

**Learning from history. Podiatric Surgery Development from its Conception. Reflective Podiatric Practice. 2018. 1(5):1-8 © Published by Busypencilcase Communications Ltd.**

Learning from History.

# **Podiatric surgery development from its conception**

**Ralph B Graham**



**In this month’s reflective review of podiatry practice, the theme of history is emphasised. Ralph Graham, a former Chair of Council, has submitted his own memories of the earliest development of podiatric surgery in the UK as a young podiatrist. The importance of his article, presented to national conference of the Directorate of Podiatric Surgery in March 2018 cannot be understated. No podiatric surgeon to date has written about their own personal experiences from those difficult periods pre-dating the acquisition of legalised local anaesthetic and the importance of the changes made to the Medicines Act of 1968. Podiatrists today would have been seriously impeded in providing a decent service to patients without far sightedness and a willingness to challenge authority. Even today there are fresh challenges and his words come with the wisdom of time.**

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**W**hen I was asked to contribute to the Podiatric surgical conference on our history I was obliged to research events and to put them in context for an audience who are enthusiastic about their profession but know little about how it happened almost fifty years ago. Through coincidence, or happenstance, my own career is the timeline we are talking about.

I qualified from the [London Foot Hospital](https://ezitis.myzen.co.uk/londonfoot.html) in June 1970. It was a Diploma course in chiropody, there were no podiatrists except as an address. The Telegraphic address of the Society of Chiropodists was **‘Podiatrist, London’**. How this originated I have no idea. It would be interesting to know if some far sighted individual chose the address with hope for the future.

During my time there from 1967 I was asked many times what on earth was I doing on the course? Why was I there? A good question. I had entered the course without the slightest intention of ever practising chiropody. I had every intention of following my passion of working in the theatre, not an operating theatre - the real theatre. Indeed, but for cuts to Arts Council funding, I would have been on a Stage Management course at the Royal Court theatre in 1967 but the course was closed one month before my start date. This supported my parents’ view that the theatre was unsafe as a career and I should join a profession.

So I started at the London Foot Hospital and spent more time in theatres whenever possible. Life intervened and I planned to marry in 1971. Clearly I needed an income so I started with Camden and Islington Councils and some private practice. I was unsatisfied and frankly bored, but persevered. One of my appointments was a twice monthly visit to Allen & Hanburys, a drug company now part of Glaxo Smith Kline. They had an excellent occupational health department with a well-equipped clinic where I treated the staff. One day I arrived to find my way barred by the Clinic Sister who said,

*‘I am afraid that we have a very important doctor here today so the clinic is not available. We have set you up in an alternative room, two chairs and a trolley in the ladies’ toilet’*

When I told her that this was completely unacceptable, she said,

*‘Oh we’ve told the staff the toilet is not to be used.’* I left never to return. I had to get out of this business.

While I wondered what else to do, take a pay cut and get a theatre job or whatever - when out of nowhere the private practitioner I worked for was contacted by Ron Laxton and Bill Day about his use of local anaesthetic and would he like to come to Croydon to see nail surgery. This recruitment was a very secretive process. The first call came on a Saturday afternoon when I was in the practice on my own. The voice on the end of the telephone asked,

*‘Was it correct that you used local anaesthetic?’* I said I did not. He then asked,

*‘Does Mr Jardine use local anaesthetic?’*

**At last we could perform a treatment that was curative…**

I responded I had no idea. I did not want to give anything away as the status of local anaesthetic use in 1971 was not clear. I suggested calling on Monday to talk to him and then warned Mr Jardine that this would happen. It became clear from further discussion that this was not a call from opponents but like minded colleagues. Ken Jardine was open and far-sighted to see possibilities and told me he intended to go to Croydon and asked me to join him.

At last we could perform a treatment that was curative not palliative, and I knew instinctively I had found like minded practitioners and we would take the profession into uncharted waters. I was enthused.

I needed to feel progress away from ‘toilet practice’. I had been an activist, Campaign for Nuclear Disarmament and anti-Vietnam war. I was in Grosvenor Square in 1968 and the march on the Daily Mirror building. I recognised determination and enthusiasm in these colleagues, not in respect of national and international politics, but in relation to the profession and the need to oppose the establishment.

Whilst I was a student, in 1968, the Chiropodists Board of the [Council for Professions Supplementary to Medicine](http://www.legislation.gov.uk/ukpga/Eliz2/8-9/66/crossheading/establishment-of-a-council-and-boards-for-certain-professions-supplementary-to-medicine/enacted),[[1]](#endnote-1) the pre-curser of the Health Care Professions Council (HCPC), had pronounced that chiropodists were not permitted to use local anaesthetic. At the time these were not restricted drugs and could be bought by anyone. The chiropodists on the Board were Society nominees and in charge of the schools; Peter Read of Chelsea and Henry Rosenstein of LFH.

**a good chiropodist needs only a keen eye and a sharp blade**

The quote to remember is ‘a good chiropodist needs only a keen eye and a sharp blade’.

**in March 1974 the Podiatry Association was subscribed and created.**

They had not reckoned with those who had trained via the forces medical corps; they had all been taught the use of local anaesthetic and were not going to give it up. If they could teach others and give them techniques like nail surgery and hyfrecation of skin lesions, there would be too many for the Board to cope with. How many could you threaten to strike off?

Indeed, how strong were the powers of the Chiropodist’s Board in any case? This was an unanswerable question because as we were to see over the coming years it is not unusual for authorities to overstate their powers until challenged. In 1972 the Chiropodist’s Board was forced to recognise the inevitable and agreed about the use of local anaesthetic by suitably trained practitioners.



Ron Laxton, first Chairman of the Podiatry Association and prime mover for the extension of scope of chiropody practice

From the initial Croydon Postgraduate[[2]](#endnote-2) group came the North London Group, West Midlands, Manchester, Wales and others. By 1973 it became clear that we needed to come together in some way and in March 1974 the Podiatry Association was subscribed and created. As an activist I was to become very close to Ramon Ariori, a great thinker. He warned that we had no idea of the consequences of creating the **Podiatry Association** and he was right.

Notwithstanding his concerns, he joined and was on the first committee with Ron Laxton in the Chair. An initial rule of membership was that to join the Podiatry Association you had to be in the Society. This annoyed our contacts from the Institute of Chiropodists[[3]](#endnote-3) where two members, Robert (Bob) Prince[[4]](#endnote-4) and Alan Proctor were persuaded it was good policy and they joined the Society.

Progress was made with lectures on digital surgery and an understanding that some like Proctor, Prince and Bell[[5]](#endnote-5) were performing bunion surgery. This was not as yet taught because there was fear and concern about the viability of the technique under local anaesthetic as a day case. Furthermore, if as many users of local anaesthetic had forced the change of policy on the Council for the Professions Supplementary to Medicine (CPSM), we could get several hundred performing arthroplasties, then this would become an unstoppable groundswell.

**The Future is Here**

We wanted to recruit members so we tried to book a stand at the Society conference, but were refused, so we said *‘Ok, we will take a stand space in the hotel and advertise ourselves as “*The Banned Stand”.’ The Society changed their minds and we had the stand. ‘*The Future is Here’* was the strap line. We recruited almost 500 new members and at the height of membership there were a thousand members.

Many opposed us from within the Society and general medicine, but the first serious hurdle was uncovered in 1976. Ariori lived only a few miles from me and telephoned about the need for an urgent discussion. He had been rummaging through some legal material and had found the [1968 Medicines Act.](http://www.legislation.gov.uk/ukpga/1968/67/pdfs/ukpga_19680067_en.pdf)

For various reasons implementation of the Act had been in stages and it would not fully come into force until 1978.

The imminent disaster was that all drugs were to be re-classified and local anaesthetic was to be restricted to only the named professions, medicine, dentistry, veterinary medicine. We were to lose local anaesthetic! I got a copy of the Act and we both read it. This was important. For many months it was clear no-one else in podiatry had taken the trouble to do the same. We thought as a profession we had been left out of the Act through ignorance of our work and conducted a campaign on that basis.

The Podiatry Association backed a campaign to lobby parliament by visiting MPs to protest at the injustice and limitation of our ability to treat patients.

We concentrated on nail and skin surgery and painless treatment in the campaign since bone surgery was too new to risk medical opposition at this stage. Every State Registered chiropodist was urged to set up a visit to their local MP to go through a provided script and if they needed help we gave it.

**Between us (we) went to about 300 MP meetings**

Between us Ariori and I went to about 300 MP meetings. Letters were sent to The Secretary of State and then to the Medicines Commission and eventually an offer to meet was made to the Society, not the Podiatry Association.

The first offer was a dose limitation to 4 mls of 1% lignocaine in any 24 hours. This we rejected. Laxton met with the Society Chair, Margaret Whitting, and was told you will not get free access and that some dose restriction was going to have to be accepted. The need to strengthen the backbone of the Society Council led to the motion of no confidence in Council at the Birmingham AGM of 1978. The motion was proposed by Ariori and seconded by myself. The meeting was packed and we lost on the proxy votes but those in the meeting were almost unanimous in supporting the motion. The offer from the Chair was the best limited dose she could agree and this was shouted down from the floor.

No access at all rather than limitation as this would be the best result to appeal. Although technically Council were not defeated, in practice they were and Whitting and several others including Read and Suvarna resigned. One sop offered was that the new Chair co-opted me onto the Society Medicines Committee although that offer did not last very long. Altogether there were 3 refusals of various dose restrictions by the Medicines Commission until July 1980. Eventually open access to four local anaesthetic agents were agreed.

In the period 1978 to 1980 no prosecution of any colleague took place although we were all in breach of the 1968 Act. Our whole campaign was based on the challenge to civil servants that they had ignored our profession and we were never told how wrong we were.

It was not until Borthwick[[6]](#endnote-6) and Graham[[7]](#endnote-7) in researching a history of the profession during the period of inception of professional changes, uncovered the facts that the Society had indeed been consulted before the Medicines Act 1968, when local anaesthetic was not permitted by the CPSM and Chiropodists Board. The response was chiropodists needed salicylic acid and other medicaments not antibiotics and local anaesthetic. The Council in 1978 did not have the courage to admit their involvement in the crisis.

**our challenges represented a ‘professionalising project’**

It was during this period that we realised the need to get our members on to the Chiropodist’s Board and this we did with Ariori and T R Galloway being elected. We also supported an independent in Colin Dagnall who edited his own Journal. Ariori’s alternate was Prince and later myself. It was due to Chiropodists Board membership that Galloway was able to get recognition for the fellowship qualification onto the statutory register held by the CPSM; Fellowship of The Podiatry Association (FPodA).

Borthwickand Graham considered as podiatry activists our challenges represented a ‘professionalising project’. That may be true but at the time we did not rationalise our ideas in that way.

What we thought we were doing was improving treatment for patients and our position as practitioners, as well as creating a representative salary as a specialist group.

This last driving force could not be ignored. When Kenneth Jardine[[8]](#endnote-8) made me an offer to be a partner in the new techniques, we had such a backlog in the Practice of suitable cases that we paid all the costs of a steriliser, instruments and galvanic treatment in the first two months. We were earning 20 times as much as routine treatment for each nail surgery. At this time almost all the early pioneers were in private practice.

One consequence of the earlier ‘debacle’ in Birmingham was the souring of relations between The Podiatry Association and The Society of Chiropodists. This culminated in a change in the rules whereby the Podiatry Association no longer required members to be Society members. The Podiatry Association was now running seminars each year with invited American speakers and we were expanding our range of work. One speaker made the case that we needed a thousand members performing arthroplasties to establish podiatry in the UK.

**The first National Health Service podiatric surgery was performed by Mike Allard Williams in Shropshire.**

Laxton unfortunately resigned from the committee due to family pressures and I had taken the Chair in 1979. My first effort in this role was not that successful and I resigned from the committee in 1982. However, whilst I was Chair, the committee realised that our approach was wrong. In this country we have a National Health Service, and if you are not in the NHS you would always be a fringe practice.

It did not take long to conclude that jobs in the NHS, when we could get them, would not run to thousands, so surgery was not about 1000 members doing arthroplasties, but 100 teams doing thousands of procedures. From such posts recognition would flow and we would be properly established.

The first National Health Service podiatric surgery was performed by Mike Allard Williams in Shropshire. He was in the fortunate position of being the Chief Chiropodist of the district and simply booked an available operating theatre for his own use and started surgery. He asked no permission and was unchallenged for a while.

Ariori and I were the first recruited appointments in Essex in 1985. The chief chiropodist Tony Cotton (who I had known since my days at London Foot Hospital) booked a theatre and appointed us to perform one session of surgery per week. Clinics ran in the morning and we operated together in the afternoon. We were paid as *sessional chiropodists* and this was a net loss for Ariori from his practice in Colchester. After one year he resigned saying he could not afford the loss and held the belief that we would never get past the medical mafia to obtain proper NHS posts. I tried to persuade him to stay but without success.

For the first time we had disagreed about prospects and the future. Of course he was right, or should have been. Neither of us could have foreseen the stance medicine and surgery would take in opposing us. If they had been rationale and methodical I think we would have lost the case for NHS podiatric surgery but they weren’t.

They made pronouncements about the legal position which were wrong in law and as we exposed these errors their position became increasingly weakened. In Essex, Cotton was told by the local orthopaedic consultant that it was a criminal offence for anyone other than a registered medical practitioner to be in control of an operating theatre. *‘It was in the Medical Act,’* he said. It wasn’t and it isn’t.

**It took a letter from the Clerk to the Privy Council to explain that “the RCS appeared to have misunderstood their Royal Charter”,**

As others were appointed around the country similar claims were made.

*‘Consent given for surgery, if you are not a doctor, has no status, and you are all liable for criminal assault’* -not so!

These objections culminated in complaints to the General Medical Council (GMC) to prosecute us and the Royal College of Surgeons

(RCS) to pronounce that they did not recognise us for performing surgery and to desist forthwith. They claimed that the RCS controlled surgery in England and Wales and if they said stop we had to stop. It took a letter from the Clerk to the Privy Council to explain that *‘the RCS appeared to have misunderstood their Royal Charter,’* it gave them control of surgical practice by their members and fellows, it did not give them control of anyone else.

Borthwickinterviewed Sir Norman Browse during his research when he had been President of the RCS. Sir Norman said, *‘You can imagine our shock and outrage when we discovered we had been entirely misinformed about our powers all this time, in fact the Charter is not worth all that much.’* The Royal College of Surgeons Council must have been pretty upset by this admission because when Graham tried to obtain an interview with the RCS a year later, no one would see her.

During the early stages of negotiation with the RCS and the British Orthopaedic Association, we tried to co-operate by agreeing to inspections and visits for surgery. One of these resulted in a member of RCS council remarking to me, *‘…that it was all very well trying to straighten a bent fifth toe for 20 minutes and very pretty too, but you could amputate it in a minute or two with less effort.’*

**we were obliged to consider a better descriptive title for ourselves, hence podiatric surgeon**

By the time wiser surgical heads started to question safety, antibiotic availability and patient understanding of who was providing the care, they had missed the boat. We were too established to be easily displaced. Do not take that to mean that the fights are over. Medicine and surgery will not make those mistakes again and if some crisis arises in the future you had better be prepared for a much more difficult fight.

When our colleagues decided to change the name of the undergraduate degrees and produce podiatrists, we were obliged to consider a better descriptive title for ourselves, hence podiatric surgeon. Nothing has no consequences, even doing nothing. This resulted in another flurry of complaints to the GMC requesting prosecution for the use of the term surgeon. This is not what the Medical Act says.

The offence is about misleading the public by the use of the term surgeon in that the public thinks you are medically qualified and registered with the GMC. The GMC have been consistent for more than 20 years in their response*. ‘We see no prospect of a successful prosecution providing the term podiatric surgeon is used.’*

The GMC gets requests to prosecute us several times a year and the response is the same. When I was Chairman of the unified Society in 2004[[9]](#endnote-9) this question was raised by the Department of Health. At a meeting with the Health Professions Officer and other officials they stated that they had legal advice that we were in breach of the law and would we advise members to stop using the term podiatric surgeon. I responded that we had legal advice that we were probably not in breach, but it was an open question since it had not (and has not) been tested in court. I offered myself as a test case and handed my personal card to them on which was printed Consultant Podiatric Surgeon. I also asked if they would provide us with a copy of the legal opinion. The response was they would consider the request. After that we asked under the Freedom of Information (FOI) for a copy of the legal advice.

International politics intervened. Tony Blair was fighting about the possible reveal of the infamous dossier of advice leading to the Iraq war in 2004. The word went out from the Cabinet Office that no government legal advice was to be released under any circumstance for fear of setting a precedent. An embargo that continues to this day. So our FOI request was denied and we have never seen their advice. I was never prosecuted and I have no reason to doubt that their advice was the same as the GMC position. Unlikely to succeed and not yet tested. Can we guarantee the outcome? No. Can the Department of Health? No. If they could they would have pushed the GMC to prosecute.

For them the worst result would be failure in court which would endorse our position. Do not forget that it is always open to government to amend the Medical Act to specifically restrict the word surgeon to registered medical practitioners.

The longer they wait, the more established our use. You will know, or should know, that currently there has recently been a consultation about new medical and health regulation.

Reducing the number of regulators from 9 to 3 and re-writing the legislation are suggested. High risk for us and I hope that our Directorate and the SCP Council are fighting for us and our practice and that they responded to the consultation.

Another aspect of development that is both critical and should not be forgotten is the importance behind grandparenting. This is the process where a new qualification or development occurs, but where dangers can inadvertently destroy or undermine progress previous made. We had our first issue back in 1977; the year of the first Podiatry Association membership examination. Those who were members already did not have to take it because they were grand parented to the qualification. The problem arose because one member believed that he would show solidarity with the examinees for the first time by taking the exam.

*‘Don’t do it,’* his committee colleagues told him but he was determined. The potential problem is clear. What do you do if he failed? Does he lose membership? Do we keep it secret? This could lead to a serious dilemma?

**We were the first non-doctor Consultants**

Fortunately we never had to solve this because he passed the examination. This principle is key to progress. Never dump the pioneers in a no win situation, lest you think this is obvious, too many professions fail to grasp the principle. Not medicine. They understand it only too well. We nearly lost our NHS title ‘Consultant’ in 1997.

Consultant title caused a further flurry of incorrect statements like, *‘the term is for the exclusive use of doctors, that is in the National Health Service Act.’* It wasn’t. We became the first non-doctor Consultants.

**Beware the nursing approach**

When meetings were held to extend this practice title to other Allied Health Professionals (AHP) and Nursing, the Royal College of Nursing wanted only those in possession of a second degree to be eligible for a Consultant post.

Several AHPs and myself argued most strongly that this was a clinical experience leadership role and existing Consultants and future consultants did not have to have a PhD or MSc as a pre-requisite. In the end agreement was reached that it was up to each profession to make the rules. As a result, it took nursing a further two years before the first Consultant was appointed as they made all their leading clinical people go back and get a second degree.

You may also recall theatre nursing colleagues having to re-qualify to do assisting roles a few years back, often re-training with colleagues in education who had not worked in theatre for many years, a wholly avoidable paper chase. Beware the nursing approach**.**

We now see this same situation putting our leading practitioners at the same risk with annotation. Whilst I could not and would not criticise the creation of a route to annotation via gaining an MSc as a safety net route; it appears (to me) that existing post FCPodS should be grandfathered on to the annotation as a right. You have the same problem as posed previously.

What happens to a Consultant who does not get the degree? Must he resign? And if you do have a panel of scrutineers as recently canvassed; who will approve the approvers? This poses a risk for existing podiatric surgeons by the HCPC. Is there more to be done? Of course. No professional development is ever finished and as you develop, so you get opposition. The undergraduate courses need improving. Now that the dead hand of manpower planning has been lifted from funding, when will we see an undergraduate course with independent prescribing, injection therapies and x-ray evaluation?

Where is the pressure for such a course, not from the HCPC? It must come from the profession. How about improving the position of our NHS consultants and registrars? When we negotiated Agenda for Change we forced the creation of Band 9 but mainly for financial control as the extra score. We were not successful in getting proper recognition for teaching which in medicine is considered an additional responsibility. So we could get someone on to Industrial relations committee and get those on Band 8D properly remunerated. But the list is endless, there is always more to do.

## **Publication for podiatrists**

Podiatrists wishing to write their own articles for publication can submit a Word document to [busypencilcase\_rcb@yahoo.com](mailto:busypencilcase_rcb@yahoo.com).

Articles are produced as e-documents only for Reflective Podiatric Practice. It is always recommended that you consider the value of your submission to a peer reviewed journal first.

The objective of R.P.P. is to allow clinicians to generate short articles, papers that can help colleagues, or provide an in-house publication for your department to circulate. These can include case histories, tips and pearls, historical items, or traditional papers. Editorial and house style will still be advised.

Plan, check, understand and even if the occupant of number 10 says such and such, don’t assume they are right without checking again and carefully considering your response.

## **References and Glossary**

1. [Council for the Professions Supplementary to Medicine](http://www.legislation.gov.uk/ukpga/Eliz2/8-9/66/crossheading/establishment-of-a-council-and-boards-for-certain-professions-supplementary-to-medicine/enacted) 1960-2003. The organisation came onto legal statute to provide the public with what is now termed governance. It comprised several Boards of which the Chiropodists Board was one. Replaced by the Health Professions Council (HPC) and then retitled the Health Care Professions Council (HCPC) [↑](#endnote-ref-1)
2. **Postgraduate Groups**. (Editor’s note). The Society of Chiropodists formed Society Branches throughout the United Kingdom. Post-graduate groups sprang up to offer more than regular monthly meetings. In essence each group laid on courses that met the educational certificate of Podiatry which led to membership (MPodA) and entry toward hands-on Practice in podiatric surgery. The full award was fellowship FPodA. Until the advent of podiatry degrees, podiatry was a separate qualification to chiropody. [↑](#endnote-ref-2)
3. [The Institute of Chiropodists](https://iocp.org.uk/) The organisation originally adopted members from correspondent courses for chiropody and colleges. Today all podiatrists have to be registered through the regulator HCPC. Now re-branded the IOCP they form the second professional body for podiatrists in the UK. [↑](#endnote-ref-3)
4. **Prince, R** Known usually as ‘Bob’, drove many of the conferences with enthusiasm for new information and supported refresher courses for the primary examinations (MPodA). His name was linked to the ‘Bob Prince Memorial Lecture’ which still runs at the National Podiatry Conference as recognition for his contributions to UK podiatry [↑](#endnote-ref-4)
5. **Bell, David R** was an early member and became a Chair and past President of the Podiatry Association offering tutorship within his independent practice in Maidenhead before NHS training was formally established. [↑](#endnote-ref-5)
6. **Borthwick, A.** A Study of the Professionalisation Strategies of British Podiatry 1960-1997. Institute for Health Research. University of Salford. PhD Thesis [↑](#endnote-ref-6)
7. **Graham, M** The Origins and Development of Podiatry in Britain 1969-1996. Department of History, University of Essex. PhD Thesis [↑](#endnote-ref-7)
8. **Jardine, K**. Was recorded as visual aids librarian in the Newsletter / Journal of the Podiatry Association 1980 p.6 [↑](#endnote-ref-8)
9. Amalgamation of The Society of Chiropodists into The Society of Chiropodists and Podiatrists in 1998 with the cessation and absorption of the Podiatry Association. This was often referred to as the **‘Camden Accord’**. The new surgical qualification FCPodS came under the College of Podiatry in lieu of FPodA, although still used by some together.

   **The views and statements made by the author are not regarded as an expression of the opinion held by Busypencilcase Communications Ltd.** [↑](#endnote-ref-9)