One Certifying Board for

APMA House of Delegates Proposition 2-24 "Single Certifying Board in Podiatric Medicine and Surgery," stated; "It is the policy of the American Podiatric Medical Association (APMA) to support the unification of the two currently recognized certifying boards under a single administrative entity resulting in

The Fallacy of a Single Certifying Board

CPME documents 220 and 230 offer a viable alternative.

BY JAMES R. CHRISTINA, DPM

Editor's Note: *This editorial is written by Dr. Christina, DPM, former Executive Director and CEO of the APMA, as a private podiatrist and represents his personal views only and not those of the APMA.*

In recent years, there has been an increased focus on establishing a single certifying board in podiatric medicine and surgery.

In recent years, there has been an increased focus on establishing a single certifying board in podiatric medicine and surgery. Proponents of this use the American Board of Medical Specialties (ABMS) as the comparative example in allopathic medicine, citing that each area of specialization has a single board. ABMS (abms.org) has 24 member boards that certify physicians (MDs) in 40 specialty and 89 subspeciality areas. There is also the American Osteopathic Association (AOA) that certifies osteopathic physicians (DOs) in 29 specialties and 77 subspecialties. Finally, the American Board of Physician Specialties certifies both MDs and DOs in 21 specialty areas.

The Purpose of Board Certification

The value of board certification is that it provides an ongoing independent evaluation to assure that the physician workforce:

- Is skilled and clinically competent
- Develops their specialty expertise throughout their careers
- Meets the standards of practice established by their peers

The value is demonstrated by the ongoing public interest in seeking out board certified physicians and

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THE *PM* FORUM

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Podiatry: Will It Work?

a single unified certifying board in podiatric medicine and surgery." This was the hot button topic of 2014. We've asked representatives on both sides of this issue to opine on this controversial issue. Part 1 is by Dr. Christina; **part 2 is by Dr. Lee Rogers, which continues on pg 71.**

One Specialty in Podiatric Medicine and Surgery Demands One Certifying Board

It could be an important step towards reaching parity with other allopathic specialties.

BY LEE C. ROGERS, DPM

Podiatry is both a profession and a specialty of medicine. As a profession, the terms podiatrist and its derivatives are legally protected by all 50 states. The scope of practice in all 50 states includes both the medical and surgical treatment of the foot, and in all but two states, the surgical treatment of the ankle. Podiatry is also a specialty of medicine, dedicated to the medical and surgical treatment of the foot and ankle. Podiatrists are credentialed and privileged to treat patients with medicine and surgery at nearly every hospital across the country. The expertise of today's podiatrist is recognized for the treatment of diabetic foot disorders, lower extremity sports medicine, reconstructive surgery, and management of lower extremity trauma, among other in-scope conditions.

As podiatric medicine has evolved through the years, the education and training has also evolved. Since 2004, all podiatric residencies have included both medicine and surgery for two or three years (PM&S 24 and PM&S 36). Since 2011, all podiatric residencies have standardized curriculum to three years of training in the Podiatric Medicine and Surgery Residency (PMSR).

We often compare ourselves to our MD/DO colleagues and efforts to improve and advance our standing in the house of medicine lead us to mirror the standards of our colleagues. Implementation of the three-year residency is the result of these efforts; thus all podiatric physicians now follow the 4-4-3 model of medical training (4 years of undergraduate education, 4 years of graduate medical education, and a minimum of 3 years of post-graduate residency training).

Having two recognized boards for the same training causes confusion and increases costs to podiatrists entering the specialty.

Board certification is considered

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specialists and by the number of hospitals and other healthcare organizations that make board certification a key qualification for medical staff privileges.

Board certification standards exceed the baseline requirements for state medical licensure, assuring the public that physicians demonstrate additional clinical skills, knowledge, and professional behavior to provide safe and high-quality specialty care.

Current State of Board Certification in Podiatry

The American Podiatric Medical Association (APMA) has designated the Council on Podiatric Medical Education (CPME) with the responsibility of recognizing certifying boards. Through their Specialty Board Recognition

The American Podiatric Medical Association (APMA) has designated the Council on Podiatric Medical Education (CPME) with the responsibility of recognizing certifying boards.

Committee (SBRC) they essentially play the same role as ABMS in establishing the standards for initial recognition and continued recognition of certifying boards. These requirements are documented in CPME 220 and 230, which are currently undergoing an update. CPME has chosen to follow the will of the APMA as expressed by their House of Delegates (HOD) to recognize only one certifying board in each area of specialization. This is consistent with the policies of ABMS as well. The two current recognized certifying boards are the American Board of Foot and Ankle Surgery (ABFAS) and the American Board of Podiatric Medicine (ABPM).

With the standardization of residency training to a three-year program in podiatric medicine and surgery, every graduating resident can pursue certification in either or both of the recognized certifying boards. It should be noted that ABFAS provides certification in both foot surgery and reconstructive rearfoot and ankle surgery (RRA). Most current residency programs qualify for their residents to sit for both surgical categories, although getting certified in foot surgery is a prerequisite for RRA. However, all graduating residents have access to foot surgery.

The process for certification by ABPM and ABFAS does differ. Graduating residents can relatively quickly become board certified by ABPM, and this is not unusual compared to allopathic medicine and becoming board certified in a non-surgical specialty. ABFAS requires the graduating resident to gather and log cases in a variety of surgical areas as well as passing didactic

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exams. The case review of surgical cases is consistent with allopathic surgical specialties. For example, the American Board of Orthopedic Surgery requires the applicant to have passed part 1 (written exam), obtained hospital privileges, and then perform cases for 17 months from November 1. Therefore, the earliest they can become certified is 17 months after November 1 of the year they complete their residency training. The oral examination is based on 12 cases from the required case log submission.

Board Certification Prior to the Standardized 3-year Medicine and Surgery Residency

Prior to 2011 and the establishment of a three-year podiatric medicine and surgery program, there were a variety of surgical programs over the years. Some were surgical and some were non-surgical. Completion of the residencies gave access to certain surgical boards. Initially, the surgical board was the American Board of Podiatric Surgery (ABPS). Their original certificate was board

Prior to 2011 and the establishment of a three-year podiatric medicine and surgery program, there were a variety of surgical programs over the years.

certification in Foot and Ankle Surgery. These were pre-1991 diplomates. After that time, certificates were offered in foot surgery and then reconstructive rearfoot/ankle surgery (RRA). ABPS changed their name to the American Board of Foot and Ankle Surgery (ABFAS) that they maintain today. Access to the surgical board has always required completion of surgical residency.

To accommodate those who did not complete a surgical residency (and there were not enough to allow all graduates to obtain a surgical residency), non-surgical residencies were developed. While these programs did involve some surgical exposure, they did not meet the criteria to be classified as surgical programs. As you can see in Chart 1, these included a rotating podiatric residency (RPR), a podiatric orthopedic residency (POR), and a primary podiatric medical residency (PPMR). The non-surgical board was the American Board of Podiatric Orthopedics (ABPO), then the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM), and then eventually the American Board of Podiatric Medicine (ABPM). As the transition to a 3-year medicine and surgery program was made, there were opportunities for those that did less than three years of residency training to become

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certified by the board(s) they were eligible to pursue. However, there was a time limit on the ability to take advantage of this opportunity and eligible providers were contacted multiple times to make them aware of this window of opportunity and that it would close.

Of this group, this left those that did not complete any residency, that completed a residency that did not have a pathway to certification, and those that failed to pass or meet the case requirements or did not complete the process in the allotted time frame, all unable to become certified.

Board Certification Becomes a Necessity

For many years, board certification was an added credential that a provider could obtain to give their patients confidence that their doctor had reached a certain level of proficiency. This was true for all of medicine. However, at some point, probably in the mid-2000s, board certification became a requirement to get on insurance panels and to become a member of a hospital staff, particularly regarding surgical privileges. It should be noted that hospitals that participate with Medicare, and the majority do, are not supposed to be able to use board certification **as the sole factor** for determining access to hospital staff or privileges, although it can be one factor among the requirements. This does not mean that this rule is always followed.

At some point, probably in the mid-2000s, board certification became a requirement to get on insurance panels and to become a member of a hospital staff, particularly regarding surgical privileges.

It should also be noted: the change in how board certification was being used was not directed by the certifying boards, but by other entities, particularly the insurance companies.

Why a Single Certifying Board in Podiatry Will Not Accomplish What Many Believe or Desire

There are two camps regarding a single certifying board in podiatry. There are those who believe that would mean one certificate in Podiatric Medicine and Surgery. The other camp sees a single administrative body that still issues separate certificates in Podiatric Medicine and in Surgery. Let's examine the two possibilities.

Issuing one certificate in Podiatric Medicine and Surgery would still require a period for a graduating

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CHART 1

CATEGORY	YEAR BEGAN	YEAR ENDED
First- Second- & Third-year Residency Also identified as R-1; R-2 & R-3	1964	1988
R-24 & R-36 Multi-Year Residency	1982	1988
(RPR) Rotating Podiatric Residency	1984	2008
(POR) Podiatric Orthopedic Residency	1984	2008
(PPMR) Primary Podiatric Medical Residency	1993	2008
(PSR-12) 12-month Podiatric Surgical Residency	1984	2008
(PSR-24) 24-month Podiatric Surgical Residency	1984	2008
(PSR-24+) 24+month Podiatric Surgical Residency	1986	1992
(PSR-24 or more) 24-month or more Podiatric Surgical Residency	1993	1997
(PM&S-24) Podiatric Medicine and Surgery-24	2004	2013
(PM&S-36) Podiatric Medicine and Surgery-36	2004	2013
(PMSR) Podiatric Medicine and Surgery Residency	2011	ongoing
(PMSR/RRA) Podiatric Medicine and Surgery Residency with Reconstructive Rearfoot/Ankle Surgery	2011	ongoing

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resident to perform and log surgical cases on their own and then go through some sort of case review. To not do this would raise concern from our allopathic surgical colleagues who must go through the accumulation of their own cases and some sort of review. This now delays the time frame to achieve board certification (remember currently the pathway to certification from ABPM is short) for all graduating residents. Also, there is the risk that those who have no desire to do surgery would now have no pathway to board certification. This would create a new group of doctors with no access to certification. It would not address the ability of those who are currently unable to access certification to gain access. It would not allow those certified by non-CPME recognized boards to somehow be absorbed into this new entity as CPME rules would not allow it. It could potentially cause more confusion for the public and other entities, as some podiatrists would have the prior certificates while others would have this new certificate.

Forming a single administrative entity that issues certification in Podiatric Medicine and in Surgery would avoid the issue of non-surgical podiatrists becoming board certified. It could potentially reduce costs for those who go through the certification process and allow more cooperation between the examinations for medicine and surgery, particularly in residency training. However, there would be very complex administrative obstacles to merging the current recognized boards into a single entity and it would require the desire of these two separate corporations to merge. It would also require approval from the CPME.

The addition of the language in 6.3 now opens the door for the recognized certifying boards to establish a pathway for those who did not complete a 3-year residency training program.

What Is the Answer?

How do we address the issue of those who never had access to certification, but now find themselves unable to get on insurance panels or are threatened with removal from hospitals where they have long been on staff? There are podiatrists who got their training from non-residency pathways and were able to obtain hospital privileges and have been providing good surgical care for some time for their patients. The changes in requirements for insurance panels and hospital privileges now leave them in an untenable position through no fault of their own. There are also those who did not complete a 3-year residency program and find themselves unable to become certified.

CPME is currently re-writing documents 220 and 230 that address specialty board certification. In its current re-write, the following is included:

6.2: The specialty board shall require candidates for initial certification to have successfully completed a minimum of three years of CPME-approved residency training. This criterion is waived for the founders group of the specialty board.

6.3: ***The specialty boards shall establish well-defined, rigorous, transparent, and equitable alternative pathways for initial board certification for those candidates that do not qualify under 6.2.***

The addition of the language in 6.3 now opens the door for the recognized certifying boards to establish a pathway for those who did not complete a 3-year residency training program. This is significant and has the potential to address the problems that some podiatrists face regarding board certification. Now it will require the certifying board to establish these pathways and they will need to be approved by CPME, but it is a step towards helping those who currently cannot access board certification.

Issuing one certificate in Podiatric Medicine and Surgery would still require a period for a graduating resident to perform and log surgical cases on their own and then go through some sort of case review.

Conclusion

The issue of board certification for podiatrists is complex. However, moving to a single certifying board that issues a single certificate in Podiatric Medicine and Surgery is not the solution. The current process is working, giving access to the recognized boards to all graduating residents. The proposed changes to CPME documents 220 and 230 have the potential to address the issues for those who do not meet the current requirements to access the recognized boards. If there are issues with the current recognized boards' examinations or case reviews, these can be addressed with the specific boards. We can improve the current processes while maintaining the integrity of the certificates that the recognized boards issue. PM

Dr. Christina is former Executive Director of the American Podiatric Medical Association.

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a voluntary process; but in reality, without certification, a physician's ability to practice to the fullest extent of their training and their earning potential is severely limited. Therefore, board certification is a necessity and it should be fair and test the standard of the residency program curriculum, not some other nebulous, higher standard.

The redundant practice of two boards in podiatric medicine and surgery is historic and has no basis in modern practice. Before 2003, there were multiple residency types including Rotating Podiatric Residency (RPR), Primary Podiatric Medicine Residency (PPMR), Podiatric Orthopaedic Residency (POR) (all 12 months in length) and Podiatric Surgery Residency (PSR) for 12, 24, or 36 months. At that time, since the experiences of each residency were vastly different, it made sense to have multiple certifying boards with various certifications.

But now, with only one standardized residency program in Podiatric Medicine and Surgery, there is no need for multiple boards that certify in only part of the residency curriculum. In support of this fact, there are no comparisons in MD/DO certifying boards. For example, when a resident completes an accredited radiology residency program, there is one recognized board that certifies in the entirety of the curriculum, the American Board of Radiology. The same is true for every other medical specialty. This is also true for specialties that have mixed training in medicine and surgery (or procedures), like obstetrics/gynecology, ENT, ophthalmology, and urology. A resident who completes an accredited residency in ophthalmology sits for board certification in the entirety of the residency curriculum, regardless of whether or not they choose to dedicate their practice to the medical portion of ophthalmology and forgo performing surgery in practice.

The *status quo* of two boards for the same specialty and same residency curriculum is harmful to our profession. Firstly, it creates a system that confuses hospitals. According to CMS Conditions of Participation, which is codified in federal law, hospital privileges are to be determined by a physician's education, training, and experience. While board certification can be an element of privileging, it cannot be the sole criterion and it must be certification in one's primary specialty. The primary specialty is defined by CMS as the first certification a physician is eligible for after their first residency. This would mean that after a Podiatric Medicine and Surgery Residency, since a graduate is eligible for both ABPM and ABFAS, either would qualify as certification in one's primary specialty. But there are hospitals that require one board over another for privileging, which is harmful to young podiatrists seeking staff privileges at hospitals.

If one board cannot be achieved, the answer might be two equal boards that certify in the entirety of the residency curriculum.

This discrepancy fosters anti-competitive behavior from podiatrists already holding staff privileges at a hospital and also from the boards themselves. In 2022, ABFAS sent a letter to all its Diplomates asking them to take it to their medical staff/credentialing committees, which stated that only ABFAS should be recognized for surgical privileges.

The confusion of two certifying boards in podiatry was cited by the American Medical Association in an article last year that has since been retracted due to the advocacy efforts of the APMA. In that article, the AMA wrote that podiatry having two boards made it difficult to determine their qualifications.

Two certifying boards makes it unnecessarily expensive for young podiatrists entering practice. Not only do residency programs pay more for two in-training exams, but young podiatrists pay for multiple certification processes costing them multiple thousands of dollars. Additionally, the cost to maintain two certifications with dues and maintenance of certification is expensive.

Even before someone chooses to become a podiatrist, they often conduct online research about the profession. Many prospective students read the Student Doctor Network blogs which are full of comments about the unnecessary duplication of certifying boards, the high cost, the differences from MD boards, and even the fact that a podiatrist may be denied surgical privileges. This exposure leads to added cautions from potential students about choosing podiatry as a career.

The reality is that it is extremely difficult to obtain ABFAS certification. Being more difficult does not mean that it is fair or a reasonable assessment of competence. ABFAS requires that podiatrists pass six tests in total to become certified in the entirety of the residency curriculum, which includes both foot surgery and reconstructive rearfoot and ankle (RRA) surgery. Sadly, ABFAS is not transparent about their pass rates, often publishing only the pass rate of a single exam, but not how many podiatrists make it all the way through all six tests, which would be the actual pass rate of the certification process. In 2022, based on published passing rates of individual tests, I calculated that the actual pass rate for RRA could be no higher than 32%.

Furthermore, no MD/DO specialty board has multiple levels of certification for the same residency program. The American Board of Radiology does not have different tests for x-rays and MRIs. This creates a tiered system and adds more confusion to one's certification.

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One Specialty *(from page 71)*

I respect Dr. Christina's presented opinion, but it is merely that, his opinion. His views are contrary to the official positions of the APMA, as the House of Delegates passed two policy propositions in 2024 supporting a single board in podiatric medicine and surgery. Podiatrists have also responded to *PM News* polls in which they overwhelmingly supported a single board in podiatric medicine and surgery.

One of the policy propositions which passed the House of Delegates with 63% of the vote was Proposition 2-24 "Single Certifying Board in Podiatric Medicine and Surgery," which stated; *"It is the policy of the American Podiatric Medical Association (APMA) to support the unification of the two currently recognized certifying boards under a single administrative entity resulting in a single unified certifying board in podiatric medicine and surgery."* Proposition 2-24 had nearly 2,000 individuals request to co-sponsor the proposition, the first time in the profession's history individuals spoke in such defining numbers co-sponsoring a policy proposition.

The passage of Proposition 2-24 resulted in the One Board Task Force convened by the APMA. However, at the time of this writing, the task force has been dissolved after just two meetings due to ABFAS's complaints that merging the boards into one would be a violation of the Sherman Antitrust Act of 1890. ABFAS could not answer how a single recognized certifying board in podiatry would be a violation of the law, but a single recognized certifying board in any other medical specialty is not a violation.

In our specialty, there needs to be one certification for podiatric medicine and surgery, certifying in the entirety of the PMSR curriculum. Only then will we obtain parity with our MD/DO colleagues for our certification standards.

However, if a single certifying board is not possible due to ABFAS's claims that this would reduce competition among boards, then there must be two equal boards in the specialty that certify in both podiatric medicine and surgery, creating the competition that ABFAS desires and allowing podiatrists to use the free market to choose which certification to possess. At the APMA House of Delegates in 2025, there are proposed propositions to modify the APMA governance documents to create just that. I encourage you to reach out to your state's delegate to the APMA HOD and ask for their support in establishing two equal recognized boards, ABPM and ABFAS, to certify in the entirety of the residency curriculum, including podiatric medicine and surgery. With your help, we can move podiatry forward. **PM**

Dr. Rogers is the immediate past president of the American Board of Podiatric Medicine (ABPM). He is the Chief of Podiatry at the University of Texas Health Science Center at San Antonio and the vice president of the International Federation of Podiatrists (FIP).