The Changing Pathways to Medical Degrees

The rapid rise in medical information may ultimately lead to degree parity.

BY JON A. HULTMAN, DPM, MBA

On November 2, 2018, I attended APMA's combined meeting of the Carrier Advisory Committee (Medicare) and the Private Insurance Advisory Committee (CAC/PIAC) in Baltimore, Maryland. The meeting featured a number of industry speakers who covered the full spectrum of reimbursement issues. APMA's complete notes from this meeting can be found on its website. One of the speakers, Robert Kettler, MD, spoke on the topic "Working with Carrier Medical Directors." This was important for attendees at the meeting; however, in his opening remarks Dr. Kettler also touched on an even more significant issue—the ever-increasing vast amount of medical knowledge available to us today. He stated that, until 1950, medical knowledge was doubling about every 50 years. As of 1980, the doubling of information took place every seven years, and by 2010 that timespan reached 3.5 years. By 2020, medical knowledge is projected to double every 73 days! What is typically being learned in the first three years of medical school will amount to only 6% of all that is known in the medical field by the end of the 2010–2020 decade. Knowledge is expanding faster than physicians' ability to learn, assimilate, and apply it effectively.

The clear response to this accumulation of knowledge has been an exponential growth in the number of specialties and sub-specialties. To put this in context, a family in the 1950s had a primary (and frequently, only) doctor who was a general practitioner. Most likely a "he", the doctor treated a wide range of conditions affecting both children and adults—even providing specialty services such as delivering babies, treating injuries, and performing or assisting on surgeries. A general practitioner was expected to know everything, but the rapid growth in medical knowledge necessitated ever more specialization. While it is difficult to ascertain the exact number of specialties and subspecialties, the American Board of Medical Specialties (ABMS) currently recognizes 24 specialties of medicine and 136 subspecialties. As the sheer volume of medical information continues to double, I expect many more subspecialties to be created—even within our own specialty—which was once, itself, considered a subspecialty.

This rapid growth in medical knowledge has tremendous repercussions for practitioners attempting to keep up with the "latest" developments. Obviously, it will not be possible for a practitioner to stay current with "everything" or for medical students to learn "everything." Even "specialists" have adapted to this growth by honing their practices to specific areas within their own specialties. These sub-specialists, in turn, are forming groups that offer a broad range of services within their specific specialty. This enables each doctor in the group to focus on keeping up with a narrower range of services.

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There is an expectation that electronic medical records will be able to assist doctors in the struggle to "stay current." They can offer more efficient ways of bringing essential medical information and decision support systems to the fingertips of practitioners in real time. Though this rapid growth in medical information poses a challenge to all practicing

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physicians, there is opportunity to be found within this challenging environment. Our specialty, in particular, has the potential to offer insights in the areas of education, training, and licensing. As it turns out, the current model used to educate and train podiatric physicians could well become a model for other specialists and sub-specialists to emulate in the future.

Due to the rate of introduction of new knowledge, simply adding more material and/or time to medical school curricula will not be an effective coping strategy. What will be needed is a fundamental change in the way doctors are educated and trained. Here is where podiatric medicine has a great deal to offer. Over the past 100 years, podiatric trainers and educators have developed a model different from that followed by allopathic medicine. The primary reason for this is that, unlike medical students, podiatric students selected their specialty at the "front end" of their educational process. This called for a different sequencing of coursework in podiatric medical schools as well as a difference in the content and sequencing of medical, surgical, and podiatric rotations throughout the students' residency training. Today, "innovative" training programs are being established for medical students that are structured similarly to traditional podiatric pathways—programs in which students declare a specialty early in their training. The model for these training programs is relatively similar to that adopted by podiatric medical schools and residency programs several decades ago—one which makes more sense for students who focus on a specific specialty or subspecialty early in the educational process.

In one scenario, medical school education has been shortened to three years for those interested in primary care. The goal is to fill the need for more primary care physicians by encouraging students to choose this as their specialty. This enables these students to begin their residencies and enter practice sooner. More recently, the orthopedic specialty has also begun testing programs through which students who want to become orthopedic surgeons are able to enter orthopedic training programs sooner. Clearly, when a student chooses his/her specialty at the "front end" of the educational process—as do podiatric physicians—a different pathway can be created to best train and prepare that student for his/her specific specialty. The more specialized we become, the more these "new" pathways become relevant, and the more similar they become to the model already in use by podiatric medical schools.

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Whether it has been by design or market-driven, since 1950, the education and training for DPMs, MDs, and DOs have evolved. It is likely that much of this evolution has had to do with the doubling of the rate of medical information—creating the necessity to specialize and sub-specialize. A gap that may have existed fifty years ago between the education, training, and practice of MDs, DOs, and DPMs is narrowing each year—evolving to a point at which they now frequently intersect. For all intents and purposes, the end products of medical, osteopathic, and podiatric educational processes—the MD, DO, and DPM practitioners—are equivalent and indistinguishable. If logic were to prevail, their degrees would be equivalent, each would hold the same plenary license, and all their specialties would be recognized by ABMS. **PM**

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