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The Power of Collaboration

There are many benefits to be derived from working together.

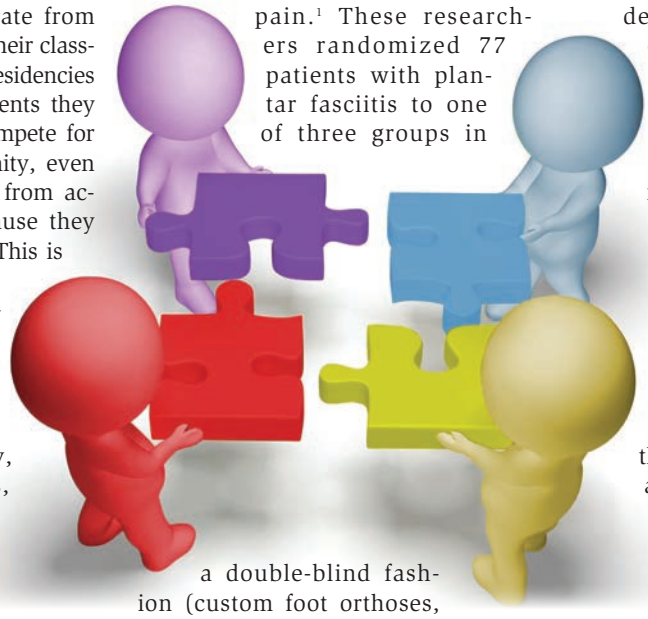
Practice Perfect is a continuing every-issue column in which Dr. Shapiro offers his unique personal perspective on the ins and outs of running a podiatric practice.

In many cases, podiatry is like a farm with different silos separating the various parts from each other. We have nine podiatry schools that are separate from each other, competing to fill their classes. We have more than 200 residencies competing for the best residents they can get. Many podiatrists compete for business out in the community, even preventing other podiatrists from acquiring staff privileges because they don't want the competition. This is an unfortunate situation.

In a country where podiatrists, like many doctors, have significant worries—political challenges from other specialties, an uncertain healthcare community, and reimbursement issues, to name just a few—it appears doubly foolish for us to compete with each other.

But it doesn't take much searching to find examples of collaboration and the power that it holds. Take two obvious examples, the APMA and ACFAS. These are two large groups of podiatrists that operate separately and increase our collective power politically (APMA) and academic status (ACFAS). Without them, our profession would be much poorer. However, consider how much greater both organizations would be if they came together, cooperated, and did joint activities. Imagine, for example, what that national conference would look like!

Here's another nice example of collaboration in action. Wrobel, Fleischer, Crews, et al. published an interesting research article in the *Journal of the American Podiatric Medical Association* examining the outcomes of custom foot orthoses on patients with plantar heel pain.[1] These researchers randomized 77 patients with plantar fasciitis to one of three groups in a double-blind fashion (custom foot orthoses, pre-fabricated orthoses, and a sham). Using objective and subjective outcome measures, they found a 5.6-fold increase in physical activity and improved outcome measures with the custom foot orthoses in comparison with the other methods at three months. Informative to our discussion here is that the authors came from the Scholl College of Podiatric Medicine, the Southern Arizona Limb Salvage Alliance (SALSA), and the University of Michigan Medical School. This was an admirable collaborative effort from different areas of the country, and as a result, we are left with one of the stronger clinical research studies on foot orthosis therapy (an area of research fraught with poor studies).



One more example involves the interdisciplinary wound care team. Rogers and colleagues did an excellent job laying out the structure of an inter-professional limb salvage team, demonstrating improved outcomes when this type of system is used.[2] Most of us are well aware of the power of podiatrists collaborating with other specialists such as those in vascular surgery, medicine, infectious disease, nursing, nutrition, etc. It makes one wonder: If collaborating is such a successful endeavor, why don't we do it more often? Perhaps, the answer gets to the more negative side of human nature such as competition, the desire to be "the best" (or at least better than your competitor), coupled with the organizational and practical challenges of working together with others.

Collaboration is successful for a couple of obvious reasons. First, it combines the best skills and knowledge of those involved, while mitigating ignorance. For example, as podiatrists we bring to limb preservation our biomechanical understanding and experience to both the prevention and treatment approaches of the diabetic foot. We don't have the skills to re-vascularize legs (the realm of the vascular surgeons) or the medical expertise (such as the endocrinologists).

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Each specialty brings its expertise while allowing others to bring theirs.

Second, collaboration allows for cross-fertilization of multiple viewpoints and perspectives. Everyone has a different perspective regarding various topics that they would not have been exposed to otherwise.

Third, resources are limited, and no one has an unending supply. Residency serves as an example. It's probable that the majority of residency programs around the country are isolated and do not collaborate with each other to any useful degree. However, every program has its strengths and weaknesses. Some programs may have strong academic resources while others may have large numbers of surgical cases available. Yet others may have faculty trained in research methods while another has a world-class clinic. No one program has it all, yet all programs together are much stronger than their individual parts.

Here is where the podiatric profession needs to change. We must integrate more at every level. First, the podiatric colleges should sit down together and figure how they can improve educational methods and share resources. The AACPM Objectives Project is a good start. Student and professor exchange programs would be another strong step.

Second, our residencies should combine into consortiums that provide residents the full gamut of necessary academic, clinical, and surgical experiences. This would require a little help and leeway from the Council on Podiatric Medical Education, as well as a framework that allows host hospitals to get paid while having their residents at other locations. (The idea of executing affiliation agreements for large numbers of hospitals at various locations makes this administratively challenging at the current time.)

Third, we need a few large, national conferences, run by those who know how to do it, that combine all the smaller professional organizations into one integrated experience.

Lastly, we need to collaborate at the practice level, be it research, clinical and surgical skill expansion, or in some cases, supergroup formation, to increase our profitability and quality of service for our patients. Imagine if we had a supergroup of podiatric experts who created different centers of excellence based on skill and interest. Our Charcot patients would see the expert on Charcot, while our bunion and forefoot patients would receive care from a podiatrist focusing on this area. Each of these experts would be fed by the larger group, and our patients would be on the receiving end of this quality improvement. The ability to bargain with insurance companies and Medicare would also be beneficial.

At some point in the future, we will come to truly realize and believe in the power of collaboration. Until then, each of us will labor in our own little silos remaining not quite what we could have been. **PM**

References

[1] Wrobel JS, Fleischer AE, Crews RT, et al. A randomized controlled trial of custom foot orthoses for the treatment of plantar heel pain. J Am Podiatr Med Assoc. 2015;105(4):281-94.

[2] Rogers LC, Andros G, Caporusso J, et al. Toe and Flow: Essential Components and Structure of the Amputation Prevention Team. J Am Podiatr Med Assoc. 2010;100(5):342-348.

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