells me. That pain affects others is one of the most important lessons I have learnt.

Walking to the phone box, one hundred feet down the corridor, felt like walking barefoot across a stony beach, shells and sharp pebbles digging in at each turn. Breathless,
I stand still, the pain lingers, meanders around my feet and ankles, travels up to my knees and hips. At the end of my journey I dial my sister Helen’s number. I scream inside as I listen to the engaged tone. ‘Get off the phone’, I panic. I can’t go away and come back again. I dial for the fifth time, sigh with relief when I hear the ringing tone.

‘Hi, are you having a fantastic time?’, she asks.

‘No!’ I screech immediately, before lowering my voice. ‘Oh Helen, it’s been awful, nothing like I imagined.’ I tell her about my week.

‘Go and see your doctor,’ she advises. ‘Don’t put a brave face on it all the time, it won’t help you.’

My new doctor prescribed heavy doses of steroid and a new drug back then, called methotrexate, which had had fantastic results in the USA. I was popping pill after pill, yet the pain wasn’t easing. When I told my doctor, that I was struggling to get to lectures and was in pain all the time, his advice was ‘Go to bed earlier; get up earlier.’ Desperate, I asked him if I could ‘up’ the dose of steroid; he said no, warning me of further side-effects. I told him I was depressed. He offered me Prozac.

Looking back, surely the most practical thing to have done was to be referred to a counsellor or pain specialist? Maybe I could have seen a podiatrist who could have given me advice on footwear and made me some insoles? My feet were a complete mess. Looking back, what I needed more than anything at this time was a holistic approach. RA cannot be cured, so what can be done to help me live with it and manage the condition?

Pain means: torture, suffering and grief. If you leave all these words alone you might as well give up. You just become a victim. These words must be balanced by: help, understanding and support. With no medicine working, I decided to take the matter into my own hands; I looked to alternative methods. I met a healer called Albert during a healing service at church and felt I had nothing to lose by meeting up with him. ‘Healing is all about accepting,’ he told me in a hotel. ‘If I try desperately to aim this piece of paper into the bin I can guarantee it won’t go in.’ He scrunched the piece into a ball and threw it towards the bin. ‘You see,’ he said, with a smile, picking it up off the floor. ‘Now if I throw it in without a second thought, it will go in.’ He threw it haphazardly over his shoulder. ‘See.’

‘It didn’t go in, actually,’ I pointed out.

‘Oh. It’s never worked, but you understand my theory. You understand’

 Needless to say Albert was a complete nutcase. The last news I heard of him was that he was in prison for credit card fraud. I think he had been on the run for years.

However, Albert didn’t put me off trying other things. In the secrecy of my bedroom in halls, I brewed fungi tea, bathed in Dead Sea salts, wore a magnet watch. I visited a dietician who told me she could cure me within two years. My father was cynical; my doctor very anti these treatments, but I just wonder, who wouldn’t have given it a go? I was prepared to try anything because all I wanted to be was a normal student. Pain is very isolating. Eventually, fellow students did find out I had RA because like my very first doctor he was talking to Alice, not a hospital number. I completed my degree after three years. Looking back, it was one of the most important decisions to stay on at Bristol. When I received my results I was so proud. ‘I walk slowly to the car, wishing with all my heart I could run. If I did not have RA I would be skipping across the park, screaming at everyone that I got a First at university. Well, I cannot run, but my heart skips instead.’

After university, I moved to London, but the RA didn’t give up. Relentlessly it ravaged every single joint, to the point where I had to admit defeat. When I moved home to be cared for by my parents I wasn’t sure how I was ever going to be independent again, and this no doubt frightened Mum and Dad too! It was during this time that, encouraged by one of my father’s friends, I began to write; he said I had a story to tell. I dug out old tennis photographs and scrapbooks and reread old tennis diaries. I began to enjoy the creativity of writing and, though it didn’t take away the pain, it certainly distracted me from it.

Continued next page

1 Anti TNF (tumour necrosis factor alpha) drugs have been in use for almost a decade now, and although expensive have shown good efficacy across a series of trials and have revolutionised the way RA is managed.
The aims of NRAS
The National Rheumatoid Arthritis Society (NRAS) helps and supports people affected by rheumatoid arthritis (RA) and their healthcare professionals by:
- Providing information, education, support and advocacy
- Raising public awareness of RA
- Raising the priority of RA with politicians and policy makers
- Campaigning for equal access to good care and services for all
- Facilitating networking and encouraging self-management
- Raising NRAS funds to work towards our vision

Learning Points for reflection
1. How does this narrative facilitate a re-consideration of how your clients with chronic, long-term conditions might cope with their complaints?
2. Alice describes how podiatric care improves her overall health. In what ways do you feel your interventions provide a net health gain and how might this be assessed?
3. How can expert patients contribute to your service or practice development and/or your CPD?

As the story progressed, I had no idea how to end it, until we heard some exciting news. As a 24 year-old, I had had RA for six years. My parents watched me get progressively worse. I was on the waiting list for an ankle replacement operation and I needed more surgery on my right hand. My eyes were tired of straining to see the light in the black tunnel. But, at last, I could see a tiny candle of hope. A new ‘anti-TNF’ drug I was to be tested on ‘guinea pigs’ in Bath and I was praying I would get a place on this trial.

A nurse handed me the now familiar questionnaire that assessed ‘your usual abilities over the past week’.
- Are you able to dress yourself, including tying shoelaces and doing buttons?
- Open a new carton of milk (or soap powder)?
- Lift a full cup or glass to your mouth?

Beside each question, I tick ‘UNABLE TO DO’. A box I never dreamt I’d go to.

When the professor running the trial entered the room Mum and Dad wished me good luck. I took in a deep breath. ‘This could be the beginning of a new life. It may be different. But I want to have another chance…’ To everybody’s huge relief, I was accepted on to the trial. Yet there was still one very major fear: one in four of us were going to be a ‘placebo’ case.

I’d like to give an even clearer idea of what life was like just before taking the drug, and just after. The trial was an hour and a half’s drive from my parent’s home in Winchester. In order to get me there, firstly I had to get up. Mum and I had got into a routine. She’d come into my bedroom, stand on the bed behind me and gently slide me into a sitting position so I could eat my breakfast. Then I’d have a shower. After that I’d lie on the sofa bed downstairs.

When the time came to leave I had to get into the wheelchair; Mum or Dad would then help me get out of the wheelchair and into the car. On arrival, everything had to be done in reverse so by the time I had reached the clinic we were all exhausted! Next I had to learn how to inject myself. I was a number on the trial; no one could tell me if I was the unfortunate ‘placebo’ case, trundling down to Bath to have what I call, ‘the #1/%...ing unlucky injection’.

The needle wavered like a drunkard towards my thigh. It was in. It stung. ‘This is it!’ I thought, ‘This has to make me better!’

On the same day, returning from Bath, I told Mum and Dad I wanted to walk from the car to the house. I managed to climb a few stairs. I didn’t have to call out for anyone in the middle of the night. I managed to go to the bathroom on my own! My steps were almost light, carefree. I had to pinch myself. Was I imagining it? The following morning I woke up and could sit upright in bed without help. In other words, it was a miracle, and that’s why ever since I have called it my ‘magic drug’.

To end, I will explain how I have rebuilt my life around RA, and what I continue to need to make life easier. Aside from my drug, I still need good treatment within the wider medical world. I have had bad experiences within the NHS. However, I have also been lucky enough to receive expert care too – from surgeons who perform miraculous operations, to physiotherapists, to my doctor whom I trust and value implicitly, and my new podiatrist. I have only known her for six months but in those months she has gone out of her way to help my feet be as pain free as possible.

Feet first: I value my podiatry sessions probably more than any other. When I moved to London five years ago and registered with my GP, I was relieved to know they had a podiatry clinic, so I put my name down on the waiting list. Though I feared it was more under control, the problems I have with my feet have happily not gone away. It’s the mechanical damage that has taken place over the last 18 years that has created a whole new set of problems.

My feet, now, are pretty much fused, so when I walk the weight isn’t distributed properly. For any person without RA the normal pattern of walking is heel down, and push through the mid-foot and then through the toes, but for me, I pretty much hit the ground full on, so I’m pivoting on
the bone, which in turn causes pressure points on certain parts of the soles of my feet. The build up of hard skin becomes excruciatingly painful, making it very uncomfortable when I walk. It's hard to believe that these sores cause such misery, but when my feet hurt, everything hurts. If the build-up of hard skin is left for too long, the sores become so deep and ingrained that there is a major risk of them ulcerating: this is why it's crucial for me to have regular sessions.

During a session the skin is pared right down and my pressure-relieving pads help enormously. It may not be particularly complicated and probably not the most interesting job for a podiatrist, but the results are amazing! Before an appointment I am in a lot of discomfort, but at the end I feel like a new person. To sum up how invaluable my podiatry care is; I dread my sessions being cancelled!! I can cope with not seeing my doctor for a check up, but when you're dealing with a chronic condition, to have an instant result is a miracle. The only thing I want now is a pair of shoes that are trendy and fashionable, as well as comfortable! I live in MBTs, which are fine, but when it comes to going out in the evenings, it's a problem – so any ideas, let me know!

The National RA Society (NRAS) have been a wonderful support. 5 Launched in 2001 by Ailsa Bosworth, they are the only patient-led charity in the UK that specialises in RA. They provide so many services, I cannot begin to list them all, but have listed their aims (box 1). They have a very informative website, including a section on the role of podiatry in the management of RA. 6 The article stresses that one of the main roles of the podiatrist is to diagnose and treat disorder and deformity in the foot, and to protect the skin, which is vulnerable to wounds and infection. It also says that podiatrists often work closely with rheumatologists, and it did make me think how, in the past 18 years, I have never been 'referred' to a podiatrist by any of my doctors. Do doctors, during an appointment, miss out on the feet and the problems we get because they're too preoccupied doing joint counts? Is this an area that needs more attention? I'd be interested to know what you think, but I wasn't even aware of a podiatry service until years later following my diagnosis. I saw specialists about arch supports, but the everyday care was definitely neglected.

Another major aspect that has given me a new path in life is my work: writing. Another Alice' is the revised copy of ‘A Will to Win’ and it is such an important book to me; not only does it raise awareness of this often misunderstood disease, but it has also helped others with RA to feel less alone. Since writing Another Alice I have had four further books published, and a new novel will be published summer 2011. Finally, the aspects that have helped me the most; RA doesn’t only affect me, it also affects all those around me. The support I receive from family and friends is incredible. My mother and father, in particular, have loved and supported me through the hell of RA unconditionally – and without them it would have been impossible. We work so well together as a team, and over the years our friendship and love has strengthened to a degree I thought impossible. Mumi’s sense of humour is such that we can still laugh through the grimmest of circumstances. My father is just special, one of the best dads anyone could wish for. I am sure that everyone in this room has had to go through a difficult experience or period in their lives. You need someone to help and support you, whether that is friends or family or if you are lucky, both. I am never alone in this fight, something for which I am eternally grateful.

ACKNOWLEDGEMENTS

We would like to thank Icon books for their kind permission to use extracts from ‘Another Alice’.

REFERENCES


The door opens in the big, yellow house in a quiet street, north of Copenhagen in Denmark. Kirsten Larsen is wearing a beige dress. On the table in the living room a small china bowl is filled with nuts. Next to it lies a Danish newspaper. Kirsten has the age and position in life to spend all of her time on bakery, bridge and glossy magazines. But she doesn’t. At least not all of the time.

At least six weeks a year, she goes to Jerusalem to work in a Diabetes clinic at the Augusta Victoria Hospital which has been established by the Danish ChurchAid and funded by the World Diabetes Foundation, an effort for which she has received the FIP 2011 Humanitarian Award.

Kirsten was shanghaied for the project in 2004 when she had just been retired. Dr. Deckert, her former supervisor at Steno Diabetes Center in Denmark, called her up and told her that he couldn’t stand to look at those miserable feet anymore.

‘I couldn’t say that I didn’t have the time. I had just lost my husband and Dr. Deckert thought that it would be good for me to experience something new. He told me that the colleagues in the clinic were ready to help me, she begins.

From scratch

‘During the first year, we were 13 Danish podiatrists who went to Jerusalem. When we arrived there was only a dark room without windows. Nothing else. However, during 2005 the clinic slowly became more and more equipped, thanks to Danish companies and colleagues who donated shoes, instruments, etc. Especially Green Comfort has been very generous.

After one year, it became clear to us that we couldn’t continue to spend our holidays on the project. Therefore, we reduced the Danish staff to four who take turns to visit the hospital’, says Kirsten.

Smiles it away

The team at the hospital is local. It includes three nurses, three diabetologists, two dieticians and a podiatrist as often as possible. ‘To begin with it was a bit of a culture shock. We were not used to the Arabic way of talking, however, one has to try to learn it. It is my hope that a smile can clear most misunderstandings.’

Fortunately, everybody speaks English. When Kirsten receives a new patient, who doesn’t speak English, the nurse tells her a bit about where the person lives, what he or she does for a living, etc. However, a lot of patients bring their children or grandchildren to help them translate.

‘Another challenge is the many illiterates as we cannot give them any written instructions. They are though very good at remembering what we tell them.’

She cannot see any difference between the diabetic feet she treats in Denmark and the ones in the Palestinian areas. The big difference is the terms of ulcer prevention. The local doctors rarely examine the patients’ feet and thus their feet are often in a severe state when they come to The Augusta Victoria Hospital.

‘In winter, we see a lot of burns as patients with neuropathy have had their feet too close to the electrical oven without being able to feel when it is getting too warm. In order to avoid these burns, we have put up posters to warn people about the ovens. It has helped,’ she says.

Daily setbacks

‘Palestine is an occupied country. You cannot go to Betlehem just like that. You need a permit for this. Likewise the patients need a card to get into the hospital. However, they are never really sure if they are allowed to get in anyway. It happens every day that patients and staff are detained for all sorts of reasons. Recently, a patient was detained because he was related to someone who had been imprisoned,’ she sighs.

The staff often visits UN clinics and public clinics. In Betlehem and Hebron two clinics of podiatry have been established. On top of that, a lot of self-help groups have popped up. They are equipped with a tuning fork, cotton swabs and a writing pad for
making paper gauges to see if the shoes fit. Quite basic, however, according to Kirsten, it makes a big difference as it makes the patients come in time.

**Tiny pinpricks**

When Kirsten is working at Augusta Victoria, she lives in a guesthouse of the World Lutheran Federation with the other volunteers. The house which is placed at the back of the hospital has around 30 rooms, a big kitchen and a garden. 'Every evening you can hear stories about the oppression of the Palestinian people. It is the tiny pinpricks' , she calls them.

Fortunately, Kirsten has never experienced a bombing or feared for her life in any way. 'You can easily walk in the streets. All you need is your passport. The Palestinian people are very honest. The only thing I have been a witness to is how bad the people are treated. I have also been detained many times. They ask me where I am going. When I explain to them what I am doing in Jerusalem, with astonishment they ask me what I intend to do there." “I help people,” she answers.”

The staff at the clinic is occupied with preserving the knowledge they have accumulated. ‘It is very important to maintain continuity in order to make sure that the work is done. We are thus occupied with keeping the staff as you cannot get an education in podiatry in Palestine,' she says.

The planning horizon of the Diabetes clinic is only one year at a time because the project is depending on funding. Therefore, Kirsten is pleased every time the DanChurchAid ask her if she wants to go one more year.

**What drives her?**

Kirsten believes what motivates her is curiosity and indignation that no one should be ill. It has been a part of her since she became a podiatrist.

When she was a child she was very active. She played in a youth orchestra and went to the local rowing club. Technically, she is on retirement today, however, she is still a moving spirit. ‘I wish that all of my colleagues on retirement would consider doing a bit of voluntary work. It is really challenging and important that we use the rest of our joy of work as we are too few podiatrists for the enormous need. You get much more than you give and people continue to be grateful for your efforts. It makes a huge difference that there is a place where people can get help. Today most of the Palestinian people know that their foot problems are not the will of Allah and that they can be prevented,' she says.

Voluntary work doesn’t eliminate all the other things people dream about when they retire. Kirsten also has the time to play golf, listen to opera, take care of her house and summer house and study Geology at the People's University of Denmark. 🏃‍♂️

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**Kirsten Larsen in short**

Kirsten Larsen became a podiatrist in 1970 and has specialized in the Diabetic foot until 2010. During the years, she has published a large amount of articles in Danish and international journals.

She has worked in the public sector in Denmark and has had her own private clinic simultaneously.

Kirsten has been an active member of the National Association of Podiatrists in Denmark where she has been negotiating with the Danish health authorities for 15 years. She has also been chairman of the podiatry counsel in the Danish Diabetes Association and vice-president of the Diabetes Foot Study Group.

**About DanChurchAid**

Established in 1922, DanChurchAid (DCA) is today one of the major Danish humanitarian non governmental organisations (NGO), working with local partners, international networks, churches and non-religious civil organisations to assist the poorest of the poor. www.danchurchaid.org

**Danish podiatrist in Augusta**

Lisa Hansen, Christian Jaillet, Karin Hansen, Linda Hansen, Annette Hweinrichsen, Erica Munthe-Kaas, Mette Nielsen, Nanna Olsen, Christina Sørensen, Mai Bomark, Kirsten Sørensen, Lis Pedersen, Bent Nielsen, Alima Ashraf og Kirsten Larsen.
## PLAN TO ATTEND

### 2011
- **November 24-26**
  SOCAP Annual Conference and Exhibition
  Harrogate, United Kingdom
  www.feetforlife.org/podiatry-news/annual-conference

### 2012
- **March 15-17**
  DFCOn Podiatry Conference
  Los Angeles, California USA

- **April 19-22**
  Midwest Podiatry Conference
  Chicago, Illinois USA
  www.midwestpodconf.org

- **August 16-19**
  APMA Annual Scientific Meeting
  Washington, D.C. USA
  www.apma.org

- **September 13-15**
  Biennial Conference
  Auckland, New Zealand
  www.podiatry2012.org.nz/

- **October 11-13**
  SOCAP Annual Conference and Exhibition
  Glasgow, Scotland
  www.feetforlife.org/podiatry-news/annual-conference

- **October 14, 2012**
  FIP Annual General Meeting
  Glasgow, Scotland

### 2013
- **July 21-25**
  APMA Annual Scientific Meeting
  Las Vegas, Nevada USA
  www.apma.org

- **October 17-19**
  FIP World Congress of Podiatry
  Rome, Italy
  www.fipnet.org

### 2014
- **July 24-27**
  APMA Annual Scientific Meeting
  Honolulu, Hawaii USA
  www.apma.org

### 2015
- **July 28-31**
  APMA Annual Scientific Meeting
  Orlando, Florida USA
  www.apma.org

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**NOTE:** If you know of a conference or event taking place, please send details so that we can include the information in future issues and post it on the FIP website.