A STUDY OF THE PROFESSIONALISATION STRATEGIES OF
BRITISH PODIATRY 1960-1997

BY

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Glossary of Abbreviations

ACChO - Association of Chief Chiropody Officers
BMA - British Medical Association
BMJ - British Medical Journal
BJC - British Journal of Chiropody
BCJ - British Chiropody Journal (forerunner of BJC)
BOA - British Orthopaedic Association
BJPM&S - British Journal of Podiatric Medicine and Surgery
BJBJS - British Journal of Bone and Joint Surgery
COPSS - Commission on the Provision of Surgical Services of
the Royal College of Surgeons
CPGG - Croydon Postgraduate Group
DHA - District Health Authority
DoH - Department of Health
JBPM - Journal of British Podiatric Medicine
LA - Local Anaesthesia
NHS - National Health Service
PA - Podiatry Association
PA Journal - Podiatry Association Journal
PSM - Professions Supplementary to Medicine
RCS - Royal College of Surgeons of England
RHA - Regional Health Authority
SMAE - Swedish Massage and Electrolysis (Institute)
Abstract

This study examines the professionalisation strategies of British podiatry between 1960 and 1997, following the introduction of state registration as a pre-requisite for NHS employment. It is primarily concerned with relations within podiatry and between podiatry, medicine and the state. Analyses of these relationships are mainly informed by the Weberian concepts of social closure, professional dominance and autonomy. The major changes, opportunities and challenges to professional development in podiatry in the post-registration era are mapped in thematic and chronological sequence.

Qualitative methods of data collection and analysis have been used to provide detail and depth in presenting a picture of the issues under investigation. Data was primarily collected from 27 key informant interviews supported with documentary evidence from both published material in the public domain and unpublished material in private possession. These consisted of documents derived mainly from primary and inadvertent sources.

Repeated efforts by the state registered sector to secure state support for the exclusion of unregistered competitors from practice or to prevent their use of common professional titles failed as a result of government opposition to professional monopolisation and its concern to meet the manpower demands of an expanding NHS podiatry provision.

Despite advances in technology which have facilitated an expansion of
role boundaries into the arena of invasive surgical practice and NHS reforms which have permitted its integration into the mainstream health service, traditional podiatric NHS practice now appears increasingly vulnerable to service rationalizations. Encroachment into other areas of medical and radiographic practice have led to inter-professional conflicts which currently remain unresolved, although medical dominance appears intact.

This study suggests that any further podiatric role boundary expansion without medical approval or delegation is unlikely, as is amending legislation to establish a trade monopoly in the provision of footcare services.
Chapter 1

Introduction
This study is concerned with the professionalising strategies of British podiatry in the post-registration era, following the introduction of the Professions Supplementary to Medicine Act in 1960. Throughout this period important developments and significant challenges to the professionalising aspirations of podiatry have involved considerable structural and operational change. An examination of the relations within podiatry and between podiatry, medicine, other paramedical groups and the state form the core features upon which this investigation is based.

The impact of internal professional and external social influences upon British podiatry from 1960 to 1997 are examined in the context of their effects on professional autonomy. Theory derived from the sociology of the professions, particularly the Weberian concepts of social closure and professional dominance, enables the processes of professionalisation to be identified and the attempt by podiatry to extend its power within the health division of labour to be evaluated.

This study addresses the growing influence of government health policy upon podiatric service provision, the effects of technology and a changing NHS on modern podiatric practice and examines how these factors impinged on professionalisation. Within the wider context of change in health services provision and government legislation, the shaping of modern podiatry in the post-registration era forms the central focus of this thesis.

Studies of the professions allied to medicine have featured in the
literature of the last two decades, which has broadened to take account of healthcare occupations other than medicine itself (Elston, 1991). Whilst earlier work tended to marginalise the non-medical occupations within the health division of labour and portray them as "semi-proessions" peripheral to the central analysis of medicine, contemporary studies have addressed the role of specific paramedical occupational groups within healthcare (Elston, 1991; Larkin, 1995).

Significant studies have been undertaken in Pharmacy (Eaton and Webb, 1979), Radiography (Larkin, 1978), Physiotherapy (Ovretveit, 1985), Nursing (Davies, 1980) and Social Work (Roach-Anleu, 1992). Other studies have addressed combinations of different paramedical groups (Hugman, 1991; Larkin, 1983; Witz, 1992). Complementary medicine has also become a recent addition to the literature, with acupuncture (Saks, 1995), osteopathy (Larkin, 1992) and homeopathy (Cant and Sharma, 1995) emerging as significant foci of study. The impact of recent reforms and managerialism in the British National Health Service has also provided a focus for new studies of the health professions (Alaszewski, 1995; Allsop, 1995; Hunter, 1994; Strong and Robinson, 1990).

Yet podiatry, classed by statute alongside such groups as physiotherapy and radiography as one of the "professions supplementary to medicine", has received virtually no attention from within the sociological literature since the work of Larkin (1983). The latter work on British podiatry spanned a timeframe extending until 1960, the point at which state registration was established. There has been little work since addressing
the key features, challenges and changes which have marked the interim period, a point acknowledged by Larkin (Larkin, 1983).

The impact on podiatry of the organisational restructuring of health services, integration within the National Health Service and shifting government health policy over the intervening years remained largely unaddressed. This lack of attention must be viewed in relation to existing evidence which indicates the significant role played by podiatry in the delivery of health care services in Britain (Cartwright and Henderson, 1986; Clarke, 1969; DoH Task Force, 1994) and the importance of footcare in the prevention of diabetic morbidity, especially limb amputation, with considerable economic implications (Apelqvist et al, 1995; Maclnnes, 1994, 1996).

Given the context of an ageing population and the rise in chronic morbidity, the analysis of the profession remains under-examined. It has been regarded, even by its own practitioners, as a "cinderella" service with little public or professional esteem (Larkin, 1983). Events such as the Medicines Act (1968), and its aftermath, served to illustrate the relative invisibility of podiatric practice in the eyes of the state and medicine. Larkin (1983) referred to the "conflict ridden, low status world of foot care" to characterise the nature of the dilemma facing podiatry at the dawn of its state registration era. It is to this period that the current study seeks to address itself.
1.1 Rationale for the Study

This study was undertaken for several reasons, reflecting both the authors personal engagement with podiatry and the many important changes which have affected podiatry since 1960. British podiatry, formerly known as “chiropody”\(^1\), has undergone several transformations in practice, structure, education and training since state registration established a legal division between its practitioners. The decline of certain professional bodies representing those disempowered by the 1960 legislation has run in parallel with the emergence of others supported by it.

The crucial question of the freedom of unregistered and unqualified competitors to practise has not been solved by state registration. Technical issues centring on the scope of practice have become a focus for professional advancement which were virtually non-existent prior to 1960. Changes in the credentials associated with state sanctioned practice have been linked with a shift towards higher education from training institutions outside the university sector.

Prior to these more recent events the occupation of podiatry, Larkin (1983) concluded, had become a “therapeutic, market-place group, with some autonomy in practice and a mixed sex membership”. Whilst the latter point remains undisputed, there have been recent attempts to acquire a scientific credibility designed to transcend the therapeutic

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\(^1\) The term “podiatry” is used throughout this thesis in preference to “chiropody”, in line with common contemporary professional usage. Only the titles of professional organisations bearing the name “chiropody” or “chiropodists” are retained, or where the term is used in data or cited in literature which is reviewed.
work image, and new strategies to challenge limits to autonomy. Larkin (1983) had concluded that the enactment of the PSM legislation (1960), registering what had previously been the medical auxiliary services, forever enshrined in law the limited, subordinate status of the professions supplementary to medicine. Central to this assertion was the notion that the affected occupations were not “empowered to re-skill themselves” through the PSM legislation, but permanently restricted by role boundaries embodied in statute and imposed by medicine during the inter-war years. The challenge to those role boundaries mounted by the post-registration podiatry profession is crucial to the events unfolding within the timeframe of the current study, marked by conflict with the medical profession and allied paramedical groups.

The maintainence of the role boundaries set by the terms of the Board of Registration of Medical Auxiliaries regulations (1938), which limited British Medical Association registered podiatrists to the care of “superficial excrescences occurring on the feet”, had been assumed to be permanent by the medical authorities. Yet it is clear that the struggles within state registered podiatry in the years since the PSM Act (1960) have focused upon challenging, expanding and re-negotiating those role boundaries. These had been viewed as non-negotiable, having been pre-determined by medicine in an earlier phase of professional emergence (Larkin, 1983). The current study re-examines these issues in the light of the impact of the PSM (1960) legislation, and reveals the events and processes concerned with role boundary alteration.
which followed.

The wider issues of health care in the post-1960 period are important.

Whilst the pre-1960 paramedical groups were able to utilise state involvement in manpower administration as a power resource (Larkin, 1983), to inflate and support their opposition to the restrictions and obvious subordination to medicine implicit within the Cope Report (1951) proposals, the same forces operated against them in the decades following 1960. Successive government agendas were concerned with manpower provision for the expanding NHS, which was to conflict with the objectives of the professional associations representing state registered podiatrists.

The integration of state podiatry within the NHS, first at local level, and then at national level needed to be addressed in relation to the issues of autonomy and professionalisation. The fall-out from the Medicines Act (1968) upon state podiatry highlighted serious problems derived from a poor public and professional image, which merited attention. The impact of the introduction of general management, both upon medicine and its hegemony, other paramedical workers such as nurses, and managers themselves has been addressed in the literature (eg. Cox, 1991), but state podiatry has been largely ignored. The Griffiths Report (1983) and its suggestion of a "non-negotiated order" (Cox, 1991) signalled a significant shift in the culture and organisation of the health services. The new

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2 Although the term podiatrist is now widely employed by state registered practitioners, the PSM Act (1960) referred only to protection of the title "state registered chiropodist" for those eligible for NHS practice. Therefore, strictly there exists no legal recognition for the title of state registered podiatrist.
management ethos was designed to promote a service ideal and be consumer driven, replacing a system which functioned to service the needs of the professions (Cox, 1991). In the same vein, the more recent "new" NHS reforms of the 1990s, which commenced with "Working for Patients" (1989), introducing GP fundholding and the "internal market", were concerned with business values and were hostile to the restrictive practices of the health professions (Alaszewski, 1995). These events were to have a profound impact upon podiatry services, both in the public and private sector, and for the registered and unregistered practitioner. It was, therefore, clear that a sociological investigation of post-1960 British podiatry was both timely and overdue, providing a justification for the present study. 

This thesis is directly concerned with the professionalising strategies of British podiatry in the period following that examined by Larkin (1983). It intends to take account of the wider social and political context within which podiatry is located, and to map the impact of those events, policy shifts and legislation which have had a bearing on podiatry and its professionalising aspirations. Inevitably intertwined within these features have been the relations within podiatry and between podiatry, the state, medicine and other paramedical groups. These are linked to the underpinning theory derived from the sociology of the professions, in particular that of the Weberian perspective. This crystallised into a thesis consisting of two central elements.

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3 With the notable exception of Larkin (1983), the professionalisation of podiatry has drawn little, if any sociological interest.
1. The first part is concerned with the relations between the professional bodies within podiatry and their attempts to negotiate with the state for full legal closure along similar lines to British dentistry, the model upon which their aspiration to professionalism was based.

2. Second, technology and scope of practice became a central focus of professional activity, designed to force back previously imposed limits to both existing and future role boundaries, which brought podiatry into conflict with medicine and other paramedical groups.

The underlying theory informed and linked both strands of the study. This thesis was therefore able to construct a sociological picture of the contemporary, post-registration era in British podiatry, in the light of those key events such as the recent NHS reforms, supported and informed by the historical context provided by Larkin (1983). This study, in important respects, picks up where Larkin (1983) left off. It attempts to update the map drawn up until 1960 by Larkin (1983), in order to take account of the considerable changes, events, challenges and threats which have littered the interim period and impacted on podiatry. The decision to adopt a sociological account was based on the desire to enrich the study, rather than assume the character of much of the previous work written on British podiatry, which tended to embrace an archival approach. Weberian and other recent work within the sociology of the professions offer a critical perspective probing beneath the taken-for-granted and public relations assumptions of the profession itself.
1.2. A Personal Perspective on the Research

A number of personal factors influenced the decision to undertake this research. As a podiatrist on the boundaries with the academic world, it became clear that a number of professional colleagues and official bodies claimed to enjoy an "autonomy" which was denied to other paramedical occupations. This centred around the apparent freedom of podiatrists to accept patients without the necessity of referral from a medical practitioner, and the unique capacity outside medicine itself to make diagnoses (eg. Berry, 1980; Bradley, 1965). These appeared to be used to bolster claims that state podiatry was inappropriately classed alongside other occupational groups which did not enjoy such freedom from medical direction, within the terms of the Professions Supplementary to Medicine Act (1960). A commonly cited professional aspiration was parity of esteem with British dentistry, rather than with medicine; a feature also evident in the data of this thesis.

Also, the unambiguous hostility which appeared to the researcher to characterise relations between two of the prominent professional organisations within podiatry provoked further interest in understanding its basis. Furthermore, the antipathy which existed between the registered and unregistered sectors, unrelentingly evident within the pages of the various professional journals, had also been part of my own professional socialisation as a student of podiatry in the 1970s, and added to this interest.

An interest in the issues of professionalisation attained through study for
an MSc in the area of health, led by Dr. Anne Rogers, my current thesis supervisor, also guided the decision to undertake this research. It became apparent that studies of professionalisation in the health professions largely ignored podiatry.

Also influential in the desire to follow this research path was the work by Pilgrim (1990) and Pilgrim and Treacher (1992) in constructing a similar investigation and analysis of British clinical psychology, which proved helpful in designing the current study.

1.3 The Context of the Study: Podiatry prior to the introduction of the Professions Supplementary to Medicine Act (1960).

In order to place podiatry in its appropriate socio-historical context, the remainder of this chapter is concerned with identifying the various professional organisations within podiatry and their relationships with each other, with medicine and the state in the period leading up to the PSM Act (1960).

1.3.1 The Society of Chiropodists

The Society of Chiropodists had been initially formed in 1945, as a result of the amalgamation of five separate podiatry organisations which had by 1942 joined the BMA register for medical auxiliaries (Dagnall, 1970; Read, 1970). The BRMA regulations (1938) were extended to include podiatry, which was to be "classed as a definite branch of medicine"
Prior to this amalgamation, the largest national podiatric organisation had been the Society’s immediate predecessor, the Incorporated Society of Chiropodists, re-named in 1915 from the National Society of Chiropodists, founded in 1913 (Dagnall, 1963). The founders of this organisation had been prominent private practitioners who had an established pedigree and prestige within the circle of podiatry by virtue of their family practice connections with service to British monarchs and royalty (Dagnall, 1963). They had also established strong links with individual medical practitioners and sought to advance their aims through links with medicine. These two features afforded the predecessors of the Society of Chiropodists an elitist standing within podiatry, stemming from an earlier association with royalty and an ideology which asserted that advancement in prestige and status would follow from medical recognition and legitimacy. The members of the BRMA group were all subject to the restrictions imposed upon scope of practice by the British Medical Association, to which they willingly submitted in return for spurious rights legitimised by medical authority. The perception existed that the acceptance of medically imposed role boundaries would be rewarded with a recognition for the continuing right to offer diagnoses and practice prescribing rights.

"An important aspect of recognition [under the BRMA, 1938] was the acceptance (in return for the right to diagnose and prescribe) of a definition of chiropody and a scope of practice" (Dagnall, 1970).

This apparently dramatic concession by medicine was, however, firmly
placed in the context of the definition of scope of practice inherent in the agreement to register podiatrists with the BMA. This effectively banned all practice by podiatrists other than that relating to the superficial calluses, corns and toenail afflictions of the foot. By 1960 these role boundaries, having survived the "historical inertia" of the 1950s, remained intact and were considered implicit within the terms of the new Professions Supplementary to Medicine (PSM) Act (Larkin, 1983). Thus, in terms of scope and content of professional practice, little had changed since the pre-Society days, indeed before the emergence of any organised professional formation (Dagnall, 1962). Medicine had demonstrated little interest in the foot, and "there had been no dramatic innovations in knowledge, instruments or treatment" (Larkin, 1983). By 1960 not even a simple foot appliance (a therapeutic insole or shoe insert) could be issued by a podiatrist working within the NHS unless authorised by a medical consultant (Murray, 1960).

The Society of Chiropodists supported the regulatory restrictions upon practice, being eager to maintain cordial and unproblematic links with medicine in order to advance their professional aspirations, which had become focused, by the late 1950s, upon the possibility of achieving a de facto monopoly of control over foot services through state registration (Larkin, 1983). In addition, the Society of Chiropodists had been primarily concerned throughout its existence with representing the rights of its essentially private practitioner membership (Read, 1970).

The National Health Service Act (1946) had omitted any consideration of
podiatric services. State funding had not been formally granted for the provision of podiatry services by local authorities until 1959, following the electoral promises of the Labour Party (Welshman, 1996).

The Society of Chiropodists was especially concerned with restricting competition from unregistered practitioners, and, with the advent of NHS podiatry looking uncomfortably imminent, local authority podiatry.\(^4\)

The Society of Chiropodists attempted to manipulate the future arrangements for NHS podiatry provision in such a way as to ensure that their private practitioner members would benefit from local authority referrals, rather than the creation of full-time NHS posts (Read, 1970). Yet the support for the PSM legislation shown by the Society of Chiropodists represented a significant climb-down from the stance of its predecessor in earlier bids for legal closure.

1.3.2. The Incorporated Society of Chiropodists

The goal of the Incorporated Society of Chiropodists had been to secure formal recognition by exclusive legislation (Larkin, 1983). Having established a system of examinations determining entry to its ranks, it then sought state registration along similar lines to dentistry. Those qualifying chiropodists had been exhorted to regard themselves as

"the vanguard of a new elite of ethical chiropodists, who, like dentists would win a specialised and important place in modern medicine" (Larkin, 1983)

and were therefore eligible for acceptance as "an extension of the science of medicine" (The Chiropodist, 1923).

The first registration bill for podiatrists (1928), introduced by Lord Novar in the wake of the Dentists Act and similar attempts to secure registration by osteopaths, was designed to parallel the dentists legislation by protecting not only title but practice. The Incorporated Society had calculated that the structure and organisation of their podiatry training offered such control to medicine that medical support for a podiatrists bill would follow, as this would expand medical jurisdiction. This strategy failed utterly for several reasons. Firstly, medicine displayed a distinct lack of concern with feet, an area which would hardly enhance prestige as it enjoyed such little esteem (Larkin, 1983). Secondly, hostile amendments tabled by non-Incorporated Society groups undermined attempts to secure exclusionary closure by legislation. Also, the Incorporated Society appeared oblivious to the medical concern that a registration bill for podiatrists would threaten medical authority, already under assault from nurses, midwives, dentists and osteopaths (Larkin, 1983).

The Incorporated Society had asserted the right of its members to make diagnoses and prescribe treatments independent of medical direction. Such an overt threat to medical authority resulted in total opposition from the British Medical Association, which in turn easily and successfully persuaded the Ministry of Health to reject proposals for the registration of podiatrists (Larkin, 1983).
A bid to acquire a Royal Charter, lodged in 1932, was dismissed by the Privy Council under advice from the Ministry of Health and in the face of opposition from The Northern Association of Chiropodists, a rival group which feared exclusion (Dagnall, 1970).

Even at this early stage in its development the mainstay of strategy for professional advancement was clear. The Incorporated Society appeared to set the trend for future Society policy in attempting to further its aims in clearly identifiable ways. Firstly, the Incorporated Society sought advancement in professional autonomy and prestige through medical legitimation, thus inextricably linking future progress with the need to establish supportive relations with medicine. It also adopted a stratagem designed to discredit its less qualified competitors who were motivated by commercial gain rather than altruistic service to the public, in contrast to the mission of the Incorporated Society (Dagnall, 1970).

The current study reveals the continuing use of these same strategies by the modern Society of Chiropodists and Podiatrists, in spite of the long experience of their failure to achieve their stated goals, and in spite of having attained state registration. Moreover, the persistence in adopting the former strategy in particular has led to a polarisation and division in state podiatry which is mapped in subsequent chapters. The Incorporated Society resigned itself to the defeat of the bill and Charter application. From that point onwards it was apparent that the terms of any likely registration would demand a reduction in ambition, aspirations and a limitation in role boundaries.
The Incorporated Society of Chiropodists took the view that medical recognition afforded a prestige and status which offset the reduction in autonomy resulting from registration as a medical auxiliary service in 1938 (Larkin, 1983). The Incorporated Society took steps to further secure the support of the medical bodies and encourage the success of BRMA registration. The Royal College of Surgeons and Royal College of Physicians were invited to provide examiners to supervise the training of podiatrists and the Articles of Association were altered to restrict advertising practices (Larkin, 1983; Murray, 1960).

The consistent view of the Society of Chiropodists across the pre-1960 period had been to accept each element of recognition granted to the profession by medicine as a platform from which to launch further moves to secure professional advancement. This was in contrast to the medical view, which saw BRMA registration for podiatrists as firmly encircling and permanently subordinating podiatry (Larkin, 1983). However, as the new National Health Service was being implemented, a divergence in direction between medicine and the state grew evident, prompting a review of medical auxiliary status.

1.3.3. The Society of Chiropodists and The Cope Report (1951)

The Cope Committee (1949) was charged with examining the supply, demand, training and qualifications of medical auxiliaries working within the NHS, and reported in 1951 (Dagnall and Page, 1992). This sought to subjugate the auxiliary occupations to an extent that was even more restrictive than the BRMA regulations, reducing the representation
of the auxiliary services on the proposed Board and Council structures, and even suggesting that the growing number of auxiliary services necessitated a blanket representation. This would deprive some auxiliary services of the right of representation at all (Larkin, 1983). It also intended to impose a system of direct medical referral of patients upon podiatrists, removing what little claim to autonomy existed under the BRMA structure.

The universal rejection of the Cope proposals by the auxiliary occupations led to their abandonment by the Ministry of Health (Dagnall, 1970; Dagnall and Page, 1992). As a result a new round of negotiations between the auxiliaries and the Ministry of Health began in 1954, from which the BMA was excluded (Dagnall and Page, 1992; Larkin, 1983). These led to the creation of the Council for Professions Supplementary to Medicine, established by statute within the terms of the Professions Supplementary to Medicine Act (1960).

1.3.4. The Society of Chiropodists and the Professions Supplementary to Medicine Act (1960)

This Act provided for a Council and unitary professional Boards, each of which would represent a constituent supplementary profession. Crucially, each Board would hold a majority of elected supplementary professionals - six podiatrists, four medical representatives and an educationalist on the Chiropodists Board (Dagnall and Page, 1992). The Council itself would comprise seven lay persons, seven medical
representatives and one each from the supplementary professions, thus retaining a majority of medical personnel (Dagnall and Page, 1992).\textsuperscript{5}

The advisory nature of the Council was stressed, although the Council did have the power to "comment on those decisions that the Boards have sent to the Privy Council" (Dagnall and Page, 1992).

The main concern of the new Act was with the protection of title for those supplementary professionals working within the NHS, without regard to those working in the private sector, and in ensuring standards of training and education through supervision and statutory control.

The Society of Chiropodists had, therefore, a history and pedigree marking them as the foremost, premier, traditional professional body representing the trained podiatrist, recognised by medicine as legitimate.

It had established schools in podiatry, which provided a three year full-time training in podiatry, approved by the Royal Colleges of Surgeons and Physicians, and now endorsed by the state. The full-time two year course, which had been sufficient for membership of the BRMA (1938), had been extended in 1953 to three years, in parallel with other aspiring paramedical professions (Borthwick, 1992; Moseley, 1970).

Yet in 1960 it was not the only organisation which was to secure seats upon the new Chiropodists Board. The BRMA registration issue had divided podiatrists, resulting in the formation of another professional body opposed to auxiliary status. This group became known as the Institute of Chiropodists.

\textsuperscript{5} The CPSM Council totals 21 members, of whom six are nominated by formal medical bodies and eight by government, including the Chairman.
1.3.5. *The Institute of Chiropodists*

The other leading protagonist of influence in podiatry immediately prior to the enactment of the Professions Supplementary to Medicine Act (1960) was the Institute of Chiropodists. This body represented those podiatrists who had chosen to oppose affiliation with the BMA registered auxiliary chiropody scheme in 1938, and continued to resist what they perceived to be the Society of Chiropodists' willing subordination to medicine (Murray, 1960).

By 1960 their membership was roughly a quarter of the size of the Society, being around 1000 as opposed to the Society of Chiropodists' 4000 (Murray, 1960). There also existed, in the decade prior to 1960, a considerable rivalry between the Institute and the Society of Chiropodists, in which the latter jealously sought to exclude the former from any state recognition which would threaten a Society monopoly in providing employees for the new NHS (Larkin, 1983).

However, signs of decline were already evident as the PSM legislation loomed. The three training schools of the Institute located in Birmingham, Glasgow and Kilburn, north London had all "transferred their allegiance" to the Society of Chiropodists, effectively abandoning any hope of meeting the requirements for NHS employment outlined in the NHS (Medical Auxiliary) Regulations of 1954, and subsequently under the terms of the PSM Act (Berry, 1980). The Institute subsequently ran training schemes for the private sector which did not satisfy the NHS regulations.

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6 Rossington MH (1954), MoH correspondence to Society of Chiropodists, 21st April, 1954.
It was nevertheless able to secure two of the six seats on the new Chiropodists Board, set up under the terms of the PSM Act(1960), and was able to formally add its qualification to the first State Register.

"The Act stated that the Board could recognise a qualification for state registration...the first Board decided that the designatory letters of the Institute of Chiropodists and the Society of Chiropodists could be included. They did this for reasons of pride...their inclusion could never have been legally justified..." (Dagnall,1985).

The PSM legislation also contained a "grandfather" clause, which permitted registration for practitioners who had been in practice for five years but could not satisfy the requirement of formal training to the standard of the Society courses. It became clear that, following State Registration, only those Institute members "grandfathered" into the system would remain eligible for NHS employment, and state recognition. The private sector remained the only option for future generations of Institute graduates thereafter.

The Institute of Chiropodists had originally formed in 1955, following Incorporation of the Joint Council of Chiropodists, the body created in direct opposition to the BRMA auxiliary podiatry scheme (Berry,1980; Dagnall,1970,1995; Murray,1960). The "dissidents" who opposed the definition and scope of practice imposed on podiatrists registering with

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7 MacLelland-Lees JL (1973), correspondence in BJC, 38:8, p. 185-6.
8 Under common law, it was not possible to deprive individuals of their livelihood, providing that they could demonstrate that podiatry had been the sole means of their income for a period of three years, an issue medicine had also faced in regard to alternative medical practice (Larkin,1995).
the BMA sponsored BRMA, regarded the Incorporated Society’s action as reducing podiatry to a “profession of hand-maidens, lackeys, if you will”. However, by opposing registration under the BRMA scheme, the predecessors of the Institute ensured their exclusion from all plans for a podiatry NHS service, and ultimately from orthodox health care entirely (Larkin, 1983).

Discord between the two bodies continued throughout the 1950s, each competing for status as the legitimate face of podiatry practice. Both organisations could boast an Executive Council, a code of ethics, Articles of Association and a professional journal. Both sought to impress medicine, government and the public alike of their altruistic and ethical practice orientation (Berry, 1980).

The conflict between the Society of Chiropodists and the Institute of Chiropodists was at its height at the beginning of the period introduced by the current study. This was marked by “acrimonious discussions” over an associate grade created for Institute members ineligible for state registration, designed to enhance and maintain the dwindling membership numbers of the Institute (Berry, 1980).

1.3.7. The Commercial Sector: The SMAE Institute and Scholl.

The Scholl organisation, which trained podiatrists via a part-time route and marketed a large range of footcare products commercially, had

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become established in Britain as a satellite development derived from its parent company, founded by William Scholl in the USA in 1907 (Berry, 1980). The first branch of Scholl launched in Britain commenced business in 1910, and its growth coincided with government sponsorship in providing "arch-supporters" for the infantry of the British Army during World War I (Berry, 1980). The accompanying media coverage which this entailed ensured that "the name of Scholl is linked in the lay mind with care of the feet" (Berry, 1980).

This organisation was overtly commercial, having no pretension to the status of a professional body. It did not seek to persuade medicine or the government to grant the privileges associated with professional status, nor did it seek inclusion within any registration Act. It had no interest in securing a foothold in the developing NHS, only to exercise its freedom to continue its legitimate business interests unimpeded (Berry, 1980).

It did, nevertheless, represent a challenge to the efforts of the Society of Chiropodists and Institute of Chiropodists to eliminate commercial competition, which blocked their path towards an exclusionary closure which might afford the "legitimate" podiatrist a much prized trade monopoly. In addition, it did much to reduce the status of the podiatrist in the eyes of the public, in the view of the professional bodies, whose relationship with Scholl was described as one of "strict armed neutrality" (Dagnall, 1973a). Scholl had withdrawn all advertising from British chiropody journals during the PSM registration period, another indication of the "hostility" between the commercial and professional factions within chiropody (Dagnall, 1973b).
At the time of state registration for podiatry in 1960, Scholl operated a three month training scheme (Berry, 1980). Scholl actually forbade its members from joining the state register, even where its members may have been eligible to do so under common law (Berry, 1980).

The SMAE Institute, although run as a commercial business, did aspire to professional status, and formed the British Chiropody Association. This body awarded credentials following a period of distance learning and part-time training. The SMAE Institute also claimed to be a training school for physiotherapists, run along the same lines. The full title of the acronym SMAE may have reflected this association, as the early council of trained masseuses (forerunners of the Chartered Society of Physiotherapists) utilised "Swedish remedial exercise concepts" (Hugman, 1991). The SMAE Institute also published an in-house journal, which at the time of state registration for podiatrists was run and edited by the business owner. Nevertheless, the SMAE Institute did not seek eligibility for state registration, nor did it covet NHS recognition. Freedom to operate within the private sector remained its priority, as had been the case with Scholl. It was not until the post-1960 period that the SMAE organisation came into conflict with the state sector, an issue which is traced in this study.

The main protagonists in British podiatry during the period prior to the focus of this study have been identified, and the important issues in the

10 Data derived from Transcript 21, 1996.

development of podiatry until that time mapped in outline. This study examines the post-registration era in British podiatry, commencing with the impact of the Professions Supplementary to Medicine Act (1960). It details both the inter-professional relations with medicine and other paramedical groups, and with the state, and also examines the intra-professional dynamics evident in the years since 1960. The next chapter reviews the literature specifically addressing the professional emergence of podiatry.
Chapter 2

Socio-Historical Perspectives on the Development of Podiatry
The literature reviewed is of two types, encompassing work derived from both historical studies and the sociology of the professions. In this chapter the majority fall into the former category and are arranged in relation to those features which mark the emergence of podiatry and its formal organisation, and which also offer evidence of its earlier attempts to professionalise.

The historical studies stemmed mainly from the work of two authors, Dagnall and Seelig, themselves practising podiatrists. These papers have been almost exclusively historical rather than analytical accounts of podiatry, and have tended to reflect the development of only one group, the Society of Chiropodists and its predecessors (eg. Dagnall 1963,1970,1985,1987). Their principal foci remained the historical development of podiatry prior to the 1960 watershed marked by the Professions Supplementary to Medicine Act (1960), with little attention to events occurring thereafter. Only in the most recent papers are relatively contemporary (post-1960) events alluded to, but these contain little detail or depth (Dagnall,1995a,1995b,1995c).

2.1 Historical Accounts of Early Podiatry (Chiropody)

Seelig (1953,1956,1957) and Dagnall (1956) provided accounts of the emergence of British chiropody prior to the development of formal, organised professional associations.

1 In this chapter the term "chiropodist" will be used in preference to "podiatrist", where the former term is employed by those authors whose work is reviewed, and because the term is consistent with the title used during the period prior to the current study.
Seelig (1953) identified the early 17th century as the period in which British chiropody emerged as a distinct occupation, one which attained little public prestige or status. The early chiropodist had been an itinerant street trader, who gained his legitimacy through a public display of his ability, as had the toothdrawer (Nettleton, 1992), and recruited clients from lower social strata than the more prestigious Barber Surgeons.

The latter part of the eighteenth century was viewed as a "remarkable epoch" in the development of chiropody, due to the emergence of an identifiable "professional attitude", characterised by a relocation from street-trading to established premises, which formed the basis of commercial activity (Seelig, 1953).

Both Seelig (1953, 1956, 1957) and Dagnall (1956, 1963, 1985a, 1985b) offered detailed accounts of the events and meetings initiated by individual chiropodists which, it was maintained, produced and shaped the profession of chiropody. Whilst accounts of later phases of development stress the development of professional associations, the early phases are viewed as a culmination of the activities of men of great integrity. These individuals, such as Durlacher and Low, shared the aspiration of raising the status of chiropody and were credited as pioneering modern professional ambition in seeking the legal exclusion of those practitioners regarded as "empirics" with the introduction of credentialist exclusionary tactics, in pressing for official certification (a "sub-diploma") (Dagnall, 1963, 1970;
Seelig (1953, 1956). Durlacher and others were distinguished from earlier chiropodists by virtue of their established family practices, and by service to prestigious patrons\(^2\). They were also credited with responsibility for establishing chiropody "as a branch of medicine and surgery". Seelig (1953, 1956) and Dagnall (1956, 1963) acknowledged and itemised the emergence of written texts and their authors, which were taken to reflect the development of knowledge and skills in chiropody\(^3\).

In addition, Seelig (1953, 1956) was concerned to highlight the dual role of the eighteenth century chiropodist, who also practised dentistry. These practitioners were variously styled as "Surgeon-Dentist & Corn operator", "Dentist and Corn-operator", or "Operator on the Teeth and Corns", reflecting the relative parity of esteem between dentist and chiropodist at this point in their occupational emergence, although Seelig (1953, 1956) offered no explanation for the subsequent status differential.

Most of the published work dealing with the early development of chiropody attributed the higher status of Durlacher and his ilk to their patronage by social elites\(^4\).

\(^2\) Lewis Durlacher was known for his service to three successive British monarchs; Miss Seymour-Hill (the first woman chiropodist of similar standing identified) as chiropodist to Charles Dickens (Seelig, 1953).

\(^3\) For example, the first textbook to be published in English was D. Low's "Chiropodologia" of 1785 (Seelig, 1953), and Dagnall (1956, 1963) referred to the work of Durlacher, Low, Rousselot and La Forest in advancing the knowledge and standing of chiropody.

\(^4\) Dagnall (1956) cited La Forest's service with Louis XVI; Watts (1976a, 1976b) noted both Hardman as chiropodist to William of Orange and Zacharie, a British chiropodist, serving President Lincoln during the American Civil War. Wiberg (1985a, 1985b) recounted his family practice association with royal patronage, via King Edward VII and George V.
2.2 Historical Accounts of the Emergence of Formal Organisations in British Podiatry (Chiropody)

Later works by Dagnall concentrated on mapping the emergence of formal, professional organisations in chiropody. Dagnall (1963) recounted the development and organisation of the National Society of Chiropodists in 1913, the forerunner of the Society of Chiropodists, and provided a description of the formal meetings convened to create this first national body within chiropody, establishing "ethical, scientific chiropody". Dagnall (1963) referred to chiropody at the beginning of the 20th century as a

"well-established craft, with developed techniques and its own literature, usefully serving the public in a sphere neglected by the medical profession. There were many able professionals practising in a professional and ethical manner, but as individuals with no co-ordinating professional body."

The Presidential address, in 1913, outlined the aims of the new group, notably the eventual establishment of chiropody on a par with dentistry and other "learned and scientific professions" (Dagnall, 1963). A sympathetic physician\(^5\) was able to engineer the development of the teaching programme provided by members of the medical profession, establishing medical involvement and influence at the outset of organised chiropody.

In another paper, Dagnall (1970) attributed the failure of chiropody to

\(^5\) Dr. Oxford, a non-practising physician.
achieve a comparable status with dentistry to the divisive tactics and bitter in-fighting of the different factions emerging within chiropody prior to the formation of the Society of Chiropodists in 1945.

The objectives remained constant, to

"to obtain Parliamentary or other legal acknowledgement of the rights and status of chiropody" (Dagnall, 1970).

Although Dagnall considered the small membership to be a significant factor in the initial failure of the Incorporated Society to attain the legislative advance it sought, he also considered relevant key post-war events which altered the situation dramatically. Prior to the First World War (1914-18) chiropodists were "few and largely served the upper and middle classes". However, following the return of soldiers to civilian life, many former foot orderlies established chiropody practices, undermining and undercutting the fully trained chiropodist (Dagnall, 70). "Quack correspondence courses" frequently flourished as the commercial potential of chiropody was seized upon by those seeking to improve their market position.

Yet Dagnall (1970) apportioned blame for the rise in competitors to the increased educational demands made on students of the Society, persuading many to take a less arduous and taxing route to practice. Dagnall's most recent trilogy of papers again addressed the emergence and history of the Society of Chiropodists & Podiatrists (Dagnall, 1995a,

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6 Dagnall used the term "quack" to denote an "inferior" competitor to the trained, full-time practitioner - an "empiric", operating an amateur, part-time practice. He later used the term to distinguish between those chiropodists eligible for registration by the state and those ineligible for state registration.
1995b, 1995c), much of which was culled from earlier papers.

Lorimer (1995) published a history of the Society of Chiropodists, which drew heavily upon the earlier writings of Dagnall. This did, however, address the development of degree education, and allude briefly to the acquisition of local anaesthesia, although the author's prominence as a key Society of Chiropodists Council figure was reflected in the emphasis upon Society pre-eminence.

2.3. **Historical Accounts of Early Attempts at Registration for Podiatry (Chiropody)**

Dagnall (1970, 1985, 1987) again provided accounts of the early attempts by organised chiropody to secure protective, exclusionary legislation. The first chiropody registration bill was presented in 1928 on behalf of the Incorporated Society by Lord Novar, but opposition from competing groups of chiropodists ensured its failure (Dagnall, 1970). A subsequent application to the Privy Council for a Royal Charter in 1932 met the same fate, being quashed as a result of a counter-petition submitted by an opposing chiropody group.

Dagnall (1970) viewed the Society's competitors as a "burden under which the legitimate bodies had to labour" in view of their failure to match the higher standards of training of the Society, and their lack of even informal medical endorsement, which served to distinguish the Incorporated Society from the other groups.

The Incorporated Society initiated the move to request recognition

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7 The Northern Chiropody Association (Dagnall, 1970).
from the BMA by way of joining the Board of Registration of Medical Auxiliaries (BRMA) in 1938. Another chiropody organisation, the British Joint Council of Chiropodists, formed specifically to oppose the application (Dagnall, 1970).

By 1945, five chiropody organisations in favour of medical recognition had been formally granted ancillary status by the BRMA. These groups merged to form the Society of Chiropodists, a settlement mapped in some detail by Dagnall, and which largely reflected the dominance of the Incorporated Society of Chiropodists in the amalgamation negotiations (Dagnall, 1970).

2.4 Historical Accounts of Scope of Practice in Podiatry (Chiropody)

Papers addressing the development of the scope of practice within chiropody are rare. Smedley (1976) attempted to outline the historical development of one particular facet of training which emerged during the 1950s, known as "appliance-making". This featured the use of shoe inserts or similar devices, designed to replace the widespread use of temporary adhesive "pads" stuck to the feet of patients. In this study Smedley (1976) reviewed the development of chiropody "as a whole", and identified a shift in teaching practices in the early 1950s to accommodate appliance-making. For Smedley (1976) this change signalled a change in emphasis in the training of chiropodists, from a
“hit and miss apprentice system to that of a more academic and organised method of training” (Smedley, 1976).

It was the formal acceptance of methods of training in appliance-making, implemented in the Society run training courses, with which Smedley (76) was primarily concerned. Although initially opposed to this innovation, due to its association with the use of “arch supports” provided by those commercial competitors regarded as “quacks”, the Society finally acceded and subsumed these techniques into its own training programme, shortly after 1963 (Smedley, 1976).

2.5. Historical Accounts of Podiatry (Chiropody) including reference to Post-1960 Events

Dagnall (1979) provided a brief sketch of significant events in a further historical paper, which largely re-stated much of his earlier work. There was only a very short passage dealing with post-1960 events. The 1960 Professions Supplementary to Medicine Act was briefly alluded to, being considered a mere extension of medical auxiliary status. The 1968 Medicines Act was mentioned simply as “continuing to cause chiropody problems and threatens our status” (Dagnall, 1979).

Berry (1980) undertook a study of the major professional bodies in chiropody, and presented an action model which, in his view, may have achieved a unified profession. This Berry saw as a pre-requisite
for successful "closure" of the profession. The failure of chiropody to achieve professional closure along the lines either of dentistry or medicine is attributed to intra-professional rivalry and conflict (Berry, 1980).

The disparate nature of the varying chiropodial organisations, journals, qualifications and training courses appeared to Berry to resemble those of the engineering profession in an earlier phase of development. The example of the solution to disunity and fragmentation employed by the engineering profession prompted Berry (1980) to construct a similar hypothetical model for chiropody, which appeared to contain within it his aspirations for the future of chiropody (Berry, 1980).

In a more recent publication (Dagnall and Page 1992) there was an attempt to provide a more inclusive critical history. Throughout the paper the development of podiatry was seen as being one and the same as that of the Society of Chiropodists. It dwelt more than in previous work on the creation of the PSM Act (1960), but this nevertheless remained relatively superficial.

The emergence of the Podiatry Association was acknowledged, but claimed, incorrectly, to have formed in 1972. The explanation given for its formation, however, does capture the underlying motive which is confirmed by the data of the current study.

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8 The term "closure" signifies the government terminology used in addressing the legal protection of title or practice for health professional groups.

9 The introduction of a common qualification "Chartered Engineer, CEng" (Berry (1980).
2.5.1. Historical Accounts of Public Administration and Policy in Podiatry (Chiropody)

Brodie (1989) examined the development of chiropodial administration in the public sector up until the mid-1980s. This work mapped the emergence of the first municipal clinics and voluntary chiropody schemes, confirming the exclusion of chiropody from the early NHS. For Brodie (1989) chiropody remained "virtually unaffected" by this exclusion, and continued to operate largely in the private and voluntary sectors. The "breakthrough" in approval for LHA provision in 1959 was viewed as resulting in considerable local variation in the quality and availability of chiropody services, affected by low salaries and under-funding (Brodie, 1989).

Brodie (1989) mapped the emergence of the Association of Chief Chiropody Officers (ACChO) within the NHS and the relationship established between it and the Society of Chiropodists. The subsequent increase in the profile and power of chiropody managers and their representative body is examined, as is the growth in service provision which was the hallmark of the 1970s. The gains of the 1974 re-structuring, in terms of expansion and improved career structure, were threatened by the streamlining of management following the implementation of the Griffiths recommendations (1983). This "severely compressed" the career structure and was regarded as a "horizontal development" by Brodie (1989). The impact of the

10 "because of dissatisfaction with the Society, which was not considered to be pushing forward the scope of practice at a sufficient speed" (Dagnall and Page, 1992).
Griffiths reform was, for Brodie (1989), an erosion of the power of the District Chiropodist, with many services fragmented and allocated to smaller units of control.

Page (1991) proposed a corporate strategy for the Society of Chiropodists, which would equip it for the challenges of the 1990s. This sought to suggest changes which would enable the Society to adapt to a growing elderly population, reduced school leaver numbers, recent government reforms and the removal of trade barriers. Page (1991) highlighted the diminished authority of the Society over pre-registration education of chiropodists following the advent of degree education in 1988, when courses became validated by CNAA polytechnics and the State Board. For Page (1991), the contemporary Society faced a serious challenge from the unregistered, rival podiatry organisations, although her thesis was written well before the current proposals for revision of the PSM Act.

The Society was also alleged to be ill-prepared in terms of future planning strategies, in particular a perceived lack of concern over the new government reforms which indicated an absence of pro-active planning. Page (1991) regarded "technological" advances in chiropody work as necessary in order to secure "greater credibility in the scientific world", without which the profession would struggle to remain viable. Finally, Page (1991) asserted a need for the Society to retain a significant NHS profile, and to promote the benefits of chiropody with the medical profession.
Welshman (96) used chiropody as a case study to illustrate the policy decisions of the government and Ministry of Health during the years 1945 to 1974. Having failed to secure inclusion under the NHS Act, Welshman argued that demand for the service throughout the 1940s persuaded the Ministry to accede to calls for local authority, rather than hospital provision of chiropody. This would save hospital beds through maintaining patient mobility, and allow a side door entry to the NHS for chiropody. The key consideration was the low cost involved in providing the service. Welshman's central point focuses on the reluctance of the Treasury to permit the provision of NHS chiropody, in spite of an acknowledgement of it's "essential and cheap" nature, which delayed the event for a decade. However, by 1962 only 7% of elderly people received chiropody treatment via the Local Health Authority services (Welshman,96).

2.5.2. Recent Accounts of Contemporary Podiatry

Berry and Black(1992) attempted to define, for a mainly medical readership, the differences in meaning attributed to the terms “chiropodist” and “podiatrist”. This followed the decision by the Society of Chiropodists to adapt its title to incorporate “podiatry”, and to convert the title of the journal “The Chiropodist” to “The Journal of British Podiatric Medicine”, a move which paralleled the emergence of degree awards in podiatry, replacing the traditional chiropody diploma. This paper may have been used as a vehicle to promote the high standards and scope of practice of modern podiatry.
in an attempt to impress a mainly orthopaedic audience. This highlighted the application of biomechanical therapy, specialist diabetes foot care and minor toe-nail surgery whilst underplaying the expansion in scope of invasive surgical practice. Although mentioning podiatric surgery, the article reflected the conciliatory tone characteristic of the Society of Chiropodists in seeking medical approval and endorsement. It was acknowledged that podiatric surgery had

“not yet been entirely accepted...by the medical profession, and this is to be expected” (Berry and Black,92).

A brief overview of the development of podiatric education was provided by Ashford, Tollafield and Axe(1995), concentrating on the recent surgical training of modern podiatrists via the Podiatry Association and, latterly, the Society of Chiropodists & Podiatrists. There was a brief outline of the introduction of undergraduate education, following the shift towards higher education institutions over the last decade. The focus of attention, however, was the structure of current postgraduate education in podiatry, which enabled practitioners to engage in invasive surgical activity. It outlined the current surgical programme offered by the Podiatry Association, and briefly alluded to the conflict with medicine which characterised this development. It is possible that the underlying objective behind the publication of this paper had been to provide the mainly orthopaedic readership with an impressive account of the
depth and quality of podiatric surgical training, emphasising its relative parity with orthopaedic training.

2.6 A Sociological Account of British Podiatry

(Chiropody)

There exists only one previous sociological account of British chiropody (Larkin, 1983). This formed part of a larger work which examined the occupational emergence and growth of four paramedical groups - ophthalmic opticians, radiographers, physiotherapists and chiropodists - in a period extending from 1900 to 1960. Larkin's approach was primarily concerned with mapping the development of chiropody in relation to its conflict with the medical profession and other rival producers in the medical division of labour. This crucially involved the need to negotiate boundaries with medical and other paramedical occupations in establishing spheres of influence and authority (Larkin, 1983). Indeed Larkin (1983) considered the "expansionist tactics" of the paramedical professions to have received little academic attention, which, he explained, may be due to "an assumption that they are liberating rather than repressive".

An explanatory narrative outlining the professionalising tactics of chiropody and the other paramedical groups was constructed, noting their advances, checks and failures. These professionalising tactics were seen to include the "poaching" of skills from other rival producers, and their delegation to improve status and market control.

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These processes were encompassed within a derivation of Freidson's model of professional dominance, which Larkin entitled "occupational imperialism", and which will be further discussed in the following chapter addressing the theory underpinning the current research.

Larkin (1983) regarded each of the paramedical occupations as having different relationships with varying arms of the medical profession. A raft of features distinguishing the different paramedical groups were outlined, and ranged from length of history, sexual composition, "scientific" or "therapeutic" work, hospital or community based work locations, public or private sector finance and work location, a "theoretical" or "empirical" knowledge base, and the intensity of medical supervision. Chiropodists, he concluded, were a "therapeutic" group, with some autonomy in their work and an even sex membership. Larkin viewed the newly established state registered chiropodist of 1960 to have been "forced into a more reduced status and skill range than they initially preferred" by their dependence upon medical approval for their advancement. State legitimation was linked firmly to medical approval, the latter becoming a valuable resource in the control of footcare service provision (Larkin, 1983). Larkin also viewed the role boundaries of pre-1960 chiropody as having been limited by the need to avoid any challenge to medicine.

Unlike Dagnall or Seelig, Larkin concentrated on the period in which
conflict with medicine emerged in earnest - the 20th Century. However, Larkin's account extended only as far as the milestone of the PSM Act of 1960.

Those organisations representing chiropodists not aligned to the Society of Chiropodists or Joint Council were described as "transitory correspondence colleges", to which little attention was directed. The current study may be able to challenge Larkin's (1983) assertion that such groups had only a "minor influence in determining its [chiropody] development", particularly since 1960. Larkin (1983) considered the extent of technical autonomy in terms of "content and context" of work, concluding that their partial autonomy was of little significance when viewed from the standpoint of medical determination.

The reasons for the acceptance of medical regulation by chiropodists were discussed. Here Larkin (83) identified three principle influences which may have led to the submission of chiropody to medical control. Chiropody did not enjoy the benefits of inclusion within the health insurance regulations during the inter-war years, and thus "missed the secure expansion of demand" (Larkin,83). Chiropodists also demonstrated "negative self-perceptions in their literature" and that this, plus their failure to "develop a science of their own", contributed to their subordination. This latter point is addressed in the current study.

Employing the concept of "occupational imperialism", Larkin (83)
charted the strategies and manoeuvres of the Incorporated Society as it attempted to improve its market position, exclude inferior competitors, combat rival groups, expand its authority and enhance its status. Medical involvement in chiropodial affairs occurred from the outset of organised chiropody, being active in policy making and actively establishing a code of practice for chiropodists. Members were not permitted to refer to themselves as "professional", "surgeon" or even "certified" for fear of incurring medical disapproval (Larkin, 1983).

The introduction of examinations as a prerequisite for membership was a response to increased competition from "unqualified" practitioners, arising from the trend for army foot orderlies, returning to civilian life, to establish chiropody practices. The first training school of the Incorporated Society followed, which fostered a sense of elitism amongst its graduates, and which subsequently characterised the image the Society sought to promote. Larkin (1983) traced the subsequent optimism felt by the Society in its growing desire to emulate the success achieved by the Dentists in 1921. He also outlined the ill-founded nature of this optimism. The apparent medical approval enjoyed by the Society only reflected its strategy of avoiding issues which would provoke medical hostility (Larkin, 1983). As soon as attempts at boundary encroachment were perceived by the medical profession, the voice of protest was loudest from those specialties most directly threatened, namely general practitioners and orthopaedic surgeons (Larkin, 1983). This is still largely the case
today.

The Incorporated Society also began a campaign to oust its own market opponents. It referred to those chiropodists who were not members, and who had not, therefore, undertaken its own formal course of training, as “charlatans” and “quacks” (Larkin, 1983). At that time the Incorporated Society’s members began to “liken themselves to qualified dentists”, in a bid to distance themselves from other, inferior, chiropodists and establish exclusionary criteria which might be used to secure a trade monopoly (Larkin, 1983). As a consequence of failure to gain inclusion within the Health Insurance Acts, the demand for chiropody services was curbed. This, coupled with the influx of returning former army foot orderlies, created considerable market competition.

The expansion of health services during the late 1920's increased the sense of threat felt by the medical profession, whose “pretence of universal medical competence” ensured their resistance to any burgeoning paramedical profession (Larkin, 1983). It was in this climate that the first, fated campaign for state-registration was launched in 1928. The definition of chiropody chosen by the Incorporated Society itself was unacceptable to medicine, in that it appeared to suggest chiropodists were to be responsible for all foot ailments barring only major surgery. What was even more unacceptable was the suggestion that any representative body of the registered chiropodist should consist of a majority of chiropodists,
with only a very few General Medical Council (GMC) representatives, denying medicine its controlling influence at executive level. Even the Dental Board arrangements did not afford dentists such a privilege.

The Ministry of Health did not approve the chiropodists' bid for state-registration for two reasons, argued Larkin (1983). Firstly, they felt a concession to one paramedical group would herald a flood of similar applications from other groups. Secondly, to have accepted the chiropodists' request would potentially threaten relations with the medical profession (Larkin, 1983).

The Incorporated Society reacted by presenting an application to the Privy Council for the grant of a Royal Charter in 1931. This was summarily dismissed, as was a further application in 1938. Larkin (83) shrewdly pointed out that the chiropodists' failure was compounded by their lack of "institutional allies". In addition, the recurrent problem of opposition from rival factions within chiropody had clearly hampered progress. These groups had influenced the Ministry of Health and Parliament, convincing them of the inadvisability of granting favour to only one group of several. The non-Society chiropodists would have been so seriously disadvantaged by the success of such a Registration Act, that their opposition to it was guaranteed.

The Incorporated Society, in subsequent attempts to acquire registered status, lowered their sights considerably. They moved from a position
of demanding a trade monopoly to merely seeking protection of title (Larkin, 1983). This in turn received less support from the Society membership, who stood to gain very little in view of the fact that they were, for the most part, private practitioners. The sense that the Society had brought the profession of chiropody into subservience to medicine was felt by many of the members (Larkin, 1983).

The first attempt to surrender to the BRMA Board was rejected (1934), although the stance of the medical profession began to soften when it became apparent that it could not exert control over the expansion in hospital appointments, schools of chiropody and public demand (Larkin, 1983). The result was an acceptance of the Incorporated Society under the umbrella of the BRMA in 1938. The Society hailed this as a great success, as some autonomy had apparently been preserved (to consult patients without direct medical referral). The response of those chiropodists who opposed the Incorporated Society in joining the BRMA was reported as claiming the Society "betrayed itself" into abject surrender (Larkin, 1983).

The newly formed Society of Chiropodists, in the lead up to the establishment of the NHS in 1948, supported the BMA wholeheartedly in its attempts to ratify the BRMA regulations. This was seen as a way to exclude other factions from employment within the new organisation (Larkin, 1983). However, Larkin (1983) also observed the concern of the Chiropody Group Council (the Society representation on the BRMA Board) that the late and apparently ill-considered
government intention of bringing chiropody within the NHS could have provoked a "sudden massive demand" for services. This in turn might have tempted the government to allow inclusion of non-Society groups within the NHS, to help meet the demand.

The British Medical Association (BMA) supported chiropody in "poaching" foot massage skills from physiotherapy, considered by Larkin (1983) to be linked to their own pre-existing conflict with the physiotherapists. Meanwhile, the Joint Council of Chiropodists argued for full state-registration and the right to equal status with doctors in health centres. The Ministry of Health rejected these demands, as the Joint Council was seen to be at loggerheads with the BMA, and the Ministry of Health wished to maintain cordial relations with medicine (Larkin, 83).

In Larkin's analysis (1983) the Chiropody Group Council viewed acquiescence to medical control as a legitimate strategy, using small, achievable, successes as stepping stones towards a further, gradual erosion in medical influence. Yet Larkin (1983) also noted that, for medicine, the restrictions imposed on chiropody practice were designed to permanently remove the threat of future expansion.

The Cope Report of 1951 recommended the exclusion of non-registered chiropodists from the NHS, finally placing the non-registered "permanently outside the pale of official health care" (although data from the current study does not concur with this assertion).

Although the Society of Chiropodists had shown considerable enthusiasm for BRMA recognition, the Cope recommendations were
criticised for impinging on their autonomy by suggesting that patients ought to be vetted by medical practitioners before being treated by chiropodists.

Larkin (1983) viewed the professionalisation of chiropody as a "product of, and part of" the process by which the medical profession, allied so powerfully with the state, influenced the development of chiropody through its control over the health division of labour. Yet he also attributes this development to the dynamic interaction of medicine, chiropody itself and other paramedical groups in determining the outcome.

Larkin (1983) viewed the final inclusion of chiropody within the Professions Supplementary to Medicine Act (1960) as a result of a change in government policy. Instead of endorsing absolute medical control over health care delivery, the issue of public demand for services altered its stance. Larkin (1983) cited the "unacceptable" options offered by the BMA as a trigger for the switch in policy, alienating the auxiliary groups who offered a concerted objection to the Cope proposals. Registration was hailed by chiropodists and other paramedics as a success in that it appeared to limit medical control and establish their status as independent "professionals" (Larkin, 1983). However, Larkin (1983) pointed out that there was little real change in medical dominance. Medicine relinquished its direct control over formal role boundary approval, standards of practice and education for the supplementary professions, ceding this
power to the Privy Council, not the paramedicals.

For Larkin (1983) the "success" of the PSM Act for chiropodists was only achieved through a reduction in demands and by accepting medical control. Yet, crucially, the actions of the paramedical groups also acted to contain medical expansionism. State-registration neither permitted total self-government nor control of role boundaries, which had been imposed, over a long historical period, by medicine (Larkin, 1983).

In his concluding remarks, Larkin (1983) acknowledged the rise in the number of challenges to the dominance of medicine evident since 1960. He considered his own study to have dealt with those features leading to medicine's dominant position in relation to the paramedical occupations, leaving to future studies any examination of the maintainence or decline of these phenomena. It is to those questions, in relation to the profession of podiatry, that the current study seeks to address its attention.
Chapter 3

Sociology of the Professions
This part of the literature review focuses upon the theoretical concepts which inform the study, and are largely derived from the sociology of the health professions.

These theories have developed largely in relation to other professions and not to podiatry. Nevertheless, they have utility in identifying the process and strategies of professionalisation in British podiatry. They have permitted an evaluation of the relative success or failure of these strategies and have facilitated an explanation of their outcomes. In particular, the Weberian concepts of closure, autonomy and professional dominance, and their elaborations, are relevant to an understanding of the attempts by podiatry to achieve professional status. These attempts ranged from moves to establish state sanctioned control over a market for services by the exclusion of competitors, to boundary encroachment aimed at medicine and related paramedical professions.

Recent challenges to the status of medical and paramedical professions have led to a renewed interest in the de-professionalisation/proletarianization theses (Hunter, 1994; Gabe, Kelleher and Williams, 1994), which merit attention in relation to the recent NHS reforms. In addition, the Foucauldian perspective and its notion of "clinical gaze" provided insights into the construction and conceptualization of podiatric boundaries and knowledge. The impact of managerialism in the post-Griffiths era upon NHS podiatry provision was also highly relevant to this study (Cox, 1991; Strong and Robinson, 1990).
3.1. **Popular Interpretations of “Professions”**

Although the concept of profession has a variety of connotations encompassing different interpretations (Freidson, 1986; Saks, 1995) the term is commonly taken to indicate competence, efficiency, altruism and integrity, in association with the possession of special skills (Pilgrim and Rogers, 1993). Therefore, to be “unprofessional” implies incompetence, inefficiency or unethical behaviour (Pilgrim and Rogers, 1993). These views are likely to accurately reflect the understanding and usage of the term “professional” employed by respondents in this study and in the variety of editorial comments, personal and public correspondence and other data sources used. These, and other largely positive attributes were also, for many years, incorporated into the earlier sociological interpretations of professions (eg. Carr-Saunders and Wilson, 1933; Parsons, 1954). These were often based upon the views of the professionals themselves and referred to as the taxonomic approach, encompassing trait and functionalist models (Klegon, 1978).

3.2. **Trait and Functionalist Theories and their Relevance to Podiatry**

The basis of the trait approach lay in identifying a “check list” of characteristics which could distinguish professional from non-professional occupations (Carr-Saunders and Wilson, 1933; Goode, 1957; Greenwood, 1957). These were used as a measure of the gradual
progression of an occupation along the path to professionalism and consisted of characteristic features such as formal educational and entry requirements, special skills and techniques based on theoretical knowledge, altruistic motivation and the possession of a code of ethics (eg. Saks, 1995; Roach-Anleu, 1992; Denzin, 1972; Millerson, 1964, Watson, 1995).

In the trait approach, professionalisation was seen as a process by which occupations attempted to become professions by progressively acquiring these necessary characteristics. The relative success or failure of each aspiring profession led to the creation of intermediate forms, identified as "semi-professions" or cases of "incomplete professionalisation" (Denzin, 1972; Etzioni, 1969). It is possible to apply this model to pre-1960 podiatry by drawing upon the most commonly cited attributes necessary to achieve professionalism (Millerson, 1964). Whilst elements within podiatry established professional associations, codes of ethics and declared a service orientation, there was no uniformity in these claims. Unregulated practice meant competition based upon commercial gain, which contravened the notion of altruism, regarded as a feature in the failure of pharmacy to successfully professionalise (Denzin, 1972). Evaluating the competence of members through clinical examinations certainly became an established feature of those organisations which sought professional status, but was undermined by the absence of monitoring of non-affiliated practitioners. The possession of skills
based on theoretical knowledge was questionable, as this lacked scientific validity and, crucially, public confidence (Larkin, 1983).

The provision of education and training was not uniform, as no requirement for formal training existed in the private sector, where the majority worked until after 1960. The functionalist approach assumed the key features of a profession to be those which possessed a functional significance for society, or the professional-client relationship (Saks, 1995, 1983; Turner, 1987). For example, in exchange for the altruistic, ethical and non-exploitative use of complex knowledge professions were granted economic and social rewards, such as the right to self-regulation without external interference (Larkin, 1983; Parsons, 1968; Saks, 1983). Barber (1963) constructed a list of professional characteristics which shared much common ground with the trait approach. These also provide an explanation for the failure of podiatry to "fully" professionalise on the basis of the partial, incomplete acquisition of features such as uniform regulation of educational standards. Unregulated, private sector podiatry, which dominated the pre-1960 period, was partially commercial, competitive and individualistic, in contrast to the functionalist view of professions as socially cohesive forces.

3.3. The Marxian Perspective and its Relevance to Podiatry

The Marxian approach to the professions has been primarily focused upon identifying the ideological role of the middle class health
professional worker (Navarro, 1978; Doyal, 1979).

For some authors the professions have been viewed as agents of the state, bearing a bourgeois ideology on behalf of the ruling class (a pre-requisite for achieving professional status) and engaging in control and surveillance of the working class (Doyal, 1979; Esland, 1980; Larson, 1977; Navarro, 1978; Pilgrim, 1990; Poulantzas, 1975).

For other theorists, middle class professionals were said to bear characteristics of both ruling and working classes, construed as "wage slaves and agents of the bourgeoisie", in which, for example, medicine controlled labour power through medical certification yet experienced increasing routinization of work tasks (Braverman, 1974; Carchedi, 1975; Johnson, 1977; Pilgrim, 1990; Saks, 1983, 1995).

However, of particular relevance to the current study, in view of the increasing challenges to the authority of health professions evident in contemporary Britain (Armstrong, 1990; Elston, 1991; Gabe, Kelleher and Williams, 1994; Larkin, 1993; Light, 1995; Weiss and Fitzpatrick, 1997), are the proletarianization/de-professionalization theses (Braverman, 1974; Haug, 1973; McKinlay and Stoeckle, 1988; Oppenheimer, 1973). These are particularly relevant to post-1960 podiatry in view of the trend towards state employment following the emergence of NHS podiatry provision, the emergence of auxiliary assistants and, conversely, the impact of boundary encroachment by podiatry upon the domain of medicine in the de-professionalization of the latter (Turner, 1987).
3.3.1. The Proletarianization/Deprofessionalisation Theses

The proletarianization thesis (Braverman, 1974; McKinlay and Stoeckle, 1988; Oppenheimer, 1973) and the deprofessionalisation thesis (Haug, 1973; Starr, 1982) alleged a decline in professional authority and privileged status (particularly evident in medicine). These were due to such factors as increasing subordination to managerial control (associated with salaried employment within bureaucratic organisations), and loss of autonomy through routinization of work. The latter was linked to increasing specialization and fragmentation in professional skills and tasks within an increasingly complex division of labour (Elston, 1991). The former aspect has assumed greater importance in recent years, following the introduction of general management within the NHS and the further NHS reforms of the 1990s (Elston, 1991; Cox, 1991).

In addition, increased lay knowledge and a growing "consumerist challenge" to professional authority are taken to indicate de-professionalization (Elston, 1991; Haug, 1973). Johnson (1977) noted that the extent to which an occupation was liable to the effects of proletarianization hinged upon the degree of "indetermination" in its knowledge and skills base, each of which merits attention in the current study (Watson, 1987). The introduction of foot care assistants in podiatry may also be viewed in terms of de-professionalisation.

\[1\] McKinlay and Stoeckle (1988) provided "seven specific professional prerogatives...lost or curtailed" through proletarianization: 1. control over criteria for entrance, 2. content of training, 3. terms and content of work, 4. clients served, 5. tools of labour (drugs etc), 6. means of labour (clinic facilities), 7. amount and rate of renumeration.
Also relevant is another aspect of the de-professionalization thesis in which medical autonomy is said to have been reduced as a result of "pressure" from encroachment by paramedical groups (Turner, 1987).

3.4. The Weberian Perspective and its Relevance to Podiatry

The neo-Weberian framework is characterised by its emphasis upon those strategies employed by professions which are designed to advance social status, corner the market for services which are rendered unique by the tactic of exclusion, acquire new spheres of influence through usurpation and encroachment, establish or negotiate control over work, and which may involve defining the needs of the consumer (e.g., Allen, 1997; Berlant, 1975; Freidson, 1970, 1977, 1983; Johnson, 1972; Larkin, 1983; Parkin, 1979; Parry and Parry, 1977; Saks, 1983, 1995; Pilgrim and Rogers, 1993; Turner, 1985, 1987; Witz, 1992). Two concepts in particular characterise the Weberian perspective with regard to professions, social closure and professional dominance (Pilgrim and Rogers, 1993).

3.4.1. Social Closure and Professions

The concept of social closure has been particularly elaborated by Parkin (1974, 1979) and Murphy (1983, 1985, 1986) and related specifically to the analysis of professionalisation by a number of
authors (Berlant, 1975; Freidson, 1970a, 1970b, 1977, 1983, 1994; Hugman, 1991; Larkin, 1983, MacDonald, 1985; Parkin, 1979; Parry and Parry, 1976; Witz, 1992). Social closure is regarded as the process by which various social groups act to restrict access to rewards and privileges to a limited collectivity of "eligibles". Utilising certain social or physical attributes, the group will use these as the basis for eligibility or exclusion (Parkin, 1979, 1982; Weber, 1968). Exclusionary action is designed to secure certain advantages for one group at the expense of other, competing groups. Parkin (1982) also referred to the emergence of sub-strata in this scheme, in which those excluded from one group may attempt to restrict access to remaining privileges or rewards to other groups, evident in the establishment of paramedical spheres of influence.

The most successful and enduring form of occupational closure would be obtained by securing legal recognition for exclusionary practices, a characteristic feature of professional behaviour (Larkin, 1983; Parkin 1979, 1982). This would involve attempts to secure the support and endorsement of the state in the acquisition of a legal monopoly over a task domain, often associated with a defined client group, resulting in penalties for those ineligible individuals who transgressed the rules. This protection would offer the privileged group a safe haven from the dangers of the marketplace (Berlant, 1975; Larkin, 1983; Parkin, 1979). Closure mechanisms of this nature would also ensure that only those within the boundaries of the
occupation, or profession, could examine and inspect its practices, guarding against the gaze of interlopers (Pilgrim and Rogers, 1993). Pilgrim and Rogers (1993) also referred to the need of professionals to convince clients, state and other outside groups of the special and unique character of the services offered, in order to preserve their social status. This must include control over a knowledge-base which has a scientific or technical rationality, yet also requires interpretive skills which render it resistant to reduction (Larkin, 1983; Pilgrim and Rogers, 1993; Turner, 1985, 1987).

Each of these aspects is relevant to the current study, illustrated by the attempts of the state registered sector to exclude non-registered competitors, and to resist the imposition of ancillary grade workers or the principles of skill mix. Its attempts to establish a unique body of knowledge to underpin a new therapeutic terrain over which it might create a market niche also reflect these processes. The definition and maintainence of professional boundaries may be achieved both by the exclusion of others (such as non-registered podiatrists or resistance to skill mix and ancillary workers in podiatry) or in usurping (challenging) the position of the excluders (particularly medicine in relation to podiatry).

3.4.2. Exclusionary and Usurpationary Closure

Parkin (1979) argued that three forms of social closure could be identified, specifically exclusion, usurpation and dual closure, which
have been used to examine the strategies employed by varying occupational groups seeking to establish and maintain professional status (Hugman, 1991; Larkin, 1983; Turner, 1985; Witz, 1992).

Exclusionary mechanisms are utilised by occupations seeking to preserve their skills and resources, whilst usurpationary tactics are designed to challenge externally imposed boundaries and undermine or resist exclusion (e.g. Hugman, 1991; Larkin, 1983).

In the former instance, power is exercised in a downwards direction, to ensure the subordination of "inferiors", whilst the latter reflects an attempt at upward social mobility (Larkin, 1983; Parkin, 1979; Saks, 1983, 1995). Dual closure represents the use of both exclusionary and usurpationary strategies by a group already subjected to exclusion, notably applied to the "welfare semi-professions" by Parkin (1979).

For Parkin (1979) the use of credentials was the central exclusionary device employed by occupations seeking professional status, through limiting the supply of entrants to the occupation in order to enhance its market value. Parkin (1979) viewed professional closure as a strategy designed to achieve a monopoly of certain forms of knowledge and practices with which the lay public could not interfere, affording the profession effective self-regulatory powers. Other authors asserted the use of exclusion as a basis for defining the boundaries of a profession with other professions, and in determining the relationship with its clients (Hugman, 1991).

Closure, then, has many dimensions, encompassing knowledge, skills
and credentialism, involving closure within and between competing professions. The paramedical professions in particular have been noted as deploying both exclusionary and usurpationary strategies to achieve professionalism (Hugman, 1991; Larkin, 1983; Turner, 1985, 1987; Wilding, 1982; Witz, 1992).

Parkin (1979) also noted that the “supreme advantage” of occupational closure based on credentialism was that the qualification attained retains its currency throughout the working life of the holder, without any requirement for re-testing competence. The recent edict demanding compulsory CPD² may therefore have implications for podiatric professionalisation.

One other relevant feature derived from Parkin’s (1979) framework merits attention. Although noting that in contemporary circumstances many professions operate as employees of the state, with which there may be conflict over terms and conditions of service (eg. Parry and Parry, 1977), the state itself, asserted Parkin (1979), rarely acts to reverse the legal privileges of the professions. The proposed legislative changes involving the professions supplementary to medicine may require a re-evaluation of this position, in view of the intended abolition of independent professional Boards and their replacement with a single, generic structure.

Having established the theoretical basis of social closure largely

² “Continuing Professional Development” is to be a pre-requisite for registration under the proposed new Health Professions Act for all professions currently state registered as Professions Supplementary to Medicine.
through an examination of the seminal work of Parkin (1979), further elaborations to support and inform the current study may be drawn from those authors specifically concerned with professional closure strategies. Although this will entail work mainly derived from the health care arena, it may be pertinent to include examples drawn from other, non-medical cases of professionalisation where these share parallels with podiatry.

3.4.3. Social Closure, Professions and State Registration

Macdonald (1985) re-examined the notion of social closure in relation to the professionalising strategies of accountancy, in particular to their attempts to secure registration. The ultimate failure to achieve registration did not, in McDonald's view, automatically result in failure to secure the status and privileges usually associated with full closure - these being achieved by other means. Berlant (1975) noted the reluctance on the part of the state, influenced by the ideology of liberalism, to endorse monopolistic practices. This in turn resulted in the granting of few all-embracing forms of legal monopoly for professions in Britain.

Thus, a tier of exclusionary devices developed, ranging from registration of a professional body under the Companies Act at the lower end of the spectrum, through Royal Chartering, which offered greater prestige and protection of title, up to an Act of Parliament registering the group and affording it full protection - a legal
monopoly (Larkin, 1983; Macdonald, 1985).

Macdonald (1985) in particular emphasised the crucial importance of registration to the establishment of a legal monopoly characteristic of closure theory. For Macdonald (1985) the professions supplementary to medicine had achieved legally recognised closure (as defined by Parkin, 1979). The current study will provide the detail necessary to clarify the exact nature of the closure achieved in podiatry, which in reality fails to fulfil Macdonald's (1985) assumption of the privileges associated with legal closure. The key areas of relevance to the current study to emerge from Macdonald's (1985) paper on the professionalising strategies of accountancy are those features from which parallels may be drawn with podiatry. A derivation of Larkin's (1983) "occupational imperialism" was used to provide an explanation of the "area of tension and conflict" between groups within accountancy, which in part was held responsible for the failure and subsequent abandonment of registration aspirations in accountancy. The influence of both internal professional and externally imposed forces operating to shape the division of labour was as evident in accountancy as it is in podiatry.

Macdonald (1985) distinguished "unattached practitioners, sub-specialisms, lower status groups and regionally based groups" within accountancy, and recognised the powerful influence exerted by outside agencies, the state and the public. Obvious similarities exist in podiatry, both in its pre-registration era (Larkin, 1983) and in its current post-registration position. The pursuit of legal protection
continued even following the chartering of certain branches of accountancy, as "imperfectly qualified outsiders" were still able to corner part of the market. Thus, as in podiatry, the pursuit of full closure continued unabated even following the partial success of Royal Chartering (state registration in podiatry).

In addition, Macdonald (1985) highlighted both the nature of accountancy knowledge, branches of which were practised almost independently and with varying degrees of skill, and the varying degrees of demand for those skills. That is, there "has always been room for the less than fully skilled accountant", a key parallel which is found within the post-registration era in podiatry, relevant to the failure of podiatric professionalising activity. The de facto monopoly achieved by sections of the accountancy profession (those recognised by the Board of Trade) both negated the need for registration (in stark contrast to modern podiatry) and led Macdonald (1985) to suggest that Weber's concept of legal monopoly might best be regarded as an ideal type, achieved only infrequently in reality. This suggestion was based upon the finding that market control had been effectively achieved without recourse to a legal enactment protecting accountancy from inferior competitors. This raises the question as to why the self-styled "premier" podiatric organisation (Dagnall and Page, 1992) failed to achieve a similar de facto monopoly without the need to pursue further legislative protection.

The use of closure strategies by medicine, involving state registration,
has been the focus of several writers and reflect its successful professionalisation (Parry and Parry, 1976; Berlant, 1975). Berlant (1975) regarded the success of medical professionalisation to have resulted from a skilful reformulation of its ideology to deflect the dominant liberal laissez-faire concern with restrictive monopolization resulting in state support. Medical acceptance of a reduction in legally exclusive authority within the terms of the 1858 Medical Act actually provided for registration mechanisms which secured state support and continued a de facto monopolisation by affording such practitioners market advantage. Medical success was seen to hinge on incorporation and exclusion in dealing with competitors (Berlant, 1975). The reaction of state podiatry to the prospect of improved protective legislation in return for incorporation of market competitors is similarly significant to the current study.

3.4.4. Social Closure and the Health Professions: Further Elaborations

A number of recent studies of healthcare professionalisation strategies have introduced further elaborations of the social closure theme which have utility for this research.

In an examination of medicine, nursing and radiography, Witz (1992) employed a modified version of Parkin's (1979) closure model, which embraced a further dimension to exclusionary and usurpationary
strategies. The four-fold distinction presented by Witz (1992) broadly encompassed exclusion, demarcation, inclusion and dual closure strategies, in which the former two were employed either by the dominant group or another occupational group within the hierarchy of closure, and the latter two reflected the responses of the subordinate groups.

The further distinction drawn between exclusionary and demarcationary strategies mirrored Freidson's (1977) view of medicine, characterised by both successful occupational monopoly and dominance of other groups within the health division of labour. Exclusionary strategies, then, are designed to secure intra-occupational control over work, resources and access to rewards, whilst demarcationary strategies are intended to establish control over, or wrest authority from, other occupations within the health division of labour (Witz, 1992). For Witz (1992), demarcationary strategies are those concerned with the creation, control and negotiation of role boundaries between occupations. Similarly, Witz (1992) attempted to provide a further division within Parkin's (1979) notion of usurpationary closure, describing inclusionary and dual closure strategies.

It is the notions of demarcationary and dual closure strategies which are of relevance to the current study in explaining the relations between podiatry, medicine and other paramedical groups. Witz

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3 Inclusionary strategies were those involving the exercise of power in an upwards direction, designed to ensure absorption into the structure from which the excluded group were "debarred" (Witz, 1992).
particularly highlighted the influence of gender in the success of professionalisation. Podiatry, like nursing, radiography, clinical psychology and other paramedical groups, has a predominantly female composition, and a preponderance of males within the upper echelons of the profession (Hearn, 1982; Howe, 1986; Hugman, 1991; Pilgrim and Treacher, 1992; Witz, 1992). Larkin (1983), however, noted that podiatry, in contrast to the other paramedical groups in his study, had a "mixed sex membership". The current investigation revealed a mixed sex membership, which, although biased numerically in favour of women, was not as emphatic as at first suspected.

Larkin's (1983) elaboration of the closure/professional dominance model, was described as "occupational imperialism". Occupational imperialism denotes a set of strategies employed by both superordinate and subordinate occupational groups in the creation, control and negotiation of boundaries. Hugman (1991) examined the professionalising closure strategies of the remedial professions in relation to "territorial" claims over knowledge and skill.

3.4.5. Social Closure: The Importance of Knowledge and Skills

Usurpationary closure strategies are most clearly manifest in the health professions as a struggle to develop discrete areas of
knowledge, largely against the cultural and social authority of medicine (Hugman, 1991; Larson, 1979; Turner, 1985; 1987). Hugman (1991) strongly emphasised the extent to which qualifications and credentials were important tools in professionalisation for the remedial professions, particularly stressing the recent trend towards claiming a scientific knowledge. This is consistent with the notion of paramedical scientification noted by Elzinga (1991).

Similarly, in a recent examination of psychotherapy, claims to a scientific knowledge, supported by case studies, were viewed as professional rhetoric justifying professional status, work and remuneration (Pilgrim, 1992; Masson, 1992; Craib, 1994). Scientific knowledge claims were considered tools to support and exercise the establishment and extension of professional power over clients and other professions (Craib, 1994).

A balance between the indeterminate and technical aspects of knowledge has also been regarded as important in the success of professional projects (Jamous and Peloille, 1970; Turner, 1985). So to was control over a "knowledge system governed by abstractions" which determined the ability of a profession to resist encroachment, whereas techniques could be delegated (Abbott, 1988; Watson, 1995). Hugman (1991) also incorporated the notions of internal and lateral closure strategies by the remedial professions. Internal closure referred not only to the development of subordinate ancillary grades - "aides" or "assistants" - but also to the development of specialists as
distinct from generalists, each distinction justified on the basis of the superior knowledge and skills of the superordinate. This concept is of considerable value for the current study in explaining the developing internal divisions within podiatry, including the foot care assistant and the specialist podiatric surgeon. Assistant workers are delegated the dirty work of the aspiring profession, which pursues higher status activities based on theoretical knowledge - the "virtuoso" roles. The specialists develop a further network of credentialist requirements which act as exclusionary mechanisms against the generalists. The tasks of the former concentrate upon curing, the latter on tending.

Hugman (1991) also described the client differentiation evident in this form of internal closure - the high status attached to children and sportspeople, for example, whilst low status is attached to the elderly, particularly those with chronic as opposed to acute health problems (also Aleszewski, 1995). "Lateral" closure reflects the tension and conflict between professions competing within the same arena, notable in relations between podiatry and radiography. The recent central challenge to medicine from nursing and the remedial professions has been in the area of diagnosis and prescription of treatment (Hugman, 1991; Watkins, 1987; Witz, 1994), a feature of equal relevance to modern podiatry. The Foucauldian perspective provides a view of knowledge which differs from the traditional, structural approach, and has utility for the study.
3.5. The Foucauldian Perspective and its Relevance to Podiatry

The Foucauldian approach has utility for this study in that it provides some insight into the disciplinary perspective of podiatry in the conceptualisation of the foot, its boundaries and the knowledge and technologies which have emerged from it, in the period since 1960. The Foucauldian analysis of dentistry and dental practices by Nettleton (1988, 1989, 1992) permits a comparative view of the development of dentistry and podiatry, through an examination of the importance of the dental "gaze" and the symbolic significance of the mouth and teeth in the professional emergence of dentistry.

Nettleton (1988, 1992) examined the issue of how the mouth and teeth became separated from the body, and perceived as a discrete area "sufficiently significant to result in an extensive knowledge of it" (Nettleton, 1988). In view of the common origins of podiatry and dentistry in Britain (Seelig, 1953; Dagnall, 1979), it is relevant to examine and account for the divergence in fortunes of these two occupational groups.

Nettleton (1988, 1989, 1992) viewed as inadequate existing accounts of dentistry which described its professional emergence as a response to dental disease, that dentistry arose because there was a need for it. Nor did the demand for dental care arise as a consequence of the supply of dental care as a commodity. The need for dental care was, conversely, created by dentistry itself, through an emerging knowledge of mouths and teeth gained through a pervading dental
gaze which monitored the mouths of individuals and populations (Nettleton, 1988, 1989, 1992). This perspective was derived from the Foucauldian notion of power/knowledge, in which creative disciplinary power produced new objects of knowledge through the disciplinary techniques of surveillance and monitoring, ensuring a "normalisation" of the mouth and teeth.

The significance of the mouth and teeth and their emergence as separate, identifiable entities worthy of a special body of knowledge and expertise, resulted from the nineteenth century concern with the prevalence of communicable diseases such as cholera which represented a major threat to public health. As advances in bacteriology led to a shift in emphasis from the dangers of the environment, previously seen as the source of contamination, to the danger posed by individuals who transmitted disease, the "points of contact" between bodies assumed great importance. The mouth became viewed as a "vulnerable margin" of the body, by which such contamination might gain entry to the body (Nettleton, 1988, 1992).

Prevention became a key focus, facilitating the techniques of surveillance and monitoring, dental education, and the training of bodies (in such methods as toothbrushing). The policing of the mouth led to a knowledge of it (Nettleton, 1988, 1992).
3.6. Professional Autonomy and Professional Dominance

In terms of closure, Freidson (1970a, 1970b, 1977) argued that the basis of medical power stemmed from the legally and politically sanctioned monopoly over the organisation and control of work unique to it within the health division of labour (Freidson, 1970). This freedom to control the content and terms of work, the power of self-regulation and freedom from external judgement contributed to a position of strength in relation to potential competitors, protecting medicine from boundary encroachment from other occupations (Freidson, 1970a, 1970b).

A key element in the maintenance of this power rested in the control over the application of medical knowledge and skill, affording medicine a unique degree of autonomy. If the same occupational knowledge and skills were held by others, asserted Freidson (1970a), this would represent a lack of autonomy as it would then be open to evaluation and criticism by outsiders. Thus the authority to supervise training and award qualifications ensured the maintenance of professional status (Freidson, 1970a, 1970b). Also necessary was the public recognition that the unique and effective nature of medical knowledge and skill was assured, thus persuading the public to grant the special status of autonomy (Freidson, 1970a). Nevertheless, the knowledge base of an occupation is not in itself said to be sufficient to secure professional status, but may be used as a resource to support claims to a monopoly jurisdiction (Freidson, 1970a; Larkin, 1983).
Therefore, the key to the power of medicine lies in its relationship with the state, which ultimately granted the authority essential to the medical hegemony and dominance in the health division of labour (Freidson, 1970a, 1970b; Berlant, 1975).

The influence of medicine extended beyond self-regulation, given its monopoly over the control and organisation of healthcare in the wider division of labour. The main element centred on the power of medicine to direct and evaluate the work of other occupations engaged in the care of patients without being subject to such gaze itself (Freidson, 1970a, 1970b). The para-medical occupations, in consequence, were excluded from the vital task of diagnosis, their work became supervised by medicine, and they lacked control over their own knowledge base (Freidson, 1970a, 1970b; Larkin, 1983). This formed the basis of Freidson's model of professional dominance, in which medicine successfully subordinated other occupations within the health division of labour; a dominance which in turn sustained it autonomy (Freidson, 1970a). Medicine, it was claimed, then determined to a large extent the role definitions of the subordinate paramedical groups (Freidson, 1970a, 1970b; Johnson, 1972).

A number of specific studies of subordinate paramedical professions and their relations with the dominant, superordinate profession of medicine support the current study of podiatry (Eaton and Webb, 1979; Larkin 1979, 1980, 1981; Ovretveit, 1985; Mercer, 1980). There are said to be three modes of medical domination in relation to allied professions,
elements of each being relevant to this study - subordination, limitation and exclusion (Turner, 1985)

Although professional dominance remains an accepted phenomenon, Freidson's construct has been regarded as inflexible and "over-muscular" (Larkin, 1983; Saks, 1983). Professional dominance suggests both "zero-sum conflict" and total control of subordinate occupations by medicine, in which the former have little influence in shaping the division of labour and are left merely to pursue a "mirage" in attempting to achieve greater autonomy over their work (Larkin, 1983). As a result Larkin (1983) introduced the concept of occupational imperialism, to denote the strategies and tactics adopted by each occupation to mould the division of labour to its advantage. The tactics employed involve poaching skills from other groups or delegating skills, to ensure income, status and control (Larkin, 1983). The expansionist tactics of the paramedical groups are encompassed within the construct of occupational imperialism.

For Larkin (1983), Freidson (1970a, 1970b, 1977) occupied a position in which the structural dissimilarities between physician and paramedical worker appear absolute. Larkin (1983) regarded the skills, knowledge and role boundaries between occupational groups as not immutable but dependent upon inter-professional and external power sources. It became necessary for medicine, in relation to the

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4 Subordination refers to the control established through delegation and supervision, such as in the medicine-midwifery relationship. Limitation implies the restriction of tasks to a specified area of the body (eg. dentistry) or a certain therapeutic technique (pharmacy). Exclusion ensures the denial of legitimization of professional tasks (eg. chiropractic) (Turner, 1985).
paramedical occupations, to distribute existing and new skills through the developing division of labour to maintain its position of pre-eminence, and to do so with state support (Larkin, 1983). Yet Larkin (1983) also viewed the reaction of the paramedical groups to this domination as important in shaping the outcome for the division of labour. Specifically in relation to the Professions Supplementary to Medicine Act (1960), the influence of the paramedical groups led to the acquisition of "skill-specific partial autonomy", acknowledging some potency on the part of the paramedical groups. Thus, Larkin's (1983) model does acknowledge the influence of paramedical groups in determining the demarcation of their work, and subsequent autonomy, which is consequently of value to this study in relation to the impact of podiatric expansionism on NHS service provision.

3.7. Medical Dominance, Managerialism and the Recent NHS Reforms

Recent challenges to medicine and the health professions in Britain have arisen as a result of the introduction of general management and the more recent NHS reforms of the late 1980s and early 1990s. The impact of these changes on the health professions has been the focus of several recent studies, although none have directly evaluated the impact upon podiatry.

Elston (1991) acknowledged the impact upon medical autonomy and dominance of the extension in managerial control facilitated through
the "Working for Patients" 1989 white paper, with a renewed emphasis on value for money. The imposition of the need to undertake audit measures and management control over consultant appointments could be similarly viewed. Nevertheless, Elston (1991) recommended caution in assuming a decline in medical autonomy and dominance based upon these changes. For example, the Griffiths Report implementation and subsequent "Working for Patients" (1989) reforms was also regarded as an "attempt to incorporate doctors into NHS management" (Elston, 1991). With regard to the relationship between medicine and paramedical occupations, Elston (1991) used the Griffiths general management strategy to highlight the relative gains made by medicine in securing management positions compared with the paramedical groups, who were much less successful, confirmed by Cox (1991).

A fuller examination of the impact on those groups concerned with the Griffiths reform and its general management aftermath, leading to "Working for Patients" (1989), was provided by Cox (1991). Cox (1991) outlined the nature of the Griffiths Report (1983), replacing consensus administrative structures which were designed to provide for the needs of professionals with a management structure detailed to assume responsibility for service provision. For Cox (1991) this reform reflected both structural and ideological concerns. The Government concern with limiting public spending in the face of escalating costs from an ageing population and higher technology
medicine was coupled with a desire to embrace a market philosophy (Cox, 1991). Although the Griffiths Report (1983) was "very respectful of medical power" in facilitating the move to general management of medical personnel, it was debilitating for many paramedical groups, for whom District level posts were abandoned and career pathways disrupted (Cox, 1991). Cox (1991) asserted that, although general management was designed to challenge the medical hegemony and autonomy, there was little evidence to suggest that the authority of the medical consultant had been diminished.

Gabe, Kelleher and Williams (1994) re-examined medical dominance in the light of the impact of the recent NHS reforms in Britain. The introduction of general management was clearly viewed as the most significant. Following on from Cox (1991), the post-Griffiths era of general management posed threats and opportunities for medicine, yet potentially signalled a "generalised dilution of power" for health professions (Cox, 1992; Gabe, Kelleher and Williams, 1994). Medicine continued to enjoy high status and to mould managerial developments to its advantage (Hunter, 1994).

Witz (1994) examined the thesis that the expansionist strategies of nursing posed a significant threat to medicine in the climate of change in the modern NHS. The new strategy designed to accomplish practitioner autonomy in relation to an enlarged role for nursing work is viewed as affording some enhanced autonomy without seriously threatening the medical hegemony (Witz, 1994).

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The challenge to paramedical autonomy posed by general management and the recent NHS reforms has also been addressed by Ovretveit (1994a,1994b), specifically with regard to physiotherapy, in which parallels with podiatry are evident. Ovretveit (1994a,1994b) regarded general management and the recent reforms as impinging upon the autonomy of physiotherapists, in permitting purchasing GPs to dictate activities or facilitating locality managers demands for increased accountability and flattening in career structures. Nevertheless, advantages were perceived in the potential for negotiating separate service contracts for tasks which could be carried out without medical direction, enhancing independence and autonomy (Ovretveit,1994b).

Aleszewski (1995) also noted the impact of the new NHS internal market upon the professions of medicine, nursing and social work. The disparate nature of medicine was reflected in the impact of the reforms on different groups within medicine. Whilst general practitioners were presented with opportunities to enhance their control over resource allocation on becoming fundholders, and public health physicians gained in becoming guardians of quality, hospital specialists became more subject to managerial control (Allsop,1995; Aleszewski,1995). This is relevant to podiatry in terms of the differing relations with fundholding GPs and hospital consultants, in relation to podiatric autonomy and encroachment upon medical practice.
3.8. **Summary**

Those aspects of theory derived from the sociology of the professions which have relevance to the current study are derived from the Weberian, Marxist and Foucauldian perspectives. Primarily, the linked Weberian concepts of social closure, professional dominance, boundary encroachment and autonomy provide the central strands underpinning this work, which have been illustrated by examples from the healthcare professions and others. The Marxist notion of proletarianization was deemed important in the light of recent challenges to health professions noted in the wider literature. A Foucauldian approach to dentistry provided a perspective which has utility in explaining the ways in which the objects of knowledge are perceived and their boundaries established or changed.
Chapter 4

Aims, Objectives and Method
4.1 The Aims and Objectives

The aims of this study can be described in terms of four main research questions. In turn these generated four key objectives at the start of the study. Derived from these main aims, and generated from the study data, are a series of sub-aims, outlined below.

4.1.1 Main Aims:

1. To provide an account of the key events, changes and main sociological features of the profession of British podiatry between 1960 and 1997.

2. To examine the extent to which the Weberian version of the sociology of the professions, with contributions from the Marxist and Foucauldian perspectives, account for these features.

3. To examine to what extent these features are a reflection of, and partially constitutive of, their socio-historical context.

4. To examine the nature, success or failure of professionalising strategies and their impact on professional autonomy in British podiatry since 1960.
4.1.2. **Sub-Aims:**

i. To examine the extent to which pre-1960 role boundaries in British podiatry have altered since 1960.

ii. To examine the impact of integration of podiatry services into the National Health Service upon the podiatry division of labour, with particular reference to "foot care assistant" ancillary grade workers and podiatric surgery.

iii. To examine the nature and development of intra-professional and inter-professional conflict and rivalry since 1960, with reference to relations between podiatry, medicine and radiography.

iv. To examine professional attempts to develop a discrete body of knowledge unique to podiatric practice, independent of medicine, and to extend podiatric practice through its therapeutic application.

v. To examine the relations between British state registered podiatry and the state since 1960, with reference to professional aspirations to full, legal, professional closure leading to a trade monopoly.

vi. To examine the impact of government health policy and legislation on British podiatry since 1960.
vii. To examine the importance of technology to the professionalising activity of British podiatry since 1960.

4.1.3. **Key Objectives:**

1. The overall features of the discourse of British podiatry from 1960 - 1997 will be recorded.

2. A detailed record of the expressed views of professional leaders and prominent officials involved in determining these features will be constructed.

3. These descriptions will be derived from both published and unpublished documentary material and oral accounts from within the profession and from medical and NHS managerial sources directly involved with podiatry.

4. The data constructed will be read and interpreted in the light of the main aims outlined above.

4.2. *Introduction to the Methodology*

This research aimed to chart and analyse the events of significance to the professionalising activities and aspirations of British podiatry over a timeframe of thirty seven years. A methodology was required which
would permit access and analysis of data derived from a variety of sources in order to construct a viable picture of professional activity, interprofessional relations and relations with the state across the given time period.

The methods employed in this study were drawn from two research traditions, interview techniques and documentary analysis. These methods were selected on a number of grounds. Little has been published vis a vis the profession of podiatry which has emerged into the public domain. Thus, in order to construct a coherent chronological and thematic picture of professional change and development, accounts of key actor informants, in terms of participation in key committees and events, and access to formal and informal documentary data relating to professional activity in podiatry across the specified timeframe were necessary. It was only through these routes that adequate data could be obtained relating to both the historical accuracy of recorded events and to the interpretations and subjective reality of those actors influenced by, and involved in shaping and determining the events in question. The data gathered related both to a socio-historical and a contemporary context, and are presented in a linked temporal and thematic order. The data were collected over a four year period, from December 1992 to January 1997.

Qualitative interviews were selected as it was anticipated that they would provide a rich source of information about the motives, beliefs and actions of the professional decision making groups (eg. Fetterman, 1989; Patton, 1987, 1990). Existing documentary evidence alone was regarded as
insufficient in providing the in-depth knowledge and views of sensitive or emotionally laden issues, or the sentiments underlying the expressed opinions or views of the individuals or groups concerned (Rogers, 1989). Interviews would permit the information and views of respondents to be probed and recorded. In addition, documentary sources, or other research methods such as questionnaires, were regarded as unlikely to reveal the more subtle features of professional activity which might be revealed through interview (Rogers, 1989).

The chapter will first address the design of the study, presenting the advantages and disadvantages associated with the research techniques of interview methodology and documentary research. Subsequent sections will examine the sampling decisions, access arrangements, and the procedures involved in the data collection. This will be followed by description of the data analysis framework employed. Each section is linked with a commentary outlining the decision making process at each stage. This should provide an account of the rationale at each juncture, in order to establish a record of the research, and which might form the basis for either replication or elaboration (Pilgrim, 1990).

Finally, a further section will address the methodological adequacy of the data in relation to the issues of reliability and validity, and comment upon the ethical issues raised in the study.
4.3. The Design of the Study

As noted above, the relative merits of each of the methods employed in the current study are presented as a justification for their use and an indication of their utility and relevance to the current research.

4.3.1. Interview Methodology

Interviewing has been regarded as the most common form of data gathering which may be used for a variety of purposes and assumes several forms (Holloway and Wheeler, 1996; Oppenheim, 1992; Yin, 1994). Oppenheim (1992) identified two primary forms, the standardized and exploratory interview\(^1\). The latter type is a qualitative, free-style interview, associated with a more "fluid" agenda and allows for more in-depth exploration of themes (Oppenheim, 1992; Robson, 1993). Grebenik and Moser (1962) viewed the various types as situated along a "continuum of formality", reflected in the common classification of structured, semi-structured and un-structured, divisions which are marked by the degree of structure or formality involved (eg. Holloway and Wheeler, 1996; Robson, 1993)\(^2\). Patton (1990) identified a sub-set of approaches within in-depth interviewing, of relevance to this research.

\(^1\)In this typology the former is associated with market research and survey designs, and characterised by a fixed sequence of pre-determined questions permitting little exploration of key issues.

\(^2\) Powney and Watts (1987) provided an alternative typology, in which the basic distinction resides in the relationship between interviewer and interviewee, described as the "respondent interview" and "informant interview". The latter is characterised by the emphasis placed upon the interviewees knowledge and perceptions within a particular context or situation (Robson, 1993), and is of particular relevance to the current study.
each serving a different purpose: the informal conversational interview, the general interview guide and the standardized open-ended interview, based upon the extent to which questions were pre-determined and standardized. Patton (1987,1990) also noted the possibility of combining any of these styles as part of the data generation and collection process.

4.3.2. Key Actor Interviews

Another, specific type of interview of central importance to the current study was the key actor or key informant interview (Fetterman,1989; Yin,1994). Oppenheim (1992) regarded key informant interviews as a variation of depth interview, specifically designed to permit the generation of ideas, and access to perceptions and knowledge about situations with which the individuals have particular experience. The access of depth and detail combined with information which illuminates and enhances understanding of motives behind actions in relation to the events under study form the core advantages of key actor interview (Fetterman,1989; Oppenheim,1992; Patton,1987,1990; Yin,1994).

Key actors provide

"detailed historical data, knowledge about contemporary interpersonal relationships (including conflicts), and a wealth of information about the nuances of everyday life" (Fetterman,1989).

The key informant is especially knowledgeable and articulate, able to provide insights into the actions and events under study (Patton,1987,1990). While a respondent might answer questions without elaboration, the key informant provides the "richness and texture"
necessary for an adequate interpretation of data (Fetterman, 1989).

Critically, key informants

"provide reliable and insightful information...[and are] extremely effective and efficient sources of data and analysis"

(Fetterman, 1989; see also Yin, 1994).³

Key actors also provide detailed autobiographical descriptions, which further inform the social context of the events under study, lending this type of interview to a description of oral history (Fetterman, 1989; Morse and Fields, 1996). They are often selected as formal or informal leaders in the community or social group under study (Fetterman, 1989). This particular feature formed the central basis for the purposive sampling selection of the key informants in this study, and will be more fully outlined in the section on sampling. For Yin (1994) the key informant not only provides detailed and insightful information and perception, but also can suggest alternative sources of corroborative evidence, both documentary and human.

4.3.3. Focused Interviews and Telephone Interviews

Two final interview strategies of importance in the current study were the focused interview and the telephone interview (Merton, 1990; Robson, 1993; Yin, 1994). The former type of interview permits the researcher to investigate particular situations or events. Individuals

³ In this respect, respondent interviewing, although a more efficient data collection strategy, is "less revealing, and potentially less valid" than key actor interviews (Fetterman, 1989).
known to have been involved in such a situation are accessed and are asked to provide both subjective interpretations and corroboration of surrounding documentary evidence (Robson, 1993; Yin, 1994). It also permits a reduction in, or exclusion of, the "dross rate" of redundant information which is likely to be feature of in-depth, open interview techniques (Morse and Fields, 1996). Telephone interviews, also employed in this study, are regarded as sharing many of the advantages of face to face encounters: high response rate, correction of clear misunderstandings, possible use of probes (Robson, 1993). Although more difficult to establish rapport, they are less prone to interviewer effect and the likelihood of resulting in "socially desirable responses" (Robson, 1993).

4.3.4. Disadvantages of Interview Methodology

There are a number of disadvantages inherent in interview methodology in general, and to the key actor/depth interview in particular. Yin (1994) particularly noted the need to report and interpret interviews "through the eyes of specific interviewees", and to regard transcripts as verbal reports rather than as absolute truth statements. The problems of bias, poor recall or inaccurate inarticulation also need to be borne in mind (Yin, 1994). Patton (1987, 1990) noted the potential problem of distorted and biased perspectives resulting from reliance upon key actor information. Calvert (1991) identified the central problem for oral histories as the "strong tendency for respondents to put the best possible
light on their previous actions”, which might only be overcome through confirmation by written evidence. These disadvantages may be overcome, or combated, through cross-corroborated with other interview and documentary evidence in a process of triangulation (eg. Allen, 1991; Denzin, 1970; Patton, 1987, 1992; Yin, 1994). Care must also be taken in selecting key informants to avoid “arousing political hostility or personal antagonism among others” (Patton, 1987). Another problem, highlighted by Morse and Fields (1996), relates to the issue of confidentiality of information given by informants at interview, designated by them “secret”.

In addition, Yin (1994) and Fetterman (1989) both caution against over-reliance upon key informants. They warn the researcher to be on guard for distortion and contamination based on an informants desire to please, or tendency to adopt the researchers theoretical or conceptual framework (Fetterman, 1989; Yin, 1994). Again, a solution is indicated in triangulation between varying sources of data (Yin, 1994). Whilst acknowledging the impossibility of excluding absolutely such bias, the current research sought to minimise it through a number of measures.

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4 During the course of the current study certain data was obtained which was initially requested to be kept secret. However, these instances shed important light upon key issues, and the researcher, following from Morse and Fields (1996), sought to recheck this status with two such key informants. Use of the material was subsequently granted, although in one case with the proviso that the interviewee should not be identified in the case of future publication.

5 For Yin (1994) the key advantages of interview methodology reside in their capacity to obtain insightful data, eliciting perceived causal inferences, and their use in targeting specific topic areas in focused form. The disadvantages of interviews rest in bias due to poorly constructed questions (researcher bias), response bias, inaccuracy due to poor recall or poor articulation. Researcher bias must first be acknowledged and every effort made to reduce this effect.
which will be outlined in the section dealing with the study procedure. Nor was the exclusion of this bias entirely desirable, because of the need to illuminate the subjective meaning of the actors.

4.3.5. *Documentary Evidence*\(^6\)

In the current context the term "document" is applied only to written material, although non-written data were available to the researcher\(^7\). Calvert (1991) asserted that research dealing with any temporal period before the present would feature documentary sources as its primary source of information. These unobtrusive measures may be used to supplement interactive methods of data collection, form the central focus of data gathering and analysis or act as a means of triangulation (Calvert, 1991; Duffy, 1987; Fetterman, 1989; Morse and Field, 1996; Robson, 1993). The current study sought to employ documentary evidence as a supplement to interview methods and as a means of triangulation. Documentary evidence has been described in two classes, primary and secondary, referring to the extent to which people constructing the documents were engaged directly with the issues being addressed - that is, first hand involvement (Calvert, 1991; Duffy, 1987)\(^8\).

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\(^6\) Documents have been defined as "an impression left by a human being on a physical object" (Travers, 1964), and can therefore be extended to include material of a diverse nature, such as a film, video and other non-written sources.

\(^7\) The latter were excluded from the study (tape recordings of minutes of meetings of a professional organisation, photographs, video footage - all held in private possession) as it was not possible for the researcher to accurately identify either the characters or the timeframe satisfactorily, nor were these data regarded as sufficiently relevant for the purposes of the current research. They did, however, provide background information and helped to situate the study and identify issues.
This study almost exclusively utilises primary sources of documentary evidence, with some supporting secondary data, held in both public and private possession. These were derived from a series of widely acknowledged documentary sources (Calvert, 1991; Holloway and Wheeler, 1996; Morse and Field, 1996; Robson, 1993; Yin, 1994). Calvert (1991) and Duffy (1987) noted a further sub-classification of documentary evidence, described as deliberate and inadvertent sources. Deliberate sources were those deemed to have been constructed for the attention of future researchers; as documents for later publication, self-justification, self-vindication or reputation enhancement (Duffy, 1987). By contrast, inadvertent sources are those constructed for purposes other than the above, for contemporary and practical purposes.

Documents assist in verifying and corroborating interview data, yet also guide the researcher to further inquiry when such evidence is contradictory rather than confirmatory (Yin, 1994). In addition,

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8 In this typology, secondary sources emanate from authors commenting upon the actions of others, without personal involvement or as a witness themselves, and commonly writing some time after the events under study occurred, whilst primary sources stem from those actively involved with the actions or events in question.

9 Official correspondence, memoranda of professional organisations, journal editorials and articles, private and official communication, minutes of meetings of professional organisations, course documentation, attendance records of professional organisations, corroborative contemporaneous newspaper articles, official State and professional publications, and various written reports for or to professional organisations.

10 The latter, identified as sources such as minutes of meetings, legislative documents, attendance records, bulletins, journals and newspapers, are regarded both as more common and more valuable primary forms of data than the former (Calvert, 1991; Duffy, 1987). It is, however, acknowledged that there is no clear boundary between deliberate and inadvertent sources of data, and that caution is necessary in dealing with both (Duffy, 1987). Indeed, Yin (1994) regarded the utility of documentary evidence as based not on accuracy or lack of bias, but as a means of corroboration and augmentation of other data sources.
inferences are permissible from documentary data, although caution
dictsates that these should be viewed as clues for further inquiry rather
than "definitive findings" (Yin, 1994). Nevertheless, for Yin (1994) the
utility of documentary evidence can be enhanced by ensuring an
awareness of the conditions under which the documents were
constructed, that is, their inadvertent nature. This ensures that in any
subsequent interpretation the researcher is

"less likely to be misled...and more likely to be correctly critical in
interpreting the contents of such evidence" (Yin, 1994).

These stipulations were also applied to archival records or documents
(Yin, 1994). In this respect the wealth of documentary evidence
preserved by a small number of key informants, held in private
possession, acted as a source of archival material.

4.3.6. Advantages and Disadvantages of Documentary
Evidence

The principal advantages of utilising documentary sources of evidence
have been recently outlined by Yin (1994) and Patton (1987, 1990).
Documents are stable, in that they are amenable to repeated review
(Yin, 1994). As unobtrusive measures they are:

1. resistant to the influence of the researcher (other than
researcher bias in interpretation).

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11 For the purposes of this research, archives are regarded as "any collection of original
documentary material...[which] may themselves be public or private" (Calvert, 1991).
2. exact in providing accurate data of historical events, characters or places (Yin, 1994).

3. provide a broad coverage of a long timeframe, helping to chart many events, activities and changes over a given time period.

Problems may arise with this methodology in respect of retrievability, access, bias in selection when access is limited, and reporting bias of the document author (Patton, 1990; Yin, 1994). Each of these potential problems, and the measures taken to address them, will be discussed in the section outlining the procedure of the current study. Finally, there are few texts dealing in any detail with the individual forms of document specific to the current study. With the exception of letters, diaries and life histories (Morse and Field, 1996; Plummer, 1983; Scott, 1990), little specificity is applied to the individual types of document under study\(^\text{12}\). Categorising documents, however, may be considered less important than correctly identifying and placing documents within their appropriate genre (Platt, 1981b). This is regarded as essential in establishing the meaning of a document's content, with clear implications for interpretation (Platt, 1981b).

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\(^{12}\) Attention is paid to other forms of document, such as photographs, film, or novels addressing true or actual events (e.g., Plummer, 1983). The remainder are classed under the generic titles of official documents or state documents (Morse and Fields, 1996; Scott, 1990), administrative documents (Hakim, 1993) or miscellanea (Plummer, 1983). The utility of addressing categories of document does, however, permit several types of document to be embraced under one, manageable heading. Hakim (1993) defined administrative records as "collections of documents containing mainly factual information compiled in a variety of ways...and used by organisations to record the development and implementation of decisions and activities which are central to their functions" providing the researcher with a degree of flexibility in placing the documents employed in this study. These will be specified in the sections relating to sampling, access and procedures.
Letters and personal documents provide rich data, which reveal the relationships between correspondents, and in numbers can inform an analysis of events or other phenomena under study (Morse and Fields, 1996). Both Scott (1990) and Plummer (1983) considered the particular problems posed by letters as data. Both representativeness and meaning in handwritten or damaged letters may be problematic (Scott, 1990). Indeed, a small number of letters accessed in this study had to be abandoned due to illegibility and absence of date, making accurate temporal sequencing impossible. The author of a letter assumes a background of "taken for granted assumptions" which are shared by the recipient and may reduce detail (Scott, 1990).

Plummer (1983) asserted that, although letters might provide insights, they are rarely used as documentary sources of evidence, and may labour under erroneous assumptions of the recipients perceptions or interpretation by the author. Finally "dross rate" may present problems, in which little content is relevant to the subject under study (Plummer, 1983). In this latter case, fortunately, the professional and focused nature of the letters accessed tended to ensure a low dross rate.

4.4. Subject and Document Sampling

Patton (1990) asserted that all sampling decisions, with regard to both sample size and sampling strategy, were dependent upon and

13 Although a separate typology of letters exists, based on Thomas and Znaniecki's (1958) "Polish Peasant" thesis (Plummer, 1983), the only category applicable to the current study is the business letter, in that these relate solely to professional or clinical issues.

14 It is considered necessary, therefore, to view the letter as an interactive product, and to examine it in the light of what is known of the recipients role (Plummer, 1983).
underpinned by previously identified units of analysis. Pilgrim (1990), in a study utilising a similar research design applied in British clinical psychology, noted that the ideal study would involve an analysis of all available material. Similarly, within the current study the ideal total unit of analysis would have comprised everything written and spoken about British podiatry between 1960 and 1997. Achieving this total unit of analysis is seldom possible and as a result sampling decisions are necessary (Holloway and Wheeler, 1996; Krippendorff, 1988; Patton, 1990). Such sampling decisions apply equally to those social actors secured as key informants as they do with available documentary sources (Patton, 1987, 1990; Pilgrim, 1990). The appropriate sampling strategy is one which generates adequate and relevant information of sufficient quality (Holloway and Wheeler, 1996).

In this study the principal sampling strategy was informed by the selection of "information-rich" cases, from which considerable data about key issues central to the research could be obtained (Patton, 1990). This purposive, or criterion based sampling strategy (LeCompte and Preissle, 1993) was designed to capture and describe the central themes identified as important in the development of British podiatry since 1960. This strategy was supported by "snowball" or chain sampling, a technique for locating further information-rich cases or sources through existing key informants (Patton, 1990). Following these

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15 A number of appropriate key informants within the Podiatry Association and those associated with certain key events, such as the Medicines legislation or radiographic expansion in podiatric practice were located via this method.
exploratory measures, the use of confirmatory and disconfirmatory measures were employed (Patton,1990). These represent cases that fit emerging patterns and elaborate such findings, adding depth, detail richness and credibility (Patton,1990). In relation to sample size in qualitative research designs, Patton (1990) asserted

"The validity, meaningfulness and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher than with sample size" (Patton,1990).

Lincoln and Guba (1985) also addressed the issue of sample size in qualitative research and concluded that the limit of sample size was determined by data redundancy.

"If the purpose is to maximise information, the sampling is terminated when no new information is forthcoming from new sampled units; thus redundancy is the primary criterion" (Lincoln and Guba,1985).

The two key questions guiding the sampling decisions of sample size and strategy were: what to sample and how to sample (Holloway and Wheeler,1996). The latter point has been addressed. In relation to the first element, two further questions arose which influenced the sampling decision (Pilgrim,1990):

a) What documentary evidence was available, in the printed form, which best reflected professional, and where relevant clinical, aspects of British podiatry from 1960 to 1997.
b) Who was available to provide an informed account of the period and would be willing to share their special knowledge, memories, views and experience with the interviewer (Holloway and Wheeler, 1996; Pilgrim, 1990).

4.4.1. Sampling Documentary Sources

In relation to the available documentary sources, the key focus was upon accessing data which would reflect professional concerns such as the status and aspirations of the profession of podiatry, the perceived role boundaries of practice in relation to medicine and other professional groups, professional advances and constraints, and the past, present and future role of podiatry in British healthcare. The documentary sources selected were those which were involved with professional concerns, primarily those issues highlighted by key informants during in-depth, open interview. These sources included both published documents in the public domain and unpublished documents held in private possession. The published documents mainly consisted of the following journal and newsletter publications, those of the main podiatry organisations active during the period 1960 to 1997 (details of each, including original or former titles, are provided in Appendix 2). The current titles are:

1. The Journal of British Podiatric Medicine
2. The Society of Chiropodists Personal Newsletter
3. Search News
4. The British Journal of Chiropody
5. The Chiropody Review
6. The Foot
7. The British Journal of Podiatric Medicine and Surgery
8. The Podiatry Association Newsletter
9. Minutes of the Meetings of the Executive Committee of the Podiatry Association

These nine core sources of commentary or narrative were considered likely to adequately reflect and provide a rich source of the concerns of both clinical practitioners and professional leaders, and would fairly represent the major concerns within podiatry as a whole. Each source of documentary data employed displayed varying degrees of editorial control and filtering. The British Journal of Chiropody enjoyed a reputation for freedom and independence in publishing, with little vetting of material other than that considered libellous or defamatory. The Editor of The Chiropodist, on subsuming the BJC in 1989, detailed the relative freedom of the BJC editor and placed in context the editorial constraints evident in The Chiropodist.

“Editorial Chairmen of The Chiropodist have envied Colin Dagnall the freedom of speech that he has enjoyed. There are no overt restrictions of any kind placed on editors of The Chiropodist; but successive Chairmen have been aware that it is the journal of the Society, and the major journal in the UK; so that a modicum of restraint has always needed to be present.” (Berry, 1989) 17.

Further evidence to illustrate the editorial vetting process within the journal of the Society arose in a dialogue between a prominent member of the Chiropodists Board and prominent members of the Council of the Society of Chiropodists regarding a dispute over the role of the Society in negotiations with the Medicines Commission\textsuperscript{18}. Nevertheless, the particular bias and editorial control likely in those journals provided valuable insights into the differing positions and views within podiatry. Issues of central importance to the professional leaders and clinical practitioners remained consistent across these journal sources.

4.4.2. Supplementary Documentary Data

The supplementary published sources used in the study consisted of data derived from a number of sources which supported particular areas of importance focused upon by key informants and highlighted in the core data sets. These data were derived from key medical journal sources\textsuperscript{19}. Also consulted were Parliamentary Bills and Acts, such as the Professions

\textsuperscript{18} The correspondent in question wrote a reply to a letter of rebuke from the Society Council members, but claimed it was not published as "the Editorial Committee found it inexpedient to publish it" (Ariori, R, 1977, The Chiropodist, 32:7, p.259). The Editorial Committee did, however, publish his letter of complaint, claiming that "as each side had already fired one shot, the committee decided to sound the Ceasefire" (Editorial Comment, ibid).

\textsuperscript{19} The British Medical Journal, British Dental Journal, Journal of Bone and Joint Surgery, the SMAE journal, Physiotherapy (journal of the Chartered Society of Physiotherapists), Therapy Weekly, Medical News, Medical Dialogue, General Practitioner, The Practitioner and from journal material accessed from the archives of one key informant who held an honorary position within the Advisory Committee of the Centre for the History of Foot Care at the Pennsylvania College of Podiatric Medicine in the USA (such as Clio-Pedic Items, and the Journal of the American Podiatry Association).
Supplementary to Medicine Bill (1959), The Medical Act (1983), the Osteopaths Bill (1993) and The Medicine Act (1968). Published material from the College and Society of Radiographers, Royal Army Medical Corps, SMAE Institute and Scholl Chiropody Prospectus was also consulted. Relevant newspaper articles and articles from other popular periodicals were also accessed, commonly on advice from key informants to support their claims (such as The Spectator). Finally, key published supplementary data issued by the Joint Consultants Committee of the British Medical Association and the Royal College of Surgeons were accessed following guidance from key informant interviewees, as were documents published by the Department of Health, the University of Dundee, the Podiatry Association, the Association of Chief Chiropody Officers and the Chiropodists Board of the Council for Professions Supplementary to Medicine (Dobby, 1993). Each specific source is highlighted in the data chapters.

The unpublished data held in private possession consisted of a wealth of archival material previously unaccessed for research purposes. These data had been accumulated by six key informants, variously held in ordered personal libraries or stored in files held in the loft space or other recesses in the home of the informant. The researcher was unable to locate newspaper articles to support certain claims in one instance (which involved reviewing 1975, 1976 and 1977 editions of the Bournemouth and Christchurch daily and weekly Echo).

These consisted of a large number of official and personal letters, memoranda and early minutes of meetings of the Croydon group, the Podiatry Association, Society and other linked groups.

The largest single archival source accessed by the researcher was a collection of data which had never before been accessed for research purposes and consisted of material relating
included a vast array of official and private material. These included a collection of letters which consisted mainly of what appeared to the researcher to be original, signed letters from key figures in a number of organisations addressed to a variety of individuals linked with the Podiatry Association in varying capacities over the time period in question. Numerous letters were also available which reflected much of the intra-professional issues and conflicts, between organisational members and executive leaders. The official capacities of the recipients varied from Secretary of the Podiatry Association, to Chairman, President, Treasurer or Committee Chairman. All letters which could not be satisfactorily dated were omitted from the study. A second archive of comparatively large size was accessed via another key informant. These data were particularly illuminating in providing "insider" confidential documentation relevant to certain events involving the State Board, Privy

To the professional business of the Croydon Postgraduate Group and Podiatry Association during the period of his executive involvement (from 1969 to 1989). This data also included the complete minutes of the meeting of the Podiatry Association from 1974 to 1981, which had been declared lost by the Podiatry Association Secretary following approval for access granted to the researcher (1993).

23 Letters, conference and course material, executive committee memoranda, state board electioneering material, invoices and order forms for medical equipment or services (ranging from National Radiological Protection Service to British Oxygen Company), Articles and Memoranda and Code of Ethics of the Podiatry Association, insurance correspondence (relating to insurance cover for medical procedures) and reports to the Executive Committee of the Podiatry Association from other committees, such as the education committee, research committee, examiners reports and other professional issues.

24 This included letters from leading figures in The Society of Chiropodists, College of Radiographers, The Chiropodists Board, The Council for the Professions Supplementary to Medicine, The Institute of Chiropodists, Members of Parliament, representatives from the Department of Health and representatives of medical bodies such as the British Orthopaedic Association and Royal College of Surgeons.
Council and Council for Professions Supplementary to Medicine which had not previously been accessed for research purposes. Each item employed as research data is fully referenced in each data chapter.

4.4.3. **Interview Sampling**

The researcher sought out key respondents to provide oral histories/key informant interviews of the period under study. Those individuals who had occupied high office within the professional organisations in podiatry in the years since 1960 were considered appropriate as these respondents would have first hand knowledge of, and involvement in, the decisions, actions and motives underlying professional activity during the timeframe of the study. Where possible, non-podiatry informants were accessed to provide insights into the roles, motives and actions of medical or other paramedical bodies in relation to events concerned with podiatry at relevant points in time. The decision to select and employ key informant interviewees was based on two factors, following the work of Pilgrim(1990) and Plummer (1983):

1. The informant accounts could be employed and justified as a source of triangulation for the printed material (and vice versa).

2. It was considered that the interviewees would bring

   "a different perspective to bear on the published documentation, as the rules of communication are different in the oral and printed forms" (Pilgrim,1990).

Initially, the researcher's a priori insider knowledge of the profession of podiatry and his MSc thesis work permitted the construction of an
immediate list of potential key respondents based upon their position of prominence within podiatry over the relevant timespan. Those people occupying official office within the key professional bodies were considered suitable candidates for selection. The official positions which were considered as appropriate were those relating to Chairmanship, Presidency or membership of the Executive Committees or Councils of the principal professional bodies\(^{25}\), or editorship of the professional journals or Headship of a School of Podiatry where membership of Council or Executive Committee was co-existent.

Eight people occupied the position of Chairman of the Society of Chiropodists throughout the period under study. The researcher interviewed four past Chairmen, due both to accessibility and the importance of events identified as having occurred during their period of office. Also important was the relative influence of these individuals in shaping and determining policy, obtained through the interview process with consecutive respondents. Chairmen and Presidents of the Podiatry Association, Institute and Chiropodists Board were selected on the basis of who remained living and who would agree to be interviewed\(^{26}\).

Later focused interviews were held with other prominent officials\(^{27}\).


\(^{26}\) In addition, one key informant who had agreed to be interviewed was subject to disciplinary action by his employing NHS Trust and as a result withdrew from the study until after the data collection phase was complete.

\(^{27}\) Representatives of the College of Radiographers, the medical examiner and advisor to the Podiatry Association, an NHS General Manager who had previously been a District Chief Chiropodist, and the Podiatry Advisor to the Department of Health. The President of the
The identities of those respondents occupying high office were initially located through a review of back-copies of the professional journals of each organisation. Key respondent interviews further elaborated upon this list and permitted identification of those individuals of especial influence, thus enabling the construction of a final list of key informants. Letters from the researcher were published in Society News and The Podiatry Association Newsletter (September 1995) outlining the work and inviting contact from further respondents as key informants or guardians of archival material. The final sample consisted of 24 respondents, occupying positions spread variably over the timespan of the study (Appendix 1). For the purposes of anonymity individuals are not named.

4.5. Access Arrangements

Much of the published documentary data in the public domain were openly accessible to the researcher. The journal of the Institute of Chiropodists was less easily accessed, the only complete collection being available at the offices of the Institute of Chiropodists in Southport. The researcher undertook an analysis of these journals during a five day block in January 1995, by arrangement with the Secretary of the Royal College of Surgeons and the Chairman of the External Affairs Committee of the Royal College of Surgeons and member of the COPSS Working Party were also sought for focused interview.

29 The journals of the Society of Chiropodists & Podiatrists were available both through the library of University of Southampton New College and a complete collection was held at the Wessex Centre for Podiatric Studies, to which the researcher had unlimited access.
Institute of Chiropodists. The Podiatry Association Journal was accessed through a key informant, who held a complete collection, as was *The British Journal of Podiatric Medicine and Surgery* and the Newsletter of the Podiatry Association. *Search News* was available to the researcher as he was a recipient of this journal by virtue of his state registration and held a complete collection. This also applied to *The Foot - The International Journal of Clinical Foot Science*. The Society's *Personal Newsletter*, subsequently titled *Society News*, was also accessible to the researcher through the same route.

The *British Chiropody Journal/ British Journal of Chiropody* was initially sought through the library of the London Foot Hospital. However, this collection was incomplete. The only complete collection uncovered was held in the private possession of one key informant, the editor and publisher of the journal from 1963 to 1988.\(^\text{30}\)

The Minutes of the Meetings of the Executive Committee of the Podiatry Association were requested, initially by direct request from the Chairman of the Podiatry Association in person. On his advice, this request was submitted in writing to the Executive Council of the Podiatry Association which finally granted access.\(^\text{31}\) No previous request had been granted

\(^\text{30}\) This informant permitted the researcher to remove a complete collection spanning the period under study (1958 - 1988) from his personal library for study for a period of five days (April, 1996), on the agreement that the material would not be taken beyond a certain distance from the respondents home and that it would be returned at the specified time. The researcher fulfilled these obligations, photocopying all relevant material whilst the journals were in his possession. A portable photocopier had been secured for this purpose.

\(^\text{31}\) Minutes of the Meetings of the Executive Committee of the Podiatry Association were deemed missing from 1974 to 1981 after an approach to the Secretary of the Association, who was the guardian of the minutes. These minutes were subsequently unearthed for the
to an outsider.

All the previously mentioned supplementary documentary data was available through the medical library of Southampton General Hospital and the library of Southampton University. Published documents issued by the Department of Health were obtained directly from that source. Key informants supplied other published data32. Access to the remaining documentary data - that held in private possession - was achieved through direct request to those key informants holding archival material. In all cases access was permitted conditionally33.

The Secretary of the Society of Chiropodists & Podiatrists was approached with a view to accessing the archival material of the late Ravi Suvarna (prominent Council member during the 1960s and 1970s), which the owner had claimed was lodged with the Society for future open reference by any researcher34. The Society claimed the documents either could not be found or did not exist.

researcher by one of the key informants, who had unknowingly stored the documents alongside other archival material at his home.

32 For example, The Podiatry Association Report of the Working Party of the Commission for the Provision of Surgical Services of the Royal College of Surgeons (as this had been withdrawn from publication).

33 Access to the vast array of documentary evidence accrued by the Podiatry Association and held by one key informant was granted to the researcher on the condition that he did not remove any documentation from the home of the respondent. Consequently, the researcher visited the home of this key informant on more than 30 occasions. This involved an analysis of documents through systematically ordering data thematically and chronologically, with note taking and photocopying of data (using a portable photocopier, which was permitted). Similar arrangements were agreed with another informant, although data was removed a short distance and a timescale for return imposed. Return journeys were arranged and agreed in advance by telephone. Visits were also used to review interview transcripts and to undertake confirmatory interviews.

34 Suvarna RR (1989), Society of Chiropodists Personal Newsletter, February 1989, p.1
Access to key informants was arranged by an initial letter of introduction to each, followed by a telephone request to confirm the agreements and explain the nature of the research and what was being asked of the respondents. Only one of the respondents approached declined to be interviewed on the grounds of ill-health. In the case of six respondents telephone interviews, rather than face to face interviews, were undertaken. Four of the telephone interviews were tape recorded at the Studio Centre of the Southampton Hospital Broadcasting Authority. Four telephone interviews were conducted without tape recording due to the closure of the Hospital Broadcasting Authority Studio over the December 1994, November 1995 and New Year 1997 period, when the four respondents were able to be interviewed. Notes were taken at the time of the interviews. The respondents had agreed to tape recordings being made. The remainder of the respondents agreed to face to face interviews, which were carried out at the homes of the respondents (9 cases), or the workplace (9 cases), at the request of the interviewees.

35 In three instances this was considered suitable for focused and confirmatory interviews, where in-depth interview was not required. Interviews could be completed without the time and expense of travelling to London, Manchester and the Home Counties, which these would have entailed. Certain key informants preferred to be interviewed by telephone, in one case due to ill-health. Another was arranged by telephone due to the heavy work commitment of the respondent.

36 The HBA lent its recording studio facilities to the researcher for a modest donation of funds to the Charity (£20.00 covered all interviews recorded).
4.6. Data Gathering, Organisation and Analysis

This section outlines the methods by which the data was gathered from interview and documentary sources, ordered, arranged, analysed and organised into a thematic and chronological narrative of events and activities shaping the profession of podiatry in Britain from 1960 to 1997. The presentation of data is therefore based on the structure suggested by Patton (1990), who described data from open-ended interviews as consisting of

"direct quotations from people about their experiences, opinions, feelings and knowledge" (Patton, 1990)

and data from document analysis as yielding

"excerpts, quotations, or entire passages from records, correspondence, official reports and open-ended surveys" (Patton, 1990)

4.6.1. Data Gathering

Initially, open, in-depth key informant interviews were arranged for between one and four hours. The actual duration was agreed by both parties as the point at which the account was deemed sufficiently full (Patton, 1990). In three cases the interviews lasted six hours, although in two of these there was a certain amount of redundant material with a high "dross rate" (Morse and Field, 1996; Holloway and Wheeler, 1996). At the beginning of the interview, each respondent was asked in an open-ended way to describe what they considered to be the major issues of professional and clinical relevance during the period in which they
occupied high office. All interviewees had been forewarned of this interview style in advance, and some respondents had prepared lists of what they regarded as key issues. As they responded, the researcher clarified points or probed further for details. A picture of key themes rapidly emerged (after the first three interviews a recurring set of themes was in evidence) and was supported by the same themes evident within the core sets of documentary data.

Interview and documentary data examination were undertaken in parallel following the initial interview with the first key informant. Thus, the interviews generated themes which were supported by the same themes evident in the available core sets of documentary data and supplemented by additional interview and documentary material from other key informants and other archival and public documents. As the number of interviews with key informants progressively increased, recurring themes became increasingly obvious; this also permitted identification of further important key informants and relevant informants for focused interview. The documentary data forming part of the core data sets also suggested other important key informants who were unobtainable 37.

37 Mr. Sam Pitts, prominent member of the Institute of Chiropodists Executive Committee during the 1960s, was too elderly and declined to participate as an informant, and died soon after personal communication by letter had been established (two letters were received by the researcher from Mr. Pitts). Mr Andrew Roberton, also of the Institute of Chiropodists and prominent in the 1960s as an Executive Committee member, was found by the researcher to have died two years prior to the data collection phase of the study. Miss Elizabeth Salmon, Principal of the School of Radiography at Kings College Hospital London was sought for a focused interview to corroborate evidence from other key informant interviews, but did not respond to inquiries forwarded to her via the School of Radiography. Miss Salmon had retired two years prior to the data collection phase of the study and the current Principal of the
27 interviews were undertaken in total, with 24 interviewees. Of these, 18 were face to face interviews, the remaining 6 were conducted by telephone. In all but 4 cases tape recordings were made, which were transcribed initially by hand by the researcher, and then word-processed. In all latter interviews where there was substantial repetition of themes key quotes were identified and selected for use. In those telephone interviews not tape recorded the main points were summarised or recorded verbatim where possible, either during or immediately following the interview.

The basic data sets, derived from the published journal and newsletter material outlined in the previous section, yielded themes which also emerged from the interviews and the minutes of meetings of the three relevant professional bodies accessed. Notes were taken from each source, chronologically identifying the occurrence of the emergent themes, with some supportive content analysis quantifying the frequency of these themes over time, where this was thought useful (appendix 3).

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38 The researcher initially employed tape recording devices available on loan from the Media Resources Department of LSU College of High Education for face to face interview taping. These provided tape recordings of variable quality, which, after one poor quality recording (Gwen French) made at University of Westminster, persuaded the researcher to purchase a new Coomber 393 tape recorder, which reliably reproduced quality recordings (at a cost of £120).

39 The Society of Chiropodists, The Podiatry Association and The Chiropodists Board.

40 This quantitative data is appended as an adjunct, in line with the notion of "cautious positivism" recommended by Silverman (1993,1997).
4.6.2 The Organisation of the Data

The data was organised so as to map and chart those professional events and changes of importance in relation to the themes identified over the chronological passage of time (1960 - 1997). The data was arranged both chronologically and thematically.

The subsequent data chapters were further presented in two main divisions dealt with separately, in order to retain both a contextual and chronological coherence. One arena concerned the post-registration era attempts by the podiatry profession to secure a trade monopoly over the provision of podiatry services through the state/legal notion of "functional" and "indicative" closure, corresponding to the Weberian analysis of legally recognised closure (Larkin, 1983). It is mainly concerned with the relationship between profession and state. It also entailed the use of a rhetorical device justifying claims for closure on the basis of public safety to exclude other types of podiatrist\(^4\).

The second arena concerned those professional activities and inter-professional relations identified which were linked with professional attempts at enhancement of professional autonomy and expansion in task domain, highlighting the issues of boundary encroachment, the establishment of claims to expert knowledge and therapeutic uniqueness and the resultant inter-professional conflicts. It also examined the intra-professional conflict which led to the creation of new professional organisations which operated internal closure strategies against the

\(^4\) The underpinning theory for this section was derived from the Weberian notion of social closure.

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existing bodies. Thus the data is structured and presented in a way which reflects and is informed by the interpretive schemata derived from the sociology of the professions. That is,

"a reading of the data sets in such a way that these theoretical sources can be tested for 'fit'" (Pilgrim, 1990).

Those themes identified from both interview and documentary sources were recorded employing the terms of reference of the key informants, and may be itemised:

1. Closure/protection of title/ change of title to podiatry
2. Local anaesthesia
3. Foot care assistants
4. Degree status
5. Podiatric biomechanics
6. Radiographic practices
7. Access to prescription only medicines
8. The Podiatry Association/podiatric surgery

Each was set in the context of the time period in which the theme was prominent. For example, the issue of professional closure was a recurring theme evident throughout the period under study. Similarly, foot care auxiliary workers became an issue from 1976, following

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42 The underpinning theory was derived from the Weberian concepts of professional dominance and professional autonomy as well as social closure. This also involved an examination of the impact of government health policy.
government proposals to impose such workers upon the profession, and continued to run as a theme until the present (both as an interview item and in documentary sources). Thus, the data was not simply collected by the researcher, but constructed by him (Plummer, 1983).

The construction of the chronological and thematic format for data presentation was undertaken one data set at a time. The next data set was approached similarly, and its data fed into the chronological/thematic picture built from the first data set. After each of the core data sets had been built into an overall picture, the supplementary archival data further illuminated the canvas created. This systematic approach permitted the many sources of data to be added to confirm the existing picture or to demand a re-examination of an alternative picture. Wide cross-corroboration of the differing data sources was thus undertaken, and the differing views and perspectives surrounding the key issues added to provide greater insights.

4.6.3. Data Analysis

The stages to data analysis were as follows. An explanatory narrative was built through developing and tracing an account of post-registration podiatry. This enabled the researcher to

"chart relevant developmental stages and issues...which [were] woven together in explanatory fashion" (Mason, 1996).

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43 For example, the themes identified from reading the journals and minutes and from the interviews were applied to one core data set - such as The Chiropodist - within the published minutes, editorials, correspondence, etc. These were constructed chronologically, beginning in 1960 and working through to January 1997.
All the data was read through and the main themes identified, from which more defined topic areas arose (Silverman, 1993). A “constant comparative method” (Glaser and Strauss, 1967; Strauss and Corbin, 1990) was employed, highlighting the differing and related perspectives of the sampled interviewees and documentary sources. The topics generated were placed in a wider, relevant context (Silverman, 1993, 1997). Whilst similar to grounded theory (Glaser and Strauss, 1967) in that the data analysis sought to generate and develop categories, the current study was also informed by the work of Larkin (1983) and the researchers a priori knowledge. The researcher was able to elaborate upon the outline of history already accessed, in which previous knowledge and pre-established themes were brought to the study. A combined chronological and thematic analysis was employed in constructing a final narrative, presented in the data chapters.

4.7. Methodological Adequacy of the Data

The issues of methodological adequacy examined in this section initially consider the cases of interview and documentary data separately, outlining the techniques employed in attempting to address the issues of reliability and validity.

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44 The seven basic requirements for grounded theory, itemised by Glaser (1978) were undertaken in some measure: theoretical sensitivity, theoretical sampling, coding and categorising, constant comparison, use of literature as data, integration of theory, writing field notes (cited in Holloway and Wheeler, 1996)
4.7.1. *Adequacy of the Interview Data*

It is acknowledged that the use of key informant interview as a central means of obtaining data carries certain hazards and flaws. These interviews depend upon the veracity and accuracy of individual memory, which may present problems (Mason, 1996; Patton, 1987, 1990; Yin, 1994). On occasion certain factual matters, which could be verified through official documents, were confused by some of the respondents. All respondents were offered copies of the tape recordings of the interviews. Six respondents requested copies. It is also acknowledged that the transcription of tapes does not guarantee a clear and unambiguous record of the encounter with the respondents (Cicourel, 1974). Although providing a record to which subsequent researchers may be granted access (Oppenheimer, 1992), interpretation of taped material is dependent upon tape audibility, and punctuation discrepancies have been noted to occur amongst different transcribers (Cicourel, 1974; Patton, 1990; Robson, 1993). There were several other potential respondents who might have been involved in the study. The timeframe of the study could have theoretically included all those members of Council or Executive Committees of each of the professional organisations in podiatry now still living. This would, however, have amounted to an unmanageably large cast of informants. Nevertheless, in general, the respondents did fulfil

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45 Three respondents stated the concern that their memories for certain events may not be as accurate as they would have wished (Mr. Read, Miss Witting and Miss French). Whilst being true of certain events, for the most part their recall was good, established by corroborative evidence from other documentary and interview sources. Some informants subsequently checked their accounts for accuracy and later amended certain features accordingly.
the three critical methodological criteria of adequacy asserted by Plummer (1983):

1. **Co-operativeness** In each case the informants were co-operative and willing to participate in the study\(^{46}\). Of those interviewed, there was no detectable reluctance on their part to engage in full discourse.

2. **High Consciousness** The respondents were all of high consciousness in that they were leaders of the profession of podiatry, or especially well-informed of certain events and knowledgeable of certain issues. The majority took part in many of the key events which were the focus of attention. Their high status, practical involvement in key aspects of official activity, or close relations with those so engaged, ensured their position as informants of high consciousness.

3. **Accessibility** Each of the respondents were accessible to some degree or other. The majority were amenable to and willing to engage in face-to-face interview, either at their own homes, or at some convenient location of their choosing (usually the offices of the official organisation to which they were linked). In each case of face-to-face interview a room suitable for interviewing was provided by the respondent, ensuring minimal interruption, quiet and comfort\(^{47}\).

In spite of the drawbacks identified with interviews the advantages of

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\(^{46}\) The only exception to this was one potential key informant, who declined to be interviewed on grounds of ill-health and age, although he was willing to contribute via personal correspondence with the researcher.

\(^{47}\) In addition, power sockets were provided for the recording equipment in all cases, which removed the necessity for reliance upon battery power.
this method have been demonstrated repeatedly in social science, even by those critical of their application (e.g. Cain and Finch, 1981; Patton, 1987, 1990; Silverman, 1993, 1997). In respect of the nature of the current research, it is likely that the interviews added a necessary depth and perspective upon the areas of central focus.

4.7.2. Adequacy of the Documentary Data

In respect of the documentary material utilised in this research, there are two central points which advance the methodological adequacy of the data. First, the combination of the core data sets, from differing sources, supported by published and supplementary archival material, permitted confirmation of a pattern of discursive features (Plummer, 1983). The use of multiple sources ensured the data were likely to be more convincing and accurate via corroboration between data sources (Patton, 1987, 1990; Yin, 1994). The plausibility of the researchers' mode of data construction could also be independently checked through an examination of these core data sources (the archival material, held in private possession, could also feasibly be accessed by other researchers).

"every...project should strive to develop a formal, presentable database, so that, in principle, other investigators can review the evidence directly and not be limited to the written reports. In this manner, a...database markedly increases the reliability of the entire...study." (Yin, 1994).

The use of multiple data sources permitted a version of triangulation (Patton, 1987, 1990; Yin, 1994) in the development of converging lines of
enquiry. This assisted in addressing the problem of ensuring construct validity, as "multiple sources of evidence essentially provide multiple measures of the same phenomenon." (Yin, 1994). In addition, however, the researcher also assumed, following Cain and Finch (1981) and Pilgrim (1990), that multiple data sources act to clarify differing perspectives on social reality and do not inevitably point "towards a single set of truth statements" (Silverman, 1993). Plummer (1983), Fetterman (1989), Patton, (1990) Robson (1993) and Yin (1994) all considered triangulation as a principal tool in establishing or enhancing the quality, or "trustworthiness" of data. Another device, designed to optimise study reliability, is to establish and maintain a "chain of evidence" (Yin, 1994)48.

The accessibility of the documentary evidence and tape material from interview suggests that these criteria may be satisfied in some measure, which Yin (1994) has taken to assist in establishing study reliability and construct validity. For Robson (1993) and Lincoln and Guba (1985), dependability is analogous to reliability in studies employing qualitative methods. As reliability is regarded as a condition of validity, so dependability is a condition of credibility (Robson, 1993). If the

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48 This requires the presentation of data which permits the reader to "trace the research process backwards" in order to establish the derivation of data cited, with clear cross-referencing to methodological procedures (Yin, 1994) “the principle is to allow the reader to follow the derivation of any evidence from initial research questions to ultimate study conclusions...the report should have made sufficient citation to the relevant portions of the study database...by citing specific documents, interviews or observations...[it] should reveal the actual evidence and also indicate the circumstances under which the evidence was collected - for example, the time and place of an interview.” (Yin, 1994).
"processes followed are clear, systematic, well documented, providing safeguards against biases...this constitutes a dependability test" (Robson, 1993).

The researcher attempted to develop these measures as far as possible, employing the criteria outlined below.

Several authors consider the use of the terms reliability and validity to be largely associated with quantitative research methods, developed in response to those research questions formulated within experimental and survey traditions, and somewhat inappropriate when dealing with qualitative research data (Robson, 1993; Lincoln and Guba, 1985; Plummer, 1983). Other authors consider these concepts to apply equally to both (eg. Kirk and Miller, 1986).

"Reliability is primarily concerned with technique and consistency - with ensuring that if the study was conducted by someone else similar findings would be obtained; while Validity is concerned with making sure that the technique is actually studying what it is supposed to study" (Plummer, 1983).

The second point about methodological adequacy stems from the work of Platt (1981) and Scott (1990), concerning their four main criteria for legitimacy - authenticity, credibility, representativeness and meaning. These are said to assist in the assessment of validity (Scott, 1990).

1. **Authenticity** The documentary material which compromised the core data sets did represent a permanent record of the official publications and records of The Society of Chiropodists (& Podiatrists), The Podiatry Association, The Institute of Chiropodists, The Chiropodists Board and The Association of Chief Chiropody Officers, from which it is
considered reasonable to suggest that these documents are authentic. The minutes of the meetings of the Executive Committee of The Podiatry Association, accessed through that organisation following written and verbal requests, also strongly indicated their authenticity. A number of key respondents also confirmed the minutes as authentic. Similarly, the supplementary data derived from the official publications of the SMAE Institute and the medical, radiography and physiotherapy professions might also reasonably be taken to be authentic. The unpublished documentation held in private archival records were, in some cases, more difficult to authenticate. Only those letters in which the respondents were clearly identifiable were used. Although it is acknowledged that authenticity of the material accessed through these private channels could not be guaranteed, the researcher considered that there were sufficient grounds for accepting their inclusion.

2. **Credibility** In view of the fact that a considerable range of material was sampled it is reasonable to conclude that a credible picture

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49 British Medical Association, British Orthopaedic Association, Royal College of Surgeons, Chartered Society of Physiotherapists, Royal College of General Practitioners and College of Radiographers

50 Letters which could not be dated (a substantial number), were illegible in part or in total, were damaged or where pages were missing were excluded from the study.

51 The archival documentary records held by one informant contained material relating to the Croydon Postgraduate Group and Podiatry Association. These were held in numerous files which the researcher was given to work through and place in order chronologically. The letters contained therein included correspondence, both official and personal, between members of the above two organisations and numerous other bodies, such as members of The Society of Chiropodists Council, the Chiropodists Board, various medical practitioners and bodies and internal correspondence from one committee to another. As far as possible important data from letters was cross-checked with interview accounts and other published data.
has been built in the data presentation. The official documents and published material do convey the particular viewpoint of each group in relation to the events in question, a point which is taken to enhance rather than diminish the quality of the data for current research purposes. Much of the private communication available to the researcher is thought likely to be credible in that it offers an insight into the individual perceptions and experiences of the authors, with the temporal and spatial proximity located close to the actual events in question (Scott, 1990). Cross-checking data permitted the researcher to place the available privately held documentary material in context, providing background to the conditions under which some of the material had been written. It is recognised that, in some cases, the data obtained from private archival sources were likely to have reflected the

"prejudices which may have led the author to adopt a sympathetic or antipathetic stance towards people and events" (Scott, 1990).

The conflictual nature of the dialogue between the Society of Chiropodists and the Podiatry Association, and the latter with the British Orthopaedic Association in particular manifest these characteristics. Robson (1993) and Lincoln and Guba (1985) regard credibility as a parallel construct equivalent to internal validity, of use in qualitative research methods, including interview as well as documentary sources. These authors suggested several techniques which might be used to enhance credibility. For the purposes of the current study those relevant include prolonged involvement, triangulation and "member checks"
(Robson, 1993).

In respect of prolonged involvement, the immediate aspect of relevance to the current study rests with the researchers a priori contact with the professional organisations under study. This may feasibly advantage this researcher and disadvantage a subsequent researcher wishing to replicate the study, or part of it, unless that researcher was also similarly "advantaged", a situation noted in other similar studies (Pilgrim, 1990). The use and utility of triangulation has been noted. Lincoln and Guba (1985), Robson, (1993) and Yin (1994) stressed the capacity of "member checks" to enhance credibility.

In the current study, as noted, tape transcripts and copies of tapes were offered to all respondents with a contact address, should alterations be requested. In addition, some respondents did view the data chapters, thus providing validity checks. Yin (1994) also considered this a vital ingredient in enhancing construct validity. Nevertheless, as Robson (1993) noted, it is also borne in mind that some respondents may "have an interest in presenting a misleading or biased case". Triangulation of data sources permitted the researcher to identify at least one significant example of this situation.

3. **Representativeness** In view of the fact that nine core data sets of official material were employed, it is reasonable to suggest that the features elicited and highlighted were typical or representative of those involving and affecting the profession of podiatry during the timeframe under consideration.

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52 A contradiction was noted in the account of one interview transcript and personal correspondence written by the same official regarding the issue of local anaesthesia.
Scott (1990) noted two sub-categories of representativeness which are necessary to the adequacy of documentary data - survival and availability. The core data sets derived from official, and largely published material (excepting the minutes of the Executive Committee of the Podiatry Association) were all deposited in library facilities, ensuring both survival and availability. The private archival collections were held variously in ordered home library format, or in disorganised files in the attic space of key respondents. Of the latter cases, two such collections were made freely available to the researcher, who had to sift, organise and arrange in chronological format prior to analysis. In relation to survival, only the minutes of the meetings of the Executive Committee of the Podiatry Association had previously been declared missing, but were found intact (vide supra).

4. **Meaning** The criterion of meaning presents greater problems in that

"there is no clear consensus within the culture of social scientific methodologists about the rules of interpretation of data" (Pilgrim, 1990).

Scott (1990) identified two categories of meaning which require attention - literal meaning and interpretive meaning. In the case of literal meaning, the extent to which the data in this study clarified and illustrated a series of events within podiatry and used to confirm such

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53 The largest collection contained a vast array of documentary material spanning a thirty year period, although it is not possible to assert that these were representative of all the personal correspondence, memoranda, course material, and other ephemera of the Croydon Postgraduate Group or Podiatry Association across this timeframe. The key respondent claimed that the material had not been "sorted out" (Scott, 1990) over time.
"factual" questions may satisfy this requirement (Scott, 1990). Interpretive meaning requires the researcher to justify the cogency of his or her interpretation of documentary evidence in accordance with what is known about the context of the production of the sources (Mason, 1996, Scott, 1990, Yin, 1994). Issues such as the author's intentions, the audience being addressed and the features of the wider social context which shaped or constrained the production of the material become relevant (Mason, 1996; Pilgrim, 1990; Scott, 1990). These requirements range from an understanding of the definitions and recording practices consistent with the period and the genre and stylisation within the text to the hermeneutical processes of interpretation (Scott, 1990). That is, the researcher must uncover as much as possible about the conditions under which the documents were produced and relate these to the individual authors concepts. This task requires interpretive decisions by the researcher so that the documents read "make sense" to the researchers audience (Giddens, 1976; Scott, 1990). In this study, the "hermeneutical circle" the researcher attempted to identify was the data in relation to the wider organisational and social policy context, in which one reflected the other and was related to the underpinning theory informing the study (Mason, 1996; Scott, 1990).

4.8. Ethical Issues
Ethical dilemmas arise for all researchers in the social sciences (Rogers, 1989). In respect of informed consent, the interview material contained a number of references to events which the respondents were
only willing to share if anonymity was guaranteed in any subsequent
publication (Fetterman, 1989; Plummer, 1983). In one case the researcher
was granted permission to cite the individual within the thesis itself\(^5^4\).
In other cases "secret information" (Morse and Fields, 1996) was
obtained, which the respondents did not wish to be released for public
viewing as the content may be hurtful and distressing to certain others.
Permission was granted for these instances to be referred to in the thesis,
but not for any publication, to which the researcher agreed\(^5^5\). Certain
items of correspondence extant within the archival collection of one key
respondent, to which the researcher had access, also revealed the hostile
nature of intra-professional antagonism which existed between
individuals representing differing organisations. Use of this data was
granted, although limited use was made of this material by the
researcher.

The taping of telephone interviews clearly requires the permission of the
respondents (Holloway and Wheeler, 1996; Morse and Fields, 1996;
Oppenheim, 1992; Robson, 1993) and this was sought in each case.

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\(^5^4\) This involved a senior Radiologist who was threatened by orthopaedic colleagues with
sanctions against his private practice if he did not disassociate himself from the Podiatry
Association, and also a disciplinary charge lodged against him by the Royal College of
Radiologists on the grounds of professional malpractice for training podiatrists in radiology (a
charge which was subsequently dismissed without foundation).

\(^5^5\) In one case a respondent played a tape recording, made at a known period of time, which
incriminated one individual member of the Executive Committee of the Podiatry Association
in a deliberate deceit designed to dupe fellow members of the Association Executive
Committee with regard to disposal of Association funds. The respondent would not grant
permission for this material to be used in any publication or in the thesis if this involved
naming the individual.
Finally, the issue of reciprocity (Fetterman, 1989; Patton, 1990) arose when one key informant, who also held a vast collection of important unpublished data, sought to trade access to this archive with an agreement from the researcher to seek to publish a small article in a professional podiatry journal\(^5\). The respondent did not attempt to coerce the researcher or influence him in relation to the content of the article, stressing his belief that the data would speak for itself. The researcher agreed to this request from the respondent, with whom he had already established a bond of trust (Fetterman, 1989; Patton, 1990).

\(^5\) This was to outline the key findings from a particular period in time - the events surrounding the acquisition of local anaesthesia by state registered podiatrists and the emergence of podiatric surgery in Britain.
Section 1: Podiatry and State

Chapter 5

Attempts to Achieve "Functional" Closure
The following two chapters are linked in order to retain a contextual and chronological coherence to the findings, and form the first data section. Both are concerned with the attempts by the podiatry profession to secure a trade monopoly in the provision of foot care services via statute, designed to exclude competitors from outside the registered sector. These attempts to ensure both protection of professional title and practice were justified through the use of a rhetorical device aimed at asserting a threat to the public safety from unregistered podiatric practice. State registration had failed to offer such protection. Across the timespan of the study two main forms of exclusionary closure were pursued by the registered sector, described by government as “functional” and “indicative”, each intended to eliminate competition from those lacking registerable qualifications. All but the most recent attempt failed, and the latter (1997) has yet to materialise.

Weber's notion of social closure has been used to explain how members of a social stratum establish and maintain their status and achieve collective social mobility (MacDonald, 1985). In particular, the registration of professional occupations has been viewed as an important aspect of closure in achieving market control and elevation in status (Larkin, 1983; MacDonald, 1985). Legally recognised monopoly is seen as the most powerful form of exclusion employed by an occupation, the "ultimate legitimizing of a task domain", the success of which is said to be dependent upon the support of
"powerful elites" (Freidson, 1970; Larkin, 1983; Parkin, 1979).

The way in which state registered podiatry deployed its resources in the pursuit of a legal monopoly over the provision of footcare services, the obstacles it faced in doing so and the tactics it employed are the focus of the following two chapters, which also illuminate the relationship between post-registration podiatry and the state.

5.1. State Registration and Occupational Monopoly in Podiatry

A legal monopoly, achieved rarely by professions in Britain, lies at one end of a range of exclusionary devices of which state registration is the most powerful (Berlant, 1975; MacDonald, 1985; Larkin, 1983). In order to achieve these goals the occupation must be

"so organised and have members with such characteristics that it can overcome the objections of its rivals in the field. It must also impress its suitability for monopoly on the public, on Parliament and on the State. For the occupation to obtain legal monopoly of practice...registration is the master stroke."

(MacDonald, 1985).

However, state registration may take several forms, varying from complete protection of practice, as in the Dentists Act (1921), to protection of title, as in the Medical Act (1858). Other forms, such as that secured for podiatrists under the Professions Supplementary to Medicine Act (1960), effected a partial protection of title, limited to NHS employment\(^1\). The limitations of this attenuated closure, in

\(^1\) Watts WD (1965), "Registration Fallacies", BJC, 30:12, p.315.
failing to secure the goal of legal monopoly characteristic of closure
theory, resulted in repeated attempts by the professional bodies
representing registerable podiatrists to alter, amend or replace the
PSM Act. This stemmed from a growing disappointment and
disaffection with the impact of the Act upon professional
advancement, which afforded few of the privileges of the Dentists Act
(1921) or the Medical Act (1858).

"Since 1912 closure has been the promised land chiropodists
have searched for. Since the 1960 Act our leaders have dangled
it like a carrot to keep the state registered chiropodists quiet."
(Dagnall, 1974)².

Neither the "indicative" nor "functional" closure strategies were
successful for podiatry throughout the period under study, with the
possible exception of the current phase of negotiation, the outcome of
which is awaited. Each attempt will be examined in turn and placed in
the context of the wider influences operating concurrently. The
main thrust of the exclusionary tactics of the state registered sector
was to outlaw the unregistrable on the grounds of a postulated threat
to the public safety.

It is also relevant to examine the emergence of the foot care assistant
ancillary grade within NHS practice and its impact upon closure
strategies. First of all, it is appropriate to examine the immediate
impact of the Professions Supplementary to Medicine Act (1960) upon
the consciousness of state-registered and non-registered podiatrists,

and those within the medical profession who were involved with podiatric development.


Although state registration did provide protection for specified titles and the means for limited supervision and control of training (Larkin, 1983), it did nothing to halt the practice of podiatry by unregistered or unqualified practitioners outwith the NHS.

Nevertheless, the introduction of state registration under the PSM Act (1960) was initially considered a success by the leaders of the supplementary professions (Larkin, 1983). However, although establishing podiatry as a "profession" and affording it state recognition, its limitations were clear.

"The Bill is but a shadow of what the early pioneers worked for...Nevertheless the Bill has been welcomed by the two major chiropodial bodies...The Bill did not give us a "closed shop" - as did the Dental Act - anyone will still be able to practice chiropody, providing he does not falsely claim to be registered. But at last we have a measure of Parliamentary recognition...a Bill of this kind will will never completely eliminate the untrained chiropodist." (Dagnall, 1959)

3 Protection of title extended no further than the terms 'state-registered chiropodist', 'state chiropodist' and 'registered chiropodist', leaving a wide range of other possibilities for the unregisterable, such as 'qualified chiropodist' (Hall JR, 1960, OGM Presidents Report, The Chiropodist, 15:6, p194). In later years, as the term podiatrist gained popularity through the exploits of the Podiatry Association, even use of the term 'state-registered podiatrist' could not be restricted under the terms of the PSM Act(1960), as technically no such title existed.

4 Dagnall JC (1959), "PSM Bill and the Chiropodists Board", BJC, 24:12, p.317-320.)
In addition, the extent of medical influence upon the first Chiropodists Board rapidly became obvious. A definition of scope of practice was stipulated only for podiatry, as the other supplementary groups were viewed as working under direct medical supervision.

"The first Board, decided, with medical pressure, for chiropody - not for the other professions, no need for a definition of scope of practice for them - they were working under medical supervision. They produced a statement of conduct which said, a state registered chiropodist should confine his practice to that area." (Transcript 19, 1996).

The leaders of the principal professional associations undoubtedly regarded the Act as a major breakthrough in the recognition of podiatry as an independent and worthy "profession", on a par with medical and nursing registration, and believed it would herald a new phase in professional advancement.

The fact that the PSM Act had been achieved in the face of opposition from the medical profession may have contributed to the euphoria with which it was greeted by those who had taken part in its construction. Political support, rather than medical support alone, had been viewed as the key to success.

"...the important friends that we had got were all doctors. Very powerful doctors...but it was then that we realised, or some of the leaders realised that they weren't the people in whose hands our fate was. Our fate was in the hands of the politicians...[The PSM Act was] a very good example of getting the ear of the House, and of the members of the House..." (Transcript 5, 1994).

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This view, however, did not reflect the wariness with which the Act was greeted, and the distinct lack of enthusiasm for what it might achieve, by many of the rank and file membership. It also proved a false dawn for many of those who had believed the PSM Act was a step towards a monopoly of service provision and the elimination of unregistered practice\(^6\).

"Lots of people at the time had the idea that that was a sort of step to closure, and that it was for the professions...at the time we thought that it would become like a state registered nurse. Over the years everybody knew what a state registered nurse was. Well, it didn't happen, because there weren't enough people to fill both the public and private sector." (Transcript 14, 1995).

Its use as a tool to provide the NHS with podiatrists was greeted with suspicion by those in private practice, who feared competition from cheaper NHS provision, fuelled by difficulties experienced by the Society of Chiropodists in negotiating private practice rates for podiatry treatments given under Local Health Authority arrangements\(^7\). Concern at the failure of the PSM legislation to eliminate unregistered competition led to calls for a change in professional title, from chiropody to podiatry, as early as 1965\(^8\). Some even regarded the PSM Act as meaningless, as it enjoyed no public recognition or esteem\(^9\).

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The Society of Chiropodists in particular did not regard the incorporation of podiatry services within NHS provision as a desirable move, although claiming the Act to be a success in other respects. Its concerns revolved around two recurring themes; the poor level of pay offered to chiropodists employed by Local Health Authorities, which would undercut private practitioners, and the possibility of a lowering in standards through the "grandparenting" clause which would permit registration for those who could not even satisfy the requirements of the NHS (Medical Auxiliaries) Regulations of 1954. Indeed, several published letters highlighted the extent of the opposition to what were regarded as derisory pays awards, embodied in one letter in which collective action, notably the withdrawal of labour, was suggested, which lends support to the notion of podiatric proletarianization.

The Society was, however, softer in its attitude to the grandparenting issue, as many of its own members had been unable to comply with the training requirements set out under the NHS regulations in 1954.10

12 The NHS Medical Auxiliary Registration Regulations, 1954, decreed that podiatrists working in the NHS must have undergone a two year full-time training, but did include a clause permitting those without such a training to be admitted providing they could satisfy the Minister "that their training and experience are adequate for employment as members of their craft" (NHS Medical Auxiliary Registration Regulations, 1954).
13 "No one regrets more than the members of Council the fact that 36% of our members do not qualify under the 1954 regulations simply and solely because they were born too soon, and had not the opportunity of taking the two year course..." (Hall JR, 1960, AGM, The
Registration, once fully implemented, would only protect certain permutations of title and only do so within the framework of the NHS, leaving the private sector as open to unlicensed practitioners as ever. However, those medical practitioners who had supported the Society of Chiropodists in its efforts to enter a state register were clearly pleased with the outcome, asserting state podiatry to be a profession now worthy of their support.\textsuperscript{14}

It is perhaps revealing that the medical men who supported the development of state podiatry viewed registration so positively. Clearly they did not perceive this move as affording podiatry a greater measure of independence from medicine. Rather it was seen as a measure binding podiatrists more firmly to the principles of medical control and supervision, a legally enshrined medical auxiliary status, although the government was keen to stress the opposite\textsuperscript{14,15,16}.

The extent of the co-operation with, and subservience to, medical authority drove a further wedge between the Society and the Institute of Chiropodists. During initial negotiations on the structure of the new professional Boards, the Society of Chiropodists had agreed with medical opinion that a majority of PSM representatives was not necessary, a servility which condemned podiatrists to the status of

\begin{itemize}
  \item \textsuperscript{14} Lord Cohen of Birkenhead (1964), The Chiropodist, 19:12, supplementary; Lord Amulree (1964), The Chiropodist, 19:12, supplementary; Lake NC (1964), The Chiropodist, 19:12, supplementary.
  \item \textsuperscript{15} Editorial, BMJ, 28th October, 1960.
  \item \textsuperscript{16} Summerskill E (1960), cited in Editorial, The Chiropodist, 15:1, p.5-6.
\end{itemize}
"hand-maidens"\textsuperscript{17}.

In view of the fact that protection of title was only meaningful to those employed within the NHS, the poor pay awards for NHS podiatrists represented a significant disincentive for registerable practitioners to actually do so, leading the Chairman of the new Council to plead openly with the Society membership to apply for registration\textsuperscript{18}.

NHS employees, for whom registration was meaningful, could expect a rate of remuneration grossly inferior to their colleagues in the private sector and faced the imposition of a code of conduct from which their competitors were free\textsuperscript{19,20}. Some podiatrists hastened to proclaim their preference for the previous arrangements effective under the BRMA regulations (1938), suggesting that this at least had enjoyed medical approval, unlike the PSM registration\textsuperscript{21}.

The Society of Chiropodists was moved to admit that state registration ought to be viewed as a stepping stone to future progress and was not in itself sufficient to elevate the status of the podiatrist\textsuperscript{22}.

It attempted to promote its own role in representing the registered sector, and to assert its authority as the pre-eminent professional body recognised by the Chiropodists Board. The first challenge it faced

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\textbf{References:}

\textsuperscript{17} Creditor H (1960), Editorial, Chiropody Review, 21:1, p.7-8.
\textsuperscript{18} Littlewood S (1963), "State Registration", The Chiropodist, 18:4, p.135-6.
\textsuperscript{19} Oliver AN (1963), The Chiropodist, 18:4, p.137.
\textsuperscript{20} Wightman SA (1963), The Chiropodist, 18:4, p.136-7.
\textsuperscript{21} Flint J (1963), The Chiropodist, 18:4, p.137; Rossignol JN (1963), The Chiropodist, 18:6, p.63.
\end{small}
concerned a dispute surrounding the task domain of the podiatrist, a conflict arising from a bureaucratic directive over-riding the professional judgement of the podiatrist, opening the door to professional boundary encroachment.

"An instance where a patient was deemed by the chiropodist who was treating the case to need monthly treatments instead of two monthly treatments as authorised by the MOH was told that in the opinion of the County Health Committee, the treatment of corns fell within the province of the District Nurse. While chiropodists are long passed the stage of being mere corn cutters, the thesis advanced by the County Health Committee is a dangerous one...The Matter was referred to the Chiropodists Registration Board [which] considered it should not interfere and that this was a problem with which professional associations should deal. There are regrettable signs that the particular problem quoted is extending to become national rather than local." (Hughes, 1964) 23.

This issue evoked several angry responses from the membership, concerned at the ceding of authority to local NHS committees, which might then delegate podiatric duties to whomsoever they pleased and allow nurses or others to "poach" skills from podiatry 24. It also drew into question the ability of the Chiropodists Board to protect the rights of podiatrists from assault within the NHS 25.

"If District Nurses are to receive official blessing to encroach upon our preserves it makes utter and complete nonsense of the whole Act..." (Hunt, 1964) 26.

24 Hartley RW (1964), The Chiropodist, 19:2, p.42;
26 Hunt J (1964), The Chiropodist, 19:4, p.84.
Disillusionment with the PSM Act and state registration was primarily focused upon its failure to secure protection from market competition and its lack of impact upon the status of the podiatrist in the eyes of the public or medicine\textsuperscript{27}.

The government was concerned to avoid any accusation that its actions would deprive practising podiatrists of their livelihood, thus permitting a clause which would ensure that all could avoid this fate, whether trained or not. Yet the need to ensure that those practising within the NHS would be safe in treating the public was also of prime importance. This resulted in the introduction, under statutory instrument, of legislation to make state registration the sole condition of NHS employment, thus establishing a credible measure for ensuring the public safety.

However, a series of loopholes existed which permitted the unregistered to continue employment with Local Health Authorities or voluntary organisations, or to transfer later to direct employment by a Local Health Authority, of which the Society disapproved\textsuperscript{28}.

Nevertheless, this was viewed by the Society as a temporary price to pay, as state registration would eventually lead to public and medical recognition with a consequent elevation in status\textsuperscript{29}. Other commentators, however, derided this belief, drawing comparisons with similar assurances made by the Society over registration with the

\textsuperscript{27} MacKay JS (1964), The Chiropodist, 19:1, p.16.
\textsuperscript{29} Read PJ (1964), "Education in Chiropody", The Chiropodist, 19:3, p.49-54.
BMA in 1938, securing medical auxiliary status from which no advance
had been possible\textsuperscript{30}.

The Society of Chiropodists nevertheless wrote to the Minister of
Health complaining about the vagaries of the grandparenting clause
and the limitations imposed on the patient profiles permitted within
the NHS\textsuperscript{31}. Under the LHA regulations (1959) only specific
categories of people were to be eligible for podiatry treatment,
essentially the elderly, physically handicapped and expectant
mothers\textsuperscript{32}. The Society sought a comprehensive service for all, on
the grounds of medical need, and gained the wholehearted support of
the medical profession, being reported widely in the medical press\textsuperscript{33}.

Although the introduction of Statutory Instrument No.940 did
eventually render illegal any employment of unregistered podiatrists
within the NHS, this highly limited form of exclusionary closure not
only failed to prevent the practice of unregistered podiatry outside the
NHS, it also failed to enlighten the public to any difference between
varieties of podiatrist.

This proved to be the spark which ignited the first of many
subsequent moves to amend the PSM Act (1960), as non-registerable
practitioners began to legally employ titles such as "\textit{qualified
chiropodist}" , adding to doubts about the utility of state

\textsuperscript{30} Watts WD (1965), \textit{"Registration Fallacies"}, BJC, 30:12, p.315-7.
\textsuperscript{31} Report of Council (1964), The Chiropodist, 19:9, p.199.
\textsuperscript{33} Editorial, The Lancet, "Care of the Feet", 22nd August, 1964; Editorial, The Medical
Attempts by the Society to publicise the meaning of state registration appeared to have had little impact, even following statements issued to 5 local Manchester papers, one national paper and a television broadcast. The lack of an appealing remuneration package for eligible practitioners entering NHS employment contributed to a national NHS shortage of podiatrists. As a result, many patients who might otherwise have elected to receive NHS podiatry care were persuaded to seek the help of the unregistrable, rather than face the costs of private treatment from the registered sector.

The Society sought to persuade the NHS to commission treatments from its own private practitioner membership, although for those in private practice opposed to any NHS provision, this was treachery. Thus, the key problem facing the registered sector was the failure of the 1960 legislation to protect the title of "chiropodist", reducing the utility of registration as a tool for further professionalisation.

It is also clear that the PSM Act came to be seen as cementing their status as medical auxiliaries, not as independent professionals. From this point of view amendment of the Act, or its replacement, became the only acceptable solution. The Act had formalised the subordinate status of podiatry, encased it within law and ensured that

36 Report of Services for the Elderly (1964), Borough of Lewisham.
only a legislative change could retrieve the situation. The only way forward, in this analysis, was to persuade government of the logic of protecting the public from the harm likely to ensue from untrained or unregistrable podiatry treatment. Within a year of the full implementation of the PSM Act and the NHS regulations associated with it, in 1964, many within the registered sector sought to amend or replace it, some members even calling for a return to medical auxiliary registration, others despairing at a “virtually useless” state register.

The Society of Chiropodists campaign to raise the awareness of the general public in the matter of differentiating between registered and unregistered by the recognition of designatory letters, in a bid to give meaning to the partially protected title, was considered a failure due to its limited “advertising penetration.”

The keynote of disaffection amongst podiatrists falling within the qualified, registerable community, evidenced by its recurring presence in the literature and correspondence of both the Society and the Institute of Chiropodists, was the perceived failure of the PSM Act (1960) to achieve full protection of title. The unregistered were even said to have gained from the “popularisation” of the title.

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"chiropodist" afforded via the PSM legislation, the assumption of which was regarded by the registered bodies as deliberately misleading the public, a charge employed in subsequent campaigns to outlaw unregistered podiatric practice\textsuperscript{45,46}.

5.1.2. The PSM Act (1960) : The Reaction of Podiatrists Ineligible for State Registration.

The exclusion of those podiatrists who, by virtue of their lack of adequate training or insufficient experience were to be denied state registration, did not evoke the outrage which might have been anticipated. This was due to their awareness of the limitations of registration and the minor impact, if any, that it would have upon their own practices. Those unlikely to satisfy the registration requirements yet already working within the NHS would, for the most part, be allowed to continue under the provisions of the "grandparenting" clause. The remainder would continue, unaffected, in private practice. The only bar to practice lay with future generations of untrained, or inadequately trained podiatrists, who would be unable to gain NHS employment. But the comparatively poor remuneration for NHS podiatrists at that time dissuaded the majority from seeking such employment anyway, as it had for many eligible for registration\textsuperscript{47}.

The SMAE Institute, the largest private training establishment outside

\textsuperscript{45} Pearson B (1965), The Chiropodist, 20:3, p.74;


\textsuperscript{47} Atkin EE (1961), The Chiropodist, 16:6, p. 165.
the state approved sector, greeted the Act by outlining its limited powers and intentions with considerable clarity.

"The Act does not prevent anyone not State Registered from practising. On the contrary it allows, assumes, almost encourages practice outside registration. In the same way that this country has always resisted any endeavour to interfere with the right of the public to...choose whatever form of treatment they will, and to be treated and administered to by whomever they will, so in this Act is such freedom perpetuated."

(Eames, 1960) 48.

The SMAE Institute recognised the deficiencies of the legislation and the limited powers of the Chiropodists Board, noting that the Act was never intended by its authors to establish monopolistic closure of podiatric practice. Its leader was immediately aware that the title "chiropodist" was not protected, and even asserted that the legislation did not promise "only ever to employ state registered practitioners" 48. In addition, the qualifying clauses permitted were viewed as virtually open-ended 48.

The only aspect of the legislation which evoked significant criticism was the disciplinary system, designed to regulate ethical conduct. This sought to establish a means of sanction against those who contravened the ethical standards laid down by the Chiropodists Board, essentially by providing a mechanism to remove the offenders name from the register. The SMAE leader implied that such legislation was unnecessary, as SMAE members were sufficiently ethical and their

standards above reproach, suggesting that few would wish to submit to "such surveillance"\textsuperscript{48}. He also derided the notion that state registration would bestow higher status on podiatrists in the eyes of the public\textsuperscript{48}.

However, the views of the SMAE Institute did not reflect those of all non-registerable podiatrists. Indeed, during the period between the enactment of the PSM legislation and its implementation many were unclear whether they would be accepted for registration. Some would be required to submit to a competency test, run and policed by the Society of Chiropodists, with the approval of the Chiropodists Board, which had no capacity to run examinations\textsuperscript{49}. Suspicion grew that the competency test would be used as a tool to engineer further exclusionary closure\textsuperscript{50}.

In response, the English Chiropodists Association (with an equivalent Scottish Association) formed in 1963, and sought registration for its members, although regarding the system as subservient to medicine. Its principle aim was to secure legislative change along the lines of the Dental Act (1921), which would include its own members\textsuperscript{49}.

\begin{quote}
"Either [chiropody] becomes a humble group, subservient to the medical profession, and in fact to all and sundry, or it takes the road that leads to full professional status, equivalent to that enjoyed by the dental and optical professions. The Professions Supplementary to Medicine Act is not the answer; it is the wrong road to take, and once accepted, reduces our status to a level from which it will take many years to rise..." (Mullins, 1964)\textsuperscript{49}.
\end{quote}

\textsuperscript{49} data derived from Transcript 8, 1995.

\textsuperscript{50} Mullins W (1963), BJC, 28:11, p.306-7.
Unwilling to accede to the lesser achievements secured under the PSM Act (1960), the English Chiropodists Association sought the withdrawal of podiatrists from the PSM legislation, and the abandonment of any policy aimed at securing employment by Local Health Authorities. One of the key complaints lodged against LHAs, by registerable and unregistrable alike, was the loss of clinical autonomy that this involved. Podiatrists were being required to treat specific numbers of patients per session, without regard to the individual needs of the patient as defined by the practitioner, a clear reduction in professional authority.

Finally, some groups representing the unregistered were concerned by, and firmly rebuffed, accusations of quackery or charlatanism arising from their registered competitors, who sought both public and medical support in outlawing unregistered practice.

5.2. Appeals for the Amendment of the PSM Act and The Emergence of the Public Safety Debate.

The theme underlying the desire to alter the PSM legislation was the attainment of a professional monopoly for the registered sector. The existing legislation had also failed to deliver the promise of an elevation of status for the registered above that of the unregistered in

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53 Provan JBG (1965), Registrar, Scottish Chiropodists Association, BJC, 30:2, p.43;
'Registration Opposed', cited in the Scotsman, 8th February, 1965, BJC (1965), 33:3, p.73;
Davidson J (1967), BJC, 32:4, p.95; Andrews PC (1967), BJC, 32:4, p.95.
54 A review of the contemporary public safety debate is included in Appendix 6.
the eyes of the public, or lead to the extinction of the latter.

"Sir Sydney Littlewood, Chairman of the Council for Professions Supplementary to Medicine, recently said: 'I am quite sure that the day will come when no one who is not on the State Register will be allowed to practise...Those who have studied the Act...are at a loss to see how what Sir Sydney Littlewood suggests can happen..." (Dagnall, 1965).

This resulted in a campaign, orchestrated by the Society of Chiropodists, which was designed to discredit all unregistered practice by claiming that the unregistered were charlatans, motivated by financial gain, unscrupulous in their methods and dangerous to the public. However, some doubt was expressed that this course of action could be wholly justified.

"We must remember too that it cannot be claimed that the SRCh is 'qualified' and that the non-registered is not. There are many non-registered who are undoubtedly 'qualified' in the real sense of the word and there are many SRCh's whose training was at a lower level than some of those outside the register. How then can we claim, let alone broadcast, the value of state registration in its present form as a means to the public recognition of the bona fide chiropodist?" (WD Watts, 1965).

Nevertheless, the Society of Chiropodists and others sought to persuade all who would listen that unregistered practitioners were unqualified and consequently a danger to the public, in the belief that such a strategy stood a greater chance of swaying Parliament in their favour. What little, anecdotal evidence existed was published,

with each detail of the misdemeanours itemised\textsuperscript{58}.

Although largely unable to provide substantive evidence of significant wrongdoing by the unregistered, or possibly because of it, the emphasis was increasingly laid upon claims that the unregistered lacked sufficient technical knowledge and training necessary to carry out podiatric care safely.

\begin{quote}
"Not only do the quacks and the untrained pedicurists do a great deal of harm to their 'patients' by acts of omission as much as commission...They create a low public image...and official and medical bodies look askance when 'chiropody' is mentioned, and why not. Because the word Chiropody unless qualified in detail means nothing."
\end{quote}

(Dagnall, 1966)\textsuperscript{56}

The distinction between the registered and unregistered did not, however, equate with that between those qualified or not. The Society of Chiropodists, and other registered practitioners, clearly regarded all who remained unregistrable as unqualified, without discrimination, and wished to limit, if not eliminate, all such practice. Within the broad category of the unregistrable, however, there existed a further sub-culture of those who regarded themselves as qualified and trained yet unable to secure the recognition of registration. These groups did not acknowledge any significant difference between themselves and registered podiatrists, other than eligibility for NHS employment\textsuperscript{59}. At the same time they sought to

\textsuperscript{58} These included burning a patients skin by the inappropriate use of heat lamps, removal of corns with inadequately sterilised equipment resulting in infection and consequent limb amputation, or the fraudulent claim for re-imbursement for radiographs which had not been taken. Cited in Dagnall JC (1966), 'Quackery', BJC, 31:5, p.127.
outlaw the totally untrained, or self-trained practitioner, who was said to practice part-time to supplement another main source of income. There was, therefore, a further hierarchy of discrimination evident within the unregistered sector to which the registered were oblivious.

"Only the part-timer need fear stricter legislation, and if he has not the skill to make a good living from his work the sooner he returns to his bus or factory bench the better for him and his patients." (Andrews, 1966) 60.

Many rank and file podiatrists were not in favour of unity between the Society and Institute, because of traditional rivalries, which hampered attempts by the leadership of both to make progress towards amalgamation 61. Whilst some regarded merger as an absolute necessity 62, others asserted that the central need was to persuade government of the desirability of outlawing unregistered practice on the grounds of the threat to public safety 39.

"It must also be widely understood that no government is in the least bit interested in protecting the profession and any attempt to achieve legislation which is inspired or widely supported by such a motive will fail. But the government does have a positive obligation to protect the unsuspecting public and the Opticians, the Dental, the Pharmacy, and the Midwives Acts all bear living testimony to that fact" (Watts, 1966) 39.

The Society recognised the need to lobby political support for any future amendment to the PSM legislation, by arguing that amendment

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61 Neal M (1966), BJC, 31:4, p.103.
was in the public interest\textsuperscript{63}. The unregistered were viewed as unethical, self-interested, undesirable and responsible for the poor public image of podiatry, and several authors called for evidence to be amassed which might be submitted to government in support of amending legislation\textsuperscript{64}.

By 1967 the Society of Chiropodists had become a signatory to the declaration of the International Federation of Podology, alongside other nations in Western Europe, Scandinavia and South America, which included an agreement "\textit{To fight against quackery}" \textsuperscript{65}. In addition, by late 1966 the Chiropodists Board itself agreed that there were sufficient grounds to seek an amendment to the very Act which had created it\textsuperscript{66}.

5.3. \textbf{A Conflict of Interest: Podiatry, Government Policy and the Introduction of Auxiliary Grades.}

The political climate rendered an amendment along the lines suggested by the Chiropodists Board particularly unlikely. The PSM Act had been introduced to provide competent practitioners for service in the NHS. Relatively few state registered podiatrists were, however, tempted into NHS practice, creating a service manpower shortage.

\textsuperscript{63} Neale D (1966), \textit{"The Profession - Today and Tomorrow"}, The Chiropodist, 21:2, p.39.
The government was clearly unlikely to introduce legislation which would further diminish the availability of podiatrists to serve the public, whether in the NHS or not. Indeed, it sought to introduce an auxiliary grade, to relieve the burden upon the beleaguered NHS podiatrist, and possibly to tempt podiatrists to work within the NHS, as the prospect of authority over a subordinate grade might appeal to their sense of status.

The Society of Chiropodists and the Chiropodists Board reacted with equal indignation. Whilst acknowledging the role played by poor renumeration and working conditions in the NHS manpower shortage, the notion of auxiliary grades imposed upon the profession in the absence of "protective" legislation spelt danger. The Chiropodists Board sought re-assurances that the government would seek to provide greater numbers of trained podiatrists through an expansion in the number of state recognised training schools, and not a proliferation of unregistrable practitioners, which auxiliary grades represented.

"If auxiliaries were to be employed, there would be a serious danger that, after gaining some experience in the employment of Local Health Authorities, and under trained chiropodists, they would then be tempted to set themselves up as private practitioners, as they would be perfectly entitled to do."

(Chiropodists Board Report, 1966)

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The Board pointed out that it would be prepared to accept auxiliary grades only on two conditions - the establishment of a supplementary register for auxiliaries, and, predictably, amending legislation to afford full protection of title. The Institute of Chiropodists, itself by then unable to train practitioners to registration standards, opposed the imposition of auxiliary grades outright.

Although the outrage and opposition to auxiliaries of all the main podiatric bodies appeared to persuade the government to reconsider its plan, the issue arose again in 1973 when the CPSM endorsed the creation of "aides" for the remedial professions, except in podiatry, as the Chiropodists Board would not countenance aides in the absence of protective legislation. The Institute of Chiropodists again opposed aides, fearing the threat of encroachment from inferior competitors.

The first inkling that podiatry aides were about to be imposed by the Department of Health arose in a local news report issued by the Area Administrator for the Stockport Health Authority. This report hinted strongly that the Department of Health were to disregard the pleas of the Society and Institute of Chiropodists.

Only the Association of Chief Chiropody Officers remained unopposed to the notion of aides, as this would improve the capacity and status of their services in the NHS. Significantly, as full-time employees in the

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70 Minutes of Meeting of Chiropodists Board (1973), cited in BJC (1973), 38:1, p.11.
NHS, they were unconcerned with the prospect of increasing competition in the private sector\textsuperscript{73}. The Department of Health directed the Chief Chiropodists to provide in-service training for aides, although that would technically breach the ethical codes of the Society of Chiropodists and State Board\textsuperscript{74}. Following the formal introduction of \textit{"Foot Care Assistants"}, opposition from the Board, Society and Institute was fierce\textsuperscript{75}. The State Board issued a statement condemning the action of the Department of Health, supported by numerous correspondents in the registered sector journals\textsuperscript{76}. The Chiropodists Board itself was castigated for permitting the Department of Health to impose foot care assistants\textsuperscript{77}. The Government imposition of auxiliary grades took effect during a phase of acute manpower shortage in NHS podiatry in 1977, and subsequently flourished under the wing of ACChO\textsuperscript{78}. By 1980 ACChO had constructed formal training schemes for foot care assistants, with national certification\textsuperscript{79}. ACChO published training guidelines for use within the NHS, taking care to advise its users on the potential

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\textsuperscript{73} Laskey H (1976), \textit{"The Institute and the Matter of Aides"}, BJC, 41:5, p.86.
\textsuperscript{74} Pike RD (1977), \textit{"Foot Care Assistants"}, BJC, 42:6, p.115.
\textsuperscript{75} Dagnall JC (1977), \textit{"Assistance Not Wanted"}, Editorial, BJC, 42:8,p.147; Dagnall JC(1977), BJC, 42:9, p.146.
\textsuperscript{77} Dagnall JC (1979), \textit{"Uproar Over Assistants"}, Editorial, BJC, 44:2, p.31.
\textsuperscript{78} Dagnall JC (1979), \textit{"Dates in the History of Chiropody"}, BJC, 44:5, p.108-110.
\textsuperscript{79} Lucas S (1980), \textit{"Foot Care Assistancy"}, BJC, 45:3, p.69.
\end{flushleft}
problem of over-training assistants, which might lead them to practice podiatry in the private sector beyond the disciplinary jurisdiction of the NHS manager\textsuperscript{80}.

Opposition to the development of foot care assistants by the Society of Chiropodists culminated in a well publicised disciplinary case in 1992, in which a District Chief Chiropodist was found guilty of infamous conduct\textsuperscript{81}. The defendant, a member of ACChO, faced charges resulting from the alleged misuse of "chiropody assistants", specifically related to the training and employment of assistants in the techniques of "scalpel work", considered the province of the registered podiatrist. The Society clearly sought to use this case as a warning that boundary encroachment from subordinate grades would not be tolerated, even if their existence could not be prevented\textsuperscript{82}. Nevertheless, these grades became firmly established in the NHS, under the guidance of ACChO\textsuperscript{83}.


By 1966 the Society of Chiropodists initially appeared to regard any

\textsuperscript{80} Pooke MJW (1986), "Guidelines for the Training of Foot Care Assistants", ACChO publication, p.1.
\textsuperscript{81} Berry BL (1992), "Lothian - Success With Reservations", Editorial, JBPM, 47:10, p.197-8.
\textsuperscript{83} The final act of endorsement for the "Chiropody Assistant" (or Foot Care Assistant as it was formerly known) was the right to award the qualification "Foot Health Support" under the National Vocational Qualifications scheme, formally launched at the Association of Chief Chiropody Officers annual conference in September 1996 (NVQ for Chiropody Assistants, ACCO, 1996).
immediate alteration to the PSM legislation as impractical. The use of
the term “protective legislation” was superceded by that of
“amending legislation” in order to reflect more accurately the view
that modification rather than replacement of the PSM Act was to be
the object of any immediate negotiation with the Ministry of Health,
more fundamental change being a longer term project. The
Council of the Society appeared to accept that any agreement to modify
the existing legislative framework would demand an accommodation of
those unregistered practitioners whose main source of income was
derived from podiatric practice. It was clear that the government
would not agree to their exclusion.

"It must be clearly understood that Parliament would not
introduce legislation which would deprive a person of his
livelihood. Therefore some provision must be made for those
who are not at present registered but are earning their living as
chiropodists if amending legislation is to be contemplated." (Witting, 1967)

Yet, although both the Society and the Board sought to introduce a new
“Register”, to which the names of those presently ineligible might be
appended, they also insisted that title and scope of practice be
protected thereafter. The proposed Society register suggested that the unregistered might
have their names appended to a “supplementary register”, producing
a two-tier arrangement of state registered and state enrolled

85 Statement by the Chiropodists Board (1967), “Closing The Profession”, cited in The
podiatrists, based loosely upon the nursing model. This had the advantage of placing Society members in an elite category, relegating the unregistered to a junior rank within a new hierarchy favouring the registered. It would also, however, provide the enrolled with an incentive to raise their standards in order to secure elevation to the state register, which would be facilitated by the Society model. The joint action of Society and State Board in seeking legislative change along the lines of the Dentists Act(1921) appeared to some both over-optimistic and undesirable, fearing a definition of scope of practice which would forever limit expansion.

The Chiropodists Board formed a working party to review the need for amending legislation, which met with representatives from the Ministry of Health and the Scottish Department in mid-1967. The government, still concerned about manpower issues in the NHS and suspicious of restrictive practices, rejected the proposals, considering there to be insufficient evidence to indicate that unregulated podiatry was a threat to the public safety and that there were insoluble problems inherent in defining and policing the scope of practice.

Just as the Society and Institute were preparing a campaign to pave the way for amending legislation, although neither could agree upon the scope of practice to be protected, the Monopolies Commission reported to Government on the issue of restrictive practices in the professions.

The Society sought support from both medical and political sources in the hope that more powerful allies might enhance the possibility of success, and sought to buttress their position by referring to similar legislation for podiatrists in New Zealand\textsuperscript{88,89}.

However, although sympathetic in principal to the ostracising of unregistered chiropodists as a trade off for continuing limitation in podiatric scope of practice, the Royal Colleges of Physicians and Surgeons of Glasgow were not convinced that sufficient evidence existed to demand the exclusion of unregistered podiatry\textsuperscript{90}.

In addition, the government indicated that there was little enthusiasm for any amending legislation. Nevertheless, the Institute of Chiropodists persuaded Mr. Bidwell MP to bring a ten minute bill seeking amending legislation to outlaw unregistered practice\textsuperscript{91}, although the Society felt such a measure could achieve little other than to draw attention to the issue\textsuperscript{92,93}.

The bill was structured in such a way as to convey the notion that the unregistered were unqualified, and therefore incompetent to practice safely. It was hoped by both Society and Institute that its introduction would lead to further Parliamentary support. Not only was this view mistaken, as those in opposition to the bill clearly did

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not favour any legislation which either promoted a monopoly or added to the burden of administrative work\textsuperscript{94}, but the hopes of the Society and Board were further dashed by the ridicule with which the suggestion was greeted\textsuperscript{95}.

Two key features emerged from this abortive attempt to interest Parliament in amending legislation for podiatry. First, Parliament would only become engaged in legislative action if all the PSM professions expressed a need to amend the existing Act. They would not countenance action in response to pleas from podiatrists alone. Secondly, neither the Society, Board or Institute could provide evidence to support their claims that unregistered practitioners were a danger to the public.

"...it must be clearly understood that any Bill to amend the existing Act must be one which will not be for chiropodists only...it will need to incorporate amendments which the other professions concerned are seeking...We have been asked in the past by the Department of Health whether the profession can produce evidence that unregistrable practitioners actually do harm to patients. It is extremely difficult to produce irrefutable evidence. It is probably truer to say that some unregistrable chiropodists do not do any good to their patients..." (Witting, 1969)\textsuperscript{96}.

The Society was advised by its parliamentary agents that further progress would require a government sponsored bill, a tall order in view of the government position.

\textsuperscript{94} A ten minute-speech of opposition was made by an opposing MP, consistent with Parliamentary procedure (Adonis, 1993; Dorey, 1995).
\textsuperscript{95} Hansard Report of the House of Commons, 21st October, 1969.
This salient lesson brought home to the Society its relative impotence, from which it determined to gradually build a firm base of Parliamentary support over time, together with a campaign to persuade the public of their need for protection.

5.4.1. **Formal Attempts to Amend the PSM Act (1960): 1970-1979.**

The central concern for the Society of Chiropodists in the new decade was "**closure of the profession**". Aspirations to secure legislative change which would protect both scope of practice and title had been halted for the foreseeable future, due to conflict with government wishes. Although practitioners continued to complain that even fellow health professionals failed to distinguish between registered and unregistered podiatrists, the working party derived from the three key professional bodies (Society, Institute and Board) began to emphasise that the changes they were seeking would not dramatically diverge from the PSM regulations, regarded by some as a retreat.

"They see the future of the profession in the supplementary sphere...The leadership of the Society have always argued that separate legislation (similar to the Opticians Act) was impossible...If the membership accepts the aim of the leadership so be it - supplementary we are, and supplementary we will remain." (Dagnall, 1970)

Although the medical authorities had offered their support for

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amendment of the PSM legislation to impose compulsory registration on all podiatrists, the government's disinterest combined with other external pressures forced the tripartite alliance of podiatric bodies to abandon immediate plans for change.

"we should recognise that for the time being the prevailing political climate is unfavourable to any more direct action towards our objective. Leaving aside the prospect of a General Election and the constant pressure of Government legislation, the questions of the Monopolies Commission's long awaited report, the possible entry into Europe and now the re-organisation of the Health Service, all individually and collectively create uncertainties and problems which cannot be resolved at this time by ourselves alone." (Neale, 1970)\textsuperscript{100}.

Clearly one of the most inopportune events which influenced the outcome of this, first, significant attempt at altering the PSM legislation was the report of the Monopolies Commission, on restrictive practices by the professions\textsuperscript{101}. The Society of Chiropodists had been asked to submit questionnaire evidence covering a variety of aspects of professional organisation and practice, to the Commission\textsuperscript{102}. The report, although damaging to the monopolistic aspirations of the registered podiatry sector, did realign its focus upon the public interest issue. This focus stemmed from three key paragraphs within the Monopolies Commission report, highlighting the significance of determining serious risk to client


\textsuperscript{101} The Monopolies Commission had been required by the Board of Trade, in 1967, under section 5 of the Monopolies and Mergers Act(1965), to report on the general effect on the public interest of certain restrictive practices in relation to professional services.

health and well-being\textsuperscript{103}.

The defeat of their demands for amending legislation to secure a monopoly of foot care services for registered podiatrists reflected the conflict of interest between profession and state, rather than inter-professional conflict with medicine. The medical authorities had demonstrated a willingness to support restrictive legislation for podiatry, as, under present arrangements, medicine would have been involved in influencing strongly the scope of practice which would have followed. Government ideology and manpower needs for the NHS determined an outcome over which the podiatric bodies had little influence.

Recognising these difficulties, the Society reduced its demands and planned a campaign to achieve protection of title, which would at least drive the unregistered to practice under a different name.

\textit{"There may be, however, a line of progress which would be entirely compatible with the observations in this report. It was quite clear from the findings of the Survey on Foot Troubles\textsuperscript{104} that the public do find great difficulty in distinguishing between qualified and unqualified chiropodists. There could be a very strong case for protecting the title 'chiropodist' and reserving its use to the qualified, a practice which the report shows to be common in other professions."} (Witting, 1971)\textsuperscript{100}.

The future strategy was initially directed at protection of title and in establishing the risk to the public posed by the unregistered, which received support from within the profession\textsuperscript{105}. Yet the notion of


\textsuperscript{104} Clarke M (1969), 'Trouble with Feet', Institute of Community Studies.
tiering retained its appeal, as a unified front might persuade
government more readily and would parallel similar demands from
other PSM professions also seeking amending legislation, enhancing
leverage in Parliament.

The Society of Chiropodists together with the Institute of Chiropodists
then set about reconstructing their demands for amending legislation
through a new Act of Parliament, re-introducing the two tier scheme
of registered and enrolled categories, and, critically, seeking a
combined action front with the Chartered Society of Physiotherapists,
which had also attempted to gain amending legislation previously.
This, it was hoped, would be an answer to the Department of Health's
assertion that they "would not embark on piecemeal legislation" to
accommodate the demands of podiatrists alone 106.

The Society and Institute agreed a definition of "chiropody" 107,
which would restrict the practice of podiatry to state podiatrists,
medical practitioners and other state registered PSM professionals,
providing patients were medically referred 108. This avoided defining
a scope of practice which might limit future expansion in practice,
especially important as the Chiropodists Board had just approved the
use of local anaesthetics by state registered podiatrists, and also
demonstrated due deference to medical authority.

However, a further threat to closure arose as a result of the re-

108 Chiropodists Board (1972), minutes of meeting, 18th July, 1972.
organisation of the National Health Service in 1974. The creation of large Area Health Authorities, with podiatric services incorporated at national level and departmental structures at each Area level, signalled a major service expansion. This threatened to compete with practitioners in the private sector, and placed a huge demand upon the profession for human resources. NHS pay awards still did not match private practice fees, which was taken to reflect the perception that the Department of Health viewed podiatry as it did other PSM professions, staffed largely by female workers whose income was secondary "pin-money". The government response to the manpower shortfall was to introduce "chiropody assistants". The Society of Chiropodists reacted to this threat by re-inventing the tiered registered and enrolled system, with one subtle addition - the latter could be employed under supervision by the former in the NHS, thus providing a solution to the shortfall in NHS podiatrists. In addition, a joint statement issued by the Society, Board and Institute agreed that a new Act would not seek to control the "practice of cosmetic pedicure" as an acknowledgement of the finality of the employment of podiatry aides.

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The Society opposed the training and introduction of "chiropody aides" on three points: that aides should not be employed in the absence of protection of title or practice for state podiatrists; that their two-tiered registered/enrolled scheme would be undermined; and that the training of aides should not be "piecemeal", without any uniform, national scheme of training, inferring that if anyone should control the scheme, it should be the Society itself.\textsuperscript{113}

The newly emergent Podiatry Association, formed to develop surgical practice in podiatry, was wary of determining a scope of practice which might limit its advance.\textsuperscript{114} It particularly feared the power of the State Board to restrict scope of practice, a distinct possibility following the recent difficulties over the acquisition of local anaesthesia, essential for surgical advance in podiatry.\textsuperscript{115}

"Once you do that it goes to the House of Commons and somebody writes down your scope - and this is what you can do. And if you're a dentist now and you want to go into oral surgery or something like that, it's beyond your scope, you can't. It's a black mark on what you can do." (Transcript 10, 1995).

The government option, it was acknowledged, avoided the intra-professional squabbling which would result from tiering, as many of those relegated to a subordinate position under practitioners they regarded as equals would not submit.\textsuperscript{116} In addition, the proposed

\textsuperscript{113} Statement of Policy of Council of Society of Chiropodists, 7th December 1974; cited in The Chiropodist (1975), 30:1, p.15.


\textsuperscript{115} Ariori AR (1975), "Closure", PA Journal, 1:2, p.3-5.

growth in state-recognised training schools appeared an unlikely solution, as recruitment to existing schools was falling. The Society two-tier alternative would be difficult and slow to construct. Unlikely to be agreeable to all podiatrists, it would give rise to complex arguments over role boundaries and would be more expensive both in training and employment.

Insult was added to injury when the government announced legislation affording protection of title and practice to farriers, under the Farriers Act (1975). This in turn served to underline the failures in strategy which undermined the podiatrists attempts to secure occupational closure.

The Joint Working Party of Society, Institute and Board persuaded the EChA to endorse the Society plan for a new register and roll, as it provided a means for upward mobility for the latter. However, the SMAE Institute remained opposed to exclusionary closure as it sought to retain its revenue from the correspondence training scheme run for podiatrists and physiotherapists. As a result, providing government with an agreed professional consensus remained elusive.

In early 1976, another ten minute bill was prepared seeking amending legislation for podiatrists. John Corrie, MP for North Ayrshire

and Bute agreed to press for amendment using the ten minute bill measure, to be followed by a re-introduction of the bill in the next Parliamentary session. This bill also received the support of Age Concern, whose recent report supported protection of title and practice for podiatry, although it also supported podiatry aides in the NHS.

Although members of the rank and file appeared unhappy with proposals which were perceived to resemble nursing rather than dentistry, to which they aspired, the tiering system provided the means of solving the manpower issue yet retaining control over the practice of podiatry in the NHS. This would provide the registered with direct power over the fate of the enrolled, determining their passage through the ranks to join the state register or their continuing subordination at a lesser grade.

The Society established a Steering Committee to examine the likely support for a further bill, consulting Parliamentary representatives, the BMA, members of the CPSM, the DHSS and the two Parliamentary parties. Support was evident in the medical press, notably General Practitioner.

However, the Corrie Bill was rejected, the government interpreting the tiering solution as adding to the problems of accessibility to

123 Age Concern (1976), 'Step On It'.
124 The Chiropodist (1976), 31:8, p.203.
125 Foxall JD (1976), The Chiropodist, 31:11, p.322.
trained podiatrists, and was seen as a restrictive amendment. The lack of "hard evidence" of any threat to the public safety sealed the fate of the Corrie Bill.\textsuperscript{127}

In a bid to persuade the government to reconsider and "review its present stand", an Early Day Motion was sought, but failed to be heard.\textsuperscript{128} Whilst the Farriers Act (1975) had enjoyed success, and the hairdressers registration bill had received a second reading in the House of Commons, closure for podiatry remained elusive.\textsuperscript{129}

The seriousness of the NHS manpower shortage became evident when the DHSS undertook to endorse the indirect employment of unregistered podiatrists. This action was justified as an "interior arrangement", on the grounds that the unregistered practitioners would only be permitted to treat patients after they had been assessed by existing state registered employees.\textsuperscript{130}

The Society responded by informing the DHSS that this would constitute a breach of the Society Code of Ethics and render members liable to disciplinary action.\textsuperscript{131}

Furthermore, the DHSS outlined their own plans to enlarge the scope of activities of foot care assistants in the employ of the Area Health Authorities, further diminishing the authority of the Society and the likelihood of closure. Initially, in accepting the DHSS directive to all

\textsuperscript{128} Report of Council (1978), The Chiropodist, 33:5, p.139.
\textsuperscript{129} Latham P (1978), The Chiropodist, 33:5, p.150.
\textsuperscript{131} The Chiropodist (1978), 33:8, p.241.
Area Health Authorities to proceed with "in-house" training for foot care assistants, the Society had specified the limited duties of foot care assistants which ensured they did not work alone, and therefore could not undertake domiciliary duties\textsuperscript{132}. The DHSS proceeded to promote domiciliary visiting by foot care assistants, and the Society was forced to accede\textsuperscript{133}.

The picture which emerged was one illustrating the relative impotence of the key professional bodies representing registered podiatry to effectively determine their own work practices, control their client groups or even their subordinate workforce. The government concern with ensuring an adequate supply of NHS podiatrists led it to ignore professional self-interest. The search for occupational monopoly through restrictive practices involving protection of both title and the practice of podiatry had persisted over two decades since the PSM legislation had been introduced, and had failed utterly. The following decades were to witness a reduction in the demands for occupational closure, from the protection of title and practice, to simply protection of title, the successes and failures of which will be described in the next chapter.

\textsuperscript{132} Jenkins JC (1977), The Chiropodist, 32:9, p.338-9.
\textsuperscript{133} The Chiropodist (1978), 33:9, p.240.
Chapter 6

Attempts to Achieve "Indicative" Closure
The failure of the Society of Chiropodists, Institute of Chiropodists or Chiropodists Board to replace or amend the PSM legislation in order to secure an occupational monopoly along similar lines to dentistry, by "functional closure", serves to support the view that professional closure is dependent for its success upon the convergence of mutual interests of profession and state (Freidson, 1970; Larkin, 1983).

In this case the interests of government were best served by refusing podiatry an exclusionary legislation which would limit the supply of podiatrists when they were most needed. It was also ideologically opposed to monopolisation, particularly of the more restrictive "functional" type.

Dissent from within the profession had also acted to dissuade government from engaging in further negotiation with the Society of Chiropodists over amendment along the lines of functional closure. In addition, the argument that elimination of unregistered practice would serve the public interest by ensuring standards of competency had "not yet convinced" the government.

Much of the intra-professional discord, which dampened government interest, stemmed from the unregistered sector, many of whom refused to accept that they were less highly trained than the state.

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1 Functional Closure was defined by the DHSS as "the right to practise being closed to all except those who are state registered". Indicative closure was defined as "the restriction of the use of certain professional titles to those who are on the state register" (DHSS Consultative Document, 1981)


registered, whom they viewed as elitist. The Society continued to lobby Parliamentary support, obtaining on several occasions questions in the House of Commons, all of which received the same reply, that "functional closure" could not be justified.


Following the General Election of 1979, heralding in a Conservative Government, the Society again sought the help of John Corrie, Conservative MP, persuading him to recommend to government its proposals for functional closure. Predictably, the new government outlined its negative view of these restrictive strategies. Its reply reflected very firmly the Tory belief in the principles of free market competition and individual freedom, excluding any possibility of functional closure, although it did suggest that a weaker version, indicative closure, might be considered.

"The new Government was opposed to any form of legislation which might restrict an individuals freedom...He [Vaughan] said the Government would not consider 'functional' closure but was prepared to look into indicative closure, by which he implied restricting the title of 'Chiropodist' to State Registered Chiropodists only" (Berry, 1980).

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The Society was encouraged by the outcome of a second meeting with Dr. Vaughan\(^8\), although the fine detail gave rise to concern that protection of title might not mean restriction of its use only to the state registered.

"In November he [Vaughan]...said he would ask his Department to look at indicative closure. A DHSS spokesman said that 'chiropodist' could be protected and only used in future by the registered and some others to be decided on. He emphasised that the legislation would have to be simple and meet with general agreement..." (Dagnall,1980)\(^9\).

During a Questions and Answers session in the House of Commons, Sir George Young, Secretary of State for Social Services, outlined the government position that only measures acceptable to all podiatrists, registered or not, Health Authorities and Parliament would be approved\(^10\). This placed the responsibility for progress firmly with the profession, and removed any hint that government would support restrictive measures which might impinge upon individual freedom of choice.

Government willingness to examine grounds for offering indicative closure was clearly a response to pressure from a number of the PSM professions, and Speech Therapy, all of whom sought protection of title. Podiatry alone had been insisting on full "functional" closure. Under pressure from its membership, the Society of Chiropodists had initially felt bound to pursue the goal of full protection of practice, as

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podiatry was alone amongst the PSM professions in facing widespread competition from unregulated practitioners operating in the private sector\textsuperscript{11}. Critics again cited the public safety issue as central to the problem and used it as a justification for the rejection of partial, "indicative" closure\textsuperscript{12}.

The Government had also sought to increase the available numbers of registered podiatrists for NHS work by expanding the number of state recognised training schools, establishing four new schools in as many years. Although the Chiropodists Board had vociferously opposed this development, claiming the expansion was carried out with excessive haste, it had been over-ruled by the Privy Council\textsuperscript{13}. In addition, the Royal Commission Report on the NHS of 1979 had concluded that there was evidence that the profession was "\textit{trying to restrict entry for monopolistic reasons}"\textsuperscript{14}, and could not reasonably justify such opposition\textsuperscript{14}.

All plans for a functional closure of podiatry comparable with that for dentistry or midwifery were crushed following the publication of a DHSS consultative document, which highlighted the basis of government opposition based on ideological and pragmatic grounds, particularly manpower provision\textsuperscript{15}.

\textsuperscript{11} Editorial (1981), Therapy, 8:23, 3rd December, 1981.
\textsuperscript{13} Dagnall JC (1981), Editorial, BJC, 46:11, p.244.
\textsuperscript{15} DHSS (1981), "Proposals for Statutory Protection of Professional Title under the Professions Supplementary to Medicine Act 1960 and Closure of the Speech Therapy
The underlying concern that little, if any, convincing evidence existed to suggest that unregistered practitioners were unsafe added to government reluctance to legislate in favour only of the state registered. The Consultative Document noted a bias evident in claims that the unregistered were unsafe, in that they usually emanated from the professional bodies representing registered podiatrists, and not from either the medical profession or the public\textsuperscript{15}. This clearly implied that such a claim was being used purely as a tool to further professional advancement and in reality had little to do with public safety\textsuperscript{16}.

In addition, the DHSS was sympathetic to counter-claims by the unregistered that there were more formal complaints lodged against registered than unregistered practitioners, particularly relevant in view of the pioneering surgical activity of the Podiatry Association at that time. The argument in support of the unregistered was made all the more compelling by the claim that they tended to receive patients by direct medical referral, unlike the registered, who acted without medical involvement\textsuperscript{15}.

The DHSS report went on to outline the disadvantages inherent in functional closure, which, although unacknowledged by the Society lay at the heart of the objections of the Podiatry Association. Indeed, the very justification for refusing state podiatry the closure it sought,

\textit{Profession - A Consultative Document}, HMSO.
would in time come to provide the emerging practice of podiatric surgery with the necessary legitimacy to expand into, and survive within, the formal medical establishment of the NHS\textsuperscript{15}. The document sought to re-introduce the grandparenting issue, to include in the proposed amendments those currently unregistered but in full-time practice. This included the Society of Chiropodist's suggestion of a two-tier system as an alternative possibility, but failed to make any impact as the Chartered Society of Physiotherapists "consistently resisted" this solution\textsuperscript{17}. The continuing absence of evidence, other than anecdote, of the danger to the public from unregistered podiatry was significant in the failure of the Society of Chiropodists campaign. The lack of consensus amongst the PSM professions over how best to implement a system which would protect professional titles yet avoid depriving individuals of their livelihood was an important consideration. The lack of a single voice representing the wishes of the profession of podiatry also influenced the outcome, and determined the future attitude of government towards podiatry. Finally, the aura of monopolistic exclusion was ideologically alien to a government committed to a free market with open competition. The rationale behind the governments tentative support for "indicative" closure rested not only with a need to respond to the concerted pressure of all the PSM professions, but also as a means to

ensure an adequate supply of practitioners in answer to the NHS manpower shortages\textsuperscript{18}.

The final conclusion of the DHSS document left the PSM professions with the tantalising possibility of obtaining protection of title, at "the first suitable legislative opportunity", providing they could secure collective agreement between and within their professional ranks\textsuperscript{15}.

However, for the Society of Chiropodists to accept this position it would be required to accede to the demand that the unregistered be admitted to a register, without condition, as they were clearly "meeting consumer demand and increasing consumer choice", a view based on the continuing use of unregistered services by the public\textsuperscript{15}. To fail to agree was to risk total failure, particularly in view of the apparent weakness of the counter-argument.

Furthermore, the DHSS promised to examine the possibility of extending protection of title to encompass not one, but several titles, in view of the trend in podiatry and physiotherapy to adopt American or other European versions of professional name. In the case of podiatry, the terms "chiropody" and "podiatry"\textsuperscript{19} were "regarded as synonymous"\textsuperscript{18}.

This proposal was to provide the Society of Chiropodists with an alternative approach to the thorny question of professional closure.

It decided upon a strategy which would provide both protection of title


exclusively for the state registered and also serve to distance them from the relatively low status label "chiropodist", by assuming a new, higher status title, emulating the American profession.

This was undoubtedly linked to the fact that, within the sub-culture of the state registered, the term "podiatrist" had already come to represent a more skilled, knowledgable practitioner with a wider scope of practice (those who practised "advanced techniques") as a result of the activities of the Podiatry Association.20

The Society initially rejected the DHSS proposal, insisting that functional closure would remain its objective21, although, sensing the mood of its rank and file, decided to seek their views22. The resultant survey of the membership, although based upon a 10% response rate, indicated that a "sizeable minority" might agree to indicative closure providing "there were adequate safeguards"23.

The Council of the Society responded by indicating to the DHSS that it would be prepared to accept indicative closure along the lines offered to Speech Therapy, providing all those admitted to the register had passed an examination "comparable to that of the current qualifying examination"24.

The government consulted widely among the PSM professions, seeking a consensus opinion upon the DHSS proposals. These consultations

were extended to the professional bodies representing the unregistered podiatry sector, which predictably opposed any measure to restrict practice. Only the English Chiropodists Association had supported the proposals\textsuperscript{25}. This lack of consensus finally persuaded the government to abandon any proposals for amending legislation\textsuperscript{26}. The CPSM sought an independent inquiry into manpower, training and registration of the PSM professions, but the government rejected this request on the grounds that it was unnecessary\textsuperscript{27}.

6.2. Formal Attempts to Amend the PSM Act(1960): The Transition from Functional to Indicative Closure.

From this point forth the Society of Chiropodists demonstrably lessened its demands. There was a growing recognition that the government view was one of anti-professionalism, citing the campaign to wrest conveyancing from the exclusive domain of the solicitor as a "\textit{witch hunt}"\textsuperscript{,28} and that independent action was unlikely to gain political support\textsuperscript{28}. However, the high level of support amongst the membership for the expansion in the surgical boundaries of podiatry, being pioneered by the Podiatry Association, rendered fortuitous the shift in stance towards acceptance of indicative closure.

\textsuperscript{25} Dagnall JC (1982), BJC, 47:2, p.27-8.
\textsuperscript{26} Finsberg G (1982), Parliamentary Under Secretary of State (Health and Personal Social Services), personal correspondence to Hughes N, Chairman of Society of Chiropodists, 17th December, 1982.
Lack of consensus within podiatry extended to the registered sector, ACChO opposing indicative closure on the grounds that NHS employees already enjoyed a de facto closure\textsuperscript{29}. 

A further round of talks with the DHSS floundered when the British Chiropody Association (SMAE) and the Fife Tutorial Association opposed any amending legislation whatsoever\textsuperscript{30}. The Society, on the other hand, recognising functional closure to be an impossible target, set out to accept the terms on offer - protection of the title "\textit{chiropodist}" to state registered practitioners only, or protection of the title "\textit{podiatrist}" or "\textit{podologist}", or both\textsuperscript{31}. The Society launched a new campaign aimed at securing the much more limited goal of protection of title, in the knowledge that the government had expressed its willingness to agree to such a demand, providing a consensus view within the PSM professions could be achieved. In addition, the recent provision under the Health and Social Security Act(1984) ensuring protection of title for opticians encouraged the Society to believe that similar legislation might be available for podiatry\textsuperscript{32}. The Society turned its attention to a specific passage, Section 6, of the PSM Act in order to effect an amendment which would protect the titles chiropodist, podiatrist and podologist, in addition to those already restricted to the state.

registered. Members of the Society were asked by the Council to lobby their local MPs in order to make representations to the Department of Health for protection of title.

Another "early day motion" was brought to the House of Commons, by Laurie Pavitt MP, in July, 1984\(^{33}\). Internecine conflict between the registered and unregistered sector had escalated following the recent campaign to exclude the latter. The SMAE Institute, representing the majority of unregistered practitioners, had issued threats of legal action for libel and slander in instances where state registered practitioners implied that their trainees were either untrained or unqualified, forcing the Society to caution its membership\(^{34}\).

The possibility of achieving a limited form of restriction which might also permit a new professional title, distinct from the unregistered, was appealing because it was evident that the SMAE Institute was powerful enough to block attempts at other forms of closure. If the Society could effect the protection of a new title, "podiatrist" or "podologist", which would leave the use of the older title of "chiropodist" to the SMAE practitioners, a satisfactory compromise for all might be attained\(^{35}\). Similar changes had recently been successfully enacted in Western Australia, in legislative amendments under the Podiatrists Registration Act (1985), achieved by consensus\(^{36}\).

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The Society's new tactic, based on working within the confines of the PSM Act rather than seeking to replace it entirely, brought rapid support from the medical authorities. The BMA wrote to the Society to underpin its support for protection of the title "chiropodist" (being unaware of plans to employ the term "podiatrist") providing this was undertaken within the terms of the PSM Act, ensuring the continuation of podiatry as a profession supplementary to medicine\textsuperscript{37}.

The English Chiropodists Association was again prepared to accept indicative closure providing its current members were grandfathered onto the new state register, and would even accede to demands that its members in part-time employment should be subject to "competency tests" before being admitted to the full register\textsuperscript{38}.

The Pavitt early day motion received the support of 53 MPs, with a further 83 supporting an amendment, but the Minister for Health asserted that he would not propose any new legislation as there was no clear consensus view within the profession\textsuperscript{39}.

Attempts by the Society of Chiropodists, the Podiatry Association and the SMAE Institute to agree some form of amending legislation failed\textsuperscript{40}, and the Society was reduced to considering some form of Joint Council, which might represent both registered and

\textsuperscript{36} Jobson JRS (1985), The Chiropodist, 40:6, p.162-3.
\textsuperscript{37} Statement of Under Secretary of BMA (1985), The Chiropodist, 40:6, p.171.
unregistered\textsuperscript{41}.

The Society came to recognise fully the impossibility of achieving functional closure under a Conservative government ideologically opposed to monopolistic practices by professions\textsuperscript{42}, and that further progress could only be made once the profession had put its "house in order"\textsuperscript{43}.

The need for unity was made clear by the DHSS, and the Society, with renewed vigour, set about this goal. Initial meetings with the Podiatry Association identified common ground, including a desire for closure. The Society also met again with the head of the SMAE Institute, who outlined the view that there were "two parallels of development within the profession as opposed to two tiers"\textsuperscript{44}.

Informal meetings had also taken place with the Institute of Chiropodists, the Association of Chief Chiropody Officers, the British College of Podiatry and the English Chiropodists Association\textsuperscript{45}. A General Chiropody Council was agreed in principle, but the Chiropodists Board, in view of its legislative role, could not endorse any arrangement which included unregistered practitioners\textsuperscript{46}.

Whilst some of the Society membership accepted a joint

\textsuperscript{46} The Chiropodist (1986), 41:6, p.242.
arrangement\textsuperscript{47}, others vociferously opposed it\textsuperscript{48}.

The Society had to tread carefully, and finally agreed upon an interim compromise, in which it would pursue a Federation of Bodies, representing only the state registered, but which would maintain a dialogue with the unregistered\textsuperscript{49}.

However, within a matter of months the Society, under severe pressure from its membership through the Branch network, was forced to abandon the Federation project\textsuperscript{50}, which had been "severely mauled"\textsuperscript{51}. Plans to unify the profession as a pre-requisite to approaching government with a view to amending existing legislation appeared in tatters\textsuperscript{52}.

Nevertheless, the message from government remained the same, being re-iterated in a letter from a Junior Health Minister, Edwina Currie MP, to the Secretary of the Institute of Chiropodists\textsuperscript{53}.

In addition, the new government White Paper, "Promoting Better Health", acknowledged the contribution of podiatry to health care only in maintaining mobility in the elderly, perpetuating an image from which the registered sector sought an escape\textsuperscript{54}.

\textsuperscript{47} Perrett JR (1986), The Chiropodist, 41:6, p.242-3.
Further failure to acknowledge any distinction between registered and unregistered podiatrists arose with the Essex Act (1987)\(^5\) and led to renewed calls for legislative change\(^6\).

The professional bodies representing the unregistered in turn sought to de-regulate podiatry, pointing to NHS waiting lists and demanding a "fair crack of the whip" for those excluded from the register\(^7,\)\(^8\). Although the registered sector failed to secure amending legislation, the unregistered sector failed to achieve deregulation, largely due to the same government logic - that only full agreement between those bodies would persuade them of the need to amend existing legislation\(^9\).

The literature yields few references to any breach of the restrictions on the use of titles imposed under the PSM legislation by the unregistered\(^\)\(^\). Yet the internecine conflict between the two sectors was serious enough to result in the collapse of the British Journal of Chiropody, following the decision of its editor to carry

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\(^{5}\) This Act limited practitioners permitted to provide "massage" (excluding Hospitals, Nursing Homes and 'any premises offering only facial or scalp massage') to registered medical practitioners, chartered physiotherapists, persons registered with any Board under the PSM Act, nurses registered with UK Central Council for Nursing, registered midwives or 'members of any organisation...which specifies qualifications for the practice by its members of chiropody, osteopathy, naturopathy or acupuncture...'.


\(^{7}\) The Scottish Chiropodists Association, an unregistrable body of chiropodists, whose President (Mr. EF Firestone) gave his name to the Firestone correspondence course in chiropody.


\(^{9}\) Lambie D MP (1988), personal correspondence to Jenkins GC, 5th January 1988.

\(^{10}\) Statement by Registrar, CPSM (1988), The Chiropodist, 43:6, p.123.
advertisements for staffing posts at the SMAE Institute\(^{61}\).

6.3. **Formal Attempts to Amend the PSM Act (1960): The Impact of the Government Reforms from 1989.**

The government view was again clarified by its response to the report upon podiatry services and the needs of the elderly, which had recommended a doubling in the level of services\(^{62}\). The government response was to enhance the use of foot care assistants, and to permit greater freedom for GP's to employ private practitioners directly, as indicated in "Promoting Better Health"\(^{63}\). The key implication of the White Papers, "Promoting Better Health" and "Working for Patients", was a shift in funding arrangements as a prelude to the introduction of GP fundholding, in which GPs would employ podiatrists, rather than Trusts or DHAs. The recent passage through Parliament of the Health and Medicines Bill (1988) also enabled cash allocations directly to Family Practitioner Committees, designed to act as an adjunct to Health Authority services\(^{64}\).

This was regarded by the Society as an assault upon the independent status of podiatry by placing it under the direction of medical practitioners, a suggestion which had not been seriously proposed

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\(^{61}\) In response to this measure, registered podiatrists withdrew their subscriptions in protest on such a scale that the journal was forced to close following a dramatic loss in sales and sponsorship. Cited in Dagnall JC (1988), Editorial, BJC, 53:12, p.231-2


since the Cope Report (1951) and ran counter to

"all the principles of independence and autonomy which the profession has held to and fought for so long"\(^{65}\).

The point of greatest concern was the lack of any guarantee that employing GPs would restrict themselves to state registered practitioners. Under Statutory Instrument No. 940 of the National Health Service Regulations (1964), Health Authorities were obliged to employ only the state registered. However, these Regulations were not binding on the Family Practitioner Committees. The BMA Code of Professional Conduct did require its members to use the services of the state registered, but this represented the only measure of protection for the registered profession\(^{66}\).

The Society sought reassurances, but received news from Roger Freeman, Parliamentary Under Secretary of State for Health, that under the new NHS Trust arrangements all previous commitments to employing only the state registered would stand for Community or Hospital Trusts and Health Authorities, but not GP fundholders or FPCs\(^{67}\).

Renewed attempts to fashion a unified consensus upon amending legislation, which might be presented to government resulted in the formation of "Spinario"\(^{68}\), a tripartite alliance between ACChO, the

\(^{65}\) Berry BL (1989), Editorial, The Chiropodist, 44:5, p.82.


\(^{67}\) The Chiropodist (1989), 44:11, p.234.

\(^{68}\) "Spinario", derived from the Latin title for a classical statue of a child removing
Society and the Podiatry Association, but this failed to agree after only two meetings\textsuperscript{69}.

However, David Alton, Liverpool Mosseley Hill MP, agreed to champion the cause for a review of the PSM Act(1960) for all the PSM professions. Alton suggested that there was a considerable groundswell of support for change amongst Ministers, facilitated by the departure of Margaret Thatcher from Office, and that hard lobbying might now succeed\textsuperscript{70}.

Within the month Alton tabled an early day motion\textsuperscript{71}. However, the SMAE Institute again lodged a "hostile amendment" opposing such amending legislation, prompting Spinario to reform and support EDM 29\textsuperscript{72}.

To make matters worse, the report of the Working Party on Osteopathy was published by the King's Fund, recommending indicative closure for this otherwise unregulated profession, independent of the PSM\textsuperscript{73}.

"\textit{most of the Osteopathy organisations and Chiropractic organisations wanted a statutory form of some sort of registration, and they learned by our mistakes and certainly didn't want to join the PSM structure...because they could see that the Act was totally ineffective as far as closure was concerned}" (Transcript 7, 1995).

The Council for Professions Supplementary to Medicine now sought

\begin{thebibliography}{73}
\bibitem{70} Alton D (1991), \textit{'The Speech that Wasn't Meant To Be'}, JBPM, 47:1, p.2-3.
\bibitem{71} Society News (1992), 4:1, p.1.
\bibitem{72} Berry BL (1992), Editorial, JBPM, 47:3, p.47.
\bibitem{73} Report of Working Party on Osteopathy, King's Fund, 1992
\end{thebibliography}
amendment of the PSM legislation, asserting that any advance in the forthcoming Osteopathy Bill would disadvantage the PSM professions\textsuperscript{74}. This provided one element of the unified front which would be required to convince the government to move on amending legislation, previously disregarded due to the intra-professional disputes evident within podiatry\textsuperscript{75}.

In addition, the view prevailed that registered podiatrists might make headway if they pressed for indicative closure through the protection of the title "podiatrist", leaving the title "chiropodist" to the unregistered sector\textsuperscript{76}.

The early day motion tabled by David Alton MP had secured 115 signatories, as opposed to 78 for the hostile amendment\textsuperscript{77}. Its intention had been to establish a clearly recognisable distinction between registered and unregistered on the basis of name\textsuperscript{78}.

Within a period of a very few years, demands for functional closure had been reduced to indicative closure, and now, out of political necessity, mere acceptance of a clearer distinction between registered and unregistered would have to suffice.

\textsuperscript{74} Berry BL (1992), JBPM, 47:4, p.65.
\textsuperscript{76} Baroness Hooper (1992), Parliamentary Under Secretary of State for Health, cited in JBPM (1992), 47:4, p.67.
\textsuperscript{77} Society News (1992), 4:2, p.1.
\textsuperscript{78} Berry BL (1992), Editorial, JBPM, 47:6, p.101.
"The Society of Chiropodists and the CPSM intend to extol quality of treatment for the benefits of patients. They do not intend, or even desire, to debar unregistered people from practising, merely that, as state registration is the only recognised parameter of quality for the profession, it must be seen and used, for the benefit of the general public..." (Berry, 1992) 79.

The Society decided to concentrate upon the issue of quality standards, in parallel with the impact of the new reforms within the NHS. This was designed to persuade the SMAE Institute and its ilk that raising their training standards would ensure acceptance upon the state register. It was hoped this would entice the SMAE Institute and Scholl to agree to the proposed amendments to the PSM legislation, and proved successful in the latter case 80.

The Osteopaths Bill succeeded because they were viewed as directly linked to private practice, whereas the government were reluctant to introduce legislation for NHS professions without first assessing the impact of the new NHS reforms 81.

The CPSM produced a report indicating its proposed intention to promote the importance of state registration with GP fundholders and others engaged in primary care, in order to ensure exclusivity in employment 82.

79 Berry BL (1992), Editorial, JBPM, 47:6, p.102.
6.3.1. *From Chiropody to Podiatry: A Change in Professional Title.*

Acting on the advice of Baroness Hooper and Health Minister Stephen Dorrell MP, the Society attempted to secure amendment of the PSM Act through a private members bill. In line with this recommended strategy Alf Morris MP presented a bill in Parliament seeking protection of the title *podiatrist*, in the hope that the unregistered sector would not react with a hostile amendment\(^{83}\). Assurances that protection of the title *podiatrist* would receive the approval and endorsement of the government were open and clear\(^{84}\).

The Morris bill failed at the second reading, as the government feared that a precedent for other PSM professions might create an avalanche in similar demands\(^{85}\).

Thus, the change in professional title adopted by the state registered sector was not accompanied by supporting legislative amendments to protect the new title, although it arose from attempts to do so.

The emergence of the title *podiatrist* in the United Kingdom arose initially through the creation of the Podiatry Association, an organisation intent upon developing and expanding scope of practice into the surgical arena\(^{86}\). The success of the Podiatry Association in

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expanding the boundaries of practice and securing state approval through the Chiropodists Board (see chapter 7), combined with the growing pressure from rank and file members to support these advances, convinced the Society to endorse podiatric surgery, albeit in a cautious and limited way.

The assumption of the title *podiatrist* by state registered bodies, as a tool to achieve closure, was a popular choice as, within the sub-culture of the state registered, it afforded a greater status due to its association with surgical skill, and advanced knowledge. It would also allow the term *chiropodist*, with its poor medical and public image (Larkin,83) to be applied solely to the unregistered practitioner. This would serve to increase public and medical differentiation between registered and unregistered practitioner, in the absence of the possibility of legislation to eliminate the latter. The Society of Chiropodists formally changed its name to the Society of Chiropodists and Podiatrists on 1st July, 199387. As the educational qualifications of the state recognised training schools became degree awards, replacing the professional award of the Society, in the period 1989-92 all assumed the titles of BSc(Hons) in either Podiatry, or Podiatric Medicine (although the latter title was dropped following medical objection)88.

The state registered sector adopted the title *podiatry* in advance of

legislative action to formally protect the title, in the belief that legislation would follow. As a consequence, those very organisations which the registered profession wished to prevent from using the title podiatrist then assumed the title themselves, presumably in a move to subvert any attempt at exclusion.

One key informant outlined the role and influence of government officials in supporting the suggestion that the registered profession alter its name to “podiatry” in order to leave the unregistered with the label “chiropody”. This would avoid the need to address a uniform protection of title which would threaten the livelihood of many unregistered practitioners. For any government to endorse a strategy which would impinge upon this common law precedent would be manifestly unacceptable to the electorate, and explained repeated government refusal to do so. The Society of Chiropodists was, however, actively encouraged to proceed with a change of name prior to legislation, being assured that the subsequent amending legislation would ensure that any unregistered person or organisation using the title would be ensnared and legally liable to prosecution.

"It was they who said 'You change your title and then we will protect it'. So then we went to 'podiatrist' and of course every other person began calling themselves podiatrist as well. We were told at that time, and there was one of the Departmental officials who was very sympathetic to the change, to protecting the new title, and felt at that time that if other people adopted it on the basis that we were going to get protection, that there might be some legal comeback on them and of course nothing happened, he left the Department and they sort of stepped back." (Transcript 7, 1995).
The Society's attempts were thwarted because they were part of the wider PSM grouping, which had failed to act as a unified group of professions speaking with one voice. The message, however, was clear. Only concerted, uniform pressure from all the PSM professions, acting in unison, could persuade the government to review the PSM Act. Because of their integral position within the dynamic of the NHS, the PSM professions could not be treated, as osteopathy had been, in isolation.


The Society persuaded Alf Morris MP to introduce a new bill, through Lord Stallard of St Pancras, in the House of Lords\(^89\). This sought a review of the PSM legislation, and enjoyed the uniform support of all the PSM professions.

Baroness Cumberledge responded by announcing that the government had agreed to commission an independent review of the Act, through JM Consulting Ltd\(^90\). One key informant considered the Osteopaths legislation to have had an impact on subsequent government agreement to review the need for new legislation for the PSMs.

"...I think it was only because their [Osteopaths] thing got through that finally the CPSM managed to convince government officials that they needed to get their house in order that things got anywhere at all. Hitherto, particularly with the Conservative government, the last 2 governments, its been very much market forces and its always been private enterprise..." (Transcript 7, 1995).


The Department of Health appointed a podiatry advisor, previously the Chairman of ACChO, another important step in raising the profile of podiatry at the Department of Health\textsuperscript{91}.

The Society was required to submit written evidence to JM Consulting Ltd, the independent group undertaking a review of the PSM Act. The core of the Society’s evidence concentrated upon the failure of the PSM Act to establish meaningful closure, which threatened the public safety by permitting anyone not on the existing register to enter into or continue to practice podiatry, without regulation. In addition, it now stressed the need to assist public comprehension as a justification for demanding change, and the right of the public to enjoy quality of treatment, a key concept emerging within the changing NHS\textsuperscript{92}.

The Society categorically stated in its submission that functional closure was no longer an aspiration, and that an indicative form, fully protecting the titles “chiropodist, podiatrist and podologist” was all that was being sought\textsuperscript{87}.

The resultant consultation document issued by JM Consulting Ltd was greeted by the Society with some optimism, and appeared to pave the way for greater progress than had previously been the case. The JM Consulting report was, however, also concerned that the use of protective titles might serve professional rather than service needs\textsuperscript{93}, but it agreed to recommend them\textsuperscript{94}. Podiatry was notably

\textsuperscript{93} Editorial (1995), JBPM, 50:12, p.189.
singled out as especially problematic, with the recommendation that either protection of one of two titles be given, or the instigation of some form of transitional grandparenting mechanism installed. The independent review was announced on 24th July 1996, which was to be used to form proposals for new legislation. The review proposed a replacement for the existing PSM machinery, which would involve expanding the number of Health Care Professions from 7 to 9, abolishing all individual professional Boards and replacing them with one main Council and 4 sub-committees dealing with specific areas, such as disciplinary activity or education.

The current recommendations for a new Health Professions Registration Act have outlined certain key areas which are clearly directed at the podiatry profession. The proposed legislation will encompass all the existing PSM professions, including new groups such as Art and Music Therapy, and make a clear demand for unified representation upon the Council for Health Professions, the new executive body. The proposals assert the need for "mature" professions to consolidate internally before entering into this legal bond, and that professions failing to meet this requirement may find themselves excluded altogether, a clear reference to podiatry.

One continuing anxiety for the Society of Chiropodists and Podiatrists is clearly the prospect that the government will again fail to differentiate between those practitioners trained through the route approved by the Chiropodists Board and those trained in privately run establishments, which have no specified standards of training. Although it appears that the JM Consulting Ltd recommendations have been accepted by government, which should establish protection of title for those professions included\(^98\), it is by no means clear that, in the case of podiatry, any distinction will be made between those currently registered and those unregistered.

The prospect of the SMAE Institute continuing to train podiatrists with the additional benefit of state approval underlies this anxiety and undermines the indicative closure on offer. However, it is likely to be broadly acceptable to the other current PSM professions, as indicative closure ought to establish a meaningful protection of title for these groups. It would appear that podiatry alone stands amongst the current PSM professions as likely to gain little through the proposed legislation, should the distinction between "high street practitioner" and state registered practitioner remain unacknowledged.

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\(^{98}\) Baroness Cumberledge (1996), personal correspondence to Edwards N, 18th July, 1996.
"But they [DoH] will obviously consult with everybody. They talk about the 'high street practice' and what they mean is Scholl and others, and that is one of the great difficulties now...if the DoH is there to protect the public and to ensure that things are correct then they ought to be looking at the private sector, but no. The DoH sometimes doesn't realise it has a duty to society and the public." (Transcript 7, 1995).

The most recent data available to the researcher clearly indicates the growing concern of the Society of Chiropodists and Podiatrists over the implications of the report issued by JM Consulting Ltd. Their fears centre around the lack of assurances regarding the details of indicative closure, and the Society's lack of influence upon the eventual outcome which, enshrined in an Act of Parliament, might take another 36 years to amend.

"...the Report, although accepted by government, leaves much vitally important detail still to be decided...The professional agenda has been ignored. Whose agenda has been taken up? Basically, the agenda of government and the civil service...Protection of 'common title' is promised : ideally just one title. It will not be specified in the Act but will be introduced (and, potentially, later amended) by subsidiary legislation...Whatever happens, a golden opportunity to produce good legislation for the profession has been lost, probably for this decade." (French, 1996)

The proposed new Health Professions Act would limit the independence and capacity for self-regulation of the profession by virtue of the new structure envisaged. This involves the proposed abolition of separate professional Boards (ie. the Chiropodists Board) and their replacement with four committees under a new Council.

These committees, detailed to address education, investigatory and disciplinary measures and health, would not contain a majority of professional representatives (as the Chiropodists Board does), but a mix of each of the professions.

This will essentially bind the future of podiatry more tightly to those other professions encompassed in the new Act, ensuring that little progress could be made without the necessary agreement of the other professions. Currently the other "supplementary" professions appear to be approaching the new legislative proposals with some enthusiasm. Following the enactment of this new Act, then, podiatry would have less power to secure change independently, being legally bound by the need to ensure the support of its fellow Health Professions before advancing its claims. Thus, an effective veto on professional development is extended to include not only medicine, but the other Health Professions also. Such a measure may be appealing to government as it ensures conformity within the "supplementary" groups, thus containing or quelling spiralling demands from disparate groups. It might also maintain the support of medicine through its continuing presence upon each of the Committees, guaranteed under the proposed regulations\(^\text{100}\).

One final point merits attention. There is evidence to suggest that the review of the PSM(1960) Act initiated by government was not purely a response to paramedical pressure, as the rejection of the Cope Report

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(1951) and subsequent shift to the alternative, PSM legislation had been.

The medical profession may again have demonstrated its influence in shaping the structure and provision of paramedical services in collaboration with the state. The loophole in the PSM legislation which permitted podiatrists and other supplementary professions sufficient self-regulatory powers to approve expansion in their scope of practice became a key concern for medicine. The power of the individual professional Boards to authorise and sanction such expansion led to shifts in paramedical practices which increasingly encroached upon medical tasks. The approval for local anaesthesia (1972), followed by "ambulatory foot surgery" (1986) by the Chiropodists Board permitted a degree of state legitimation for podiatrists undertaking surgery. There was no requirement that the formal medical authorities be consulted about these changes. In consequence, medicine, at face value, appeared to support paramedical calls for amendment of the PSM Act. However, this support was motivated by a desire to promote a replacement for the PSM legislation which re-established medical control and authority over the scope of paramedical practice. In this, it may have succeeded. If the current proposals, which have been accepted by government and appear inevitably to be moving toward the statute book, come into effect in the form presented by JM Consulting Ltd (1996), then the "health professions" self-regulatory powers will be significantly curtailed.
In 1986 the Chiropodists Board extended their approval for podiatric surgery without approaching, for approval, the General Medical Council, Royal College of Surgeons, Royal College of Physicians or British Orthopaedic Association. Instances like this prompted the decision to review the Act [PSM Act]. The Boards in the new Act will follow the pattern and dictates of the Council, which will have a strong medical representation...” (Transcript 26, 1996).

The two previous chapters have illustrated the failure of state registered podiatry to obtain legislative amendments to the PSM Act(1960) which would secure full protection of either scope of practice or title. This failure was not due to medical opposition, but to government policy. Yet the success of the osteopathy and chiropractic bills did further emphasise the subordinate and marginal position of podiatry within a medically dominated grouping. The final approval for a formal review of the PSM Act stemmed not from the efforts of podiatry alone, but only following unified pressure from all the PSM professions. The following section examines more directly the inter-professional relations with medicine and other paramedical groups, and their impact upon the alteration in skill and role boundaries evident in post-1960 podiatry.
Section 2. Podiatry: Inter-Professional Relationships

Chapter 7

Podiatric Role Boundaries:

The Acquisition of Local Anaesthesia
The remaining chapters are concerned with the expansion in scope of practice and re-negotiation of role boundaries evident in British podiatry since 1960, with particular emphasis placed upon the use of local anaesthesia, and the subsequent emergence of surgical practice. These developments, designed to enhance the status and autonomy of podiatry, led to conflict with medicine and with other paramedical groups. Podiatry sought to extend the boundaries of its practice into areas officially the responsibility of medicine. It also threatened to encroach upon the boundaries of radiography. These activities are described in terms of usurpationary and lateral closure strategies (Hugman, 1991), encompassed within the model of occupational imperialism provided by Larkin (1983).

"Occupational imperialism refers to attempts by a number of occupations to mould the division of labour to their own advantage...It involves tactics of 'poaching' skills from others or delegating them to secure income, status and control" (Larkin, 1983).

At the heart of the bid to attain and assert control over its own work, in terms of content and boundaries, podiatry offered a challenge to the pre-existing dominance of medicine in determining its affairs. Whilst "autonomy of technique" has been viewed as important in defining a profession and its relations with the state, the determining features of a profession have been described as emerging from competitive struggles for areas of expertise in the workplace, through negotiated jurisdictions (Abbott, 1988; Freidson, 1970; Johnson, 1995).
The following accounts of the stratagems of the state registered sector in podiatry to establish and extend its role boundaries and technical autonomy highlight the successes, failures and obstacles encountered since 1960.

The initial investigation examines the unlegislated use of local anaesthetics by podiatrists during the 1960s, prior to the introduction of the Medicines Act (1968) and the Chiropodists Board report (1968) which sought to ban their use. The activities and conflict which subsequently led to state approval for the use of local anaesthesia, and the exemption secured under the Medicines Act, are mapped in sequence.

The transition from circumscribed, non-invasive practices to invasive surgical practices in podiatry will also be considered as a direct result of the legal right to use local anaesthetics. Invasive surgical practices will become the focus of further chapters, facilitated by the use of local anaesthetics.

7.1. The Relevance of Local Anaesthesia to the Professionalisation of Podiatry

The available documentary evidence tends to suggest that the significance to current scope of practice achieved through the use of local anaesthetics is widely acknowledged. The use of these agents has been perceived as instrumental in permitting a widening in the scope of practice through surgical intervention, the provision of pain
free treatment impossible without their use, and an elevation in status comparable with dentistry.

The final acquisition of the legal right to administer local anaesthetics represented the first successful challenge to medical authority in determining the role boundaries and skill range in podiatry since the submission of the Incorporated Society of Chiropodists to medical auxiliary status in 1938 (Larkin, 1983).

As a result, the attribution of responsibility for securing this perceived advance gave rise to a prolonged series of intra-professional disputes between the differing professional bodies keen to ascribe this honour to their own efforts.1

7.2. The Use of Local Anaesthesia in Podiatric Practice prior to 1968.

Although the registration of podiatrists as medical auxiliaries under the BMA regulations had specifically restricted the scope of practice to exclude any invasive procedure which would puncture the "true skin", including parenteral local anaesthetic delivery, this was not legally binding. Practitioners who were not BRMA registered were

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free to access and use local anaesthetics.

Although formally opposed by the medical authorities and the Society of Chiropodists, a small number of practitioners did develop the techniques associated with parenteral local anaesthetic use. It is evident that these practitioners acquired the necessary skills during service in the armed forces, and not via BMA approved training schools. During the Second World War and in the period of national service that followed, podiatrists were permitted to undertake procedures which were outside the scope of practice normally observed in civilian life.

"They'd mostly been in the RAMC during the war. Of course, in the Army you did what you were told whether you were qualified to do it or not. And they had got used to using local anaesthetics for this, that and the next thing and they knew how to handle them. So there was a group of ex-army or air force people who had become proficient and they realised it could be a useful addition to their practices...And it was those people who started the movement" (Transcript 13, 1995).

This view was supported in the accounts of several key informants, some of whom had acquired their skills via military service. In addition, the use of local anaesthesia in podiatry prior to the investigation launched by the Chiropodists Board in 1965, culminating in the report recommending its exclusion in 1968, was largely invisible to the Council of the Society of Chiropodists and to the BMA.
"Very few were using it [LA]. Quite the exception. I mean we had one man on Council I remember, from south Wales, who occasionally talked to us about using ring blocks and he had to explain what he meant by that. Most people were quite indifferent to it and as to the different types of local anaesthetics and their different properties, this was a shock to most people." (Transcript 8, 1995).

For the Institute of Chiropodists the role model for professional advancement was British dentistry, which offered a vision of autonomous and surgically orientated practice. The practice of local anaesthetic injections was also seen by some as a means of elevating the low status of the podiatrist to equal that of the state registered nurse, viewed as enjoying a greater autonomy and status based on their range of approved skills.

"If the future of state registration is to be of any practical value, local anaesthetics will have to be included in the future training of students...State Registered Nurses can give injections, State registered Chiropodists cannot, so the chiropodist is lower in status than the nurse (how ridiculous)." (Lutas, 1961).

The low status of state podiatry in the NHS and the perceived failure of the PSM Act(1960) to enhance prestige re-inforced the belief that podiatry required changes in practice before advancement along the lines of dentistry was possible, and that such advance would validate the expansion of the training course from two to three years,

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3 Lutas J (1961), BJCh, 26:8, p.222.
introduced in 1953\textsuperscript{5}.

However, even within the membership of the Institute there was opposition to the use of local anaesthetics\textsuperscript{6}. The grounds for opposition usually cited were the perceived lack of need for the technique and the fear that it would result in de-skilling, removing the need for the dextrous, careful handling of painful corns which was the hallmark of the traditional "chiropodist"\textsuperscript{7}.

Nevertheless, prominent Institute members ran short courses on the theory of local anaesthetic use in podiatry, and may have run informal impromptu practical sessions for interested colleagues\textsuperscript{8}. However, these courses sought to use only small concentrations of local anaesthetic agents for limited application, rather than signalling an intent to widen the scope of practice into a surgical arena\textsuperscript{9}. The Institute view, then, appeared to suggest that support for local anaesthesia extended no further than its application within the existing scope of practice, not as a means to extend it.

Rank and file Institute members called for plans to formalise training in local anaesthesia\textsuperscript{10}, some asserting that the practice was

\textsuperscript{5} Davis A (1968), "local analgesia", correspondence, BJC, 33:8, p190.
\textsuperscript{8} Roberton JA (1960), correspondence, Chiropody Review, 21:10, p.21; Roberton JA (1961), "Local and Regional Anaesthesia in Chiropodial Practice", BJC, 26:6, 26:7; Roberton JA (1962) "Radical Extirpation of Verruca Pedis", Chiropody Review, 23:6; Roberton JA (1963), Course Advertisement, Chiropody Review, 24:2, p. 25.
\textsuperscript{10} Kendall JA (1962), correspondence, Chiropody Review, 23:9, p.25; Smith ES (1962),
common\textsuperscript{11}. Opposition to the technique was dismissed as "\textit{bigoted rubbish}"\textsuperscript{12}.

The use of local anaesthesia by podiatrists did, however, finally prompt both the Society and the Chiropodists Board to launch separate investigations into the practice, the former a response to enquiries from within the membership\textsuperscript{13}. The Education and Examinations Committee of the Society was directed to investigate the views of the "\textit{Heads of Schools}"\textsuperscript{1}, which agreed that the technique was neither necessary nor desirable.

"\textit{The Heads of Schools met and I was there on the Heads of Schools Association. I remember this because I was one of the people who said I didn't think there was any clinical need for local anaesthetics and therefore said no, I don't think we need it, full stop.}" (Transcript 10, 1995).

The two principle professional bodies in podiatry were diametrically opposed over the issue of local anaesthesia, reflecting the differing strategies of compliance with and independence from medical authority. Whilst the Institute policy was in favour of local anaesthesia\textsuperscript{14}, the Society were opposed to any development which did not enjoy medical endorsement\textsuperscript{15} or might open the floodgates to invasive surgical practice which would provoke medical hostility\textsuperscript{16}.

\begin{flushleft}
\textsuperscript{15} Statement by the Society of Chiropodists (1968), The Chiropodist,23:4, p.131.
\textsuperscript{16} Gibbard LC (1965), The Chiropodist, 20:12, p.374-6.
\end{flushleft}
7.3. **The Medicines Act (1968).**

The Medicines Act (1968) was introduced by the government in response to a legitimisation crisis in an area of healthcare remote from the professional concerns of podiatry. The thalidomide catastrophe had prompted a review of legislation concerning the safety, quality, description, access and administration of drugs and medicines which resulted in the Medicines Act (1968). The Act established a Medicines Commission to advise the Minister of Health, members of which were to be appointed by him after consultation with the Royal Colleges, General Medical Council, Medical Research Council and BMA as well as those organisations representing veterinary surgeons and the pharmaceutical industry. Medicines were re-categorised under this legislation into three types, including local anaesthetic agents in the "Prescription Only Medicines" bracket. The immediate impact of this was to exclude podiatrists from legitimate access to and use of these drugs.

"...doctors, dentists and vets...[were] the only ones with access to the POM's when the Medicines Act changed from 'dangerous drugs' and 'controlled drugs' classifications to 'POM', 'Pharmacy only' and 'General Sales List' drugs...we were out of everything but the GSL drugs and no mechanism existed for getting us into POMs as we were not approved prescribers". (Transcript 1, 1992).

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20 Medicines Act (1968), HMSO. “General Sales List”, “Pharmacy Only”, “Prescription Only Medicines".
This resulted in restrictions which both impinged upon existing practices in podiatry and appeared to eliminate the possibility of any future expansion in access to drugs within the POM category. In a single move the future for expansion in scope of practice along surgical lines, similar to dentistry, had apparently been abolished. The Medicines Act (1968) excluded podiatrists from access to local anaesthetics, and the right to administer them, largely because its authors were unaware that podiatrists would have an interest in their use, rather than as a deliberate attempt to exclude them. It was, however, a tool which medicine would employ in an attempt to restrict podiatric expansionism.

"the Department of Health consulted the people they thought they should - Doctors, Dentists and Vets - as being the only people who prescribed drugs" (Transcript 1, 1992).


The Chiropodists Board appointed a working party to investigate the use of local anaesthesia in podiatry in 1967. Although the Chiropodists Board enjoyed a majority of professional representatives\(^1\), the Working Party held a majority of medical members\(^2\).

Although the Board had previously advised the Society not to


circularise its members to ascertain how many were using the
technique, the final report claimed that there was little evidence of
the widespread use of local anaesthesia in podiatry\textsuperscript{28}.
The report of the Working Party was endorsed by the Board, and
issued to all state registered podiatrists in June 1968\textsuperscript{35}. This
concluded that local anaesthetics should not be used by podiatrists at
all, stressing the dangers the practice would pose to the public, and
the lack of adequate training currently available.

"The Chiropodists Board report on the use of LA was
absolutely damning. It virtually suggested that if
chiropodists were allowed to use it, toes would drop off"
(Transcript 1, 1992).

The principle concern had been the issue of training and scope of
practice, each of which were deemed "insufficient to justify" the use
of local anaesthetics by podiatrists. The report sought to clarify the
extent to which training and education in dentistry differed from
podiatry, emphasising that dental students received a "thorough
training" and that they enjoyed the benefits of a "very close
association with medical schools". The willingness of the podiatrists
sitting on the Board, who were a majority, to acquiesce in the face of
medical opposition reflected the Society belief that little could be
achieved without medical support.

"But we couldn't do much in those days without medical
assistance. We couldn't. You couldn't fly in the face of it."
(Transcript 14, 1995).
7.4. *The Emergence of the Croydon Postgraduate Group and Resistance to the Chiropodists Board Report (1968).*

The Chiropodists Board Report on the use of local anaesthesia in podiatry represented the agreed action of the podiatry and medical members of the Board. The public face of the Society assumed a moderate view, asserting that there might be a "*marginal*" need for local anaesthetic usage by podiatrists but that the training was currently inadequate\(^\text{28}\). The private face of the Council was largely against antagonising medicine, and many were opposed to local anaesthetic usage\(^\text{23}\).

The Society of Chiropodists was alarmed by reports that, following the Medicines Act and Chiropodists Board report of 1968, an independent group of practitioners had formed with the express aim of developing local anaesthetic techniques in podiatry. It immediately attempted to disassociate itself from this development, fearing any threat to its otherwise cordial relations with medicine.

"*an increasing number of chiropodists have been using local anaesthetics, some probably on the strength of their training experienced in the forces, but others without training and possibly without insurance cover. Some chiropodists have been eager to enlarge their scope of practice and to master this particular technique...and have organised and undertaken post-graduate training courses for themselves, with the help of medical consultants."

(Witting, 1970)\(^\text{24}\).

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The Council of the Society regarded this situation as "unsatisfactory", and sought to rectify the problem by instructing its own Education and Examination Committee to create a syllabus which would provide the Society with a means of controlling the practice through an examination process\textsuperscript{24}. It would also provide the way forward by allowing the Society to invite the medical profession to oversee the process, thus eliminating any potential conflict between the professions. The Society was keen to stress the marginal nature of this technique in relation to chiropodial practice, referring to it as "this small problem"\textsuperscript{24}. 

The Croydon Postgraduate Group had formed from a local Society branch\textsuperscript{25} with the express intention of establishing courses in local anaesthesia for state registered podiatrists, as a direct response to the Chiropodists Board report.

"The group was formed with a specific view to running courses in local anaesthesia." (Transcript 2, 1993).

This group sought professional advancement for podiatry through an expansion in role boundaries which the use of local anaesthesia would facilitate. From an early stage the goal of enhancing professional status to a level comparable with dentistry provided the motivation for the group to organise courses in local anaesthesia, radiographic techniques and pathology, all of which would be necessary to

\textsuperscript{25} Initially formed in response to a new scheme introduced by Croydon Council, which would limit the fees paid to private practitioners by patients who fell into the new categories established under the LHA regulations. Cited in Day WL (1965), "Savant", Chiropody Review, 26:8, p.13.
underpin a future shift towards surgical practice.

The definition of scope of practice established by the Chiropodists Board following the introduction of state registration simply specified the scope as \textit{"that which he is trained to do"}. This relatively open definition made possible an expansion in scope of practice, providing the podiatrist was \textit{"trained"}. The Croydon group initially developed courses in local anaesthesia which were run in 1969 and 1970, involving practical as well as theoretical components\textsuperscript{26}. These were carried out in breach of the edicts of the Chiropodists Board, in the face of legislation outlawing the practice and without insurance cover.

\begin{quote}
\textit{"my head was on the block in the first course...we had no insurance...I decided that the only way to do anything was to do it first and argue about it afterwards. Run a course - to hell with it. And thats what we did."} (Transcript 2, 1993).
\end{quote}

The Croydon group had managed to recruit the support of individual medical advisors sympathetic to the podiatry cause, but their input was necessarily limited.

\begin{quote}
\textit{"the anaesthetists were very cagey...because I had told him, in fairness, about the Boards report...So after all that he was prepared to come along and lecture, providing we did the demonstrations. The Faculty of Anaesthetists would not let him get involved, considering the Boards report."} (Transcript 2, 1993).
\end{quote}

Following the completion of the first course, covert contact was established between the Croydon group and the Society of Chiropodists

\textsuperscript{26} Local Anaesthesia Course Attendance Records, Croydon Postgraduate Group 1969, 1970.
Council. This contact appeared to offer the Croydon group implicit support, although official sanction was denied. The Council of the Society remained divided over the issue of local anaesthesia, with some Councillors opposed to action which might provoke medical hostility and others who attended the outlawed courses.

"We knew that other people were or had been involved...I don't think there was any effort at concealment but equally people weren't shouting it from the treetops. [name] was certainly wanting to move, [name] was wavering, but there was still some, quite a fair number of councillors who were not keen to go along those lines. There were some people who were political heavyweights, but weren't particularly keen to upset the applecart..." (Transcript 7, 1995).

The Council of the Society was largely opposed to the use of local anaesthetics, as was the podiatric contingent within the Chiropodists Board, which, although numerically superior to the medical representatives, enjoyed less social and cultural authority. As a consequence, the medical view prevailed in official circles. Any association with the activities of the Croydon group was disapproved and open to censure.

"...lots of our members had already done the Croydon course and they were doing it and it was illegal as far as the Board was concerned - I said it really is a bit of an embarrassment and he [named] said 'and you and ... are the people that are causing the embarrassment', because we were on Council and seen to be leading a rebellion..." (Transcript 7, 1995).

The Croydon courses recruited exceptionally well, attracting the interest of many of the state registered rank and file, beyond the boundaries of the Croydon area\textsuperscript{28}. The sense of professional stasis, lack of development in terms of scope of practice and the link between professional advancement and improved status all contributed to the rise in support for the Croydon group courses.

"By 1968 I was very disillusioned with the limitations of chiropody...When I then heard on the grapevine of...the use of local anaesthesia ...through the Croydon Postgraduate Group. I was looking...to find something that would make the profession more challenging" (Transcript 12, 1995).

The nature of the contact between the Society and Croydon group was highly confidential, the exposure of which "was regarded as personally damaging" to both parties\textsuperscript{29}.

The relationship began to soften, as it became evident that the courses run by the Croydon group enforced high standards which were designed to withstand medical criticism. The Council of the Society also became increasingly aware of the popularity of the courses with the rank and file membership. By 1970 the Society chose neither to actively endorse nor openly condemn the Croydon courses, but to view progress from a distance. Once convinced, the Society would absorb the courses, assume responsibility and approach the medical authorities for approval.

\textsuperscript{28} Laxton RL (1970), personal correspondence to Suvarna RR, 24th February, 1970: "I have been approached by 3 branches and 40 individual members of the Society regarding LA courses".

\textsuperscript{29} Law RWH (1970), personal correspondence to R. Laxton, 18th March 1970.
"the Croydon Post Graduate Group had started teaching it...around Council it was said 'don't get involved with this, let's see which way the cookie crumbles before we get ourselves involved'...in the early stages Council was told to keep away - let's see what's happening, then when it was obviously going to be the thing then senior councillors were put to negotiate with the different [Royal] Colleges [of Surgeons and Physicians] " (Transcript 3, 1994).

The continuing problem for the Society was the need to be seen to observe the state regulations and the law. To have compromised this situation would have been to invite disaster, as it would provide the medical authorities with an ideal opportunity to halt and reverse podiatric expansionist tactics.

The Society attempted to draw up a syllabus for training in local anaesthesia which would be submitted to the Chiropodists Board for approval, and which was based upon the Croydon Postgraduate Group model.

The Institute of Chiropodists also attempted to devise a structured syllabus in local anaesthesia training, but insurance difficulties made practical demonstrations impossible.30 Only the Croydon group was prepared to risk action which might lead to disciplinary action by the State Board.

"Our course had us acting as tutors, not the anaesthetists. The anaesthetists would not touch it because of the Chiropodists Board report. It was a red hot potato " (Transcript 2, 1993).

The position of the Society was clear. In order to retain the

endorsement of medicine, which contributed to the state sanctioned
three year course run by the Society and provided examiners under
the arrangements set in place in 1938, it was obliged to distance itself
formally from the activities of the Croydon group. However, the
advantages which might accrue from the provision of quality courses
in local anaesthesia could advance the scope of practice and prestige
of podiatry.

"it could have been a roaring success, but it could have been
a total disaster - the medical profession could have said 'hey,
these upstarts are doing things they're not supposed to do'
and crunch, they could tread on us. If a dentist loses a
patient in the chair because of inappropriately administered
LA, or whatever else, a doctor or a hospital loses a patient
there is a whole load of rumpus but everybody says, well, you
win a few, you lose a few. But if a chiropodist were to lose a
patient in the same way it could set the whole profession
back" (Transcript 3, 1994).

The Society could not risk either the wrath of medicine nor the
censure of the Chiropodists Board, which would have damaged its
reputation. Medical dominance of the State Board ensured that its
support could not be assured.

"Some councillors were very nervous of the fact that the
Board, which was largely controlled by medics, had deemed
that it was an offence to go beyond the bounds...it was
nervousness that if we went down that road it would bring
the Society into disrepute...and upsetting the Chiropodists
Board, and the legal framework within which we operated,
and that was a great consideration, we couldn't have
everyone being struck off the register." (Transcript 7, 1995).

In addition, the Society was also conscious of the problems which
might arise in its campaign for securing professional closure, by protection of title or scope of practice. The unregistered sector might use any clinical misdemeanour by the registered sector to deflect claims that they were a threat to the safety of the public.

"SMAE would go to town on that....SMAE have always said that chiropodists shouldn't be doing that [using local anaesthesia]" (Transcript 3, 1994).

The Chairman of the Croydon group approached the Society for course insurance cover. In order to increase the leverage of his case, Laxton implied that the rival Institute of Chiropodists might benefit from the Croydon expertise in developing the practical component of their local anaesthesia courses.

"I was quite prepared to imply, ...that if the Society were unwilling to support me I might be prepared to offer the Institute assistance in developing their syllabus for presentation to the Board" (Transcript 2, 1993).

The Society quietly arranged to provide insurance cover for the Croydon courses, having been persuaded of their high standards, and once a number of its own Council members had dignified them by their attendance. It was also a prelude to a formal submission to the Chiropodists Board for approval for local anaesthesia courses.
"it was by the time...that several of our members had been on [the courses] and were actually practising we then decided that we would submit formally to the Board...and I think we more or less decided that it was respectable and worth putting ourselves at risk for. But on the other hand you had to be professionally insured, indemnified and the insurers were willing to take on the professional indemnity for that so that was a service to members who had all put their state-registration on the line, it was part of acting responsibly so that when we went to the Board we had done all the things we should do." (Transcript 7, 1995).

The Medicines Act (1968) had yet to be fully implemented. The Medicines Commission had been created to consult widely with other professional groups in order to highlight and clarify difficulties\(^{19}\). The Croydon group recognised that efforts by the Institute to obtain approval for extremely limited volumes and concentrations of local anaesthetic might jeopardise future attempts to negotiate with the Medicines Commission for unlimited access. Should the medical members of the Board become convinced that podiatry sought only minimal use of local anaesthetics for a restricted range of therapies, then the Medicines Commission might restrict its approval to these minimal levels. The Institute greeted the advent of the Ampin injector system as a major innovation, although this device limited anaesthetic delivery to minimal volume and strength\(^{31}\).

These concerns were amplified when the Ampin company contacted one of the medical members of the Chiropodists Board to promote the Ampin device\(^{32}\).

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\(^{31}\) Bell ME (1969), personal correspondence to Martin JF (Ampins Ltd), 20th June, 1969

\(^{32}\) Veitch-Anderson A (1969), personal correspondence to Bell ME (Ampin Ltd), 5th July
Initially a Society Councillor submitted, as the sole signatory, a minority report to the Chiropodists Board arguing the case for local anaesthesia to become an approved technique. The Society then acted collectively to submit a draft syllabus of the proposed course in local anaesthesia to the Chiropodists Board in 1970, but this was rejected, the Board claiming that the syllabus was "not in any way adequate".

The influence of the medical representatives sitting on the Board, in tandem with those traditional podiatry leaders who also opposed local anaesthesia, was sufficient to quash the usurpationary moves of the Croydon group and the Society itself. Nevertheless the Society delegation to the Board had not expected a rejection and had miscalculated the extent of the Boards opposition.

"I think we all went in person to the Board, and the Chairman of the Board at that time ...who was a traditionalist and an anti-LA man, and another anti - ...a consultant surgeon at the Edinburgh school, a former close colleague of mine, which was a little embarrassing...We presented our case...and we were quite shattered to have it turned down."

(Transcript 8, 1995).

Opinion on the Chiropodists Board was divided, the weight of which was clearly against permitting local anaesthesia. The Society delegation, although hopeful, had been aware of the delicate balance

1969
of opinion which might be swayed in either direction\textsuperscript{35}.

In order to convince the Chiropodists Board to change its stated policy over approval for the use of local anaesthetic techniques, the Society sought to demonstrate that large numbers of practitioners had attended the courses run by the Croydon group as an indication of the demand within the profession for the technique.

"Having run several courses, [named Society Councillor] said to me, 'I want numbers - and with your anaesthetist we should satisfy the Board" (Transcript 2, 1993).

The Croydon Group made considerable efforts to accommodate sufficient numbers to assist the Society's bid to present a strong case to the Chiropodists Board. The numbers had reached 300 by the time the Society's case was finally ready\textsuperscript{36}. The Society reconstructed its syllabus as a postgraduate course of thirty hours duration, and resubmitted it to the Chiropodists Board.

The second Society delegation to the Board had its submission accepted, and local anaesthesia became a state-legitimized, approved technique in podiatry\textsuperscript{37}. Although the terms of the Medicines Act (1968) had yet to be fully discussed with the Medicines Commission, a major obstacle to podiatric expansion in role boundaries had been removed following state approval for this technical advance. The Society declared that the change in stance adopted by the Board had resulted

\textsuperscript{35} Wordsworth V (1971), personal communication to Laxton RL, 18th June.


\textsuperscript{37} "Use of Local Analgesia by State Registered Chiropodists" (1972), Chiropodists Board, The Chiropodist(1972), 27:3, p. 90.
from technical improvements in the safety of local anaesthetic delivery, such as the use of anaesthetic cartridges instead of multi-dose bottles and the development of disposable syringes, coupled with the view that there was "no legal bar" to the use of local anaesthetics, at least until the Medicines Act (1968) was brought into effect.  

The compromise implicit in the ceding of this authority to podiatrists by medicine was nevertheless clear. Podiatrists would have to undertake a course of training which would finally be examined by a consultant anaesthetist, not a podiatrist. The Board was assured that the use of the technique would be minimal "since few of our techniques would be enhanced by its use." In addition, the Board specified that the use of local anaesthesia by podiatrists should be used solely for the relief of pain and not to "enable the practitioner to use techniques which he has not been trained to use".  

There is, however, some evidence to indicate that the change of heart of the Chiropodists Board was due to factors other than an improved course syllabus. Personnel changes on the Chiropodists Board, with more sympathetic podiatrists replacing the hardline traditionalists, may have contributed. In addition, one key informant, an alternate member of the Chiropodists Board at that time, claimed that final

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38 "Local Analgesia in Chiropody" (1972), The Chiropodist, 27:3, p. 88.  
39 "It is apparent that the use of local anaesthesia as a natural part of the technique of chiropody cannot come about without medical goodwill". Hawes KD (1972), Editorial note, The Chiropodist, 27:8, p. 316.
acceptance was granted in the absence of key medical opponents at the crucial meeting which voted on the issue.

"The Chiropodists Board then determined, in 20 minutes on a wet Friday afternoon, with a very poor medical attendance at the Board meeting, and only sympathetic ones at the Board meeting...sometimes things can get slipped through because certain people are not attending, they're not following the drift of the thing. Certainly there were medical members, I can assure you, if they had been present at that meeting...no way, if they had been present, would that ever have got through." (Transcript 19, 1996).

The significance of this success lay in the opportunity it provided for podiatry to expand its scope of practice into invasive surgical work which had been the exclusive domain of the medically trained surgeon or the dentist. For the first time since submitting to the edicts of the BMA under the BMRA regulations (1938) podiatry had extended its legitimate domain beyond the boundary of the "true skin and its excrescences". Although the Board directive had been conditional, designed to limit expansion, its powers to do so were limited by the wording of the definition introduced following the PSM legislation, which specified the limit as that which a podiatrist was trained to do. The implication was, that should podiatrists arrange to train themselves to standards which were comparable with, or equivalent to those of other medical or dental specialisms, the Board could not justifiably refuse further advance.

Although not on a legislative par with dentistry, podiatry had gained a significant foothold in its struggle for greater technical autonomy.
Nevertheless, internal ambivalence had played as significant a role in these events as had external opposition. Some senior Society figures remained suspicious of the motives of the Croydon group, fearing an internal closure strategy which would, in time, exclude other state registered practitioners.

"Before you could go on a [Croydon] course you had to guarantee that you would not communicate the contents of that course to any other person...they wanted to prevent the Schools using it, you see. And it was an attempt to seize on one aspect of the profession and make it a closed shop. It didn't really work." (Transcript 5, 1994).

The Society of Chiropodists assumed control of local anaesthesia training, and the first courses ran on a postgraduate basis from late in 1972, becoming incorporated into the three year initial training from 1977\textsuperscript{40}. The Croydon Postgraduate Group released its control of these courses and turned its attention to furthering surgical development, a process which involved encroachment upon areas of practice associated with medicine and radiography, resulting in considerable inter-professional conflict.

\textsuperscript{40} The Chiropodist (1972), 27:8, p.323; Jenkins GC (1976), "Chiropody - The Next Ten Years", The Chiropodist, 31:12, p.337.

The Medicines Act (1968) had been designed as a consumer protection measure, to ensure that all drug preparation, manufacture and administration was subjected to rigorous control\(^{41}\). In this context, the Society of Chiropodists had welcomed its introduction\(^ {42}\).

The intention behind creating the new drug categories was to ensure that the distribution of drugs would be monitored by those recognised as experts, as dictated by notions of public safety\(^ {43}\).

As the Medicines Act (1968) began to impact upon podiatry, however, it became clear that podiatric practice would suffer from restrictions which would impinge upon its already limited autonomy\(^ {44}\).

The Medicines Commission, a statutory body created within the terms of the Medicines Act (1968), was designed as an "independent" body to advise government. Invested with the necessary authority to make recommendations to government in respect of the implementation of the Act, the Commission worked closely in conjunction with the Medicines Division of the Department of Health And Social

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\(^{41}\) Editorial (1977), Podiatry Association Newsletter, September, p.1


\(^{43}\) Those drugs on the General Sales List would incorporate medications which were regarded as safe for members of the public to purchase for themselves, without recourse to medical (or pharmacy) direction. Pharmacy Only agents could only be distributed by or in the presence of an authorising Pharmacist. Prescription Only Medicines were to be confined to "recognised prescribers".

Services\textsuperscript{45}.

The composition of the Medicines Commission was, predictably, comprised of medical and scientific personnel recruited largely from the Medical and Pharmaceutical Associations, immediately affording the medical profession considerable powers and virtually assuring government endorsement. This body was granted discretionary powers to introduce amendments in the form of exemptions, as it judged fit\textsuperscript{46}. The Commission was to examine the particular requirements of a variety of professional groups with regard to drug prescription, manufacture and administration, and create exemptions under the new legislation to accommodate these needs.

The Chiropodists Board did not have the power to determine the type, form, concentration or volume of local anaesthetic agent available, nor offer administration rights to podiatrists\textsuperscript{47}.

Without the approval of the Medicines Commission, the Chiropodists Board decision to permit the use of the technique of local anaesthesia by state registered podiatrists held little practical meaning.

The ramifications of the Medicines Act (1968) were to span three key areas. First, the Act would deprive podiatrists of the right to manufacture many of their own, topical drug preparations\textsuperscript{48}.

Second, the use of local anaesthetic agents, recently approved by the

\begin{itemize}
\item \textsuperscript{45}Hey CP (1977), DHSS, personal correspondence to J Roberts/JS Holland, 31st October, 1977.
\item \textsuperscript{46}Editorial (1976), PA Newsletter, September 1976.
\item \textsuperscript{47}Neale D (1977), BCJ, 42:2, p.32.
\item \textsuperscript{48}Hawes KD (1975), Editorial, The Chiropodist, 30:7, p.176.
\end{itemize}
State Board, was to be denied them. Finally, and most significantly, there were to be no means for providing for future expansion in therapeutic practices, short of amending an Act of Parliament. The implementation of the Medicines Act did not impact upon podiatry until 1973\textsuperscript{49}. The Society was approached by the Medicines Commission with a view to identifying the extent of drug usage by podiatrists\textsuperscript{50}. Just as the Act itself had failed to recognise podiatry as an occupational group likely to have a significant interest in drug administration, the Medicines Commission gave the Society of Chiropodists ten days in which to respond\textsuperscript{8}.

Although the immediate concern was to retain the right to prepare the traditional array of topical agents, it did not fully consider the implications for local anaesthesia, nor the likely outcome for moves to secure antibiotic, steroid, anti-inflammatory, vasopressor or sedative drugs, which were being targeted by the Croydon Group's national successor, the Podiatry Association\textsuperscript{51}.

The DHSS issued an interim circular distributed to all Health Authorities concerning the implementation of the Medicines Act. In response the Society formed a Medicines sub-committee to consider the Act and its implications. An appeal to the membership was issued to note any difficulty in obtaining drugs normally used in the course of practice\textsuperscript{52}. The DHSS assured the Society that it would be

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consulted on any further proposals regarding the Part III component of the Act, which dealt with the sale, supply, exemptions and special provisions for drugs use\textsuperscript{53}. The DHSS acknowledged that registered podiatrists, like ophthalmic opticians, physiotherapists and rescue teams, had been accustomed to obtaining Schedule 1 and 4 poisons, and that the Medicines Commission would be making recommendations for exemptions, without specifying the contents of the Schedules to the respective Orders in question\textsuperscript{54}.

The Society, on receipt of documents from the Medicines Commission, was willing to accept that the acquisition of rights to prescribe, or use, topical antibiotics and corticosteroids was not forthcoming, but assumed local anaesthetic agents would be protected\textsuperscript{55}. However, a prominent member of the Podiatry Association had become alarmed following comments suggesting that the Medicines Act would deprive podiatrists of local anaesthetics.

"...speaking at the...conference was a pharmacist, who said 'you realise of course that the Medicines Act is going to stop you having access to local anaesthetics' ...And it became apparent that things were in a pretty parlous state" (Transcript 1, 1992).

There is some evidence to indicate that the Society was ill-prepared for the subsequent actions of the Medicines Commission, which sought to impose restrictions in volume and strength of anaesthetic solutions

\textsuperscript{54} Hawes KD (1976), Editorial, The Chiropodist, 31:4, p. 104.
\textsuperscript{55} Hawes KD (1976), Editorial, The Chiropodist, 31:6, p.141.
available to podiatrists. It was willing to acquiesce over certain key issues relating to local anaesthetic access, and the Podiatry Association, fearful of the implications for surgical practice, was prepared to oppose this deference to medical opinion.

As a result the Chiropodists Board elections of 1976 were contested not only by the usual Society Council figures but also by Podiatry Association Executive Committee members, as their body had gained widespread popular support. The popularity of the Podiatry Association in promoting "advanced techniques" persuaded the executive committee to campaign over the issue of the Medicines Act (1968) in the Chiropodists Board elections. The Podiatry Association candidates were elected, defeating two of the Society members who had participated in the initial negotiations with the Medicines Commission.

"the uproar that this, local anaesthesia, [caused], that they had only just got officially into their hands from their own Board, was about to be snatched away from them through the incompetence of the Society, resulting in Read and Suvarna losing their seats - which was unheard of."

(Transcript 1, 1992).

The Medicines Act was due to come into full effect in October 1976, beyond which there could be no negotiation. The Society were

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56 The earliest extant minutes of the meetings of the Executive Council of the Podiatry Association are 18th November 1974, from which it is clear earlier meetings occurred.
58 8 of the 12 podiatry Board members and alternates were also Society Councillors prior to this change, The Chiropodist (1976), 31:12, p. 328.
accused of failing to appreciate the seriousness of the situation in the light of this deadline\textsuperscript{60}.

The Podiatry Association concern was with the Society strategy of compliance in accepting the restricted lists of the Medicines Commission, which would render any future surgical development impossible\textsuperscript{61}.

The Society local anaesthesia courses had been directed by the Faculty of Anaesthetists, which had determined that the anaesthetic solutions used were limited to 1% vials, not the 2% cartridges that the Croydon Group had favoured\textsuperscript{62}. The Medicines Commission subsequently assumed that this would represent the limit of podiatric access to local anaesthetics.

This also threatened to eliminate the possibility of podiatrists developing skills in limb local anaesthesia, culled from American podiatry, which could eclipse medical skill in that area, particularly if access was limited to only 49 milligrams\textsuperscript{63}.

"we got to the stage where they were prepared to offer us 49 milligrams of local anaesthetic, as a total. And of course that was a totally inadequate amount of local anaesthetic...Well of course at that time British anaesthetists knew absolutely nothing about local anaesthesia...he could no more induce anaesthesia in a digit, in a toe, than fly in the air...we had the American technique of inducing anaesthesia, and we were getting anaesthesia consistently." (Transcript 1, 1992).

\textsuperscript{60} Minutes of Executive Committee (1976), Podiatry Association, 27th April, 1976.


\textsuperscript{62} Dagnall JC (1976), Editorial, BJC, 41:9, p.163.

\textsuperscript{63} Dagnall JC (1978), Editorial, BJC, 43:4, p.67.
The Society was criticised by both the Podiatry Association and many rank and file podiatrists for demonstrating an over-readiness to compromise over the Medicines Act\textsuperscript{64}. The Society negotiators believed their move established a foothold for the profession, from which further concessions might be secured.

"...it was actually passed through the Board under 'any other business', it wasn't an agenda item...the Podiatry Association were very angry at this and I got into a lot of trouble from members...for having agreed to a 1% solution. From my point of view, as I saw it, it was getting the foot in the door."

(Transcript 5, 1994).

The new Chiropodists Board, with Podiatry Association representation, sought access to local anaesthetics without restriction\textsuperscript{65}. The maximum safe dosage and "good clinical judgement" were to guide the podiatrist, not a medically imposed limit\textsuperscript{66}. The Board formed a Medicines Committee, to deal directly with the Medicines Commission, excluding the Society from negotiations\textsuperscript{67}. The Society, in response, modified its own submission to parallel that of the Board\textsuperscript{68}. The Board asserted that 1% solutions would demand the injection of unacceptably large quantities of solution to induce anaesthesia\textsuperscript{69}. The Medicines Commission rejected the proposals of the Board, asserting that it saw little reason why state registered podiatrists

\begin{thebibliography}{9}
\bibitem{64} Dagnall JC (1977), Editorial, BJC, 42:5, p. 87-8.
\bibitem{65} Dagnall JC (1976), Editorial, BJC, 41:8, p.149.
\bibitem{66} Hawes KD (1976), Editorial, The Chiropodist, 30:9, p.156.
\bibitem{67} Ariori AR (1977), correspondence, The Chiropodist, 32:2, p.77.
\bibitem{68} Jenkins GC (1976), personal correspondence to Day WL, 21st May, 1976.
\bibitem{69} Hawes KD (1976),The Chiropodist, 31:9, p.146 ; Dagnall JC (1976), BJC, 41:9, p.163.
\end{thebibliography}
should “be dealt with any differently to other members of the public”, effectively relegating podiatry to a lay skill\textsuperscript{70}.

There is evidence that the Medicines Commission had acted to limit podiatric surgical expansion, as “medical disquiet” at the recent attempted use of intravenous sedation for podiatric surgery had been passed to the DHSS\textsuperscript{71}. At a meeting of the Medicines Division of the DHSS and the Chiropodists Board, it became apparent that the former could not discern registered from unregistered, and insinuated that podiatrists were untrained.

\begin{quote}
"One speaker in connection with a matter of which nurses had received special consideration, remarked that 'nurses were trained', implying that chiropodists were not trained!...the DHSS were treating chiropodists as if they were untrained but skilled amateurs" (Ariori, 1978)\textsuperscript{72}
\end{quote}

The Pharmaceutical Society had successfully achieved a six month extension on the implementation of the POM orders, as they were “still negotiating” with government over the British National Formulary, and the Chiropodists Board sought to do likewise\textsuperscript{73}. The Society again, however, sought compromise and agreed to half the maximum safe dosage of local anaesthetic. The outcry from the rank and file was so great that the Society leadership narrowly defeated a vote of no confidence at its AGM in 1978, by using proxy votes\textsuperscript{74}.

\begin{footnotesize}
\begin{enumerate}
\item Hawes KD (1977), Editorial, The Chiropodist, 32:9, p. 313.
\item Ariori AR (1978), PA Journal 2:1, p. 3-5.
\item Hawes KD (1977), Editorial, The Chiropodist, 32:2, p.60.
\item Graham RB (1978), The Chiropodist, 33:6, p. 175.
\end{enumerate}
\end{footnotesize}
"The Society ...were preparing to negotiate and they were going to have a fallback position of half the maximum safe dosage. Which they announced in advance of their negotiations. At the Annual General Meeting at Birmingham, an absolute uproar resulted when we went and spoke and poor [named Society Councillor] was almost shouted off the podium...I think the Society's credibility sank to its lowest ebb." (Transcript 1, 1992).

The Medicines Division of the DHSS agreed to a delay of six months\textsuperscript{75}. The Medicines Commission then presented an alternative proposition to the Chiropodists Board, that a maximum safe dosage of local anaesthetic would be introduced, limiting chiropodists to 30mg bupivacaine or 40mg lignocaine in any 24 hours\textsuperscript{76}. Further modifications were suggested, only to be "forcefully" rejected by the Chiropodists Board\textsuperscript{77}.

Deferment for a further twelve months was agreed, in view of the impasse created by the uncompromising Board stance. However, the Chiropodists Board finally gained an audience with the Minister of State for Health, Dr. Gerard Vaughan\textsuperscript{78}, which was followed by notification that unrestricted access to local anaesthetic agents would be granted, providing the Board in future took a

\begin{quote}
firm stance against the practice by state-registered chiropodists of techniques which the Board itself does not recognise.
\end{quote}

\textsuperscript{76} Hawes KD (1978), Editorial, The Chiropodist, 33:5, p. 131.
\textsuperscript{77} Dagnall JC (1979), Editorial, BJC, 44:9, p. 209.
\textsuperscript{78} Parnell JE (1980), DHSS statement, The Chiropodist, 35:1, p.20; Dagnall JC (1979), BJC, 44:12, p.271.
This represented an explicit medical demand that, in exchange for unrestricted freedom to use local anaesthetics, the Board would be compelled act to prevent surgical development in podiatry. However, if accepted, the Chiropodists Board would actually hold the power to determine the content and boundaries of surgical practice in podiatry. The Chiropodists Board accepted the proposals, which were duly confirmed\(^{80}\).

This was hailed as a "complete victory"\(^{81}\). The Chiropodists Board, under the influence of its Podiatry Association representatives, had abandoned the strategy of compliance with medical wishes in favour of a reasoned persistence, in the hope that the medical authorities would eventually concede.

"There was an official meeting at the Department [of Health]...because we had made so much fuss with Ministers and we had got members of the profession to make a fuss through their Members of Parliament...Eventually they decided that discretion was the better part of valour, get these ruddy chiropodists of their backs and we finally got just the anaesthetics we asked for..." (Transcript 1, 1992)

Although the Chiropodists Board had succeeded in prising open access to local anaesthesia from the Medicines Commission, they had been denied access to several other drugs, including antibiotics, adrenalin, steroids and intravenous valium, which they had sought to underpin podiatric surgical development.


Medical influence over access to drugs by podiatrists extended well beyond the medical members of the Medicines Commission and the Medicines Division of the DHSS. The Faculty of Anaesthetists, Anaesthetists Association and British Medical Association had all consulted the Minister for Health, and the final agreement, although brokered by the Minister, comprised conditions set out by the Faculty of Anaesthetists in a bid to restrain podiatric surgical and anaesthetic expansion. The acquisition of local anaesthesia marked a significant, if limited advance in clinical autonomy for podiatrists. It had been achieved against a backdrop of medical resistance and state indifference. Yet, set in its wider context, this minor advance was outweighed by the extent of the failure to secure drug access on a par with other paramedical workers, such as nurses or rescue workers. Nevertheless, the potential for surgical expansion became a reality, which was to shape the future of podiatric practice and its NHS profile, and lead to a wider conflict with medicine and other paramedical groups.

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Chapter 8

Boundary Encroachment : Podiatric Surgery,

Radiography and Anaesthesia
The period following the approval of local anaesthesia as a legitimate technique in podiatry was marked by the rapid development of invasive surgical practice by members of the Croydon Postgraduate Group, coupled with a supporting framework of study in radiographic techniques and "dissectional" anatomy. The popularity of these activities within the state registered sector resulted in an expansion which led to the establishment of a new national professional association concerned with developing surgical practice and extending existing role boundaries.

This body, the Podiatry Association, challenged the authority of the Society of Chiropodists as the leading professional organisation in podiatry. It also challenged the dominance of medicine in determining the limits of podiatric practice, adopting a more confrontational approach to the medical profession than had previously been the norm.

The Society sought medical endorsement of every technical or political advance in podiatry. The introduction of courses in local anaesthesia within the state sanctioned training schools, run by the Society, was dependent upon medical support.

"Teaching it in the Schools was a major consideration. Where are you going to get the anaesthetists of good will - you've got to generate the goodwill. There is no compulsion. You can't just say you've got to go and teach chiropody students how to use those syringes. It was all a question of gradually building up confidence and compliance with general procedures and getting an overall approval..." (Transcript 8, 1995).

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The Croydon Postgraduate Group rapidly developed a system of "postgraduate" education in podiatry, which was supported by individual medical specialists but not dependent upon formal medical approval. The educational framework adopted was based on part-time, week-end courses in three key areas, designed to underpin surgical practice: "dissectional" anatomy, "interpretive" radiography and "skin surgery". Each course title was carefully chosen to deflect criticism or accusations of deception.

The policy of the Croydon group was to establish surgical practice within podiatry as a norm, without seeking medical approval. The clear encroachment upon the boundaries of medical practice would ensure medical opposition. By developing surgical practice without alerting the medical authorities, the Croydon group leadership sought to invoke common law to protect podiatric surgery. That is, by ensuring that a substantial part of the income from podiatric practice was surgical, and that it had sustained the practitioner for a period of five years, under common law precedent the livelihood of that individual would be protected. This would establish the legal right to practice podiatric surgery without medical interference.

8.1. Boundary Encroachment: The Emergence of Podiatric Surgery

The acquisition of the right to practice local anaesthesia provided the Croydon Group leaders with the opportunity to model podiatric
practice on the more successful practice of dentistry, which had achieved an acknowledged professional status, independent of medicine. The Chairman had acquired basic surgical skills whilst serving at the Cambridge Military Hospital in Aldershot, which included the use of radiographic, local anaesthetic and minor surgical techniques.

"The Society took over running the LA courses, which enabled us to carry on with the development of skin surgery with nail wedge resections and hyfrecations, interpretive radiography and dissectional anatomy" (Transcript 4, 1994)

Although initially confining surgical practice to relatively simple techniques such as removal of toenails, the group advanced into bone surgery under the guidance of a visiting American podiatrist. Podiatry in the USA enjoyed a wider scope of practice and greater prestige than its British counterpart, and assistance from individual American podiatrists was to shape the practice of podiatric surgery in Britain\(^1\). In addition, members of the Croydon Group visited practising podiatric surgeons in the USA, in order to build upon their essentially self-taught surgical expertise, based on preceptor methods.

"Bill Day and Laxton brought Jack Powers over from the States and they were doing a hammer toe operation in Croydon...They came to my surgery and did a hammer toe procedure there and taught me in effect. Bob Prince and Alan Proctor were also doing surgery at that time and we were sort of self-taught at this point. Bob Prince had seen things done in the States..." (Transcript 1, 1992).

The Croydon group initially consisted of small numbers of practitioners, but expanded as news of their innovative surgical activity became known within podiatry. The Society and the medical bodies had not been informed of these developments, although individual sympathetic medical practitioners had been recruited to assist.

Other postgraduate groups began to form, in emulation of the Croydon group which had taught practitioners from many parts of Britain. In order to retain control over the expansion in surgical practice in podiatry, the Croydon group leaders sought to establish a national professional association, the Podiatry Association. This would, however, heighten the profile of the organisation and its surgical activities, and draw the attention of the Society of Chiropodists and the medical profession. The Croydon leadership also became concerned at the rate of surgical expansion, fearing the consequences of litigation and medical opposition.

"within a year we became a digital surgery course - I was beginning to worry about Bob and Alan. One minute they don't know how to put a needle in, next minute they're doing bone surgery. This happened over a two year period, and it's [local anaesthesia] only just got through the Board "

(Transcript 2, 1993).

The Society of Chiropodists immediately disassociated itself from the new organisation as soon as the extent of surgical practice became

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2 Laxton RL (1974), personal correspondence to Dr. J. West, Poole Hospital, 28th January, 1974; Lee M (1972), personal correspondence to Proctor A, 6th December 1972;
apparent. Initially the Society had provided insurance cover for the Podiatry Association members, as they were also Society members, but this was halted once it became known that podiatric surgery was involved.

"With this American influence, you see, Jack Powers and others that Bob Prince had got from going over to the States. And I remember quite distinctly saying to them 'Have you got the bottle for it? - with this you are crossing the rubicon, you are getting into dangerous waters here. The Society will not take this lying down, it will be taken as a threat'" (Transcript 1, 1992).

The Podiatry Association, although initially modelled upon British dentistry, quickly became influenced by American podiatry, which was regarded as a successful and autonomous profession in comparison with its British equivalent, and which willingly gave its support. The approach of the Society in demonstrating deference to medical authority was regarded as ensuring the subordinate status of podiatry, from which the Podiatry Association sought an escape.

"It was obvious that we had to remain separate from the Society as they were obsessed with working close to the medical profession for their own survival. This was not the time to ask the medical profession for permission to perform surgery. Do it first, ask afterwards, as we did with local anaesthetics...the Americans didn't get involved with the medics, they got involved with the politicians. I think their history shows that that was a successful way of doing it." (Transcript 11, 1995).

In addition, the Podiatry Association leaders believed that the use of

\footnote{Kanat I, President of APA (1975), personal correspondence to Laxton RL, 15th April, 1975}
local anaesthesia to perform podiatric surgery would finally provide a clear distinction between the registered and unregistered podiatrist, on the basis of legal rights to a specific skill range. As the unregistered were unable to obtain the certificate in competency in local anaesthesia, which was issued by the Chiropodists Board, they would consequently be unable to develop surgical skills. They would be excluded from podiatric surgical practice, further enhancing the market value of the registered podiatrist.

"Local anaesthesia opened the door for us to carry out procedures which the patient could not do for himself. This was the big difference. Before the Podiatry Association there was no practical difference between a SMAE chiropodist and a state-registered chiropodist" (Transcript 11, 1995)

The Podiatry Association also attempted to increase its authority and power, in order to challenge the strategy of appeasement of the Society of Chiropodists, by campaigning to have its own candidates elected to the Chiropodists Board, which, as previously noted, was successful. The conflict which emerged between the Society and the Podiatry Association revolved around the relationship of each with the medical profession.

“And then suddenly when they, the establishment, were very much in charge and dictating the terms of everything, then these chaps come in and then want to do surgery and of course the Society, some of them, threw up their hands in horror and said 'You'll upset the medical profession!'. Which it did. Which it would, wouldn't it?" (Transcript 10, 1995).

The Podiatry Association were forced to seek independent insurance,
which proved onerous to sustain, as many companies withdrew insurance when they became aware of the nature of podiatric surgery\(^4\). The key stumbling block was that these surgical practices were regarded as outwith the normal scope of podiatry\(^5\).

Eventually, following agreement to satisfy rigorous criteria, laid down by the group itself rather than the Society or the medical profession, to ensure standards of practice, insurance was granted\(^6\).

The Society of Chiropodists had become alarmed at the rapidity with which the Podiatry Association advanced into surgical procedures which were regarded as orthopaedic in nature\(^7\), and following enquiries from the DHSS it withdrew all support from the Podiatry Association\(^8\). The Podiatry Association leadership also realised the dangers inherent in antagonising the medical profession at a time when their practice might be compromised by accusations of inadequate training, and called a halt to further surgical

\(^6\) \textit{the conditions are...} 1) procedures are carried out in a surgery of approved standard and subject to inspection, 2) that these procedures are not carried out independently until a certificate of competence is issued, 3) a comprehensive medical history, as laid down by your group, be taken before any procedure, 4) members of the group should have reached the necessary standard ie. completed a local anaesthesia course, dissectional anatomy course and skin surgery course and received a certificate if competence from the group to perform arthroplasty of the digits..."(Fraser AR, personal correspondence to Laxton RL, 13th February, 1974).
\(^8\) Myers R (1975), DHSS, personal correspondence to Jenkins GC, Secretary of Society of Chiropodist, 3rd November 1975: Jenkins GC (1975) personal correspondence to Myers R, 11th November 1975.
progression^9.

"We sent out a circular...so we stopped. I said 'we're heading for trouble, we could lose all, because the Orthopaedic Association had heard about our bunion surgery...we knew that if you had one bad claim that went through Lloyds you would then be doubling up on your insurance and that would finish you." (Transcript 4, 1994).


Running in parallel with the programme of expansion in surgical practice, the Podiatry Association attempted to expand its activities into other areas of medical practice, most notably radiography. This policy of encroachment led to interprofessional conflict with radiography, a fellow supplementary profession, and, later, the Royal College of Radiologists.

Very few practising podiatrists possessed X-ray equipment or attempted to access the facility before the development of the first formal course in radiography run by the Croydon Postgraduate Group in 1973^10. A small number of practitioners had been trained in radiographic techniques during service in the armed forces, as had been the case with local anaesthesia and minor surgery. In addition,


^10 Ronald Laxton claimed in interview to have conducted an extensive telephone survey in 1963 and concluded that no more than 10 podiatrists were using X-Ray equipment at that time.
there was no legislation to prevent podiatrists from purchasing and using X-ray equipment in the course of their work during the 1960s or 1970s.

Although some of the state recognised training schools in podiatry possessed X-ray units as early as 1947, only qualified radiographers used the equipment.

"At the London Foot Hospital we had the facilities, but we had a Radiographer to take them for us - we never took them ourselves, we used to employ a Radiographer to take them". (Transcript 14, 1995).

The Society of Chiropodists had approached the BMA and Society of Radiographers regarding the difficulties faced by podiatrists in the access to X-ray reports and the commissioning of X-rays from radiologists as early as 1968, but had been rebuffed. The Society had been informed that podiatrists

"had no right to make a direct approach to a radiologist or commission a report"11.

Further approaches to the Faculty of Radiologists and the Radiologists Group Committee of the BMA received the same dismissive reply12.

Interest in radiographic technology as a means with which to elevate the status of the podiatrist emerged at this time13. Comparisons drawn between British and American podiatry concluded that the

prestige of the UK profession fell far short of its American relative, and that the technical autonomy of the latter had been enhanced by the freedom to employ radiographic techniques in achieving independent diagnoses.

"Our American friends for instance take their own radiographs to assist them in diagnosis; in fact they would claim that you could not make a diagnosis in the majority of cases without the aid of radiography...In this country it is argued that as we have orthopaedic surgeons to do the surgery, radiologists to give us X-ray diagnosis and physicians to prescribe medicines, we should be encroaching on their provinces to attempt to enter these fields" (Dagnall, 1963)14

The creation of courses in radiographic technology and techniques by the Croydon Postgraduate Group in 1973 was part of a planned expansion to follow the model of British dentistry as much as an emulation of American podiatry. The use of American podiatric techniques, however, became an integral part of British podiatric practice. A unique device designed to permit X-ray images to be taken of the foot, which had no parallel in British medical practice, was introduced by the Croydon Group following the American example15. The course was referred to as "interpretive" radiography, in order to clarify the point that the planned encroachment would not extend to the core medical responsibility of diagnosis, but would provide a guide for surgical intervention, similar to the practice of dentistry.

14 Dagnall JC (1963), BJC, 28:8, p. 247.
"We called our courses 'Interpretive' Radiography - we are not making a clinical diagnosis, we want to see what the bones look like as we are performing bone surgery - I am not operating on a cancer, or whatever. The terms of reference are different, rather like the dentist before he takes a tooth out - before I do it I want to interpret the angle, the amount of alignment...otherwise you have no justification for it." (Transcript 4, 1994).

The emphasis on the use of the term "Interpretive" as opposed to "Diagnostic" (and Radiography as opposed to Radiology) was designed to assuage the fears of the Society of Chiropodists and the medical profession that podiatrists were attempting to practice the medical skills of radiological diagnosis. To have used the term "Diagnostic" would have been difficult to justify in view of the limited extent of their practice.

However, the Croydon Group paid little heed to the possibility of provoking hostile reactions from the radiography profession. The use of X-ray technology within podiatric scope of practice would allow podiatrists the opportunity to raise their status by expanding their technological repertoire and improving their therapeutic, rather than diagnostic, capabilities. In this respect the threat to medical power was less obvious than the encroachment upon the skills of the radiographer. Through the Croydon Postgraduate Group podiatrists attempted to assume skills which were essentially the province of the radiographer.

The Croydon Postgraduate Group looked to America for support in running their first interpretive radiography course. A prominent
American podiatrist spécialising in podiatric radiography agreed to participate in both radiographic and surgical demonstrations. The invitation to the American highlighted the precarious position of podiatric radiographic expansion in Britain at that time.

"You will appreciate that due to the chiro-political situation here we must tread carefully at this introductory course and play down ownership of X-ray machines...in this country, chiropodists are not practising major foot surgery but only simple digital procedures..." (Francis, 1973).

The first course also received the support of members of staff from the School of Radiography at Kings College Hospital, London, who were paid high fees for their contribution. The Principal of the school of radiography also participated, following a visit to the practice of the Croydon Group Chairman to view the range, safety and standard of the radiographic equipment in use.

The standards of practice demanded by the Croydon Group of its members ensured that the group would be able to withstand criticism from external agencies. The group was aware that the dental profession had been experiencing difficulties with accidental over-exposure of fingers whilst holding X-ray film in situ. The Radiological Protection Service of the Ministry of Health introduced a

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16 Dr. Milton Lewis, Head of the X-ray Department at the Chicago College of Chiropody 1949 - 1962, author of two recent texts in podiatric radiography.
new finger tip dosimeter in a bid to overcome this problem\textsuperscript{22}.

"At the time we were doing our radiography there were still one or two dentists getting over-exposure of the thumb when they were putting the apical film in place by holding it themselves rather than getting the patient to hold it... So because we were introducing it we took care, having lead shields, sending in the meters every three months [radiation monitor meters] to be read" (Transcript 11, 1995)

The Croydon Group adopted a cautious approach in order to secure the support of the Society, to help counter any medical threat\textsuperscript{23}. Consequently their attention to safety measures was a major focus, particularly in view of the legislative requirements set out under the new Health & Safety Act, introduced in 1974, which regulated X-ray use\textsuperscript{24}. The Postgraduate Board of the Society, although prepared to validate courses run by their own Branches as well as the Podiatry Association, were deeply concerned at the prospect of podiatrists acting outwith the limits of their expertise, in particular by physically directing X-rays themselves, essentially a radiographers role\textsuperscript{25}.

For the Podiatry Association the legal position surrounding the dispensing of ionising radiation was ambiguous under the Health and Safety Act (1974). In addition, the support of the Society of

\textsuperscript{22} Jones BE (1966), Memorandum, March 1966, RPS, MoH & Medical Research Council.
\textsuperscript{25} Minutes of Postgraduate Board (1976), Society of Chiropodists, 14th May, 1976; Minutes of Postgraduate Board (1976), Society of Chiropodists, 10th Sept, 1976.
Chiropodists and the school of radiography could not be relied upon to continue without ensuring every necessary precaution had been taken.

By 1976, external agencies had become aware of the radiographic practices of the Podiatry Association, and sought details to clarify their extent and nature. The National Radiological Protection Board, the Society of Radiographers and the Royal College of Radiologists all raised initial enquiries with the Society of Chiropodists, as the professional body recognised by the state as representing podiatry.26 One key issue of concern had been reports of podiatrists physically directing X-rays from dental units which had been adapted for podiatric use.27

The Education Committee of the Podiatry Association was completing its plans for the introduction of an examination structure for membership to the Podiatry Association. The aim, to introduce a certificate in podiatry, was consistent with the policy of development which involved a strategy of internal closure, creating a division within podiatry delineated by the use of credentials which would establish a "virtuoso" role for the surgical practitioner, capable of curing deformity in the foot, with the aid of radiographic technology.28

The Society of Radiographers objected to the practices of the Podiatry

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27 Law RWH (1976), Hinders-Leslies Ltd, personal correspondence to Laxton RL, 28th April, 1976.
28 Minutes of Education Committee (1976), Podiatry Association, 15/16th May, 1976.
Association, whose activities were seen as an encroachment upon the legitimate duties and functions of radiographers. As a consequence, the Society of Radiographers formally withdrew all support for courses in which radiographers might be engaged in the teaching of radiography skills and practices for the benefit of, and use by, podiatrists.

"We then went through the Society of Radiographers...and as a result the Society of Radiographers trade union complained, no, we shouldn't be taking X-ray pictures, it should be them that should be doing it...They stopped...all the radiographers being involved with the training of chiropodists in interpretive radiography, which meant the teaching of the practice of radiography, the taking of X-ray pictures, development and interpretation of films."

(Transcript 11, 1995).

The Royal College of Radiologists joined the Society of Radiographers in its condemnation of podiatric involvement in radiographic technology. As a result the CPSM called a meeting of each of the interested professional bodies to discuss the conflict. The DHSS was also informed, and asked to intervene over the issue of the refusal of NHS X-Ray departments to accept referrals from podiatrists.

"The organisations of both Radiologists and Radiographers seem to have 'set their faces' against active co-operation, ie. teaching and participating in courses of instruction"

(Hutchinson, 1977).

The CPSM meeting drew together the Royal College of Radiologists, College of Radiographers, the Radiographers Board, Society of Chiropodists, Podiatry Association and the Chiropodists Board.

The Chiropodists Board themselves had also become involved in negotiations with the Society of Radiographers and the National Radiological Protection Board, as a result of the increasing use by podiatrists of X-ray technology. The core concern of the Royal College of Radiologists was the protection of the role of diagnostian, and less with the encroachment upon radiographic work, although other medical bodies also became involved.

As the legal requirements for the use of ionising radiation had been met by the Podiatry Association, they could not be forcibly halted. However, access to radiographic support or radiological referral remained blocked. Negotiations between the Chiropodists Board and the Radiographers Board continued unresolved for over a decade, although the challenge to radiographers role boundaries was not limited to podiatry.

The question of the legal right of podiatrists to access X-ray facilities

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33 Donald BL (1977), Registrar, CPSM, personal correspondence to Graham R, 6th May, 1977.
34 Within a month the talks had been extended to include the Faculty of Anaesthetists and the BMA, in response to Podiatry Association encroachment upon other areas of medical practice, notably in the use of intravenous sedation. Cited in Donald BL (1977), Registrar, CPSM, personal correspondence to Graham R, 15th July, 1977.
35 Dagnall JC (1985), BJC, 50:1, p.16.
whilst engaged in private practice, as opposed to NHS practice, concerned the dispensing of ionising radiation. Although podiatrists practising within the NHS were bound by local agreement or NHS regulations, those in private practice were subject only to the legal restrictions, which, prior to the 1974 Health and Safety Act, were embodied within the Ionising Radiation (Sealed Sources) Act (1969). The key elements of all legislation regarding the use and dispensing of ionising radiation from the enactment of the Health and Safety at Work Act (1974) until the introduction of the POPUMET regulations (1988) placed the emphasis on an ability to satisfy Health and Safety supervisors that premises were provided with suitable safety methods, in the form of lead floor lining, lead shields and aprons, radiation monitoring badges and satisfactory operative X-ray machinery. Providing these measures were undertaken, no other qualification was required in law of those practitioners engaged in the processes of taking and interpreting X-rays, including podiatrists.

The POPUMET regulations (1988) consisted of a mandatory training programme for all those intending to undertake the dispensing of ionising radiation involving patients.

37 Although a further series of legislative changes were enacted, in the form of the MARS regulations (Medicines - Administration of Radioactive Substances Regulations, 1978), and Ionising Radiations Regulations (1985), it was not until the POPUMET (1988) regulations came into force that a legal requirement was introduced ensuring that all those taking and interpreting X-rays had undergone a "core of knowledge" training.

38 POPUMET: Protection Of Persons Undergoing Medical Examination and Treatment Regulations (1988)

The Podiatry Association immediately incorporated "core of knowledge" training courses to satisfy these regulations. The key significance of the POPUMET regulations for podiatry was the legal right to physically as well as clinically direct X-rays. However, the issue of podiatrists accessing radiographic or radiology facilities within the NHS was not resolved primarily because of opposition from the Royal College of Radiologists and College of Radiographers. As podiatric surgical activity increased, so did the demand for radiological and radiographic support. The increasing sophistication of radiographic investigation rendered the purchase of equipment by podiatrists impractical. The Royal College of Radiologists advised its membership that non-medically qualified people might request X-rays, but that the radiologist was invested with the authority to accept or reject the demand.

Even following the NHS reforms of the 1990s, podiatric surgeons, appointed at consultant level for NHS Hospital Trusts, largely failed to secure the co-operation of radiography or radiology departments, in spite of access to other support facilities.

"podiatrists have actually been appointed as specialists in podiatric surgery - given theatre time, given nursing time, given all the infrastructure, and they can't get an X-ray. In the local hospital a podiatrist had been appointed as a specialist in podiatric surgery and given all the surgical access that he could wish for. But he was not allowed any access to X-rays" (Transcript 16, 1996).

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40 PA/BCP course programme 1st April, 1989
41 Confirmed in interview by Dr. I. Turnbull, Senior Consultant Radiologist, 1996.
Podiatric boundary encroachment into the radiographic domain had in reality been largely defeated by the power of medical dominance. Whilst able to satisfy the formal regulations concerning the use of ionising radiation, as had osteopaths and others, crucial access to NHS radiographic and radiological services continued to be denied on the authority of the radiologist.

8.3. Boundary Encroachment: Intravenous Sedation for Podiatric Surgery - The Response of the Anaesthetists

In 1977 the Podiatry Association had become concerned with enlarging the scope of drug access and administration rights, which was threatened with the impending implementation of the Medicines Act (1968). The approach of the Society of Chiropodists had been interpreted as reflecting traditional “chiropody” values and did not accommodate the needs of a rapidly expanding scope of practice involving surgical advances.

In response, the Podiatry Association leadership arranged a course to introduce intravenous valium administration into the repertoire of podiatric practice in a bid to extend drug access rights prior to the final implementation of the Medicines Act. This would also enable the podiatrist to perform more advanced surgery without having to rely upon general anaesthesia, which was totally inaccessible. The reaction of podiatrists towards the Medicines Act (1968) had taken the Medicines Commission by surprise and, for a period, created an
ambiguity surrounding the interpretation of the Medicines legislation which the Podiatry Association attempted to exploit to their advantage. The use of intravenous sedatives for podiatric surgery had been influenced by clinical developments in both American Podiatry and British dentistry. It had been considered a significant advance in the practice of dentistry, facilitating more invasive surgery without the need to resort to general anaesthesia42. This extended from conservative dentistry and the treatment of mentally-handicapped patients, where compliance might otherwise have been problematic, to oral surgery 43.

The techniques established closer parallels between podiatric and dental practices, although British dentistry distanced itself from comparisons with podiatry, which it viewed as inferior44. The American podiatry profession had, however, already embraced intravenous sedation with enthusiasm45.

The Podiatry Association arranged a two day postgraduate seminar in intravenous sedation, which involved the administration of valium to patients prior to podiatric surgery 46.

The status of podiatric access to valium under existing legislation

(prior to the implementation of the Medicines Act, 1968) was ambiguous, a position exploited by the Podiatry Association. One of its members, elected to the State Board, felt assured that approval from the DHSS was to be forthcoming\(^{47}\). In addition, attempts to obtain valium from pharmacists had met initial resistance, but access was granted on the advice of the Pharmaceutical Society, permitting the course to proceed\(^{48}\).

"...And [PA Executive member] assured me that he had even got one of the Ministers coming down to see the course, that everything was arranged...Because there was a lot of trouble about the purchasing of valium, and I think at the time it was arguable...he was saying there is nothing to stop you going into a Pharmacy, for your work, and demanding that you be sold valium, IV or tablets. Which I did. I went in, we had the argument, they phoned the Pharmaceutical Society and I was sold them...We quickly got hold of valium and thought 'this is it'. (Transcript 11, 1995).

Styled as an "Advanced Local Analgesia Course", the programme was constructed around key lecturers, all consultant anaesthetists in NHS employment\(^{49}\). The content of the programme advanced existing podiatric practices in three areas: through intravenous sedation, below knee local anaesthetic administration and the parenteral administration of vasopressor drugs in surgical emergencies\(^{50}\). However, several problems arose. First, the assurance that had

\(^{47}\) Laxton RL (1977), Diary Entry recorded 18th February 1977.

\(^{48}\) Receipts for the valium purchased by the Podiatry Association Chairman remain extant, dated 9th December 1977.

\(^{49}\) Dr C Birt and Dr R Leatherdale, Consultant Anaesthetists, Poole Hospital.

\(^{50}\) Podiatry Association (1977), "Advanced Local Anaesthesia Course Programme", 5th -6th March, 1977.
apparently been given by a Minister from the DHSS supporting the course did not materialise. Second, inadequate safeguards had been put in place to ensure patient safety\textsuperscript{51}. 

"We had patients wandering around in a daze, with no one to take them home and no one at home to look after them...Intravenous valium was one of his [PA Executive member] little babies that went wrong and that wasn't good politically. " (Transcript 11, 1995).

The Faculty of Anaesthetists became aware of the course and responded immediately to halt any further use of intravenous drugs by podiatrists, asserting the illegality of the practice and claiming in a letter to the Chiropodists Board that it was "outside the scope of practice of anyone other than a trained anaesthetist"\textsuperscript{52}. The Association of Anaesthetists of Great Britain and Ireland embarked upon a fact finding inquiry into British podiatry, and voiced specific concerns about the use of intravenous valium\textsuperscript{53}. The Podiatry Association hastily withdrew from courses in intravenous sedation and did not attempt to repeat the exercise, following the severance of relations with the Society of Chiropodists over the affair\textsuperscript{54}. The extent of medical hostility in response to the

\textsuperscript{51} For example, the Medical Defence Union specified the need to ensure patients are accompanied home after IV sedation. Cited in Dando P, "Medico-legal Aspects of Minor Surgery", Medical Defence Union publication.

\textsuperscript{52} Donald BL (1977), Registrar CPSM, to Graham RB, Secretary Podiatry Association, personal correspondence, 12th August 1977.

\textsuperscript{53} Minutes of Meeting of Emergency Meeting of Executive Committee, Podiatry Association, 3rd April, 1977; Laxton RL (1977), personal correspondence to Rosen T, Association of Anaesthetists, April 23rd 1977.
encroachment of podiatry into radiological, anaesthetic and surgical practice had proved too great, and the Podiatry Association were forced to retreat.

"...if it had paid off valium would be a controlled part of practice. It meant that you would be regarded as educated in your profession to use valium with your own patients. Had it been alright it would have been another step forward. But that wasn't to be and we paid the price for failure."

(Transcript 11, 1995).

The weak position of podiatry was again highlighted by its inability to resist medical dominance in preventing a successful encroachment into IV anaesthesia. Medical outrage was sufficient to ensure that the Medicines Commission did not permit an extension of the exemptions under the Medicines Act to include IV sedatives in podiatric practice.

8.4 Boundary Encroachment: Podiatric Surgery and The Response of Orthopaedics.

Popular support for the Podiatry Association had resulted in the loss of the Society's pre-eminence upon the State Board55. The Chiropodists Board had been alerted to the surgical activities of the Podiatry Association and sought clarification from the Podiatry Association as to its scope, relations with medicine and the authority to control its membership56.

56 Donald BL (1979), Registrar, CPSM, personal correspondence to Graham RB, PA Secretary, 7th August, 1979.
However, as has been noted, most of the earlier enquiries to the Chiropodists Board arose from medical bodies such as the British Medical Association, Faculty of Anaesthetists, Association of Anaesthetists and Royal College of Radiologists during the initial phases of expansion and encroachment by the Podiatry Association. The extent of the threat to these medical specialisms, although new, was largely peripheral to the core work of radiologists or anaesthetists. The expansion of podiatry posed a far greater and more direct threat to orthopaedic surgery.

The first formal objection to the practice of podiatric surgery from the medical specialism of surgery outlined its intent to limit podiatry to the scope of practice laid down by the BMA in 1938. There was concern over the distinction between the traditional term “chiropodist” and the newer term “podiatry”, in which the latter was taken to represent an insidious American influence advocating surgery that had “infiltrated” chiropody.

"The working party of the College...has for so long been considering what advice it should offer to assist the Chiropodists Board to protect the practice of chiropody from the infiltration of podiatrists has at last reached a conclusion...' That in the interest of patients' safety, chiropodists should be allowed to operate only upon the skin of the foot and those structures (such as callosities and toenails) which derive from it. This resolution is being forwarded to the Conference of Medical Royal Colleges and their Faculties in the UK, if they agree, be able to bring it to the attention of Health Authorities..." (Johnson-Gilbert, 1980) 

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57 Johnson-Gilbert RS (1980), RCS, personal correspondence to Donald BL, CPSM, The
The Society of Chiropodists publically condemned this action by the Royal College of Surgeons, responding not only to the RCS itself, but also writing to the Minister of State for Health, forwarding copies to the Registrar of the Chiropodists Board\textsuperscript{58}. Nevertheless, the Society pursued a damage limitation exercise, rejecting demands that podiatry should revert to its 1938 scope of practice yet attempting to smooth relations with the Royal College of Surgeons by asserting its wish that the latter should continue to assist podiatry in its development\textsuperscript{59}. The Royal College of Surgeons replied that it would reconvene its working party investigating the practice of surgery by podiatrists after the next meeting of the Chiropodists Board, "in the hope that some acceptable compromise can be reached"\textsuperscript{60}. The Society sent representatives, including a prominent podiatric surgeon serving on the Society Postgraduate Board, to meet the Working Party of the Royal College of Surgeons, at which they presented a formal statement asserting their support for podiatric surgical advancement, and their right to control such developments\textsuperscript{61}. Recriminations within podiatry spread as it became apparent that


\textsuperscript{60} The Chiropodist (1980), Statement by the Royal College of Surgeons, 35:3, p.90.

some traditionalists within the Society had written to the Royal College of Surgeons to invite their "protection" from "the infiltration of podiatrists", referring to the surgical members of the Podiatry Association\textsuperscript{62}. However, members of the Chiropodists Board were incensed by the interference of the RCS, and pointed out that its authority did not extend to defining the limits of podiatric practice.

"Then there is the fact that the letter from the College was not only arrogant but foolish. Foolish, in that the College has no authority to rule on the scope of chiropody and no power to enforce its rulings. Foolish, in that there is a statutory body that has the authority and power - the Board."

(Dagnall, 1980)\textsuperscript{63}.

Further meetings between the Royal College of Surgeons and the Society of Chiropodists revealed the underlying medical concern that British podiatry would seek to emulate its American counterpart and significantly intrude into the orthopaedic domain.

"It seems that the main worry of the Royal College is that British chiropody will follow the pattern of American podiatry." (Smidt, 1980)\textsuperscript{64}.

The Society appeared in danger of being usurped by the challenge from the Podiatry Association for authority on the State Board, resulting from its popularity with the wider state sector membership\textsuperscript{65}. In turn, certain traditionalists on the Board

\textsuperscript{64} Smidt L (1980), Statement by Chairman of Society, The Chiropodist, 35:5, p.182-6.
\textsuperscript{65} Dagnall JC (1980), BJC, 45:9, p.207.
appealed to the BOA for action to control podiatric surgical expansion, duly identified as senior Society figures⁶⁶, who denied any attempt to undermine surgical practice in podiatry⁶⁷.

The Chiropodists Board moved to install an advisory committee on the development of surgical practice in podiatry, in a bid to demonstrate to the medical authorities that it was acting responsibly and that medical co-operation would ensure a greater medical voice in the decision making process⁶⁸. The conflict over surgery in podiatry highlighted the fact that the authority to determine the existence or extent of podiatric surgical practice was invested in the State Board, rather than the medical bodies. Significantly, the first challenge to the surgical sovereignty of the RCS since dentistry had exposed a weakness in the medical case, which was later to be more fully exploited by the Podiatry Association.

The activity of the Chiropodists Board in promoting podiatric surgical development, coupled with the increasing numbers of surgical operations being carried out by podiatrists, further alerted the medical profession to the surgical ambitions of the Podiatry Association.

The British Orthopaedic Association launched an offensive against what it perceived as an insidious development and directed its members to disassociate themselves from podiatry. This directive also

acknowledged a failure of orthopaedic surgery to address adequately disorders of the foot, which had been commonly ranked as low status work to be delegated to junior staff, creating an unmet market need exploited by podiatrists.

"An increasing number of these practitioners, who have no basic surgical training are appearing in Great Britain and are known to carry out orthopaedic operations on feet and, it would seem, higher up in the lower limb...The appearance of a 'service' of this type suggests to some extent, a failure on the part of orthopaedic surgeons to satisfy demand...The Executive also wished to stress the undesirability of any direct association between the BOA and podiatrists, in particular with regard to training in operative techniques." (British Orthopaedic Association,1981)69.

The British Orthopaedic Association circulated copies of its directive to a wide variety of medical bodies, including the BMA, Royal College of Surgeons, Royal College of General Practitioners, The Vascular Surgical Society of Great Britain, British Diabetic Association, British Association of Rheumatology and Rehabilitation and the Association of Anaesthetists70. The Times Health Supplement also reported on this issue, further widening the audience71.

The BOA clarified the orthopaedic view that surgical procedures ought not to be performed by "non-medically trained" personnel72, and that the podiatric scope of practice should be limited to that agreed

71 Times Health Supplement, 27th November, 1981.
under the 1938 medical auxiliary regulations\textsuperscript{73}.

The Podiatry Association responded by asserting a clear difference between orthopaedic surgery of the foot and podiatric surgery, based upon the use by podiatrists of underlying principles of "foot function", inferring a superiority of podiatric theory over the mere cosmetic corrections carried out by orthopaedic surgeons.

"...Indeed we also refuted that podiatrists were carrying out orthopaedic surgery but were in fact carrying out podiatric surgery; a considerable difference...We have asked the President of the BOA to retract the statement that he has made...undoubtedly it is due to the fact that BOA and its members are feeling threatened by the obvious success that podiatrists are having with foot surgery" (Bell, 1982)\textsuperscript{74}.

The BOA threatened to withdraw support for the examinations of the Society of Chiropodists, an endorsement of Society policy which had existed since medical auxiliary status had been granted by the BMA\textsuperscript{75}. Without its support the Society could no longer run its pre-registration course with medical approval, a prized source of prestige and status.

The Society adopted a conciliatory tone and again sought to distance itself from the activity of podiatric surgeons\textsuperscript{76}, a move which was rewarded with a letter of assurance that the BOA would not withdraw

\textsuperscript{74} Bell DRC (1982), "Podiatrists and Surgeons", BJC, 47:6, p.112.
\textsuperscript{76} Jenkins GC (1982), personal correspondence to Mitchell GP, BOA, 27th February, 1982.
support from the Society, but sought only to outlaw surgical podiatry\textsuperscript{77}.

The difficulties within podiatry over the best course of action to pursue in the face of medical criticism created divisions, essentially between the Society, seeking legitimacy through medical approval, and the Podiatry Association demanding freedom to operate without reference to medicine\textsuperscript{78}.

The development of podiatric surgery also drew criticism from within podiatry for its exclusionary nature, seeking to create an internal hierarchy with podiatric surgeons occupying the most prestigious, elite positions. This strategy of internal closure was opposed most vociferously by the Institute of Chiropodists, already increasingly excluded from the privileges of state recognition.

\textit{"it is being taken to mean that a podiatrist is superior to a chiropodist, and that podiatry is in advance of chiropody...it will increasingly endanger the livelihood of other colleagues and confuse the public"} (Shipper, 1983)\textsuperscript{79}.

The Joint Consultants Committee of the BMA issued a statement in full support of the British Orthopaedic Association, endorsing its view that surgery should be limited to medically qualified personnel\textsuperscript{80}.

The reluctant stance of the Society led the Chiropodists Board to exclude it from future meetings with the Royal College of Surgeons regarding podiatric surgery, which laid the foundations for the

\textsuperscript{77} Mitchell GP (1982), personal correspondence to Jenkins GC, 12th March, 1982.
\textsuperscript{78} Dagnall JC (1982), Editorial, BJC, 47:7, p. 127.
\textsuperscript{79} Shipper SG (1983), BJC, 48:1, 1983, p.11-12
establishment of a Working Party on Chiropodial Surgical Practice. The BOA, however, continued to oppose any recognition for the practice of podiatric surgery, asserting that claims to parity with the primary fellowship examinations of the RCS were "manifestly untrue".

However, at this stage all podiatric surgery was practised wholly in the private sector, essentially marginal to the established health services. The Podiatry Association sought to establish greater legitimacy for podiatric surgery through the authority of the State Board, within which it could exert some influence. This influence first secured the addition of the Podiatry Association surgical qualification to the list of designatory letters recognised by the Board, and finally the formal recognition of "Ambulatory Foot Surgery."

A modification was introduced under the Statement of Conduct issued by the Disciplinary Committee of the Chiropodists Board to assert the legitimacy of the practice of surgical techniques by state-registered podiatrists. Following the decision of the Board to recognise

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podiatric surgery, the Society actively supported the integration of podiatric surgery within the NHS, the prime objective of the Podiatry Association\textsuperscript{88}.

The British Orthopaedic Association had failed to eliminate or prevent podiatrists from undertaking invasive surgery, in spite of vociferous efforts to contain this development. Yet the Podiatry Association had not yet challenged orthopaedic surgery within the NHS, the heartland of medical dominance. The next phase of usurpationary activity was designed to establish podiatric surgery within the NHS, and the Health Service reforms of the 1990s would help to promote this objective.

\textsuperscript{87} This amendment established the phrase \textit{ambulatory foot surgery}, implying a specific form of surgery which would be performed under local anaesthesia, enabling patients to undergo such surgery on a day-case basis.

\textsuperscript{88} Smidt \textsc{L} (1985), "Address to the Council of Society", The Chiropodist, 40:9, p.271-4.
Chapter 9

Podiatry in the "New" NHS:

The Impact of General Management,

the Internal Market and GP Fundholding
The final data chapter examines those key developments within podiatry which occurred during the period following the introduction of the “new” NHS reforms\(^1\). These reforms form the backdrop against which the recent changes in education, knowledge organisation and practice of podiatry are mapped. The impact of the NHS reforms spanned three distinct areas, which are examined in turn.

First, the academic advances which followed the advent of graduate status, in line with other paramedical professions, appeared threatened by plans to re-integrate podiatry education within the NHS. This was opposed by the profession on the grounds that it would adversely affect the academic credibility gained by association with the higher education sector.

Second, the core practice of “podiatric biomechanics”, which initially appeared to provide podiatry with a knowledge base distinct from that of medicine and a justification for podiatric surgery in the NHS, was subject to greater scrutiny in response to the “culture change” in the NHS (Stocking, 1995). This change resulted in the emergence of evidence-based practice research as part of a new strategy to ensure clinical effectiveness (Baker, 1995; Stocking, 1995). The impact of this change appeared to undermine podiatric claims to biomechanical therapeutic effectiveness.

Third, the integration of podiatric surgery within the NHS, achieved

\(^1\) Following the White Paper “Working for Patients”(1989).
with the support of general management, appeared to suggest a successful usurpation of medical control and an extension in the legitimate role boundaries of podiatric practice. Conversely, non-surgical podiatry faced cuts within NHS Trusts, unwelcome competition from unregistered podiatrists in GP fundholding work and a disintegration in career structure within the NHS. Medical authority appeared to have been extended as fundholding GPs were provided with purchasing power over podiatric services, counterbalancing the perceived success of podiatric surgery. A brief examination of the importance of the NHS reforms in the professionalisation of podiatry is relevant.

9.1. Podiatry and The NHS Reforms

The NHS and Community Care Act (1990) and the preceding White Paper\(^1\) established the principles of an internal market, or "managed market", with divisions between purchasing authorities and provider units (Ham, 1995). The reforms sought to address the chronic financial problems facing the NHS, improve the efficiency of services and firmly establish the shift from health service administration, or consensus management, to general management, a process initiated by the Griffiths reforms of 1984 (Cox, 1991; Ham, 1994, 1995; Honigsbaum, 1995; Strong and Robinson, 1991). The impact on podiatry, as on other health care professions, emphasised the need to operate within a competitive marketplace, to
demonstrate value for money through the introduction of quality measures such as clinical audit, and to respond to local needs (Brooks, 1995).

The ascendency in primary care, including the introduction of GP fundholding practices, provided both opportunities and threats. The opportunities arose in the provision of foot surgery which was cost-effective, clinically effective and accessible in comparison with orthopaedic services. The threat to podiatry arose when GP fundholders exercised the authority to purchase non-surgical podiatric services from unregistered podiatrists, introducing competition on an economic basis, rather than employing a credentialist agenda.

Within the new Hospital and Community Trusts the general management structures enabled podiatric surgery entry to those established areas of health service provision from which they had previously been excluded. The authority of general managers to determine the nature of service provision, rather than medical opinion, facilitated this advance. Yet the financial constraints implicit within the new scheme also meant that cost-efficiency and patient need demanded a prioritization of services which made non-surgical podiatric services vulnerable to rationalisation. Whilst the authority of medicine to exclude competition from podiatric surgical services had been diminished, so too had the limited autonomy of podiatry, which was subject to the purchasing power of the GP.

Podiatric management suffered from a dismantling of internal
hierarchies, flattening career structures and a deprofessionalising reduction of services to locality management.

The increasing emphasis on clinical audit and clinical effectiveness brought into question the principles upon which certain podiatric practices were based. The introduction of clinical accountability through evidence-based practice demanded a clear evaluation of therapeutic action and outcome. Podiatric biomechanics and its underpinning theory was exposed to empirical research and found wanting, threatening to undermine podiatric claims to a unique body of knowledge with important therapeutic applications.

Education and training had undergone a gradual shift from NHS funded institutions towards higher education over the previous two decades, a trend which was viewed as elevating the status and credibility of podiatry. Degree awards for all undergraduate podiatry courses had been achieved just as the new reforms were introduced². The NHS reforms sought to re-integrate all non-medical education within the NHS, which also threatened to expose the training establishments to competitive market forces which, it was feared, few would survive. Each of these issues will be addressed in turn.


The link between educational developments in podiatry and the impact of the NHS reforms was established within Working Paper 10, a Department of Health initiative designed to realign the funding of all non-medical education and training from the education sector to the NHS\(^3\).

These plans also proposed that training and educational activity was to be subject to a competitive NHS marketplace, which posed a dual threat for the profession at the beginning of the 1990s - a potential reduction in schools of training, which would be funded solely on the basis of NHS needs, and a subordination of professional aspirations to NHS service requirements.

The recent transition in podiatric education, with the advent of degree awards and graduate status, had occurred within a relatively short timespan. Prior to degree awards, qualification involved certification from the professional body, the Society of Chiropodists, which came to be known as a diploma by the mid-1980s. Although aspirations to graduate status preceded the reality by several decades, it was only by 1990 that the conversion was complete\(^4\).

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Under Working Paper 10 the onus was to fall upon Regional Health Authorities for allocating funds, planning and assessing demand in order to ensure adequate provision for the needs of the new NHS\(^5\). In some cases, such as nursing and midwifery, where the education and training of NHS personnel already operated mainly within the NHS, little change was initially forecast\(^3\). However, for other groups, in particular the "professions supplementary to medicine" a radical shift in funding arrangements was implicit within the terms of WP10\(^6\).

The additional guidance provided to those stakeholders involved in commissioning or providing services for the NHS by the DoH outlined the delegation of responsibility for assessing demand to NHS trusts and directly managed units\(^3\). It also categorically placed full responsibility for manpower planning with "those who are providing the service", leaving to them the task of determining the balance of staff training requirements, skills and skill mix. These requirements would then be vetted by each Regional Health Authority on the basis of available financial resources, recruitment possibilities, training capacities and costs, and the "changes in


standards expected” by professional bodies.

One other feature which was to have a potential impact on podiatric education and training was the necessity for Regions to have a broad awareness of where to locate training establishments. The Podiatry Advisor to the DoH noted this as problematic, due to the low profile of podiatry within the NHS.

“If a school of podiatry has not made itself known to a Trust, the Trust might not even know it is there and no money would go its way.” (Transcript 25, 1996).

All educational institutions were to have clear contracts with purchasers of training in order to guarantee security of funding.

The response of the PSM professions, including podiatry, was one of caution and dismay, expressed in a CPSM conference report to Stephen Dorrell, Under Secretary of State for Health, in July, 1991.

The principle concerns outlined by the PSM registration Boards centred around the belief that these arrangements took no account of their input to non-NHS employment, the difficulties created by competitive tendering from currently “un-approved” training institutions and the practical problems of establishing contracts. The problem of contracting for podiatric education and training was regarded by the advisor to the DoH as inordinately complex.

“If we had gone fully into Working Paper 10 originally, each Trust would have had a separate contract with each school...What a mess, an administrative nightmare.” (Transcript 25,1996)

The key, immediate flaw in Working Paper 10, as far as podiatry was concerned, was its overwhelming emphasis on the provision of staff based on NHS manpower needs. This took no account of the numbers of registered podiatrists ("one third of that profession") which were claimed to be working in the private sector.

Another concern for the PSM professions arose from the proposals by Regional Health Authorities to link the reforms of Working Paper 10 to the introduction of skill mix. This led to considerable debate within the CPSM Council and dialogue with representatives of the Regional Health Authorities. The argument against the skill-mix measures hinged on the following points. First, certain mundane duties which were to be delegated to "assistant" grades often required the application of an abstract knowledge which only the fully trained professional possessed, and mistakes might lead to litigation. Second, those staff who were "trained, as opposed to educated" would lack the capacity to judge the boundaries between tasks within their competence and those outwith it. Finally, protection of the patient was cited as the foremost responsibility of the professions, which would be compromised by delegation to the extent proposed by Regions. Regions were portrayed as acting only to limit expenditure, using "assistant" grades as cheap alternatives to fully-trained professionals.

The RHA representatives countered with those concerns relevant to NHS needs. These included NHS manpower projections, which

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8 CPSM (1991), "CPSM and the NHS Reforms", CPSM publication.
indicated an imminent shortfall in available school-leaver recruits\(^9\), an upsurge in technological advancement which rendered many tasks "simple and straight-forward" and the new NHS focus on quality outcomes rather than quality input measures, which, it was argued, could be enhanced through skill-mix.

There was implicit criticism of the shift from diploma to degree status by the PSM professions, which could not be justified in terms of service requirements or service provision. Refusal on the part of the CPSM to co-operate, it was suggested, might lead to the elimination of some of the smaller professions.

> "the professionalising process is being primarily driven by the education sector and the professions rather than the by explicit service requirements...which has relatively little legitimacy as far as NHS management is concerned...a consequence of the [refusal to co-operate], might be the extinction of some of the smaller professions" (Vickerman, 1991)\(^7\).

In addition to the general problems facing all the PSM professions under WP10 outlined above, specific issues of importance for podiatry resulted in its exclusion from the transfer of funding of education and training to the NHS.

The Society of Chiropodists noted that the lack of a national perspective when deciding upon Regional manpower needs created difficulties. Qualifying students seldom sought employment exclusively in the local Regional area. They also trained students for

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independent, private practice, which, it was claimed, had no relevance to NHS manpower planning.

The Society also objected to the restriction upon patient profiles which would result from exclusively accommodating NHS needs, under the terms of the NHS regulations, limiting them to the elderly, handicapped and children categories. In addition, the proposals suggested that recruitment would operate at a level reflecting current NHS provision, which had already been deemed inadequate to meet existing needs.

There was a fear that variations in Regional requirements, which would be accounted for in a flexible, sliding scale funding scheme, might lead to redundancies and closures of schools. The mandatory grant award system was to be replaced with a bursary mechanism funded by the local Regional Health Authority, which was to be conditional upon a fixed term commitment to work within the Region.

Podiatry was exempt from the initial implementation of Working Paper 10. The "functions and manpower" review introduced by the Secretary of State in 1993 (Ham, 1995), culminating in "Managing the New NHS" outlined the new structure of NHS management, with the

12 Dobby J, (1993), "An Evaluation of Courses of Training and Education which lead to State Registration as a Chiropodist", CPSM publication.
dissolution of Regional Health Authorities and their replacement with regional offices of the NHS Executive. As a result the Department of Health did not press podiatry to enter the Working Paper 10 arrangements\textsuperscript{13}. Whilst podiatry sought to retain its HEFC funding, this too presented problems, as outlined by the podiatry advisor to the DoH. In addition, this informant suggested that the transfer of funding for podiatric education and training to the DoH was inevitable.

"The profession believes it trains for a mixed economy and that it is better off in higher education...HEFC are equally facing serious financial problems...education will come under the microscope...the Department of Health feels it has responsibility. The whole question needs to be led by manpower requirements. For the Department of Health to be involved and responsible is the only way forward." (Transcript 25, 1996).

Podiatric education was left in limbo, marginalised and operating under different funding arrangements to the other PSM professions. However, recent evidence indicates the accuracy of the above account, which further highlights the weakness of the profession in influencing funding arrangements\textsuperscript{14}.


\textsuperscript{14} A recent press release from the Secretary of State for Health, Frank Dobson, outlined new proposals to integrate all health care professional funding, including podiatry, into the NHS. All tuition costs will be met, and NHS bursaries available, from September 1998. This confirms the account of the podiatry advisor to the DoH. Cited in DoH Press Release, 23rd September, 1997.
9.3. *Podiatric Biomechanics: The Implications of Evidence-Based Practice for Podiatry in The New NHS.*

Larkin (1983) referred to the self-perception of podiatrists as "cinderella" practitioners, lacking scientific and therapeutic credibility, and noted the absence of a sound scientific identity, distinct from medicine. These observations relate to podiatric education, training and knowledge in that they serve to demonstrate the core deficiencies which modern podiatry sought to address through invasive surgical practices and the development of a podiatric science, referred to as "podiatric biomechanics". This "science" was claimed by podiatrists as unique to their own professional practice, providing a discrete body of knowledge separate from medicine, employing a distinct vocabulary and asserting a new framework of pathology amenable to podiatric diagnosis and treatment. There is evidence that it continues to be regarded as the defining feature of modern podiatry, providing an identity carefully guarded from interlopers (Philps, 1995). The application of this knowledge also provided podiatry with apparently effective and unique therapeutic capabilities previously lacking.

This science, imported from American podiatry during the 1970s, served to differentiate traditional, palliative "chiropody" practices and theory from new "podiatric" theory and practice, affording the practitioner the status of diagnostician. It became the cornerstone of a quest for scientific legitimacy, and enabled podiatry to shift its attention towards new, higher status client groups, such as athletes,
sportspeople and children\textsuperscript{15}. In addition, it provided podiatry with the means to pursue an imperialisation of the body, extending its authority to regions of the body beyond the traditional boundary of the foot.

It was also used to further legitimise surgical practice in podiatry, by enhancing understanding of overall foot function. This in turn was to be used to persuade NHS employers of the benefit to patients of the application of this form of science-based surgery, enhancing both the market position of podiatry and its relative prestige and status within the formal health care system\textsuperscript{16}.

It also provided podiatry with the tools to fill the void in the market created by the poor regard for foot surgery within orthopaedics and to lay claim to this jurisdiction\textsuperscript{17}.

However, increasing pressure to provide scientific justification for clinical practices, culminating in the new NHS Research and Development Strategy (1991) ensured that evidence of clinical effectiveness would guide purchasing decisions in future\textsuperscript{18}.

Contemporary research began to reveal flaws within the core assumptions upon which the practice of podiatric biomechanics was

\textsuperscript{15} The traditional, lower status patient group was the elderly, for whom palliation was the only achievable goal of treatment.


\textsuperscript{18} "It may come as a shock to realise that most of what is offered by health professionals is actually based on opinion rather than research". Baker M (1995), "Reinventing Healthcare", in 1995/6 NHS Handbook, NAHAT.
built, undermining already precarious claims for legitimacy. In addition, dissemination of these methods to other groups, who rapidly assimilated the techniques and knowledge base, deprived podiatry of its unique expertise in this field. In any case, the adoption of American podiatric biomechanics was not unanimously supported by all podiatrists in the UK, creating further difficulties in establishing its use.

"This American idea - they're looking for...something that will set them apart, give them a unique status and position. They have been struggling for legitimate recognition, they say...what we now call biomechanics, quite a bit of that is based on anecdotal ideas. Not all of it has been subjected to strict scientific scrutiny." (Transcript 19, 1996).

Yet the impact of foot biomechanics, devised by an American podiatrist in the late 1950s, was significant, and hailed as a science which would provide podiatry with an identity and credibility.

"Root is almost revered as a God because basically what he did was, almost singlehandedly, he established a scientific basis for chiropody/podiatry...David Hayward ever after said it had given him some insight into Paul's experience on the road to Damascus, and I don't think that was an exaggeration. Certainly the whole of [podiatric] surgical practice is based on biomechanics, the whole of orthotic therapy is based on biomechanical principles." (Transcript 15, 1996).

The growing emphasis on clinical effectiveness and the development
of knowledge-based research in the NHS ran in parallel with an emerging research base in podiatry, resulting from the shift to degree education. This resulted in research investigations which began to unravel many of the assumptions upon which the "Rootian" practice of podiatric biomechanics was based.

Work began to expose as inaccurate claims that biomechanical techniques were reliable or that biomechanical orthotic devices prevented the onset of deformities and suggested that these therapies accelerated the pathological processes\(^\text{22}\).

This uncertainty had implications for podiatric surgery within the NHS. Part of the key to legitimacy was the distinction between podiatric and orthopaedic surgery, based on the application of biomechanical principles, in order to argue that podiatric surgery was not a medical task, but a podiatric function, based on a greater understanding of foot function.

"I think we've a different approach - I think our training makes us different. We worry about foot function. That's linked with understanding mechanics, and with some understanding of how the foot's going to function on the ground rather than how it looks." (Transcript 24, 1996).

It is, however, significant that the relative lack of sufficient research

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data to underpin many of the podiatric biomechanical assumptions guiding podiatric surgical intervention was also cited as a reason why further expansion in the physical boundaries of podiatric surgical practice is currently unlikely.

"I don't see surgery moving outside [current boundaries]. We have so much to do to perfect what we do do, and not only to perfect it but to understand it because we can't claim to understand HAV deformity. The biomechanical theories are not adequate and not only are they not adequate but when we even think they work there's no evidence beyond heresy. I think Kilmartin's exercise with the children was interesting because it didn't support the well-believed hypothesis. It didn't show us what we ought to believe either." (Transcript 24, 1996).

9.4 Podiatric Practice in a Primary Care Led NHS : The Impact of GP Fundholding.

In 1993, the GP fundholding scheme was first expanded to include certain community services, most notably district nursing, health visiting, dietetics and podiatry (Ham, 1994; Petrioni, 1993). This renewed emphasis on primary care afforded the fundholding GP considerable power, as both a commissioner and provider of services. Crucially, fundholding GPs were invested with the power to negotiate contracts with individual providers, and to "shop around to get the best value for money" (Petrioni, 1993). They were also free to employ "such staff as they require" and to pay them as they saw fit, without any obligation to observe national pay awards or guidelines (Shapiro, 1995; Petrioni, 1993).

Initially, the Society of Chiropodists was hostile to the introduction of
the new GP contracts, shortly preceding fundholding status, with prospective powers to employ community health service staff such as podiatrists. This represented a threat to the autonomy of the podiatrist, who had previously worked independently of immediate medical direction, a point of pride for many podiatrists. There was concern that the poor image of the podiatrist would lead the GP to refer only routine, mundane cases, depriving podiatrists of access to more varied and responsible work. In addition, there was considerable anxiety over the prospect of GPs discarding national pay agreements and failing to provide podiatrists in their employment with adequate working facilities.

Furthermore, a key point of conflict arose from the belief that GPs, under the "entrepreneurial ethos" of fundholding, would compete with podiatrists in carrying out minor surgical procedures such as removing toe-nails under local anaesthesia, which would result in deskilling. The Society outlined its concern to the Royal College of General Practitioners and in a journal editorial.

"The Society has...grave concern[s] at the thought of some GPs 'having a go' without any practical training. They [nail operations and ankle block anaesthesia] require a high level of manual dexterity, which is part of every state registered chiropodist's expertise. Is a GP going to be able to achieve a similar dexterity by watching a video or an afternoon's instruction?" (Berry, 1990)

Similar concerns were expressed when GP fundholding came into full

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effect, including the realisation that state registration was no longer a pre-requisite for employment by GPs\textsuperscript{24}.

The Department of Health issued recommendations to fundholding GPs, indicating that employed podiatrists should be asked to renew their registration annually, but refused to impose a registration requirement on fundholders\textsuperscript{25}. In addition, the NHS Executive published guidelines in which it was suggested that GP fundholders "may wish to specify" state registration, but did not insist upon it\textsuperscript{26}. This appeared to render state registration meaningless, for although the NHS Executive and DoH issued recommendations and endorsements of state registration, they did not require it\textsuperscript{27}.

This exemption extended only to fundholding GPs. Health Service Guidelines directed Health Authorities to engage only state registered practitioners, which became law under the Health Authorities Act(1995), effective from 1st April 1996\textsuperscript{28}.

The Chiropodists Board sought clarification of the position regarding GP fundholding from the Welsh Office Health Department, which refused to insist that GPs conform to state registration requirements for podiatrists in their employment\textsuperscript{29}.

GP fundholding served to highlight an emerging distinction between


\textsuperscript{25} Berry BL (1993), "Chiropody services and general practitioners", Editorial, JBPM,48:3, p.35-6.

\textsuperscript{26} NHS Executive (1995), (HSG(95)28),1995.


\textsuperscript{28} Health Service Guidelines (1995), (HSG(95)11).

types of podiatric services. Although certain aspects of podiatric care appeared to be threatened, such as minor surgery, and the autonomy of those practising mainly traditional, palliative skills, podiatric surgery flourished\(^\text{30}\).

Podiatric surgery offered cost-effective, quality treatments, without the expense of hospital bed costs. Although willing to undertake minor surgical work themselves, GPs were much less likely to attempt the type of procedures offered by podiatric surgeons. The prospect of unregistered practitioners acting as potential competitors held little fear for podiatric surgeons, as they would not attempt to engage in surgery which was well beyond their scope of training or practice. The following account, of a prominent private sector podiatric surgeon working for fundholders on a cost per case contract, illustrates these points.

"I think some of them [GPs] do their own minor surgery - I don't get any nail surgery from one practice I deal with but they send me all the bone surgery and all the odd foot problems. And they send me their failed nail surgery cases...We have one here...an unregistered chiropodist working in a doctor's surgery at their invitation...But what's interesting is that they send their query foot problems to me." (Transcript 24, 1996).

The traditional, more basic skills associated with "chiropody", nevertheless remain the central core of podiatric services provided by NHS Community Trusts. The threat to these services posed by GP fundholding was seen as much greater, as competition from cheaper,

unregistered practitioners was permissible, as it was from registered private practitioners, who could approach GPs directly for work, as noted by one informant, an NHS general manager.

"I think because podiatry is a small amount of money for each practice it's going to get away with it for a while longer. It presents more opportunities than threats at the moment because Health Authorities are able to work with GPs. There is also the opportunity for individual chiropodists to go out and work with GPs on their own. Maybe that's the future. That's the essence of the new reforms - providers can go straight to the source. There's no middle man." (Transcript 22, 1996).

The division between the success of podiatric surgery under GP fundholding and the threat to non-surgical podiatry widened. In non-surgical, traditional podiatry work, standards were perceived to have lowered, due to the employment of unregistered practitioners, poor conditions and terms of service. The podiatry advisor to the DoH outlined this concern.

"The only concern we have about fundholding is that standards appear to be dropping. That is, practitioners are prepared to accept standards that certainly weren't acceptable in the NHS, such as facilities, accommodation and equipment, and even at the rate at which they treat a patient. A GP sees a patient at 5-10 minute intervals, why can't a chiropodist do the same? Equally, it's about a cupboard and why do you need a consulting room like mine? " (Transcript 25, 1996).

Podiatric surgery thrived under GP fundholding. Clinical autonomy may have been dampened, as GPs specified the services they purchased, but surgical decisions were largely independent of GP control. Podiatry emerged as a provider of foot surgery where
orthopaedic surgery, its only competitor, failed to meet demand, having relegated surgery of the foot to a lower status than other areas of orthopaedic interest\textsuperscript{31}. The cost-effectiveness, quality (measured through surgical audit), accessibility and a lack of comparable services offered by competitors, made podiatric surgery an appealing service option for the fundholding GP, who was apparently unconcerned with the boundary dispute between podiatry and orthopaedics\textsuperscript{32}.

"...it's been a rip-roaring success. No doubt about it. Fundholding is now sustaining and promoting podiatric surgery. And, in fact, the Department of Health has about finished its survey and research into cost-effectiveness of podiatric surgery and I can tell you...the GP practices side is very positive - yes please, we want more of it. That's because they are able to specify and they can buy what they want." (Transcript 25,1996).

9.5 The Impact of General Management and the "Internal Market" on NHS Podiatry

The internal market was designed to establish a competitive marketplace and act as an incentive to improve efficiency, cost-effectiveness, quality of treatment and increased responsiveness to patient needs (Ham, 1995; Maynard, 1993; Strong and Robinson, 1991). The introduction of a range of quality standards, covering areas such as waiting times, patient satisfaction and a requirement to subject


clinical practices to clinical audit followed (Brooks, 1995; Flynn Williams and Pickard, 1996; Ham, 1994).

The increasing emphasis on quality issues, accountability to purchasers (whether managers or fundholding GPs) and clinical effectiveness became the key motivating factors shaping the delivery of podiatric services in the new NHS.

The introduction of general management, following the "Griffiths Report" (1983), gave managers authority to manage across professional boundaries, at each level, which was extended under the reforms of the 1990s, with wider powers to operate within largely autonomous Trusts (Ham, 1995; Strong and Robinson, 1991).

The impact of management scrutiny of podiatry was similar to that encountered by other health care professions. Podiatry services were accountable to general managers and service managers were required to justify podiatric clinical practices. Many perceived this as a threat to their departmental autonomy, noted by one key informant.

"When general management came in it was probably the worst thing that could have happened to chiropody. It shouldn't have been, but it was. The result was fairly insular departments affronted by these general managers coming up and saying to them 'what do you do?'. They said 'How dare you ask me what I do, I'm a District Chiropodist'...if those individuals [general managers] don't understand something they are spending half a million pounds on...they are going to ask questions and they are going to come to some conclusions." (Transcript 22, 1996).

Although the growing power of the managers, facilitated through the NHS Management Inquiry Report (1983), chaired by Sir Roy Griffith, Managing Director of Sainsburys supermarket chain.
new reforms, became ever stronger, it was easier for them to exercise their power over the smaller professions, who were seen as softer targets than medicine. The need for cost efficiency within existing financial limits meant that when service cuts became necessary, non-surgical podiatry would be vulnerable. The result was a contraction of podiatry services within Trusts, and non-voluntary redundancies.

"A lot of Trusts were under a great deal of financial pressure. Individuals, held responsible, were saying 'if I don't get my finances in order, I'll be sacked - what can I hit?' Well, they would go for District Heads and break them down into localities or care groups. Chiropody simply did not give itself a good enough profile" (Transcript 22, 1996).

The growing emphasis upon evidence-based clinical effectiveness by purchasers was also seen as an area of relative weakness for conventional, non-surgical podiatry services. Failure to provide adequate evidence of effectiveness in future would, it was predicted, lead to further cuts in services.

"Until we've got our act together and start presenting a unified, evidence base, then we will not make progress and you will see more of the Winchesters" (Transcript 25, 1996).

Following the implementation of the reforms, traditional podiatric services within NHS Trusts became a focus for savings resulting in service cuts. The NHS was considered to be over-staffed. The


utility of existing podiatric services was questioned, and cuts imposed where practices were not adequately justified\(^\text{36}\). Although a relatively inexpensive service, the low profile and nature of the "basic" work being carried out left it open to criticism\(^\text{37}\). However, the appeal of the more specialised podiatric surgical services rose dramatically. NHS managers, increasingly convinced of the greater cost-effectiveness, quality and availability of podiatric surgical services in comparison to those of orthopaedic surgery, led to the establishment of podiatric surgery within the NHS, in the face of fierce medical opposition. In spite of this success, however, it will be demonstrated that these apparent gains in clinical autonomy and freedom from medical dominance were limited. Nevertheless, the support of the empowered NHS managers bestowed a legitimacy on NHS podiatric surgery which had previously been denied.

9.6. *The Impact of the "Internal Market" on NHS Podiatric Surgery*

As a result of the NHS reforms, fundholding GPs and NHS Trusts became more autonomous (Ham, 1995). Within the Trusts, managers were afforded the power to employ staff as considered appropriate to meet the needs of the patients served\(^\text{38}\). Although likely to take advice upon clinical matters from healthcare professionals, particularly medical practitioners, they were not obliged to act upon

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\(^{38}\) DoH (1989), "Working for Patients", para 3.11.
If managers could be convinced of the benefits to patients and purse alike of podiatric surgery, then medical objection alone would be insufficient to prevent the establishment of podiatric surgery within the NHS. This potential had been recognised by the Podiatry Association in advance of the Griffiths reforms, which set the agenda for later progress within the new NHS.

It was at this time that the Podiatry Association sought to limit the use of the word “podiatry” to signify only podiatric surgical practice, distinct from the title “chiropodist”, which was to be left to describe the traditional skills associated with that name by public and medicine alike. The internal closure mechanism employed, which required stringent post-registration qualifications for membership, ensured the Podiatry Association course the distinction of being the only adequate surgical training which could withstand medical objections.

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41 “...not only would we save the Government millions of pounds...but would also save the general public considerable discomfort and waiting time...With the introduction of General Managers...we will be making representations to show how we could assist to this end.”. Cited in Bell DRC (1985), “Chairman’s Message”, PA Journal, July, 1985, p.2.
42 Although one individual podiatric surgeon had succeeded in securing a recognised post within the NHS as early as 1977, this success was considered so vulnerable that the postholder requested the Podiatry Association Executive to refrain from mentioning it in discussions with the British Medical Association, for fear it might “jeopardise the precedence to be set within the NHS”. Cited in Allard-Williams M (1977), personal correspondence to Laxton RL, 26th July, 1977.
criticism\textsuperscript{45}.

The leaders of the Podiatry Association saw an opportunity not only to establish a recognised surgical service in the NHS\textsuperscript{46}, but also a distinction between the mundane, low status practices generally linked with the chiropodist and the more prestigious practice of surgery \textsuperscript{47}.

However, the subsequent move by the Society of Chiropodists to incorporate the titles "podiatrist" and "podiatric medicine" prevented the Podiatry Association from establishing a distinct and separate identity for its new, better qualified, foot specialist\textsuperscript{48}.

The Podiatry Association forwarded evidence of the cost-effectiveness and auditing practices of its surgical practitioners to the DoH in a bid to secure formal recognition for NHS practice\textsuperscript{49}.

The issues of quality service provision and the importance of medical endorsement for the practice of NHS podiatric surgery became central to the acceptance of podiatric surgical integration in the NHS.

\textsuperscript{45} "It would be irresponsible to train people to do bone surgery, with a background of chiropody training as their only academic qualification. We would merely be branded by the medical establishment as technicians who do not have the necessary medical knowledge to cope with the problems that arise from surgical practice..." Cited in Bell DRC (1984), "Chairman's Message", PA Journal, January, 1984, p.2-3.


9.6.1. **Podiatric Surgery: Quality Assurance in the NHS.**

The Podiatry Association viewed the growing emphasis on quality of care measured through clinical audit as an opportunity to demonstrate its worth\(^{50}\).

It proceeded to build upon the scant earlier data on NHS podiatric day surgery with a view to constructing a firm basis to argue for the establishment of podiatric surgery in the NHS. Several other pieces of work were undertaken in support of NHS podiatric surgery, on the basis of day care surgery, improved discharge rates, surgical outcomes and the advantages of podiatric surgery over traditional chiropody\(^{51}\).

By 1994 the Podiatry Association was able to point to an increasing number of official appointments for podiatric surgeons within the NHS\(^{52}\).

The Society of Chiropodists latterly attempted to compete with the Podiatry Association in establishing podiatric surgery within the NHS, but its surgical training syllabus was regarded as inadequate by the medical allies of the latter\(^{53}\).

It also disagreed with the PA strategy for establishing NHS podiatric surgery, reflecting again its policy of appeasement in the face of


\(^{51}\) Ariori, Graham and Antony (1989); Hood, Kilmartin and Tollafield (1994); Kilmartin, Tollafield and Jones (1991); Laxton C (1993); Milsom P (1995); Poole G (1994); Tollafield (1993); Tollafield and Parmar (1994); Turbutt (1994).

\(^{52}\) Editorial, (1994), Podiatry Association Newsletter, September, 1994, p.3.


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medical hostility, and its tendency towards compromise.

"The Podiatry Association strategy for gaining formal medical recognition and integration within the NHS has had insignificant results...The Society is certain that working closely with orthopaedic surgeons is an important way of making NHS podiatry treatment available to all those who might benefit from it" (Berry, 1989)54.

By 1995 the availability of podiatric surgery was becoming noted in the medical press55. Comparative medical audits were carried out, under medical direction, examining the provision of forefoot surgical services by orthopaedics, podiatry and general practice and which addressed efficiency and effectiveness together with market pressures on services. Podiatric surgery emerged as the option most likely to be selected by GPs56.

The Podiatry Association circulated the main findings of the recent COPSS57 report on foot surgical services to General Practitioner, which praised podiatric surgery and highlighted its popularity 58.

The key factors cited as enhancing the establishment of podiatric surgery in the NHS have been cost-effectiveness, clinical effectiveness, market need in an area neglected by mainstream

medicine and, most significantly of all, accessibility.

"As you know, the waiting lists for orthopaedics, nationally, are the worst in comparison to all the medical specialty waiting lists, so it's access that, I think, has won the day. Cost ultimately will creep into it, but it's so hard to compare at this moment in time...It's been accessibility. They've been prepared to do it. I would say the average waiting list is three months and no longer for foot surgery. In orthopaedics the average is way beyond the Patient's Charter norms." (Transcript 25, 1996).

The notion that the podiatric surgeon would be more practised, and therefore more proficient at foot surgery than an orthopaedic surgeon also appears to have been a powerful factor in the argument to employ podiatric surgeons in spite of formal orthopaedic objection, as noted by the general manager key informant.

"If you look at the general surgery that doctors do, how do they become surgeons? They work with other surgeons and they develop their skills. But they actually get their practice from doing it. I think if you've got a podiatrist who's done 300 small toe procedures, I would rather have him or her than an orthopaedic surgeon who does them once a year."

(Transcript 22, 1996).

The vigour with which the Podiatry Association appeared to address the issues of quality assurance in the provision of podiatric surgery was regarded as important in ensuring its survival within the NHS.

The recent White Paper "Service With Ambition", emphasised the requirement for clinical effectiveness, and the podiatry advisor to the

59 The Patients Charter "guarantees admission...by a specific date no later than two years from the day when your consultant places you on a waiting list". Cited in The Patients Charter, DoH, 51-1003 10/91 C23000.
DoH further underlined this view in interview.

"It still needs to be scientifically proven...I think in time that process will weed out the professions. I think we will survive if we can say that 25% is based on good, rock-hard evidence. If you do less than that I suspect you will not survive. With diabetes, POMs, podiatric surgery and a more realistic approach to biomechanics and orthotics, I think we will survive at least another 50 years." (Transcript 25, 1996).

9.6.2. Podiatric Surgery and Medical Dominance in the NHS

The remaining events mapped in this chapter illustrate the reaction of medicine, or more specifically the Royal College of Surgeons and the British Orthopaedic Association, to the insinuation of podiatric surgery within the NHS following the recent government reforms. They demonstrate the impact of medical opinion upon podiatric surgery in the NHS, and the strategies of the RCS and BOA in attempting to undermine these practices.

The key features of medical objection centred around four themes. First, the use of terms normally limited to medical personnel was questioned, notably "surgeon", which, it was claimed, breached the terms of the Medical Act (1983). The assumption of the title "consultant" was also challenged, on the basis that only medically trained personnel were permitted this distinction. The lack of accountability of podiatric surgeons to medical (as opposed to managerial) authority appeared to signify a loss of medical power.

This raised objections and resulted in a wider medical effort to outlaw
"medical" practices by non-medically qualified staff. Finally, when this strategy failed, medicine claimed authority over these practices by exercising control through "medical delegation".

The establishment of podiatric surgery in mainstream NHS practice presented a challenge to the power of medicine, or more specifically, orthopaedic surgery. This challenge, and its impact upon medical dominance of podiatry, is best illustrated through an examination of the progress, outcome and aftermath of the COPSS inquiry, launched in 1991 and reporting in 1995, although never formally published.

The COPSS inquiry was initiated by the Royal College of Surgeons to examine ways in which foot surgery in the NHS could be improved, through increasing co-operation between specialists contributing to the care of foot problems. The prominent profile of podiatric surgery ensured that podiatry would become the focus of attention, as a competitor in this neglected area of service. The recognition by the medical authorities that podiatric surgery had become established in the NHS prompted moves by them to secure control over podiatric surgical practice. Control was, therefore, a substitute for elimination, which had not been achieved.

The RCS/BOA position was clear. Although they did not seek to question the technical ability of podiatrists undertaking surgical procedures, concerns about their overall ability to manage the wider medical issues in patient care were raised. By suggesting that podiatrists, although technically skilled, could not possess the depth of knowledge which characterised the medically qualified, the RCS/BOA
implied that podiatrists were merely technicians who ought to perform surgery only by delegation from their medical superiors.

"The problems that can occur in podiatric surgery - well, no one was arguing about their expertise, that was accepted, but if the patient had a more general medical condition, if they did not have a medical training they might miss a medical condition that they might not have been trained to recognise..." (Transcript 27, 1997).

The Podiatry Association countered this view by asserting its legal right to act independently of the RCS or BOA, particularly in day case surgery, as hospital admissions were still controlled by medicine.

"The real sticking point was over responsibility for the patients admitted. Podiatrists said 'we carry out this in our own right', but orthopaedics felt that patients admitted must be under the care of medically trained consultant. The podiatrists said 'But we are not admitting patients as it is day care' - so went the argument." (Transcript 27, 1997).

Nevertheless, the negotiations did reach a significant level of agreement with regard to scope and boundaries of podiatric surgical practice, at least initially. This is significant, for it indicated that the Podiatry Association was willing to impose a limit to the boundaries of surgical practice in return for formal medical recognition. This implied a realisation that it would only be with medical approval that full integration into mainstream healthcare could be achieved.

"All that we accepted was that the foot would be defined as distal to the malleoli, whereas it's never been defined before, its always just been 'the foot'. It's acceptable because it wouldn't stop me from doing much" (Transcript 23, 1996).
The concern over the independent practice of surgery, in NHS hospitals, by podiatrists prompted the Royal College of Surgeons and British Orthopaedic Association to attempt to assert their power over the practice of surgery in the UK. This, to their surprise, fell far short of the authority which had been assumed. The primacy of the Royal College of Surgeons in the field of surgery had not been challenged in recent decades, and there existed a general assumption that the terms of the Royal Charter assured the Royal College of Surgeons the right to "govern" surgery. Further investigation, via the Privy Council, indicated that the power of the Royal College extended no further than the "promotion" of surgery. The significance of this finding was clear to the Podiatry Association representatives.

"they had a letter [from Privy Council] in which they are told quite clearly that they are not responsible for control of surgical practice in the United Kingdom. Whatever you think your job is, that's not it. What your job is, is to promote control, training and standards of your members." (Transcript 24, 1996).

The Department of Health supported further development and integration of podiatric surgery within the mainstream NHS, on the basis of cost-effectiveness, efficiency and accessibility. The success achieved in securing the support of the State Board and Department of Health, and of persuading NHS purchasers of the value of podiatric surgery, in spite of medical objection, all appeared to

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suggest a diminishing medical, or orthopaedic, dominance. The discovery that the Royal College of Surgeons held no power to enforce limits on the practice of podiatric surgery in the NHS further illustrated this position. The President of the RCS indicated that the support for podiatric surgery from general managers reflected a general trend towards challenging medical authority.

"NHS managers have sided with the smaller professions, a tendency to be anti-medic, doctor bashing. A sort of 'who do they think they are?'. They feel it is cheaper to employ podiatrists, although it's not really much cheaper...They say, 'well, if you're not interested we'll get someone else'." (Transcript 26, 1996).

Although the Royal College of Surgeons was essentially powerless to halt the practice of NHS podiatric surgery, it sought ways to contain its progress. Just such an opportunity arose with the increasing demand for support facilities which accompanied the growing sophistication of podiatric surgical procedures. These facilities included admission rights and general anaesthesia for some operative procedures. The Royal College and British Medical Association were able to intervene to block such an expansion at a formal level, on two counts.

First, NHS regulations specified that all patients admitted to hospital should be under the care of a named, medically qualified consultant. Thus, although several podiatrists had achieved the rank and title of consultant, they did not have access to the 24 hour "on call" care associated with the medical "team".

Second, only a few podiatric surgeons had full drug prescribing
authority and access to general anaesthesia, by local agreement only. The BMA and Royal College successfully blocked podiatric surgery from being carried out under general anaesthesia, on the grounds that the limited power invested in podiatry via the State Board did not extend beyond the use of local anaesthesia.

"We were not really able to do anything about it until the podiatric surgeons wanted a list for general anaesthesia. The anaesthetists, with our advice, said no, we won't do it. The Chiropodists Board rules said they only approved local anaesthetics" (Transcript 26, 1996).

The Royal College of Surgeons, BMA and the Podiatry Association also became locked in a dispute over the use of the title "surgeon" by podiatrists. The use of the title was technically made illegal to all but the medically qualified by the Medical Act(1983). However, from legal advice taken by both sides it emerged that, providing the title was pre-fixed appropriately, it might be defendable in a court of law. Finally, however, The Podiatry Association chose to direct its members not to use the title, as the legal outcome would be based upon an interpretation of the Medical Act, which could not be predicted.

"If you say 'I'm a tree surgeon' there is no doubt that you are not pretending to be a medical doctor. I'm a podiatric surgeon. That pre-supposes that I'm not attempting to pretend I'm a doctor on the basis that I'm telling you up front I'm a podiatrist...Our advice was, somebody might find themselves in court and we couldn't tell you you would win. But we couldn't tell you you would lose..." (Transcript 24,1996)

The Standards Committee of the BMA also decided not to prosecute any case against podiatrists using the title "podiatric surgeon" for the same reasons. The result was a comfortable stand-off, with the Podiatry Association reserving the right to re-introduce the issue at a later date.

"A complaint was made, informally, by the Scottish surgeon on the Board to the BMA. As a result of which the Standards Committee secretary wrote to us...Their legal advice was, 'don't attack somebody for podiatric surgeon because you might not win'. Mirror image of our own. They told the surgeon on the Board this, and he was absolutely furious...And we did agree that we would let the GMC know if we did decide to change the policy on that issue. We would tell them. Not ask their permission." (Transcript 24, 1996).

The Royal College of Surgeons then objected to the appointment of podiatrists in NHS hospitals at the grade or title of "consultant", on the grounds that this was in contravention of existing Statutory Instruments under the NHS regulations. This latter assumption could not be clarified by the researcher on further inquiry to the British Medical Association, which asserted that no statutory instrument protected this title. One key informant, a podiatric surgeon and PA Executive member clarified the nature of the objection.

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"The only other contentious title is consultant and it isn't contentious as far as we are concerned but it is contentious as far as some of the other medics are concerned vis-a-vis the orthopaedic surgeons. Because it looks like we're on a par with them, and they would be very unhappy about that."

(Transcript 23, 1996).

Similarly, the Department of Health offered no objection to the appointment of podiatric consultants, confirmed by the DoH podiatry advisor.

"The other thing that they have been saying is to use the word consultant is suggested or alluded to being being a medical practitioner. The Department was keen to see if there was any harm, but there doesn't seem to be any suggestion of that anywhere." (Transcript 25, 1996).

The factual conclusions of the COPSS inquiry, in terms of the utility of podiatric surgery, and its popularity with GPs, patients and other purchasers, unreservedly supported podiatric surgery. The Royal College of Surgeons and British Orthopaedic Association Council, however, refused to ratify the document, due to the ongoing dispute over control of surgical practice.

In consequence the Podiatry Association published a minority document, circulated to all Health Authorities and Trusts63. The RCS and BOA, together with the Society of Chiropodists & Podiatrists, opposed this, threatened legal action and forced a withdrawal of the Podiatry Association Report64.

The British Medical Association and Royal College of Surgeons proceeded to launch a campaign, directed at all non-medically qualified personnel practising medical techniques. Having failed to halt such practices, they attempted to subsume them by offering their approval for delegated tasks\(^65\). Medicine would therefore retain overall control and responsibility of invasive surgical practice, relegating the non-medically trained to the status of technician whilst acceding to their surgical involvement. This stance, however, received little sympathy from within the Department of Health, which was reluctant to support the monopolistic tendencies of medicine.

"when medics come across as being a very closed shop, very protectionist - the BOA is a very good example of this - the Department takes a very short view of that...The question around the General Medical Council was about delegation... Again they had taken it too far and they had a bad reaction. Our view within the Department is...to do nothing at this point in time."
(Transcript 25, 1996).

9.6.4. **Podiatric Surgery in the NHS: Conclusions**

Medical dominance of podiatry and the practice of podiatric surgery must be viewed in the context of medicine as a system of specialty areas, rather than a homogenous, unified professional entity. The fundholding GP enjoyed an extended economic authority over

podiatry. Orthopaedic surgery, however, failed to eliminate podiatric surgery or prevent its integration within the framework of mainstream NHS work. Thus, the challenge to medical dominance posed by podiatric surgery lies within the hospital environment, where the orthopaedic surgeon has no power of veto over the appointment of podiatric surgeons. The NHS Trust manager holds ultimate responsibility and makes the final decision, based on factors unrelated to professional self-interest.

General managers within the NHS may, however, become convinced that the natural progression of podiatric surgery will carry it into an alliance with medicine, in which medicine occupies the premier position. Greater emphasis on the co-ordinated, integrated, multi-disciplinary delivery of care is a feature of the most recent modifications to the new reforms66. Although unwilling to shed a service which appears accessible and responsive to patients needs, there is also evidence of a perceived need for an accommodation with medicine. This may signal the future for NHS podiatric surgery.

"And when the orthopaedic surgeons were jumping up and down and saying 'no, we're not putting up with this' I guess any general manager worth their salt would take them to the wall and say 'well, okay, if you don't like it, go.' And we all know the answer to that. They would say 'Okay, we'll have it in, but under our terms and conditions, we want to oversee these people.' That's not unreasonable. These people are very skilled and very experienced and I don't think many podiatrists would mind working under the aegis of another consultant. And that's maybe the way it has to happen..." (Transcript 22, 1996).

The NHS reforms of the early 1990s presented both opportunities and threats to podiatry. Podiatric surgery was accepted into mainstream NHS work, and proved popular with fundholding GPs and general managers. Traditional podiatric services, conversely, suffered from a lack of visibility which rendered them vulnerable to service cuts. Medical dominance of podiatry was clearly enhanced within the primary care setting, yet partially limited within the hospital environment following the successful integration of podiatric surgery as an accepted and legitimate service.
Chapter 10

Conclusions
This chapter seeks to bring together the main findings and implications of the study. It acts to highlight the principle professional features evident in podiatry in the post-registration era and to identify the processes which can account for such change. Throughout, the Weberian concepts of social closure, professional dominance (and its elaborations) and professional autonomy have been found useful concepts for analysing the relations within podiatry and between podiatry, medicine, the state and other paramedical professional groups. The influence of post-Griffiths managerialism has also been important. Throughout the period under study the professionalising strategies of British podiatry have been marked by their lack of success. This chapter will attempt to provide an explanation for these outcomes in relation to their socio-historical context.

10.1. Podiatry and the State: The Failure of Occupational Closure Strategies

Repeated attempts by the state registered professional bodies to achieve occupational closure and secure a trade monopoly by the exclusion of the unregistered sector failed for a number of reasons. Podiatry did not develop in a social vacuum, but was driven by, and adapted to, the demands of the state. It inherited an agenda set for it by pre-existing government health policy in relation to manpower provision for the NHS. The introduction of the PSM Act (1960) initially appeared to offer podiatry the prospect of enhanced professional status, elevating it from an
auxiliary service to a state recognised profession. It was hailed as a stepping stone towards occupational closure, in which the newly created registered sector would enjoy the esteem of the public and of medicine, forcing the unregistered into terminal decline. This outcome did not materialise.

The PSM Act primarily reflected the government desire to ensure a recognised standard of practice for NHS employees, and disregarded professional aspirations. The vast majority of registerable practitioners prior to 1960 practised in the private sector, for the most part in open market competition with those less qualified, or even unqualified. Whilst the PSM Act did exclude the unregistrable from NHS employment (excepting those granted admission on the grounds of previous experience), it offered no benefit to the majority who sought to continue working in the private sector. Reduced clinical autonomy in the NHS resulted from the imposition of categories of eligible patients, determined by the state rather than the profession, and, later, of ancillary grades. Even existing podiatric role boundaries were brought into question by the state medical authorities, illustrating the failure of podiatry to preserve its boundaries and skills, an acknowledged aspect of successful exclusionary closure (Freidson,1970; Larkin,1983; Hugman,1991). Thus, the PSM legislation failed to deliver the promise of a monopoly of footcare services for the registered sector. As a credentialist exclusionary device providing legally recognised closure it failed utterly.

Podiatry, as a medical auxiliary service, had little independent influence
upon government. Collectively, the PSM professions had previously demonstrated that they were sufficiently potent to influence government policy when the aspirations of both converged, in preventing the imposition of a legal auxiliary status (Larkin, 1983). However, podiatric post-registration strategies directly conflicted with government policy, which sought to address NHS personnel shortages. For the other PSM professions, largely employed within the NHS, registration more or less secured a de facto monopoly in the provision of services. Deprived of the influential collective support of the other PSMs, and in the absence of the support of a powerful elite, podiatry stood little chance of achieving occupational closure.

The unregistered had not been deprived of a market for their services by the PSM Act. It was in this climate that the registered sector launched its ill-fated campaigns for occupational closure. The rhetorical device repeatedly employed by the registered sector to justify the exclusion of their competitors, an alleged threat to the public safety, could not be sustained.

Formal attempts to amend the PSM legislation were often not only defeated, but crushed. The Parliamentary mechanisms employed were weak as they did not enjoy the support of the government.

In addition, the poor public image of podiatry was such that, at the airing of the 1969 Bidwell registration bill, the House of Commons collectively

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1 The Accountancy profession had employed a similar strategy (MacDonald, 1985).

laughed at the idea that, if held to account for its actions on the anniversary of Trafalgar, it would have to reply that it was registering podiatrists. Thus, the combined factors of poor public image and opposing government interests and ideology conspired to thwart occupational closure strategies. Podiatry was unable to convince the public or the state of the special and unique character of its services, essential to successful social closure.

In addition, any attempt to limit the number of podiatrists available to the public, by restrictive legislation, would have been a direct threat to government interests. The government solution to the problem had been to introduce assistant grades, a cheaper alternative to the tiering structure suggested by the Society of Chiropodists. This again illustrated the weakness of the podiatric bodies in resisting pressure from the state.

The public, government and Ministry of Health viewed podiatry as "unimportant", whilst the medical profession was indifferent to its monopolizing aspirations. As a distinctly subordinate group it is clear that without the support of these necessary allies, professional closure could not succeed. In addition, every private members bill introduced to the House of Commons was met with a hostile amendment, lodged on behalf of the unregistered sector, whose Parliamentary lobbyists enjoyed equal, if not greater, success than their registered counterparts.

State support could only be achieved with clear evidence of a "serious

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4 "Mr. Smith, who opposed the bill, is not alone in thinking the public are becoming over-protected". Cited in Witting op cit.
threat” to public safety from unregulated practice. The political climate of the 1960s had been characterised by opposition to restrictive practices, resulting from a growing tendency to attribute declining economic fortunes to the inflexible, closed-shop activities of the trade unions (Dorey, 1995; Dutton, 1997).

Diligently constructed networks of supporters, which included the BMA and the CPSM, failed due to continuing conflict with government interest. The DHSS sought to address the critical shortages in the NHS by employing unregistered podiatrists. This conflict of interest between profession and state militated against professional closure. Unlike other paramedical professions, podiatry was not seen as essential to the functioning of the NHS, reducing its capacity to influence health policy. Whilst the government and its Ministers demanded adequate provision for the NHS, they did not value the skills of the state podiatrist more highly than the “high street chiropodist”.

The failure of the second Corrie bill, during the Thatcher years (1979), reflected the government’s ideological opposition to monopolization. The free market economy, with freedom of consumer choice paramount, rendered professional closure projects redundant. In fact the unregistered sector received greater sympathy in ministerial circles, being viewed as a legitimate group unjustly exposed to exclusionary oppression by an undeserving, self-interested cabal. The Minister of Health repeatedly refused to countenance any legislation for podiatry in the absence of an internal consensus.
The new NHS reforms signalled by "Working for Patients" (1989) acted to reduce the limited exclusionary qualities of the PSM Act itself, offering fundholding GPs the opportunity to purchase any practitioner, whether registered or not. Working Paper 10 also promoted the introduction of skill mix for all the PSM professions, which, in the absence of protective legislation for podiatrists, diluted even further the minimal exclusionary power of the PSM legislation.

The growing antipathy of all the PSM professions towards these reforms facilitated the success of the Morris private peers bill in securing a review of the PSM legislation.

Obtaining a government sponsored review did not, however, represent either a successful advance in the pursuit of professional closure nor any diminution in medical dominance. Whilst the government did respond to unified paramedical pressure, it also responded to the countervailing power of the medical profession, which sought to contain paramedical expansion by eliminating independent professional Boards.6

Attempts to ensure the exclusion of the unregistered from practice, in order to attain greater professional status and a market monopoly failed because state podiatry was not held to be better, safer or more skilled than its unregistered competitors7, and because the government needed to solve the manpower crisis in the NHS. Medicine already enjoyed a monopoly, which further highlighted the weakness of the podiatry case.

Medical dominance played a role in obtaining rather than preventing

6 This was a reference to the Chiropodists Board, which had usurped orthopaedic control of foot surgery by approving ambulatory foot surgery for state podiatrists in 1986.

change to the PSM legislation, but only when it became apparent that medical authority was being undermined by the activity of the Chiropodists Board.

Internal divisions within podiatry clearly hampered attempts to achieve professional closure, as the unregistered sector countered every Parliamentary exclusionary tactic with hostile amendments. These actions led the government to conclude, as they had with accountancy (MacDonald, 1985), that there was "always room for the less than fully skilled" practitioner.

Podiatry had also failed to learn from the example of medicine in its relations with the state when seeking occupational closure. Berlant (1975) noted that the passage of the Medical Act (1858) had been achieved by medical acceptance of an incorporation with apothecaries and barber surgeons. Had podiatry accepted integration with its "inferior" competitors on an equal footing, rather than pressing for exclusion or subordination on some supplementary register, the politically vociferous unregistered sector might have accepted protection of title, and the government might have provided it. Podiatry was unable to capitalise upon the more favourable responses of government to the paramedical groups at the time of the PSM Act (1960), due to internal divisions and an over-reliance on medical rather than political support. Subsequently, the adverse political climate was less amenable to professional projects, and podiatry could not advance its position.
10.2. **Podiatric Education and Knowledge**

It has been widely recognised that training and education, knowledge and skills serve the professions in providing weapons in the struggle for closure, and increased credibility and legitimacy (eg. Elzinga, 1991; Hugman, 1991; Larkin, 1983; Turner, 1985). Increased claims to a scientific knowledge base have also been associated with a shift towards higher education as the location for professional training, evident within nursing and other paramedical professions in recent years (Atkinson, 1988; Hugman, 1991; Sim, 1989) and equally evident in podiatry. Professional attempts to acquire a recognised and separate body of knowledge and applied skills, publicly accepted as unique and effective, emerged with the adoption of American podiatric biomechanics. This offered podiatrists the potential to develop and secure for themselves a unique knowledge which could be applied independently of medicine, or any other paramedical group, and which would incorporate the essentially medical responsibility of diagnosis. Through the creation of "new", previously unrecognised pathologies which were amenable only to podiatric diagnosis and therapy, based upon specialised podiatric knowledge, state podiatry sought to establish a market advantage in footcare provision. This also acted to extend the authority of the podiatrist over wider areas of the human body and to establish a credible scientific base to his or her work which had an identity distinct from medicine and outwith medical control.

It is here that parallels emerge with the recent Foucauldian study of
dentistry (Nettleton, 1988, 1989, 1992). The American perspective appeared to signal a shift in podiatric “gaze”, extending disciplinary power beyond existing boundaries in such a way as to view the foot not as an independent entity, but as part of a locomotor system through which pathology was manifest in the foot. Whereas the foot had been previously seen as subject to pathologies due to intrinsic structural problems or the influence of footwear, the emerging perspective saw the foot as the point at which pathologies of the locomotor system became visible. It thus became necessary to extend the examination of the subject to the locomotor system, to the leg and thigh, knee, hip and vertebral joints, as points of origins of foot problems. Similarly, intrinsic foot disorders were seen as creating pain in these other regions. Thus, the podiatric gaze became extended to include the lower limb and back as part of one system of pathology, which was amenable to interpretation and normalisation. “Orthotic therapy” thus consisted of rigid shoe insert devices which “balanced” the limb mal-alignments, abolished pain and prevented deformity. The notion of prevention provided a means of expanding the techniques of surveillance to a wider population which harboured widespread, undetected pathologies which, untreated, would lead to deformity and disability. However, dental professionalisation succeeded in part because of the symbolic significance of the mouth and teeth as the “vulnerable margin” of the body through which communicable diseases gained entry. As the gatekeepers of health, in preventing epidemic disease and maintaining healthy bodies, dentists established their professional status.
The foot, however, did not enjoy the same symbolic significance as a barrier to disease. The foot was also difficult to glamorise, its own symbolic associations with dirt, smell and "impurity" rendering it unattractive in dominant cultural norms (Douglas, 1966). In addition, the Foucauldian analysis locates power, in the medical encounter, not at the centralised level of the state, but embedded within "day to day practices" and techniques (Lupton, 1997a, 1997b; Turner, 1997). This focus upon knowledge and techniques of power is useful in viewing the conflict which emerged between podiatry and medicine. The central conflict did not emerge over salary or status but over techniques, practiced on subjects in the clinic or hospital. These "micro-powers", exercised at the level of everyday life, such as local anaesthesia or podiatric surgical procedures, became the main focus of dispute.

Podiatric biomechanical knowledge, although appearing to offer an indeterminacy which could be used to resist simplification (Jamous and Peloille, 1970; Pilgrim, 1990), was undermined by a number of factors. As it became more widely published in the podiatric literature and applied in practice, other healthcare workers concerned with limb and locomotor function modified and subsumed it. Podiatry had no means to exclude potential competitors from access or use of this knowledge due largely to its subordinate status. In addition, the growing demands for accountability of clinical practices, through clinical audits and other measures, became problematic. Clinical methods of assessment and evaluation were found to be unreliable, pathological concepts invalid and
therapeutic interventions (orthoses) in some studies were seen to produce detrimental effects. Scientific validity of professional knowledge and a plausible scientific background are "important resources" in professionalisation (Turner, 1985), and podiatric strategies were clearly adversely affected by the continuing absence of scientific credibility. The shift of training and education towards higher education, which also potentially enhanced academic credibility, came under threat with Working Paper 10. The advent of degree qualifications was seen within podiatry as adding to its credibility, academic worthiness and its "status in the medical world". Yet this was threatened by the NHS reforms which were designed to ensure an adequate and relevant provision of services to satisfy service requirements and patient needs. The state did not view degree status as necessary. Opposition to degree education was implicit within WP10, which viewed the more academic, theoretical structure of degree education as serving professional interests and not service requirements.

The concept of internal closure outlined by Hugman (1991) helps to explain the development and rise of the Podiatry Association in relation to rival podiatric organisations. Professions concerned to raise their status tend to stress the "glamorous" aspect of their work and delegate or retreat from the routine or "dirty work", noted in studies of social work and nursing (Howe, 1986; Hugman, 1991). The routine work of podiatry was associated with an elderly client group, palliative care and a low level

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8 Berry BL (1989), JBPM, 44:9, p.201.
of skill. Podiatric surgery became associated within podiatry with a curative role, demanding high levels of skill and knowledge and a broader client base. This "virtuoso role" based on skills and knowledge divided the profession, by separating the prestigious elements from the mundane. Access to such prestige was restricted by the barrier of further training, in the case of the Podiatry Association by the introduction of the "certificate in podiatry". This exclusionary credentialist device consisted of further part-time training, surgical pupillage and the hurdle of rigorous examination, which became central to its claim to professional status.

10.3. Medical Dominance and Boundary Encroachment: The Impact on Autonomy, Skill and Role Boundaries

The professionalising strategies of podiatry consisted, in large measure, of the tactic of boundary encroachment aimed at particular areas of medical specialism, primarily orthopaedic surgery, anaesthetics and radiology. Similarly, podiatry sought to infringe upon the domain of the radiographer, which may be explained as "lateral" closure, in which occupations of similar status compete for expertise in the same area (Hugman, 1991).

The professional Boards created under the PSM legislation, although still subject to the cultural and social authority of their medical members, held the power to determine the training, education and role boundaries of the PSM professions. The numerical advantage of the paramedical representatives did not, however, reverse the dominance of medicine,
which acted to inhibit and divide the podiatry representatives and their tactics.

The scope of practice had been defined in order to confine podiatry to the limit of its existing training, and to install a medical veto. Yet the definition did permit expansion in role or skill boundaries, providing adequate training enabled it. Nevertheless, the Society of Chiropodists continued to view medical legitimacy as the only way forward in achieving its aspirations for full legal closure and recognition within the medical establishment, in contrast to its rival, the Podiatry Association.

Thus, podiatric boundary expansion was restricted not only by medical dominance but by internal ambivalence and a lack of core values in relation to a shared clinical mentality. Podiatry could not put forward a coherent strategy to ensure professional recognition externally.

The PSM Act (1960), Medicines Act (1968) and the Chiropodists Board Report (1968) all appeared to conspire to weaken claims for professional autonomy, and acted to dampen aspirations for enhanced professional status and more firmly subordinate podiatry to the limited role of medical auxiliary.

The exclusion of podiatry from drug access and administration rights reflected the invisibility of podiatry. The Medicines Act did not represent a deliberate exclusion of podiatry as part of a more pervasive strategy of medical dominance. Rather, it was an indication that neither medicine nor the state had considered drug use relevant to the practice of podiatry. Parenteral administration of drugs by podiatrists, when it later
became visible, horrified medicine. The ambivalence of the Society members on the State Board compounded the problem by supporting medical opposition to local anaesthesia in podiatry, endorsing its own subordination as a strategy of advancement.

The Podiatry Association sought to combat medical opposition and the Society's compliance with medical wishes. This dual strategy, designed to resist medical dominance, proved successful in certain respects. The bid to ensure representation upon the State Board, by challenging and replacing those Society members inclined to submit to medical pressure, was a significant success. An expansion in lawful surgical practice was undertaken without medical endorsement, largely protected by common law precedent, which also proved successful. Both these strategies were facilitated by the very definition which had been designed to limit expansion. The clearly codified restraints on role expansion characteristic of paramedical professions (Larkin, 1983) proved insufficient to prevent podiatric expansion in the area of surgery. The State Board definition of practice permitted an interpretation which the Podiatry Association exploited in order to expand role boundaries into an invasive surgical arena. This was the first time a PSM profession had challenged the supreme authority of the Royal College of Surgeons, and found it assailable.

In approving lawful podiatric access to local anaesthesia, under assurances from the Society that there would be medical supervision and control of training, and that it would be used only to manage problems
within the existing scope of practice, the DHSS and medicine had not foreseen the implications.

British law permitted the practice of surgery by non-medically qualified practitioners, reflecting the absence of full legal closure in medicine. Within the private sector, medicine was powerless to stop podiatrists performing invasive surgery, which they proceeded to do without medical support.

Yet, however lawful, within five years the Podiatry Association bowed to orthopaedic pressure and limited its own scope of surgery to simple toe operations, for fear of permanent exclusion from legitimate healthcare. Orthopaedic outrage was sufficient to halt further advance. Yet this may be viewed as a strategic position adopted to ensure longer-term progress towards a more "favourable jurisdiction" (Freidson, 1970). Such a strategic retreat may serve to prevent a rout, a concession given "in order to avoid being driven back" (Larkin, 1983).

The extent of medical dominance in relation to podiatry became evident as the Podiatry Association sought to expand role and skill boundaries within the NHS. Medical opposition impaired podiatric attempts to encroach upon radiological and anaesthetic practice, in the latter case supported by exclusionary legislation. Individual medical practitioners acting in support of the Podiatry Association were ostracised by colleagues and subject to disciplinary action9.

The Society of Chiropodists sided with medicine and condemned the actions of the Podiatry Association, on the grounds that antagonising

9 Derived from data, transcript 16.
medicine would damage professional progress in podiatry. In claiming to represent the legitimate face of podiatry it sought to distance itself from the "mavericks" of the Podiatry Association. In turn, the medical authorities accepted the Society as the responsible and legitimate leaders of podiatry and were encouraged to view the Podiatry Association as no more than a radical, unrepresentative splinter group.

The potency of contemporary medical dominance in podiatry is evidenced by the continuing denial of access to NHS radiology and radiography facilities throughout Britain. In addition, with the notable exception of local anaesthesia, little progress had been made in establishing an expansion in prescribing rights in podiatry.

Larkin (1983) noted that health occupations subordinate to medicine are able to influence rather than fully establish their own boundaries of competence, and are usually forced to reduce claims to any kind of legitimate advance in their autonomy in order to secure a limited encroachment or expansion of roles or practice. In order to achieve full legal access to local anaesthetic drugs and state approval for their

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10 The increasing sophistication of podiatric training, in the use of magnetic resonance imaging, computed tomography and isotope scanning, ensures a demand for access to NHS radiological facilities.

11 Recent proposals to offer state registered podiatrists enhanced rights of access to various POM drugs were said to be conditional upon accepting the terms of a new Health Professions Act, not favourable to podiatric professionalisation (data derived from Transcript 23,24,25). In fact these proposed access/administration rights have been largely denied (Medicines Control Agency Facsimile to Medicines Committee, Society of Chiropodists & Podiatrists, 20th October 1997.

12 The underpinning framework of occupational imperialism, unlike Freidson's professional dominance, does not require total control over the entire medical division of labour, simply the successful negotiation of role boundaries with a more powerful neighbour.
usage podiatrists were obliged to ditch claims to access a whole range of further drugs and to promise that they would not use local anaesthetics to expand their scope of practice.

The abandonment of technical advance in the area of intra-venous sedation, with all its advantages for surgical practice, was a rationally constructed response to medical outrage and expressed government anxiety. The distancing of the Society of Chiropodists from the actions of the Podiatry Association might also be viewed in this light.

The approval given by the Chiropodists Board for "ambulatory foot surgery" was tentative, as the Board sought medical co-operation by inviting the Royal College of Surgeons to provide representatives to "appraise developments and promote high standards", thus apparently offering medicine a voice if not a veto.

Reactions to podiatric encroachment varied within medicine itself. The British Orthopaedic Association predictably responded with intense hostility whilst the Royal College of Surgeons demonstrated greater tolerance, reflecting the degree of threat to the core domain of the orthopaedic surgeon. For the Royal College, control over the practice of podiatric surgery appeared feasible through representation upon an advisory committee, which, although not ideal at least seemed acceptable.

The British Orthopaedic Association, by contrast, sought to eliminate the threat of podiatric surgery, and failed.

Popular support for podiatric surgery persuaded the Society to endorse invasive bone surgery, which became relevant as the unity of purpose
which resulted from this decision led to a new confidence previously unseen in podiatric relations with medicine. This confidence was enhanced by the introduction of general management within the NHS, which shielded podiatric surgery from the threat of exclusion by medicine.

10.4. Podiatry and Medical Dominance: The Impact of Managerialism

The introduction of general management did not immediately signal a lessening in medical dominance in relation to podiatry, but it did reflect an increasing accountability to management. Under the Griffiths reform the new District podiatry managers were separated by several tiers from senior management, and hence the decision making process. As the "new" NHS reforms took shape the emphasis upon primary care and the internal market presented significant opportunities and threats for NHS podiatry.

The generalist and specialist forms of podiatry performed differently under the new reforms, the former increasingly threatened with downsizing, whilst the latter emerged as a prized service. Medical dominance was clearly strengthened under GP fundholding, and podiatric professional autonomy compromised, as state registered practitioners became directly accountable to GPs. Directly employed podiatrists became salaried at rates determined by the GP, and were required to accept referrals from the GP. Length of treatment time,
number of patients treated per session, and the range of tasks undertaken could all be determined by the employing GP, including requiring the podiatrist to treat those mundane cases which had previously been dealt with by podiatric auxiliaries. In addition, GPs undertook clinical procedures which were considered an encroachment into the established domain of the podiatrist, and avoided obligations to national pay awards. In particular, GP fundholders were not restricted to state registered employees, being free to "shop around" for the best deal. As a result, many unregistered podiatrists were employed by fundholding GPs. However, podiatric surgery flourished under GP fundholding in the community, and under managerial control in the hospital. GP fundholders avidly sought the services of the podiatric surgeon, whose specialist work brought financial rewards. Its cost-effectiveness (as day care), apparent clinical effectiveness and accessibility provided the fundholder with a service which orthopaedics failed to supply. GPs did not undertake such specialized surgery themselves, nor did they dictate the choice of procedure, leaving such decisions to the podiatric surgeon. In addition, unregistered podiatrists posed no threat to the podiatric surgeon. Although able to compete with registered practitioners offering traditional services, the unregistered podiatrist did not possess the skills to compete in the market for foot surgery.

The same mixed fortunes were evident within NHS Trusts. Traditional podiatry services suffered due to down-sizing, including non-voluntary redundancies, as it remained a soft target for financial cuts, with loss of department structure, hierarchy and status. The lack of a credible public
image, a powerful client lobby or a persuasive evidence base contributed to a vast contraction of NHS services nationally.

Podiatric surgery, conversely, became highly successful under the NHS reforms. It was at this level that medical dominance was challenged by podiatry, and blunted. NHS Management facilitated the establishment of podiatric surgery within the NHS, justified by criteria which its medical opponents failed to undermine. NHS Managers became aware of the provision of podiatric surgery through a prolonged campaign by the Podiatry Association to promote it, latterly assisted by the Society of Chiropodists. The demand for services was high, and its accessibility, cost-effectiveness and clinical effectiveness persuaded NHS managers of its value. Although the BOA made several attempts to undermine the acceptance of podiatric surgery, its establishment within mainstream NHS services was secured.

It was in the area of podiatric surgery that podiatry made its most important advance in professionalisation and its most significant challenge to medical dominance. The incorporation of podiatric surgery within the NHS marked a significant recognition and legitimation of podiatry, and a successful re-negotiation of role boundaries. Professional autonomy for the podiatric surgeon had been enhanced, his or her status elevated and legitimacy established. Many were appointed to consultant posts.

Yet the price which had been paid to achieve this limited goal involved a division in podiatric services, and an inevitable accommodation with
medicine in order to remain viable within the mainstream health service. Having failed to exclude podiatric surgery, medicine now seeks to subordinate it, through delegation of surgical work to "non-medically qualified" personnel, who are portrayed as technicians without the necessary knowledge base to support claims to autonomous, professional practice. This reflects the view that it is not control over technique which affords professional advantage, but a "knowledge system governed by abstractions" which facilitates successful encroachment (Abbott, 1988; Watson, 1995).

NHS managers supported the establishment of NHS podiatric surgery because it provided a service for which there was a demand, in the absence of any alternative. They now demand that these services integrate within the existing framework of health services, which inevitably necessitates its subordination to medicine. Thus, the establishment of NHS podiatric surgery was achieved because it coincided with government health policy and NHS service needs, and its future integration similarly demands that such a provision is accepted as subordinate to medicine.

10.5. Podiatry and the Proletarianization/Deprofessionalisation Theses.

The recently renewed interest in these concepts has been linked to the increasing accountability of professionals to managers within the "new" NHS (Hunter, 1994; Gabe, Kelleher and Williams, 1994). In addition,
other aspects of these concepts are also relevant to a study of podiatry. Since 1960 podiatry has been incorporated into the bureaucratic machinery of the NHS, to which it was previously peripheral.

Integration within the NHS was part of a government strategy, largely opposed by the professional bodies. The pay and working conditions imposed on NHS podiatrists were generally considered worse than those in private practice, which deterred many from entering the NHS. Selected NHS client categories, treatment duration times and numbers of treatments were all imposed, where this had not directly been the case before. The professional bodies were unable to control the supply of labour, as a "reserve army" of alternative practitioners were ready to step in, as the government considered the employment of the unregistered and imposed auxiliary workers to accommodate manpower shortages. More recently, the new GP fundholding scheme also permitted the employment of unregistered podiatrists, providing a cheaper labour force.

Task routinization and fragmentation was evident in the imposition of auxiliary assistants, created to assume tasks deemed safe for the less highly trained. However, podiatric surgery as a specialism represented enhanced skilling rather than de-skilling. Managerial influence promoted podiatric surgery, viewed within podiatry as confirmation that a special, higher level of skill existed.

Yet, although NHS management decimated traditional NHS practice,

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13 The Society of Chiropodists had assumed the role of a trade union in negotiating for better pay and conditions, an collective action and withdrawal of labour had, from time to time, been muted. Data from Transcript 14.
discarding many services when cuts were necessary, due to a "fiscal crisis of the state" (Parkin, 1979) rather than an assault upon semi-professional autonomy, it is clear that podiatry became vulnerable to the goals and values operating in its employers interests.

10.6. Professionalisation Strategies since 1960: Conclusions

For Larkin (1983) the state registration of podiatry represented the final step in its subordination to medicine, by ensuring medical control in defining the practice of podiatry in such a way as to translate what had previously been unethical practice into unlawful practice. Yet it did not outlaw the practice of medical techniques by podiatrists, it simply asserted that they could only practice techniques in which they had been trained. The legislation was, therefore, open to interpretation, within which lay the key to expansion in scope of podiatric practice and lawful boundary encroachment, unanticipated by Larkin (1983). However, Larkin (1983) did assert the dependency of podiatry upon medical support, viewed as a resource in the "conflict ridden, low status world" of the competitive market for foot services. It was this dependency by the Society of Chiropodists upon medical approval which resulted in the internal divisions within the state registered sector, which, in turn, shaped modern podiatry. The podiatry profession held no collective view or common perceptions. Boundary encroachment and role/skill expansion was limited not only by the countervailing powers of medicine but by internal opposition, often acting to further undermine and divide
podiatric professionalising strategies. In addition, Larkin (1983) regarded the unregistered sector as having "remained a minor influence in determining" the development of podiatry. It has been clear in this study, however, that the unregistered sector in fact played a key role in influencing government in preventing further restrictive legislation. Thus internal divisions within podiatry were as important as external forces in shaping and limiting its professionalisation.

10.7. The Future for Podiatry

Within the existing structural framework of the health services, it seems unlikely that podiatry can achieve professionalism on comparable grounds with dentistry or medicine. Podiatric surgery may provide some advance in professional status, but this is likely to be achieved at the expense of full independence from medicine. The necessary freedom from medical control or influence, endorsed by the state, is no more likely now than it was in 1960. Podiatry would not satisfy the criteria for professionalism of either the trait theorists, on the grounds of a lack of dominance in discrete areas of knowledge and skills, nor the degree of autonomy or monopoly over services thought necessary by later Weberian theorists (Freidson, 1970)\textsuperscript{14}.

The overriding feature of the proposed legislation\textsuperscript{15} remains the degree to which the future of podiatry continues to be anchored to the existing

\textsuperscript{14} However, it is clear that podiatry did not attempt to usurp the hegemonic position of medicine, but, as is characteristic of paramedical groups, acted to enhance its own position within the existing framework of the health division of labour (Larkin, 1983).

\textsuperscript{15} Hall MD (1997), Registrar, CPSM, Search News, Issue 84, May Issue.
PSM professions, with implications for autonomy. The new bill firmly binds together the future of the health professions currently within the PSM structure, diminishing even further the capacity of individual professions to express or control professional concerns, and reflects an intention to impose boundary limitations on podiatry. It might also be argued that the new legislation further undermines occupational closure based upon credentials, previously regarded as providing a "meal ticket for life" (Parkin, 1979) in that the new requirement for continuing professional development (CPD) demands regular re-evaluation of professional competency.

The separation of state podiatry into two strands based upon service provision, (NHS surgical practice and non-NHS traditional podiatry) may emerge. There are few parallels with other paramedical professions in this respect, due to the prominence of the private/state service dichotomy, although pharmacy remains divided along similar lines. Traditional podiatric practice remains a "soft target" for Trust or GP rationalisation, particularly those palliative treatments provided in perpetuity. Without an adequate evidence base to justify its continued inclusion or worth, it may fail to attract funding. Podiatric surgery seems set to thrive. However, although now established within the NHS, it is unlikely to continue to be permitted to operate independently of

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16 The issue of protection of title also raises concerns, as the exact scope of practitioners eligible for inclusion in a protected register is to be finalised through subordinate legislation, which affords a variety of interpretations over time (Adonis, 1993).

17 With safeguards against "potential harm arising from...invasive procedures...which can substantially impact on patient/client health or welfare" (JM Consulting, 1996, p. 52).
medicine. The managerial control which facilitated the establishment of podiatric surgery on the basis of service need is likely to demand integration within existing medical structures for the same reason, confirming podiatric subordination to medicine. Although medicine could not halt podiatric surgery, it may yet control it through a countervailing strategy of delegation developed to combat the threat from encroachment by subordinate professions. Podiatry has successfully extended its role boundaries to include invasive surgery of the foot but little else, a limited achievement which has not disturbed the overall medical hegemony. A negotiated settlement of role boundaries seems likely to contain podiatric expansionism and regulate its advances by delegation from medicine, an outcome which will suit all but the professionalising aspirations of the podiatric professional bodies.

10.8. Future Research

The changes evident in the time lapse between the current study and that of its predecessor (Larkin, 1983) demonstrated the need for an up-dated sociological examination of podiatry and provided pointers for further enquiry. Further research could address the perspectives on the profession offered by its service users, particularly in the light of recent interest in deprofessionalisation and clients as active consumers. It might also be informative to focus more on the "micro-politics and power dimensions" of podiatric practice, as suggested by Lupton (1997a) in relation to medical practice. The significance of academic and
educational developments in podiatry, with the recent emergence of degree courses, graduate status and integration within the university sector requires further attention (cf. Wilensky, 1964). The trend towards compulsory higher education degree-standard training amongst paramedical professions, it has been argued, may lead to simultaneous "re-skilling" and "de-skilling", in which a "minority stratum" progress to senior managerial or academic positions whilst entry standards for the majority are reduced (Larkin, 1988). The career paths of some podiatrists now appear to reflect these changes, with the emergence of general and locality managers, deans and even professorial appointments, which suggests a further potential area for fruitful inquiry.

Reflecting back on the study methodology, and the "insider" status of the researcher, it is important to acknowledge the necessity of reflexivity in managing qualitative data. The constant critical self-scrutiny implicit within the research process and the role of the researcher in that process necessarily features prominently in qualitative studies. The notion of epistemological privilege stemming from insider knowledge has been challenged, requiring the researcher to demonstrate a careful retracing and reconstruction of the research methods and interpretation (Mason, 1996). The key challenges to the credibility of the data in this study arose from the biases which characterise the qualitative methods of interview and documentary sources, such as veracity, accuracy and representativeness of the accounts, and were approached with caution
when interpreting and analysing the data.

The current intense phase of professional activity, with regard to government legislation, NHS provision and internal organisational change, suggests a need to extend this research area in the near future. NHS podiatry must now face the countervailing power strategy of the medical profession in assuming the position of endorsement by delegation, designed to maintain the subordinate status of podiatry. The potential re-alignment of emphasis in healthcare, away from a market philosophy, may bring new challenges and opportunities for podiatric professionalisation, yet much remains uncertain, particularly in view of the recent change in government following the 1997 general election\(^\text{18}\).

\(^{18}\) In the absence of apparent progress in the proposed new Health Professions Bill, following the election of a Labour Government, the Society of Chiropodists & Podiatrists are currently drafting another independent Podiatrists Bill, to be presented as a private members bill (Draft, 22nd September, 1997).
Appendices
Appendix 1

List of Transcripts from Interviews with Key Informants

Under the direction of the examiners of this thesis, all reference to the names of the key informant interviewees has been deleted to protect the anonymity of each individual subject. Only those details which were considered unlikely to reveal the identity of the interviewees have been included.

Transcript 1

Member, Chiropodists Board of Council for Professions Supplementary to Medicine;
Member of Executive Committee of Podiatry Association.
(Interview held at the offices of the Council for Professions Supplementary to Medicine, Kennington, London, 11th December 1992).

Transcript 2

Member, Croydon Postgraduate Group;
Member, Podiatry Association Executive Committee;
Member, British College of Podiatry
(Interview held at respondents home, 8th February 1993)

1 Details of date of interview accompanied by the positions of office held by the interviewees during the period under study are included. Interview duration varied from 30 minutes to 4 hours. Those acknowledged as members of the Council of the Society of Chiropodists also variously held posts within several minor committees of the Society. Final endorsement of Society policy could only be granted through the Council; therefore, unless otherwise stated, only Council membership is recorded.
Transcript 3

Member of Council of Society of Chiropodists;
Editor of Journal of the Society of Chiropodists;

Transcript 4

As Transcript 2
(Interview held at respondents home, 16th April 1994).

Transcript 5

Head of School of Chiropody;
Member, Council of Society of Chiropodists;
(Interview held at respondents home, 16th November 1994).

Transcript 6

Member, Institute of Chiropodists;
Member of the Chiropodists Board of Council for Professions Supplementary to Medicine.
(Telephone Interview, 5th December 1994).

Transcript 7

Member of Council of Society of Chiropodists;
(Interview held at interviewees place of work, 29th March 1995).
Transcript 8

Member, Council of Society of Chiropodists;
Member of Chiropodists Board of Council for Professions
Supplementary to Medicine;
(Interview held at respondents home, 11th April 1995).

Transcript 9

Head of School of Chiropody;
Member of Council of Society of Chiropodists
(Telephone Interview, 14th May 1995).

Transcript 10

Head of School of Chiropody;
Member of Executive Committee of Podiatry Association;
Member of Council of Society of Chiropodists.
(Interview held at respondents home, 19th May 1995).

Transcript 11

As Transcript 2,
(Interview held at respondents home, 15th September 1995).

Transcript 12

Member, British College of Podiatry;
Member of Executive Committee, The Podiatry Association.
(Telephone Interview, 22nd October 1995).
Transcript 13

Professional and Educational Officer,  
The College and Society of Radiographers  
(Telephone Interview, 7th November 1995).

Transcript 14

Member, Council of Society of Chiropodists;  
Editor of Journal of the Society of Chiropodists;  
(Interview held at offices of the Society of Chiropodists & Podiatrists,  

Transcript 15

Head of School of Chiropody;  
Member of The Podiatry Association;  
(Interview held at respondents home, 10th - 12th January 1996).

Transcript 16

Medical Advisor to the Podiatry Association;  
(Interview held on 16th February 1996).

Transcript 17

Member, Association of Chief Chiropody Officers (NHS);  
(Interview held at respondents home, 22nd March 1996).

Transcript 18

As Transcript 12  
(Telephone Interview, 17th March, 1996).
Transcript 19

Editor, professional periodical;
Member and Alternate Member, Chiropodists Board of The Council for Professions Supplementary to Medicine.
(Interview held at respondents home, 2nd & 6th April 1996).

Transcript 20

Head of School of Podiatry;
(Interview held at School of Podiatry, 17th April, 1996).

Transcript 21

Principal of Private Sector Training Institution
(Interview held on 11th July, 1996).

Transcript 22

General Manager Elderly Services NHS Community Trust;
General Manager, Paramedical Services;
District Chiropodist.
(Interview held at workplace, 5th August 1996).

Transcript 23

Consultant Podiatric Surgeon;
Member of Executive Committee, Podiatry Association.
(Interview held on 22nd July 1996).

Transcript 24

Member of The Executive Committee of the Podiatry Association;
Member of The Chiropodists Board,
(Interview held at respondents home, 7th August 1996).
Transcript 25

Official of the Department of Health;
(Interview held at respondents home, 2nd September 1996).

Transcript 26

Official of the Royal College of Surgeons of England;
(Telephone Interview, 17th December 1997).

Transcript 27

External Affairs Committee, Royal College of Surgeons of England;
(Telephone Interview, 7th January 1997).
Appendix 2

Details of the 9 core documentary data sets derived from podiatric professional publications

1. The Chiropodist, the official organ of the Society of Chiropodists¹ from 1960 to 1990, thereafter retitled The Journal of British Podiatric Medicine (from January 1991). The journal is published monthly and the editorials address those issues of professional concern to the Society of Chiropodists, and reflect the views of the Society's ruling Council ². There is also a section for the publication of correspondence, and includes conference reports, official committee reports and a newsletter. The Journal of British Podiatric Medicine also publishes the minutes of the meetings of both the Council of the Society of Chiropodists & Podiatrists, and those of The Chiropodists Board of the Council for Professions Supplementary to Medicine³.

2. The Society of Chiropodists Personal Newsletter, (begun in 1989) subsequently titled The Society News. These deal with topical issues of professional interest and importance, rather than academic clinical papers, which are restricted to the main journal.

3. Search News is a publication of The Association of Chief Chiropody Officers, and is distributed free to all state registered

¹ The Society of Chiropodists was re-named The Society of Chiropodists & Podiatrists in June, 1993.
³ Although it is accepted that the published minutes of both organisations are likely to have been subject to some editing, each are nevertheless presented in considerable detail.
chiropodists (podiatrists). This monthly publication began in March 1990 to provide a platform for the state registered to express their views and concerns outwith the influence of the Society of Chiropodists. This periodical provides a section for correspondence, official comments, open letters or statements, reports of the meetings of the Chiropodists Board of the Council for Professions Supplementary to Medicine (edited minutes) and NHS job advertising.

4. The British Chiropody Journal, retitled the British Journal of Chiropody in 1963, was active during the period under study from 1960 to 1988, at which time it officially became absorbed into the journal of The Society of Chiropodists. This periodical was independent of affiliation with or dependence upon the existing professional bodies within the state registered sector. This journal published editorials purporting to deal with issues of importance to the profession of chiropody free from the interference of the vested interests of the main professional bodies. The journal also published articles relating to professional matters, correspondence, official statements and reports, as well as articles of academic or other interest.

5. The Chiropody Review has been the official organ of the Institute of Chiropodists (the Institute of Chiropodists and Podiatrists

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5 The current Journal of British Podiatric Medicine continues to carry a sub-heading noting this incorporation.
7 The editor was for many years a member of the Chiropodists Board of the Council for the Professions Supplementary to Medicine.
since 1996) throughout the period under study. Initially a monthly journal, this became a bi-monthly journal in 1973 due to escalating costs.

The journal has published editorials dealing with professional issues of importance to the Institute, correspondence from members and readers, official statements of Institute policy, official statements from the Chiropodists Board of the Council for Professions Supplementary to Medicine and other official comments.

6. The Foot, sub-titled the International Journal of Clinical Foot Science, commenced publication in 1991 as part of a multi-disciplinary approach to foot healthcare. Although essentially concerned with clinical matters relating to the foot and serving a mainly medical audience derived from orthopaedics, rheumatology, radiology, plastic surgery and medicine, its editorial board reflects both medical and podiatric officers. It also occasionally publishes articles or editorials highlighting professional issues in podiatry.

7. The journal of the Podiatry Association, initially published as PA - the Journal of the Podiatry Association in May 1975, was retitled the British Journal of Podiatric Medicine and Surgery in January 1989 to coincide with their membership of the European Association of Podologues and as preparation for an International Association of Podiatry planned with the American Podiatric Medical Association. The Podiatry Association formed to represent that part of

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the state registered sector intent upon developing surgical advancement in podiatry. This publication contained editorials dealing with issues of importance to the Podiatry Association, correspondence, policy statements, other official statements (by State Board, The Society of Chiropodists, The British Orthopaedic Association and other relevant bodies), official committee reports (eg. education committee, liaison committee, COPSS negotiating team in 1995-1996) in addition to papers of academic interest.

8. Also, the *Podiatry Association Newsletter* was published initially as an adjunct to the PA journal, subsequently (1980) as a separate issue; bi-monthly to 1992, monthly thereafter (from 1993). The Newsletter held a regular "From the Chairman" section dealing with current issues of professional concern, coupled with correspondence, official statements, executive committee reports, comments and other matters of professional interest.

9. Finally, the *Minutes of the Meetings of the Executive Committee of the Podiatry Association* were accessed, from 1974 to 1997. These contained material relating to the business of the Podiatry Association across the timespan relevant to the current study. They provided insights and detail of events and views of the Executive Committee in relation to inter-professional and intra-professional issues, insurance issues, scope of practice, State Board elections, and other official policy matters.

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12 This journal was initially published irregularly - volume 1, number 1 was issued in May 1975; volume 1, number 2 published in December 1975; and volume 1, number 3 was issued in May 1977. However, by 1979 this had become a monthly journal.
Appendix 3 - Content Analysis

**Figure 1.** frequency of theme referred to as "professional closure" in *The Chiropodist* 1960-1969

![Graph showing frequency of theme referred to as "professional closure" in *The Chiropodist* 1960-1969.](image1)

**Figure 2.** frequency of theme referred to as "professional closure" in *The Chiropodist* 1970-1979

![Graph showing frequency of theme referred to as "professional closure" in *The Chiropodist* 1970-1979.](image2)
Figure 3. frequency of theme referred to as "professional closure" in The Chiropodist 1980-1989

Figure 4. frequency of theme referred to as "professional closure" in The Chiropodist 1990-1993
Figure 5. Frequency of theme referred to as "professional closure" in British Journal of Chiropody 1960-69

Year

Figure 6. Frequency of theme referred to as "professional closure" in The British Chiropody Journal 1970-1979

Year
Figure 7. Frequency of theme referred to as "professional closure" in British Chiropody Journal 1980-1988

Figure 8. Frequency of theme "podiatric biomechanics" in British Chiropody Journal 1975-1988
Figure 9. Frequency of theme referred to as "professional closure" in Chiropody Review 1960-1969

Figure 10. Frequency of theme referred to as "professional closure" in Chiropody Review 1970-1979
Figure 11. Frequency of theme "local anaesthesia" in Chiropody Review 1960-1969

Figure 12. Frequency of theme "local anaesthesia" in Chiropody Review 1970-1979
Figure 13. Frequency of theme "local anaesthesia" in British Chiropody Journal 1960-1969

Figure 14. Frequency of theme "local anaesthesia" in British Chiropody Journal 1970-1979
Figure 15. Frequency of theme "local anaesthesia" in British Chiropody Journal 1980-1988

Figure 16. Frequency of theme "foot care assistant" in British Chiropody Journal 1970-1988
Figure 17. Frequency of theme "foot care assistants" in Chiropody Review 1970-1981

Figure 18. Frequency of theme "radiography" in British Chiropody Journal 1960-1979
Appendix 4

The POPUMET Regulations 1988

The POPUMET regulations (1988) identify the self employed as equivalent to employers in respect of responsibility for ensuring that persons using X-ray technology either by physically directing or clinically directing\(^1\) medical exposures are adequately trained; that is, they must have completed the core of knowledge training. The use of ionising radiation for scientific research is specifically excluded from the regulations. The regulations also require that the institutions involved in running the core of knowledge courses should provide a certificate to attest to the competence of those completing their course (POPUMET regulations, H88/1861, 1988).

Radiological Protection supervisors are required to police and enforce the regulations under both the Health and Safety at Work Act (1974) (section 15), and under regulation 4 on behalf of the Secretary of State (POPUMET regulations, H88/1861, 1988). The institutions regarded by the DoH as "appropriate bodies to approve courses" are identified as The Royal College of Radiologists, College of Radiographers, Institute of Physical Sciences in Medicine, National Radiological Protection Board (NRPB) and British Nuclear Medicine Society, and others not specified (DHSS circular HO(88)29, 1988). All the above mentioned institutions are controlled by Radiologists or Radiographers.

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\(^1\) physically directing an exposure refers to "effecting the medical exposure", clinically directing means "having clinical responsibility for the decision to effect a medical exposure".
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