Putting Our Best Foot Forward:
Towards a Model of Foot Care for Ontarians

Response of the Canadian Federation of Podiatric Medicine to the proposals for a review of the Chiropody and Podiatry Professions by the Health Professions Regulatory Advisory Council (HPRAC), 2014

June 24, 2014
Putting Our Best Foot Forward: Towards a Better Model of Foot Care for Ontarians

Executive Summary.............................................................................................................................................. 3
The Current Model of Foot Care in Ontario............................................................................................................... 4
  Chiropody vs. Podiatry........................................................................................................................................ 4
Ensuring Access to Care .......................................................................................................................................... 7
  Demographic Change and the Future Foot Care Needs of Ontarians ................................................................. 7
  Province-wide Accessibility....................................................................................................................................... 8
A Better Way (Forward): Realizing Efficiencies and Quality Measures Through a More Effective Foot Care Model for Ontarians ........................................................................................................................................ 9
  The Case Against an American Style of Podiatry ................................................................................................. 9
  Providing Quality Care, Access to Care, Patient Safety and Efficiencies: A Competency-Based Approach.................................................................................................................................................. 10
  One Scope / One Practice ..................................................................................................................................... 11
About the Canadian Federation of Podiatric Medicine (CFPM) ............................................................................. 12
Executive Summary

The Canadian Federation of Podiatric Medicine (CFPM) is a national association representing the needs and interests of chiropodists and podiatrists across the country. As the organization that represents the greatest number of footcare practitioners in the province of Ontario, we have a vested interest in ensuring a regulatory system that encourages greater access to care while improving patient outcomes.

CFPM is fully supportive of efforts to enhance regulatory efficiency and efficacy through the Health Professions Regulatory Advisory Council (HPRAC) review process. Footcare in Ontario is governed by the outdated Chiropody Act, 1991. As HPRAC considers modifying the rules that govern the delivery of foot care to better reflect the advancements in assessment, diagnoses, prescription, and treatment of foot ailments that have taken place since the legislation’s introduction in 1991, the CFPM endorses adopting the highest levels of podiatric scope through a competency framework model. Specifically,

- Establishing a single podiatry profession, regulated by a single college, in which all members practice under the title of “podiatrist;”
- Extending scope of practice to include the ability to communicate a diagnoses to both chiropodists and podiatrists; and,
- Extending x-ray (including MRI and CT), lab testing (blood work, biopsy, C&S), and podiatric surgery privileges.

The CFPM believes that establishing a single title and extending roles would allow Ontario to draw upon the range of expertise and best practices from across the anglophone world – allowing the province to better respond to the footcare needs of today and tomorrow.

The efficiencies that will be realized with a new expanded scope of practice will allow for greater access to quality care and improve patient safety throughout all of Ontario.
The Current Model of Foot Care in Ontario

Foot care in Ontario is regulated by the Chiropody Act, which came into effect in 1991.

In the decades since then, advancements in assessment, diagnoses, prescription and treatment of the foot have rendered the legislation out of date. Quite simply, the rules that govern foot care in Ontario undermine both patients’ and practitioners’ best interests; foot care has advanced, but the legislation has failed to keep pace. To maintain our mission vision and values we need to give Ontarians complete access to care, quality of care and keep current with best practices.

The legislation restricts professional development and recognizes outmoded and divisive classifications, separating “chiropodists” and “podiatrists.” This no longer accurately reflects the skills and knowledge in the profession.

Every profession can reasonably expect to grow and develop over time. Indeed, professional development and sustained provision of high-quality care depend on a profession enhancing and extending its knowledge, skills and roles in response to changing technological developments, population disease profiles and population needs (Gilmore et al 2011; Nancarrow and Borthwick 2005; Borthwick 2000; Cameron and Masterson 2003; McPherson et al 2006).

Chiropody vs. Podiatry

Ontario’s active foot-care workforce is made up of chiropodists and podiatrists. However, since 1993, the number of registered podiatrists has been capped, meaning comprehensive foot care is increasingly performed by highly trained members designated as chiropodists.

In fact, the vast majority (568, according to recent figures) of professional practitioners in Ontario are classed as chiropodists. Recent figures indicate there are 84 registrants classed as podiatrists and holding a doctor of podiatric medicine (DPM) degree; however, as many as 10 are now over 70 years of age, and thus unlikely to be part of the active workforce, and as many as 14 do not actually practise in Ontario, although they are registered here (based on primary site of practice data).

In short, chiropodists trained in Ontario, alongside chiropody registrants educated and trained in other anglophone nations with recognized high standards (United Kingdom N= 39, Australia N= 1, South Africa N= 3, USA N= 70), constitute the largest foot-care skill resource in the province (Muenzen 2013).

Under the Chiropody Act, both chiropodists and podiatrists are defined as practising “the assessment of the foot and the treatment and prevention of diseases, disorders or dysfunctions of the foot by therapeutic, orthotic and palliative means.” In contemporary practice, there is relatively little, if any, difference between chiropody and podiatry; both undertake the
prescription of relevant medicines and the use of injectable agents (such as local anesthetics or corticosteroids), as well as surgical procedures.

That’s not to say there is no distinction.

First, podiatrists registered in Ontario before 1993 are entitled to undertake a scope of practice wider than that of chiropodists. Implicit in this distinction is the assumption that the level of education is markedly different between the two. This bias is based on the notion that the American degree course is taught at doctoral level, while non-U.S. qualifying courses, such as those in Ontario, the U.K., and Australasia, are not. However, this is misleading, as indicated by the conclusions of the U.K. National Academic Recognition Information Centre (UK NARIC), the British equivalent of the Government of Canada's Foreign Credential Recognition Program.

NARIC is the only official source of information on international education and training systems and skills attained from outside the U.K. NARIC considers the American DPM degree in podiatry as “not equivalent to research doctorates, despite the fact they use the title doctor in the title. Each of these degrees is in fact a first degree in a specific field” (NARIC accessed 2012). It is thus considered to be an equivalent of the U.K. BSc honours degree, and its Australasian counterpart (bachelor of applied sciences), with graduate entry and surgical residency requirements added.

Importantly, the Advanced Diploma in Health Sciences (Chiropody) offered by the Michener Institute is also a graduate entry program.

Furthermore, 83.1 per cent of Ontario chiropodists who have qualified since 1994 from the Michener Institute now possess a bachelor’s degree or higher qualification. As well, 49.3 per cent of those qualifying from George Brown College (that is between 1982 and 1993) now have a minimum of a bachelor’s degree. Twenty-seven chiropodists have subsequently achieved a higher degree, either at the masters or doctoral level (COCOO 2014).

The arguments used in Ontario in 1977 (Hedlin Menzies & Associates 1977) to draw a clear distinction between chiropodists and podiatrists on the basis of training are no longer relevant. Historical differences have gradually eroded as the profession has advanced. Since 1991, chiropodists trained in Ontario have developed skills and knowledge that equip them at a level comparable with those elsewhere in the world. The Advanced Diploma in Health Sciences (Chiropody), a graduate entry program modelled on and influenced by programs across the anglophone world, now reflects these advances. Chiropodists have proven efficiencies for the health-care system and have delivered a high standard of foot care and access to care for all of Ontario including all rural areas.

Simply put, Ontario-trained holders of an Advanced Diploma in Health Sciences (Chiropody) make up a highly educated and skilled workforce. These practitioners have high levels of practical skill and specialized knowledge. Representing the largest foot-care resource in Ontario, they prevent excessive strain and over-reliance on physicians’ time and services.
The practical limitations of the Chiropody Act show how legislation can fall behind advances in practice, and, in some cases, can lead to unnecessary restrictions that wind up denying the public access to high levels of skill and knowledge.

Assessment, diagnosis and treatment of foot ailments is part of both chiropodists’ and podiatrists’ day-to-day clinical practice. However, only podiatrists, who make up less than 15 per cent of the province’s foot-care specialists (and this number is shrinking), are allowed to communicate diagnoses, or the reasons behind particular courses of treatment, to their patients.

Communicating diagnoses is widely recognized as part of the remit of both U.S.-trained podiatrists (who hold the DPM degree) and of chiropody/podiatry practitioners across most of the anglophone world, particularly in the U.K. and Australasia.

This is just one example of the current disconnect between the legal definition of practice and the range of skills acquired by both types of practitioners owing to advances in education programs in chiropody.

The efficiencies that will be realized with the new expanded scope of practice will allow for greater access to quality care throughout all of Ontario and most of all improve patient safety moving forward in all areas of the province.
Ensuring Access to Care

Demographic Change and the Future Foot Care Needs of Ontarians

The fundamental impetus for legislative and regulatory change is to ensure health-care services meet the needs of the population. Over the coming decades, key demographic and workforce changes will impact the Ontario public and health-service providers.

In Canada, the post-war “baby boom” period unfolded between 1947 and 1966, peaking in 1961 (Foot 2013, 2007). As a result, there are 10 million Canadian baby boomers; most of them are just entering their 50s, while those at the upper end are approaching 65 and starting to retire. Critically, the “coming years will see the beginning of a 30-year decline in the ratio of the working-age population to seniors.” (Gomez and Foot 2013). As in Europe, the demographic picture in Canada will feature a smaller working-age population and an older society with higher demands on health care. This will become particularly evident in Canada in the 2020s and 2030s. (Foot and Gomez 2006; Foot 2007).

From a foot-care perspective, Ontario will most benefit from a model of chiropody/podiatry in which specialists have particular skills and knowledge in the management of complications of chronic, long-term conditions, including arthritis, diabetes and vascular disorders, as well as incidents including falls, foot ischemia and foot infections. (Bagust et al 2002; Brooks 2003; Foot 2011; Foot et al 2007; Foot and Gomez 2006; Foot et al 2000).

It will be central to this model that chiropodists/podiatrists be recognized as capable of making independent diagnoses and undertaking confirmatory investigations so they can prescribe the appropriate medication, for example, to treat a potentially limb-threatening foot infection in a vulnerable patient (CoP 2012; DH 2011a, 2011b, 2012).

Perhaps the most striking feature of this demographic study of Canadian health-care needs is the stark conclusion that “the Achilles heel of future health-care delivery, however, is likely not to be Canada’s ability to pay, but its inability to find sufficient health-care workers” (Foot 2007). While it is widely accepted that, “we are going to need large numbers of health-care providers to look after the aging baby boomers over the next forty years,” not enough providers have been recruited. (Foot 2013).

Other provinces are trying to increase “the number of medical and rehabilitation training programs in universities,” or are “putting a priority” on immigration or recruitment of second-career students. The Ontario chiropody program has already sought to develop and exploit these strategies (Foot 2011, 2007). Additional steps must be taken.
Policy makers and regulators must ensure that legislation and regulations allow for workforce flexibility—the capacity to use resources that already exist in Ontario and the ability to welcome skills and knowledge from other nations.

Trends clearly indicate the changing health-care needs of the public, as well as the need to redesign the workforce to make the best use of skills. A redesigned health workforce will be a key element of ensuring a sustainable health service for the future. (Denton et al 2002; Foot and Gibson 1993; Foot 2007, 2013).

**Province-wide Accessibility**

Location of practitioners is an important element in providing access to foot care.

Most chiropodists in Ontario practice in single-practitioner clinics as opposed to hospitals.

According to Foot (2007), older patients, who are the key consumers of health care, prefer not to live in central urban areas where most hospitals are located, but in smaller communities. Distance from appropriate care can be particularly debilitating for older patients.

To ensure patients receive a universal standard of care, irrespective of where they choose to live, Foot (2007) emphasizes the need to provide health care in accessible clinics in both urban and rural settings, in precisely the same manner Ontario’s chiropodists currently practice.
A Better Way (Forward): Realizing Efficiencies and Quality Measures Through a More Effective Foot Care Model for Ontarians

Ontario’s foot-care profession and patients’ needs have evolved, and the antiquated, out-of-sync Chiropody Act must be re-examined.

The Canadian Federation of Podiatric Medicine (CFPM) supports amendment of the current legislation, which no longer adequately reflects the skills and knowledge of the profession and limits the use of available foot-care resources.

Above all, the CFPM embraces the adoption of a hybrid “one scope/one practice” foot-care model that borrows best practices from around the world to best meet Ontarians’ current and future needs.

Establishing a single podiatry profession, regulated by a single college, with all members practising under a single title will eliminate confusion, lower costs and wait times, and ultimately provide more comprehensive care, while ensuring greater access for Ontarians.

The CFPM believes that by drawing on the range of expertise and best practices from across the anglophone world, the profession can offer Ontarians who need foot care the highest professional standards and incorporate the best clinical, evidence-based advances. (ACPS 2008; PA 1995; DH 2012).

The Case Against an American Style of Podiatry

Importing a U.S. DPM model, as Alberta and British Columbia have done, will not achieve better quality, greater access and more efficient care.

Adopting a model with an exclusionary basis would be overly restrictive, monopolistic in effect, and prevent access to the wide range of potential resources available from within and outside the province.

The CFPM recognizes and supports the principles underpinning the Fair Access to Regulated Professions and Compulsory Trades Act (2006), which, according to Michael Colle, who was then Minister of Citizen and Immigration, aimed to ensure that “those with great global experience have a fair shot at working in their profession” and that Ontario “is attracting some of the best educated, and highly skilled people from around the world” (Colle 2006).

In light of the expected shortfall of foot-care practitioners in relation to the province’s aging population, it would be short-sighted at best to adopt an inflexible and exclusionary model that undermines Ontario’s ability to attract the best and brightest from around the globe.
Lessons can be learned from the past. Amendments to the Chiropody Act (1944) upgraded education requirements. In seeking to raise standards, the new legislation led to lower workforce recruitment numbers. This resulted in a de facto monopoly by practitioners from U.S. training programs, leading to only 70 recruits to Ontario between 1950 and 1967 (Fraser 1970). The literature agrees that models that encourage monopoly supply have the potential to produce a shortfall in required numbers. (Foot 2007; Duckett 2005, Nancarrow and Borthwick 2005).

The Committee on Healing Arts (1966-1970) expressed concern that proposals to introduce a model of podiatry (from the U.S.) that emphasised significant invasive surgical practice would not directly meet the needs of the Ontario public at that time (Grove 1969).

While both the skills of the profession overall and the needs of the public have changed in the intervening years, the CFPM supports development of an advanced model of care in which podiatric surgery forms a valued and integral part of providing foot care. As well, the CFPM stresses the need to balance the practice of podiatric surgery with the range of other and advanced skills that Ontario’s new podiatrists would be able to offer—specifically skills required to meet the needs of aging baby-boomers who face higher incidents of chronic illness through their later years (Bagust et al 2002; Bajcar et al 2010; Brooks 2003; Foot 2013, 2007). These needs are best met by practitioners who can act independently, reducing duplication of services and waits for referrals from or to busy physicians who have other priorities and who may not have the skill to treat what chiropodists and podiatrists treat on a daily basis (Brooks 2003; Gilmore et al 2011).

Providing Quality Care, Access to Care, Patient Safety and Efficiencies: A Competency-Based Approach

The CFPM believes that a competency framework model would provide the best fit for Ontario, enabling highly skilled practitioners from around the globe, who bring new advancements and particular skills, to bolster the province’s foot-care workforce.

As opposed to models founded on an exclusionary basis, a competency framework approach to foot care will ensure registrants meet standards of care, without imposing a single education model requirement, which does not align with the province’s need for workforce flexibility (Cameron and Masterson 2003; Nancarrow and Borthwick 2005; Schofield and Beard 2005).

Each of the varying tile- and degree-holders offers particular foot-health skills and knowledge, which should be harnessed to provide the best possible care for the specific needs of the population of Ontario. It is thus preferable to recognize the merits of the varying skills and training of chiropodists trained in Ontario and elsewhere, rather than select a single model that may not be suited to Ontario’s specific foot-health needs.

Competency frameworks already operate successfully, for example, in the U.K. The Single Competency Framework for all Prescribers (NIHCE 2012) provides a unitary set of competency
standards for every profession engaged in the prescribing of medicines—from physicians and surgeons to podiatrists and physiotherapists (NIHCE 2012). While specific chiropody/podiatry education programs around the world vary in emphasis, there is a growing standardization (particularly across the anglophone world), which would ensure a highly skilled workforce (e.g. APodC 2006; ACPS 2008; PA 1995). The CFPM recognizes that, to date, moves to ensure the mutual recognition of professional qualifications as part of the Inter-Provincial Labour Mobility program and Agreement on Internal Trade have not yet been possible across Canada, but wishes to see this ideal come to fruition. To date, chiropodists who have qualified through the George Brown Institute (1982-1993) and subsequently the Michener Institute for Applied Health Sciences (1992-present) are eligible to work as podiatrist in seven of Canada’s ten provinces.

A single competency framework is clearly best to ensure Ontarians’ needs are met fully. It would foster the finest skills and knowledge from global educational programs to ensure the highest possible standards of care for patients.

**One Scope / One Practice**

In order to best meet the needs of the Ontarian population and provide sustainable podiatry/chiropody care, the CFPM supports revising regulations to enable a single, inclusive profession to emerge, one that draws on the very best practices of the profession from around the world and supports Ontario’s physicians and surgeons through an extended scope of practice. This will enhance patient access and reduce the burden of care on hard-pressed physicians (Bajcar et al 2010; Borthwick 2005; Denton et al 2002; House 2012).

The CFPM recommends Ontario do away with the title of chiropodist, which is universally regarded as redundant. A one scope/one practice podiatry model would eliminate public confusion about the distinction between chiropody and podiatry and would address an inconsistency that no longer exists anywhere the profession is regulated and where formal standards exist, outside of Canada.

Establishing a single podiatric designation, regulated by a single college, with all members practising under the title of “podiatrists” will eliminate confusion, lower costs and wait times, and ultimately provide more comprehensive care and greater access to services for Ontarians.

Establishing a single title and extending roles to include ordering and interpreting radiographs, ordering laboratory tests and undertaking podiatric surgery, would be consistent with developments in chiropody/podiatry throughout the anglophone world. This would also conform with key workforce strategies, adopted throughout the Western world, that seek to enhance role substitution, flexibility and the transfer of tasks over role boundaries (Cameron and Masterson 2003; Gilmore et al 2011; Nancarrow and Borthwick 2005).
About the Canadian Federation of Podiatric Medicine (CFPM)

The Canadian Federation of Podiatric Medicine constitutes the largest professional body representing chiropodists and podiatrists in Canada, accepting members from every province. Established in 1999 as the Canadian Federation of Foot Specialists, the organization aims to provide a national association open for membership to all chiropodists and podiatrists, to aid the profession through representation to government, and to promote unity within the profession in the service of the public. The majority of CFPM members reside and practise in Ontario, and its membership reflects the range and diversity of skills, knowledge and education across the profession, with members educated and trained in validated and regulated programs in Ontario, the United States, the United Kingdom, Australia, and South Africa (Muenzen 2013). The CFPM is best placed, therefore, to offer an insight into the rich diversity of highly educated and skilled practitioners of podiatry and chiropody from across the anglophone world currently practising in Ontario.
References


Brooks PM (2003), The impact of chronic illness: partnerships with other healthcare professions, Medical Journal of Australia, 2003, 179: 260-262


Department of Health, Background Paper from Department of Health to the Commission on Human Medicines Subgroup on proposals to introduce independent prescribing by podiatrists, London: DH. 2012.


Redmond A, http://medhealth.leeds.ac.uk/profile/750/732/anthony_redmond


University of Leeds, Leeds Institute of Rheumatic and Musculoskeletal Medicine, http://medhealth.leeds.ac.uk/info/700/leeds_institute_of_rheumatic_and_musculoskeletal_medicine