

60. Laurie

(1) Tell me about your background.

Well, I was born in St David's Hospital in Cardiff, in South Wales. I grew up in Cardiff itself, in an area called Llanrumney. Then we moved into the centre of Cardiff, in a place called Canton. Pretty sort of normal upbringing; my father was a postman, my mother was a housewife. Went to a normal secondary modern school. Wasn't that adventurous - pretty boring, I suppose you'd say, now. I left school. Didn't go to University, because I couldn't wait to leave school - didn't like school that much. Started work - because Cardiff, South Wales... there are not that many big industries, at the time - so I went into the steel industry. And I seemed to be doing reasonably well in the steel industry. I went from various departments. One day I was promoted to a position where I was working with the commercial director of one company, which was a private company. And I was going along okay, but it was pretty boring. When you're in a large company, you're making money, which is okay, but you're not really helping anyone. And, because I was in a privileged position to see what the long-term plans were for the steel industry in South Wales, and the fact that investment wasn't really happening, and they had to compete with the Japanese and Koreans, I could see that there wasn't really a future in that sort of occupation. And I was looking around for something else to do. At the same time, my grandmother had diabetes, and she developed a problem with her foot and went into hospital, and, unfortunately, had a leg amputated. And this got me curious about why diabetes would affect feet. And, round about exactly the same time all this was going on in my head, there was a two page article in the local newspaper - the South Wales Echo - on the fact that there was a shortage of chiropodists. Now, at the time, podiatrists were called chiropodists. So, I went along to have a look to see what chiropodists did, and I was lucky enough that they were just interviewing for the next intake into the Cardiff School of Chiropody. And I was lucky enough to get in as a mature student, because, although I didn't sort of stay in school, I had the equivalent number of O levels. And they said that provided I did some extra work on the science subjects, they'd let me... they'd take me on, so to speak.

How old were you?

I'll have to pause here a second...

(2) Well, it was 1976, so I must have been round about twenty three (in fact twenty). And it was quite a big career move, because I had a well paid job. I'd done some extra qualifications, so I had an HNC in business studies. And they said, in the company, that, if I carried on in my present position for another two years, I'd be a manager. I had an expense account. So, everything was going, you know, pretty well. And people thought I was slightly mad to become a student again, and doing this chiropody, which nobody really knew much about. But I felt that I needed to do something different. So, 1976, I went to Cardiff School of Chiropody and started the

three year, full-time course, because, in order to work for the National Health Service, you needed to complete a course that was validated for you to work in the NHS.

What was the course like?

It was a bit intimidating at first, because, although I was only twenty three, a lot of the other students were straight from school. And I did feel older than everybody else, and my outlook was different. They seemed to want to have fun, whereas I seemed to want to know more, and get down to learning about biological sciences and how the body worked. So, I suppose I was... slightly different approach from a lot of people. But there were other mature students, so I tended to sort of mix with them more than the people straight from school.

How scientific was the course?

Looking back, not very scientific, because little was known about how a cell worked. It was very basic. I mean, I've got a twelve year old daughter now, and she's learning things that are beyond the level that we were learning back then. So, I'd say the course was a lot more practical than the podiatry courses that occur now. But, having said that, before we actually left the, you know, three year course, we would have treated probably thousands of patients. So, we had a much more practical training. And you had a foundation, then - if you were interested in various subjects - to do extra work yourself. And, at the time, I thought that it, you know, it was quite hard, but, looking back, it was quite easy.

And you say you'd have treated, perhaps, at least a thousand

(3) patients. In what kind of circumstances, and how controlled?

Right. What they would do is, they would grade patients, as far as difficulty was concerned. So, it's a three year course. You would start to see patients after about six weeks. So, you started to treat each other. And what they would do - because a podiatrist is using a scalpel - rather than just, sort of, take a scalpel to each other, they would get wax. And they would get little grains of millet seed, and they would embed the millet seed in wax, and then stick it on fellow students. And you'd learn how to debride the wax. And then you'd move on, then, to a patient who had simple callus or corns. And in the second year, you'd maybe go on to ulcers, and in the third year, you'd be treating patients with a full regime of problems. And it was all supervised. You had clinical tutors moving round the clinics - and we were all in quite big clinics, in separate cubicles - so that the school was providing a service to patients, but, at the same time, we were all learning, and it was in a controlled environment.

Can you remember when you first encountered someone with diabetes?

In the third year, we encountered people with diabetes, but not a lot was said about diabetes. I mean, we were taught the very simple, basic information. I didn't actually come across a patient that really, sort of, impacted on my psyche,

until I'd actually qualified and I'd started work. And I treated a patient, who happened to be a GP, who had to give up general practice because of retinopathy - he was going blind. And he was quite young; he was married and he had children. And, I suppose, it really sunk into me that this disease was causing devastation to somebody's life, for the first time - even though my grandmother had diabetes - and I was interested. It hadn't really struck home how devastating, demoralising... I can't think of a word... diabetes is. It's a chronic disease that you have to live with seven days a week, twenty four hours a day; you can never forget about it. And basically, at the time, diabetic's life was quite miserable, really. I mean, there was an obsession with what you were eating, and weighing what you were eating, and keeping records of what you were eating. If you were a Type 1 diabetic, you had to inject yourself; the needles were quite large; it was quite frightening.

- (4) Just back-tracking to your training. What were you and your fellow students expecting to do when you qualified?

Well, we all thought that somebody would come along, before we'd actually finished the course, and offer us jobs. And, surprisingly, that was the case. At the time, there was a huge shortage of chiropodists in the NHS, and various managers from parts of the country would come and visit the school, and say "come and work in Edinburgh", "come and work in York", "come and work" - in my case - "in Bristol". And the manager in Bristol said "do you want to work in the centre of Bristol, do you want to work in the countryside, do you want to work out alongside the coast?" And that's what I did. I went for an interview. At the interview, they said "where would you like to work?". It was practically not an interview. And I had the stretch of coastline between Portishead down to Weston-super-Mare. So, compared to what happens in 2007, it was an ideal set-up. I mean, you didn't have to do any work at all, to find a job. It was a dream come true!

You said you had a stretch of coastline. In what kind of institutions were you working?

Were working in health centres, and looking back now, they were quite modern health centres. They were brand new buildings; potted plants. You were working with GPs in practices. You seemed to be regarded more as part of their practices, rather than being an isolated chiropodist. 'Cause one of the problems with chiropody is that we spend all our time in a room with patients, and we very rarely come out of that room to interact with other people; particularly in that, sort of, period of time. I was fortunate, in that you were regarded as part of the health centre. All the patients were booked in by the reception staff that booked in patients for the GPs. It was up to you to decide which patients you were going to see, how many patients you were seeing, how many domiciliary visits you were going to do. So, to a certain extent, you had a free rein in everything. You would control your day, your week, your month. And there was very little checking up on you to make sure that you were doing what you were supposed to do, which was good in one way, but bad in another. Because, on the few

occasions I did, sort of, ring up the headquarters of the podiatry department for more help, they said “well, it’s your area; it’s up to you to decide what you wanted to do”. So, in a way, it was quite a shock going from a student, because - although I said

- (5) that we had to see patients - my first day, once I’d qualified in a job, I had twenty two patients booked in to see me. Now, a student may see six patients, so the shock of seeing twenty two patients... I’m afraid, in the first week, I went home, and I was in bed probably about seven o’clock. And the first week I slept quite a lot, because it was quite a tremendous shock, having to do all this work. But, I suppose that’s the danger of being a student!

Were you able to give each patient far less time than you were used to?

Yes and no. One of the luxuries you have, when you’re a student - or at least you did, then - is that you could take your time. You didn’t have to focus down on what you needed to be doing, whereas I learnt very quickly to focus in on what I needed to be doing. ’Cause the other advantage of being a chiropodist was that you could talk to your patient while you were treating them, so it’s not like a dentist. I go into my dentist, the dentist puts loads of hardware into my mouth, and then tries to carry on a conversation - of course, you can’t. But a chiropodist, in a certain way, is a captive audience for twenty minutes, or so. So, you could have conversations. The other advantage with my first job is that, because it was just me, I got to know all my patients, so they weren’t just patients - I would be seeing them again. So, whatever chiropody practice I was doing, if it didn’t work, I’d know about it again, because I was seeing the patient again. And the patient would complain to me, or praise me, according to what I was doing. And, I suppose, that’s why I said that the first diabetic patient I came across had an impact, because I got to know the patient as a friend, as a person. And I cared a lot about what was happening to the patient. Whereas, in the modern NHS, you could see a patient, and you may not be the same podiatrist that’s going to see the patient again, or you may not see the patient for a couple of years, because of rotation. So, you don’t build up, maybe, the same rapport with patients that I did back then.

You mentioned that it was up to you how many domiciliary visits you did. How many did you do?

I did as many as I needed to do. I mean, one of the advantages of being in total control is that you are in total control. So, you can organise your life. And you very soon work out how many times you need to see a patient in order to get on top of the problem.

- (6) So, I saw quite a lot of patients. I wouldn’t say I was hard done by. But, because you’ve got the freedom to design your own day, design your own workload, you can plan routes with domiciliary visits that make sense, rather than have somebody plan a route for you, where you’re going to

the east, to the west, to the north, to the south. You can plan a logical route. So, being in control, to a certain extent, makes your life easier.

We're talking about late 1970s, early 1980s. What kind of state were their feet in?

I was seeing a mixed number of patients, so not all my patients would be diabetic; I'd be seeing the general population. A lot of the very elderly population have quite a lot of deformity. It's quite surprising. It would be interesting to have a documentary on just how bad some people's feet are. I don't think the general public realise that some of their mothers, their grandmothers, their feet are quite deformed, they're in a lot of pain walking around, and just how valuable chiropody/podiatry is, to keep people mobile. The diabetic patients often would come in as an emergency, where they weren't receiving treatment, and then a big problem would arise. And often they would be treated, but would have to be admitted into hospital. And, looking back to then, you would see cases of gangrene, which we don't often see, that much, in 2007.

Did you get any impression of what the care had been like for their feet before you arrived?

Well, previous to me - I started work in 1979 - the NHS used to employ private podiatrists to provide care, and pay the private podiatrists. And it's ironic that, in the year 2007, it looks as though we've come full circle, and that private - not just podiatry - but private medicine, as a whole, is being regarded by the government as the way forward. So, that's full circle in thirty years, or so.

Did the patients talk about what care they'd received previously?

Yes. It was mixed. To a certain extent, care was very simple: it was just removing corn and callus, patching up ulcers. There wasn't much in the way of advanced off-loading, because it just didn't exist, at that time.

(7) So, you haven't really any real impression of what the private chiropodists were like, then?

No. I mean, from a patient's point of view, a patient would be quite happy with the treatment if the podiatrist was affable. They wouldn't know whether they were being treated with sterile instruments or not. There weren't autoclaves, at that time. A lot of patients were treated with what was called "cold sterilisation", where instruments were kept in a dish with an antiseptic fluid. From a patient's point of view, they're not gonna know whether accurate records are kept, or not, and they're probably not interested. They just want to know if the patient's nice to them, if their feet are not causing them any pain. When I first started working in the health centre, there were no records, really, before me, because the system had changed from a private one to an NHS one. So, I had little documentary evidence that... what was happening to any of the patients, really.

So, did you begin to develop record keeping?

Yes. I mean, part of the NHS is that you keep records on patients. And, by keeping records on patients, then you can tell if your podiatry/chiropractic is actually having an effect, and is actually working. And we were starting to record what the patients said. So, today we use something called a "SOAP format", which starts off with the subjective information that comes from the patient, which is quite a useful way of starting. So that I usually say "how are your feet?", to get the conversation going. And patients will often tell you "yes, my feet are hurting", or "no, they were very comfortable after the last treatment". But it was a nice way to find out what the patient thought of the treatment.

(8) What did you do after you left Avon?

Well, at the time I was what was called a Senior II Chiropractor. So, I worked from 1979 to 1983, and this was in health authorities; in what's called primary care, now. And I'd been doing this for four years. And I had a colleague, who I was in college with, and he went to Oxford. And he said "why don't you come down to Oxford, because there's more going on?" And I thought "well, I might do that". So, I went for an interview. And I took along to the interview a Spectrum computer and a tape recorder, because I thought it would be a good idea to computerise patients' records. So, at the interview, I can remember getting a very old Spectrum computer, and trying to make sure that the connection was working between the tape recorder. And I'd put about a hundred and twenty patients - just fictitious patients - onto this database, and at the interview, I demonstrated that. And the manager of the podiatry services, at the time, thought that was a really good idea, and thought, "yes, that would be useful". And I was offered a job, and I started work in Oxford. And again, this was in primary care, as a Senior II Podiatrist. And it was in a sort of larger environment, because before I was in a sort of rural environment, by the coast, so it was relatively quiet, and this was a change.

Your former college friend had told you there was more going on. What did that mean?

Well, I thought it meant that there would be more opportunities to develop and gain promotion. But, there were a lot... loads of politics entering the NHS now, and there were shortages of resources, so there was a lot going on in Oxford, yes.

(9) So, how did this new job differ from what you'd done previously?

Well, I was working in the centre of Oxford, and perhaps the most deprived areas of Oxford. I was working in Blackbird Leys, and I was working in East Oxford - Cowley Road. And I was seeing a completely different type of patient. There's not a huge ethnic minority in Oxford, but I was starting to see some patients from ethnic groups, and I was starting to see more diabetes than I was seeing previously. And diabetes was becoming a more popular disease. I suppose I got to see more podiatrists, because I was quite isolated, in a way, because, as I said, I was given an area and I was told to get on with it. Whereas now, I was in a department that had regular meetings, so you got to see other podiatrists. And, I suppose, one of the downsides of being a podiatrist is that you can be

quite isolated, so that you may work all day in a room and have little contact with other podiatrists. So, although my first job, it got you to - forgive the pun - stand on my own two feet, it's very lonely. Whereas, if you've got other podiatrists to talk to, you can compare notes and be more part of a team.

Were you travelling round to different clinics or surgeries?

Yeah, we were travelling round. One of the problems travelling round in a city is the traffic. But, again, we're still talking about 1983, '84, '85. So, the traffic then, we thought at the time, was a problem, but compared to 2007, it wasn't a problem at all. It was nice to travel around different clinics. We had some mobile units, which we used to take to small villages, and leave them, sometimes all day, sometimes overnight. And we'd provide services to small little villages, and that was quite different. We'd have a little pump that would pump water up into a sink, and we could wash our hands. And I know in the winter, the water would be frozen, and we'd have to wash our hands in something called Chlorhexidine, which is 70% alcohol, and an antiseptic. And it was quite cold sometimes. But that was an interesting sort of, not so much sideline, but it was an interesting event to look forward to, going to these little villages.

Do you feel you were providing a good service?

Yes, I think we were providing a very good service. The trouble was, say, providing a mobile service to small communities, is that you'd have to tow the mobile unit with a Land Rover, and you've got the upkeep of the Land Rover, you need a driver, you've got the upkeep of the mobile unit itself. And I know, as time progressed, we left the mobile unit at a place in Oxford called Rose Hill, and society was changing, and the mobile unit would be vandalised. You'd leave it overnight and it would be vandalised, whereas before, nobody would dream of vandalising something to do with the health service. There seemed to be more respect for medical people, for GPs, doctors, nurses, policemen. So, society was changing. I know it sounds as though I'm a fuddy-duddy, but society was changing.

(10) You said you met, now, with other podiatrists. Podiatrists or chiropodists?

Yeah, let's straighten that out. When I qualified back in 1979, we were called chiropodists. But there was no protection of title, so that anybody could be a chiropodist - set themselves up, having done a correspondence course, and treat patients. They could treat diabetic patients with a scalpel. But, in order to work for the Health Service, you had to have done a three year course that was recognised by the NHS, to become a chiropodist. Now, the government were going to take steps to protect the title Chiropodist, but there was to-ing and fro-ing. And eventually they decided they were going to protect the term Podiatrist, and we'd all call ourselves Podiatrists. And podiatrist is a better term to use, 'cause chiropody is somebody that treats hands and feet, and we were only just treating feet, so that the term podiatrist would be the more correct usage. And in America, in New Zealand, Australia, people that treated feet were called podiatrists. So, it made sense to call us all podiatrists and protect the

title. So, when I use the term chiropodist/podiatrist, they're interchangeable in my mind, because I was trained as a chiropodist, and I'm a podiatrist now. So, I'm afraid I will keep on, sort of, switching back and forth.

When you met these other podiatrists - or chiropodists, as they were probably called, now - at departmental meetings, what sort of people were they? What sort of age, what sort of background?

Sort of mixed background and mixed ages. I mean, some of the people in the department were new, but they were younger than me, because I was a mature student. Some of them were older than me, but not many of them were a lot older than me. And, I wondered what happened to a lot of the elderly podiatrists, because they just don't seem to exist. And when I went to outside meetings, you wouldn't see that many elderly podiatrists. And I wondered what happened to elderly podiatrists. Did a hand come out of the sky, pick them up and take them somewhere? And at the moment, in 2007, there are not many podiatrists that are older than me, and yet I'm only sort of fifty-ish. So, they must go somewhere, but I'm not sure where they go.

(11) Tell me about your next job.

Well, my next job was in the John Radcliffe Hospital. I think, at the time, the John Radcliffe Hospital - fairly big general hospital, teaching hospital - was about the fourth largest hospital in Great Britain. So, this was a complete change, in more ways than one. At the time, in order to get a bit of exercise, I'd taken up something called Tae Kwon Do, which is a Korean form of Karate. And when I was working in primary care, in community clinics, I knew that I could finish work at a certain time, and then I could go to the Tae Kwon Do lessons. But, when I got my next job in the hospital, you simply couldn't stop. You had to carry on and finish, till you'd finished that patient. So, I would turn up late for the Tae Kwon Do lessons, and, unfortunately, if you turned up late for Tae Kwon Do lessons, they would practice the next move on you. So, the instructor would practice the next move on you, and I didn't like that very much. And also, it was seen as being disrespectful, being late, so I had to give up Tae Kwon Do. But, it was a completely different environment. The nature of the patients - their problems - were more serious. And I was working in outpatient area, at the John Radcliffe hospital. And just because we were there for a small amount of time, just out of prioritising your caseload, you tend to see more vascular patients and more diabetic patients. So, I was gradually moving into seeing more and more diabetic foot patients. Now, my predecessor was ill, and ended up in a wheelchair. And I was working with a nurse called Kate Dempsey, and she was very kind, and taught me quite a lot. And it was a two-chair clinic, at the time. And one day, I found some notes - personal notes - that my predecessor had made, which were quite funny, because he'd outlined all the problems that I faced, but he'd outlined them neatly, telling me that things hadn't changed. And Kate said that I should look after myself, because they would work me to death, like my predecessor. And it was a complete change, because - whereas before, you would just see outpatients - we would also start treating some of the



inpatients. So, you'd get to see a more thorough, whole picture of care that was provided to a patient, from a medical point of view. So, you'd get to

- (12) see what would happen to a patient once they'd entered hospital. Because, I suppose, one of the other - not problems - but one of the other facts of life, if you're a community podiatrist, is that you have a patient. And if their foot condition deteriorates, it's almost like a hand has plucked the patient out of your care and the patient's ended up somewhere else, and you don't get to see what happens next. And this was very interesting to see what would happen once the patient had gone into hospital. If a patient had any surgery, what happened then afterwards, how the patient was rehabilitated, and recovered from any sort of surgical procedure that had been instigated. So, you're getting a fuller picture of the whole process of care, and this was quite interesting.

Would it have helped you, at all, to see how various serious conditions could be avoided?

It would, but not much time was devoted to education. Not quite sure why this was. Even today, education is seen as a sort of luxurious add-on, often, to a patient's care, whereas really, preventing problems in diabetic patients, as far as feet are concerned, is far better than waiting until the problems occur. But, if you think about it, we don't have a National Health Service; we have a National 'Ill-Health' Service, 'cause there are only the resources to care for people once they have diseases, rather than to devote these resources into prevention. And it's only now, say, in the year 2007, that people are thinking, perhaps more should be undertaken as far as prevention is concerned.

What was your impression of diabetes clinics in the second half of the '80s, beginning of the '90s?

Well, I remember some of the clinics used to be on a Friday afternoon, and they would go on and on, and on and on and on.

- (13) Yes, and at the time, Derek Hockaday was the consultant, and they'd have maybe fifty patients for an afternoon clinic. And my room was in the exactly same area as they were holding the diabetic clinic, and I remember every time I opened my door, all the patients would look at you to see if you were next. And it was quite disconcerting when you called in Mr Jones, and Mr Jones came in, and the look on their faces. There were other clinics running on. There were clinics, I think, on a Thursday morning, and Robert Turner had the UKPDS clinics running, and Rury Holman was there. And I can remember those clinics, but they were much more normal run clinics. The Friday afternoon clinics were quite busy.

Who decided who needed your care?

Well, I would have my own patients on my list. And then, because I was running a clinic alongside the diabetic clinic, if any of those patients needed attention, I would be asked to come along to the clinic, have a look at the patient. And

either I would see the patient there and then, or I'd make an appointment, then, for a follow-up appointment. So, it was quite useful. But it was a more informal set-up, in the sense that I just happened to be conveniently there geographically, but it was. . . I was spending more and more time with diabetic foot patients, so that more and more of my time was being monopolised by patients with diabetes. I remember that one of the senior registrars, at the time, was David Matthews. And I know that when Derek Hockaday retired, David Matthews was successful in getting the consultant's post. And he had a plan on having a diabetes centre, but I think it was more attainable at the Radcliffe Infirmary than at the John Radcliffe Hospital. So, we all ended up going to meetings on. . . I can remember on a Wednesday evening, we'd go to meetings, planning on having a diabetes centre. And this went on for quite a while. And eventually we were successful, and they opened a diabetes centre in the old Radcliffe Infirmary. And I have fond memories of that. Even though we were all sort of shoehorned into this very old building, and we were all in corridors, and there wasn't enough room, it was a very happy time, because we were all working in each others' pockets, so to speak. And we were all suffering together in this environment. I'm not sure what the patients thought, but a lot of patients have said to me that they much preferred the old Radcliffe Infirmary, because everybody was so nice.

(14) When was it that you moved from the John Radcliffe Hospital to the Radcliffe Infirmary?

Well, as I said, David Matthews became consultant, I think, in around about 1992. And then I can remember that we spent Wednesday evenings at meetings, planning and fundraising. So, I think it was round about 1994 that we actually moved down to the Radcliffe Infirmary. And the area was very long and thin, with many small rooms coming off this long corridor. And the area we had for podiatry, it was a two-chair clinic. We had a window to the outside world, and we had a view of the bricks of the university college next door. Our waiting area was in the corridor, so we had some chairs placed in the corridor. So, it wasn't ideal for patients, it wasn't ideal for us trying to do podiatry, at the time. There was no area for the receptionist; the receptionist was in the same room as the clinic, so we were all in one big clinic together. There was no privacy for the patients, in the sense that they weren't separate cubicles; there was just a dividing curtain between the two podiatry chairs. But despite that, I think everybody got on very well. The patients enjoyed coming to see us. If there was anything really serious that you had to say to a patient, then we would just see that patient on their own, and we wouldn't let another patient in until we'd broken bad news, or said to the patient they needed to come into hospital, whatever. But I have fond memories of the Radcliffe Infirmary. The other advantage was that the League of Friends - or the League of Fiends, as we used to call them - weren't far away, so that we could have food. Because, one of the problems in our present building is that the canteen is so far away, by the time you've got to the canteen to eat something, it would be time to come back. So, it was all very convenient; all in one small cramped space. And it just seemed nice, from a friendly, sort of, point of view. All the secretaries were in the next

room to us, so if you were trying to write a letter, the secretaries would be in the next room. They had to say hello to you as they passed outside your door. They'd practically be tripping over the patients in the corridor. Yes, it was nice. And about that time, we had a receptionist come and join us called Suzi Mayer, and she was very jolly, and the patients all liked her and, well, all loved her. And sadly she died last year, so that was sad. But I have fond memories of the Radcliffe Infirmary.

And was it from now, around '94, that you were specialising entirely in diabetes?

Yeah. I mean, the move from the John Radcliffe - where I was still seeing vascular patients, and other patients with foot problems - down to the Radcliffe Infirmary, was a move from seeing all-comers to just dealing with diabetic foot patients. So, five days a week, I was seeing diabetic foot patients; just those patients.

(15) Did you have any extra training?

Well, I mentioned that there was a move towards calling us podiatrists, rather than chiropodists. And around about 1989, they brought out a degree in podiatry. And I did a top-up degree down at Brighton. Yeah, I did this degree in Brighton; it was actually in Eastbourne, in the Leaf Hospital. And my tutor was Alistair McInnes, who was very interested in diabetes, and is editor of The Diabetic Foot magazine. So he, like me, was a diabetic foot person. And I did my thesis on education. I wanted to look to see what sort of educational advice we were giving to patients with diabetes. So, I looked at all the pamphlets that were produced locally and nationally, all the videos, all the posters, and then I broke down all the bits of information into small packets of data, and analysed them. And I came to the conclusion that some of the advice was conflicting and confusing. So, an example of this would be that some of the information leaflets would tell patients to cut their toenails straight across, and other leaflets would say to follow the shape of the nail, which would be round. So, even as professionals, we weren't giving consistent advice. And then, from that, I devised a patient questionnaire to try and look at the information that they had been given, and whether they actually retained it. This doesn't mean that they're actually going to change their behaviour, but at least it would tell you whether they had the information on board in the first place. So, I put out that questionnaire. I went through the ethics committee and did a proper study. And the results showed me that some of the patients that seemed to be repeating a lot of the mistakes, were ones with a higher score. So, what this meant was that they were very good patients, they knew what they should do, but they just didn't change their behaviour. So, this was quite interesting. So, I did that course in... between 1990 and '91. And some of the emphasis in the degree course was on research, so this got me thinking more critically in the papers that were being produced on the diabetic foot. So, I bought books like Frykberg's high-risk diabetic foot book, and I looked at the work that was coming out of King's with Mike Edmonds, looked at the work coming out of Manchester with Andrew Boulton. There was work being done in America. So, it started to make you think more critically about the care you were providing to patients, and the behaviour patients were

exhibiting in the information that you'd given them; whether they were actually carrying out the information. And then, I started thinking about quality of life, and I was thinking "well, yes, we give all this advice, but what effect is it having on the patient?" And diabetes is a chronic disease, as I said previously, which affects various bodily systems, so the patients with the foot disease are the same patients, often, with eye disease, kidney disease. So, you're presenting them with just another set of things that they have to do, and you have to join the queue. And from the patient's point of view, what's the most important thing for them to get through that day? So, I was starting to sort of think more deeply into what I was doing.

(16) And what conclusions did you come to?

I came to the conclusions that what I think is best for the patient, may not be the best thing for the patient at that particular time. I did another study, and I was looking at mobility. And if I had scored the patient's mobility, I would have put it very, very low, because they were having to walk with a walking stick or a frame. But when the patient scored, on a questionnaire, their mobility, they thought their mobility was quite good. And from their point of view, all they wanted to do would be to get from their front door out into the garden, out to the front gate to talk to the neighbour. And that was the sort of mobility that they wanted, whereas I was thinking of mobility as being able to walk, maybe, half a mile, or so. So that my perception, as a health professional, is completely... was completely different - hopefully it's changed now - was completely different, at the time. And my expectations were not the same as those of patients.

Any other memories of your time at the Radcliffe Infirmary?

Yes, we held multidisciplinary clinics. So, we had - at the Radcliffe Infirmary - we had Tim Goodacre, who was a consultant plastic surgeon, on site, who we'd often asked to help us with patients with surgery. And plastic surgeons were quite clever at using soft tissue in closing defects and being creative with the foot. We had help from Linda Hands, the vascular consultant, who was sited up at the John Radcliffe, and she would come down. And we'd do a combined clinic with vascular, plastics and David - diabetologist. And then, later on, Tony Berendt from the Bone Infection Unit came in, as well, and joined us. And it was good to have different professions, all thinking about the same patient, the same problem, and trying to come up with the best way forward for some of these difficult cases. I'm not so sure the consultants liked me too much, because I would try and book, say, thirteen patients into a one session. And I think they... they weren't used to the intensity of having to work like that.

(17) I think they didn't like me that much, because often they would say "can we stop for a cup of tea, now?" But, I think the diabetic foot clinic was starting to gain more respectability. Mike Edmonds had started it off at King's, and they were starting to have conferences. I remember that William Jeffcoate, from Nottingham - a diabetologist - set up a meeting in Malvern; that was the first diabetic foot meeting in Malvern. And they

had one in London. So, the diabetic foot and podiatry were starting to become an entity. I mean, looking after the diabetic foot had always been a sort of 'Cinderella service', which medical people didn't know really what to do with. It was a sort of strange practice that just happened in sort of darkened corners, and it was starting to sort of come into the light. Admittedly, now, we still don't get the resources we should have, but at least it was being talked about; the diabetic foot was being talked about a lot. I remember a doctor from Brazil, a Linda Pedrosa. I remember, back at the time I was at the John Radcliffe, in the days of Derek Hockaday, she was spending time with me looking at patients with diabetic foot problems. And I think they thought she was crazy, spending time with the diabetic foot. But I told her to go and see Andrew Boulton in Manchester. And then she went back to Brazil, and she set up the diabetic foot programme for Brazil. And it was only, I think, her sort of spending some time with me - not that I'm gaining any sort of kudos, or anything - but I think she realised that you could do something for the diabetic foot, and it got her interested. And then, when she saw Andrew Boulton - someone that really had some resources and a voice - then she went back to Brazil, and I think Andrew Boulton then went to the government, and they got a proper diabetic foot programme set up in Brazil. And it was good to see her enthusiasm. And, in the early days, she wasn't put off by what people thought of her, and, you know, the fact she was mad, spending time. And I met her at a conference, and she sort of stopped talking to somebody quite important, and came over. And they wanted to know who I was, and I'm just nobody, but she remembered that, you know, I was that mad person that was interested in feet, so.

From the patients' point of view, you mentioned that some of the people with serious foot problems had many other serious problems. So,

(18) to them, how important is their feet?

Very important. A lot of the patients that we see are not that mobile, and keeping them on their feet means that they can carry on with their life. And, once that's gone, you're taking a lot of these patients' lives away from them. So that, we've got patients that we've been seeing maybe seventeen years, and we've kept them on their feet. They may have profound neuropathy, or they may have a fair degree of peripheral arterial disease, and they may have had amputations - may have had ulcers, and they may have lost toes - but we've kept them on their feet. And this is a new way of thinking. I mentioned William Jeffcoate before. Traditionally, people look at the success of care by whether the patient's had an amputation or not. But William Jeffcoate has suggested that maybe keeping people going 'X' number of years, or 'X' amount of years without an ulcer, or without an amputation, may be another outcome that could be measured. Because, a lot of the studies seem to show that we can't actually prevent a lot of these ulcers, but we can minimise the effect of the ulcer, and prevent it going to amputation, prevent it going to hospitalisation. And that's

a good thing. And when I said, previously, that we don't see many cases of gas gangrene, we don't. We've got a reasonably good infrastructure, in primary care, to spot these problems and catch them early, so that they don't become these major problems that we used to see twenty years ago; you know, twenty, twenty five years ago. So that, although patients have ulcers, they're less of a serious problem than they were back then. I mean, you get the odd case, but, thankfully, we don't see loads of cases of gas gangrene any more.

Can you talk about the relationship between primary care and hospital care, for feet?

Yeah. I mean, quite lucky in Oxford, because I was employed, sort of, full-time, working in the diabetic foot clinic. But Philip Joyce, the person in charge of all of podiatry, had the foresight to see that it would make sense to provide some care as well. So, we'd rotate podiatrists into our clinic, who could then go out, and take some of what we were doing in the hospital outpatient clinics, out into the community. Sadly, not enough resources are put into this, and that's not necessarily his fault; it's a problem getting resources for podiatry in general. But, it meant that I wasn't, sort of, working on my own - that there were other people from the podiatry department sort of working with me. So, it means that, if we had more resources, we could take out a lot of the work that we were doing, and we could take it out into the community. Because, even today, I don't think general practitioners realise just how serious some of the diabetic foot cases can be, and that if you spot things quickly, you can lessen their effect on the patient, and on the NHS.

(19) And can you tell me about your own career progression?

Well, when I moved from the John Radcliffe Hospital, down to the diabetic foot clinic, I was promoted to Chief III Podiatrist, so I could concentrate on providing care to the diabetic foot. So that that was the, sort of, start of me devoting all my time to the diabetic foot. And there weren't that many Chief III posts about, in the UK, at the time. Since then - now, in 2007 - we've had something called Agenda for Change, which is a single pay spine for the majority of the professions in the health service, except for dentists and doctors; they, luckily, have managed to avoid that. So, everything has changed yet again. But, I've reached as far as I can go. The only thing open to me is to become a surgical podiatrist, and I think, at my age, I'm probably too old to do that. I've just started - well, half way through - a supplementary prescribing course, because the government are changing the legislation on who can prescribe medicines. So, maybe in the future, podiatrists will get independent prescribing rights, and would be able to prescribe, in a sort of very narrow, sort of, band of medicaments. So, that would be the, sort of, next change for me. I've been lucky, in that I'm interested in education; not just of patients, but of staff. So, I was fortunate that I gave some lectures at the Warwick diabetic foot module, which is a Master's module. And they asked me whether I'd like to run the course, so I've been doing that for the last two years. So, I'm a very lucky individual, in that I've got a nice job, and I can have my little fix of education at the same time. My

only complaints are that there are not enough resources for the diabetic foot, in general; not just in my area, but throughout the UK.

(20) Can you talk about the move from the Radcliffe Infirmary to where you're working now?

Well, we knew that when we were in the Radcliffe Infirmary, that it was only a short-term venue, but we were there, I think, ten years or so. And we were fundraising to build a purpose-built diabetes centre, so we were all looking forward to this. And I can remember going... I measured the amount of space, I would need, to see patients safely. And I remember going up to the building site, and putting Wellingtons and a hard hat on, and I took a tape measure with me, and I measured out my area. And I said to David Matthews that it wasn't correct, and it wasn't big enough. But David said "no, don't worry. They haven't finished building it, yet". And then, when I came to see the bit where the walls were put on, and there was a bit of a roof, I measured out again, and again I said I didn't think this is right. But, not being that familiar with building processes, I had to wait. And then, when we had the final build, I measured it out, and it was just simply too small. And this is despite the fact that the architects had spent an hour and a half, and I'd got the biggest wheelchairs that I could, and wheeled them round the area, so that they could measure it and see the turning services that they'd needed. So, I was quite disappointed when I saw the final podiatry suite that they'd built. And it was unworkable. So, I had to... when they opened the building, I had to go... Luckily, the building was a sort of joint venture between the NHS, Oxford University and various companies - Novo Nordisk being one of them. And the Oxford University side thankfully helped out, and I was able to work in the Oxford University area on the ground floor, until they'd knocked all the walls about and redesigned the podiatry suite. The overall building is very, very nice to look at, but I think some more thought should have gone into its design, as far as patients are concerned, and from some of the staff are concerned. I know this may seem as a criticism, having spent ten years working in a very small room with a corridor. But I do think that, whenever they build a new building, they really need to make doubly sure exactly what they're building, from the patients' point of view, and the staff's point of view. But I do realise that there are many, many factors which are out of control, so that I think David Matthews has done quite well just to get the NHS and Oxford University and private companies all together in one room, even to build the place in the first place. So, it may seem like sour grapes, from my point of view, but I'm sure, given hindsight, they would have done it differently.

(21) Have things changed much in the treatment of the diabetic foot?

Yes and no. Yes, in that they're much more sophisticated in off-loading the diabetic foot, to keep pressure off the foot. So, we have simple measures like felt, healing shoes, specialist shoes, made-to-measure shoes, special orthotic devices made of various foams. We also have things called diabetic walkers, which are sort of off-the-shelf polypropylene shells that have air chambers. So, it's like

having a replaceable cast that you can put on a patient. So, an example would be when David Beckham broke one of the toes in his feet, and when Wayne Rooney broke a toe, they were put in these devices. So, we can use those for off-loading. Other developments are treatment of infection, although we are coming to a point where resistant strains of bacteria are causing problems, so we have the emergence of MRSA, and we are running out of antibiotics that we can use to fight infections. But things have improved to a certain extent. We've also got dressing materials, which may help in healing diabetic foot ulcers. As a result of that, I wanted to know more about dressings, so in 2004, I did a wound healing course at the Wound Healing Research Institute in Cardiff; I did a Master's degree down there. And for my thesis, I looked at quality of life for patients, because I was interested in what the patient thought of the treatment that we were providing. And, again, that was interesting. And I suppose, to summarise, the results were that I took patients that had ulcers, and we gave them some quality of life questionnaires - some of them were specific to wounds - and looked at their quality of life while the wounds were healing up. At the end of it, when patients had wounds that were healed up, I was naïvely expecting - part of me was naïvely expecting - that their quality of life would vastly improve. And, although we were using wound-specific quality of life questionnaires, which should bring out the difference as far as the wound is concerned - because a generic quality of life instrument wouldn't pick out the problems with diabetes as a chronic disease, because you wouldn't expect quality of life to improve from that aspect - but with the wound-specific quality of life questionnaires, we didn't find a tremendous increase in the quality of life, because

- (22) we were still subjecting patients to these non-weight-bearing regimes. We were still saying to patients "you can't walk as far as you'd like. We still want you to rest. We still want you to wear these special shoes, these special insoles", et cetera, et cetera. So that again, our perceptions, as health practitioners, may be different from the perceptions of patients. And that it's made me think more about the care I provide from the patient's point of view, than from my point of view. So, I tend to compromise more than I did before.

Can you give me an example of a compromise?

Well, a patient, say previously, I would want them to wear, say, special shoes with special insoles to protect their feet, to prevent reoccurrence of an ulcer. So, someone's come with an ulcer; maybe they've had an ulcer for six months. We get it to heal up, and in order to keep it healed up, you need to wear these special shoes. Now, the special shoes, they don't look nice. Hand on my heart, I mean, they don't look nice. But, if you want to keep the foot in one piece, you need to wear them. Now, the patient: if I just simply say to the patient "you have to wear these shoes, you know, all the time", then the patient may not wear them. But if I say to the patient "well, you need to wear these shoes if you're going to go out, or you're going to go for a long period of walking, or you're going to go round the shops, or you're going to go on holiday", because loads of patients get



ulcers when they go on holiday. And the patient really understands what I'm saying to them, but they can compromise. And if they're going to wear shoes, if they're going out for the evening, or they're going to a wedding, they understand that they're taking a risk, and that they check their feet while they're wearing these other shoes. Then it's a compromise between what they want, and what I want. And I've had patients ring me up at Heathrow. They've just got back from holiday, they've worn sandals 'cause it was too hot, but they've spotted the problem quickly. They've rung me up from Heathrow, I've seen them there and then, and we've minimised the problem. So, to a certain extent, I think if health practitioners compromised a bit more, and that patients fully understood the difficulties they're up against, and the difficulties that the health practitioners are up against in trying to get their feet better, then often you can come up with a compromise that may not be ideal, but at least there's a greater chance the patients are going to wear these shoes. 'Cause hand on my heart, they don't look nice.

And finally, can you talk about the awareness of the importance of the foot, both for patients and for health professionals?

Well, Diabetes UK now has information on feet, which is quite comprehensive. There are Masters degrees in the diabetic foot appearing for podiatrists. There are Masters degrees in diabetes, and there are diabetic foot modules as part of those Masters, so that I think, generally, patients and health professionals are more aware of the diabetic foot, and it's coming more to prominence. Now, whether that's due to the fact that there is more diabetes now, or whether that's due to the fact it takes a long time for a specialist area to start to emerge, I don't know. But I do think, generally, things are improving.