Interprofessional relationships between orthopaedic and podiatric surgeons in the UK

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ABSTRACT

INTRODUCTION The first comprehensive report on the interprofessional relationships between foot and ankle surgeons in the UK is presented.

MATERIALS AND METHODS A questionnaire was sent to orthopaedic surgeons with membership of the British Foot and Ankle Surgery Society (BOFAS), orthopaedic surgeons not affiliated to the specialist BOFAS and podiatrists specialising in foot surgery. The questionnaire was returned by 77 (49%) of the BOFAS orthopaedic consultant surgeons, 66 (26%) of non-foot and ankle orthopaedic consultant surgeons and 99 (73%) of the podiatric surgeons.

RESULTS While most respondents have experience of surgeons working in the other specialty in close geographical proximity, the majority do not believe that this has adversely affected their referral base. The experience of podiatrists of the outcomes of orthopaedic surgery has been more positive than orthopaedic surgeons of podiatric interventions. Podiatrists are more welcoming of future orthopaedic involvement in future foot and ankle services than in reverse. However, there are a sizeable number of surgeons in both professions who would like to see closer professional liaisons. The study has identified clear divisions between the professions but has highlighted areas where there is a desire from many clinicians to work more harmoniously together, such as in education, training and research.

CONCLUSIONS While major concerns exist over issues such as surgery by non-registered medical practitioners and the suitable spectrum of surgery for each profession, many surgeons, in both professions, are willing to provide training for juniors in both specialties and there is a wish to have closer working relationships and common educational and research opportunities than exists at present.

KEYWORDS

Foot and ankle surgery – Orthopaedic surgeon – Podiatric surgeon

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In the UK, there has been a rapid expansion in the clinical activities undertaken by various healthcare professionals that were once deemed the preserve of medically qualified clinicians. Supported by Department of Health publications, such as *Meeting the Challenge: a Strategy for the Allied Health Professions*,¹ this expansion may be explained, in part, by factors such as changes in the healthcare market, changes in regulations which previously restricted clinical activity to certain groups, and patient acceptability and choice.

The history of non-registered medical practitioners undertaking foot and ankle surgery has its origins in the US. The term podiatrist was first used by Felix Von Defele in 1918; in 1958, the name of the profession in the US was changed officially from chiropody to podiatry.² By 1987, 73% of all hallux valgus surgery and 57% of hindfoot surgery in

the US was undertaken by podiatrists. In 1991, there were 9400 podiatrists and 17,000 orthopaedic surgeons in the US. However, only 574 orthopaedic surgeons belonged to the American Foot and Ankle Society (6.1% of all orthopaedic surgeons) with only 125 (0.7%) undertaking solely foot and ankle surgery.³

Foot and ankle surgery has been an important part of orthopaedic surgery for over 100 years including the treatment of conditions such as club foot, trauma management, diabetes and osteomyelitis, and dealing with the complications of neuromuscular disorders such as polio. However, Klenerman³ alerted the orthopaedic community to the potential loss of foot and ankle surgery from its repertoire because of its perceived preference for surgery in other parts of the body and the increasing complexity of work in those alternative sites.

Within Europe, only Spain and the UK allow non-registered medical practitioners to undertake foot and ankle surgical procedures.⁴ In the UK, a number of chiropodists were employing local anaesthetic techniques in the mid 1960s, learnt during service in the Royal Army Medical Corp.⁵ Under guidance from American podiatrists, individuals with a background in the conservative treatment of foot disorders commenced training in nail and hammer toe surgery in the early 1970s.⁶ Within 20 years, it was determined that over 22,500 procedures a year were being performed by podiatric surgeons in the UK.⁷

To become a podiatric surgeon, practitioners undertake a 3-year degree course in Podiatric Medicine, and complete a minimum 1-year post-registration year before commencing a Master's degree course in the Theory of Podiatric Surgery. Subsequently, they complete an Objective Assessment of Professional Skills Test. A minimum of 2 years in supervised training posts in NHS departments of podiatric surgery follows to gain experience in foot surgery. Further practical examinations in clinical diagnosis and surgical treatment planning are completed before the final Fellowship examination when candidates must perform a comprehensive range of foot surgery on a number of patients. Once awarded Fellowship of the Faculty of Podiatric Surgery (FCPodS), the surgeon is entitled to apply for specialist registrar posts in the NHS. At the end of 3-year specialist registrar posts, the surgeon submits a log book to the Faculty of Podiatric Surgery for the award of the Certificate of Completion in Podiatric Surgical Training (CCPST). The CCPST allows the podiatric surgeon to apply for consultant podiatric surgeon posts in the NHS. All such posts are awarded by an appointment panel. The minimum training period for UK podiatric surgeons is 9 years.⁹

Although, within the UK, examples of collaborative and mutually beneficial working practices can be found, relationships between orthopaedic surgeons and podiatric surgeons have largely been strained at both individual and institutional level. The King's Fund report⁸ looked at the cost-effectiveness of podiatric surgery. Following stakeholder interviews, the authors concluded that both professional groups shared many ideals and there was a significant desire for more joint working across the professional divide. Where joint working already took place, it was generally harmonious. Borthwick and Dowd¹⁰ conducted interviews with several orthopaedic surgeons addressing such themes as experience of podiatric surgery, podiatric surgery training and future collaboration. Accepting that many barriers remained, senior members of the podiatric community were well-regarded although there was a general lack of knowledge about podiatric surgical training.

The aim of this study was to assess current views on foot and ankle surgery provision and interprofessional relationships between orthopaedic and podiatric surgeons in the

UK by canvassing opinions from three groups: (i) orthopaedic surgeons with membership of the British Foot and Ankle Surgery Society (BOFAS); (ii) orthopaedic surgeons not affiliated to the specialist foot and ankle society; and (iii) podiatrists specialising in foot surgery. We believe that this is the first UK survey formulated by orthopaedic and podiatric surgeons together and is the first attempt to contact all foot and ankle surgeons in this country.

Materials and Methods

A questionnaire was developed, the design of which contained input and agreement from both an orthopaedic surgeon with an interest in foot and ankle surgery (WJR) and podiatric surgeons (INR and TEK). The only alternative method of data collection is direct interview, which would be prohibitively expensive, time-consuming and with its own set of problems, including whether interviewees feel constrained from expressing their true views.

Postal questionnaires were sent to: (i) all 156 members of the British Orthopaedic Foot and Ankle Society (BOFAS); (ii) a random selected sample of 250 British Orthopaedic Association (BOA) members who were not BOFAS members; and (iii) all 136 surgical fellows of the College of Podiatrists, Society of Chiropodists and Podiatrists (SoCaP).

The questionnaire addressed seven main areas:

1. Professional 'title'.
2. Geographical proximity to surgeons from the other discipline.
3. Overall experience of the outcomes of surgery for the alternative profession.
4. Impediments to closer working practices.
5. Present and future working practices.
6. Training and educational opportunities.
7. Suitable spectrum of surgery for each profession.

The results were entered onto SPSS v.11.5.0 for Windows and analysed.

Results

The questionnaire was returned by 77 (49%) of the BOFAS orthopaedic consultant surgeons, 66 (26%) of non-foot and ankle orthopaedic consultant surgeons and 99 (73%) of the podiatric surgeons. The low response rate of the non-BOFAS orthopaedic surgeons might result in possible statistical bias in their responses; therefore, a decision was taken to not consider further the responses from this group in the study.

Professional title

The background details of the respondents are given in Table 1. All 406 orthopaedic surgeons contacted had achieved consultant

Table 1 Details of respondents

	Podiatric surgeons	BOFAS orthopaedic surgeons	General orthopaedic surgeons
No. of replies (total number contacted)	99 (136)	77 (156)	66 (250)
Years as consultant or since podiatric fellowship	10.9	11.1	10.9
No. in full-time private practice (%)	17 (17.2 %)	7 (9.09%)	4 (6.06%)

surgeon status. Of the podiatric surgeon respondents, 56% currently working use the title consultant podiatric surgeon indicating that they have been appointed to a substantive NHS appointment at consultant level. Only 17% of podiatric and 9% of orthopaedic respondents worked full-time in private practice.

Geographical proximity

The number of respondents working in close geographical proximity to members of the other profession was established. Of respondent orthopaedic surgeons, 61% were aware of podiatric surgeons working within a 10-mile radius of their own base hospital, while 87% of podiatric

surgeons were aware of orthopaedic surgeons, with a specific interest in elective foot and ankle surgery, working within 10 miles of their base unit.

Close geographical proximity led to the perception by 38% of podiatric surgeons and 40% of orthopaedic surgeons who responded that referral rates were decreased to their own unit/practice. Overall, 44% of podiatric surgeons and 55% of orthopaedic surgeons felt the presence of cross-specialty practitioners had no impact on their referral rate. A minority felt that it had led to an increase in referrals (18% for podiatry and 5% for orthopaedics). There was no significant difference in the responses between professions ($\chi^2 P = 0.082$).

Table 2 Overall experience of the outcomes of surgery for the alternative profession

	Podiatry on orthopaedics	Orthopaedics on podiatry
No experience	5.4%	28.8%
Very poor	4.3%	5.5%
Poor	26.1%	43.9%
Satisfactory	48.9%	15.2%
Good	10.9%	6.1%
Very good	4.3%	1.5%

Overall experience of the outcomes of surgery for the alternative profession

Respondents were asked to rate their impression of the surgical outcomes obtained by cross-profession surgeons. They answered in one of the following categories: 'no experience', 'very poor', 'poor', 'satisfactory', 'good' and 'excellent'. The results are shown in Table 2.

If those surgeons who had no experience of work of the other profession (5% for podiatry and 29% for orthopaedics) are excluded, for podiatric surgeons the most common perception was 'satisfactory' outcomes (51.7%), though just fewer than 32% considered orthopaedic results 'poor' or 'very poor'. Conversely, 68.1% of

Table 3 Major impediments to closer working practices

Ranking	Orthopaedic surgeons		Podiatric surgeons	
1st	Issues with surgery by non-registered medical practitioners	88%	Issues with surgery by non-registered medical practitioners	79%
2nd	Issues of role boundaries and responsibilities	84%	Lack of understanding of podiatric surgical training	70%
3rd	Lack of understanding of podiatric surgical training	35%	Issues of role boundaries and responsibilities	64%

Table 4 Present and future working practices

PODIATRY					ORTHOPAEDICS				
Common NHS operating facilities	Future	Yes No	Present		Future	Yes No	Present		
			Yes	No			Yes	No	
			39%	49%			7%	32%	
			0%	12%			10%	51%	
Common NHS clinics	Future	Yes No	Present		Future	Yes No	Present		
			Yes	No			Yes	No	
			10%	78%			20%	27%	
			0%	12%			2%	51%	
Common private hospital operating facilities	Future	Yes No	Present		Future	Yes No	Present		
			Yes	No			Yes	No	
			29%	62%			13%	23%	
			2%	7%			7%	57%	
Cross referrals	Future	Yes No	Present		Future	Yes No	Present		
			Yes	No			Yes	No	
			47%	49%			45%	20%	
			0%	4%			5%	30%	
Podiatric surgeons with official positions in orthopaedic departments	Future	Yes No	Present		Future	Yes No	Present		
			Yes	No			Yes	No	
			13%	66%			10%	35%	
			0%	21%			2%	53%	

orthopaedic surgeons, with experience of podiatric outcomes, rated the results of their local podiatric surgeon as 'poor' or 'very poor'.

Impediments to closer working practices

The questionnaire investigated the causes for apparent poor relationships between the two professions. Respondents were asked if any of the following were specific impediments to closer working practice: (i) lack of understanding of podiatric surgical training; (ii) issues of role boundaries and responsibilities; and (iii) issues with surgery by non-registered medical practitioners. A free-text section in the questionnaire further questioned the basis for disharmonious professional relationships and impediments to closer working practices. The results are shown in Table 3.

Both professions rated role boundaries and responsibilities and issues relating to surgery by non-registered medical practitioners as major issues.

The three points most commonly raised in the 'free-text box' by BOFAS orthopaedic surgeons were: (i) use of the title 'surgeon'; (ii) perceived discrepancies in training/

regulation, and (iii) effect on private practice. Podiatric surgeons' views in the 'free-text box' overlapped to some degree with the following points most commonly raised: (i) private practice was a significant restriction to closer working patterns; and (ii) medical protectionism and 'snobbery'.

Present and future working practices

Surgeons from both specialties located within close proximity to each other were asked further questions on the degree of close working practices and their future preferences for the same. When respondents were asked if their cross-specialty colleagues could play a part in future NHS foot and ankle services, 92% of podiatric surgeons felt orthopaedic surgeons had such a role while only 62% of BOFAS respondents felt the same was true of podiatric surgeons. These viewpoints were significantly different (Pearson $\chi^2 P < 0.0005$).

Surgeons of both specialties were asked whether they presently use or in the future would welcome the following:

1. Common NHS operating facilities.
2. Common NHS clinics.
3. Common private hospital operating facilities.

Table 5 Education, training and research

PODIATRY					ORTHOPAEDICS				
Common education and training Sessions	Future		Present		Future	Yes	Present		
		Yes	No	Yes			No		
		12%	82%	8%			42%		
		No	0%	6%		No	0%	50%	
Common research projects	Future		Present		Future	Yes	Present		
		Yes	No	Yes			No		
		9%	86%	8%			44%		
		No	2%	3%		No	0%	48%	

4. Cross-referrals between professions.

5. Podiatric surgeons with official positions within orthopaedic departments.

The answers are shown in Table 4. The majority of podiatric surgeons were in favour of future collaboration in all of the five areas questioned. For orthopaedic surgeons, only cross-referrals had majority assent, although all four other areas received 36–47% approval.

Training and educational opportunities

Where each profession works in close proximity to the other, similar questions were asked regarding common educational sessions and research collaboration. The results are shown in Table 5.

The respective professions were asked whether they would be willing and/or able to provide training opportunities for trainees of the other specialty. They were also asked whether the other specialty could provide useful training for their own trainees. The podiatric profession was overwhelmingly in favour of close ties for education, training and research. For orthopaedic respondents, about half of the surgeons would welcome future educational, training and research collaboration: 56% would offer podiatric trainees training opportunities but only 30% would welcome their trainees being seconded to podiatric surgery units. The results are shown in Table 6.

Table 6 Collaborative training

	Podiatry	Orthopaedics
Provide training for other specialty trainees	94%	56%
Own trainees to receive training from other specialty	92%	30%

Suitable spectrum of surgery for each profession

Finally, respondents were given a list of surgical procedures and asked if orthopaedic surgeons or podiatric surgeons should carry out each of the procedures. The results are given in Table 7. The views of the two professions were significantly different for all the listed procedures (Pearson $\chi^2 P < 0.0005$).

Discussion

The 21st century has seen the pace of change within UK healthcare continue unabated. Fresh challenges to long-established patterns of health provision occur on an almost weekly basis. Political dogma, government agencies, economic expediency, and pressure from various quarters including healthcare professionals and patient support groups all contribute to the present debates. Opposition to change is often portrayed as reactionary and self-serving. The debate over the provision of optimal surgical foot and ankle care epitomises many of these tensions present within the modern NHS. Interest in the various issues relating to foot and ankle surgery may be gauged by the response rate from the three groups canvassed. Orthopaedic surgeons without a particular interest in foot and ankle surgery were only half as likely to respond to the questionnaire as BOFAS members. The much higher response rate from podiatric surgeons may reflect a greater interest in airing views and resolving some of the problems raised.

Since the inception of the NHS in 1948, the use of the title 'consultant' has traditionally been restricted to medical graduates who had completed a satisfactory period of higher medical training, gained entry to the General Medical Council (GMC) Specialist Register, and been appointed to a senior NHS medical position. In recent times, various other groups (such as nurses, physiotherapists and podiatrists) have adopted the title for senior practitioners; according to

Table 7 Common foot and ankle surgical procedures

	All by orthopaedics	Mostly by orthopaedics	Either profession	Mostly by podiatry	All by podiatry
2nd toe PIP correction					
Podiatry	0%	0%	23.5%	33.7%	42.8%
Orthopaedics	32.4%	10.8%	45.9%	10.8%	0%
2nd MTP unreducible dislocation					
Podiatry	0%	0%	28.9%	36.1%	35.1%
Orthopaedics	53.3%	16.0%	29.3%	1.3%	0%
Hallux valgus correction					
Podiatry	0%	0%	28.6%	35.7%	35.7%
Orthopaedics	46.7%	24.0%	28.0%	1.3%	0%
Morton's neuroma excision					
Podiatry	0%	0%	27.6%	33.7%	38.7%
Orthopaedics	40.0%	17.3%	38.7%	4.0%	0%
Soft-tissue swellings (e.g. ganglia)					
Podiatry	0%	0%	37.1%	29.9%	33.0%
Orthopaedics	37.3%	16.0%	38.7%	6.7%	1.3%
Hindfoot fusions					
Podiatry	7.2%	19.6%	59.8%	11.3%	2.1%
Orthopaedics	96.0%	1.3%	2.7%	0%	0%
Tibialis posterior insufficiency surgery					
Podiatry	7.2%	15.5%	62.9%	11.3%	3.1%
Orthopaedics	98.7%	1.3%	0%	0%	0%
Ankle arthroscopy					
Podiatry	17.7%	39.6%	38.5%	4.2%	0%
Orthopaedics	90.5%	6.8%	2.7%	0%	0%
Ankle fusion					
Podiatry	27.1%	41.7%	30.2%	1.0%	0%
Orthopaedics	97.3%	1.3%	0%	0%	0%
Achilles surgery					
Podiatry	7.2%	17.5%	66.0%	9.3%	0%
Orthopaedics	80.0%	12.0%	8.0%	0%	0%
Plantar fasciitis release					
Podiatry	2.1%	4.1%	59.8%	20.6%	13.4%
Orthopaedics	67.6%	11.3%	19.7%	0%	1.4%
1st MTP fusion					
Podiatry	1.0%	1.0%	39.6%	31.3%	27.1%
Orthopaedics	60.0%	17.3%	21.3%	1.3%	0%
In-growing toenail					
Podiatry	0%	1.1%	21.5%	17.2%	60.2%
Orthopaedics	8.0%	2.7%	36.0%	33.3%	20.0%

our survey, this remains a major issue for orthopaedic surgeons. The first podiatric consultant was appointed in the NHS in 1994; in 2007, over half of the podiatric respondents use the term consultant. The number of consultant podi-

atric surgeons working within the NHS has risen from 21 in 2000 to 47 in 2007 (Register of the Society of Chiropodists and Podiatrists [SCP]). The lawful and ethical debate pertaining to the use of the title 'Consultant Surgeon' is well

described elsewhere.^{5,9,11,12} Salient points relating to this debate include responsibilities, competency, and clarity and transparency of what such a title means to patients being treated. Confusion remains amongst the public relating to qualifications, training and statutory regulation behind titles such as consultant, orthopaedic surgeon and podiatric surgeon. The potential for confusion was highlighted by Freudman and Caesar.¹¹ This study highlighted the potential for confusion with 95% of the general public and 84% of healthcare practitioners questioned believing that a consultant podiatric surgeon was a registered medical practitioner.

The advantages of orthopaedic training with its emphasis on the 'application of surgery to the body as a whole',³ extensive experience in trauma and internal fixation techniques, undergraduate and postgraduate clinical attachments in specialties such as neurology, diabetes, dermatology, vascular surgery, plastic surgery and rheumatology must be balanced against a shorter, but intensely focused, podiatric training period on the foot and ankle with greater emphasis on areas such as conservative management of foot pathology, lower limb biomechanics, and greater depth in anatomical teaching of the foot and ankle. The development of the MSc in the Theory of Podiatric Surgery, jointly validated by SoCaP, the Royal College of Physicians and Surgeons of Glasgow and the Royal College of Surgeons of Edinburgh is of note.¹³ The lack of in-patient beds and access to general anaesthesia, particularly in the initial period of podiatric surgery in the UK, meant that most podiatric surgical procedures were, and remain, undertaken using local and regional anaesthetic techniques.

Advocates of orthopaedic surgery have emphasised the restricted prescribing lists for podiatrists, particularly in areas such as analgesics, non-steroidal anti-inflammatory drugs (NSAIDs), and antibiotics and their reduced experience of systemic pathology when faced with untoward medical problems. However, recent changes to podiatric prescribing lists and the UK Government's stated goal of reducing medical postgraduate training time and encouraging earlier sub-specialisation may negate some of the 'perceived advantages' for future generations of orthopaedic surgeons.

The demand for foot and ankle surgery is unlikely to diminish and could not be met totally by one profession alone. Overall, 92% of podiatric and 62% of orthopaedic respondents acknowledge the future role of each other in the NHS. With nearly 2000 orthopaedic consultants in the UK in 2007, foot and ankle elective work probably represents about 400 full-time equivalent consultants' (and their junior staffs') workload with considerably more involved in providing foot and ankle trauma care. In comparison, there are only 47 podiatric consultants presently employed within the UK and a further 109 surgeons on the SCP Register. Certain areas, such as foot and ankle trauma work, arthroscopic procedures, and major paediatric foot deformity cor-

rections will remain the preserve of the orthopaedic community for the foreseeable future as the podiatric trainee has relatively little exposure to such sub-specialty areas.

Does this survey demonstrate the way forward to achieve closer harmony between the two surgical professions? Most podiatric and orthopaedic surgeons involved in foot and ankle work have surgeons from the alternative profession working in close geographical proximity. The majority, in each profession, feel that this has not had a detrimental effect upon the pattern of patient referrals and, therefore, does not appear to be a threat to each individual profession's practice.

Experience of the surgical outcomes of the other profession's work seems to have been more positive for podiatrists than orthopaedic surgeons. However, experience is usually confined to second opinions for postoperative problems. Opinions may be based on a small number of cases and should always be set in the wider context of the total caseload of a clinician. Combined audit would help break down some of these barriers. Revision foot surgery is probably an important activity for both groups and much can be learned from critical analysis of why foot surgery fails and the likely outcome of revision procedures.¹⁴

Orthopaedic surgeons feel they have a better understanding of podiatric training than podiatrists believe. Both feel that unresolved issues over non-registered medical practitioner performing surgery, role boundaries and responsibilities are major impediments to future closer working. The effect of the alternative profession's presence on each other's respective private practice has been raised by respondents on both sides.

The King's Fund report⁸ recognised the lack of properly constructed, randomised, controlled studies to establish the cost-effectiveness of forefoot surgery in the hands of podiatric and orthopaedic surgeons, respectively. A 2003 survey¹⁵ indicated significant satisfaction by a general practitioner community with local podiatric surgical services. Overall, 95% of podiatric and 52% of orthopaedic surgeons would welcome further future research projects to answer issues such as these.

Already, 39% of podiatric and 17% of orthopaedic surgeons share common operating facilities in the NHS at the present time and 88% and 39%, respectively, would like to in the future. Although for orthopaedic surgeons, who presently share NHS operating facilities, 59% would prefer separate arrangements in the future.

There is a minority of orthopaedic surgeons who would welcome future common operating facilities (32%), combined clinics (27%), cross-referrals (20%) and common training and educational sessions (42%). Orthopaedic surgeons (56%) were less willing than their podiatric colleagues (94%) to provide formal training positions for juniors from the other specialty. However, changes to the traditional 'firm'

structure caused by initiatives such as the European Working Time Directive (EWTD) and the present uncertainty over future surgical training structures are placing strains on providing adequate surgical exposure for medical graduates and might make it difficult to assimilate additional trainees from other professions easily. At present, the podiatric surgical profession, coming under the auspices of the Health Professions Council and not accountable to the Postgraduate Medical Examination and Training Board (PMETB), has not been exposed to the changes in areas such as training, inspection and examination structure experienced by orthopaedic surgery. On a positive note, the overwhelming majority of podiatric surgeons already working in close collaboration with orthopaedic surgeons at both operational, training, educational and research levels wish to continue with this practice.

In 1997, the King's Fund report⁸ highlighted difficulties in the training of junior orthopaedic surgeons in forefoot surgery secondary to the diversion of referrals to podiatric surgeons and urged discussion amongst training agencies. The increasing trend of primary care trusts to channel referrals to podiatric services is further endangering orthopaedic training. It also called for greater collaboration between health authorities, general practitioners and surgeons to build an integrated referral system. It encouraged the development of referral protocols to ensure patients reach the most appropriate clinician with the least delay. A key question is who should be undertaking various surgical procedures? For a number of procedures, there are clinicians in both professions competent to undertake such work. However, as in all branches of surgery, not all clinicians are trained to undertake every foot and ankle procedure. With regards to the question of spectrum of surgery, there appears to be, in our survey, a majority view that nail surgery should be undertaken by the podiatric community. Similarly, 100% of orthopaedic surgeons and 57.3% of podiatric surgeons believe that all, or most, ankle arthroscopies should be undertaken by orthopaedic surgeons, and 100% and 68.8%, respectively, have a similar view for ankle fusions. The greatest discrepancies between the professions appear to lie in the areas of forefoot surgery (apart from the nail) and plantar fascial/heel surgery.

The greatest opportunity for patients to receive timely and competent surgery from the most appropriate foot and ankle surgeon is most likely to arise if the two professions can agree common protocols and closer working practices. If not, it is likely that outside agencies, often with limited knowledge, will increasingly make these decisions based upon priorities other than pure clinical grounds. Clinical initiatives to provide combined orthopaedic-podiatric units have been established for a number of years in a small number of centres (*e.g.* Northampton, Oxford and Swindon) and the outcomes monitored by BOFAS.

Conclusions

Foot and ankle surgery is a major component of musculoskeletal surgery in the UK. There are two professions providing assessment and surgical care. This study demonstrates that wide concerns still exist between the two specialties about each other. However, there is evidence that a number of practitioners would welcome better relationships. Common teaching, education, audit and research associations and a review of presently established combined units would appear to be the first stages in developing closer links.

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