
Brian J. Burgess, DPM


Ronald Guberman, DPM


Jason N. Atves, DPM


Kiera Benge-Shea, DPM


Lee C. Rogers, DPM

Podiatric Fellowships

What they are, and should you pursue one?

BY STEVEN SHALOT, DPM

As the profession of podiatric medicine became more specialized at the end of the last century, the concept of fellowships was put into practice to mirror those in allopathic and osteopathic medicine and surgery. It was then that the CPME along with the ACFAS began to formalize standards in the early 2000s. More specialized fellowships emerged focusing on specific areas of podiatric surgery such as MIS and rearfoot procedures. These were often combined with advanced training in wound care and limb salvage—especially diabetes.

In this roundtable, we asked five fellowship directors about their programs, and what the fellows could expect from their training. A last question on billing and coding was asked to show to the podiatric community how these fellowships prepare the fellows for the real world of podiatric practice. This information is especially valuable to students and residents who may desire such training to further their careers. Here is this month's panel:

Brian J. Burgess, DPM, Joliet, IL: Dr. Burgess is a 2009 graduate of The Scholl College of Podiatric Medicine and Surgery at Rosalind Franklin University. He is the Fellowship Director at the Illinois Bone & Joint Institute (IBIJ), Foot and Ankle, Hinsdale Orthopedics. He completed his undergraduate studies at the University of Illinois. Outside of his duties, Dr. Burgess enjoys golfing and spending time with his family.

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Ronald Guberman, DPM, Brooklyn, NY: Dr. Guberman is a 1987 graduate of The New York College of Podiatric Medicine (Touro University) and is the Fellowship and Residency Director at Wyckoff Heights Medical Center in Brooklyn, NY. He has been in private practice for over thirty-six years, where he sees a full range of podiatric patients. His interests include academia and current innovations in podiatric medicine and surgery. When not practicing, his interests include spending time with family, and sports.

Jason N. Atves, DPM, Washington, DC: Dr. Atves is a 2015 graduate of Kent State University College of Podiatric Medicine, Independence, Ohio, and is the Fellowship and Residency Director at MedStar Health, Washington DC. His podiatric interests include gait analysis, deformity corrections, external fixations, tendon transfers, and fusions. When he isn't in the clinic or the operating room, he loves carpentry, woodworking, gardening, travel, and hiking.

Kiera Benge-Shea, DPM, St. Louis, MO: Dr. Benge-Shea is a 2020 graduate of the Des Moines University College of Podiatric Medicine and Surgery. She is currently the Assistant Director of the Center for Advanced Foot and Ankle Surgery Fellowship in St. Louis, MO. When not busy working with residents and fellows, she enjoys spending lots of time outdoors with her dogs, cooking at home with her husband, and traveling.

Lee C. Rogers, DPM: Dr. Rogers is a 2004 graduate of the Des Moines

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College of Podiatric Medicine and Surgery, is presently the Chief of Podiatry at the University of Texas Health in San Antonio, TX, where he is a Louis T. Bogy Professor of Podiatric Medicine and Surgery, and an Associate Clinical Professor of Orthopedics at the UT Health Center San Antonio. He is the immediate past President of the American Board of Podiatric Medicine, Fellow Faculty in Podiatric Medicine at the Royal College of Physicians and Surgeons, Glasgow, Scotland. He is an Associate Editor of The Journal of The American Podiatric Medical Association, and Vice President of The International Federation of Podiatrists (FIP). Outside of the podiatry arena, he enjoys spending time with his family and enjoying all the things San Antonio has to offer.

PM: *What is the focus and scope of your program? Tell us about the typical case diversity (especially reconstructive surgery, diabetic limb salvage, sports medicine, trauma).*

Guberman: The focus of our program is wound care. It is a CPME-approved fellowship in wound care. The scope is mainly related to wounds of the foot, ankle, and leg, but there are also days when the fellows work with vascular surgery and our general surgery wound care team. We are certainly focused on limb salvage. We also try to include as many existing and and newer technologies and therapies in our program. The academic and clinical program reflects this with ongoing changes and updates as well as lectures, presentations, and conferences. Research is also a requirement for our fellows. We have a large volume of patients with a diverse set of issues that require a wide variety of elective, urgent and reconstructive surgery, and trauma surgery. Surgery is optional for the fellows.

We refer to our program as a "choose your own adventure."—Benge-Shea

The Amputation Prevention and Research Fellowship is a twelve-month CPME-approved fellowship that focuses on the medical management and surgical treatment of the complex patient at risk for limb loss.—Rogers

Burgess: Our fellowship program at the Illinois Bone and Joint Institute (IBJI) has a strong surgical focus and scope. Being affiliated with such a large orthopedic and musculoskeletal group affords a great variety and volume of surgical pathology. The fellow has the opportunity to work alongside several other surgical DPMs and foot and ankle orthopedic surgeons. The program is well balanced between reconstructive surgery, sports medicine, and trauma cases. There is very little limb salvage, with the exception of an occasional on-call case. In recent years, our fellows have matriculated with over six hundred surgical cases.

Atves: Our fellowship program aims to deliver a well-rounded world-class educational training experience, primarily focused on multi-disciplinary patient care with an emphasis on reconstructive limb salvage. In this way, we offer a truly unique approach to patient management which combines podiatric, plastic, and vascular specialties into a cohesive multidisciplinary team which we feel is the 'gold standard' for advanced and complex patient management. Our fellows have access to a multitude of case diversity and complexity, ranging from infection and limb salvage to advanced and complex limb reconstruction involving osseous and tendon reconstructions, external fixation, soft tissue including flap reconstructions, and open and endovascular procedures, as well as elective reconstructions including total ankle replacement (TAR). These experiences act as a platform for the fellow's required research interests, projects, and publications.

Benge-Shea: The Center for Advanced Foot and Ankle Surgery Fellowship was designed to augment what is already learned in residency and fill in any gaps that residency graduates may feel that they have. We refer to our program as a "choose your own adventure." We have several high caliber/high volume orthopedic surgeons who are extremely podiatry-friendly, and who provide complex rearfoot and ankle/leg reconstruction and trauma cases. We have a plastic surgeon who does many lower extremity reconstructive flaps. We also have several practitioners, our director included, who have built long-standing successful private practices. We have the ability to provide learning opportunities centered in whatever the fellow is looking to have exposure in.

Rogers: The University of Texas at San Antonio has two fellowship programs, one in Amputation Prevention and Research and the other in Diabetic Foot Research.

The Amputation Prevention and Research Fellowship is a twelve-month CPME-approved fellowship that focuses on the medical management and surgical treatment of the complex patient at risk for limb loss. This is one of the oldest podiatric fellowships in the U.S., founded in 1993. We are also home to the oldest residency program in continual existence since 1972. There is no case diversity outside of the fellowship focus, but the fellow will gain a diversity of experience in wound management, inpatient infection man-

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agement, chronic limb-threatening ischemia, diabetic foot surgery, and Charcot foot reconstruction.

The fellow has a dedicated clinical rotation with vascular surgery, orthoplastic surgery, and hyperbaric medicine. The fellow will meet the criteria to obtain and test for the UHMS Certificate at the completion of the program. The fellow has opportunities to work on research projects, engage in speaker development, and publish papers. The fellowship director is Collin Pehde, DPM, and we accept two fellows annually on August 1st. The fellow is paid a UT-standardized PGY-4 salary plus benefits, which in 2025 is $78,000 per year.

The Diabetic Foot Research Fellowship is directed by Lawrence A. Lavery, DPM, MPH, and is one to two years in length. It accepts one fellow annually with a variable start date and the fellow may either be a U.S.-licensed DPM or foreign MD, PhD, or podiatrist. This fellow gains tremendous experience in clinical trial design, research protocol, and publishing. This fellowship is somewhat individualized to the research interests of the fellow. UT was recognized as the most productive institution in the world for diabetic foot research over the past decade. Our faculty publish about thirty manuscripts per year and lecture at major national and international conferences. The fellow's salary is dependent upon their years of training (domestic or foreign) and scaled to UT standards.

PM: *What is the typical applicant to your program looking for? Is there a shift towards a career in academia, hospital, private practice? Can you give us some examples of previous fellows' experiences?*

Burgess: We favor applicants to our program who come from a well-rounded surgical residency program. It is one of our main objectives to elevate the fellow's surgical skills and medical decision-making, and it helps when they are starting with a strong base. Applicants are hopefully open-minded when it comes to their future employment opportunities. We have placed our past fellows in a variety of practices, including several in orthopedic groups, several in multiple specialty groups, and one in a hospital setting. Our past fellows have found success in finding employment in Illinois, Wisconsin, Indiana, and Colorado.

Guberman: Applicants to our program have to have a great interest in wound care. Beyond that, some are interested in using this in their private practices, others to obtain hospital positions full or part time, others to work at wound centers both hospital-based or free-standing. Some are interested in academia and resident education. We have residents who have done and are doing all of these things. The graduates have communicated to me that they felt the program was very good and prepared them well for their patient management and have helped them in their careers; and that has made us want to continue with the program.

We have had multiple fellows successfully navigate into positions in larger group practices, hospital-based practices, and academic positions directly out of fellowship.—Atves

Atves: By far, the most common interest of our applicant pool has been a desire to pursue a career in academia, hospital-based practice, and larger or multidisciplinary group practice. However, and understandably, these types of jobs are traditionally more selective and sparsely available. That said, and after much effort in the job search processes, we have had multiple fellows successfully navigate into positions in larger group practices, hospital-based practices, and academic positions directly out of fellowship. Most recently, our immediate past fellow accepted a position in an expanding hospital practice within our health system.

Benge-Shea: Our typical applicant is someone who has a good surgical base but is looking to expand their knowledge in more complex and revision cases. I was the first fellow, and I am able to provide my experience: I wanted to have a higher degree of understanding and exposure to complex hindfoot cases and revisional cases to increase both my knowledge and comfort in managing difficult cases. I logged over four hundred cases in my year, mainly total ankles (and revisions) and reconstructions, both from a planned and trauma-based approach.

I also wanted to have more guidance in practice management and billing/coding. I chose to pursue a position in private practice that has a heavy hand in education with involvement with both a residency program and this fellowship. Our more recent graduates have pursued more reconstructive cases during their time with the program and have secured positions in private practices as well, although there has been consideration for hospital work.

Rogers: While past matriculants of the Amputation Prevention and Research Fellowship have practiced in all settings, we steer the fellow toward a career in academic medicine and hospital/program leadership. Previous fellows are currently leading clinical programs at hospitals or academic programs at universities. Some have been society or association presidents, and have taken roles in the American Diabetes Association, the National Institutes of Health, and the Food and Drug Administration. David Armstrong, DPM, PhD, MD is a graduate of the fellowship and is the most published podiatrist in the world.

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Q ***PM:*** *Are there any opportunities for teaching and interacting with residents? For example, what is the fellow's role in teaching the residents, if any, and what percentage of cases involve the residents?*

Burgess: There are many opportunities for the fellow to be involved in medical education. Annually, our fellow is invited to present at several CME-accredited medical conferences. As faculty of these meetings, the fellow receives excellent external mentorship and guidance from experienced speakers. Unfortunately, there is little interaction with residents within our fellowship program, and less than 10% of the fellow's surgical cases involve a resident. Lastly, the fellow does provide guidance and works in tandem with our summer research intern to assist with data collection and manuscript preparations.

Guberman: The residents and fellows work closely together and generally partner when it comes to wound care. The fellows do teach and assist the residents, especially the first and second year residents. We have the teaching going in all directions as it should be. Sometimes someone has an idea or insight that can be shared, noted, taught. This is true for attendings, residents and fellows, and we encourage this interactive environment as ultimately it will be best for the patient and all of us.

Atves: YES! Opportunities to work directly with students and residents abound! Not only does our fellow work directly with podiatry students and residents but also medical students from across the country, including Georgetown University, and residents across multiple specialties including plastic surgery, vascular surgery, orthopedic surgery and general surgery, to name a few. In the OR, the fellow scrubs with residents 100% of the time, with rare exception. As a priority of the fellow's experience, it is incumbent to treat every experience as a learning experience not just for themselves, but for the residents and students alike. The fellow has much interaction with residents and students in the performance of research in a multitude of scenarios. This is an important understanding and reflective of our commitment to the collective educational experience of all trainees.

Motivated, self-learners are drawn to our program, and we feel that this approach has been successful to date.—Burgess

Benge-Shea: There is a large opportunity for teaching in this program. Our private practice, Missouri Foot & Ankle, allows for one resident (from the local program) to rotate with us at a time as a private practice rotation. During this rotation, they work under the fellow (as their attending) helping the fellow with rounds and acting as their first assist in cases. In the past, the fellow has even led academic sessions and helped teach labs for the residents. There is no dual coverage between the residency and fellowship in regard to the orthopedic or trauma cases, so there is no fighting for the knife, so to speak. However, there is an opportunity to work with residents as a more senior physician.

Rogers: The amputation prevention and research fellow is considered "junior faculty" and is directly involved in teaching residents and students. The goal of the fellowship is to aid in the development of teaching and leadership skills. All surgical cases scrubbed by the fellow involve residents and students. In many cases, the fellow will be directing the instruction of the resident during the surgery. In more complicated surgical cases, the fellow will be learning from faculty.

Q ***PM:*** *As a director, what is your teaching style and the program's approach to learning? What opportunities are available for independent learning and mentorship with the different attendings?*

Burgess: Motivated, self-learners are drawn to our program, and we feel that this approach has been successful to date. The weekly surgical volume does not allow for much time for face-to-face didactics. However, as a program, we participate in a large volume of local, regional, national, and international conferences, ensuring that the educational volume remains very high and the content is of a high level.

Guberman: It's hard to specifically define a teaching style but I would say that I try to listen, observe, and also lead by example, share my knowledge insights and opinions, and offer feedback to the fellows continuously. I often let the fellows evaluate the patients by themselves and sometimes with me to offer different approaches. I will also evaluate them and their assessments, review patient labs and studies, results etc., and we will create a plan together. I want to encourage them to be independent. That is the goal. But I realize as well that they need to work as a team member at present and in the future. We have an active and excellent complement of attendings who actively see and treat wound patients, and this helps our fellows see and learn different styles, points of view and opinions on evaluation and treatment that we often discuss. We highlight evidence-based medicine as a rule.

Atves: Perhaps the most poignant of all questions. Our collective approach to Fellowship training is a 'fellow first' mentality. Fellowship represents an experience that should offer training experience above and beyond that which might be normally experienced during residency. But there is a careful balance of autono-

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my and close and direct mentorship. Fortunately, combining the fellowship with our already extensive and burgeoning network of educational opportunities, both with and without direct patient care, creates an environment that affords the fellow significant flexibility in exposure to a multitude of experiences, be it in the ORs, clinics, or in any number of research projects and publications.

Benge-Shea: Dr. Holtzman and I both approach this program with the idea that you get what you want out of it. There is plenty of work and cases to perform, but there are few mandatory times carved out during the week, which allows for the fellow to choose what they want to be seeing and doing. An average work week with our program goes as follows:

- Monday: Surgery with Dr. Holtzman in AM, opportunity for trauma or hospital cases in PM
- Tuesday: Option of clinic with Dr. Holtzman to work on billing/coding/practice management all day, trauma cases, plastic surgery cases, or the wound care clinic.
- Wednesday: Cases with Dr. Buck Smith (a Foot and Ankle Ortho), trauma cases with Dr. Wang (a trauma ortho who worked with podiatry in fellowship), or clinic with Dr. Holtzman.
- Thursday: Fellow's clinic in the AM (consists of their own post-ops or patients that were curated by other physicians), inpatient or trauma surgery in the afternoon
- Friday: Surgery with Dr. Smith, clinic with Dr. Holtzman, or Dr. Wang

Our most recent fellow, Daniel Narowitz, DPM, completed research with Dr. Smith, which is scheduled to be published later this year. We are working on establishing additional research protocols for projects that will be available for our current (and future) fellow to take part in.

Rogers: As Chief of Podiatry, I am responsible for the clinical training, research strategy, and operations for the entire Division of Podiatry at the University. The directors of the two fellowships are Collin Pehde, DPM and Lawrence A. Lavery, DPM, MPH. We truly believe in providing solid mentorship and that mentorship extending beyond the years of the fellowship. Our faculty still serve as mentors to residents and fellows who have previously graduated. We were formerly known as the University of Texas Health Science Center at San Antonio (UTHSCSA) before merging with University of Texas at San Antonio (UTSA) in September 2025, becoming the third largest university in Texas. Post-merger, there are tremendous resources among all specialties and disciplines of medicine and science available to self-directed learners.

We have a very good camaraderie and want to ensure the success of our people.—Guberman

PM: *Does your program provide any business experience for the fellow in the day-to-day running of a podiatric practice, such as billing and coding?*

Guberman: We have had an ongoing series of presentations on coding and billing, and several of our attendings also teach about running a practice and share ideas and pearls with the fellows. We have a very good camaraderie and want to ensure the success of our people.

Atves: Yes—the fellow may join in any number of multiple established clinics with physicians of varying years of experience, including physicians who have been practicing between 5 years to 30 plus years, as well as varying foci, including purely podiatric, plastics, orthopedic, vascular, dermatology, rheumatology, and multidisciplinary clinics. In this way, the fellow has exposure to a multitude of patient populations, structures, management patterns, and billing and coding practices which are aimed at providing ample experience for beginning individual practice.

Burgess: We offer the fellow several opportunities to help develop their business experience as it pertains to running a practice. We view this as a very important part of the fellowship and something that is currently lacking at the residency level. We provide support for the fellow to attend the annual ACFAS Billing and Coding Seminar at the ASC. The fellow also gains frontline experience running their own clinic and is required to submit their own charges and affiliated diagnosis codes. The fellow is also educated and eventually involved in the decision-making process as it pertains to ASC vs. hospital procedures, DME, and ancillary services.

Benge-Shea: Our program was built with the goal of providing the education that Dr. Holtzman and our partners wish they had when they graduated. Dr. Holtzman specifically strives to ensure that at the end of the fellowship year, our graduate feels comfortable billing and coding in both office and clinic and can see their desired volume of patients each day with their time managed well enough that they are not left with a stack of notes to complete at the end of the day. As someone who has matriculated through this program, I can confidently say that this objective is met.

Rogers: The residents and fellows get experience and insight into documentation standards, coding best practices and ethical billing. They also receive insight into the RVU system and hospital and academic center employment. PM

Dr. Shalot is a well-published freelance writer specializing in a wide variety of topics, such as podiatric medicine, health and technology, geopolitics, and Jewish and Israeli news. He is a former senior editor of *Podiatry Management* magazine, and a contributing writer for *Pharmacy Times.*