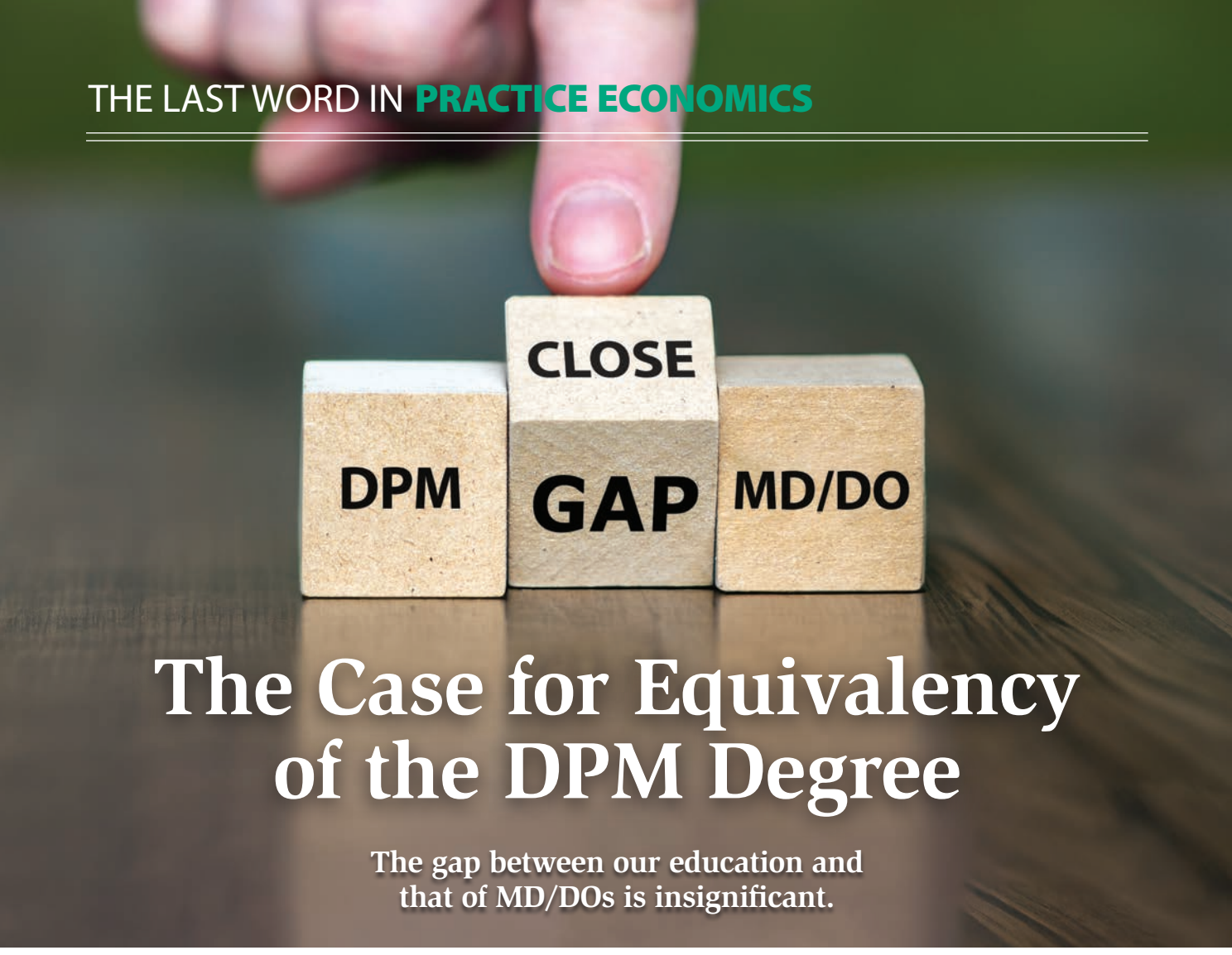


# The Case for Equivalency of the DPM Degree

**The gap between our education and that of MD/DOs is insignificant.**

BY JON A. HULTMAN, DPM, MBA

On November 2, 2018, I attended APMA's combined meeting of the Carrier Advisory Committee (Medicare) and the Private Insurance Advisory Committee (CAC/PIAC) in Baltimore, Maryland. A number of industry speakers were featured, covering the full spectrum of reimbursement issues. One of the speakers, Robert Kettler, MD, spoke on the topic, "Working with Carrier Medical Directors." For attendees at the meeting, this was an important topic; however, in his opening remarks Dr. Kettler touched on a secondary issue that was most significant—the ever-increasing volume of medical knowledge. He stated that up until 1950, medical knowledge had doubled approximately every 50 years and related that this timespan was shortening significantly. As of 1980, the doubling of information was taking place every 7 years, and by 2010 this timespan had reached 3.5 years.

Incredibly, today, medical knowledge is doubling every 73 days! A similar early prediction made by an emeritus professor at University of Iowa Health Care, Peter Densen, MD, was as follows, "What is typically being learned in the first three years of medical school will amount to only 6% of all that is known in the medical field by the end of 2020. Knowledge is expanding faster than physicians' ability to learn, assimilate, and apply it effectively." Taken aback by the information put forward at this meeting, I began to wonder just how this might impact medicine in the future.

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**—Peter Densen, MD**

What has resulted from this rapid accumulation of knowledge is an exponential growth in the number of medical specialties and

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sub-specialties. To put this in context, picture a family in the 1950s. This family typically had a primary and, frequently, only doctor who was a general practitioner. She/he (most likely a he) treated a wide range of conditions affecting both children and adults. This doctor often provided what now are specialty services such as delivering babies, treating injuries, and performing or assisting on surgeries. A general practitioner was expected to know everything. The rapid growth of medical knowledge made this ever-more challenging, necessitating more and more specialization.

While it is difficult to ascertain the current, exact number of specialties and subspecialties, the American Board of Medical Specialties (ABMS) now recognizes 24 specialties of medicine, along with 136 subspecialties. As the sheer volume of medical information continues to double, many more of these subspecialties will emerge. This is even happening within our own specialty, which was once itself considered a subspecialty by many.

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This rapid growth in medical knowledge has resulted in tremendous repercussions for practitioners attempting to keep up with the "latest." Obviously, it is not possible to stay current with "everything" or for medical students to be taught all that there is to know. Even specialists have adapted to this growth by honing their practices to specific areas within their own specialties. These sub-specialists, in turn, are forming their own groups that offer a broad range of services within these sub-specialties. Breaking specialties down even more has enabled groups to focus on keeping up with an ever-expanding range of services. An effective tool has been developed to assist doctors in this struggle to "stay current." There has been rapid innovation in the development of medical records. The tool of electronic medical records now offers practitioners an efficient way of addressing this ever-growing amount of knowledge. It puts ac-

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cessibility to essential information and decision support systems at their fingertips in real time, assisting them in their task of "staying current."

Though this rapid growth in medical information does pose a challenge to all practicing physicians, for our specialty in particular, there is serendipity to be found within this challenging environment. Specifically, podiatry has the potential to offer insights into other specialty disciplines in the areas of education, training, and licensing. Because we have been a specialty group from our inception, the model used to educate and train podiatric physicians could well become a future model for other specialists and sub-specialists to emulate.

Due to the rate of the introduction of new knowledge, simply adding more material and/or time to medical school curricula will not suffice as an effective coping strategy; this rapid growth phenomenon necessitates a fundamental change in the way doctors are being educated and trained. Here is where podiatric medicine has something to offer—we have developed a model that can serve as a prototype for other specialties. Over the past 100 years, podiatric educators have developed a pathway different from that followed by traditional medicine. The primary reason for this is that, unlike medical students, from podiatry's inception, its students have selected their specialty at the "front end" of their educational process. This has called for a different sequencing of coursework as well as a difference in the content and sequencing of medical, surgical, and podiatric rotations throughout the students' residency training.

"Innovative" training programs that are being established for medical students today are structured similarly to the traditional podiatric pathway—programs in which students are allowed to declare a specialty early in their training. The structures for these "new" training programs are relatively similar to that which was developed by the podiatric profession for its medical schools and residency programs several decades ago—a model which makes more sense for students who focus on a specific specialty or subspecialty early in their educational process. Indeed, much medical training is becoming more like that employed by podiatric medical schools.

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An example of the changing education of physicians is that some schools have shortened medical education to three years for those interested in primary care. The goal to be achieved by structuring these programs in this way is to fill the current need for more primary care physicians. The thinking is that because this will enable these students to begin their residencies and enter practice sooner, more will choose primary care as their specialty. More recently, some orthopedic programs have also begun testing programs that allow students wanting to become orthopedic surgeons to enter orthopedic training programs sooner in their coursework. Clearly, when students choose their specialty at the "front end" of the educational process—as do podiatric physicians, new pathways can be created to best train and prepare those students for their specific specialty. The more specialized we become, the more these "new" pathways become relevant, and the more similar they become to the model already being utilized by podiatric medical schools.

Whether it has been by design or has been market-driven, since 1950, the education and training for DPMs, MDs, and DOs have all evolved. It is likely that much of this evolution leading to specialization and sub-specialization has had to do with this ever-increasing volume of medical information.

Currently, a gap that may have existed fifty years ago between the education, training, and practice of MDs and DOs and that of DPMs is narrowing each year—evolving to the point at which all now frequently intersect. For all intents and purposes, the end products of medical, osteopathic, and podiatric educational processes—MD, DO, and DPM degrees, are equivalent and indistinguishable. The only difference now is the license that they receive. If logic were to prevail, the three degrees would not only be equivalent—all would hold the same plenary license, and the specialties and subspecialties of all would be recognized by ABMS. PM

**Dr. Hultman** is the president of Medical Business Advisors, specializing in practice evaluations, practice valuations, and mergers. He is the author of *Reengineering the Medical Practice* and *Medical Practitioner's Survival Handbook.*