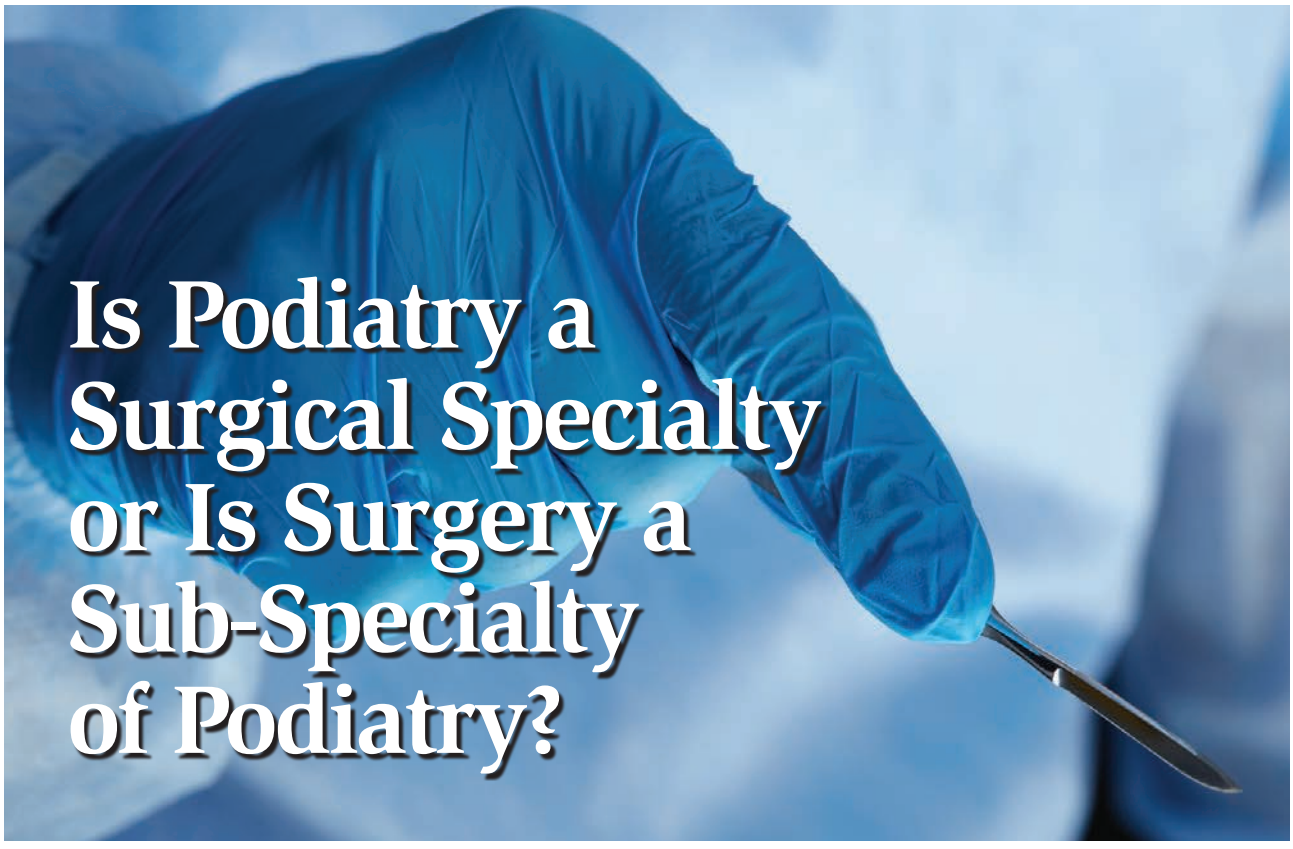

Is Podiatry a Surgical Specialty or Is Surgery a Sub-Specialty of Podiatry?

Point—Counterpoint

BY ALAN SHERMAN, DPM AND JARROD SHAPIRO, DPM

Alan Sherman, DPM

The question of whether podiatry is a surgical specialty, or whether surgery is a sub-specialty of podiatry frames the next important milestone that podiatry must reach to secure our place as a vital medical specialty in the healthcare delivery system.

This message must begin with an apology, because what's about to be said cuts to the core of the very identity of many of our colleagues. But my firm belief is that in 2019, our very identity should be re-examined, for the long-term sustainable reputation and credibility of podiatry, and our service to the American healthcare system and the public health. The question is: Is podiatry a surgical specialty, or is surgery a sub-specialty of podiatry?

My son is a pediatric emergency specialist. He did a 3-year fellowship after his 4-year pediatric residency. While all pediatricians do some emergency care, and general pediatricians work beside him in the emergency department, he is recognized as a pediatric sub-specialist in emergency care. Last year, the pass rate on the American Board of Foot and Ankle Surgery (ABFAS) Part II Certification Exam and the case review process was around 28%, and it's long been below 50% and that seems about right. It's not outrageous to have that low a passing rate. It is really as it should be.

Most podiatrists are general practice podiatrists and a subset of us are fully qualified specialty surgeons. About 20% of podiatrists, give or take, are fully qualified, talented, and competent surgeons. Whatever surgery a patient needs can be done competently by them, and done in fact better than anyone else on the planet. The rest of us are general practice podiatrists, and should not be judged by how they do on the ABFAS certification process. They

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should be judged, officially, by how they do on the American Board of Podiatric Medicine (ABPM) certification process.

Improving Public Health

As far as our service to improving the public health, which is our most important mission as a medical specialty, we don't need and shouldn't want all podiatrists to be specialty surgeons, for a number of important reasons. First and foremost, like general medical schools, we don't even try during the admission process to select out candidates that have skills that would lead to being the best surgeons. This makes sense for medical doctors, and it makes sense for us, because most of what needs to be done for patients as medical doctors or podiatrists is not surgical.

What doesn't make sense is that we channel all podiatrists into 3-year surgical intense training programs. Why are we surprised that not all become skilled specialty surgeons? The medical doctors aren't all predisposed with the skills to be great surgeons, and many of them rise to the top as medical specialists (internists, cardiologists, dermatologists) and even cognitive specialists (psychiatrists). Why do we, in 2019, feel that we can or even should make all of us that are admitted to podiatry schools into specialty surgeons?

Like general medical schools, we don't even try during the admission process to select out candidates that have skills that would lead to being the best surgeons.

This path was taken years ago and we shouldn't fault our predecessors for doing this. We felt we all needed to be surgeons to get on the hospital staffs, to get on the insurance panels, and to be able to be paid for our services. And we shouldn't fault our surgical forefathers, the Earl Kaplans, the Harold Schoenhauses, the Lowell Weils for pushing the training of podiatrists in surgery. It did get us into hospitals and get us recognized as capable of greatness and competency as a profession.

But now that we have a recognized well-run certifying board in podiatric medicine, and now that certification in podiatric medicine gets us on hospital staffs and insurance panels, we are long overdue to recognize that not all podiatrists need to be surgical specialists and shouldn't be compelled to pretend that they are surgical specialists. And of course, all podiatrists do and should do some surgery, in their offices, hospitals, and surgery centers, just as all dentists do some surgery.

We need to distinguish, for our benefit and that of the public, the difference between a general practice podiatrist who does some surgery, and a podiatric surgical subspecialist, who does all foot and ankle surgery and is among the best foot and ankle surgeons on the planet. It would seem that both the excellent foot and ankle surgeons and the general podiatrists will both feel vindicated once the clear distinction between them is made.

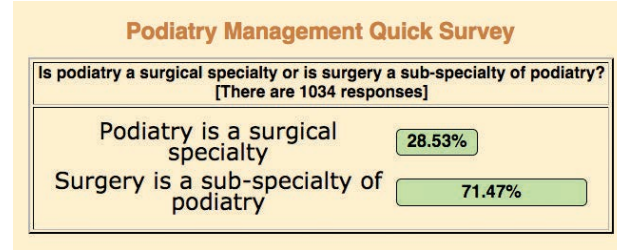
Do We ALL Need to Be Advanced Surgical Specialists? No.

If advanced foot and ankle surgery is a sub-specialty of podiatry, then our podiatry schools and residency training should reflect this identity. I think it's pretty clear that this is not currently the case.

Jarrod Shapiro, DPM

Dr. Alan Sherman recently posed an important question to the profession in *PM News* and Barry Block, DPM accompanied it with a survey asking the question, "Is podiatry a surgical subspecialty, or is surgery a sub-specialty of podiatry?" This question comes on the heels of the very important Council on Podiatric Medical Education's call for comments during their rewrite of the CPME 320 document that defines the rules for podiatric residency programs. Dr. Sherman's question brought a number of interesting responses, and it probes an issue topical to contemporary podiatry: our multifaceted identity.

The poll results are as follows:



These results demonstrate the respondents' overwhelming view that podiatry is NOT a surgical subspecialty but rather a profession with a surgical component. My general opinion is to agree with the majority, but there are nuances to this topic that should be explored.

Why Does This Question Matter?

To some, this question may seem academic, but it truly gets to the heart of many of our problems as a profession. Since podiatry acquired a surgical aspect years ago, we have been on a trend toward an ever-increasing surgical role while relinquishing many of our non-surgical aspects (the schizophrenic identify referred to by some). Let me say at the outset that I'm a surgically trained podiatrist, and surgery is an important part of my professional

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life. We should not give up surgery and ought to continue expanding the procedures in our scope (for example, we should be allowed to do below knee and Symes amputations, which are not permitted in many states).

On the other hand, we should not lose the original components of podiatry (biomechanical-related treatments, wound care, office-based practice, etc.). Both aspects are simply two sides of the same coin, and we should use both surgical and non-surgical methods to obtain the best patient outcomes possible. Does it mean we all individually have to do both? No. The same or better outcomes can occur with podiatrists who have focused expertise.

Advanced Surgery as a Sub-Specialty of Podiatry

If advanced foot and ankle surgery is a sub-specialty of podiatry, then our podiatry schools and residency training should reflect this identity. It's pretty clear that this is not currently the case. For example, of the 1,000 clinical encounters required of our residents during training, only 75 of them are biomechanical examinations. This compares with a minimum 400 surgical procedure requirement. Similarly, our community appears to value surgeons over clinicians.

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Don't agree? Go to an ACFAS conference and see the number of attendees and vendors. There's a reason this is one of our largest yearly conferences. This is all despite the fact that upwards of 70-80% of most of our practices are non-surgical.

The Dual Track Third Year for Podiatric Residency Education

To rectify these problems, Dr. Sherman has advocated for a revised model of residency training in which residents with the most potential to be advanced foot and ankle surgeons are tracked into an advanced surgical third year (with the possible creation of other 3rd year emphases such as wound care, biomechanics, etc.). He makes a convincing argument and, on the face of it, I agree. There's no issue with changing podiatric education to focus on our strengths (surgically oriented folks becoming surgeons and others becoming clinicians). There is a concern, however, with the details and possible ramifications of this change.

Consequences to Consider

There are four major consequences or hurdles to consider:

1) Creation of a confusing identity to the medical profession.

2) Residency conversion difficulties and unanticipated consequences.

3) The surgery versus clinical hierarchy.

4) Incorporating the general practice podiatrist into the current job market.

Confusing Identity and Characteristics for the Profession

In the not so distant past, there was an alphabet soup of podiatric residencies: primary podiatric medical residency (PPMR), podiatric surgical residency (PSR) 12, 24, 24+, 36, rotating podiatric residency (RPR), and primary orthopedic residency (POR). With all this variety, it seemed that few within the podiatric profession understood the different training programs, much less the rest of the medical profession. One of the benefits of the profession's move toward a more standardized residency training is the ability to clearly advertise our training to the medical community. It remains a challenge to explain what we do to other providers, and there's a fear that going back to a more variably-appearing training could be damaging.

Residency Conversion Difficulty and Reactions

It's not certain that our residency programs are structured to easily convert to a format that re-directs the residents to an advanced surgery 3rd year as their programs progress. Each residency has a certain amount of resources available, with some programs being more surgical, while others having a mixture of surgery and clinic. The objectives, outcomes, and assessment methods would need to differ to some extent (which, again, would increase variability to the outside world). These differences in tracks could make it very difficult for program directors to convert their programs.

One might ask if a three-year residency is actually necessary for those not on the surgery track.

Perhaps somewhat obviously, one might ask if a three-year residency is actually necessary for those not on the surgery track. If the third year is dedicated to specialty aspects such as surgery or wound care, and those who do these sub-specialties need only two years of general practice podiatry training before practice, can we conclude that two years is actually enough training for general podiatric practice?

The answer to this question is absolutely not. Residency training needs to remain three years because as a resident transitions from first year to third year, how they interpret their experiences changes and matures. This is especially true for those programs that chose surgical procedure assignments by year (third years doing the larger reconstructive procedures with first years doing smaller surgeries). If a majority of surgical training occurred in the third year, would this be enough for a resident's understanding to mature?

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Hierarchy Hassles—What do Students Want?

We also need to address the unfortunate hierarchy of surgery over clinical practice head on. Despite the results of the poll above that examined practicing provider opinions, many of our students still want to be surgeons, despite the unreality of this desire. It would be interesting to see the results of a poll of the students in our nine podiatric colleges. If a majority of students actually want to be surgeons, then a change in residency structure could affect how applicants chose residency programs. Given how competitive residency programs are—even in the face of fewer programs versus more applicants—there is concern as to what behavioral changes would happen. One can also envision a hierarchy created within residency programs with the surgical residents on the top tier above others.

Where Is the Non-Surgical Job Market?

The next concern is about available job positions after residency graduation. It appears that having a heavily surgical training improves a graduate's chances at obtaining a higher paying job—at least initially. An example of this is a job with an orthopedic practice that typically pays more, and the Kaiser Foundation that pays its surgical podiatrists higher than the non-surgical ones. In private practice, this dichotomy likely holds a little less true. However, a graduate with both heavily surgical training plus the ability to run a clinic is the most competitive young podiatrist.

What jobs would be available to our non-surgical colleagues? What extra skills would they bring to make them marketable? As it stands now, you would not want to be a non-surgical pod looking for a job. Let me make it clear that I'm not saying a clinical podiatrist is inferior in any way to a surgical podiatrist. But what does seem clear in the current job market is that a surgically trained podiatrist who is able to do at least some aspect of clinical medicine is a more desirable applicant for a job.

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Another View—Paul Kesselman, DPM

Much has been lamented the last few months over whether podiatry is a surgical specialty, or whether surgery is a sub-specialty of podiatry. There have been many good opinions offered supporting both sides of this argument. The opinions offered here are done so because both sides have failed to address a subject which most podiatrists maturing academically from the mid-1970s to mid-1980s really understood. The first was there were an untold number of biomechanical experts and theorists whereas today that number is far more limited. The second and equally important fact was that until one understood lower extremity biomechanics, one could not master surgical decision-making.

The number of podiatric masters in biomechanics is far fewer now than ever. Given the current trend, there will be fewer in a decade, with few (if any young) masters to replace those currently still practicing, lecturing and/or publishing.

During one early lecture in biomechanics in 1978 at ICPM, the professor offered the following statements: Until you truly understand lower extremity biomechanics, you will not be a master surgeon. Your hands may create the perfect surgical fracture and you may perfectly fixate the osteotomy, but your surgical choice may fail if the procedure does not adequately address the patient's biomechanical needs. This is as true today as it was more than 35 years ago. Lectures offered by seasoned practitioners at recent symposiums illustrate many complex surgical procedures with excellent fixation, which ultimately fail due to poor pre-surgical planning based on the patient's biomechanical needs.

The number of podiatric masters in biomechanics is far fewer now than ever.

Various orthotic laboratories have confirmed that comprehension of biomechanical principles are lacking from new practitioners. This as evidenced by prescribing inabilities to match clinical conditions to the appropriate devices as compared to those practitioners educated more than twenty-five years ago. Plaster casting seems to have also become a lost art, with scanning becoming more popular among the newer generation. The debate over the superiority of scanning as opposed to casting cannot be settled here. What is more crucial for the new practitioner is the ideal patient positioning during the impression process, which eludes many new practitioners.

A solution to developing new biomechanical masters in podiatry must come from many places. At the undergraduate level, podiatric medical education must be re-emphasized. As one of the most complex subjects any podiatrist must master, a few clinical rotations are insufficient. Classroom and clinical time must either be re-introduced

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A Solution—The General Practice/ Advanced Surgeon Partnership Model

There is a potential solution to this, which has been written about previously: pair non-surgical and surgical podiatrists in clinical practice. The clinical podiatrist spends the majority of their time in clinic, and, when a patient needs surgery, sends that patient to their surgical partner. Each focuses on his or her expertise with increased patient volume within that expertise. Both would be contributing equally to practice, so should be equally compensated.

The bottom line here is if we make the potentially beneficial recommended changes to our residencies that Dr. Sherman suggests, this might create an unwelcome confusion about the profession, would require changes in how residencies function that may be too burdensome, may cause a worsening of the current non-surgical versus surgical podiatrist dichotomy, and possibly leave our non-surgical brethren with uncertain futures. These potential ramifications should be considered before we undertake major changes to how our post-graduate education is structured. Perhaps our first step should be to address our podiatric identity crisis. But that's another debate. **PM**

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Dr. Sherman is CEO of PRESENT e-Learning Systems

Another View—Paul Kesselman, DPM *(Continued from page 118)*

or re-emphasized. Casting (and/or scanning) education must be strengthened.

An orthotic fabrication rotation whereby the student performs biomechanical exams, casts the patient, and works in the laboratory where the device is fabricated was standard during the educational process of the 1970s. This apparently is missing from the current undergraduate curriculum. The students' participation in the "building" of an orthotic has its intent on providing them with a more comprehensive understanding of device utilization and impact on the functional capacity of the patient. Providing students with a superior ability to prescribe devices and perform in-house repairs and modifications is something of a missed art, needing immediate rectification.

Residency programs need to continue to re-emphasize and advance the biomechanics learned during undergraduate podiatric education. Fifty supervised biomechanical examinations during three years (this as compared to more than one-hundred during a one year post-graduate program in the 1980's) is simply insufficient. Rotations through orthotic manufacturers should not be optional but mandatory.

Industry must fund educational opportunities for students and residents. Industry needs to work with the schools to identify those who excel in biomechanical thinking and foster their growth as part of a new wave of creative biomechanical innovators.

At residency level, industry should fund educational and fellowship opportunities to continue this expansion of master biomechanical experts among the newcomers to the profession.

APMA has an extremely important role by integrating all the above ideas and provide additional funding to those involved in undergraduate and graduate level programs. It is incumbent on APMA, industry, and the schools to all work in a collaborative fashion in order to provide solutions to this complex issue.

Whether podiatry is a surgical specialty or surgery is a sub-specialty of podiatry was not intended to be answered here. Yes, it is important for our profession to provide a concise and clear response to that question to both the public and the remainder of the medical community. However, whether part of the answer to that question comes from outside the podiatric profession remains to be seen.

The question of whether podiatry is the profession of biomechanical experts or not remains squarely within the control of this profession.

The question of whether podiatry is the profession of biomechanical experts or not remains squarely within the control of this profession. It is something for this profession to resolve, and the need is immediate as time is running out for us to find solutions as other professions are looking to fill this void.

Currently, podiatry is empowered with sufficient brain trust to find solutions, which may require uncomfortable and new methodologies. To paraphrase two well-known quotes: If not us, then who? If not now, then when? Who we are and what we do is up to us! Every piece of work needs the right people in the right place at the right time. Perhaps APMA 2019 in Salt Lake City will be that place for a fresh start! •