Can Podiatric Physicians Also Be Primary Care Providers?

If not, why not?

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Note: *The opinions expressed in this article are not necessarily those of Podiatry Management Magazine.*

Rationale

While members of the podiatric medical profession provide medical and surgical care to people for problems affecting their pedal extremity, is it not also true that because of the nature of podiatric medical practice, they are or can also provide primary care? Many physicians, because of the nature of their specialty, focus on an organ of the body (e.g., ophthalmologist, otorhinolaryngologist) and do not provide primary care. Other physicians provide a specific function supporting the medical care process (e.g., radiologist, anesthesiologist). Typically, primary care physicians such as those who practice family medicine, internal medicine, geriatrics, pediatrics, and obstetrics and gynecology have a longitudinal relationship with patients, seeing them several times yearly. Patients receiving podiatric medical care are also typically seen several times a year and part of such longitudinal services could be considered primary care.

Because of the nature of problems affecting the pedal extremity, podiatric physicians often also see patients for multiple years. This gives them an opportunity to provide primary care for patients, monitoring many of the medical indices associated with chronic health problems that may not originate in the foot. Consider, for example, patients with a history of hypertension, who while not visiting their internist for several weeks and not self-monitoring their blood pressure, may make multiple visits to their podiatric physician, where at every visit their blood pressure is monitored. This determines the degree to which a patient's hypertension is being controlled. Such information is an essential component of primary care, so important in preventing such issues as a cerebral vascular accident, cardiovascular disease, or kidney problems.

An obvious question is whether podiatric physicians have the education and training to be a major participant in the provision of primary care. Not too many years ago, a justifiable response might have been no. But over the past several decades, podiatric medical education and training has gone through a major metamorphosis. Part of the basis of this has been the enrichment of the podiatric medical education and training experience. For decades, this has included the same pre-medical requirements required for entrance into schools of medicine and osteopathic medicine, including taking the Medical College Admissions Test (MCAT) as a requirement for admission to podiatric medical school. Also, the basic science component of the podiatric medical curriculum is equivalent to that required by U.S. accredited medical schools, which should include the ability to complete Part 1 of the U.S. Medical Licensing Examination (i.e., USMLE). In addition, podiatric clinical training now includes didactic as well as hospital-based experiences, requiring knowledge and skills in physical diagnosis as well as several of the medical specialties (e.g., medicine, emergency medicine, surgery, dermatology, orthopedics, etc.).

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All this is within the four-year course of undergraduate podiatric medical education and part of graduate podiatric medical education, with a three-year, hospital-based residency.

Exceptions to the clinical training podiatric medical students receive during their four year pre-doctoral studies is the absence of medical school required obstetrics/gynecology, pediatrics, and psychiatry, rotations, typically totaling sixteen to eighteen weeks. With a current and growing shortage predicted for physicians over the next several years, including those who provide primary care, this deficit in podiatric medical training should not be a major issue.

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Primary Care Provider *(from page 41)*

Need

The Association of American Medical Colleges states that by 2025 there will be a shortfall of between 14,900 and 35,600 primary care physicians. This shortage is fueled by the rapidly growing population, especially of people age 65 years and older, which is projected to account for 81 percent of the change in demand.[1, 2] These people are especially vulnerable to a number of chronic diseases. Also, successes in medical science have converted diseases that previously were acute to become chronic disorders. Because a large percent of the population seen by podiatric physicians are elderly, this same phenomenon has led to and will continue to make the need for podiatric physicians increase exponentially.

In addition, the increasing prevalence of type two diabetes, which has as one of its major complications ischemic and neurological conditions, requires the providing of podiatric medical and surgical care. Such care is often required over the lifetime of the diabetic patient. In addition, the pedal extremity is frequently affected by osteoarthritis, which can be painful and not infrequently debilitating, especially in but not limited to older people. Again, such problems often require a longitudinal relationship with the podiatric physician, including physical assessment that not only is essential to podiatric medical management, but also is part of the information one needs for the providing of primary healthcare. These primary care functions that the podiatric physician provides are not done so in isolation. The information podiatrists obtain from the examination of patients at each visit, as well as information regarding the medical and surgical care they provide, is often shared with other physicians, both those designated as primary care physicians as well as appropriate medical and surgical specialists. In this way, podiatric physicians may function as part of a team providing comprehensive, coordinated, collaborative, and continuous care.

Because of these factors, it is suggested that the uniqueness of podiatric medicine makes it appropriate for the profession to consider expanding its designation and become identified as one of the small army of primary care providers. This designation in no way is a device to modify the profession's knowledge and skills in the diagnosis and medical and surgical treatment of problems affecting the pedal extremity. What is being proposed is the inclusion of additional responsibilities as a primary care physician. Indeed, the special focus of providing podiatric medical care makes it logical for the profession to accept the addition of primary care responsibilities. Furthermore, such a modification makes a major contribution by podiatric medicine, with relatively little modification to its education and training, to the rapidly expanding primary care shortage.

Road Map

The following road map is suggested:

- Require podiatric medical students to satisfactorily complete Part I of the USMLE at the end of the second year of podiatric medical school.
- Require completion of the requirements for a degree in podiatric medicine.
- Add clinical and didactic experiences in pediatrics, psychiatry, and obstetrics/gynecology (estimated total of sixteen to eighteen weeks) completed during the course of the fourth year of podiatric medical school and first year of residency.
- Require podiatric medical students to satisfactorily complete Part II of the USMLE at the end of the first year of residency.
- Require podiatric residents to satisfactorily complete Part III of the USMLE at the end of the second year of residency.
- Receive unrestricted license to practice medicine upon completion of USMLE, Part I, II, III.
- Become board certified in podiatric medicine or surgery after the 3rd year of residency.

Conclusion

Podiatric medicine has grown exponentially in the last 80 years. Today, there is minimal difference in the education and training of allopathic physicians and podiatric physicians. As a result of changes in the demography of the United States, the need for primary care is growing very rapidly and there still is much to do to meet this need. Combining the rapidly changing needs of healthcare with the major education and training advancements in podiatric medicine provides an opportunity to make a significant contribution to the primary care crisis. **PM**

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References

[1] HRSA Health Workforce, November 2013. Projecting the Supply and Demand for Primary Care Practitioners Through 2020.

[2] Journal of the American Medical Association, 2018.320:1706-1707. New Assistant Physician Licensure Program Raises Concerns. https://m.facebook.com/story.php?story_fbid=10158320747842969&id=710742968https://m.facebook.com/story.php?story_fbid=10158320747842969&id=710742968.

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