BY JARROD SHAPIRO, DPM

Podiatry's Dual Personality and Downstream Effects

The battle of the certifying boards is detrimental.

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.

Anyone reading *PM News* recently will be aware of the fight between the American Board of Podiatric Medicine (ABPM) versus the American Board of Foot and Ankle Surgery (ABFAS) regarding the Certificate of Added Qualification in surgery offered by the ABPM. Podiatric physicians should be disheartened by this situation. For those not taking part in the fight, or "in the know," there's understandably anger and frustrations on both sides of that argument, but it is most saddening to see the public nature of the debate.

It's not known if the two organizations discussed the situation before the ABPM's Certificate of Added Qualification went public, but it doesn't appear that way from an outsider's viewpoint. It's unfortunate that this situation went public at all because it may damage the profession. This opens us up to criticism by those bent on limiting our scope, evidenced by the recent ridiculous orthopedic "research" article with poor methodology that tries to compare outcomes between orthopedists and podiatrists.

You can understand these organizations' desires to expand their services (on the side of the ABPM) and desires to protect their turf (on the side of the ABFAS). It's questionable if there is a reasonable solution at all, but a respectful and private discussion and debate would likely have been beneficial. It may already have happened previously—who knows? But the one thing this situation highlights is the never-ending problematic dichotomous nature of the podiatric medicine and surgery profession. Podiatry suffers from a dual personality disorder.

We, as a profession, spend a lot of energy separating these two aspects. We advertise podiatry to potential future students as a surgical specialty, our residency programs have become increasingly surgical, and we have two major certifying boards. These separating actions have important downstream effects.

Alienating Potential Applicants?

A major effect is that we may be inadvertently alienating potential podiatric medical school applicants by pushing the "sexier" surgical side of podiatry, advertising "you too can be a surgeon." Although it's true that podiatrists are surgeons, it doesn't have to be a requirement—we are

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just pushing the profession in that direction. There are plenty of excellent podiatric physicians who don't do surgery and give high quality care to patients in the office. There are some stellar ones, and they are just as effective and important as the surgeons.

The clinical part of my own practice generates a lot of personal pride. You have to wonder that the marketing schemes over the past several years that are failing to bring applicants to our schools—as evidenced by the ever-decreasing applicant pool—could be the result of focusing too much on surgery, eliminating those more interested in the medical side. Consider how many applicants there are to MD and DO schools, realizing that many of them do not want to be surgeons. Most of them go into non-surgical specialties. We are missing out on an entire pool of potential future podiatric physicians at the very time that the need for us is rising.

Our residencies are now unified 3-year podiatric medicine and surgery programs, resulting from the past elimination of the alphabet soup that used to exist. PPMR, POR, and RPR programs are gone, and you can absolutely understand the impetus behind unifying the training so the profession can present a single, consistent appearance to the public. But is it possible that this went a step too far? Perhaps we pushed this unification too much toward the surgical side, regardless of calling our residencies "podiatric medicine and surgery." How many of our resident graduates understand lower extremity biomechanics? Can you count how many times you've heard respected surgeons argue that you have to know biomechanics to be a good surgeon, while at the same time you see decreasing requirements for biomechanics training in residency?

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Surgical vs. Non-Surgical

Why do we keep trying to hide the medical aspect of what we do? It's a fantastic part of the profession. Some of the most famous podiatrists have become so by focusing on the non-surgical side. Kevin Kirby and Doug Richie are two of our best known biomechanists. They didn't become famous by pushing surgery. You can learn more from both of them than from any surgeon, and incorporate much of their teaching into your own podiatric medicine and surgery practice. Similarly, our single best-known podiatrist, David Armstrong, didn't become internationally famous because of his surgical prowess. He's famous and universally respected because of his work on limb salvage, having published an immense amount of work that included both surgical and non-surgical care. You should have the deepest respect for these doctors because their work affects all aspects of our practices, not because any of them are famous reconstructive surgeons.

Now, in reality, the duality of the profession is not black and white. Podiatry is heavily procedural, whether in the office or in the OR, and it's also heavily medical. This is actually one of the great advantages of podiatry as a career—at least for me. Enjoy both aspects. There should be no problem with recognizing the dichotomy between the medical and surgical sides. In fact, we should stop thinking of ourselves as one or the other but rather recognize the equal importance of both sides—and act accordingly.

You should like the fact that there is a medicine and surgical board. Some advocate combining the boards

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into one, which isn't going to happen. Too many people have too much invested for that kind of change, and it would not be good for the profession. We should keep both boards, allowing the surgeons and physicians to attain certification in their respective areas. Whether the ABPM should have an added surgical credential is not for me to decide. You should note that the term "non-surgeon" was used because we should not be defining the medical side by a negative. Vocabulary matters.

Two Types of Residencies

We, as a profession, should also work to provide a reasonable route toward a medical emphasis for those who don't want to be surgeons. No, we shouldn't return to the alphabet soup of the past, but perhaps two types of residencies would be in order. Or perhaps the Council on Podiatric Medical Education should pursue an accreditation system that would allow residencies to create medical and surgical tracts rather than one surgical program. Residency programs could easily convert to this mixed type of training system without changing the size of the program or its quality. In fact, you would likely need to increase the number of residents if this were the case, and the training would be better.

Similarly, podiatric practices and patients would benefit from a medicine/surgery split. Surgeons spending most of their time in the OR would hone their skills to an even greater level, while the same would be true for the non-surgeons. Referrals back and forth is simply better medicine, and our patients would be the beneficiaries of this method. The field of podiatric medicine and surgery itself would benefit with increased quality applicants to the schools, better residency training, better physicians and surgeons, and, hopefully, a more positive interaction between our various leaders. It's a blue sky, naïve view, yes, but we should all remember that the duality between the medical and surgical sides have significant downstream effects, some of which are currently hurting a wonderful profession. **PM**

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