The Future of Podiatry

Our experts discuss the outlook for the profession.

BY MARC HASPEL, DPM

To say that these are tumultuous times for podiatric medicine—as well as for all medicine, for that matter—is beyond dispute. Today, podiatric physicians are being hit from all directions with a veritable alphabet soup of acronyms, from ACA, ACOs, and PQRS to ICD-10, HIPAA, and MU—and all are designed to change the way they deliver their services to the public. Moreover, podiatric physicians also find their practices being encroached upon by other allied health professionals seeking to expand their own patient bases and services provided (though one school of thought in this matter involves placing blame on podiatry itself).

Still, despite this turbulent climate, podiatric medicine is well equipped not only for survival, but the ability to thrive. By holding on to the basic tenets of practice necessary to satisfy a growing and demanding patient population, safeguarding and continuing to embrace services vulnerable to the encroachment from others, and moving towards parity with allopathic medicine, podiatric practitioners can be well assured that the future remains strong for their chosen profession.

Joining this roundtable to discuss these and other issues regarding the future of podiatric medicine:

Jon Hultman, DPM is Executive Director of the California Podiatric Medical Association, practice management and valuation consultant for Vitera Healthcare Solutions, and author of The Medical Practitioner's Survival Handbook (available at www.mbagurus.com).

Bryan Markinson, DPM is chief of podiatric Medicine and surgery at the Leni and Peter W. May Department of Orthopedic Surgery at the Mount Sinai School of Medicine in New York City, where he is also an instructor in the Department of Dermatologic Surgery. He is a clinical consultant to Bako Podiatric Pathology Laboratories.

Andrew Schneider, DPM is in private practice in Houston, Texas at Tanglewood Foot Specialists. He is a fellow and member of the Board of Trustees and secretary of the American Academy of Podiatric Practice Management (AAPPM), a fellow of the ACFAOM and APWCA, and a member of the Top Practices mastermind group. He lectures internationally on topics related to practice management, marketing, wound care, and biomechanics and is an adjunct faculty member of Kent State University College of Podiatric Medicine.

Jarrod Shapiro, DPM is an assistant professor at Western University College of Podiatric Medicine in Pomona, California and has been in active clinical and surgical practice for eight years. He is the author of *PM's* every-issue "Practice Perfect" column.

Elliot Udell, DPM is a diplomate of the American Board of Podiatric Medicine. He is a fellow and current president of the American Society of Podiatric Medicine and a fellow of the American Society of Podiatric Dermatology.

Q ***PM:*** *How do you see podiatric practice changing because of the potential impact—positive or negative—of the Affordable Care Act?*

Hultman: In spite of all the iterations created in healthcare's attempt to reform and fix healthcare, none have actually been successful at fixing the cost, quality, and access

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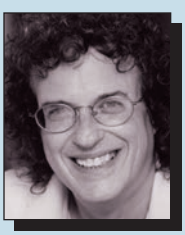
Andrew Schneider, DPM

Jarrod Shapiro, DPM



Elliot Udell, DPM

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problems that plague the system. One can assume that this most recent attempt won't be the last. While we expect that the ACA will increase demand because more people will be covered by insurance, the continual lowering of reimbursement as the primary method for addressing costs, along with the growing complexity involved in billing and fulfilling compliance requirements, make the achievement of cost savings, quality improvement, and quicker access ever more difficult to attain.

Regardless of the ACA—or whatever future iterations of healthcare reform lie ahead—the good thing is that there will be a growing demand for the foot and ankle services provided by podiatric physicians. Unless one has a concierge or niche type practice, my recommendation is that one build a practice model capable of thriving in an environment that demands quality and quick access—even when challenged by low fees, high volume, and ever increasing complexity. The most effective model for addressing this type of environment is an efficient, integrated group model, one consisting of multiple doctors at multiple locations. A group's cost goal is to spread a greater volume of patients and services over stable fixed costs, and its quality goals are to offer same-day availability, utilize evidence-based medicine, and include doctors with different skill sets and training within the group, so that patients with any type of foot or ankle problem will be able to access a doctor within the group who is qualified to treat the patient's specific condition.

Shapiro: I don't think anyone truly knows what will happen as a result of the ACA. Time will tell. By looking at current trends, though, one could anticipate significant changes to podiatric practice. Many of the changes (increased paperwork for compliance, ACOs, and increased governmental regulation) will place increased pressure on solo practitioners and smaller groups. Physicians will be increasingly pushed into larger organizations to absorb the administrative paperwork. This may mean the end of solo providers, which would be a great shame. On the positive side, a larger number of patients with health insurance means a greater potential patient load for providers.

Regardless of the ACA—or whatever future iterations of healthcare reform lie ahead—the good thing is that there will be a growing demand for the foot and ankle services provided by podiatric physicians.—Hultman

Schneider: The Affordable Care Act has already caused some changes to occur in podiatry, along with all medical specialties. There are some positive elements, such as a wider pool of insured patients seeking care from our offices.

Some of the negatives are increased administrative burden to practices. The ACA is a tremendously detailed document and most podiatrists will rely on the APMA and other organizations, such as AAPPM, to decipher and educate on the necessary steps to take. That said, it is easy to fall behind with the new administrative and documentation burdens, which can lead to potential fines if offices are audited.

As employers, the ACA affects whether a practice is mandated to provide health insurance and the scope of the policy. This will affect the financial burden on average podiatry practices.

Udell: The concept of enabling everyone in the country to have healthcare insurance is a very good idea. The way it has been implemented, however, is creating problems for both patients and physicians. One area that is affecting all of us is that patients often choose inexpensive plans and these patients come to the doctor thinking they are fully insured only to find that they have a large substantial annual deductible and/or considerably large co-payment for each visit. In my practice, we have provoked the anger of some patients when we sent them bills for services which they were told were covered by their insurance companies but were applied toward their deductibles. Other patients have become angry when we asked them to pay their co-payments and could not comprehend that unless we collected this money all their insurance plans would be paying us are minute amounts for the visits. I believe that the concept of affordable healthcare is a good one, but the system still needs a great deal of tweaking without more political meddling.

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Markinson: The Affordable Care Act's most visible effect, in my opinion, will result in more people being insured. Yet, the greatest majority of covered individuals will be those who have transferred out of

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or lost traditional coverage and have become Medicaid-eligible, or those who have elected very poor-paying plan options that also have high deductibles and co-payments. I actually think that this is a golden opportunity for podiatrists to take a stance against the insurance company abuse of doctors and reject poor reimbursements. Unfortunately, so many of our colleagues are stuck believing that "patients won't pay." In my experience, the 20% of the patient population that will be willing to pay clearly outweighs the 80% who insist on the doctor being on the plan. I certainly have not lost money by ending participation in poor-paying plans.

PM: *Other recent developments in healthcare—most visibly PQRS, Meaningful Use, and ICD-10—will likely necessitate DPMs making changes in their practices. What sort of adaptations do you foresee?*

Schneider: Considering that the three developments that are cited involve the government effectively using physicians for data collection, there is every reason to think that more optional incentives leading to punitive payment adjustments will come. Each past development, as well as any in the future, will require a significant change in one's office workflow.

It is for this reason that one's office workflow should be well-documented, staff well-trained and, most importantly, the office needs to be adaptable to future changes. Now more than ever it is vital that every office have a manual documenting every office function and operation. It is also essential to have a treatment protocols manual. The manuals should be available to the entire staff in printed and electronic form.

Having such a manual will ensure that the entire staff, including doctors, front and back office, schedulers, billers, etc., are able to access the correct way to perform a task or approach a patient, in the practice. When the team is in the habit of referring to such a manual, any changes to workflow that become necessary with future healthcare changes can be incorporated into the systems and protocols. This will help to minimize the disruption to workflow and allow the office to maximize efficiency.

Hultman: These are but a few of the new things being heaped upon doctors, who are already overloaded dealing with the complexities of billing and maintaining compliance. It is becoming far too difficult and time-consuming for small practices to stay on top of all the old things, much less the new ones. This is just one more reason to consider merging practices or becoming employed by a group.

Since the primary goal of PQRS and meaningful use is improvement in quality, a group should follow Steve Covey's advice as found in his book The *7 Habits of Highly Effective People,* this being, "Begin with the end in mind." The "end", in this case, is quality, and the reduction of variation is the definition of quality in every industry. Quality is worth more to patients and payers, and having the ability to measure it is what should eventually enable pay for quality reimbursement methods.

Healthcare is currently faced with a major hurdle to the achievement of clinical quality, and this is the huge variation in treatment of patients who present with the same problem; this is something that we need to change. A patient with heel pain could go to ten different doctors with the exact same symptoms and get ten different treatment recommendations. All doctors in a group should be utilizing one set of treatment guidelines, and they should be measuring their patients' outcomes. This will assure payers that care within the group is consistent, regardless of location or the specific doctor treating the patient. Such a protocol also makes it possible for doctors to recognize when a change in a specific guideline improves outcomes, enabling continuous improvement in quality.

Shapiro: PQRS and meaningful use will mandate electronic medical records, which is added pressure especially for the solo provider who has yet to switch over. Granted, this is a small number of providers, but these initiatives also increase the administrative costs of providing care. This will be a headache for providers, since they require extra documentation and, in some cases, extra face time with patients. Providers, however, should maintain a positive outlook and understand that the extra information gathered is intended to improve patient care. Savvy physicians may also find opportunities to increase their billing levels due to a more comprehensive patient visit. By adding much of this information to patient intake forms, physicians can remain in compliance, while not increasing their in-room times.

The meaningful use and PQRS and the $44,000 dollar incentive for implementation of EMR, as well as threat of penalties for not implementing, have been a proven boondoggle for which podiatry fell for hook, line, and sinker.—Markinson

Udell: The central pathway to meaningful use is via electronic health records used to document patients' cases. Actually, we have been using EHR in our office for many years. The programs we have used have created clean, legible notes. The problem is that the government has forced doctors to use government-approved programs, and all of these programs are cumbersome, some-

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times very expensive and create a great deal of extra time-consuming work on the part of physicians. This time could have been better spent caring for patients. Because these government-approved-and-supervised programs are so cumbersome, it is ironic that very often information about patient care happens not to be clearly visible to multiple doctors in a clinic or hospital setting. A recent article in the New York Times implied that these cumbersome EHR systems might have been the reason why the medical staff at a Dallas hospital sent home a patient suffering with Ebola, causing that man to die and risk spreading the disease.

Markinson: The meaningful use and PQRS and the $44,000 dollar incentive for implementation of EMR, as well as threat of penalties for not implementing, have been a proven boondoggle for which podiatry fell for hook, line, and sinker. It has already come to fruition, for some, that the incentive payments are quite lower than the true cost of implementation and ongoing support required.

Equally confounding to me is the threat of relatively meager percentage penalties, which drove the frenzy to implement without really evaluating the depth and breadth of the process properly. Additionally, it is undeniable that entire visits can now take place with physicians continually typing and looking at a computer screen. This is all moot, however, as failure to implement, irrespective of penalties and encumbrances on practices, will leave practices isolated and unable to communicate with the potential referral physician community, hospitals, and patients.

PM: *One of the creations of the Affordable Care Act is the promulgation of Accountable Care Organizations or ACOs. Discuss the importance of podiatric physicians joining ACOs.*

Shapiro: Since the Affordable Care Act will lead to a much larger presence of ACOs, it will become mandatory for podiatrists to become part of these plans to prevent losing patient volume. ACOs will be beneficial if they actually do what they have promised: decrease costs, improve coordination, and improve patient outcomes. The unanswered question is whether ACOs will actually reach these objectives. Regardless, ACOs will be better able to absorb the increased costs of doing business, so will likely outcompete smaller practices. This will have a significant effect on podiatric physicians.

Hultman: I feel that the jury is still out on whether these organizations will succeed, but because podiatric physicians can belong to multiple ACOs, I see no downside to joining. The most important factor is that when doing so, these joining doctors must be able to maintain or even build new referral sources. If we view podiatric physicians as being those who get people walking and keep them walking, rather than as physicians who just treat foot and ankle problems, we could argue that they could have the greatest long-term impact on cost and quality. Walking as little as thirty minutes a day has been proven to reduce the complications of some of the most costly conditions in healthcare (e.g., obesity, osteoporosis, diabetes type II, ischemic heart disease, stroke, hypertension, and even depression). The more evidence we gather to show that increased walking is an outcome of podiatric medicine, surgery, and biomechanics, the greater our value will be to ACOs or any other new and improved delivery model in the future.

Schneider: I agree that ACOs continue to be a significant source of confusion. As specialists, we are able to join multiple ACOs, eliminating some of the concerns that primary care physicians face. Even so, I have found that the ACO penetration at this point is very regional and, as of now, I am not finding many practitioners jumping on board locally. That's not to say that other podiatrists are not affected by ACOs in their region.

PM: *What are your thoughts about the future of podiatric physicians remaining in solo practice versus either forming partnerships or aligning with larger group practices, given today's emerging climate?*

Since the Affordable Care Act will lead to a much larger presence of ACOs, it will become mandatory for podiatrists to become part of these plans to prevent losing patient volume.—Shapiro.

Udell: Because of the reduced fees being paid to doctors, many physicians, especially primary care physicians, are not able to make ends meet, and their practices are being taken over by hospitals and corporations. I have spoken to some of these physicians, who, after many years of private practice, are still in their same offices, but are essentially employees of the hospital that purchased their practices. In some cases, these physicians are happy not to have to deal with the paper work and billing issues associated with modern-day healthcare delivery. Others, however, regret the day they made the decision, and are now actually being told that they will be fired if they spend too much time with any one patient and/or fail to produce increased revenues. Many of these entities monitor how many tests and procedures that their employed physicians do. Consequently,

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they either bonus them for doing more tests and procedures, or threaten to fire them if they don't meet threshold expectations.

Schneider: As a solo practitioner myself, I do not see the current or approaching healthcare climate to be the end of solo practice. Many patients see value in a small practice and feel that they are getting more exclusive treatment. It is true, however, that some insurers may look towards larger groups for contracting. There are already some signs of that around the country, especially with newer plans from the ACA marketplace. If this trend ends up excluding the solo practitioner from insurance contracts, those wishing to stay solo may drop all insurance plans and opt for the specialist's version of a concierge practice.

As with anything, there are pros and cons to joining larger groups or forming super groups. There is strength in numbers, and with that comes economies of scale when negotiating costs for supplies and equipment. A larger group theoretically will have greater negotiating power with insurers and reimbursement rates. That said, many insurers are moving away from a numbers game and focusing more on efficiencies and outcomes.

With larger groups and partnerships come many different personalities. When you have podiatrists used to running their own practices, it's difficult to relinquish even a little bit of control. If they are pursuing such models, there needs to be superior communication and understanding so each partner involved remains on equal footing.

Shapiro: Simply put, given today's climate, it seems increasingly difficult for podiatric physicians to remain in solo practice. Our current system seems to be creating a natural evolutionary pressure towards larger practice types.

QPM: *With the trend towards higher co-payment and deductible requirements, what recommendations do you have for billing and collecting of fees, including the importance of proper insurance verifications?*

Hultman: I think that higher co-payments and deductibles are potentially a good thing. The biggest disaster in years past was capitation in conjunction with five-dollar co-pays. These low co-pays increased patient utilization rates, but because the capitation payment was fixed, often at a rate 50% lower than needed to provide full service, these patient visits over-and-above the average utilization rate were basically reimbursed at $5 a visit. Harry Goldsmith, DPM, used to say that capitated patients went to his office because it was cheaper than going to a movie.

Many decades ago, doctors complained because patients who had once paid cash when they were treated now wanted their insurance billed. Eventually, doctors began to like this idea because indemnity insurance paid the doctors' usual and customary fee. Those who charged more got more, which led to higher and higher charges. This, in turn, eventually motivated insurance companies to erect more hoops and barriers for doctors to jump through in order to get paid. If nothing else, higher cash payments for patient visits is a partial return to earlier times.

One thing to remember about cash is that it is 99% collectable on the day of a visit; however, the collection rate drops each day thereafter, and becomes significantly low at 90 days out. Practices that employ technology at all points of service have access to a patient's deductibles, co-payments, and cash balances before patients leave the office, making it much easier to collect the cash.

Schneider: Over the years of practice, we have seen deductibles steadily increase. Now with the Affordable Care Act, we are hit from multiple sides. For one thing, we now see patients who may never have had insurance before and don't understand what a co-pay or deductible is. They think that they paid for insurance so the rest should be free. Our office staff is now placed in the unenviable position of educating these patients about insurance and often is blamed for asking patients to pay their deductible or co-payment.

Because of this trend, our offices must collect and update insurance information at the time an appointment is scheduled. This action will allow verification and detailed knowledge about coverage prior to the visit. This may seem onerous and time-consuming to our schedulers, especially in smaller offices, but it is necessary to keep our cash flow positive. It is much simpler to collect fees due at the time of service than to bill the patient afterwards. In addition, the chances that payment will be received after the time of service decreases significantly.

Additionally, it is also essential that offices be proactive in getting the contracted fee schedules for all

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of the plans that are accepted. These fee schedules should be placed in a searchable spreadsheet and readily accessible by everyone in the office. This will help any deductible be collected prior to the patient leaving the office.

Markinson: In my practice, every new patient is insurance-verified, but it is becoming increasingly necessary to monitor this closely, as people are moving in and out of plans regularly. In addition, most Medicare Advantage plans have marketing professionals who routinely convince traditional Medicare patients to switch into an advantage plan, and these patients have no clue that they no longer have traditional Medicare. This process is called "slamming" and is, in my opinion, completely unethical.

In my practice community, elderly Hispanic traditional Medicare patients fall victim to this practice routinely, only to find that their primary care physicians and many of their other specialists are not in their new plans. With regard to high deductible and co-payment plans, occasionally, physicians will be taking a hit where verifications are not done and the patients cannot be informed at the time of the visits what their true responsibilities are. Therefore, practices have to have this information at every visit. I find that patients who are correctly informed at the time of service are more apt to pay than when they get a bill four weeks rather than being surprised that they have additional monetary obligations.

Udell: I recently brought in a professional consultant who is affiliated with the American Academy of Podiatric Practice Management. One of the first pieces of advice she gave me is to stay out of the billing and, under no circumstances, discuss billing issues with patients. Prior to this admonition, if a patient was upset with paying a co-payment or had a high deductible that was not met, that patient would come into my consultation room, give me a hardship story and sway me into waiving the co-pay or the balance because of a high deductible. This may have worked in the past when insurance paid the majority of what a patient owed, but today when some plans are only reimbursing less than two dollars for a visit, "being a good guy" and waiving what was owed nearly put my office on the brink of bankruptcy. Another problem is that some patients bought insurance under the Affordable Care Act, received an insurance card, but never paid their premiums and, subsequently, had their policies canceled. Nonetheless, they still gave us their insurance cards. As a result, we now have to verify coverage for every new patient in order to avoid the risk that we will be working for nothing.

I disagree that other professions are encroaching on podiatric medicine's reputation as the experts in biomechanics. Quite the contrary, in my opinion, our profession has wrapped the title in a nice package and given to others.—Schneider

PM: *It has been said that other professions—from orthopedists to pedorthists to PT's—have been encroaching upon podiatry's reputation as the "world's experts in the biomechanics of the lower extremity." Do you agree? Does the problem lie in podiatric education, research, or in the promotion of the profession to the general public? And will this encroachment change the face of the profession?*

Markinson: Podiatrists have been claiming ownership of being experts in biomechanics for as long as I have been involved with podiatric education, training, and practice. It is undeniable that podiatric medical education emphasizes biomechanics and its relationship to function and pathology. It is also true, however, that these same podiatrists might be somewhat humbled by simply reading a single physical therapist's consultation report regarding foot pathology, demonstrating their thorough understanding of biomechanics. Likewise, an experienced pedorthist may also be very competent at resolving foot complaints using biomechanical principles. In my opinion, podiatrists who do biomechanics well should have no worries about anyone encroaching. On the other hand, podiatrists who measure their biomechanics success by how many pairs of $800.00 pieces of flat graphite they order for five inch heels will eventually feel that others are encroaching.

Schneider: I disagree that other professions are encroaching on podiatric medicine's reputation as the experts in biomechanics. Quite the contrary, in my opinion, our profession has wrapped the title in a nice package and given it to others. I believe that blame lies with everyone, from the individual practitioner who takes unilateral foam impressions and instructs the lab to make mirror image orthotics, to those so set on podiatric medicine being a surgical specialty that they eschew biomechanics entirely.

The colleges do have some blame, although they have to deliver the current expectations of the profession. For instance, most residency interviews never include having candidates showcase their knowledge of gait analysis or orthotic modification. This shunning of biomechanics is a disservice to our profession, a disservice to our patients, and hurtful to our business bottom line. With rare exception, nearly every condition that is seen in the average podiatry practice either has a biomechanical cause or involves a surgical outcome that will have an effect on biome-

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chanics. To perform surgery without a proper understanding of biomechanics will increase the chances of a poor result, complication, or recurrence.

Why many podiatrists do not utilize proper biomechanical treatment, whether pre-operatively or post-operatively, is beyond me. In my experience, proper use of it only leads to increased patient satisfaction and fosters an understanding that surgery is only addressing the result of patho-mechanics. I'm proud that here in Houston, our two largest residency programs, West Houston Medical Center and Kingwood Medical Center, have embraced the importance of biomechanics and provide didactic and clinical experience for residents to take into practice.

Udell: This is not a new problem. Many of the labs that make orthotics for podiatrists also market their services to other medical professions. I was stunned recently when a chiropractor called and told me that an orthotic lab that sponsors lectures at many of our podiatry seminars gave my name to her as a reference so that that she can start making foot orthotics for her patients. Needless to say I won't use that lab.

The greater problem, however, is that we as a profession have not undertaken the needed research in order to justify the use of biomechanical examinations and the casting for foot orthoses. Hence, in a world where evidence-based medicine is held supreme, there is a lack of evidence to support what modalities work and do not work in the realm of biomechanics and foot orthoses. Even when there are lectures on the topic at podiatry seminars, the speakers are seldom university-based biomechanics experts with extensive research supporting them, but rather orthotic mavens, who often own labs and offer individual theories about orthotic treatment regimens. I cast for custom orthotics all of the time because they help my patients, but I am left with little evidence-based information to base my complaints on when I read articles written by orthopedists instructing the public that over-the-counter foot orthotics are as good as custom made ones.

Shapiro: I do agree that there's a problem, and I agree with everything mentioned in the question you asked. The problem lies in all of the above-mentioned reasons. First, podiatry as a profession increasingly markets itself to potential students as a surgical profession. Connected to this is the emphasis on surgery during undergraduate and graduate residency programs. Increasingly, our surgeons do not have an appreciation of foot function. This is all propagated by the lack of biomechanics research by the profession as a whole, including the colleges and residencies. We have a few notable experts that continue to remain on the forefront of international biomechanics. Until we recognize that the rest of the world is moving beyond Root's theories, with increased emphasis on physics concepts and new research methodologies, we will fall ever behind these other professions.

The greater problem, however, is that we as a profession have not undertaken the needed research in order to justify the use of biomechanical examinations and the casting for foot orthoses.—Udell

PM: *What will it take to achieve true parity with MDs and DOs?*

Hultman: I, as well as my California colleagues, believe that true parity with MDs and DOs is not just a matter of being called a physician and surgeon; it is being licensed as a physician and surgeon with the same rights, privileges, and responsibilities as MDs and DOs. The training and education of DPMs has advanced from four to seven years over the past forty years. DPM residents train side-by-side on rotation with MDs and DOs, are entrusted with the same level of responsibility, practice no differently than any other specialty of medicine upon completion of their programs, and are held to the same standards as other physicians.

Ophthalmology is a good example of a specialty which has received a broad education but has chosen to limit its focus to an anatomical area. Privileges are based on training and education without the need to change the law to gain a new privilege for which the physician has been trained to perform. True parity will be when the medical licenses for MDs, DOs, and DPMs are equivalent, when MD equals DO equals DPM.

Markinson: Podiatry will achieve true parity with MDs and DOs on the day when whoever is going to practice podiatry graduates from an MD or DO school. Not one day before. To me, it's pure and simple. Showing the podiatry school syllabus has no effect on getting closer to parity. Podiatrists simply are not members of the same club, and that is all there is to it. Ironically, podiatrists claim superiority in biomechanics based on the same principles for which the MDs and DOs are resistant to accept. I have to wonder whether or not parity is desirable anyway. I love the practice of podiatry. Although the parity issue bothers me occasionally, in my opinion, those podiatrists who believe parity is the key difference between being professionally satisfied or not, are delusional.

Schneider: I believe that parity will only occur from the top down, starting with legislation at the national level. That is why I contribute to APMAPAC to help our leadership

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and lobbyists spread the word about the true nature and scope of podiatric medicine and surgery.

Shapiro: First, in my opinion, it is important to define what parity is. Parity is not equality. Due to differences in training, true parity is unlikely to happen. I believe, however, that this is not necessary. We need to achieve respect based on our expertise, training, and experience. This eventually will happen, according to Lawrence Harkless, DPM, Dean of the Western University College of Podiatric Medicine, when we have resident and student training programs embedded within the majority of teaching institutions. Much of the parity argument comes down to money. Orthopedists may not want podiatrists to repair ankle fractures, for example, because this encroaches on their income. In situations like that, all we have to demonstrate is our training and proficiency in order to compete.

Q ***PM:*** *All things considered, despite the obvious changes in healthcare, what elements of podiatric practice do you feel will remain the same and should be emphasized in order for practices to remain successful?*

Markinson: Walking around one's office in surgical scrubs, and proclaiming one's specialty to be foot and ankle surgery is truly the privilege of a select few podiatrists. Relatively speaking, a very small minority of podiatric physicians have limited practices to foot and ankle surgery. If one were to look at the podiatry billing data globally for the profession, the largest bulk of dollars paid is for non-surgical foot care. People seek out podiatry care for painful foot conditions that are largely manageable without surgery. Nevertheless, podiatric medicine's role in diabetic foot care is indisputable. In truth, a true worry should be more about the manpower shortage in podiatry, as documented by the federal government. By default, physician assistants, nurse practitioners, and other physician extenders with unlimited anatomical scope will increasingly continue to gravitate towards non-surgical foot care needs that are unmet by the podiatric profession and are declared beneath the level of expertise of far too many podiatric physicians.

Hultman: I believe that an integrated specialty group will remain the most effective model for addressing the future. In addition to achieving efficiency, the big advantage of this model is that each doctor practicing in a group can focus on the areas of practice that a doctor most enjoys and is best trained to do. In a group model, all the elements of successful podiatric practice, both present and future, can be emphasized without giving up anything. This scenario is virtually impossible in a solo or small group practice. Any patient with a foot and ankle problem should be able to be referred to a group, knowing that within the group, there is a doctor who has the training, experience, and desire necessary to treat that specific problem. Accordingly, in this way, the doctor who joins such a group will enjoy practice more fully, and patient results will be better: a win-win for healthcare.

Much of the parity argument comes down to money.—Shapiro

Schneider: There are two areas where I see that podiatric practice will remain the same. One is treating the diabetic patient, and the other is treating the recreational runner, along with other elements of sports medicine. It is no secret that as the waistlines of Americans are expanding, diabetes is continuing to be a major source of concern in the United States.

Recently, studies have shown that there are fewer pedal amputations due to complications of diabetes; however, cases of diabetes continue to rise. The podiatrist is a recognized member of the diabetic health team. Whether it be for preventative care, therapeutic shoes and insoles, wound care, or surgical management, there are few signs of our diabetic patient base slowing down.

Likewise, runners, triathletes, and other recreational athletes will also be continued patients to most podiatric practices. These patients are very driven to reach their athletic goals, stay fit, and excel. They are willing to put in the work needed to recover and are willing to invest in themselves when their insurance does not cover certain treatments or services. We see this phenomena now with custom orthoses, shockwave and platelet-rich plasma therapies, and other means to help patients recover and keep them active.

Most importantly, podiatric medicine and surgery will continue to thrive with our colleagues providing comprehensive care to our patients. When patients tell their friends to "just go to their podiatrists…they work miracles," those podiatrists are doing something right.

Shapiro: I couldn't agree more. The bottom line is simple; I recommend podiatrists provide the best patient care possible. All the other problems will work themselves out eventually. If podiatrists treat every patient with the kindness and respect they deserve, and cure their ailments, then everything else will fall into place. **PM**

Dr. Haspel is senior editor of this magazine and past-president of the New Jersey Podiatric Medical Society. He is a member of the American Academy of Podiatric Practice Management.