PRESIDENT'S PERSPECTIVE

What is Past is Prologue: The Future of Podiatry

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President

In allopathic and osteopathic medicine, dentistry, and even the veterinary sciences, specialization is the norm, not the exception. Hundreds of medical specialties, certifying boards, and professional associations exist to advance the specialist's skills, profession, and the public health. This uniquely American trait to organize was first recognized in 1831 in Alexis DeTocqueville's masterpiece "Democracy in America."

Our "cousin" in allopathic medicine, the American Orthopaedic Foot and Ankle Society is one of 12 independent, specialty societies that evolved from the American Academy of Orthopaedic Surgeons; and AAOS itself is one of 107 specialties represented in the AMA House of Delegates. Osteopathic medicine has 17 independent specialties, and dentistry has nine.

Contrary to what you might think, this pluralism is a big advantage when legislative or regulatory issues arise. "Coalitions" are the way things get done in government these days. Even the mightiest lobbies (AARP, NRA, or the U.S. Chamber of Commerce, for example) reach out to related associations and form coalitions to push legislation so that decision-makers see the size, diversity, and collective influence of a group of interests, not just one.

Podiatry, albeit a smaller and younger profession, is slowly but surely experiencing its first taste of specialization. There are seven specialty colleges in podiatry, the largest of which is ACFAS, but our colleagues in primary podiatric medicine and sports podiatry medicine, in particular, are coming on strong. We should celebrate and embrace this diversity of specialization because it marks yet another evolutional step in our profession's maturity.

The profession of podiatry has grown in stature and scope from its inception in the late nineteenth century to the present. Our community now contains some of the most highly trained individuals caring for the human foot. The need for scientific growth in foot and ankle surgery was recognized early on, and it continues to drive this field of study today. Research and the publication of meaningful, peer-reviewed papers serve as the life blood of any medical specialty.

Over the last several years, we have seen a significant increase in the number of meaningful papers being published in the field of foot and ankle surgery. This is due, in part, to the fact that research design is being taught at the medical school level and is also part of post-graduate education in many of the residencies and fellowships in foot and ankle surgery.

Currently, the profession has decided that the post-graduate experience for DPMs will require three years to complete. This determination was resource based and driven by the competencies needed by today's podiatrist. This is as it should be. We have the ability to make this happen by integrating residency programs within communities and sharing their resources. The plan calls for all graduates of podiatric medical schools to train for three years, which will cover all of the competencies for certification in surgery and in the non-surgical aspects of podiatry.

However, the length of training and the depth of study to completely train a foot and ankle surgeon already exceed three years. How then will there be time to learn about biomechanics, behavioral health, and content included in the certification process of the American Board of Primary Podiatric Medicine and Orthopedics? As someone who is involved in the training of foot and ankle surgery residents and fellows, I think its short sighted, perhaps unrealistic, for the podiatric profession to funnel all of the podiatric medical graduates into a common pathway.

First, not all graduates are capable of or desire to become surgeons. Second, there are a growing number of individuals who don't wish to enter general podiatry, but would rather limit their practice to surgery. Additional training is required to do this. It has been suggested that podiatrists interested in further training in the field of surgery pursue a post-residency fellowship. Unfortunately, these fellowships are few and far between, and federal funding for these programs is provided at a reduced rate (50% for the direct reimbursement for graduate medical education), compared to the funding for residencies, making the sponsorship of fellowships relatively less attractive to most hospitals and medical centers.

This begs the question whether this group of individuals, with the desire to be fully trained as foot and ankle surgeons, is to be ignored. If the present model is left unmodified, this is precisely what will happen. As painful as this might be, we must look at our profession objectively. It is no longer homogeneous.

There has always been a segment of the podiatric community whose primary interest was in surgery. That is why, in fact, the ACFAS was organized in 1942.

The podiatric community now consists of general practitioners, surgeons, and a growing list of other specialists. This has been the history of other medical professions and it is the future of our profession.

Granted, many podiatrists engage in surgery, but they choose to regard themselves primarily as podiatrists. Certainly, surgery is an important part of any podiatric practice, and current and future graduates of podiatric residencies must be well prepared by competent teachers to practice that part of their profession. But the future of foot and ankle surgery lies with the formal recognition of surgery as a true specialty of podiatry. This is not a fantasy of what I personally envision for the future, but rather an observation of what I have seen in my community and in those communities where my former residents and fellows practice.

Podiatric foot and ankle surgeons assume the responsibility for managing trauma patients and diabetics with limb threatening infections and long lists of co-morbidities, as well as dealing with the disgruntled foot surgery patient whose failed operation must be revised. These are challenging patients, and those who treat them require specialized training. Let the foot and ankle surgeons decide how to train those who come after us. Let us decide how long the training experience should last, what its content should be and what form it should take.

Finally, we as foot and ankle surgeons should not be competing with general podiatrists for patients with non-surgical problems. Our interests and our activities should lie elsewhere, and we should be supportive of our podiatric medical colleagues, just as our allopathic colleagues routinely refer patients to one another, create intra- and inter-specialty coalitions, and collaborate on a multitude of professional and patient issues.

As a profession, we need to recognize the differences that will always exist among ourselves and celebrate those differences, rather than ignoring them. Let us continue to pursue excellence in education at all levels, for both podiatrists and podiatric foot and ankle surgeons. And let us celebrate our profession's maturity, diversity, and collective wisdom.

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