

# Chapter 1

## The sociology of podiatry as a profession

*Amateurs built the Ark, but professionals built the Titanic.*

**Anon**

The aim of this chapter is to provide a brief sociological perspective of podiatry, and of its associated implications for podiatric practice.

### Similarities between podiatry and medicine

An intra-professional hierarchy has long been recognised within medicine. Merton *et al.* (1956), Becker *et al.* (1961) and Schartzbaum *et al.* (1973) all describe such a hierarchy, which is led by specialist surgery, followed by general surgery and thereafter various divisions of internal medicine. General practice and dermatology follow, with psychiatry generally being regarded as the least prestigious branch of the profession (Abbott, 1981). Within the health care professions, a hierarchy has begun to develop which closely mirrors that found in medicine. For example, podiatric surgery has an extensive history but has only recently developed into a speciality in its own right. Borthwick (2000) describes the issue of podiatric surgery and the boundaries of clinical practice. The training to become a podiatric surgeon requires postgraduate study and clinical practice in order to meet the requirements of the Faculty of Podiatric Surgery. Similarly, there are emergent specialisms in podiatric medicine, including rheumatology, diabetic care, paediatrics and biomechanics. Observation suggests that those podiatrists who specialise are deemed to be higher in the professional hierarchy than are those who remain generalists. It may be salutary to note

that, by contrast, there is as yet no 'speciality' for the podiatric care of older patients, despite the fact that older people represent the majority of our patients.

## Podiatry and other health professions

In general, podiatry as a profession has had a long and convoluted history. It was solely in search of recognition (and hence status) that a few of the many bodies formerly representing podiatrists came together under the Board of Registration of Medical Auxiliaries' (BRMA) recognition in 1942. It was not until 18 years later that a 1960 Act of Parliament established the Council for Professions Supplementary to Medicine (CPSM) as the statutory and regulatory body for these professions. Each professional discipline within the Council was then given its own regulatory board.

The Health Professions Council (HPC) replaced the CPSM in April 2002, and there are no longer separate boards for each profession. Within the HPC, interdisciplinary hierarchies are still seen to exist. Yet as the professions concerned are roughly comparable in terms of income, power and education, such hierarchies cannot be explained by traditional criteria.

Early sociologists employed a number of approaches in attempts to explain the process of professionalisation; these theoretical orientations are outside the focus of this book, but are described in considerable detail elsewhere (Carr-Saunders and Wilson, 1933; Parsons, 1939). Later, Greenwood (1957) considered the successive steps any occupation goes through in order to achieve professional status. He suggests that the process involves:

1. Doing (full-time) something that needs to be done. The sick were always nursed, but technical and organisational developments created nursing as a profession.
2. Early practitioners (or the public) campaign for the establishment of a formal training school. While not all schools originated in universities (e.g. in the case of public-sector administrators, city planners and accountants), they all eventually sought support from universities.
3. Proponents of prescribed training, and the first alumni, combine to form a professional association.
4. Pressure is exerted in order to win legal protection of the job territory and its sustaining code of ethics.

Eventually, rules are made to eliminate the unqualified, to reduce internal competition and to protect clients. The ideal of service then becomes embodied in a formal code of ethics (Wilensky, 1964). Later, Storch and Stinson (1988) suggested that the two main distinguishing characteristics of a profession are a body of abstract knowledge and an ideal of service.

### Professionalism and professional status

While status differences create gross hierarchical structures, they do not automatically produce the exact *order* of hierarchy, which is generated by measures of honour, power, wealth and knowledge. Abbott (1981) maintains that income, power and client status are important factors in determining such order. Yet income may be an unreliable determinant of status; for example, within NHS medicine, salaries are similar irrespective of the area of specialism, yet different specialisms clearly have different status.

However, Abbott also suggests complexity as an alternative basis for determining intra-professional status; put simply, high status is attributed to non-routine work. General practitioners refer difficult, non-routine cases to specialists, who handle them or in turn pass them on to even more specialist practitioners. Conversely, routine aspects of professional practice are often delegated to the paraprofessional level (Freidson, 1970). In the case of podiatry, patients may be referred 'upwards' to specialist podiatric surgeons or 'downwards' to foot care assistants.

Most foot conditions worsen with age, and systemic complications are more likely in older people. It is therefore the case that the majority of patients in receipt of podiatry care are over 50 years of age. Many authors have noted the ageism intrinsic to Western society. Given the current status of podiatry in relation to other health professions, Abbott (1981) may be correct in citing client status as an indicator of professional status. If this is the case, then podiatric practitioners must develop not only their own professional status but also coping mechanisms for dealing with the attitudes of other professionals in the meantime.

Education and knowledge have always been emphasised by professions seeking higher status (Larson, 1977). Abbott (1981) maintains that 'the overall correlation of education and social status is undeniable'. However, this fails to explain the relative status of professional groups whose education and levels of knowledge may be similar, for example podiatrists and physiotherapists. Even though both receive education of a similar level (in some institutions physiotherapy and podiatry students share classes), the British public perceives physiotherapists as being of a higher status than podiatrists (Mandy, P., 2000).

Two other factors may also influence the status of a professional group: the gender balance of the profession and the nature of the professional practice. Professions having a higher proportion of female members consistently have lower status than professions that are male-dominated. A frequently cited example is the relationship of nursing to medicine. However, medical school intakes in the United Kingdom have been balanced by gender for many years, and certain areas of nursing (notably psychiatry) have always attracted roughly equal numbers of men and women. Nevertheless, in both professions women are under-represented in senior

positions. Thus, Abbott's fourth factor, the nature of professional activity, may provide better explanations of the hierarchical structure of the health professions. However, it is this factor that is by far the least investigated.

### **Professional autonomy**

For a paramedical profession to attain autonomy, it must concern itself with a discrete area of work that can be separated from the main body of medicine. It must also be able to practise that area of work without routine contact with, or dependence on, doctors. From an early period, podiatry has provided services through an occupational structure separate from medicine. This is also true of opticians, speech therapists and speech pathologists. But despite gaining relative autonomy of practice, higher status has not yet followed.

Monopolisation is an established tactic for restricting the number of competitors and ensuring the maintenance of a profession. Dentists gained a similar monopoly with professional closure in 1921, despite continued conflict with medicine. At the time of writing, podiatry has still to acquire any such legal privileges. A profession maintains its position by recognising that changes in medical knowledge and technology, as well as changing patterns of morbidity and mortality, result in important modifications (Elton, 1977). Some roles become obsolete, others emerge: specialisation breeds occupational homogeneity, and groups with conflicting interest appear, thus weakening professional solidarity and potentially threatening a profession's dominant position. External challenges come from different sources: other occupations, whether they are in direct competition or in a position of subordination to the dominant group, also try to improve their status and increase their work autonomy.

Historically, dominant professions such as medicine and law have experienced inter- and intra-professional conflicts as well as conflict with the state. Their responses have involved both their clientele and the recruitment of 'suitable' new members in the maintenance of occupational cohesiveness, a process known as 'patrolling the entrance gate'. In organising formal training and in instituting qualifying procedures, occupations seeking professional status assert that only their members have the competence to perform certain tasks or to deliver certain services. Finally, professional groups engage in political activity to gain state recognition and to develop a legal monopoly of certain activities.

### **Practitioner – patient relationships**

In considering the nature of practice, it is important to consider the relationship between the professional and the patient. Parsons (1951)

portrays the doctor–patient relationship as one of reciprocity, in which the doctor and patient have certain obligations and privileges attached to their respective roles. Morgan *et al.* (1991) suggest that Parsons’ analysis of the relationship is based on the two parties being socialised in their roles. The patient, as part of the obligations attached to the sick role, is expected to seek technically competent help usually from a doctor and to trust the doctor and to accept that the doctor is a competent help giver. Conversely, the doctor is expected:

- to act in accordance with the health needs of his or her patient
- to follow the rules of professional conduct
- to use a high degree of expertise and knowledge
- to remain objective and emotionally neutral.

This reciprocity is particularly pertinent in the case of Charles Walters, a patient described in Chapter 7.

A more detailed analysis of the doctor–patient relationship was developed by Szasz and Hollender (1956), and is considered in greater detail in Chapter 4.

The practitioner–patient relationship will be explored later in the book in the context of the character of Suzi Dalton in Chapter 5.

Podiatry patients are often prepared to assume an active role in their treatment. Friedson (1971) presents patients as active and critical in rejecting professional services, when they contradicted their own conceptions of illness. In some cases, he argues, patients perceived their own and other lay alternatives to be superior to professional medical opinion.

When examining podiatric care, it is interesting to consider these issues. Patients are able to observe the whole treatment process to their feet and, indeed, often attempt their own treatment, sometimes with painful or damaging results. They have a clear idea of both what they think they require and how it should be achieved. By their ability to observe the podiatrist at work, they can take an active role in their own treatment. Thus, Friedson’s analysis may be applied accurately to podiatry. Clinicians are advised to consider carefully the patient’s social and cultural context. The character of Sheetal Joshi (Chapter 9) considers this issue in greater detail.

People are able to examine their own feet. As a result, patients attending podiatric services will have formed a view of the aetiology of their conditions and will attend for treatment rather than preventative monitoring. Monitoring is an important part of podiatric care, particularly for patients suffering from diabetes. Such patients often experience complications, such as peripheral arterial disease and its associated neuropathy. Minor cuts or abrasions, if untreated, may result in ulceration and ultimately amputation of the toes or limb. In addition regular monitoring of the vascular status of the patient may identify such complications early enough to

initiate treatment which will minimise their effects. These issues will be discussed further in the characters of George Archer in Chapter 21 and Charles Walters in Chapter 7.

Such monitoring requires well-developed communication skills on the part of the podiatrist. Communication skills and communication theory are discussed in the context of the characters Suzi Dalton in Chapter 5, Enid Hilton in Chapter 10 and James Watt in Chapter 8.

Professionalisation is pertinent to podiatric practice, where the desire to improve professional status may be in danger of overshadowing the intrinsic altruism of the occupation. Perhaps ironically, there is no evidence that an increase in professional status improves the practitioner's self-esteem or feelings of professional worth. Traditionally, high-status professionals may also suffer from low self-esteem, and the prevalence of psychological problems among 'higher' professionals has reached alarming proportions.

Nevertheless, social status has profound effects upon human relationships, and this issue is discussed in the context of the character Bill Canning in Chapter 11. Podiatry currently has comparatively low professional status, partly because it does not meet some established status criteria, but mainly because much of its work can be routine and less than glamorous. However, this should not deter its practitioners: if podiatrists take an objective view of podiatry's position and accept the reality that expert foot care is, and increasingly will be, required, then the profession could prosper. Paradoxically, by not attempting to pursue the criteria for high status but instead establishing its own professional niche and improving its own expertise, the professional standing of podiatry could rise.