Chiropody & Podiatry

A Rapid Literature Review on Scopes of Practice and Models of Foot Care in Other Jurisdictions

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Health Professions Regulatory Advisory Council

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SUMMARY OF MAIN FINDINGS

Scopes of Practice

- Over the past several decades, the term "podiatry" and the additional competencies associated with it replaced the term "chiropody" and are generally accepted in the majority of developed countries today. Ontario remains the only jurisdiction identified in this review to use the chiropody model. In Ontario, podiatrists and chiropodists differ in their education, service provision, and billing privileges.
- Scopes of practice for podiatrists across jurisdictions include the prevention, diagnosis, treatment, and palliation of disorders and conditions of the foot such as full-body history and physical examinations, setting or casting a fracture of a bone of the foot or lower leg, gait analysis and manufacture and prescription of orthotics, and prescribing and administering drugs. Notable differences among jurisdictions concern the use of X-rays, administration of anaesthesia, amputation privileges, and treatment of systemic diseases affecting the foot.
- Jurisdictional variations were identified on whether their scopes of practice for podiatrists included the foot with or without the ankle and leg. In the US, the states of New York, Virginia, and Texas recently changed the foot wound care and ankle surgery privileges, access to areas above the ankle to harvest skin grafts, and the definition of the foot.
- Older people suffer from foot problems in greater proportions and degrees compared to younger people. Further, unkempt toenails can cause or contribute to falls in older people who may find it difficult to maintain their foot hygiene from arthritic hips or neglect due to dementia. In the UK, low-level foot care, such as toenail cutting and tending to corns and calluses, was identified as an area that required increased public funding.
- The conflicts between podiatry and other medical professions such as orthopaedic surgery were highlighted in various jurisdictions including the US, Australia, and the UK in defining the scopes of practice and medical boundaries for podiatry.

Models of Care

- Several jurisdictions highlighted the importance of multidisciplinary and integrated settings for delivering foot care and identified podiatrists as key foot care team members. Other team members included nurses, geriatricians, and orthopaedic surgeons.
- Podiatrists' surgical skills and understanding of the biomechanics of the foot and ankle were identified as important for a multidisciplinary approach to diabetic limb salvage (i.e., the preservation of a functional foot without the need for a prosthesis).
    - Additional team members included dietitians, microbiologists, endocrinologists, reconstructive surgeons, vascular surgeons, and physiotherapists.
    - In several jurisdictions, people with diabetes were classified based on their risks of foot diseases so that foot care could be provided by an appropriate health care professional at a frequency appropriate to the patients' needs and that the limited number of podiatrists could be allocated to those who most need podiatrists' skills.
    - The need to provide timely access to foot care services was also noted for people with diabetes.
- Several jurisdictions including Ontario, the US, the UK, Australia, and Demark provide some public funding for foot care.

OBJECTIVES

The requestor's stated objectives were to identify and summarize the literature on the scopes of practice and models of care for podiatry and chiropody in other jurisdictions. Specific information was requested on the following:

- Trends and changes in the scopes of practice for podiatrists and chiropodists;
- Delivery of foot care (e.g., practitioners, consumers, practice settings);
- Payment models for foot care; and
- Diabetic care and senior care related to foot care.

For this update, the requestor was particularly interested in technical terms and details (e.g., different medical definitions of the foot as described in various legal documents).

SEARCH METHODS

Individual peer-reviewed articles were identified through the Ontario Ministry of Health and Long-Term Care's computerized library database, PubMed, and Google Scholar. Grey literature was identified through Google and relevant government websites. The search was limited to English sources and therefore may not capture the full extent of initiatives in non-English speaking countries.

The Medical Subject Heading (MeSH) terms "Podiatry", "Chiropody", "Accreditation", "Certification", "Licensure", "Health Services", "Models, Organizational", "Delivery of Health Care", "Fees and Charges", "Financing, Organized", "Aged", and "Diabetes Mellitus" were used in combination with the following keywords to identify relevant articles and documents for this review: "podiatry", "podiatrist", "chiropody", "chiropodist", "foot care", "scope of practice", "authority", "role", "professional responsibility", "practice setting", "regulation", "model of care", "framework", "payment", "funding", "compensation", "fee", "senior", "aged", "elderly", "diabetes", and "diabetic".

A total of 56 references were identified and cited in this updated review: 19 narrative reviews/ overviews/commentaries from peer-reviewed journals, eight original research papers from peer-reviewed journals, and 29 documents from the grey literature. Table 4 in Appendix B contains a summary table with details for each of the sources cited in this review. In total, the searching for relevant material and the writing of this review took approximately 16 days to complete by one person.

DESCRIPTION OF THE FINDINGS

1. Limitations of the Literature

The majority of the articles from peer-reviewed journals (19/27) identified during the search for this review were narrative reviews (rather than systematic reviews),[a] overviews, or commentaries and may have been subject to the author(s)' bias on the article topics. Further, limited information was found on delivery of foot care and payment models for foot care.

[a] For more information on different types of reviews, see Cochrane Library.

2. Terminology

In some jurisdictions, the terms "podiatry" and "chiropody" or "podiatrist" and "chiropodist" were reported to have identical meanings (South Carolina Code of Laws, 2013) and be used interchangeably (Hayes & Bussey, 2011). However, according to the Ontario Podiatric Medical Association,[b] in Ontario, there are important differences between podiatrists and chiropodists in their education, service provision, and Ontario Health Insurance Plan (OHIP) coverage as follows:

- Podiatrists have post-baccalaureate and four-year Doctor of Podiatric Medicine (DPM) degrees whereas chiropodists have post-secondary diplomas in chiropody;
- Podiatrists may communicate a diagnosis and perform surgery on bones whereas chiropodists may do neither; and
- Podiatrists have OHIP billing privileges whereas chiropodists do not (Ontario Podiatric Medical Association, 2014).

In this review, podiatry and chiropody are distinguished to be consistent with the podiatry and chiropody models found in Ontario.

3. Scopes of Practice

Table 1 in Appendix A summarizes the scopes of practice for podiatrists (and chiropodists where available) for each jurisdiction, highlighting some of the health care services and anatomy within different jurisdictional scopes of practice. Table 2 in Appendix A further summarizes the podiatric scopes of practice from US state statutes.

3.1. Podiatrists vs. Chiropodists

Initially, the term applied to the profession specializing in foot care across jurisdictions was "chiropody." Over the past several decades, the term "podiatry" and the additional competencies associated with it have spread and are accepted in the majority of developed countries today (Ontario Podiatric Medical Association, 2014) including the US (Sanders et al., 2010) and the UK (Maher, 2013). In Canada, provinces other than Ontario admit new practitioners as podiatrists and use the term "podiatry" (Health Professions Regulatory Advisory Council, 2008); chiropodists are not entitled to practice in British Columbia, Alberta, Manitoba, and Quebec (Canadian Podiatric Medical Association, n.d.). Ontario remains the only jurisdiction identified in this review to use the chiropody model[c] and includes both podiatrists and chiropodists as regulated health professionals.[d]

The Office of the Fairness Commissioner of Ontario[e] defined the scopes of practice for both podiatrists and chiropodists as "the assessment of the foot and the treatment and prevention of diseases, disorders, or dysfunction of the foot by therapeutic, orthotic, or palliative means."

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[b] The Ontario Podiatric Medical Association serves podiatrists in Ontario by advocating to government and other stakeholders on behalf of the profession.

[c] As of July 1, 1993, new members registering with the College of Chiropodists of Ontario are required to be registered as chiropodists. However, those podiatrists who registered with the College before July 1, 1993 are permitted to continue to practice as podiatrists (Office of the Fairness Commissioner, 2007).

[d] The *Chiropody Act* in Ontario includes both podiatrists and chiropodists as regulated health professionals.

[e] The Office of the Fairness Commissioner ensures that everyone who is qualified to practice a profession that is regulated in Ontario can get a licence to practice in the province.

However, while both professions are authorized to prescribe drugs and cut into the subcutaneous tissues of the foot, only podiatrists are allowed to cut into the bony tissues of the forefoot[f] and communicate diagnoses to patients (Office of the Fairness Commissioner, 2007).

3.2. Health Care Services

Scopes of practice for podiatrists include the prevention, diagnosis, treatment, and palliation of disorders and conditions of the foot (British Columbia Regulation, 2010). Several types of health care services were identified from multiple jurisdictions and summarized below where available.

Use of Technologies

The *Health Professions Act* in British Columbia permitted podiatrists to apply X-rays for diagnostic or imaging purposes, employ laser for cutting or destroying tissues, and authorize others to apply ultrasound, electromagnetism, or X-rays (British Columbia Regulation, 2010). In contrast, the South Carolina Legislature restricted podiatrists' right to use X-rays for diagnostic, but not imaging, purposes (South Carolina Code of Laws, 2013).

Administration of Anaesthesia

Legal documents from the states of California, South Carolina, and Wisconsin included the administration of local, but not general, anaesthesia in the scopes of practice for podiatrists (Medical Board of California, 2010; South Carolina Code of Laws, 2013; Wisconsin Statutes, 2014). However, in Wisconsin, podiatrists may use a general anaesthetic when it is administered under the direction of a person licensed to practice medicine and surgery (Wisconsin Statutes, 2014). An overview of podiatry by a consultant podiatric surgeon in the UK reported that podiatrists in the UK are also trained and able to administer local anaesthesia (Maher, 2013).

Prescription of Drugs

The *Health Professions Act* in British Columbia authorized podiatrists to prescribe, compound, dispense, and administer drugs and inject intravenous fluids (British Columbia Regulation, 2010). An overview of general podiatry (Hayes & Bussey, 2011) and a commentary on podiatric care for early rheumatoid arthritis (Woodburn et al., 2010) by researchers in the UK stated that podiatrists in the UK are also licensed to access and supply antibiotics, analgesics, and steroids.

Amputation of the Foot

The Medical Board of California[g] stated that DPMs, with their expertise in the care and preservation of the diabetic foot, may perform partial amputations of the foot (Medical Board of California, 2010). In contrast, the South Carolina Legislature prohibited podiatrists from amputating the foot or toes (South Carolina Code of Laws, 2013).

Treatment of Systemic Diseases

The *Health Professions Act* in British Columbia (British Columbia Regulation, 2010) and the South Carolina Legislature (South Carolina Code of Laws, 2013) prohibited any treatment of systemic

[f] The Health Professions Regulatory Advisory Council (2008) reported that in 1993, the practice of podiatry was capped in Ontario, and some surgical privileges including backfoot surgery were removed in the province.
[g] The Medical Board of California is a state government agency which licenses and disciplines medical doctors in California, US.

diseases causing manifestations in the foot or lower limb. In contrast, the Australian Podiatry Association of Victoria[h] stated that podiatrists are able to diagnose and treat any foot- and lower limb-related complications of bone and joint disorders, soft-tissue and muscular pathologies, and neurological and circulatory diseases (Australian Podiatry Association of Victoria, 2002).

Treatment of Other Conditions

Podiatrists are also allowed to:

- Manage skin and nail disorders, lower limb soft tissue disorders, and complex wounds and treat bunions, nerve entrapments, and tendon disorders in the UK (Maher, 2013).
- Diagnose and treat lower extremity ulcers and harvest skin grafts from areas above the foot and ankle to treat ulcers in Virginia (American Podiatric Medical Association, 2011).[i]
- Diagnose and treat foot injuries and infections from sports or other activities in Victoria, Australia (Australian Podiatry Association of Victoria, 2002).

Other Health Care Services

Other podiatric services include:

- Medical history and physical examinations in the state of California (Medical Board of California, 2010; Levy, 2012).
- Setting or casting a fracture of a bone of the foot or lower leg and reducing a dislocation of a joint of the foot or lower leg in British Columbia (British Columbia Regulation, 2010).
- Gait analysis and manufacture and prescription of orthotics in the UK (Maher, 2013).
- Sharp debridement,[j] application of biomechanics, footwear modification and education, neurovascular assessment, and toe pressure measurements in Australia (Butters, 2011).
- Assisting Doctors of Medicine (MDs) and Doctors of Osteopathic Medicine (ODs) in podiatric or non-podiatric surgery in California (Medical Board of California, 2010).

3.3. Anatomy

Jurisdictions varied with respect to whether their scopes of practice for podiatrists included the foot with or without the ankle and leg as follows:

- The *Health Professions Act* in British Columbia included the foot and the bones, muscles, tendons, ligaments, and other tissues of the lower leg in the services provided by podiatrists (British Columbia Regulation, 2010).
- According to the American Podiatric Medical Association, although the podiatric scopes of practice statutes vary from state to state, all 50 states and the District of Columbia permit the treatment of the foot; 44 states[k] and the District of Columbia also permit the treatment at or above the ankle (American Podiatric Medical Association, n.d.). The American

[h] The Australian Podiatry Association of Victoria is an independent, member organization serving both the profession and the community in Victoria, Australia.
[i] The American Podiatric Medical Association represents podiatrists in the US and provides foot and ankle health information to the public.
[j] Sharp debridement refers to the use of a scalpel, scissors, or other instruments to cut dead tissue from a wound.
[k] The 44 states include all but Alabama, Kansas, Massachusetts, Mississippi, New York, and South Carolina (American Podiatric Medical Association, n.d.).

College of Foot and Ankle Surgeons[l] summarized the states' and District of Columbia's statutes on whether they include:

- The ankle, leg, or hand;
- The toe and (partial) foot amputation; and
- General anaesthesia (American College of Foot and Ankle Surgeons, n.d.).[m]

3.4. Change in Scopes of Practice

According to the American Academy of Orthopaedic Surgeons,[n] the US podiatric community has pushed for the expansion of its scope of practice through state legislative, regulatory, and judiciary means in recent years (American Academy of Orthopaedic Surgeons, 2012). For example, the American Podiatric Medical Association aims to achieve a "uniform scope of practice" by 2015, allowing podiatrists to treat patients in their specialty without restrictions (American Podiatric Medical Association, 2007). Several jurisdictions in the US have changed their scopes of practice:

- In 2014, the state of New York expanded its scope of practice for wound care and surgery:
  - According to the Office of the Professions in the New York State Education Department,[o] effective February 17, 2014, podiatrists are no longer restricted to wound care on the foot but may treat wounds if they are near and related to a wound on the foot (New York State Education Department, 2014a).
  - The Office of the Professions also stated that the Laws of 2012 expanded the scope of practice for podiatry on ankle surgery privileges, enabling podiatrists holding the privileges to perform certain procedures they had not previously been authorized to perform (New York State Education Department, 2014b).[p]
- According to the American Podiatric Medical Association, effective July 1, 2011, podiatrists in the state of Virginia are authorized to access areas above the foot and ankle to harvest skin grafts in the treatment of ulcers (American Podiatric Medical Association, 2011).
- In litigation that began in 2002, the Texas Medical Association (TMA)[q] and the Texas Orthopaedic Association (TOA)[r] challenged the definition of the foot that was expanded by the Texas State Board of Podiatric Medical Examiners (TSBPME)[s] to include the ankle (Reddy, 2005). In 2010, the TMA reported on the Texas Supreme Court's decision on the eight-year legal case to reject the TSBPME's change in the definition of the foot that would

[l] The American College of Foot and Ankle Surgeons is a professional society of foot and ankle surgeons founded in 1942 that addresses the concerns of foot and ankle surgeons in the US.

[m] The American College of Foot and Ankle Surgeons provided no date for the summary of the podiatric scopes of practice from the statues (American College of Foot and Ankle Surgeons, n.d.). Therefore, it is unclear which of the two sources – the American Podiatric Medical Association and the American College of Foot and Ankle Surgeons – presented the most recent information.

[n] The American Academy of Orthopaedic Surgeons provides musculoskeletal education to orthopaedic surgeons and others across the US and international jurisdictions.

[o] The New York State Education Department administers professional regulation in the state of New York through its Office of the Professions.

[p] For the definition of the ankle and the detailed description of the ankle surgery privileges, see Podiatric Ankle Surgery Privileges (New York State Education Department, 2014b).

[q] The TMA represents the physicians and medical student members across the state of Texas.

[r] The TOA represents the public policy interests of orthopaedic surgeons in the state of Texas.

[s] The TSBPME licenses podiatric physicians and regulates the practice of podiatric medicine in the state of Texas.

have allowed podiatrists to perform procedures on the bones and tissues of the lower leg below the knee cap, including fractures that extend into the ankle joint (Conde, 2010).

The American Academy of Orthopaedic Surgeons cautioned against the expanded scopes of practice for podiatry in some states by noting that all DPMs with or without post-graduate residency or surgical training are now legally allowed to treat ankles and lower legs, contributing to variations in the skills of licensed practitioners (American Academy of Orthopaedic Surgeons, 2012).

3.5. Senior Care

Two narrative reviews on podiatry by medical professionals and/or researchers in the UK reported that older people are afflicted with foot programs in greater proportions compared to younger people (Vernon et al., 2011; Mandy, 2008). Often associated with the musculoskeletal system, foot problems can affect the mobility of older people who may have already-reduced mobility or other medical problems affecting the foot, such as diabetes, and are unable to take care of their own feet (Vernon et al., 2011). The authors noted that the provision of foot care for older people can improve their mobility, independence, and quality of life (Vernon et al., 2011; Mandy, 2008).

However, a Letter to the Editor by medical professionals (Dindyal et al., 2009) and a commentary on supporting older people with foot care by a Health and Social Care Policy manager (Ellis, 2006) in the UK stated that public funding for basic foot care (e.g., toenail cutting) by the National Health Service (NHS) is only available for people with diabetes or heart problems or who are at increased risk of infections, leaving the rest of the population to tend to their own feet. The authors further identified long, unkempt toenails as a frequent cause of or contributor to falls in older people, who may find it difficult to maintain their foot hygiene from a lack of strength, arthritic hips, and neglect due to dementia, and noted the need for training and special tools for cutting older people's tough toenails.

3.6. Allied Health Professionals vs. Physicians

Conflicts were identified in the US between podiatry and other medical professions in defining their scopes of practice and medical boundaries. For example:

- A historical overview of podiatry by a DPM in the US stated that podiatry has allegedly antagonized the physician profession for decades with their pursuit of an unrestricted medical license (Levy, 2012). For example, the legal case in the state of Texas over the definition of the foot highlights one such conflict (see Section 3.4, above).
- An overview of podiatric medicine by the Deputy Executive Director of the American Podiatric Medical Association noted that while the scopes of practice for MDs and ODs are determined solely by their education, training, and experience, those of DPMs are determined by state laws and often influenced by politics (Levrio, 2009).

Others noted that podiatry has succeeded as a medical profession in establishing its niche:

- Two commentaries by chiropractors and/or researchers in the US (Murphy et al., 2008) and the UK (Nancarrow & Borthwick, 2005) stated that podiatry established itself as a respected and integrated health care profession despite the difficulties of encroaching on the traditional territory of the well-established orthopaedics. In fact, DPMs in the US were

included in Medicare as physicians within the scope of their practice in 1968 and granted practice privileges in hospitals in 1977 (Levy, 2012).

- A 2009 Australian study compared the workload of podiatric surgeons in the private sector to that of orthopaedic surgeons in the public sector for the provision of great toe joint surgery which is traditionally accepted as an area of expertise for the medically-trained orthopaedic surgeons. The authors found that podiatric surgeons performed the surgery 2-16 times more often compared to orthopaedic surgeons and suggested extending the role of podiatric surgeons within the Australian public sector (Gilheany & Robinson, 2009).

4. Models of Care

4.1. Multidisciplinary and Integrated Care

The need for and/or existence of multidisciplinary and integrated settings for delivering foot care and the importance of podiatrists in these settings were recognized in several jurisdictions:

- According to the Australian Podiatry Association of Victoria, podiatrists establish and maintain collaborative relationships with other health care providers, often within a site-based, multidisciplinary team (Australian Podiatry Association of Victoria, 2002).
- A report by the Department of Health in Western Australia stated that integrated teams consisting of medical, surgical, nursing, podiatry, and allied health professionals have been shown to help heal wounds and ulcers, diminish the incidence of amputations, and improve the prognosis for limb salvage (Government of Western Australia, 2010).
- According to an Australian pilot study, previous studies had found that: 1) podiatrists were valuable core team members in high-risk foot care services at a number of tertiary institutions; and 2) high-risk foot services were found in all major hospitals within Melbourne and Victoria (Butters, 2011).
- The importance of podiatrists in multidisciplinary teams were also recognized in diabetes care in the UK (National Institute for Health and Care Excellence, 2004) and the care for rheumatology in the UK (Juarez et al., 2010; Woodburn et al., 2010) and New Zealand (Rome et al., 2013; Rome et al., 2009).

Several documents were identified that discussed different practice settings for podiatrists:

- The results of a 2007 survey of podiatrists conducted by the American Podiatric Medical Association showed that individual practice has decreased over the years (61% in 1996 to 50% in 2007 among the surveyed podiatrists). Of the surveyed podiatrists, 19% were in a podiatric medical group, 16% were in a partnership, 7% were in a multi-specialty group, and 2% were in an orthopaedic group (Al Fisher Associates, 2007).
- An overview of podiatric medicine by the Deputy Executive Director of the American Podiatric Medical Association stated that podiatrists serve on the staffs of hospitals and other facilities and collaborate with other professionals whether the podiatrists practice individually or in a group (Levrio, 2009).
- A UK study on the integration of podiatric surgery within an orthopaedic department contrasted the US system (where podiatric surgeons increasingly operate in orthopaedic departments) with the UK system (where combined podiatric and orthopaedic units only exist in isolated pockets) (Armanasco et al., 2012).

4.2. Diabetes Care

Several important elements in providing diabetic foot care were identified and summarized below.

Disciplines

The importance of multidisciplinary approaches was also recognized for diabetic foot care:

- An overview of podiatry in diabetic limb salvage (i.e., the preservation of a functional foot without the need for a prosthesis) by medical professionals in the US stated that podiatrists' surgical skills and understanding of the biomechanics of the foot and ankle are important for a multidisciplinary approach to diabetic limb salvage (Kim et al., 2012).
- A position statement by Diabetes UK[t] reported that variations in the coordination of foot care services leading to late referrals contribute to large variations in amputation rates across England and supported the provision of foot care services by multidisciplinary teams (Diabetes UK, 2013).

Several documents identified disciplines that are important for multidisciplinary approaches:

- A joint statement from the Society for Vascular Surgery[u] and American Podiatric Medical Association identified vascular surgeons and podiatrists as essential components of multidisciplinary diabetic foot care teams along with orthopaedic surgeons, microbiologists, endocrinologists, physiotherapists, pedorthists,[v] and orthotists[w] (Sumpio et al., 2010).
- A historical perspective on team approaches to amputation prevention of the diabetic foot by medical professionals in the UK stated that specialized diabetic foot clinics need to be able to obtain rapid vascular, podiatric, and orthopedic opinions and arrange for emergency admissions to the hospital (Sanders et al., 2010). The Scottish Diabetes Foot Action Group recommended that foot clinics also have access to diabetes specialist nurses and dietitians and be clear in their referral routes (Leese et al., 2011).
- An Australian study describing a multi-organization podiatric model of care for people with diabetes also identified the need to involve general practitioners (GPs) who can coordinate the management of people with diabetes (Perrin et al., 2012).

Risk Classification

In several jurisdictions, people with diabetes are classified based on their risk of foot diseases so that foot care can be provided by an appropriate health care professional at a frequency appropriate to the patients' needs (Health Service Executive, 2011) and that the limited number of podiatrists can be allocated to those who most need podiatrists' skills (Leese et al., 2011).

- The Irish Health Service Executive[x] used an adapted version of the National Institute for Clinical Excellence (NICE)[y] guidelines to classify people with diabetes into low, moderate, or high risk for their National Diabetes Programme (Health Service Executive, 2011):

[t] Diabetes UK is a diabetes charity across the UK.
[u] The Society for Vascular Surgery is a not-for-profit professional medical society that advocates for vascular surgeons and other medical professionals who work in vascular diseases across the US.
[v] Pedorthists are foot orthotic and orthopaedic footwear experts.
[w] Orthotists are professionals specifically trained and educated to design, fabricate, and fit orthoses.
[x] The Health Service Executive provides all public health services in hospitals and communities across Ireland.
[y] The NICE provides national guidance and advice to improve health and social care in the UK.

  - Patients at low risk of diabetic foot diseases are to be managed preventatively through annual screening and regular foot examinations by primary care nurses (i.e., practice, community-registered, public health, or senior-care nurses).
  - Patients at moderate risk of diabetic foot diseases are to be referred by GPs to podiatrists either in the community or a hospital for an annual review and remain under the clinical governance of GPs and podiatrists or a hospital clinic with a foot protection team consisting of representatives from diabetes consultants, diabetes nurse specialists, and podiatrists based in the community or a hospital.
  - Patients at high risk of diabetic foot diseases are to be seen at least annually by, and remain under the governance of, a diabetes foot protection team.
  - Active diabetic foot diseases (e.g., active foot ulcer) are to be managed by a multidisciplinary specialist foot care team, comprising an endocrinologist, diabetes nurse specialist, senior podiatrist, and other podiatrists, in conjunction with vascular surgery, orthopaedics, and orthotics input as required.
- Similar classification systems were identified in Scotland (see Figure 1 in Appendix A for the stratification scheme) (Leese et al., 2011) and Australia (see Table 3 in Appendix A for the classification systems in Ireland and Australia) (Perrin et al., 2012).

Timely Care

Some documents identified the need to provide timely foot care services to people with diabetes.

- A 2003 commentary on foot diseases and assessments for people with diabetes by medical professionals in the UK noted that when new ulceration occurs, the patient should be referred to podiatry or a foot care team within 24 hours (Duncombe et al., 2003).
- According to a 2009 narrative review on models of care in diabetic foot ulcers by medical professionals in the UK, the NICE also recommended that all patients with a new foot care emergency (e.g., new ulceration, swelling, discoloration) be referred to a multidisciplinary foot care team within 24 hours. However, the authors stated that not all hospitals have a multidisciplinary foot care team and even when such a team exists, it is not always possible to gain access within the 24-hour timeframe (Ndip & Jude, 2009).

4.3. Payment Models

Several jurisdictions provide some public funding for foot care:

- According to the Ontario Podiatric Medical Association, in 1980 podiatrists provided services in their clinics primarily on a fee-for-service basis under OHIP whereas chiropodists were mainly employed in hospitals and other health care institutions on a salaried basis in Ontario (Ontario Podiatric Medical Association, 2014). Today less than 20% of Ontario chiropodists practice in hospitals, community health centres, and in other publicly-funded health care delivery institutions; the vast majority of them practice in private clinics (Health Professions Regulatory Advisory Council, 2014).[z]
- Medicare in the US (Levy, 2012) and the NHS in the UK (Kilmartin, 2002; Turbutt, 1994 as cited in Gilheany & Robinson, 2009) provide public funding for podiatry. In both countries,

[z] This information was obtained from a comment submitted by the Ontario Podiatric Medical Association to Ontario's Health Professions Regulatory Advisory Council during a stakeholder consultation period in 2014 (Health Professions Regulatory Advisory Council, 2014).

podiatric surgery may be incorporated into the public sector through independent units or within general surgical or orthopaedic units (Gilheany & Robinson, 2009).

- An Australian study describing a multi-organization podiatric model of care for people with diabetes stated that podiatric services in Australia are provided by a combination of public health services and the private sector (Perrin et al., 2012). According to a 2010 report by the Department of Health in Western Australia, the majority of podiatrists (84-90%) work in the private sector. Access to podiatrists in the public sector (10-16%) was noted as severely limited by excess demand and relatively low staffing, requiring clinics to implement strict eligibility and discharge criteria (Government of Western Australia, 2010).[aa]
- A 2009 Australian study on the utilization of podiatric services stated that starting in 2004, allied health services including those of podiatry were eligible for Medicare rebates through the Enhanced Primary Care program[bb] for patients with chronic conditions or complex care needs. The authors reported a marked increase in the number of podiatric consultations provided from 2004 to 2008 (Menz, 2009).
- A 2005 overview of health benefits by researchers in Denmark stated that foot care is partially covered by public funds and requires referrals from GPs (Bilde et al., 2005).[cc]

[aa] The statistics were results from the 2007 Podiatry Labour Force Survey as cited in the 2010 Government of Western Australia report.

[bb] The Enhanced Primary Care chronic disease management program is coordinated by the patient's GP who prepares a management plan, initiates the referrals to allied health professionals, and reviews progress every six months. A maximum of five allied health services are allowed per calendar year (Menz, 2009).

[cc] The authors referred to the type of providers as chiropodists instead of podiatrists (Bilde et al., 2005). No information was found on whether Denmark applies the podiatry or chiropody model.

APPENDIX A

Table 1. Scopes of Practice for Podiatrists and Chiropodists in Different Jurisdictions

Jurisdiction	Scope of Practice
Ontario	The scope of practice for both podiatrists and chiropodists is the assessment of the foot and the treatment and prevention of diseases, disorders, or dysfunction of the foot by therapeutic, orthotic, or palliative means. Chiropodists are authorized to prescribe drugs designated in the regulations, cut into the subcutaneous tissues of the foot, and administer, by injection into the foot, a substance designated in the regulations. Podiatrists have the same authorized functions as chiropodists listed above, but they are also authorized to cut into the bony tissues of the forefoot[dd] and communicate diagnoses (Ontario Podiatric Medical Association, 2014; Baumann & Blyth, 2009; Office of the Fairness Commissioner, 2007).

British Columbia	"Podiatric medicine" means the health profession in which a person provides the services of prevention, treatment, and palliation of diseases, disorders, and conditions of the foot and the bones, muscles, tendons, ligaments, and other tissues of the lower leg that affect the foot or foot function. However, it does not include any treatment of the foot or lower leg that may affect the course of treatment of a systemic disease unless the treatment of the foot or lower leg is provided in collaboration with a medical practitioner.
	
	A podiatrist may do any of the following:
	• Make a diagnosis identifying, as the cause of signs or symptoms of the individual, a disease, disorder, or condition of the foot or lower leg;
	• Perform a procedure on tissue below the dermis of the foot or lower leg;
	• Set or cast a fracture of a bone of the foot or lower leg;
	• Reduce a dislocation of a joint of the foot or lower leg;
	• Administer intravenous fluids by injection;
	• For the purpose of arthroscopic surgery (i.e., surgery using an endoscope that is inserted through an incision near a joint and used for the visual examination, diagnosis, and treatment of the interior of a joint)[ee] of the ankle, put an instrument or a device, hand, or finger into an artificial opening into the body;
	• Apply:
	  ○ Laser, for the purpose of cutting or destroying tissue; or
	  ○ X-rays, for diagnostic or imaging purposes, excluding X-rays for the purpose of computerized axial tomography;
	• Issue an instruction or authorization for another person to apply, to a named individual:
	  ○ Ultrasound for diagnostic or imaging purposes, excluding any application of ultrasound to a fetus;
	  ○ Electromagnetism for the purpose of magnetic resonance imaging; or

[dd] The Health Professions Regulatory Advisory Council (2008) reported that in 1993, the practice of podiatry was capped in Ontario, and some surgical privileges including backfoot surgery were removed in the province.

[ee] Medical definitions were interpreted using three online dictionaries (i.e., Merriam-Webster, Free Dictionary, Dictionary.com) and additional sources identified through Google searches.

	○ X-rays for diagnostic or imaging purposes, including X-rays for the purpose of computerized axial tomography; • With respect to a drug specified in Schedule I or II of the Drug Schedules Regulation, B.C. Reg. 9/98: ○ Prescribe the drug; ○ Compound the drug; ○ Dispense the drug; or ○ Administer the drug by any method; • Conduct challenge testing for allergies: ○ That involves injection, scratch tests, or inhalation, if the individual being tested has not had a previous anaphylactic reaction (i.e., a severe, whole-body allergic reaction to a chemical that has become an allergen); or ○ By any method, if the individual being tested has had a previous anaphylactic reaction (British Columbia Regulation, 2010).
Manitoba	The practice of podiatry is the use of medical, physical, or surgical methods to prevent, diagnose, and treat ailments, diseases, deformities, and injuries of the human foot but does not include treatment of systemic disease, except for the local manifestations in the foot. For the purpose of the *Podiatrists Act*, the human foot includes the articulation of the tibia and fibula (i.e., the two bones of the lower leg from the knee to the ankle) with the bones of the foot and the muscles and tendons directly affecting foot function. Subject to the regulations, in the course of practicing podiatry, a podiatrist may: • Cut into the subcutaneous, ligamentous, and bony tissues of the foot and the tendons directly affecting the function of the foot; • Inject substances into the foot; and • Prescribe drugs (Manitoba Laws, 2001).
California	Doctors of Podiatric Medicine (DPMs) are licensed under Section 2472 of the *State Medical Practice Act* to assist Doctors of Medicine and Doctors of Osteopathic Medicine in any surgery – podiatric or non-podiatric – in addition to performing foot and ankle surgeries. In addition, DPMs may: • Perform full-body history and physical examinations in any setting for any patient. • Perform partial amputations of the foot as far as proximal with the Chopart's joint (i.e., the joint between two rows of bones in the tarsus (i.e., the ankle) that divides the foot as the forefoot and backfoot). • Administer intravenous sedation, although the administration of general anaesthesia may only be performed by an anaesthesiologist or certified registered nurse anaesthetist (Medical Board of California, 2010).
Connecticut	"Podiatric medicine" means the diagnosis and treatment, including medical and surgical treatment, of ailments of the foot and the anatomical structures of the foot and the administration and prescription of drugs incidental thereto. According to Connecticut state law, podiatric medicine shall include treatment of local manifestations of systemic diseases as they appear on the foot. A doctor of podiatric medicine, licensed pursuant to Chapter 375 (Podiatry) of Title 20 (Professional and Occupational Licensing, Certification, Title Protection and Registration. Examining Boards) of the General Statutes of Connecticut, may prescribe, administer, and dispense drugs and controlled substances (Connecticut Statutes, n.d.).
Georgia	"Podiatric medicine," which includes chiropody, podiatry, and podiatric medicine and surgery, means that portion of the practice of medicine identified by the acts described in any one or more of the following: • Charging a fee or other compensation, either directly or indirectly, for any history or physical examination of a patient in a person's office or in a hospital, clinic, or other similar facility prior to, incident to, and necessary for the diagnosis and treatment, by primary medical care, surgical, or other means, of diseases, ailments, injuries, or abnormal conditions of the human foot and leg; • Holding oneself out to the public, either directly or indirectly, as being engaged in the practice of podiatric medicine; • Displaying or using a title or abbreviation such as "Doctor of Podiatric Medicine," "D.P.M.," "Foot Doctor," "Foot Specialist," "Foot Surgeon," "Foot and Ankle

	Surgeon," or other letters, designations, or symbols or signs of any type which expressly or implicitly indicate to the general public that the user renders treatment to the foot, ankle, and leg under the provisions of Chapter 35 (Podiatry Practice) of Title 43 (Professions and Businesses) of the Georgia Code; • Performing surgery on the foot or leg of a patient, except that when such surgery is performed under general anaesthesia it shall be permissible only when said surgery is performed at a facility permitted and regulated as a hospital or ambulatory surgical treatment centre under Article 1 (Regulation of Hospitals and Related Institutions) of Chapter 7 (Regulation and Construction of Hospitals and Other Health Care Facilities) of Title 31 (Health) of the Georgia Code and when said general anaesthesia is administered under the direction of a duly licensed physician; • Performing amputations of the toe; or • Performing amputations distal to and including the tarsometatarsal joint (i.e., the joint between tarsal and metatarsal bones) in the foot but only when performed in a facility permitted and regulated as a hospital or ambulatory surgical treatment centre under Article 1 of Chapter 7 of Title 31 and when performed by a podiatrist who is certified by the board in meeting the requirements which shall be established by regulations of the board which have been jointly approved by the board and the Georgia Composite Medical Board (Georgia Statutes, n.d.).
New York	Prior to February 17, 2014, podiatrists were restricted to wound care on the foot. Effective February 17, 2014, the scope of practice for podiatry was expanded so that podiatrists may treat wounds if they are near and related to a wound on the foot. A podiatrist may not, however, provide wound care beyond the level ending at the distal tibial tuberosity (i.e., a large prominence of a shin bone serving for the attachment of muscles or ligaments) (New York State Education Department, 2014a). Chapter 438 of the Laws of 2012 for New York State established two new credentials, the holders of which are authorized to perform podiatric ankle surgery. The two new credentials are: • Podiatric Standard Ankle Surgery Privilege: Podiatrists who hold a privilege to perform podiatric standard ankle surgery may perform surgery on the ankle which may include soft tissue and osseous (i.e., bone-related) procedures, except those procedures specifically authorized for podiatrists holding a podiatric advanced ankle surgery privilege. • Podiatric Advanced Ankle Surgery Privilege: Podiatrists who hold a privilege to perform podiatric advanced ankle surgery may perform surgery on the ankle which may include: o Ankle fracture fixation; o Ankle fusion; o Ankle arthroscopy;[ff] o Insertion or removal of external fixation pins into or from the tibial diaphysis (i.e., the shin bone shaft) at or below the level of the myotendinous junction (i.e., the muscle-tendon junction) of the triceps surae (i.e., the triceps of the lower leg or calf muscles), but does not include the surgical treatment of complications within the tibial diaphysis related to the use of such external fixation pins; and o Insertion and removal of retrograde tibiotalocalcaneal (i.e., the ankle and subtalar combined) intramedullary rods[gg] and locking screws up to the level of the myotendinous junction of the triceps surae. Possession of a podiatric ankle surgery privilege does not authorize: • The surgical treatment of complications within the tibial diaphysis related to the use of external fixation pins;

[ff] Ankle arthroscopy is a surgical procedure that uses a thin fibre-optic camera or "arthroscope" that magnifies and transmits images of the ankle to a video screen.
[gg] Intramedullary rods are a means of fracture fixation in which a long metallic implant is inserted at one end of a long bone through the medullary canal.

	• Partial or total ankle replacements; or • The treatment of pilon fractures (i.e., broken bones near the bottom of the shin bone at the ankle joint) (New York State Education Department, 2014b). The practice of podiatry is defined as diagnosing, treating, operating, and prescribing for any disease, injury, deformity, or other condition of the foot and may include performing physical evaluations in conjunction with the provision of podiatric treatment. For the purposes of wound care, however, the practice of podiatry shall include the treatment of such wounds if they are contiguous with wounds relating to or originating from a wound on the foot or if they are in the course of treatment of a wound on the foot within the podiatric scope of practice. Wound care shall not, however, extend beyond the distal tibial tuberosity. The practice of podiatry may also include diagnosing, treating, operating, and prescribing for any disease, injury, deformity, or other condition of the ankle and soft tissue of the leg below the tibial tuberosity if the podiatrist has obtained an issuance of a privilege to perform podiatric standard ankle surgery or advanced ankle surgery in accordance with Section 7009 of Article 141 of the *Education Law*. Podiatrists may treat traumatic open wound fractures only in hospitals, as defined in Article 28 of the *Public Health Law*. For the purposes of this article, the term "ankle" shall be defined as the distal metaphysis (i.e., the growing part of a long bone) and epiphysis (i.e., the end of a long bone)[hh] of the tibia and fibula, the articular cartilage (i.e., the cartilage that covers the joint surfaces of bones) of the distal tibia and distal fibula, the ligaments that connect the distal metaphysis and epiphysis of the tibia and fibula and talus (i.e., the entire ankle), and the portions of skin, subcutaneous tissue, facia (i.e., a sheet of connective tissue covering or binding together body structures), muscles, tendons, ligaments, and nerves at or below the level of the myotendinous junction of the triceps surae. The practice of podiatry shall not include treating any part of the human body other than the foot, treating fractures of the malleoli (i.e., either of the two rounded protuberances on each side of the ankle), or cutting operations upon the malleoli unless the podiatrist obtains an issuance of a privilege to perform podiatric standard ankle surgery or podiatric advanced ankle surgery. Podiatrists licensed to practice, but not authorized to prescribe or administer narcotics prior to the effective date of this subdivision, may do so only after certification by the department in accordance with the qualifications established by the commissioner. The practice of podiatry shall include administering only local anaesthetics for therapeutic purposes as well as for anaesthesia and treatment under general anaesthesia administered by authorized persons. The practice of podiatry by any licensee shall not include partial or total ankle replacements nor the treatment of pilon fractures (New York State Education Department, 2014c).
South Carolina	"Podiatry" shall mean the diagnosis and medical and surgical treatment limited to ailments of the human foot, except the administration of an anaesthetic other than local. • "Diagnosis" shall mean to ascertain a disease or ailment by symptoms and findings and does not confer the right to use X-ray other than for diagnosis. • "Medical treatment" shall mean the application or prescribing of any therapeutic agent or remedy for the relief of foot ailments, except the medical treatment of any systemic disease causing manifestations in the foot. • "Surgical treatment" shall mean the use of any cutting instrument to treat a disease, ailment, deformity or condition of the foot but shall not confer the right to amputate the foot or toes (South Carolina Code of Laws, 2013).
Virginia	With the new legislation that updated the definition of the practice of podiatry in the state of Virginia, Podiatrists in Virginia are now authorized to diagnose and treat lower extremity ulcers as well as access areas above the foot and ankle to harvest skin grafts in the treatment of ulcers (American Podiatric Medical Association, 2011).

[hh] A long bone consists of a growing part (i.e., metaphysis) between the shaft (i.e., diaphysis) and the end (i.e., epiphysis).

Wisconsin	"Podiatry" or "podiatric medicine and surgery" means that branch or system of the practice of medicine and surgery that involves treating the sick which is limited to conditions affecting the foot and ankle but does not include the use of a general anaesthetic unless administered by or under the direction of a person licensed to practice medicine and surgery (Wisconsin Statutes, 2014).
Wyoming	"Podiatry" means the diagnosis or the medical, mechanical, or surgical treatment of the ailments of the human foot, ankle, and tendons that insert into the foot. Podiatry also includes the fitting or the recommending of appliances, devices, or shoes for the correction or relief of minor foot ailments. The practice of podiatric medicine shall include the amputation of the toes or other parts of the foot but shall not include the amputation of the foot or leg in its entirety. A podiatrist may not administer any anaesthetic other than local. A general anaesthesia shall be administered in a hospital by an anaesthesiologist or certified nurse anaesthetist authorized under the laws of Wyoming to administer anaesthesia. Podiatrists are permitted to use and prescribe drugs and controlled substances as may be necessary in the practice of podiatry (Wyoming Statutes, n.d.).
UK	A 2013 overview of podiatry by a consultant podiatric surgeon in the UK identified the management of skin and nail disorders, management of lower limb soft tissue disorders, gait analysis, manufacture and prescription of orthotic shoe inserts, and management of complex wounds as podiatric services. The author also reported that the most common conditions treated by podiatric surgery are bunions, hammer toes, hallux rigidus (i.e., a restricted mobility of the big toe due to stiffness of the joint between metatarsal bones and digital bones of the foot especially when due to arthritic changes in the joint), nerve entrapments, soft tissue lumps and bumps, and tendon disorders. The author also reported that podiatrists are trained to administer local anaesthesia (Maher, 2013). A 2011 overview of podiatry by researchers in the UK stated that podiatrists are licensed to access and supply a limited range of prescription-only medicines including antibiotics, analgesics, and steroids for intracapsular injection (i.e., injection within a capsule of a joint) (Hayes & Bussey, 2011). A 2010 commentary on podiatric care for early rheumatoid arthritis by researchers in the UK also noted that podiatrists have access to analgesic, corticosteroid, and antibiotic medicines (Woodburn et al., 2010).
Victoria, Australia	Podiatry deals with the prevention, diagnosis, treatment, and rehabilitation of medical and surgical conditions of the foot and lower limb. The conditions podiatrists treat include those resulting from bone and joint disorders such as arthritis and soft-tissue and muscular pathologies as well as neurological and circulatory disease. Podiatrists are also able to diagnose and treat any complications of the above which affect the lower limb, including skin and nail disorders, corns, calluses, and ingrown toenails. Foot injuries and infections gained through sport or other activities are also diagnosed and treated by podiatrists. A range of skills are employed by podiatrists. Direct consultations include a clinical history composition, physical examination, diagnosis, preparation of a treatment plan, and provision of a range of therapies. Clinical assessment techniques aim to secure a diagnosis and prognosis and take into account clinical, medical, and surgical history, footwear, and occupational and lifestyle factors and may incorporate the use of diagnostic equipment such as vascularscopes or radiology. Gait analysis will often be undertaken through visual or computerized means and might include range-of-motion studies, postural alignment evaluation, or dynamic force and pressure studies (Australian Podiatry Association of Victoria, 2002).
Australia	A 2011 Australian pilot study on the impact of podiatry on interdisciplinary chronic wound care identified sharp debridement, application of biomechanics, footwear modification and education, general wound management and treatment, neurovascular assessment, ankle brachial pressure indices,[ii] and toe pressure measurements as podiatrists' skills (Butters, 2011).

[ii] The ankle brachial pressure index test is a way to check one's risk of peripheral artery disease. It compares one's blood pressure measured at one's ankle with one's blood pressure measured at one's arm. A low ankle brachial pressure index number can indicate narrowing or blockage of the arteries in one's legs, leading to circulatory problems, heart disease, or stroke.

Table 2. Summary of Scopes of Practice for Podiatric Surgeons in the US

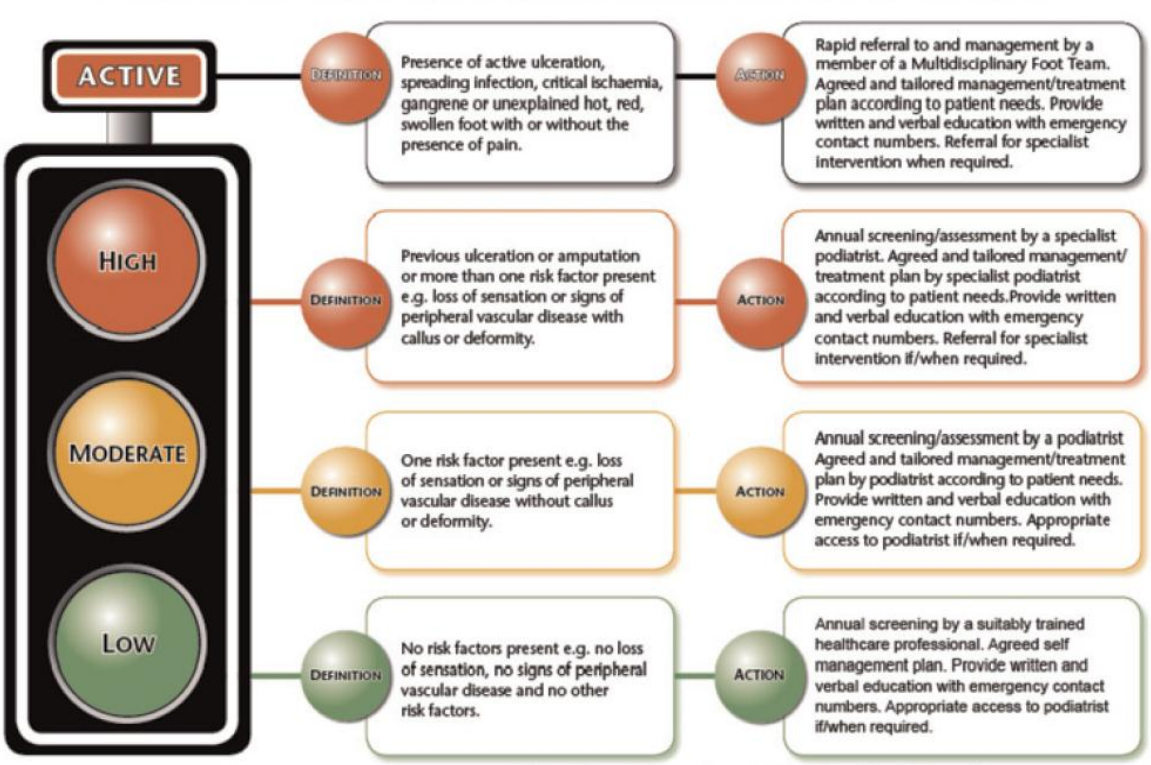
State	Includes Ankle	Allows Toe Amputation	Allows Foot Amputation	Allow Partial Foot Amputation	Includes Leg	Can Administer General Anesthesia	Includes Hand	No Restrictions on Where Surgery is Performed
Alabama		Silent		Silent				√
Alaska	√	Silent	Silent	Silent	√	√	√	√
Arizona	√				√			√
Arkansas	√	Silent		Silent				
California	√	√		√	√			
Colorado	√	Silent		Silent				√
Connecticut		√		√		√		√[2]
Delaware	√	Silent	√	Silent		√		√
DC	Silent	Silent		Silent				√
Florida	√	√		√	√	√		√
Georgia	√	√		√	√	√[3]		
Hawaii	√	√			√			√
Idaho	√	Silent		Silent	√			√
Illinois	√	Silent		Silent				√
Indiana	Silent	√		√				√[4]
Iowa	√	Silent		Silent		√		√
Kansas	Silent	√		Silent				√
Kentucky	Silent	Silent	Silent	Silent	Silent	Silent		√
Louisiana		Silent	Silent	Silent				√
Maine	√	Silent	Silent	Silent		√[3]		√
Maryland	√	Silent	Silent	Silent				
Massachusetts	Silent			Silent				√
Michigan	√	Silent		Silent			√	√
Minnesota	√	√		Silent	√		√	√
Mississippi		Silent	Silent	Silent				√
Missouri	√	Silent		Silent				
Montana	√	Silent	Silent	Silent				
Nebraska	√	Silent		Silent				
Nevada	√	√		Silent	√	Silent		√[4]
New Hampshire	√	Silent	Silent	Silent	√			√
New Jersey	√	Silent		Silent	√	√		√
New Mexico	√	Silent		Silent				√
New York		Silent	Silent	Silent				√
North Carolina	√	Silent		Silent				
North Dakota	√	Silent	Silent	Silent		√		√
Ohio	√	Silent	Silent	Silent	√	√	√	
Oklahoma	√	Silent	Silent	Silent		Silent		√
Oregon	√	Silent		Silent				
Pennsylvania	√	Silent		Silent	√	√		√
Rhode Island	√	Silent	Silent	Silent	√	Silent		√
South Carolina	Silent			Silent		Silent		√
South Dakota	Silent	Silent	Silent	Silent		Silent		√
Tennessee	√	Silent		Silent				
Texas	√	Silent		Silent		Silent		√
Utah	√	Silent		Silent				
Vermont	√	√	√	√	√			√[4]
Virginia	√	√				√		√[2]
Washington	√	Silent		Silent		√[3]		√
West Virginia	√	Silent	Silent	Silent		√[3]	√	√
Wisconsin	√	√			√	√[3]		√
Wyoming	Silent			Silent				√

The table summarizes the podiatric scopes of practice from state statutes (American College of Foot and Ankle Surgeons, n.d.). "Silent" means that the statutes do not speak to the issue.

Table 3. Risk Classification of the Diabetic Foot in Different Jurisdictions

Jurisdiction	Risk Classification of the Diabetic Foot
Ireland	The National Diabetes Programme was established in June 2010 under the Clinical Strategy and Programmes Directorate. In 2011, funding was received to establish a national multidisciplinary foot care service for people with diabetes. Foot care management in diabetes is based on three categories of risk: • Patients "at low risk of diabetic foot disease" will be managed preventatively through annual screening and regular foot inspections/examinations by primary care nurses (i.e., practice, community-registered, public health, or senior-care nurses). Low-risk foot patients have normal foot pulses, normal vibration and sensation to 10g monofilament (i.e., a filament used to make sutures), no history of foot ulceration, no significant foot deformity, and no visual impairment. • Patients "at risk of diabetic foot disease" may be stratified as either moderate risk or high risk. All patients will be under regular surveillance by primary care nurses/general practitioners (GPs). Patients being fully managed by the hospital clinic will receive their foot care from the foot protection team, consisting of representatives from consultants, diabetes nurse specialists, and podiatrists based in the community or hospital. o Moderate-risk patients will be referred by the GP to the podiatrist, either in the community or in the hospital, for an annual review. These patients will remain under the clinical governance of the GP and podiatrist. Moderate-risk patients have either impaired peripheral sensation or impaired circulation or significant visual impairment or a structural foot deformity. o High-risk patients will be called to be seen at least annually by the diabetes foot protection team in one of the 16 designated centres, and will be under the governance of the foot protection team for their foot care. High-risk patients have an abnormality that predisposes them to foot ulceration. This can be impaired sensation and impaired circulation, or a previous foot ulcer, previous lower limb amputation, or previous Charcot foot. • Patients with "active diabetic foot disease", defined as patients with an active foot ulcer (i.e., a full thickness skin break) or a Charcot foot, will be actively managed by a multidisciplinary specialist foot care service, in conjunction with vascular surgery, orthopaedics, and orthotics input as required. Their foot will be examined at least once weekly or as required (Health Service Executive, 2011). For more details on the classification system, see the Health Service Executive report (2011).
Victoria, Australia	To develop a common language, an agreed risk classification system to identify patients' risk of future foot morbidity was adopted. The University of Texas Diabetic Foot Risk Classification System (UT risk) was chosen as it was deemed a reliable, valid, and predictive tool for identifying future foot health outcomes for people with diabetes. The Podiatry Diabetes Model (PDM) of care was developed based on this system. According to the model, the person's level of risk determined the service most appropriate. Within the model, the multiple podiatric services are grouped into three categories (i.e., community, subacute, and acute): • Patients who do not have an active diabetes-related foot complication (UT risk categories 0-3) should access podiatric services in the community. • Patients with current, active diabetes-related foot complications or who were at high risk of such pathology (UT risk categories 3-6) should be managed by the subacute podiatric services of the Diabetic Foot Clinic, which is a multi-disciplinary service that has an established track record in managing serious diabetes-related foot morbidity. Health disciplines that are represented in the Diabetic Foot Clinic include podiatry, nursing, medical (rehabilitation speciality), and orthotists. • Patients admitted to an acute hospital ward should have contact with the acute podiatric service in addition to the medical, nursing, and allied health care received as part of their admission. The model also sets out a flexible, shared arrangement where patients with a history of diabetes-related foot complications (UT risk category 3) should be admitted to both the community and subacute services in order to facilitate the appropriate level of podiatric input required at any given time. This shared admission arrangement was developed in recognition that this group of people are at a very high risk of developing a new diabetes-related foot complication and have a greater potential to move back and forth between the subacute and community services (Perrin et al., 2012).

Figure 1. Foot Risk and Screening Stratification Scheme in Scotland



The figure summarizes the foot risk and screening stratification scheme in Scotland (Leese et al., 2011).

APPENDIX B

Table 4 – Description of the Content in the Articles and Grey Literature Being Summarized[36]

No.	Description	Reference
Review/Overview/Commentary Articles in Peer-Reviewed Journals		
1	**Purpose:** This overview by a consultant podiatric surgeon describes podiatric surgery provided by the allied health professionals in the UK. **Relevant Information:** Podiatry is the allied health profession responsible for the assessment, diagnosis and treatment of the foot and lower limb. Formerly known as chiropody, the profession changed its name in the 1990s falling in line with other English speaking countries. Over the last 40 years, podiatric surgery performed by podiatrists has become established as a viable, safe, and cost-effective alternative to traditional models of service provision. Today, podiatrists are able to offer a range of treatments, including the management of skin and nail disorders, management of lower limb soft tissue disorders, gait analysis, manufacture and prescription of orthotic shoe inserts, and management of complex wounds. Podiatrists also graduate with the ability to undertake minor surgical procedures (to address skin and nail lesions) and are also trained to administer local anaesthetics. The current scope of practice in podiatric surgery is quite simply – the foot and its associated structures. In practice, the most common conditions treated by podiatric surgery are hallux valgus (bunions), hammer toes, hallux rigidus, nerve entrapments, soft tissue lumps and bumps, and tendon disorders. Podiatrists have an important role within multidisciplinary healthcare teams and work closely with nurses and doctors, particularly in the fields of tissue viability, diabetes, and rheumatology.	Maher, A. (2013). Podiatry: An illustration of surgery provided by allied health professionals. *Journal of Perioperative Practice, 23*(10), 218-21.
2	**Purpose:** This overview by medical professionals describes the role of a podiatrist in diabetic limb salvage in the US and internationally. **Relevant Information:** A podiatrist is a limited scope physician with expertise in the assessment and treatment of pathologies of the structures related to the foot and ankle. Although there are regional differences in the scope of practice within the United States, all include assessment and treatment of disorders of the foot, and most states include the ankle. Internationally, chiropodists also provide conservative care for the foot but often do not perform surgery. Functional amputations and long-term post-operative care are also important aspects of podiatric care. The podiatrist brings a comprehensive understanding of the biomechanics of the foot and ankle and skills to perform the necessary surgical interventions. While the field of podiatry continues to evolve as a surgical subspecialty with increasing training requirements and standardization, the clinical and surgical role of a podiatrist as a key contributor to the diabetic limb salvage team is now well established through evidence-based practices.	Kim, P. J., Attinger, C. E., Evans, K. K., & Steinberg, J. S. (2012). Role of the podiatrist in diabetic limb salvage. *Journal of Vascular Surgery, 56*(4), 1168-72.

[36] Please note the studies, programs, and findings presented in this table may originate from jurisdictions with health systems that are significantly different from Ontario's. If there is intent to draw heavily from one or more sources presented in this table, we recommend that you contact the lead author of this review for assistance with evaluating the local applicability.

No.	Description	Reference
3	**Purpose:** This historical overview by a Doctor of Podiatric Medicine (DPM) describes the historical and current status of DPMs in the US. **Relevant Information:** Many of the current initiatives in podiatric medicine may be perceived by some as "antagonizing the physician". Medicare included DPMs as physicians within the scope of their practice in 1968. In 1977, the American Medical Association and the American College of Surgeons finally recognized the right of DPMs to have practice privileges in hospitals based on their education, training, and experience. Then in 1976, podiatric medical house staff (residents) were recognized by the Joint Commission of Health Care Organizations, which also confirmed that DPMs can perform the medical history and physical examination for patients admitted to hospitals subject to state laws and the endorsement by a duly licensed Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (OD). Although podiatric medicine hardly resembles what it was 80 years ago, the present movement by many DPMs to also acquire an MD or OD degree and an unrestricted medical license has escalated significantly since 2000.	Levy, L. A. (2012). A historical and current analysis for the DPM acquiring an MD or DO degree and an unrestricted medical license. *Journal of American Podiatric Medical Association, 102*(2), 172-6.
4	**Purpose:** This overview by researchers describes podiatry in the UK. **Relevant Information:** Podiatry is a fundamental discipline within medicine that goes beyond trimming toenails, removing hard skin, and relieving painful bunions. The scope of practice for podiatrists in the UK includes the use and supply of a limited tariff of prescription-only medicines (e.g., antibiotics, analgesics, steroids), injection therapy, and non-invasive surgery as well as the management of long-term conditions such as diabetes, lower limb biomechanical dysfunction, and ambulatory foot surgery. Podiatric surgery in the UK is also not a recent development, with the first training in podiatric surgery having been developed over 30 years ago. The terms "podiatry", "chiropody", and "foot healthcare" are often regarded as interchangeable.	Hayes, C., & Bussey, S. (2011). Podiatric medicine unravelled. *British Journal of Healthcare Assistants, 5*(12), 596-9.
5	**Purpose:** This overview by medical professionals describes a national approach to diabetic foot care in Scotland. **Relevant Information:** While the number of patients who have diabetes in Scotland has more than doubled over the last ten years, there has been no corresponding increase in the number of podiatrists. In light of this, the skills of podiatrists need to be used more efficiently. Since it is not possible for most podiatrists to see all patients with diabetes routinely, podiatrists should see patients who need their skills most. Foot screening and foot risk stratification programmes have been recommended in an attempt to help this process, as foot screening should detect patients at greatest risks of developing foot problems. While multidisciplinary foot clinics can reduce the rates of amputations, there is no consensus as to what defines a multidisciplinary foot clinic. The Foot Action Group established a consensus that the clinic should include a podiatrist and consultant diabetologist who are always present, with an experienced orthotist being co-located with the main diabetes foot clinic, such that the podiatrist and orthotist can see patients together if needed. The clinic should have access to a diabetes specialist nurse and dietitian, vascular surgeon, orthopaedic surgeon, rapid access to an X-ray department within one working day, and the facility to admit patients at any time. It became apparent that this is a useful model where there is a large population base but is not necessarily applicable for remote and rural areas. It is also important that multidisciplinary foot clinics are easily accessed and that the referral routes into and out of the clinics are clear. Delayed referrals from community to specialist foot care are a common problem and may be partly due to cumbersome referral pathways.	Leese, G. P., Stang, D., & Pearson, D. W. (2011). A national approach to diabetes foot risk stratification and foot care. *Scottish Medical Journal, 56*(3), 151-5.

No.	Description	Reference
6	**Purpose:** This narrative review by medical professionals and researchers describes podiatric services for the management of foot problems in older people in the UK. **Relevant Information:** Older people are subject to the same classes of foot problems as the general population, but larger numbers are affected, and their problems can be compounded by the presence of other conditions, such as diabetes, which place the foot at greater risk. Foot problems can affect mobility and be associated with toenails, soft tissues, and the general musculoskeletal system. At its most basic level, simple foot care is sometimes required for people unable to provide it for themselves due to increasing age, reduced mobility, or other medical problems. Podiatrists work to improve the mobility, independence, and quality of life for their patients by providing preventative care, diagnosis, and treatment of a wide range of problems affecting feet, ankles, and lower limbs. A wide variety of treatment modalities can be used to reduce pain and preserve or improve foot health including manual debridement, applying medicaments or padding, using thermal and surgical techniques, and the manufacture of orthoses.	Vernon, W., Borthwick, A., & Walker, J. (2011). The management of foot problems in the older person through podiatry services. *Reviews in Clinical Gerontology, 21*(4), 331-9.
7	**Purpose:** This historical perspective by medical professionals in the UK highlights some of the pioneers, milestones, teams, and system changes that have had a major impact on the management of the diabetic foot during the past 100 years. **Relevant Information:** In 1934, American diabetologist Elliott P. Joslin noted that mortality from diabetic coma had fallen from 60% to 5% after the introduction of insulin, yet deaths from diabetic gangrene of the lower extremity had risen significantly. He believed that diabetic gangrene was preventable. His remedy was a team approach that included foot care, diet, exercise, prompt treatment of foot infections, and specialized surgical care. The history of a team approach to management of the diabetic foot chronicles the rise of a new health profession, Podiatric Medicine and Surgery, as well as the emergence of the specialty of Vascular Surgery. The partnership between the diabetologist, vascular surgeon, and podiatrist is a natural one. The complementary skills and knowledge of each can improve limb salvage and functional outcomes. Comprehensive multidisciplinary foot care programs have been shown to increase quality of care and reduce amputation rates by 36% to 86%. The development of distal revascularization techniques to restore pulsatile blood flow to the foot has also been a major advancement History has taught us that optimal management of diabetic foot complications is best provided in a hospital-based diabetic foot clinic. The clinic must be available to manage emergencies and equipped to perform urgent investigations, wound debridement, and to initiate immediate parenteral antibiotic therapy. It must also be able to obtain rapid vascular, podiatric, and orthopedic opinions and to arrange for emergency admissions to the hospital. In the US, the ambiguous term “chiropodist” was changed to podiatrist in 1957 because of public confusion with the chiropractic profession. **Conclusions:** Diabetic foot patients are among the most complex and vulnerable of all patient populations. Specialized diabetic foot clinics of the 21st century should be multidisciplinary and equipped to coordinate diagnosis, off-loading, and preventive care; perform revascularization procedures; aggressively treat infections; and manage medical comorbidities.	Sanders, L. J., Robbins, J. M., & Edmonds, M. E. (2010). History of the team approach to amputation prevention: Pioneers and milestones. *Journal of Vascular Surgery, 52*(3 Suppl), 3S-16S.

No.	Description	Reference
8	**Purpose:** This joint statement from the Society for Vascular Surgery (SVS) and American Podiatric Medical Association (APMA) describes the role of interdisciplinary teams in the management of the diabetic foot. **Relevant Information:** The pathophysiologic mechanisms underlying diabetic foot diseases are multi-factorial and include neuropathy, infection, ischemia, and abnormal foot structures and biomechanics. It is, therefore, not surprising that the management of the diabetic foot is a complex clinical problem requiring an interdisciplinary approach. Vascular specialists maintain a critical management role since untreated inadequate perfusion to a limb will always result in a non-healing wound and possible amputation. Podiatrists play key roles in the interdisciplinary approach. Successful management of foot ulcers involves the recognition and correction of the underlying etiology as well as appropriate wound care and the prevention of recurrence. An aggressive interdisciplinary approach to foot diseases should provide optimal medical and surgical care and improved outcomes. However, many groups describe their team consisting only of a vascular surgeon and podiatrist. Others argue that the team should be broader and include other groups such as orthopedic surgeons, infectious disease specialists or medical microbiologists, endocrinologists, reconstructive surgeons, physical therapists, pedorthists, and orthotists.	Sumpio, B. E., Armstrong, D. G., Lavery, L. A., & Andros, G. (2010). The role of interdisciplinary team approach in the management of the diabetic foot. *Journal of Vascular Surgery, 51*(6), 1504-6.
9	**Purpose:** This commentary by researchers describes podiatric care for early rheumatoid arthritis (RA) in the UK. **Relevant Information:** Targeted foot care should be delivered by specialist podiatrists working in a multidisciplinary clinic in both primary and secondary care. In the UK, multidisciplinary foot clinics in rheumatology are not new and generally comprise of a podiatrist, extended-scope physiotherapist, and orthotist. A rheumatologist, nurse specialist, and orthopaedic surgeon may be in attendance, or a rapid referral pathway may be developed. Evidence for such an approach is lacking, but the area has been identified as a research priority. Minor surgical procedures including nail surgery and cryosurgery are within the scope of practice for UK podiatrists. Bone, joint and soft-tissue surgery is restricted to those with advanced training. UK podiatrists also have limited prescribing rights: Within the multidisciplinary clinic for early RA, access is generally limited to analgesic, corticosteroid, and antibiotic medicines.	Woodburn, J., Hennessy, K., Steultjens, M. P., McInnes, I. B., and Turner, D. E. (2010). Looking through the 'window of opportunity': Is there a new paradigm of podiatry care on the horizon in early rheumatoid arthritis? *Journal of Foot and Ankle Research, 3*, 8.
10	**Purpose:** This Letter to the Editor from medical professionals identifies need for more access to foot care services for older people in the UK. **Relevant Information:** Long toenails are a frequent cause of or contributor to falls in older people. Older people may find it difficult to maintain foot hygiene from simple mechanical difficulties resulting from arthritic hips or neglect due to dementia. Solving this problem in hospitals is difficult because few nurses have the special training or tool required to cut old people's toenails which are often tough. While some hospitals offer services to remedy the problem of long toenails in older people, those services are only available for diabetic patients or those at increased risks of infections.	Dindyal, S., Bhuva, N., Kumaraswamy, P., & Khoshnaw, H. (2009). Falls in the elderly – the need for more access to chiropody. *Age and Ageing, 38*(1), 127-8.

No.	Description	Reference
11	**Purpose:** This overview by the Deputy Executive Director of the American Podiatric Medical Association describes podiatric medicine in the US. **Relevant Information:** In the US, podiatrists' scopes of practice are determined by state laws (and are often influenced by politics) with variances across the states. Doctors of Podiatric Medicine (DPMs), just like allopathic Doctors of Medicine (MDs) and Doctors of Osteopathic Medicine (ODs), are physicians, but physicians who specialize exclusively in diagnosing and treating ailments affecting the lower extremity. Podiatrists are sometimes categorized as "limited licensed practitioners" as their license "limits" them to medical and surgical treatment of the lower extremity, with most US states agreeing that this definition minimally includes the foot and ankle and the majority of the US states including governing structures (i.e., soft tissue, bone) above the ankle. While DPMs are physicians and surgeons qualified by their education and training to diagnose and treat conditions affecting the lower extremity, the recognition of these qualifications appears to be largely ignored as their scope of practice is determined solely by what the state laws allow. This distinction contrasts with MDs and ODs whose scopes are determined solely by their education, training, experience, and credentialing. Many podiatrists are integral members of group medical practices while others have their own solo medical practices. Medical specialists in primary care, endocrinology, rheumatology, and geriatrics routinely refer patients to podiatrists who serve on the staff of hospitals and other facilities and on the faculties of schools of medicine and teaching hospitals.	Levrio, J. (2009). Podiatric medicine: A current assessment. *Journal of the American Podiatric Medical Association, 99*(1), 65-72.
12	**Purpose:** This narrative review by medical professionals describes models of care for diabetic foot ulcers in the UK. **Relevant Information:** In 2004, the National Institute for Clinical Excellence published guidelines on foot care for patients with diabetes. These guidelines recommend that all patients with a new foot care emergency (e.g., new ulceration, swelling, discoloration) be referred to a multidisciplinary foot care team within 24 hours. The multidisciplinary team is defined as a team of highly trained specialist podiatrists and orthotists, nurses with training in dressing diabetic foot wounds, and diabetologists with expertise in lower limb complications. However, not all hospitals have a multidisciplinary foot care team, and even where this exists, it is not always possible to gain access within the 24-hour timeframe.	Ndip, A., & Jude, E. B. (2009). Emerging evidence for neuroischemic diabetic foot ulcers: Model of care and how to adapt practice. *International Journal of Lower Extremity Wounds, 8*(2), 82-94.
13	**Purpose:** This overview by medical professionals and academics describes the major issues related to foot care for patients with arthritis and provides key recommendations for improving access to podiatric services in New Zealand. **Relevant Information:** A foot and ankle symposium was held and attended by orthopaedic surgeons, rheumatologists, physiotherapists, podiatrists, and specialist nurses. It was clear from the discussions that ensued that what is needed is an integrated approach to the management of foot problems with podiatrists being the key practitioner in coordinating the assessment and management of the foot and its related problems.	Rome, K., Chapma, J., Williams, A. E., Gow, P., & Dalbeth, N. (2009). Podiatry services for patients with arthritis: An unmet need. *New Zealand Medical Journal, 123*(1310), 91-7.
14	**Purpose:** This narrative review by a researcher in the UK describes the professional status of podiatry in the UK. **Relevant Information:** Most foot conditions worsen with age, as systemic complications are more likely in older people, and the majority of patients in receipt of podiatry care are those over 50 years of age. The provision of pain-free mobility for the elderly through foot care would have enormous health care benefits, not only in terms of the feet and lower limbs, but also in sustaining other body systems, maintaining independence, and improving the quality of life of the individual.	Mandy, P. (2008). The status of podiatry in the United Kingdom. *Foot, 18*(4), 202-5.

No.	Description	Reference
15	**Background:** The chiropractic profession has succeeded to remain in existence for over 110 years despite the fact that many other professions which had their start at around the same time as chiropractic have disappeared. Despite chiropractic's longevity, the profession has not succeeded in establishing cultural authority and respect within mainstream society, and its market share is dwindling. In the meantime, the podiatric medical profession, during approximately the same time period, has been far more successful in developing itself into a respected profession that is well integrated into mainstream health care and society. **Purpose:** This commentary presents a perspective on the current state of the chiropractic profession and to make recommendations as to how the profession can look to the podiatric medical profession as a model for how a non-allopathic healthcare profession can establish mainstream integration and cultural authority. **Relevant Information:** There are several key areas in which the podiatric medical profession has succeeded and in which the chiropractic profession has not. For example, why did the American Medical Association (AMA) not try to "contain and eliminate" the podiatric medical profession (despite the several turf battles podiatry has had with the orthopaedic specialty)? A key occurrence in the development of the podiatric profession was when the AMA determined that medical physicians should not get involved with "minor" foot problems. This opened the door for podiatrists to flourish in their chosen area of specialty.	Murphy, D. R., Schneider, M. J., Seaman, D. R., Perle, S. M., & Nelson, C. F. (2008). How can chiropractic become a respected mainstream profession? The example of podiatry. *Chiropractic & Osteopathy, 16*, 10.
16	**Purpose:** This commentary by a Health and Social Care Policy manager describes foot care needs of older people in the UK. **Relevant Information:** Older people need access to basic foot care services such as toenail cutting to avoid dire consequences that arise when they attempt to tend to their own feet. Basic foot care services may prevent older people from becoming housebound and dependent and also reduce the risk of falls – especially for those with arthritis who have difficulties bending down. However, access to most podiatry services by the National Health Service in the UK was cut, and older people with no major conditions such as diabetes or heart problems are no longer eligible for coverage.	Ellis, J. (2006). Supporting older people: Unmet foot-care needs. *British Journal of Community Nursing, 11*(4), 153-5.
17	**Purpose:** This overview by researchers describes health benefits in Denmark. Specifically, it provides an overview of the laws regulating health benefits and a description of the regulatory mechanism for the provision of curative care in hospitals and in primary care offices. **Relevant Information:** Chiropody services are partially covered by public funds and require referrals from general practitioners.	Bilde, L., Ankjaer-Jensen, A., & Danneskiold-Samsøe, B. (2005). The "Health Benefit Basket" in Denmark: A description of entitlements, actors, and decision-making processes in the curative health sector. *European Journal of Health Economics, Suppl 1*(6), 11-7.
18	**Purpose:** This commentary by researchers describes professional boundaries in the health care workforce in the UK. **Relevant Information:** Podiatrists successfully competed with orthopaedic surgeons on the basis of cost to undertake certain lower limb procedures. However, the opposition that they faced to adopt these tasks highlights the difficulties of encroaching on the turf of a well-established and powerful profession.	Nancarrow, S. A., & Borthwick, A. M. (2005). Dynamic professional boundaries in the healthcare workforce. *Sociology of Health & Illness, 27*(7), 897-919.

No.	Description	Reference
19	**Purpose:** This commentary by medical professionals describes foot diseases and assessments for people with diabetes in the UK. **Relevant Information:** For low-risk feet, the nurse should arrange annual review of the feet and offer lifestyle advice and health education. For at-risk feet, the nurse should arrange to see the patient more frequently, ideally every three months, and should inspect the feet at each visit. These visits also provide opportunities for patient education. For the high-risk foot, the nurse should ensure referral to a specialized podiatry service. If the findings are confirmed, the patient should be seen frequently by that team every 1-3 months. When new ulceration occurs, the patient should be referred to a specialized podiatry or foot care team within 24 hours. For ulcerated feet, the patient should remain under specialist care until the ulcer has healed.	Duncombe, G., Purser, P., & Burden, A. C. (2003). Foot assessment in GP practices for people with diabetes. *Nursing Times, 99*(17), 51-2.
Original Research Papers in Peer-Reviewed Journals		
20	**Purpose:** This study aimed to identify the impact of a new podiatric rheumatology service on reducing foot pain, impairment, and disability in patients with foot problems associated with rheumatic diseases and report on patient satisfaction with the service in New Zealand. **Relevant Information:** In support of specialist foot care, a new podiatric rheumatology service was established following an evidence-based approach highlighting the need for improved access to podiatry care for rheumatology patients in New Zealand. The role of the podiatrist in the rheumatology team is becoming recognized as a vital component in the integrated care given to patients by the multidisciplinary team. Increasingly, consultants and their teams are requesting specialist foot care services, and it is suggested that the podiatrist is a key practitioner in the management of patients with musculoskeletal diseases.	Rome, K., Erikson, K., Ng, A., Gow, P. J., Sahid, H., & Williams, A. E. (2013). A new podiatry service for patients with arthritis. *Journal of the New Zealand Medical Association, 126*(1370), 70-7.
21	**Purpose:** This paper aimed to evaluate patient experience and satisfaction following foot surgery within a National Health Service (NHS) orthopaedic department before and after the appointment of a podiatric surgeon in the UK. **Relevant Information:** Podiatric surgeons operating in an orthopaedic department has become increasingly common in the context of the American health care system. While podiatric surgery is well established in the NHS in the UK with over 50 podiatric surgery units, combined podiatric and orthopaedic units only exist in isolated pockets.	Armanasco, P., Williamson, D., & Yates, B. (2012). Integration of podiatric surgery within an orthopaedic department: An audit of patient satisfaction with labour force implications. *Foot, 22*(3), 200-4.

No.	Description	Reference
22	**Purpose:** This paper described and tested a novel collaborative, multi-organization podiatric model of care for people with diabetes in a large regional Australian setting. **Relevant Information:** Diabetes-related foot complications are a significant burden on health systems and individuals with diabetes. Podiatric services are important in the prevention and management of complications such as peripheral neuropathy, ulceration, and lower limb amputations. Podiatric services in Australia are provided by a combination of public health services and podiatrists employed independently in the private sector. Podiatrists in the public sector are generally employed in acute or rehabilitation hospital settings and community settings. In any particular region in Australia, there may be multiple different public organizations involved in providing podiatric care. Often, the different podiatric services in a particular region, and individual podiatrists themselves, operate in relative isolation, with little formal collaboration or planning of services. Further, podiatric services of different organizations often demonstrate a lack of coordination in their service planning, inconsistent clinical practice, and a lack of agreed pathway for patients at various stages of diabetes foot-related problems. The key goals for improving podiatric services to people with diabetes were identified, with a focus on developing a common language for all podiatrists to use with respect to clinical decision making, minimize any service gaps and duplications, and develop a model of care as a means to coordinate and deliver the podiatric services to people with diabetes. An agreed risk classification system to identify patients' risks of future foot morbidity was adopted in Victoria, Australia. The University of Texas Diabetic Foot Risk Classification System (UT risk) was chosen as it is a reliable, valid, and predictive tool for identifying future foot-health outcomes for people with diabetes. In addition, a Podiatry Diabetes Model (PDM) of care was developed where individual levels of risks of foot diseases, categorized as community, subacute, and acute, determined the most appropriate service. According to the PDM: 1) patients who do not have an active diabetes-related foot complication should access podiatric services in the community; and 2) patients with current, active diabetes-related foot complications or who were at high risks of such pathology should be managed by a multidisciplinary service that has an established track record in managing serious diabetes-related foot morbidity. Health disciplines that are represented in such multidisciplinary service include podiatry, nursing, medical (rehabilitation speciality), and orthotists. Private podiatrists are well-equipped to deal with people at low risks of diabetes-related foot complications, but people at high risks or with an active foot complication are less likely to be able to obtain the required intensive, often expensive, multidisciplinary care through a private podiatrist. There would be advantages in incorporating private podiatric services within the PDM to ensure appropriate podiatric care is provided to this group of people. Also, there is a need to formally involve General Practitioners (GPs). GPs are often the coordinators of the management of people with diabetes, and it is important that those providing services in regional areas are aware of how the PDM functions to ensure appropriate access to podiatric services and consistent quality care for patients. It is important to organize health care systems to ensure appropriate and efficient services are provided for people with diabetes. It is possible to collaborate across multiple organizations to provide a comprehensive publicly funded podiatric service to people with diabetes that encompasses the entire risk spectrum for future diabetes-related foot complications.	Perrin, B. M., Gardner, M. J., Kennett, S. R., Cornelius, J. L., & Fanning, M. J. (2012). An organised approach to the podiatric care of people with diabetes in regional Australia. *Australian Health Review, 36*(1), 16-21.

No.	Description	Reference
23	**Purpose:** This pilot study aimed to determine preliminary outcomes for clients attending a chronic wound service with podiatry involvement as a core component in an interdisciplinary model of care in Australia. **Relevant Information:** Podiatrists offer a diverse range of skills including sharp debridement, knowledge of biomechanics, footwear modification and education, and general wound management and treatment as well as neurovascular assessment, ankle brachial pressure indices, and toe pressure measurements. There is literature suggesting that podiatrists are becoming more involved with the care and treatment of people who have high-risk chronic foot wounds. Clinical podiatrists have been core members of clinic teams in high-risk foot care services at a number of tertiary institutions and are seen as valuable team members in assisting with the achievement of key, long-term outcomes for these clients. The establishment of these clinics has shown reduction in wound healing time, increased percentage of healed ulcers, diminished incidence of amputation, and improved prognosis for limb salvage. These high-risk foot services are now within all major hospitals within Melbourne, Victoria, Australia. In this pilot study, services ran two days a week and were staffed by a Division 1 nurse and podiatrist with a half-day medical support (geriatrician). The criteria for referral to the chronic wound services were that a wound had been present for greater than six weeks and that the wounds could be to any area of the body. Clients were assessed jointly by the nurse and podiatrist at the first appointment, and medical involvement was determined at this appointment or in subsequent reviews.	Butters, T. (2011). Interdisciplinary chronic-wound care services involving podiatry – a strengthened model of care? *Wound Practice and Research, 19*(4), 229-33.
24	**Purpose:** This study aimed to assess the prevalence of foot problems and quality and availability of foot care services at a UK district general hospital. **Relevant Information:** British Society for Rheumatology and the National Institute of Clinical Excellence guidelines advise that rheumatoid arthritis patients should be treated by a multidisciplinary team with dedicated podiatry services. However, in clinical practice, funding constraints often limit availability of podiatry services. A review of provision of foot health services in Rheumatology Departments in the UK found that only 50% of them reported adequate basic foot care services, and fewer than one in ten had formal care pathways or mechanisms for referral to foot services. The foot therefore continues to be neglected in inflammatory arthritis.	Juarez, M., Collins, E. P., & Williamson, L. (2010). Deficiencies in provision of integrated multidisciplinary podiatry care for patients with inflammatory arthritis: A UK district general hospital experience. *Foot, 20*(2-3), 71-4.

No.	Description	Reference
25	**Background:** In the UK, podiatric surgery is provided by the publicly funded National Health Service (NHS) (Kilmartin, 2002; Turbutt, 1994). Internationally, programs where podiatric surgery is incorporated into the public sector have been a success over a long period of time. Such incorporation is well established in both the US and the UK. There are variations in the models of incorporation. These models range from the use of independent units to incorporation of podiatric surgeons within general surgical or orthopaedic units. **Purpose:** This study aimed to describe and compare the frequencies of procedures performed by podiatric surgeons and orthopaedic surgeons for elective surgery to the great toe joint – an area of identified clinical need in Australia. The objective was to determine whether podiatric surgeons in the private sector possess a surgical skillset which can be utilized in the public sector. **Methods:** The Medicare Benefits Schedule from Medicare Australia was reviewed to identify all codes relating to great toe joint surgery, and frequency data were obtained for the period July 1999 to June 2003. A separate audit of the activity of Victorian podiatric surgeons was conducted from the records of the hospital where the practitioners performed the surgery. **Results:** During the four years in Victoria, the number of procedures performed on this joint by 152 orthopaedic surgeons was 5,882. Two podiatric surgeons in Victoria performed 1,260 operations on this joint over this period (17.6% of all great toe joint surgery over the four-year audit period). Utilizing orthopaedic workforce figures and on a per-surgeon basis, during this period, the podiatric surgeons performed this type of surgery between two and 16 times more often than the orthopaedic surgeons. **Conclusions:** Consideration should be given to using these skills in the public sector to address the growing demand.	Gilheany, M. F., & Robinson, P. (2009). Is there a role for podiatric surgeons in public hospitals? An audit of surgery to the great toe joint in Victoria, 1999-2003. Australian Health Review, 33(4), 690-5.
26	**Purpose:** In 2004, as an extension of the Enhanced Primary Care (EPC) program, the Australian Government introduced a policy of providing Medicare rebates for allied health services provided to patients with chronic or complex health conditions. The EPC chronic disease management program is coordinated by the patient's GP, who prepares a management plan, initiates the referrals to allied health professionals, and reviews progress every six months. A maximum of five allied health services are allowed per calendar year. The objective of this study was to evaluate the utilization of podiatry services provided under this scheme between 2004 and 2008. **Methods:** Data pertaining to the Medicare item 10962 for the calendar years 2004-2008 were extracted from the Australian Medicare Benefits Schedule database and cross-tabulated by sex and age. Descriptive analyses were undertaken to assess sex and age differences in the number of consultations provided and study temporal trends over the five-year assessment period. The total cost to Medicare over this period was also determined. **Results:** During the 2004-2008 period, a total of 1,338,044 EPC consultations were provided by podiatrists in Australia. Females exhibited higher utilization than males (63% versus 37%), and those aged over 65 years accounted for 75% of consultations. There was a marked increase in the number of consultations provided from 2004 to 2008, and the total cost of providing EPC podiatry services during this period was $62.9 M. **Conclusions:** Podiatry services have been extensively utilized under the EPC program by primary care patients, particularly older women, and the number of services provided has increased dramatically between 2004 and 2008. Further research is required to determine whether the EPC program enhances clinical outcomes compared to standard practice.	Menz, H. B. (2009). Utilisation of podiatry services in Australia under the Medicare Enhanced Primary Care program, 2004-2008. *Journal of Foot and Ankle Research, 2*, 30.

No.	Description	Reference
27	**Purpose:** This study reported on the results of the 2007 Podiatric Practice Survey which collected information about the practice experience of the American Podiatric Medical Association (APMA) members in 2006, including practice location and arrangements. **Methods:** A 34-question survey form was designed by the APMA to collect information on various topics including general practice information (e.g., practice arrangements, practice size, practice location) from its members with more than five years of practice experience. **Results:** Practice Arrangements: Solo practice remained the primary arrangement for 50% of the podiatrists that responded to the survey in 2007, which was significantly less than the 61% in 1996. A substantial percentage of respondents practiced primarily in a partnership or group practice setting (44% in 2007 versus 40% in 2005). In 2007, 19% were in a podiatric medical group, 16% of the respondents were in a partnership, 7% were in a multi-specialty group, and 2% were in an orthopedic group. Practice Size: Most podiatric practices were small. In 2007, members in partnership arrangements reported a median of two physicians in their practice, compared with three physicians in 2005. The median number of podiatric physicians in multispecialty groups was two, and the median number in podiatric medical groups was three. Orthopedic groups had a median of one podiatric physician, while health maintenance organizations (HMOs) had six podiatric physicians and hospitals had two. The maximum number of podiatric physicians varied from one in solo practice to 100 in a multispecialty group, with one partnership reporting 22 podiatric physicians and one podiatric medical group reporting 60 podiatric physicians. One orthopedic group had 23 podiatric physicians, and one hospital had eight. One HMO employed 350 podiatric physicians, a number also found in 2005. **Conclusions:** The percentage of members in podiatric medical groups has increased over time while the percentage of solo practitioners has decreased.	Al Fisher Associates. (2007). 2007 podiatric practice survey. Statistical results. *Journal of the American Podiatric Medical Association, 97*(6), 496-519.
Grey Literature		
28	**Background:** To provide context for an upcoming analysis of the regulation of podiatry and chiropody in Ontario and to address a broad component of the Minister of Health and Long-Term Care referral, an initial consultation session was held on the current model of foot care in Ontario. The objective of the consultation session was to gather information on how foot care is delivered in the province and to learn more about the issues facing foot care providers, patients, and other involved Ontarians. In total, Ontario's Health Professions Regulatory Advisory Council received 198 submissions from 197 stakeholders. **Purpose:** This document provides the stakeholder submissions. **Relevant Information:** The Ontario Podiatric Medical Association (OPMA)'s submission outlined its view on the current model of foot care in Ontario and provided a historical overview of podiatry and chiropody in Ontario. In particular, the OPMA noted that today, less than 20% of chiropodists in Ontario currently practice in hospitals, community health centres, and in other publicly funded health care delivery institutions.	Health Professions Regulatory Advisory Council. (2014). Stakeholder Feedback on the Chiropody/Podiatry Referral: The current Model of Foot Care in Ontario – Part II(b): Other Submissions. Accessed August 2014.

No.	Description	Reference
29	The New York State Education Department administers professional regulation in the state of New York through its Office of the Professions. Relevant pages accessed include: (2014a). Frequently Asked Questions. The answer to the question "What is included in the scope of practice of podiatry with respect to the provision of wound care?" on this page describes the expanded scope of practice for podiatry, effective February 17, 2014, allowing podiatrists to treat wounds that are not only on the foot but near and related to a wound on the foot. (2014b). Podiatric Ankle Surgery Privileges. The "Types and Scope", "Standard Ankle Surgery Requirements", and "Advanced Ankle Surgery Requirements" sections on this page describe the expanded scope of practice for podiatric "standard" and "advanced" ankle surgery, effective February 17, 2014. (2014c). Education Law. Article 141, Podiatry. The "Definition of practice of podiatry" describes the scope of practice for podiatry.	New York State Education Department website: http://www.op.nysed.gov/ Accessed August 2014.
30	**Purpose:** This legislative document defines medical practices in the state of Wisconsin including those of podiatry. **Relevant Information:** The term "podiatrist" refers to an individual possessing the degree of Doctor of Podiatric Medicine or that of surgical chiropody or an equivalent degree as determined by the affiliated credentialing board and holding a license to practice podiatry or podiatric medicine and surgery granted by the affiliated credentialing board. The term "podiatry" or "podiatric medicine and surgery" means the branch or system of the practice of medicine and surgery that involves treating the sick which is limited to conditions affecting the foot and ankle but does not include the use of a general anaesthetic unless administered by or under the direction of a person licensed to practice medicine and surgery under Subchapter II.	Wisconsin Statutes. (2014). Chapter 448. Medical Practices Subchapter IV. Accessed August 2014.
31	**Purpose:** This position statement describes the recently-introduced Any Qualified Provider (AQP) in the UK and identifies the need for a coordinated multidisciplinary care for people with diabetes. **Relevant Information:** There is a tenfold variation in amputation rates across England (Holdman et al., 2012), a large part of which is thought to be due to variation in the co-ordination of foot services leading to late referrals. The Foot Protection Team (FPT) is largely made up of podiatrists with a primary responsibility for prevention, and the specialist diabetes foot Multidisciplinary Team (MDfT) is required to coordinate the management of all new disease. The FPT and MDfT must work closely together with clear pathways of care consisting of defined roles and responsibilities to ensure prompt and effective transition across health care boundaries. The Department of Health recently introduced the Any Qualified Provider (AQP) scheme in England, prioritising adult podiatry services as a key area for development to increase the choice about which services can be used within the National Health Service (NHS). Care must be taken to ensure that: 1) services do not become more fragmented; 2) patients are clear about where they go for what services; and 3) there is no increase in the incidence of limb loss or overall costs to the NHS or people with diabetes. The delivery of greater choice of podiatry services within the AQP scheme must not be at the expense of services and care for people with diabetes whose feet are at increased risks of developing foot ulceration, other foot diseases, and amputations. To improve foot care services for people with diabetes and reduce amputations, local health teams must work together in a structured way by ensuring annual foot assessments by competent staff, provision of information and education to reduce risks, and timely referrals to foot protection and multidisciplinary specialist foot care teams for preventing, treating, and managing diabetic foot diseases.	Diabetes UK. (2013). Any Qualified Provider (AQP) Podiatry – Commissioning Integrated Diabetes Foot Care Services. Position Statement. Accessed August 2014.

No.	Description	Reference
32	**Purpose:** This legislative document defines podiatrists and podiatry and describes their scope of practice in the state of South Carolina. **Relevant Information:** The terms "podiatry" or "podiatrist" and "chiropody" or "chiropodist" have identical meanings. The term "podiatry" shall mean the diagnosis and medical and surgical treatment limited to ailments of the human foot, except the administration of an anaesthetic other than local. "Diagnosis" shall mean to ascertain a disease or ailment by symptoms and findings and does not confer the right to use X-ray other than for diagnosis. "Medical treatment" shall mean the application or prescription of any therapeutic agent or remedy for the relief of foot ailments, except the medical treatment of any systemic diseases causing manifestations in the foot. "Surgical treatment" shall mean the use of any cutting instrument to treat a disease, ailment, deformity, or condition of the foot, but shall not confer the right to amputate the foot or toes.	South Carolina Code of Laws. (2013). Title 40 – Professions and Occupations. Chapter 51. Podiatrists and Podiatry. Accessed August 2014.
33	The American Academy of Orthopaedic Surgeons provides musculoskeletal education to orthopaedic surgeons and others across the US and international jurisdictions. Relevant pages accessed include: (2012). Information Statement. The section titled "Expansion of Podiatric Scope of Practice" on this page describes the US podiatric community's push in recent years to expand its scope of practice.	American Academy of Orthopaedic Surgeons website: http://www.aaos.org/ Accessed August 2014.
34	**Purpose:** This news brief describes the 2011 scope of practice bill in the state of Virginia. **Relevant Information:** The scope of practice legislation updated the current definition of the practice of podiatry in Virginia, giving Virginia podiatrists the statutory authority to diagnose and treat lower extremity ulcers and access areas above the foot and ankle to harvest skin grafts in the treatment of ulcers.	American Podiatric Medical Association. (2011). Governor Signs Virginia Scope of Practice Bill. Accessed August 2014.
35	**Purpose:** This report describes foot care management in diabetes in in Ireland according to the standards of the National Institute for Health and Care Excellence. **Relevant Information:** In 2011, funding was received to establish a national multidisciplinary foot care service for people with diabetes. Foot care management in diabetes is based on three risk categories. Patients at low risks of diabetic foot diseases will be managed preventatively through annual screening and regular foot examinations by primary care nurses. Patients at risks of diabetic foot diseases may be stratified as either moderate risks or high risks. All patients will be under regular surveillance by primary care nurses or general practitioners (GPs). Moderate risk patients will be referred by GPs to podiatrists, either in the community or a hospital, for an annual review. These patients will remain under the clinical governance of GPs and podiatrists. High risk patients will be called to be seen at least annually by the diabetes foot protection team and will be under the governance of the foot protection team for their foot care. Patients with "active diabetic foot diseases" (e.g., active foot ulcer, Charcot foot) will be actively managed by a multidisciplinary specialist foot care service, in conjunction with vascular surgery, orthopaedics, and orthotics input as required. This integrated model of management or care pathway for the diabetic foot is intended to provide a structure and organization to the foot care needs of patients with diabetes. The key feature is foot care being provided by an appropriate healthcare professional at a frequency appropriate to the patients' needs.	Health Service Executive. (2011). Model of Care for the Diabetic Foot. Accessed August 2014.

No.	Description	Reference
36	**Purpose:** This *Health Professions Act* defines podiatric medicine and its scope of practice in the province of British Columbia. **Relevant Information:** Podiatric medicine means the health profession in which a person provides the services of the prevention, treatment, and palliation of diseases, disorders, and conditions of the foot and the bones, muscles, tendons, ligaments, and other tissues of the lower leg that affect the foot or foot function but does not include any treatment of the foot or lower leg that may affect the course of treatment of a systemic disease unless the treatment of the foot or lower leg is provided in collaboration with a medical practitioner. Restricted activities include making a diagnosis, performing a procedure on tissues below the dermis of the foot or lower leg, setting or casting a fracture of a bone of the foot or lower leg, reducing a dislocation of a joint of the foot or lower leg, injecting intravenous fluids, applying laser for cutting or destroying tissues or X-rays for diagnostic or imaging purposes, and issuing an instruction or authorization for another person to apply ultrasound, electromagnetism, or X-rays, and prescribing, compounding, dispensing, or administering drugs.	British Columbia Regulation. (2010). *Health Professions Act*. Podiatrists Regulation. Accessed August 2014.
37	**Purpose:** This news clipping describes the legal battle among the Texas Medical Association (TMA), Texas Orthopaedic Association (TOA), and Texas State Board of Podiatric Medical Examiners (TSBPME) over podiatrists' scope of practice surrounding the definition of the foot in the state of Texas. **Relevant Information:** Since 2002, the TMA and TOA had been locked in litigation with the TSBPME and Texas Podiatric Medical Association (TPMA) over podiatrists' scope of practice. The case concluded in August 2010 when the Texas Supreme Court denied the TPMA's motion for rehearing. In June 2010, the Supreme Court of Texas declined to review an appellate court's previous decision rejecting the TSBPME's rule that would have allowed podiatrists to treat ankle injuries. In 2008, the appeals court stated that the TSBPME was wrong when it adopted a rule in 2001 that defined the foot as "the tibia and fibula in their articulation with the talus, and all bones to the toes, inclusive of all soft tissues (muscles, nerves, vascular structures, tendons, ligaments, and any other anatomical structures) that insert into the tibia and fibula in their articulation with the talus and all bones to the toes". The appeals court concluded that the TSBPME "exceeded its authority when it promulgated the rule and that the rule is invalid." The TMA and TOA sued the TSBPME in 2002, contending that the board's change in the definition of the foot illegally expanded podiatrists' scope of practice. The proposed rule would have allowed podiatrists to perform surgical and non-surgical procedures on the bones and tissues of the lower leg below the knee cap, including "fractures that extend into the ankle joint".	Conde, C. (2010). TMA Wins Victory in Legal Battle with Podiatrists. *Texas Medicine, 106*(10), 20-4.

No.	Description	Reference
38	**Purpose:** This report describes multidisciplinary models of care and payment models for the high risk foot. **Relevant Information:** Multidisciplinary Models of Care: Internationally, it is widely acknowledged that people with the high risk foot, particularly when complex foot disorders develop, should be managed within a multidisciplinary environment. Integrated teams consisting of medical, surgical, nursing, podiatry, and allied health professionals have been shown to: 1) reduce wound healing times; 2) increase the percentage of healed ulcers; 3) diminish the incidence of amputation; and 4) improve the prognosis for limb salvage. Multidisciplinary teams are therefore considered to be the best practice strategy in the management of multifaceted foot conditions that require expert and coordinated care. This integrated approach acknowledges that no one specialist possesses all the expertise and knowledge to manage the patient. Payment Models: The majority of podiatrists work in the private sector. For example, the 2007 Podiatry Labour Force Survey found that approximately 84-90% of podiatrists work in the private sector whereas only 10-16% of podiatrists work in the government sector. People from low socio-economic backgrounds and Aboriginal populations may face limited access to podiatry due to the often prohibitive cost of private care for those without insurance or who require regular follow-up or specialist footwear or orthotics to reduce the risk of high-risk foot complications. Access to public metropolitan podiatry services is severely limited by excess demand and relatively low staffing, requiring clinics to implement strict eligibility and discharge criteria.	Government of Western Australia. (2010). Model of Care for the High Risk Foot. Accessed August 2014.
39	The Medical Board of California is a state government agency which licenses and disciplines medical doctors in the state of California. Relevant pages accessed include: (2010). Information on Scope of Practice. This page defines the scope of practice for Doctors of Podiatric Medicine in the state of California.	Medical Board of California website: http://www.bpm.ca.gov/ Accessed August 2014.
40	**Purpose:** This report provides background information to support the development of guidelines for the integration of internationally educated health professionals into the workplace in the province of Ontario. **Relevant Information:** Chiropodists assess the foot and treat and prevent diseases, disorders, or dysfunctions of the foot by therapeutic, orthotic, or palliative means. Chiropodists are able to cut into the subcutaneous tissues of the foot, prescribe drugs designated in the regulations, and administer injection into the foot.	Baumann, A., & Blythe, J. (2009). Integrating Internationally Educated Health Care Professionals into the Ontario Workforce. Ontario Hospital Association. Accessed August 2014.
41	**Purpose:** This jurisdictional review on podiatry and chiropody by the Health Professions Regulatory Advisory Council in Canada outlines inconsistencies in the regulation of the professions across the country. **Relevant Information:** Ontario is an anomaly with respect to titles. In every other province, the designated term for the professional providing foot care is “podiatrist”; in Ontario, it is “chiropodist”. Prior to 1993, both titles and practices were in place in Ontario. However, in 1993, the practice of podiatry was capped, and some surgical privileges (e.g., backfoot surgery) were removed from the scope of practice for the members at the time. Since then, all new practitioners were identified and practice as chiropodists. Other Canadian provinces admit new practitioners as podiatrists and use the term podiatry.	Health Professions Regulatory Advisory Council. (2008). Prescribing and Use of Drugs by Non-Physician Health Professionals: A Jurisdictional Review of the Professions of Chiropody & Podiatry. Accessed August 2014.

No.	Description	Reference
42	**Purpose:** This member resource letter describes Vision 2015 – a plan to obtain national recognition of the podiatric physician in the US. **Relevant Information:** The American Podiatric Medical Association aims to achieve a "uniform scope of practice" by 2015, allowing podiatrists to treat patients in the physicians' specialty without restrictions.	American Podiatric Medical Association. (2007). Vision 2015: A Plan to Obtain National Recognition of the Podiatric Physician. Accessed August 2014.
43	**Purpose:** This report describes the registration practices of regulated professions including those of podiatry in Ontario, Canada. **Relevant Information:** The scope of practice for both podiatrists and chiropodists is the assessment of the foot and the treatment and prevention of diseases, disorders, or dysfunctions of the foot by therapeutic, orthotic, or palliative means. Chiropodists are authorized to prescribe drugs designated in the regulations, cut into the subcutaneous tissues of the foot, and administer by injection into the foot a substance designated in the regulations. Podiatrists have the same authorized functions as chiropodists listed above, but they are also authorized to cut into the bony tissues of the forefoot and communicate diagnoses. The COCOO regulates chiropodists and podiatrists. As of July 1, 1993, new members registering with the College of Chiropodists of Ontario are required to be registered as chiropodists. However, those podiatrists who registered with the College before July 1, 1993 are permitted to continue to practice as podiatrists. Ontario's practice of registering chiropodists but not podiatrists makes it unique in North America. A person with a Doctor of Podiatric Medicine degree who is trained as a podiatrist may currently register in Ontario but only as a chiropodist and is allowed to perform only the acts of a chiropodist authorized by the *Chiropody Act*, 1991. In Quebec, parts of western Canada, and most of the US, the regulated profession is podiatry. Academic programs in the US offer programs in podiatry and not chiropody.	Office of the Fairness Commissioner. (2007). Study of Registration Practices of the College of Chiropodists of Ontario, 2007. Accessed August 2014.
44	The Ontario Podiatric Medical Association serves podiatrists in Ontario by advocating to government and other stakeholders on behalf of the profession. Relevant pages accessed include: (2014). About OPMA. The section titled "Podiatry and Chiropody" on this page describes differences between podiatrists and chiropodists.	Ontario Podiatric Medical Association website: http://www.opma.ca/ Accessed August 2014.
45	**Purpose:** This news clipping describes the Texas court ruling on the expanding scope of practice for podiatrists in the state of Texas. **Relevant Information:** The Texas Judicial District Court upheld the position that the definition of the foot as including the ankle was valid and that the ankle is within the scope of practice for podiatrists practicing in the state of Texas. The Texas State Board of Podiatric Medical Examiners (TSBPME) had redefined the foot to include the "tibia and fibula in their articulation with the talus, and all bones to the toes, inclusive of all soft tissues (muscles, nerves, vascular structures, tendons, ligaments, and any other anatomical structures) that insert into the tibia and fibula in their articulation with the talus and all the bones to the toes." Opponents of the expanded definition, namely orthopaedists and physicians, had in response claimed that the inclusion of the bones of the ankle within the proposed TSBPME definition unilaterally redefined the statutory term "podiatry" as it is employed in Section 202.001 of the Texas Occupations Code and Section 151.052(a)(5) of the Texas *Medical Practice Act* and sought a judicial declaration that the lawful practice of podiatry in Texas is limited to the treatment of the foot and that it does not extend to the treatment of the ankle bones or any other anatomical structure as a matter of law.	Reddy, B. S. (2005). Texas Court Expands Scope of Practice for Texas Podiatrists. University of Houston Law Center. Accessed August 2014.

No.	Description	Reference
46	**Purpose:** This report provides recommendations to help health care professionals in their management of people with Type 2 diabetes including their foot care. **Relevant Information:** Multidisciplinary teams providing education should include, as a minimum, a diabetes specialist nurse (or a practice nurse with experience in diabetes) who has knowledge of the principles of patient education and a dietitian. Although not formally assessed in this appraisal, input from other disciplines, such as podiatry, has potential value.	National Institute for Health and Care Excellence. (2004). Clinical Guidelines for Type 2 Diabetes. Prevention and Management of Foot Problems. Accessed August 2014.
47	The Australian Podiatry Association of Victoria is an independent, member organization serving both the profession and the community in Victoria, Australia. Relevant pages accessed include: (2002). Scope of Practice. This page defines the "scope of practice" for podiatrists in Victoria, Australia.	Australian Podiatry Association of Victoria website: http://www.podiatryvic.com.au/ Accessed August 2014.
48	**Purpose:** This legal document describes the practice of podiatry in the province of Manitoba. **Relevant Information:** The practice of podiatry is the use of medical, physical, or surgical methods to prevent, diagnose, and treat ailments, diseases, deformities, and injuries of the human foot but does not include treatment of systemic disease, except for the local manifestations in the foot. For the purpose of the *Podiatrists Act*, the human foot includes the articulation of the tibia and fibula with the bones of the foot and the muscles and tendons directly affecting foot function. Subject to the regulations, in the course of practicing podiatry, a podiatrist may a) cut into the subcutaneous, ligamentous, and bony tissues of the foot and the tendons directly affecting the function of the foot; b) inject substances into the foot; and c) prescribe drugs.	Manitoba Laws. (2001). *Podiatrists Act*. Accessed August 2014.
49	The American College of Foot and Ankle Surgeons is a professional society of foot and ankle surgeons founded in 1942 that addresses the concerns of foot and ankle surgeons in the US. Relevant pages accessed include: (n.d.). State Scope of Practice Provisions for Podiatric Foot and Ankle Surgeons. This page summarizes the scopes of practice for podiatric surgeons in the 50 states and District of Columbia in the US.	American College of Foot and Ankle Surgeons website: http://www.acfas.org/ Accessed August 2014.
50	**Purpose:** This primer for policymakers describes the education and training of Doctors of Podiatric Medicine (DPMs) in the US. **Relevant Information:** The federal government and the majority of the states recognize DPMs as physicians. DPMs are authorized to practice podiatric medicine by state statutes and are regulated and licensed to practice podiatric medicine in all 50 states and the District of Columbia. Although the podiatric scope of practice statutes vary from state to state, all states permit treatment of the human foot. Also, 44 states and the District of Columbia permit treatment at or above the ankle with Alabama, Kansas, Massachusetts, Mississippi, New York, and South Carolina being the only states in which the ankle is not included in their podiatric scopes of practice as of 2009.	American Podiatric Medical Association. (n.d.). Podiatric Medicine: A Primer for Policymakers. Accessed August 2014.
51	The Canadian Podiatric Medical Association is a non-profit organization working on behalf of Canada's foot specialists. Relevant pages accessed include: (n.d.). FAQs. The section titled "What is the difference between a podiatrist and a chiropodist?" on this page describes differences between podiatrists and chiropodists as well as provincial differences in terms of chiropody.	Canadian Podiatric Medical Association website: http://www.podiatrycanada.org/ Accessed August 2014.

No.	Description	Reference
52	**Purpose:** This legal document (Chapter 375, Title 20, of the General Statutes of Connecticut) describes the professional and occupational licensing, certification, title protection ad registration, and examination for podiatry in the state of Connecticut. **Relevant Information:** "Podiatric medicine" means the diagnosis and treatment, including medical and surgical treatment, of ailments of the foot and the anatomical structures of the foot and the administration and prescription of drugs incidental thereto. It shall include treatment of local manifestations of systemic diseases as they appear on the foot. A doctor of podiatric medicine, licensed pursuant to this chapter, may prescribe, administer, and dispense drugs and controlled substances.	Connecticut Statutes. (n.d.). Chapter 375. Podiatry. Accessed August 2014.
53	**Purpose:** This legal document (Chapter 35, Title 43, of the Georgia Code) describes the regulation for podiatrists in the state of Georgia. **Relevant Information:** "Podiatric medicine", which includes chiropody, podiatry, and podiatric medicine and surgery, means that portion of the practice of medicine identified by the acts described in any one or more of the following: A) charging a fee or other compensation, either directly or indirectly, for any history or physical examination of a patient in a person's office or in a hospital, clinic, or other similar facility prior to, incident to, and necessary for the diagnosis and treatment, by primary medical care, surgical, or other means, of diseases, ailments, injuries, or abnormal conditions of the human foot and leg; B) holding oneself out to the public, either directly or indirectly, as being engaged in the practice of podiatric medicine; C) displaying or using a title or abbreviation such as "Doctor of Podiatric Medicine", "D.P.M.", "Foot Doctor", "Foot Specialist", "Foot Surgeon", "Foot and Ankle Surgeon", or other letters, designations, or symbols or signs of any type which expressly or implicitly indicate to the general public that the user renders treatment to the foot, ankle, and leg under the provisions of this chapter; D) performing surgery on the foot or leg of a patient, except that when such surgery is performed under general anaesthesia it shall be permissible only when said surgery is performed at a facility permitted and regulated as a hospital or ambulatory surgical treatment centre under Article 1 of Chapter 7 of Title 31 and when said general anaesthesia is administered under the direction of a duly licensed physician; E) performing amputations of the toe; or F) performing amputations distal to and including the tarsometatarsal joint but only when performed in a facility permitted and regulated as a hospital or ambulatory surgical treatment centre under Article 1 of Chapter 7 of Title 31 and when performed by a podiatrist who is certified by the board in meeting the requirements which shall be established by regulations of the board which have been jointly approved by the board and the Georgia Composite Medical Board.	Georgia Statutes. (n.d.). *Georgia Podiatry Practice Act*. Accessed August 2014.
54	**Purpose:** This legal document (Chapter 9, Title 33, of the Wyoming State Statutes) describes the *Podiatry Practice Act* and defines "podiatry" in the state of Wyoming. **Relevant Information:** "Podiatry" means the diagnosis or the medical, mechanical, or surgical treatment of the ailments of the human foot, ankle, and tendons that insert into the foot. Podiatry also includes the fitting or the recommending of appliances, devices, or shoes for the correction or relief of minor foot ailments. The practice of podiatric medicine shall include the amputation of the toes or other parts of the foot but shall not include the amputation of the foot or leg in its entirety. A podiatrist may not administer any anaesthetic other than local. A general anaesthesia shall be administered in a hospital by an anaesthesiologist or certified nurse anaesthetist authorized under the laws of Wyoming to administer anaesthesia. Podiatrists are permitted to use and to prescribe drugs and controlled substances as may be necessary in the practice of podiatry (Wyoming Statutes, n.d.).	Wyoming Statutes. (n.d.). Board of Registration in *Podiatry Practice Act*. Accessed August 2014.

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