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Classifications, Posture, Dentistry, and Podiatry

These seemingly disparate topics blend to create better healthcare.

Practice Perfect is a continuing every-issue column in which Dr. Shapiro offers his unique personal perspective on the ins and outs of running a podiatric practice.

One of the perks of being part of a university with a lot of colleges is the convenience of obtaining care (as long as you're okay with treatment by students). Most patients going to the Western University College of Dentistry clinic have been very happy with their care. The students are friendly and sharp, and the faculty members are excellent. Going to this clinic for regular dental maintenance always provides one with interesting things to think about. So, let's talk about a few seemingly disparate topics that actually blend together to form quality healthcare.

First, classifications. Apparently, there is a classification of gingival quality that is based on the depth of the pocket between the gum and the tooth and the amount of plaque. Zero is best, three is worst. At first, it may sound reasonably good to be a two, but if you think about it, two is on the lower half of gingival health. Too bad. Apparently no one is a zero, so perhaps it's not as bad as one would think.

Most practitioners are generally not giant fans of classifications. Most classifications are just fodder for residency interview questions, and for doctors to get their names into the medical literature. However, in some cases, classifications can be useful. One such classification is the International Working Group on the Diabetic Foot (IWGDF) system that categorizes risk in diabetic patients.[1] This classification is useful for two simple reasons. The first is that it has been validated by legitimate research. Second, it's useful in predicting the risk of diabetic complications. Figure 1 shows the odds ratios of various diabetic foot complications as a result of each category. It's validated, easy to use, descriptive, and perhaps even educational for our referring primary care doctors and patients. What more can we ask from a classification?

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FIGURE 1

Stage	Description	Risk of Complications (by Odds Ratio)			
		Ulcer	Infection	Amputation	Hospitalization
0	No PN, No PAD				
1	PN, No PAD, no deformity	2.4	1.9	0	10
2a	PN and deformity, No PAD	1.2	2.3	10.9	13.6
2b	PAD	9.3	13.5	60.9	124.8
3a	Ulcer history	50.5	19.2	36.3	60.7
3b	Amputation	52.7	62.3	567.9	650.3

Figure 1: IWGDF Foot Risk categories and associated complications (PN = Peripheral neuropathy. PAD = Peripheral arterial disease).

Classifications *(from page 53)*

Posture

So, what does posture have to do with podiatry? Recently, there was an interaction between a student dentist and her attending about proper sitting position. Understandably, dentists are going to have a very intimate relationship with their apparently expensive chairs. The attending discussed, demonstrated and corrected the student's sitting position with a full explanation of the advantages to various sitting positions for optimal ergonomic and clinical effectiveness.

At Western University, we are constantly harping on my students for their poor sitting and standing positions when in clinic and surgery. One cannot count anymore the number of times inexperienced students will slowly get closer and closer to the surgical field while they're suturing. It's almost as if they're going to try suturing with their faces! This would be funny if they weren't going to contaminate the surgical field. In clinic, they lean over patients' feet, and a few times when entering the room while they're working, it seems as if the students are turning into Quasimodo, the hunchback of Notre Dame. Kyphosis here we come! One time, one of the students was so bent over the patient's feet that we thought one of his intervertebral disks was going to shoot out his back.

The one unfortunate part of this dental story is that the student doctor didn't seem to appreciate the "sitting" discussion. Some eye rolling was seen during and after the conversation. Beware to all of you who don't heed the warnings of your elders! Hunch and lean at your own risk. God only knows how much eye rolling my students do when they are corrected!

When you think about these two issues, you realize how seemingly unrelated they are and yet how in reality they blend to form the basis for quality medical care. Here's how. The classifications topic is a metaphor for the mind, the thinking aspects of our medical science.

On the other side of this coin is the physical aspect, the technique, of medicine and surgery. Proper technique takes time and experience to master (with a judicious sprinkling of wisdom from those who've come before to guide us). It's not always comfortable or easy, but mastering technique gives us the power to translate what is in the mind to the world of the physical, to actually "fix" our patients.

It takes two sides of this coin—the mental yin to the physical yang—to make us effective patient care providers.

It takes two sides of this coin—the mental yin to the physical yang—to make us effective patient care providers. Think of that the next time you sit down to treat a patient. **PM**

References

[1] Lavery LA, Armstrong DG, Murdoch DP, et al. Re-evaluating the way we classify the diabetic foot: restructuring the diabetic foot risk classification system of the International Working Group on the Diabetic Foot. Diabetes Care. 2008 Jan;31(1):154-156.

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