Future Star Michael Gibboney, DPM

This podiatrist has devoted his career to federal service.

BY MARC HASPEL, DPM

Service to one's country immediately places an individual in good standing as a potential leader in the community. Likewise, recognizing such individuals and acknowledging their commitment to the nation automatically puts them in the front of the pack as potential future leaders in their chosen professions. Nominated by fellow colleague, Mark A. Dreyer, DPM, for *Podiatry Management's* series on Future Stars, Navy Lieutenant Commander Michael Gibboney, DPM, has thus far impressed his peers. Doctor Gibboney was pointed towards a career in podiatric medicine having spent years following September 11th, 2001, as a surgical technologist at National Naval Medical Center, Bethesda, Maryland where he witnessed podiatric physicians working alongside other professionals in the treatment of military personnel. A career serviceman, he sees himself continuing his podiatric service to the Veterans Administration for many years to come. Recently, Gibboney took time to reflect on his young podiatric career, and offered thoughts about the profession today, and the future.

PM: *Who in podiatric medicine influenced you the most thus far in your career? To whom else do you give thanks?*

Gibboney: I would have to say my residency director Guido LaPorta, DPM has had the largest influence, but there are several others deserving of credit. There have been mentors at every stage of my career that have been influential, at Des Moines University, James Mahoney, DPM, played a huge role pushing to strive for more when I began to struggle during my first year, forcing me to ask myself hard questions about what I really wanted, and if podiatric medicine was the answer. Ellianne Nasser, DPM, also played a huge role in where I am now. I feel she complimented Dr. LaPorta perfectly, and pushed me to have the textbook knowledge and understand the smallest details. Dr. LaPorta expected that as well, but it was more of an afterthought. His expectations were broader and more practice-based. He expected me to be able to turn that knowledge into practical use on the fly, understanding if complications arose during a case that I already possessed the knowledge on how to address the situation in order to obtain the best possible outcome. He expected his residents to independently solve problems, present him with those problems and appropriate solutions. His knowledge was terrifying at times, it would push me to study more, discuss topics with my fellow residents, and practice different techniques in an attempt to ensure I was as prepared as possible for all aspects of podiatric medicine.

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PM: *What first attracted you to a career in podiatric medicine?*

Gibboney: I joined the Navy immediately after high school, about three weeks before September 11, 2001, and spent 5 years as a hospital corpsman. During a significant portion of the major combat in Iraq, and while working as a surgical technologist at National Naval Medical Center Bethesda, I was able to see podiatric physicians working in the operating room along with general surgeons, orthopedic surgeons,

Continued on page 142

Dr. Gibboney *(from page 141)*

and every other specialty that could be mentioned working on horrific wounds. Prior to this exposure, I had aspirations to become either general trauma surgery or orthopedic surgery, but something during that time just seemed to click for me. I enjoyed the surgeons with whom I was able to work. During my last year of undergrad at Northern Illinois University as I began to apply for medical schools, I received a pamphlet in the mail from Temple University regarding podiatric medicine as a career. At that time, I had almost forgotten about my time with those military podiatrists. As I took the time to do some more in depth research, I began to have an increased interest in podiatric medicine again. Remembering the time spent with those military podiatrists, I realized that podiatric medicine interested me. That is what solidified my decision about my choice of profession.

PM: *What are your goals both short term and long term for your career in podiatric medicine?*

Gibboney: Right now, my focus has shifted to resident education, having recently assigned to Captain James A. Lovell Federal Health Care Center in North Chicago, I have been selected to serve as an assistant residency director. The programs newest first year resident has joined the team, and the other residents and faculty are working closely with all of the residents to promote competency and learning.

Long-term, I would like to expand the scope of podiatric medicine in the military, as well be a part of the effort to move podiatric physicians from the Medical Service Corps (allied health specialists) to the Medical Corps. As it stands in the military, all officers are paid based on rank, podiatric physicians enter as O-3, Navy Lieutenants and Army/Air Force Captains, and often do not receive any bonus incentives, as where a physician assistant or operating room nurse at the present time does receive incentive bonuses.

PM: *What College of Podiatric Medicine did you attend? Where, and how would you describe your post-graduate training?*

Gibboney: I attended Des Moines University College of Podiatric Medicine and Surgery graduating in 2014, and then attended Geisinger Community Medical Center PMSR/RRA graduating in 2017. Training under Dr. LaPorta afforded me many opportunities, not only was the case volume considerable, but the types of cases routinely done in his practice and, by those associated with his residency, was staggering. For being a program that may not have as much initial name recognition as Crozier or West Penn, we were performing similar procedures and similar volume of procedures, while maintaining an inpatient load of sometimes more than twenty patients in a community hospital. At the time, I was fortunate enough for Community Medical Center to have merged with Geisinger, which allowed us to rotate at Geisinger's level I trauma center, work with infectious disease, orthopedics, vascular surgery and all the other specialties and see unique pathology associated with a large 500-bed hospital.

PM: *What are your thoughts about APMA, the certifying boards and other organizations that function within the profession?*

Gibboney: I think the American Podiatric Medical Association is essential to this profession, and that is many times lost in new graduates training. I think this profession has attempted a shift to highly surgical, which is fantastic, and the training continues to improve, but this niche was built from a lack of basic foot and ankle care from other specialists. The American Board of Podiatric Medicine, in my opinion, should be the initial board required, with American Board of Foot and Ankle Service being a supplementary board to be earned once ABPM certification has been obtained.

I feel as a new practitioner that APMA and American College of Foot and Ankle Surgeons are sometimes fighting with each other for membership, and a sense of importance. I feel that they are both equally important. Not every podiatric physician will practice mostly surgical; all need office time to see post-op patients, to gather new patients, and many will practice non-surgical. I believe if podiatric physicians are all primarily surgeons, that would be doing this profession a disservice. In fact, the profession will lose ground to those who will wish to perform these non-surgical services such as nurse practitioners and other mid-level providers.

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PM: *What sub-specialties interest you in podiatric medicine, and why?*

Gibboney: Right now most of my interest is in sports medicine, I always found that aspect interesting in school, but having previously served as a military podiatrist at Naval Medical Center Camp Lejeune I am was one of three podiatrists responsible for treating all of Level II Marine Expeditionary Force, which comprises roughly one-third of the United States Marine Corps, in addition to the staff at the Naval Medical Center and the dependents and retirees in the surrounding area. Podiatric medicine and Orthopedics work closely, but there are any fellowship trained foot and ankle orthopedic surgeons,

Continued on page 144

Future Star: Gibboney *(from page 142)*

so most foot and ankle pathology is treated by podiatric physicians. Due to the patient population, a considerable amount of sports medicine injuries is seen. Moreover, the patient population is always training, generally performing at an elite level, so the treatments provided must be the best and most likely allow these young Marines to return to combat readiness.

PM: *What type of practice arrangement, i.e. solo, small or large group, suits you the best?*

Gibboney: I feel I work best in a large group setting; I am constantly pushing myself to be more productive, see more patients, and a larger group practice especially the military model allows essentially a never-ending supply of patients that need treatment. I enjoy having a close relationship with other medical specialists. I value being able to walk across the hall to orthopedics and just talk to colleagues, discuss cases, and coordinate care.

PM: *Where do you see your career being in 10 years, 20 years?*

Gibboney: I would love in ten years to still be active duty military working in a similar situation to the one I am at now, well maybe a couple of ranks higher. I enjoy the work I do and enjoy serving those who serve and go into harm's way to defend our nation. I would still be happy doing this for the military in twenty years, though with the changes that are being enacted, I mostly see myself at a V.A. facility continuing the care for those who have defended our country.

PM: *What are your thoughts on the overall role of podiatric medicine in the current healthcare system?*

Gibboney: I think podiatric medicine is grossly underutilized. Dr. David Armstrong and others are constantly publishing data on how podiatric care can have huge healthcare savings in both the short and long term. Sadly, I feel with the emphasis on advancing scope, the fight for basic foot care is being lost. In residency, we had a wound care center attached to our hospital, and slowly over the course of my three years we lost podiatric care and gained general medical specialists.

Unfortunately, we allowed part of our specialty be taken without a fight. One can argue that bunions and hammertoes are many times elective procedures, but treatment of infections and wounds, is in no way elective. I feel that is where the emphasis of care should be. I love spending some of my days performing nail debridement and treating the senior patient population. I find that they are generally so grateful and have many great life experiences to share with people who are just willing to listen.

PM: *What should this profession do to continue to attract sound quality individuals like yourself?*

Gibboney: I think the AMPA is doing a good job on promoting the profession, but there is a need to build upon already existing opportunities. A few years ago, there was an attack on United States Congressmen practicing baseball in Washington D.C., Representative Brad Wenstrup of Ohio was one of the first responders credited as a hero for his actions during that incident. There was a lot of publicity about that, but I honestly do not remember hearing a great deal about him being a podiatric physician. I feel that there are quite a few podiatric magazines, but there needs to be focus on mainstream magazines, getting people to understand what podiatric physicians do and why that is important. I would like to see a push to undergrad universities and get the pre-medical advisors and groups involved and interested in this profession.

PM: *Would you be in favor of degree change as well as name change from the term "podiatric" to "foot and ankle" medicine?*

Gibboney: The short answer is no; I do not think we should undergo a name change. Frankly, I am a podiatric physician, I like to think a good one, and I love what I do. I do not introduce myself as a foot and ankle surgeon or a foot and ankle specialist, I am a podiatrist. As for a degree change, on that I am torn. It would increase the profession's level of parity, and for that reason I would be in favor, but what would the cost be? Would the curriculum taught at podiatric medical school be in addition to traditional allopathic or osteopathic curriculum? Or more than likely it would go away, and residents would enter podiatric residency with no understanding of lower extremity biomechanics or pathology.

I feel that a name change to foot and ankle medicine may broaden our patient base and improve understanding of our profession. Often, when patients I am treating for complex ankle or hindfoot pathology realize I am a podiatrist they are initially confused, and I "enlighten" them as to the full scope of our expertise.

PM: *In the event you are raising a young family, how are you managing a busy work life balance?*

Gibboney: I have a wonderful wife, and three children; Michael (age 7), Elliott (age 4), and Benjamin (age 4). My key to having any work life balance has been set boundaries, or as much as possible. I attempt to always be present when I am home, unless something is urgent, it can wait until after 7 or 8PM when my children are in bed. I do not allow it to cut into my time spent with just my wife, and she is as understanding as she can be. My wife is truly the one who holds our family together and keeps me as honest as possible with my work. **PM**

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.