Jarrod Shapiro, DPM Interviews Drs Michael Cornelison, John Steinberg, and Chris Reeves

Jarrod Shapiro: Hi, everyone, my name is Jarrod Shapiro, and I am the Editor of the Practice Perfect Blog. I'm here today with three members of the Joint Taskforce of Orthopedic and Podiatric surgeons. Many of you have heard about the joint taskforce, and the American Medication Association Resolution J21-203. This bill proposes to investigate if the accreditation, education and certification processes for podiatry are comparable to those of MDs and DOs.

So this movement has generated significant controversy, so I'm trying to better understand the issue. In prior Practice Perfect editorials, I've interviewed Dr. Steve Wan, who was a member of the California Physician and Surgeon Taskforce, that was our progenitor of the current taskforce. And I also interviewed Dr. Kathleen Satterfield, Dean of the Western University College of Podiatric Medicine.

Tonight, I'm very excited to take this topic further, with an interview with three national podiatry leaders, and members of the current joint task force, who graciously agreed to take time out of their busy schedules and discuss their participation.

Joining us tonight is Dr. Michael Cornelison, who's in practice in Cupertino, California, is past President of the California Podiatric Medical Association, and President-elect of ACFAS, congratulations, Dr. Cornelison.

We also have Dr. John Steinberg, practicing at MedStar Health in Washington DC, he's the Director of the Podiatric Residency Training Program at MedStar Washington, and the past President of ACFAS.

And then we also have Dr. Chris Reeves, in practice at the Orlando Foot and Ankle clinic in Orlando, Florida, and is the immediate past President of ACFAS. Congratulations on being the immediate past President.

Thank you all for joining me tonight. If you're all okay with this, I'd like to keep this relative informal and if we can go by first names, if that's okay.

John Steinberg: Of course, we're up to it.

Jarrod Shapiro: Okay. Also for full disclosure, I'm an Associate Professor at Western University College of Podiatric Medicine, and I am on record, both written and verbal, as being a supporter of the joint taskforce.

However, today, I'd like to push back a little bit, and take the devil's advocate on some of our topics so we can have a nice rounded conversation. So, Dr. Cornelison, if I can start with you, Mike, can you give us a short synopsis on sort of how this taskforce came to be, and what it proposes to do?

Michael Cornelison: You mentioned that you had already interviewed Dr. Wan, so I had the privilege of working side by side with Dr. Wan, and the California physicians and surgeons taskforce, and you in California already know that the physicians and surgeons certificate is essentially a license for both MDs and DOs to practice in the state of California.

And interestingly enough in California, the curriculum that's required to meet the standards to get the certificate, is well spelled out in state code, and basically recognizing in California that the podiatric curriculum, closely parallel that of what was required for the physicians through the certificate.

The California Podiatric Medical Association pursued the California Medical Association, to compare the curriculum, and both on paper as it was in the wall, but also in practice, by visiting the two schools of podiatric medicine in California and also for residencies, to establish exactly how comparable they really were, and to figure out what might need to be done to bridge the gap, so that podiatrists could, in the state of California, receive the certificate, essentially from their license. And that's basically how the California taskforce is born.

It went through a long process. I think that Dr. Wan covered it quite well. But in the end, it became quite evident that the things, the next steps that needed to be taken after it was established by this taskforce, which also included the California orthopedic

association and the osteopathic physicians and surgeons in California, that the curriculum was in comparison, both again, on paper and in practice, but the next questions had to do with accreditation, licensing exams, and even in the long run, certification or accreditation of post graduate term. These are all national issues and at the same time, there were ongoing discussions between national players and this is stuff I think that both Chris and John can cover as well.

AAOS, AOFAS, and as well as APMA, those organizations as well, and this goes back to people who are familiar with the MISSION Act, the VA bill that helped to elevate the recognition of podiatric physicians and surgeons and the VA system. That really opened some door for some collaboration, at the same time that the California taskforce recognized that this needed to go national.

And some of the people involved with this, were involved in these various discussions, and it's just a natural fit to throw this into the idea of a national taskforce that include the, again, the American Academy of Orthopedic Surgeons, the American Orthopedic Foot and Ankle Society, APMA and ACFS as well, and from that, the taskforce is born, and the California taskforce, the California physicians and surgeons taskforce, to endorse the idea of sending this project on to the national taskforce, so that this process could be considered.

Jarrod Shapiro: And your current process with the other organizations, maybe you guys could give us sort of a feel for how that went, sort of I guess, how the projects sort of maybe got started or even, how you even were able to reach out to the orthopedic societies and have them as participants in that? Maybe John, if you might want to comment on that part of the process?

Christopher Reeves: If I may, I can take that one.

John Steinberg: Yeah, go ahead, Chris, yeah.

Christopher Reeves: Yeah. So when I was president of ACFAS, Tom Lee was the current president, outgoing president of AOFAS, and he and I have known each other

for a while, and had taken the opportunity to begin discussions and start to collaborate on some ideas. And so the genesis really, or some of the taskforce, as Mike mentioned, I think is run in parallel, the genesis of the taskforce, really were organizations coming together and really trying to put aside differences and find the common ground that we have in common to work on for our patients and for our members.

And we all agree that we agree on 95% of everything and there are certain things that we don't agree on, but we can put it across aside some of those differences and move forward. And so on the docket for some of the things that we thought we could bring a taskforce together with, were policy initiatives, were patient education, were continuing medical education, things that we could collaborate on, dealing with governmental affairs.

And so as Tom and I discussed, putting together a taskforce, so basically FAS and AOFAS, at the same time, AAOS and APMA had also been collaborating under the A bill and some other ideas on some national topics.

And so, the four leaders of those organizations really kind of put our minds together and really established a taskforce before any topics were really, and before this agenda item even really surfaced.

And so really going into the first taskforce meeting, this wasn't even an agenda item. The first part being really centered around, one, breaking down barriers and communication walls, and then two, finding those like topics that we can move forward on. And then the next taskforce meeting or two, was where the two sides of the podiatric portion of the California and the Orthopedic forces in California kind of brought the idea of this being a potential project for the taskforce to kind of dig into and work on.

So the taskforce really wasn't created for this resolution or for this topic, the taskforce was created, really, to just get the four organizations together to collaborate and the agenda items just kind of started to fall in front of us.

John Steinberg: Yeah, and Jarrod, if I can follow up on that too, because I think the audience will appreciate some of the history that you're trying to play out here, is that, from being in the board room of ACFAS for all these years, each year, we would get a report from Steve Wan, and in the early time before Mike was on the board, it would be from Mike as well, telling us about the progress that the California initiative was making, and then hearing about their major roadblock was that this needed to really be a national initiative that we needed to get AMA support, somehow, to be able to take the USMLE, that none of this was going to go forward until there was a national effort to solve that block.

So that was an interesting history that we had been getting these updates to this amazing dialogue and progress that California had been making, but also hearing of their frustration that, hey, this needs to be a national task, not a state task at this point, because we've proven that things are comparable and equivalent here in California.

But that's not going to help us be able to take the USMLE, because that's not a California thing, that's a national thing. So that was an interesting background for us to realize that that's a real pain point for this and a real struggle, is that, none of these initiative goes forward, until we can take the same tests so that we can speak the same language.

Jarrod Shapiro: So, do you think that taking the USMLE, part of this is necessary in order for the original kind of purpose of the taskforce with working with the orthopedics and the AMA, and if it didn't happen, would that stop you from being able to work with them to kind of accomplish the other goals that you had originally planned for?

John Steinberg: No, I think just like Chris Reeves had said, the taskforce really, we went in with a pretty open agenda, our first meeting in Chicago was just to get a feel for, hey, is this something where we're going to actually be able to act like adults in the same room and have a dialogue after all these decades of animosity and sphere throwing? From across the aisle, I think it was really, once we saw that, hey, these folks have come to the table to actually work with us, and they've come to the table to accomplish something meaningful.

And they're actually bothered by the uncomfortable situation we're in right now, as well, it's not us. Orthopedics does not like this situation and this kind of gray zone of mixing of terms and they would like some clarity and help in that as well.

So it's interesting that we think it's all about us, and it's all about our pain, but where was a lot of frank and honest discussion on the orthopedic side, of hey, this is pretty weird for us too, and we don't like all these state battles that come up every year and these legislative knockdown, drag out fights that we have to spend tons of money on. because it doesn't build professional relationships and we all see each other in the same hospital for the same patient.

Jarrod Shapiro: I'm sure you guys have probably heard criticisms that it's ACFAS and APMA, kind of involved or kind of in this taskforce and that there are other stakeholders that might want to be involved or maybe, it should be, could you guys maybe comment on those criticisms and what you think about the fact that there are other stakeholders that might want to be involved in this process?

John Steinberg: Yeah, I'll take the first stab at this and I'm sure Mike and Chris would want to follow up, but that is a core concern here, and I know that there are a lot of feathers that were ruffled, and rightly so, from folks who felt that they were left out of the process, not part of the dialogue and that are key stakeholders for this going forward, and those are all fair concerns and fair critique and I embrace that motion, but I would tell you that, from our very first meeting with orthopedics, when we realized that these folks were serious about actually wanting to accomplish something meaningful, and that they were willing to take risks in their own professional image relationships, with their membership, to go out on a limb, and take some risks of establishing the definition of physician, formally, by the AMA for our profession, it was very clear that we were not going to have a chance at accomplishing this, if it was in the public forum, and debated in public dialogue, and ripped apart and shredded and misinterpreted, along the way.

The only way we were going to be able to get their embrace from their legislative side, and their legal side, and being able to actually come up with some verbiage, was to keep this in intimate group, with fair representation, I mean, you can't get too big or

national podiatric organizations than ACFAS and APMA, with broad representation from those groups, and support from their board, and a lot of dialogue.

The key point that I think that the stakeholders who are really offended at this moment, who feel like they were left out, who were going to be a big part of this, ever going forward, and being successful, CPME and deans, and AACPM, these are all groups that are major stakeholders in our podiatric education, no matter what shape it takes going forward, is that, our task, was not to dictate how we do this, not to dictate the timeline for when we do this, was not to dictate any of the details about this.

Our task, was to open the door, so that our key educational organizations can access that doorway, and decide if or how, or when, we want to go through that doorway and take the step as a profession. APMA and ACFAS certainly don't dictate the education of our profession, but what we used was the leverage of these organizations and our board's skillset of navigating these politics, to shove that door open. And that's what were in the process of accomplishing. And that door has never been open, there's never been a pathway to open that door.

So this dialogue that has happened, is new, it has a lot of other areas that we can succeed in, but that's I think, the key element here is that, yes, CPME and AACPM and the deans, this will be their wagon to tow, and figure out how we actually do the details and when and where we decide to take step one and what year or decade we might implement step two pre assembly and if or when we'll ever implement step three.

There are so many more questions than there are answers right now, but again, I would just ask everybody to step back for a second and realize, this is about access to the tests, period. That was our task and that's what we're still in the process of finalizing, but we've taken some pretty major steps to open that door.

Christopher Reeves: Yeah, I would agree, and I will use the analogy of building a house through this, as you don't pick up the paint color before, you have architect, you got to line something on paper. And the paint color and the furniture is the last step of this, and until we have a lot and land, and the design, to even consider what this is

going to look like, we can't really pick out the rest of it. And so we're really in the architectural design stage of this.

And John is exactly right, the ability to even have access to this, and to do this, through the front door, and not through a rear entry portion of this, and really trying to be an example of other organizations that are reached and for the same type of goals and the ability to have access to this test, that's not been there before, it's a very key component to this. And we fought legislatively for years, and have made incredible strides to where we are, but eventually, if you're going to stay the same and continue to fight legislative battles, you're eventually going to reach a point where you're either eaten as a stalemate, spin your wheels or just spinning an incredible amount of money. And this is an opportunity for true parity and coming in the correct way, for an opportunity that has never been presented before.

Jarrod Shapiro: Mike, did you want to comment as well?

Michael Cornelison: I muted myself, it's a little noisy outside. Yeah, I think that really, the key thing term that John used as well, this is opening the door. The impetus about whether to even go through the door, let alone to determine the pathway through it, really isn't up to us, and we recognize that, we want the opportunity to be there, but by no means was this process trying to dictate how those who are involved in the education of our students, and our post graduates, our trainees, we're not trying to dictate how bad that plays out, how that works, but we want that opportunity to be there, because the line in the sand that's been drawn by those that control the house of medicine, has been the USMLE, that exam.

Does it mean that that's the only way that we can establish comparability measurements via an examination? No. There are potentially other options out there as well, but this is the one that has been given the target. And by the nature of this taskforce and how it's working, and also going back to how it's working in California and the relationships that's been established, it was the right thing to do from the standpoint of cultivating those relationships that we focused on USMLE.

The only other thing I'd add is, and this is really the biggest thing about the examination as far as the breakthrough in the California process. Initially, the California Orthopedic Association is adamant about the idea if this is going to go through in California, that podiatric medical schools would have to be accredited by the Council on Medical Education. They would have to become medical schools. We know that's a deal breaker, that would mean that podiatric medical education as an entity in itself, would cease to exist.

But as it turns out, the real goal of requiring that certification or that accreditation from the Orthopedic Association's standpoint, was simply to be able to have access to the USMLE, because that is, as far as they saw, the requirement, is that you'd have to have graduated from a college of medicine, accredited by the SME, to have access to the USMLE. Once they realize that there are other pathways to do that, and this is where it has to go national as well, to petition the powers that be that control the USMLE, that's when the door open in this… that's when this element became part of the national taskforce that Chris laid out so well.

Jarrod Shapiro: Yeah. I think it's an interesting point to make that, you know, this process has happened in California and there was a review that occurred and, you know, podiatrists still exist in California, we're still practicing, nothing has really changed from that standpoint. I think that's an interesting point that I've known about the California version for quite some time and really not seeing that kind of gloom and doom situation happen which is the criticism that I'm hearing… you know, that is the orthopedist review podiatry, then we're going to suffer and it's going to be the end of podiatry. I'm guessing you guys have heard that criticism before.

Michael Cornelison: Yes. And interestingly enough, when… you know, this goes back almost 40 years now, to state legislation in California that basically extended our scope of practice. And this was done in concert with the California Medical Association. And the key to that was actually opening the doors at CCPM at the time and a couple of residencies in the San Francisco, Bay Area to show the California Medical Association exactly what it was we did because their conception of what podiatric medical education

training was so archaic and so inaccurate. And it just blew them away, and to the point where… you know, we… in most states, it's still the case if there is a bill that goes before the state legislature to clarify or expand anything to do with podiatric scope of practice. Chances are the medical association and orthopedic association of state is going to be opposed to that. And everybody circles a wagon and they find an ally in the legislature to force that bill through, and so hard fight if they winged late. What has that done for the relationship that they have with some medical associations and even how that trickles down to how they relate individually with their colleagues and their hospital staff? That process, though, in California when we rolled that transparency, opening our doors and shattering those misconceptions, opened so many doors that ultimately led I think to where we are now, and established good relationships and it had so many spinoffs in other directions in terms of collaboration like Chris said, whether it's orthopedist or just the MD world in general, we have 95% in common, 5% differences. And we can focus on those things and it's been very, very fruitful.

And I think like really the most important thing is that we know how… we know what we do. We know what our qualifications are. We should not be afraid to share it because chances are we're not going to have anybody believe anything that things were a lot better than they would have expected as far as our colleagues in medicine go. I think they'll all be very surprised by this. We really shouldn't have much to hide here or anything like that.

John Steinberg: Yeah. That last point, Mike, I think is key. We have nothing to hide. I am so proud, and I know, you know, there's been a big critique or big concern about not wanting to see what's behind the curtain in podiatric medical education. We need to broadcast this from the top of whatever building we can because look at where we're at now. And look at the unified education we have with DOs and MDs. There is so much that we should be broadcasting from the top of every building. I am not afraid at all of having our education reviewed by any outside group because we've already seen how that goes with California. And I tell the relationship that we have been able to see the very inside workings of now between the California Medical Association and the California Podiatric Medical Station is amazing to see how their president of their

medical association would go about for podiatric medicine now and he's doing so for us as well on this initiative. It's fascinating.

And that becomes… that comes from the fact that they now know that we are physicians. They understand our struggle, they understand where we're at. And we're not their target. Their concern as far as the outside world are not DPMs. They're concerned about people who want to label themselves as physicians is from much larger, bigger, different groups that want to be labeled as physicians. DPMs are a small group. I think we're a highly respected group and I have no fear of them coming to evaluate our education. It will work in our favor. It has already in California. And we should have no concern. I know some folks are really nervous about that. And the reality is that information is already out there. For anyone who wants to review it on the Internet, you can see our full education mapped out by CPME and everybody else. So I… we have no secrets. Bring it on. I'd love to have whatever review we can. We need to create a pathway, similar to what the DOs did. And this is the obvious way to do that. We're not talking about a two-year plan, we're not talking about a five-year plan. We're probably talking about a 15 to 20-year plan. But with a lot of pressure to make that we protect the existing practitioners, that we protect the profession and the identity of the profession, but that we pave a pathway forward for our future graduates who have an education that it is world class.

Jarrod Shapiro: So, John, you mentioned that, and I'd say as a member of Western University CPM, we've been very transparent about the education that we're accursed, but I've heard some concerns from other colleges. I'm not sure if they're concerned about like showing their education. I mean like you said, most of this is public. But what would you say to maybe some of our other colleges that might be a little bit more concerned about having… maybe, you know, the concern that their students might somehow not do well in the USMLE or if their education process is scrutinized that they might somehow suffer? What would you say to those people or those colleges in that situation?

John Steinberg: My first answer would be that our schools are not all the same and we do have some schools that are better prepared for this pathway today versus others. And there will be some more work perhaps for some schools that have to do to prepare themselves and their students to move on this pathway. But again, nothing's happening in six months or two years or even five years. We're talking about something that's going to be a long pathway. There'll be plenty of time for those schools that do need to do some retooling to do it. And I think most of those schools are already on that pathway anyway. It's the obvious pathway. It's the pathway of making sure their first two years of education were completely identical to allopathic medical education. And I've spoken to just about all the deans in the past couple of weeks. None of them, even some of those deans who are pretty hard fast against this, just about none of them have a concern with step one. Just about everybody agrees that our first two years of education, our students could probably take USMLE step one now and have a great respect or chance of passing a test to do well. I think the concern comes in step two and step three. And I embrace those concerns. I have some concerns there as well. It means a lot to the MDs and DOs, though, so we have to find a way forward to meet that criteria or maybe it the 15 or 20 years that it takes for us to go down this pathway, that step two and step three aren't part of the final decision here. Maybe there's a different hybrid pathway where we take step one and we all show that we've had a baseline education and then we get some agreement as we navigate this road that step two and step three are modified for DPMs. We don't even know what options are out there, but if we're not willing to take the first step down this road and have some courage and belief in our profession, then we're going to stay right where we're at.

Christopher Reeves: Taking another spin on that, if there are educational facilities out there that are deficient in some way, don't we as a profession… should we as a profession expect those deficiencies to be corrected? And if this process points those out and allows those to be corrected, then I think that makes our profession that much stronger. And I don't think at any point should our education arm in the profession be concerned that they don't make that criteria. But if they don't, then this certainly gives them the opportunity to get up to speed.

Jarrod Shapiro: Definitely. So to switch gears slightly, I had taken a look at the LCMEs, their guidelines regarding accreditation of the various steps that the taskforce is looking at. And it looks like their standards are very similar to CPME's, which is obviously good. So if… when the review actually occurs and it goes through this process, if they find that that is in fact true, that those accreditation methods are… they are so similar, do you think that will have an effect on the kind of overall… the process, or do you think it will sort of start to change the view of this kind of situation that we have? Chris, maybe you can answer that one.

Christopher Reeves: Yeah. You know, the interesting thing about this is that the two organizations that we're talking about both in the allopathic and podiatric standpoint here are all… are both accredited by the Department of Education in the United States. And so being accredited or recognized by the same governing body should put us in a position to succeed in the review. And I don't know if this answers your question directly, but I think that we are there, we think we're there. They think we're there quite honestly. Because neither the podiatric community or the podiatric side of this taskforce or the orthopedic side of this taskforce wants this review to be met with anything other than success. This isn't a aha, got you moment. This isn't… you know, there's not time in the world for that. There's not a time in this taskforce for that. This hasn't been set up that way. This is a… this had been conversions over, you know, to the rudimentary forces of exactly how these organizations are set up in the background, in the backbone of how the resolution is written and how the white paper is written. There's a ton of research and time that's gone on to this to really put it into a position to succeed. And based on all of that, all of that criteria, all of that research, all of that knowledge base for the four organizations, you know, we believe we've put it in a position to be successful when it gets to that point, all the way down to the rudimentary, like I said, the rudimentary nature of the government entity that accredits these bodies.

Michael Cornelison: I guess, Jarrod, the question I have for you is do you mean specifically in terms of the comfort level amongst our stakeholders, or do you mean more in terms in general the house of medicine and perhaps the AMA?

Jarrod Shapiro: Yeah, I think more the AMA and the folks on the kind of the other side of the aisle.

Michael Cornelison: Yeah, I think so. If there's one thing that I think should be very clear here is that medicine in general knows very, very little about us, what we do and probably more importantly how we're trained to do it. Again, a lot of people on the allopathic medical side are still using references that go back to the scope of practice partnership module in podiatry which you've seen from so many years ago was just way out there in terms of, again, being archaic and full of misinformation. I think very likely that the first time that anybody or that a number of people on the AMA side ever heard of the Council of Podiatric Medical Education was when they read the white paper or saw the resolution. And so, I think the whole concept of this idea of a study is just to verify that as an accrediting body, to me, like any other educational accrediting body under the auspice of the Department of Education, has to do all of the same types of things.

And curriculum is just a small part of it. And it all has to do with the viability and sustainability of the institution, the oversight, the overview of the financial arrangements within it. And curriculum is just a small part of that. And that goes even just within the medical schools themselves. If you look at the LCME guidelines, there's very little talk about absolutes in curriculum. And I think that's really what's important in terms of them focusing more on the test, the USMLE, as opposed for saying, okay, here's what you need to make up in terms of curriculum in this area and that area, this many weeks of medicine, or again, when you hear all about behavioral health and OB-GYN as far as the parts of the curriculum that seem to be missing from the podiatric curriculum in comparison.

Well, those issues are relatively minor, when it's more about, again, schools allotted to figure out how to teach the necessary information that is on the examination. So again, getting back to that point of the accreditation, that should be a fairly easy comparison. It will simply establish that the CPME is a legitimate accrediting body just as the LCME is. And I think that's the information that needs to be recognized for them to be able to

petition to the national board of medical examiners and those other… the other organizations involved in control in the USMLE that this is, again, a legitimate petition, a legitimate request with all of that information provided and the support of organizations like the AMA, like the ALS, as well as our organizations. Then it makes the likelihood of that access to that examination that much more viable than if we just simply said, hey, MVME, do you want to take the USMLE? What do you think? And that's not going to get us anywhere with that broad consortium of support.

John Steinberg: And Jarrod, if I could follow up. Chris very appropriately mentioned that the folks who are concerned about the aha moment or the feeling that this could be a trap and that we're just falling right into a trap and this is going to be weaponized against us and used against us, hey, we all know that sound bites can be taken from anything and you could crop my voice from this conversation and make some totally irrelevant statement as well or try to make some false impression from what I'm saying. But what I would tell you is that if you take the white paper in its entirety and you take the resolution in its entirety and you read the document, as our legal team did, and as our boards carefully reviewed, you will realize that it's not something that is an aha moment or that we've fallen into a trap. This has been very thoroughly vetted by the APMA legal counsel, by the ACFAS legal counsel. And this is not something that can be weaponized.

Now, can someone outside of our profession or what has happened recently inside or our profession, take half a sentence out of one of those documents and make it look like there's a problem? Sure. I could do that with any email that I receive today and try to convince you that the author was trying to say something totally different or that we admitted to something that was a problem. But again, if you take this in its entirety and you look at the fact of the physician definition and how we have written that, we are trying to satisfy the house of medicine and we've used this analogy a bunch here recently. We talked about that during the ACFAS directors' forum that we did recently. We have built an amazing tent for podiatric medicine and surgery. And I'm really, really proud of it and I love the initials that are after my name, and I'm happy to call myself a podiatric physician.

But if we want to keep staying in this tent and we're okay with that, and that's where we're going to exist, then I guess that's okay. But if we want to be part of the bigger tent in the house of medicine, then we have to follow and meet some of their criteria and some of their rules just like the DOs did. And that's our choice here is that we can continue existing as a third party on the outside in a small tent or we could pitch our tent up to the big tent and speak some of their common language by taking some common tests. I think there's a lot of merit to doing that when we look at the long-term future of our profession rather than trying to go alone and remain on our island in our small tent. I'm almost… I'm sorry. But if it all fails, and everything implodes and our resolution didn't work, then we still have our tent. We're just fine. The tent is still there. Nothing's going to implode that tent. There's no legislation that's going to suddenly invalidate our profession or say that what we're doing is illegitimate, that's just… that's something that just doesn't exist in any of these documentation and has been insinuated. There's no damage to the current profession. There's only opportunity to move it forward.

Jarrod Shapiro: So how do you guys respond to those individuals that seem so strenuously in the opposite side? So I've spoken to folks who argue that we are overly optimistic about this and that there are… I guess the implication is that there's a group of podiatrists who are quote, "high powered" in academic institutions and residencies and we have this access… some access to the MD academic world and that it's okay for us, but what about the quote, "mainstream" podiatrists? I've heard this kind of argument. How do you guys respond to that type of thing where it seems like they're kind of strenuously disagreeing with like the, I guess, the position that you're coming from?

John Steinberg: I'll take the first stab. We're all going to want to answer this one because you've gotten to the core of the matter here, Jarrod, as any good interview should, at just the right time I think too. So the reality here is that what we are doing here and what we are setting ourselves up here for is that we need to believe in this profession. And we need to believe and take credit for our accomplishments of the past 50 years and we need to look towards the next steps. We can't and shouldn't keep

doing the same thing, that's not going to move this profession or our specialty forward. We should look for ways to improve ourselves and to raise the bar and we have educationally. And now what we need to do is prove that to those outside of our profession and show what we've done and take the proper credit for it.

I would tell you that my biggest concern is that when folks look at this and they believe that, again, this is the reality of do we believe in the profession enough to do it, I think we already have accomplished a lot of the task and we could take credit for it but if we're not willing to move this forward, then we're going to stay exactly where we're at and we know that we can move this forward, we know we've done the work and we need to believe in our profession enough to know that we've done the work. There's two analogies that have been used exactly to what you were saying here, Jarrod, is that this resolution stands to potentially divide our profession and this was in writing that I read recently, divide our profession just like residency requirements divided our profession and just like board certification divided our profession.

Well, you know what, Jarrod? I'm really proud of the division that us requiring residency training for our profession made because it advanced our profession. Imagine where we'd be at if we didn't require residency training for podiatric medicine and surgery, that was… in my opinion, if we were doing that now, it would reckless and be irresponsible to the public. You can't do what we do without residency training. We have to be willing to look forward and what we're doing right now is not for my practice, is not for Chris' practice, it's not for Mike's practice, it's for the folks that aren't even in podiatric medical school yet. That's what we're doing, is to advance this profession and set that table. So if you're thinking anything else, in my opinion you're being a little selfish about the fact that yeah, this is not for you, it's not going to change your practice, you're not going to get to take the USMLE, I don't plan to take the USMLE, I don't think Jarrod's going to go back and take the USMLE but I would love for son who's probably going to enter podiatric medical school in another four, five, six years to be able to take the USMLE, that'd be great. Or maybe it's not even for him, maybe it's another 10 years past that but I'd love to set that table.

Christopher Reeves: Yeah, and not a whole lot to add there, John. You hit the bullet points on that. At one point, our profession didn't do surgery, you know? And had there not been forward thinking, had there not been advancements, had there not been all of these things John just laid out, then we wouldn't be doing what we do now. And the other thing that I point out and it's really hard have conversations when the negativity and false information is so deep rooted and deep seated and there's not an open mind to it, a lot of the things that have been put out there and discussed are just complete fabrications of what the white paper and the resolution's saying.

And to walk through that line by line is a whole other interview quite honestly, it's part of what we've done in some of the presentations that we've done at various conferences thus far with this where we've been asked to do it but at no point in here does it say that we're not physicians now and it just doesn't say that, at no point does it say that our education is deficient, it simply is opening… attempting to open doors. Those folks that are negative, haven't been in the room, they have not been the benefit of the legal reviews and seen the core organizations work together on this and the attorneys work on this and so that would be what I would say, to piggyback on John, is that the forward thinking is imperative and that fully understanding what is written is just as imperative in this process prior to firing cannons across the bow of this process.

Michael Cornelison: I would also add the American College of Foot and Ankle Surgeons and also the
American Podiatric Medical Association, both have obligations to their members to advocate for the members from the first day of their practice to the absolute last. And so a lot of us, we hope that's going to be 20, 30, 40 years. That's a long time, who knows what medicine is going to look like 20, 30 years from now versus next year. And we also recognize from an education standpoint we're trying to hit a moving target here. But that's a long time and we have to look ahead to what is going to be best for our specialty because that's what we are, we especially function as a specialty of medicine.

So, in many ways, in terms of licensing and state laws and how we're treated from an administrative standpoint and even from a standpoint of insurers, we're still not considered specialty medicine, but we're expected to function that way. Someone comes out of residency training now, they are expected to be able to function in a hospital setting, in a private practice setting or in a clinical setting the same way as any other specialty does and that's where the difference is and that's going to continue and we have to be able to set the table for that from an advocacy standpoint and I think that's really the message. Now whether that ultimately results in some sort of stratification between those who have taken and passed the USMLE and those of us who haven't and never will, I think that's going to be overshadowed considerably by the fact that this process will elevate the image of the entire specialty and that's something we're very cognizant about, it's something that we will focus on and have focused on, is how do we make sure that the benefit of this process is something that's good for everybody, not just those who ultimately are the beneficiaries on paper in this process in terms of being able to take USMLE and be licensed in a plenary fashion as a physician, be recognized in every state of the term as being a physician because even though a lot of us we can call ourselves a physician depending on what state you're in when some of us can't, we are not officially physicians and so we are universally recognized that way and that has to be part of this process.

And again, focusing on the idea that there is going to be this difference between those practicing who have taken the examination and those who haven't and this isn't the first time that something like that's happened whether it's in our specialty, our profession or any other, it's happened throughout the development and the evolution of medicine.

We're keenly aware of that I think as advocates for our profession, and we intend to make that a benefit rather than a liability.

Jarrod Shapiro: It seems like the one… just one small sort of benefit is just that everyone understands who we are and what we do more. Without sounding too Pollyannaish about all of this, I feel like the problems that I have as a podiatrist in practice really stem when somebody doesn't know what we do and whether it's hospital

privileging or just attitudes towards podiatrists, it's when they don't understand what our training is and what our capabilities are that we... I then see problems, I've had those types of issues myself. It seems like this process just opens up a better understanding of what we do, if for nothing else, just a better understanding for the rest of the community about what we do as podiatrists.

So just a few last I guess sort of questions before we sort of close out, I wanted to cover a couple of concerns I guess or maybe criticisms that some say. One was if our students come in and they have a... they're coming into a USMLE eligible education where our students then could take the USMLE, then why pursue podiatry? That was a question I've received, one of you guys want to answer that question?

Christopher Reeves: As far as pursuing a profession based on what test you take is kind of a unique way to choose what you do for a living, so I would just probably ask that question back and if someone can explain to me why you would choose... rhetorically choose a profession based on what test you have access to, then that to me doesn't make any more sense than the white paper does to those who haven't actually read it.

Jarrod Shapiro: Fair enough. I've had a question where a person asked if our students can take the USMLE, then is... does that mean that the NBPME is I guess no longer necessary and would then be dissolved? Is that... maybe that's a little hard to answer because it's something in the future but could you potentially extrapolate an answer to that person's question?

Michael Cornelison: And again, it's hard to really predict this and one of the things I've loved coming out of California than someone from the CEO of the California Medical Association, this is fairly unprecedented in terms of this project, we're making it up as we go along and there's some truth to that, though of course doing so very carefully and critically. The bottom line is there will still be things that define us as doctors in podiatric medicine that are specific to that degree that will likely need to be evaluated and that's probably more at the state licensing level, every state will have the opportunity to determine how they want to license their healthcare practitioners, whether they're MDs,

DOs, DPMs, any other type of healthcare provider, they'll all have specific differences in terms of how they decide to do this. Now if they choose to use what amounts to a standardized examination, that could be used from state to state to state and for the reciprocity purposes, very likely there'll be some type of module that is very specific to podiatric medicine and surgery.

And I would see that... from that standpoint, the NBPME or some entity similar to that would still exist and to develop that and whether that would be under the guise of the NBPME itself or separate, who knows? But I think there will always be something that's specific to what we do, just in the same way as they're specific in terms of OMP with osteopathic physicians as well, I believe there's still components of... for instance, the common exam that would still continue to exist even if the rest of that examination disappears as post graduate training gets assimilated between osteopathic and allopathic medicine which is going on right now. So it'll be interesting to follow that trend as a way of almost being the canary in the coal mine in terms of predicting how our core process goes.

Jarrod Shapiro: So for me, the last question that I have is to maybe ask you to sort of look into the future a little bit and let's say that everything happens according to I guess plan or kind of the way we as podiatrists would like it to happen and the AMA does in fact recognize podiatrists as physicians, could you predict maybe some outcomes of that? Would there be the potential for like scope of practice issues if we're sort of under that umbrella of the AMA, would that help us with some of those kind of battles or... you know, insurance billing or any of those types of things, do you see sort of general outcomes that might occur as a positive result of us being called a physician by the AMA?

Christopher Reeves: Jarrod, I think if when we reach a point that it reads MD/DO/DPM, I think that that opens every door imaginable.

I think... yes, I think it opens the door for national scope to practice, whether those are open beforehand or not, which I think would be something that can certainly be worked on here as well, but I think when you... I think all of the above, I think scope to practice, I

think insurance issues, I think Medicaid and Medicare, I think any type of inclusionary or exclusionary things and the Medicare and Medicaid governmental programs that we don't know or what are going to exist down the line, I think that being included in that game 20, 30 years from now is going to be extremely important, we won't really know where healthcare in this country's going and I don't think anyone who thinks that they know that is kidding themselves. And so I think that reaching that point of parity is going to be very important moving forward I just don't know how soon it's going to be that important. It could be a lot sooner than we want it to be but I think once we get in that document and those documents will be much more secure than we are.

John Steinberg: And I would add to that too. I think one of the things that our profession... and this is not the reason we're doing this project but one thing that our profession has as a weakness is our visibility, we all know that. how do people end up in our schools, a lot of times it's this trivial, crazy example of happenstance that they luckily met a DPM and somehow fell into it. If MD, DO, DPM becomes the same phrase, becomes commonly seen in the same abbreviations together, I think our visibility increases and I think our applicants to podiatric medical schools could increase, I think that visibility would be so helpful to our profession.

We need that, we've got so much that we have to offer but we still are just in the shadows, and we're not known and visible to most medicine and the public and I think this would really help with that if it was formal that physicians were MDs, DOs and DPMs.

Jarrod Shapiro: That's great. So guys, I want to be cognizant of your time, so I'd like to give you guys the last word if... maybe if each of you might want to say something in sort of a general kind of sort of wrap up type of thing, I'd like to give you the floor.

John Steinberg: Yeah, I'm happy to go first. I would say number one, I hope that we can have everyone have the confidence in this profession and the work that we've done in the past 50 years to believe that this is a good idea and to believe that we can do this and we can accomplish this, we need that because I think we've earned that, we've done the work and let's go take some credit for it and get the recognition for it and get

the visibility for it for our profession and get us out of... it's a pretty darn comfortable gray zone, I love my practice, I love what I do, I think we all do, we're very proud of our daily work and our profession but it sure would be nice to settle some of this unsettling part of where we fit professionally. So I would say have the confidence in our profession to realize that we can move this forward and then my second closing statement would be please take the time to actually read the entire white paper and read the entire resolution rather than excerpts or census or parts of census and realize the intent and reality of the document for yourself rather than letting someone dissect it for you and try to convince you of their opinion. We did pretty darn good on the PM news polling for this when the general public reviewed this and thought about it.

I think the topic itself makes sense and let's realize that there's a... you asked a great question, Jarrod, what happens to the NBPME? There's another 40 or 50 questions like that but let's not get caught up in those details and realize that the way to do this is to take the first step forward and open that door and then we're going to have lots of difficult roads to pave after that but I'm confident we've got the skillset to do that and do it the right way.

Christopher Reeves: And to pay you back on that and kind of closing this out is realizing where we've come as a profession and that we didn't get here by resting on our laurels and sitting around and if you look at the history of our profession and we got... how we've progressed to where we are has been with forward thinking and having a vision of what the next 20 to 30 years looks like and what the opportunities that may arise for us to do so. And so as you mentioned, Jarrod, the other things that can come out of this such as recognition of what we actually do, improvement in relationships with our orthopedic colleagues, sitting down in a room and covering all the other items that we agree on and the benefit of our patients and our members, all those are important and this... we mentioned, this taskforce does not necessarily go away and is not just built on this resolution and white paper and that's important. So having the support of the taskforce in general is imperative, realizing that there is support and backing of the profession for what this taskforce charge was, this taskforce charge was taken as a direct initiative from the board of directors of APMA and ACFAS and is... and that is

important to understand in realizing that these are doors that we're trying to open moving forward and it's our job to take the opportunity, try to walk through those.

Michael Cornelison: A common thing here has been that this is about opening a door and you heard Chris say or John say at least multiple times, that we said multiple times in the past as well and I think one of the things that's most scary, some people who are troubled by this process is right now that door was closed. You can't see through a closed door, you have no idea what's on the other side of it. At the same time, when that door opens, no one's pushing anybody through that door that very second. I think we as a profession, we need to peer through that door, have a look around, see how we will navigate what's on the other side and step forward when we're ready. And I think if everybody understands that rather than feeling that this is something... has some type of mandate to do this as soon as possible, I think it makes a little more clear, a little more friendly, a little more easy to actually figure out how to do this right and do it in a way that works for all the stakeholders involved.

And again, this is going to be a long process, but we can't get anywhere without first…

Jarrod Shapiro: Dr. Michael Cornelison, Dr. John Steinberg, Dr. Christopher Reeves, thank you very much for taking the time tonight, really appreciate it. I think as you said, this is definitely a process that's going to take time and I can only imagine how much time you've already put into this, so whether somebody agrees or disagrees, I think they should really be happy with the fact that we have people who are willing to take the time to work on this. So thank you for very much for taking the time tonight, we really appreciate it. Thank you.