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Michael Trepal, DPM

Licensure and Podiatric Medicine

Our expert panel of educators discusses this hot button topic.

BY MARC HASPEL, DPM

The call for the increase in the scope of licensure for podiatric physicians is one that seems to surface year in and year out. In the past, that subject may have been a tad premature. With the uniform expansion of global three-year post-graduate podiatric residency training (the hallmark of classic four-four-three medical training—four years undergraduate, four years medical, and three years post-graduate), the call has never been louder. Today, podiatric physicians train alongside their allopathic counterparts of all disciplines, share similar clinical experiences, and participate in many of the same hospital rotations. Yet, limitations in licensure prevent many of these same podiatric physicians from practicing to the full extent of their abilities, experience, and training.

Podiatry Management has invited a distinguished panel of podiatric educators and political leaders to discuss this critical topic. Their contributions to the field are already profound, and their input on this potential advancement could be the most significant of all. Joining this panel:

David Armstrong, DPM is professor of surgery at Keck School of Medicine of University of Southern California and the founding president of the American Limb Preservation Society (ALPS). He is an inductee into the *PM* Podiatry Hall of Fame.

Jeffrey DeSantis, DPM is the current president of the APMA. He is board certified by ABFAS in Foot Surgery as well as Reconstructive Rearfoot & Ankle Surgery. His passion throughout his tenure as a Trustee has been Vision 2015, with tangible advancements such as the standardized three-year PMSR moving our specialty into the 4-4-3 model.

Lawrence Harkless, DPM is interim dean, University of Texas Rio Grande Valley (UTRGV) School of Podiatric Medicine and, professor in the Department of Surgery School of Medicine UTRGV. He is an inductee into the *PM* Podiatry Hall of Fame.

Allen Jacobs, DPM is a Summa Cum Laude graduate of the Pennsylvania College of Podiatric Medicine. He completed his residency in surgery at Monsignor Clement Kern Hospital for special surgery in Warren, MI. Dr. Jacobs is in

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private practice in St. Louis, Missouri. He is an inductee into the *PM* Podiatry Hall of Fame.

Leonard Levy, DPM is professor emeritus and, up to June 30, 2016, for seventeen years served as associate dean for research and innovation for the Dr. Kiran C. Patel College of Osteopathic Medicine of Nova Southeastern University (NSU COM) in Fort Lauderdale, FL.

Bryan Markinson, DPM is Chief of podiatric medicine and surgery at the Leni and Peter W. May Department of Orthopedic Surgery of the Mount Sinai School of Medicine. He is the 2021 inductee into the *PM* Podiatry Hall of Fame.

Kathleen Satterfield, DPM is a graduate of Des Moines University College of Podiatric Medicine, the first of the modern podiatric colleges that began to embed education into existing medical schools without abandoning podiatric principles. She is now the dean of Western University of Health Sciences, College of Podiatric Medicine, the newest college which continues to pursue parity for podiatric medicine.

Michael Trepal, DPM is vice president for Academic Affairs, and is dean and professor in the Department of Surgery at the New York College of Podiatric Medicine.

PM: *Should podiatrists obtain a plenary medical license? If so, why? If not, why not?*

Trepal: A plenary license in medicine is defined as one without restriction as to what one can practice in the jurisdiction which issues it. In its purest form, hypothetically, the holder could diagnose and treat, by any means, any and every possible human ailment. In practice, we know there are checks and balances which would mitigate that from occurring. Getting back to the question, it is not an easy answer. Would attaining such a license be feasible for all podiatric physicians, both current and future? If yes, how do we bring all existing DPMs into educational compliance to qualify? If no, will we be promoting two classes of podiatric physicians?

Assuming a workable pathway, the gorilla in the room is the resolution of feasibility and desirability. I dare to say that there is unanimity among all podiatric physicians that the goal is equal pay for equal work and elimination of any degree-based discrimination, which would pejoratively and arbitrarily interfere with our ability to provide the services we are well qualified to perform. Any reasonable mind will recognize the enormous advancements our profession has made towards achieving these goals under our current DPM licensure. The question before us now is what the most prudent path is to cross the finish line.

"We are at a historic point in podiatric medical education, and as a profession, we need to make a choice whether we continue to grow or if we go backwards."—Satterfield

DeSantis: Today's podiatric physicians and surgeons are exceptionally well trained and those that have the desire to help medically manage their patients, such as those with diabetes, peripheral vascular disease, etc., should be able to perform those services. Their current educational training and experience exceeds the scope of practice that is available in any of the fifty United States.

Harkless: I believe podiatric physicians should obtain a plenary medical license. We always say that we are physicians and that thus we practice medicine. I believe we do; however, there are many things that we do not do. Hence, the only way to be the same is to challenge the same classes and examinations, including the clinical basic science exam (CBSE). Allopathic medical schools require passage of CBSE prior to sitting for USMLE Step1. There is an eighty percent concordance of passing USMLE upon passing CBSE. Successful completion of these examinations supports MD equals DO equals DPM.

As founding Dean of Western University of Health Sciences CPM, I oversaw that students take all pre-clinical classes with the medical school in the first two years, except for osteopathic manipulative medicine. In the clinical curriculum third year, three months of medicine and three months of surgery were required. The fourth year clinical curriculum required four months as a sub intern, two months medicine, and two months surgery. These rotations prepared students to be true physicians and surgeons of the foot and ankle. All the colleges of podiatric medicine should change their curriculum to reflect equivalence by challenging the same examinations CBSE and USMLE Step 1and 2.

Satterfield: Yes, podiatric physicians should receive it if their education and training live up to what is needed to achieve that privilege. We are at a historic point in podiatric medical education, and as a profession, we need to make a choice whether we continue to grow or if we go backwards.

For years, mainstream medical education and, in particular, the orthopedic leaders, have challenged podiatry. They didn't give us a hard "no" about trying to achieve parity, but they made it clear that if we wanted to join their club, we would have to standardize and broaden medical education and training. Currently, there exists a piecework quilt of educational models across the schools of medicine. Some models treat the feet as disconnected pieces of anatomy and not as integral parts of the larger picture. This profession has to provide that standardization.

Markinson: An unfettered, unlimited medical license of course is desirable as it may eliminate the past

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40 years of podiatrists being objects of curiosity and confusion when it comes to hospital staffing, legislative issues, insurance coverage of podiatric services, etc. Having DPM listed in the same paragraph as MD and DO would be a huge benefit. However, there is an ocean between the DPM and the MD/DO experience (starting from the application processes to the colleges) which we must accept, define, acknowledge, and fix. My impression is that our profession has understated the depth and breadth of the ocean, which makes this question moot. Plenary licensure will not come from just the asking or wanting or thinking we deserve it.

"There is an ocean between the DPM and the MD/DO experience (starting from the application processes to the colleges) which we must accept, define, acknowledge, and fix."—Markinson

Levy: Podiatric physicians should have the same license and degree as other physicians (i.e., MD or DO) and yes, the DPM degree would be retired, and all in the profession would earn an MD or DO degree. They currently function no differently than other medical specialists, and the education and training that they now receive is virtually the same as that of other physicians with the exception of OB/GYN, psychiatry, and a few other areas which can be added very likely in six months or less. I served for seventeen years as a senior member of the administration (Associate Dean for Research and Innovation) of the osteopathic medical school from which I recently retired as well as on the curriculum committee of a new allopathic medical school, which is now part of the same academic health center. I can make these statements not only based on experience, but because of the many contacts that I had to make in the allopathic and osteopathic educational community.

Armstrong: In my opinion, podiatric physicians in the United States are either a) overtrained or b) under licensed. Almost all of the data suggest that b) is probably the one that is most likely, and therefore, should guide us toward the future. I believe

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that either an unlimited license DPM, adding an MD, or just eliminating the DPM, would be the best way forward. This is a not a profession. This is a specialty. As the grateful son of a podiatrist and the father of a third-generation podiatric medical student, I am excited to see this specialty evolve to where it is now.

PM: *What are the advantages or disadvantages of obtaining a plenary license?*

Trepal: First, we need to distinguish between a degree and license. In my opinion, and of course I could be wrong, receiving a plenary license without an MD or DO degree in the foreseeable future is a tall order. Perhaps someday medicine will evolve to a system of limited license MDs. In such an environment, we would conceivably see limited license psychiatrists, ENTs, etc. Podiatric Medicine would be a natural fit in such a rubric. Until such a time, that such a paradigm shift occurs,

"Let me be clear when it comes to competency in the diagnosis and treatment of lower extremity pathology, podiatric medical education is second to none."—Trepal

DPMs, under the current system, would need to demonstrate to obtain a plenary license that the undergraduate and graduate education system is not simply equivalent, but more likely identical or nearly so to that obtained by their allopathic and osteopathic colleagues. Hence, the major disadvantage we would face is the need to fundamentally change the content of our curriculum.

Postings in various podiatric forums, where folks opine that all which is needed is simply to add a few hours in OB/GYN and psychiatry, and we are there, stem from some altered universe and are laughable. Let me be clear when it comes to competency in the diagnosis and treatment of lower extremity pathology, podiatric medical education is second to none. And that is no easy feat nor serendipitous, but rather the culmination of a well-designed continuum of undergraduate and graduate medical education. One of many examples might be where podiatric medical students spend an entire semester studying the anatomy and structure of the lower extremity. Medical students spend very few hours on anatomy distal to the ankle.

Podiatric medical students spend, on average, three clinical months studying podiatric surgery. Medical students do not spend three minutes. Podiatric medical students spend countless hours studying biomechanics, peripheral vascular disease, lower extremity dermatology, and much

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more than time permits in the standard allopathic curriculum. Likewise, medical students spend three months on general surgical clerkships for which time would not allow in our podiatric medical curriculums. My point is that a potential disadvantage to obtaining a plenary license is that it might require a significant adjustment of the DPM curriculum to the extent that we potentially could lose our superiority in knowledge and skills of lower extremity medicine at the time of awarding of the first professional degree.

Harkless: The advantages are that podiatric physicians would be considered equal to MDs in training with a subspecialty in the foot and ankle. Obviously, it would be recognized in that regard only if the education and training are the same. The disadvantages would be that podiatric doctors would not be able to practice as physicians since they were not accepted by and graduated from an LCME MD COCA DO accredited medical school. Thus, podiatric medicine needs more schools fully integrated within academic health centers. The most segregated aspect of healthcare for this profession is the academic health center. Podiatric medicine is not there yet. Currently, and unfortunately, there are two podiatric schools that are affiliated with allopathic medicine out of 155 MD medical schools in America.

"The advantages are that podiatric physicians would be considered equal to MDs in training with a subspecialty in the foot and ankle."—Harkless

Markinson: At this point, I see one major undesirable. I have often stated that to get to the point of a plenary license, we must acquiesce as a profession to the demands of the MD/DO process, including undergraduate requirements, MCAT scores, all exams and educational experiences, etc. In my opinion, having achieved the ability to apply for training in any medical specialty, podiatric medicine by the DPM as we know it will be extinct. I know that many, if not most podiatrists, including myself, are so satisfied with our wonderful profession that they think podiatry will be a viable, even popular choice amongst students trained to the point of ability to apply for any specialty. I strongly disagree. If

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we go this route, the best we can hope for is a very diluted podiatric specialty than the one we have now. There will be no one trained in lower extremity medicine anywhere near the depth we are trained now.

Levy: Having a plenary medical license would allow podiatrists to practice their specialty without having to endure what really are artificial and political roadblocks, which would create hours of wasted time. It also would provide professional and legal recognition to perform the duties of the profession, receive reimbursement from private and governmental agencies on the same basis as the rest of the medical community, and receive the same recognition from the community as other physicians do.

"Having a plenary medical license would allow podiatrists to practice their specialty without having to endure what really are artificial and political roadblocks, which would create hours of wasted time."—Levy

Jacobs: I have long believed that to some extent, podiatry education is a truer model of what medical education should be, a curriculum constructed to the specific needs of a particular "specialist ". With that said, however, the awarding of a plenary degree is not a simple matter of adding a few additional courses. There is a difference in the degree of participation, patient responsibility, and involvement between podiatry students/ residents and medical students/residents. This would require changes to clinical experiences if the awarding of a plenary degree were the objective. I would strenuously argue that excellence in podiatric medicine does not, for example, require an obstetrics or ENT rotation. There is no dispute that a plenary degree would be helpful for certain political and licensing problems facing podiatrists.

Armstrong: This is the only specialty I know that tries to pre-credential itself. We have these silly Mason-Dixon lines at joints named after old French surgeons. Why? Like all other specialists, podiatrists should be credentialed based on training and experience. I am happy to see that this has started to happen.

DeSantis: A plenary license would allow podiatric physicians and surgeons to provide comprehensive treatment for their patients, equivalent to what an MD or DO could provide. Some believe a plenary license would create physician recognition for podiatric physicians and surgeons and ensure equal reimbursement.

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PM: *Should podiatry have a uniform scope of practice? If so, how can that best be achieved?*

DeSantis: Until podiatric medicine is practiced with an unlimited license, yes, in my opinion, there should be a uniform scope of practice adopted by all states. APMA created a uniform scope of practice template under the aegis of its Vision 21st Century Committee. APMA defines podiatric medicine and surgery as "the specialty that addresses the diagnosis and treatment of pathologies and conditions of the lower leg, with special emphasis in the diagnosis and treatment of the foot, ankle, and their governing and related structures of the leg by any and all means with osseous surgical treatment limited to that part of the lower leg below the anterior tibial tubercle."

Achieving a uniform scope of practice likely would require buy-in and support from our orthopedic colleagues. If they chose to support it, passing it through state legislatures should be much easier. APMA works closely with national orthopedic and medical societies to build and foster supportive relationships and to educate their leadership about our education and training.

Jacobs: Of course it should. However, the lack of uniformity of residency experiences, the acceptance of a ridiculous number of "board certifications" results in an eclectic collection of residency graduates and unreliability in credible assessment. What matters are the state legislators, as the APMA has been unable to provide such uniformity from state to state.

Satterfield: It would be my preference to have a uniform scope. I feel it would be wonderful to be able to practice to the fullest extent of one's license and training, without regard to a statewide decision that limits one in one state or another. Imagine having the freedom to move from one state to another, and not having to jump through hoops.

To make that happen will take a unified national voice and the support of a concerted group of strong states behind it. I'm not the politician here, but I do know that if the leaders in states like California, New York, Pennsylvania, Texas, Ohio and other thought leaders align their efforts, this could be achieved. Perhaps the Federation of Medical Boards, the AOA, and the AMA would be logical starting points. As this profession inches closer to a model that looks more like that of our proposed partners, through ACGME standards and the like, podiatric medicine will get there.

Harkless: Podiatrists should have a uniform scope of practice. It will be difficult to achieve as scope of practice is regulated by each state. Most state statutes include foot and ankle, and soft tissue structures in the leg that govern the function of the foot. Federal law does not supersede state law as it relates to regulation of the practice of professions, hence this will be difficult. During project 2015, APMA evaluated the scope of practice in all states. Data demonstrates all but three states have an ankle law. A uniform law is difficult because each state wants to have its own independence and freedom, and not be regulated by the federal government.

Levy: Issues related to scope of practice would virtually disappear and what podiatrists do would be based on education and training rather than on political acumen.

PM: *What is the best way to ensure equal reimbursement to podiatrists for performing the same services as MDs and DOs?*

Trepal: By continually making the case that podiatric physicians are not only competent to do what they do and achieve similar if not better outcomes in a cost-effective manner. While common sense would dictate that equal pay should be the norm, the flower of reason does not grow in everyone's garden; therefore, it most probably necessitates well-planned legislative and possible legal challenges.

Satterfield: Simply put, if podiatric physicians were granted the degree of MD or DO and licensed as such, it would be virtually automatic to be reimbursed as any other MD or DO.

Harkless: This is an issue of degree, and the insurance companies. Obtaining the plenary medical license should eliminate this problem. Everything, however, is about the dollar bill. Insurance companies will do everything they can to save money. Because the degree remains different, they pay podiatric physicians less. The VA Provider Equity Act passed by Congress is more ammunition in the arsenal in order to obtain financial parity.

"In the medical lexicon, because of this separate degree, podiatric physicians are something of an asterisk."—Armstrong

Markinson: I am at a loss to explain this disparity in reimbursement. But this I know for sure: podiatrists in New York City in large measure will accept and par with any plan regardless of the poor reimbursement. Those that reject these plans are in the large minority. Medical directors and CEOs of insurance companies are well aware of this. We have no one but ourselves to blame. I am not even so sure that plenary licensure would change this, as podiatric services are sometimes largely devalued, even eliminated by some carriers.

Armstrong: I have to agree. In the medical lexicon, because of this separate degree, podiatric physicians are something of an asterisk. Realistically, there is not some sort of evil cabal out there trying to eliminate podiatry.

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Jacobs: Good, credible outcome studies demonstrating the cost effectiveness of podiatric services when compared to the same services performed by non-podiatrists. A plenary degree would likely be helpful, but at what cost? Podiatrists should be reimbursed at a higher rate than non-podiatrists for the same or similar services. 7-8 years vs. a one-year orthopedic foot and fellowship? How does knowledge of gastritis improve the treatment of a bunion?

DeSantis: The best way to accomplish equal reimbursement is to ensure that every insurance provider pays the same way Medicare does with a uniform fee schedule that is not based on specialty or degree. Providers are reimbursed based on the CPT code they submit, and the CPT code (except for some geographic adjustments) is paid the same to all providers.

Again, this change might require state legislation regarding equal pay for equal work. APMA has a model fee parity law for states to implement. The purpose is to ensure that patients have access to foot and ankle care services from the healthcare providers of their choice, and that insurers do not discriminate against Doctors of Podiatric Medicine in terms of coverage or amount of reimbursement.

APMA also strongly recommends that podiatric physicians carefully consider the details of their contracts with third-party payers before agreeing to a fee schedule. Moreover, it is recommended that podiatric physicians consult with their attorneys and negotiate more favorable agreements when appropriate. APMA has resources available to help members demonstrate the value of podiatric education, training, and care.

PM: *Should podiatry seek to maintain the DPM or seek an MD or DO degree? If you are in favor of a degree change, what steps would be necessary to achieve that goal?*

Trepal: In the United States, the DPM degree may only be conferred by Colleges of Podiatric Medicine accredited by the Council on Podiatric Medical Education (CPME). Such institutions must be in compliance with published standards comporting with the podiatric medical curriculum. The CPME is not empowered to accredit any institution to award the MD or DO degrees. Institutions awarding these degrees must receive their accreditation from the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA). Therefore, contrary to the opinions of some, it is not simply a matter of "changing or converting" a DPM degree into an MD or DO degree, as the degree granting institution would need to be accredited by either LCME or COCA. Our Colleges of Podiatric Medicine would need to obtain their accreditation from one of those agencies and CPME would be rendered irrelevant. We would then be MDs or DOs who specialize in lower extremity medicine. There are other questions that would need to be answered involving, for instance, who would approve our residency programs; whether the national organization of choice would be APMA or AMA; determining who would recognize the certifying boards.

Other possibilities might include a United States Podiatry College partnering with a willing U.S. or offshore medical college to offer a joint DPM/MD degree. This would surely entail more years of study and increase in student debt, and then a decision as to what type of residency program to enter. The logical outcome would be that the individual holding such a joint degree would practice under the MD license. The question would remain about what would happen to those who do not choose this pathway.

Levy: I believe those in the specialty of podiatric medicine and surgery should be granted the allopathic or osteopathic medical degree and, upon completion, if they choose to be a specialist in podiatric medicine, take a residency of three years or four years if additional specialization in that specialty is desired. It should be noted that there are now sixteen allopathic medical schools in the United States that have a three-year program leading to the medical degree, and there certainly is a possibility that other schools will do the same. Our current national board would be modified to become our specialty board, and its examination would be given to become board certified in podiatric medicine. A difficult task could be a "buy in" by the current podiatric medical schools, the American Podiatric Medical Association, and likely a significant number of members of the profession, who may not be able to make this transition. If this does not get accomplished first, allopathic and/or osteopathic medical schools may be reluctant to engage in the difficult and complex discussions that likely would be necessary to make this major transition.

Satterfield: The osteopathic physicians faced this in California and, at first, it was a matter of sending in one's license along with a fee and one would get an MD license in the return mail, although there were clearly differences between the two. Many osteopaths objected and appreciated their unique skills. Thus, after much work, laws were changed. It was so controversial that a book was written about it, *The Merger: MDs and DOs in California* by Michael Seffinger, DO. I certainly think it is a worthwhile read to understand the complex history and appreciate the similarities.

I agree with my osteopathic colleagues who fought to maintain their own identity. Those initials speak to why we are different. I'm comfortable in my skin and want to be identified as a DPM. I want, however, to earn the same pay as my DO and MD colleagues doing similar work.

Harkless: I am not in favor of a degree change. If podiatric physicians want a degree change, they should have to go to an LCME MD or COCA DO accredited medical school and obtain the MD/DO degree. Having served on the admission committee at two allopathic medical schools, admission to medical school is difficult, and most podiatric physicians would not qualify. Therefore, the plenary medical license is appropriate. I

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would not seek to change to a MD/DO degree.

DeSantis: At this time, my vision is that podiatric medicine and surgery retains the DPM degree and achieves recognition that MD = DO = DPM. Podiatric medicine has come a long way by adopting a standardized three-year, hospital-based, postgraduate residency training program. The PMSR gives us a four-four-three model (undergraduate, medical school, residency training) equivalent to allopathic and osteopathic medicine. As the profession progresses with the USMLE for licensure, the degree change will be the decision of its future leaders.

PM: *Why should podiatric medical students be allowed to take the USMLE Exam?*

Trepal: Step one USMLE like Part I APMLE tests subject matter in the pre-clinical sciences. For the most part, podiatric pre-clinical curriculums mirror those found in allopathic and osteopathic medical colleges. Therefore, it could make sense for podiatric medical students to sit for this exam. There are some notable differences, however, in the respective exams, which would need reconciliation. For example, twenty-five percent of Part I APMLE is devoted to lower extremity anatomy. There are few if any lower extremity anatomy questions on the USMLE. The APMLE emphasizes questions in pharmacological, physiological, and pathological disciplines pertinent to lower extremity medicine. I am quite confident that podiatric medical students could pass Step One USMLE, but we would risk stratification with attendant scrutiny of podiatric medical students against other cohorts of students taking the exam. Having podiatric medical students sit for the USMLE Step two (CK) exam is an entirely different story as content matter in that exam does not parallel as closely content material in the APMLE Part two Exam, which is configured to assess competency in mastering the podiatric medical curriculum. I would suspect that as a group, medical or osteopathic students would do poorly if they were required to sit for the APMLE part two Exam.

Satterfield: I do not see why not. I have to refer to the challenge that orthopedists threw down decades ago. They made it clear that to join their club, podiatrists would have to play by their rules. I have rarely encountered a profession where a portion of the practitioners wanted to grow, and another was equally intent on not progressing. I believe everyone wants to improve and challenge themselves. I know the young podiatric physicians do.

Markinson: I believe that experiment already took place. The silence about it is deafening. An entire retrofit of podiatric medical education would be required to make this a viable effort. That means much more than sitting next to an MD/DO student for two years.

Harkless: I believe podiatric medical students should take the USMLE to demonstrate that their knowledge and skills are equivalent to those of medical students. Successful passage would provide evidence, and confirm and validate it.

Jacobs: Both the AMPLE and USMLE should be taken by our students. This would serve as another attestation to the growing competency of today's podiatric student. It would serve as another "brick in the wall" for consideration of a plenary license or at least expanded scope of practice for the DPM.

"Part of achieving recognition that MD equals DO equals DPM is taking the same exams as MD and DO students."—DeSantis

DeSantis: Part of achieving recognition that MD equals DO equals DPM is taking the same exams as MD and DO students. The indications received from some of the allopathic colleagues are that podiatric physicians need to take, and pass, the same exam they pass to demonstrate that the education is comparable. If this profession is to push for a plenary license, there is a strong case to be made that a podiatric physician and surgeon who passes all three parts of the USMLE should be granted a plenary license. APMA has worked to achieve the goal of gaining access to the USMLE for podiatric medical students. We want the deans and the colleges of podiatric medicine to believe in this path for our future and to prepare podiatric medical students to pass the exam. **PM**

"Both the AMPLE and USMLE should be taken by our students. This would serve as another attestation to the growing competency of today's podiatric student."—Jacobs

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.