BY JARROD SHAPIRO, DPM

Should All Podiatrists Be Primarily Surgeons?

Surgical and clinical practitioners should co-exist.

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.

With the upcoming Council on Podiatric Medical Education (CPME) 320 rewrite, the changes to the document that relate to the rules and regulations of running a residency, there has been quite a bit of discussion about the way podiatric residencies are structured. As we all know, some years back the 3-year podiatric residency became more standardized, eliminating the alphabet soup of past residency options. Gone are the days of the PPMR, PSR-12, PSR-24, PSR-36, POR, and RPR. If you don't know what those are, then don't worry about it. You're the beneficiary of a hard-earned change.

One of the possibly unfortunate and unanticipated results of this change has been a move toward a heavier focus on surgery with loss of the non-surgical side of training. Like it or not, a student is going to be trained in foot and ankle surgery. However, as many distinguished leaders in our field have stated, there is a non-surgical side to practice, which, for most podiatrists, covers the majority of their practices. Very few podiatric practices come anywhere close to even 50% surgical volume. The reality for most is actually much, much less.

As a side note, for those of you currently in training, remember it is possible to create a fine and successful practice without a major surgical component. If having a non-surgical practice is what you want, it is strongly suggested that you make sure your residency has a clinic or that you can work in one of your attending's practices. Understand that training is likely to remain heavily surgical, but that doesn't mean a podiatric residency graduate must do surgery. Complete your minimum activity volume to satisfy the basic graduation requirements. Remember, it's also important to know which of your patients will need surgery, whether you do that surgery or not.

As many of us also know, podiatry has a recruitment problem. Having so few applicants to podiatric colleges is very bad for the profession. Dr. Alan Sherman once brought up the excellent point that some number of potential applicants to podiatric colleges may be dissuaded from applying because all of our marketing is toward the surgical side. Consider this important point for a moment. There must be some percentage of potential applicants to podiatry school that don't want to become surgeons. Look at allopathic and osteopathic physicians. Most of them are not surgeons. Bear in mind all of the medical fields that are not surgical. Maybe some of them wanted to be surgeons but didn't make the cut, but most of them wanted to enter non-surgical professions.

How many potential applicants to podiatry schools are we missing because they don't want to be primarily surgeons?

With this thought in mind, why aren't podiatrists advertising both the surgical and non-surgical aspects of practice to potential applicants? Why not advertise to all of our strengths? How many people are we missing by avoiding this aspect of our practices?

This long-winded discussion

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brings us to the point of today's commentary: Maybe it would be better if we created a practice structure in which non-surgical podiatrists teamed up with surgical podiatrists. This type of combined dichotomy has the potential to be highly successful.

What if surgical podiatrists partnered with high-quality non-surgical podiatrists? (let's call those practitioners *clinical podiatrists*). We should not define anyone by what they don't do, but instead by a more positive measure. The clinical podiatrist would see a certain number of patients and "specialize" in treating patients without surgery. Eventually, some of those patients will end up needing surgery, and they would be funneled to the surgical podiatrist.

Imagine how good each of those podiatrists would be if they were able to focus on the aspects of patient care about which they were truly passionate? The clinical podiatrist would gain huge experience treating foot and ankle pathology in novel non-surgical ways, while the surgical podiatrist would have thousands of surgical experiences under his/her belt.

To some extent, this model exists in large-scale organizations such as Kaiser Permanente, which employs clinical podiatrists. These doctors provide very important treatment to the large number of patients that don't need surgery. The surgical podiatrists benefit from the large numbers of patients screened by the clinical podiatrists. Only a small percentage of patients need surgery, but all end up being referred to surgical podiatrists, creating the large surgical volume they long for.

Of course, what is yet to exist in this organization is an equal pay structure between the surgical and clinical podiatrists. Kaiser offers a lower compensation package to clinical podiatrists than it does to the surgical ones. I'm sure Kaiser has done some kind of analysis to determine pay ranges, but one would have a hard time believing the surgical ones are really worth that much more money than the non-surgical ones. It's well known that in private practice, the clinical side can bring in much more income than the surgical.

Advantages of Team Practice

That brings us to the advantages of this type of team practice. Besides improved patient care resulting from docs who emphasize their skills and passions, the docs stand to make greater incomes. Clinical practice can bring in more money than the surgical except when the surgical side has very high volume. Increasing the volume brings with it economies of scale in which efficiency is maximized and less time is lost.

Another advantage brings us back to the beginning of today's discussion about podiatric college applicants. If our podiatry schools learned to equally emphasize clinical podiatry and surgical podiatry in their marketing messages, and in the way they advocate for students once they enter the schools, the schools would begin attracting all possible types of applicants, including both those looking to be primarily surgical and those looking to be primarily general practice—clinical podiatrists. Imagine what our applicant pool would look like if we let everyone know just how varied and open to opportunity the podiatric profession really is. One of the ways to do this would be to open the pathways of practice to all directions by having clinical and surgical podiatrists team up. The future will be bright for podiatric medicine—as long as we continue to innovate technologically and inclusively. **PM**

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