

DPM=MD=DO

# The Path to Parity

Here are some thoughts on clarifying the confusion of degree vs. license vs. scope of practice.

BY JON A. HULTMAN, DPM, MBA IN COLLABORATION WITH  
THE CALIFORNIA PODIATRIC MEDICAL ASSOCIATION BOARD OF DIRECTORS  
AND THE CALIFORNIA APMA DELEGATION

In 1966, as a prospective student, I visited several podiatric medical schools, asking many questions throughout my tour. My first question at each was, “What is the difference between the education and training of a medical doctor and that of a podiatrist?” The response was that they were almost the same, with the first two years of basic science education being identical. I was told that the primary difference lay in the clinical years during which the podiatrist would begin specialty training sooner than a medical doctor. My second question was, “Upon completion of education and training, what are the differences in clinical practice between a podiatrist and a medical doctor?” Again, the response was that they were quite similar.

The schools’ “tour guides” informed me that, similar to an MD, a podiatrist was able to diagnose and treat, held pharmaceutical and X-ray licenses, could admit patients to hospitals, and could perform foot

surgery. Both medical and surgical care were covered by third-party payers. At that time, it was mandatory that an MD complete a one-year residency program in order to receive a medical license, while to receive a podiatric license, a one-year residency program was optional in

was predicted forty years ago!

In 1966, after learning about the education that DPMs were receiving at the podiatric medical schools, in residency programs, and in the “real world” practice of podiatric medicine and surgery, the thought never occurred to me that DPMs would

**“A society grows great when old men plant trees whose shade they know they shall never sit in.”**  
—Greek Proverb (sometimes attributed to Aristotle)

most states. It was not many years before a one—or even two-year—residency program was required for podiatric licensure. With this expansion of training, many podiatric physicians in practice and in leadership were predicting that the education and training between DPMs and MDs was becoming so similar that it would not be long before DPMs would be “given” MD degrees. This

not be considered physicians or that they did not already have “parity.” It turns out that, as a student, I had little understanding of the difference between a limited and a universal license, between a doctor and a physician, or of being a foot and ankle specialist as contrasted to practicing a specialty of medicine (such as ophthalmology).

*Continued on page 72*

*Path to Parity (from page 71)*

## Limited License

If one were to ask an objective lay person to guess the profession of an individual who independently diagnoses and treats patients, has a full pharmaceutical license, admits patients to hospitals, performs H&Ps and foot and ankle surgery, works as a member of a medical team, and has full responsibility for the post-operative care of patients, I think most would say that that person was a physician practicing a specialty of medicine.

Unfortunately, this person guessing may be mistaken because the one who might actually be being described may be a non-physician, allied health practitioner who is an optional provider under Medicaid—a podiatric physician. It turns out that this classification of practitioner does not have a medical license and is not considered to be practicing a specialty of medicine; instead, s/he has a limited license, his/her specialty is not recognized by the American Board of Medical Specialties, and his/her scope of practice is not determined by training and education, but rather, by statutes written by legislators—most of whom are not in the healthcare field.

Today, DPMs are held to the same standards as any other medical or surgical specialist, but they are not accorded all the rights and privileges of one. We have been saying for forty years that because our training and education are so similar to that of MDs and DOs, “It won’t be long before we would achieve parity.” While many leaders in medicine now recognize that the coursework, clinical training, and competencies of the DPM “end product” are almost indistinguishable from those of MDs and DOs, one of the things that has actually slowed our process towards parity is confusion and disagreement among podiatric practitioners themselves regarding just what parity is and how to achieve it. Some think that being referred to as a physician is the same as being a physician. Some believe the only way to achieve parity is through the MD degree; yet, others say that they are proud to be

podiatrists and would never want an MD degree. The end result is disagreement and inaction as to how this goal of parity should be accomplished, and this is because the primary focus and debate has been on degrees rather than on licensure.

## Grasping the Distinction

A stumbling block on the path to achieving our goal is that many DPMs do not fully grasp the distinction between holding a limited license and holding an unlimited one.

a DPM’s authority to write a prescription for medications clearly within his/her scope and DEA licensure.

A UCLA physician once said to me that he felt podiatrists were over-trained. I commented back that we were either over-trained or under-licensed. A limited license limits a DPM’s ability to practice to the level of his/her education, training, and experience. At the same time, his/her education and training are not “limited.” A plenary license enables a doctor to practice within the level

---

**Today, DPMs are held to the same standards as any other medical or surgical specialist, but they are not accorded all the rights and privileges of one.**

---

Many comment, “Why would a podiatrist need a universal license? Are they going to be delivering babies or doing brain surgeries?” This confusion and lack of consensus regarding “degree” and “licensure” is where the discussion and progress towards parity has stalled for over forty years. At the same time, we actually have reached consensus on several important issues that can lead to parity. I think every DPM would agree that we are physicians and that we have earned the right for parity based on our training, education, and patient responsibilities in the practice of medicine and surgery.

All physicians hold plenary (unrestricted) licenses, regardless of degree or specialty. Whether we choose to recognize it or not, the way that today’s graduates practice podiatric medicine and surgery is indistinguishable from that of any other medical specialist, and they have the same patient responsibilities; however, they do not have the same rights and privileges because they hold limited licenses and are considered to be non-physicians. Not only does this designation keep DPMs as “optionals” in Medicaid, it is the basis for pay discrimination, a lower rank than MDs and DOs in the military, lower pay at the VA, and a host of other discriminatory practices—including the fact that some pharmacists still question

of his/her education, training, and experience. Because education, training, and experience are life-long processes for physicians, scope should not be limited by one’s license, but rather, by one’s training, education, and experience. Currently, a DPM cannot write a physical therapy prescription to rehab a hamstring strain for a patient even though that pathology may have a direct effect on the patient’s gait (a condition that is within a DPM’s license to treat); however, if this same treatment request were signed by a dermatologist, it would be recognized.

The difference between DPMs and MDs and DOs is not knowledge or lack thereof; it is that DPMs have a limited license and the others have a plenary, or unrestricted, license. A DPM discussing diet and walking programs with patients for the purpose of improving their overall cardio-vascular health, reducing their risk of stroke, improving their blood pressure, or impacting their weight loss (which will help the national obesity epidemic and reduce the parameters for developing diabetes) would not be reimbursed for that consultation, whereas an ophthalmologist can be reimbursed for such consultation. Again, the difference is that the DPM does not hold a plenary license and is, therefore, not judged

*Continued on page 76*

## *Path to Parity (from page 72)*

by his/her knowledge or expertise but, instead, by the type of license s/he holds.

Even MDs and DOs who refer patients to DPMs are confused about their education, training, and licensure because they often have received biased and incorrect information regarding the actual training, education, and experience of DPMs. One reality that medical doctors are not confused about is that they find podiatric physicians to be indistinguishable from MD and DO residents during their training years. Medical practitioners also find that their experience working with practicing podiatric physicians is no different from that when dealing with any other medical or surgical specialist. It is difficult for our naysayers to support the argument that we are a profession “separate” from medicine—such as chiropractic, acupuncture, or naturopathy—as opposed to the reality that we practice allopathic medicine in the same way as other specialties of medicine such as ophthalmology or otolaryngology. In order to achieve true parity, we need to define and come to agreement as to what parity is. The entire profession then needs to get behind achieving this one goal of parity. We need to progress from talking to taking the relevant action that can actually accomplish this goal. If we continue to argue degrees, or believe that those who are seeking parity are not proud to be DPMs, then we will continue to “bicker” and never achieve parity.

### **Resolution 2-15**

In 2005, the APMA House of Delegates passed Resolution 2-15 which contained the following language: “Resolved that the American Podiatric Medical Association (APMA) commit itself to achieving the goal by 2015 of podiatrists being defined as physicians who treat patients in the physician’s specialty without restrictions.” The overall mission of this resolution was that podiatrists be universally accepted and recognized as physicians, consistent with their education, training, and experience. This resolution did not go unnoticed by the American Medical Association

or by the American Academy of Orthopedic Surgeons. Interestingly, the following year, the American Medical Association created the Scope of Practice Partnership to help its state medical associations fight scope battles, and this was followed by the AMA “Truth in Advertising Initiative”—put forth as a “patient safety measure” to “clear up” public confusion regarding just who was a physician and who was not.

Fortunately, this initiative emphasized the training, education, and ex-

surgical care; however, they choose to limit their medical and surgical scope of practice to their training, education, and experience, and hospitals limit their privileges in the same way. Ophthalmologists are licensed to deliver babies and perform foot surgery, but for good reason, they do not. An example through which to view this “choice to limit scope” when holding a universal license is to consider that I am a licensed DPM in California and also hold an ankle certificate. I am licensed to perform any

---

**CPMA’s definition of parity is not focused on degree because parity does not require a degree change; rather, it requires a licensing change.**

---

perience of physicians—comparing it to that of non-physicians. There was a flaw in the execution of this initiative: the hours of clinical training required of DPMs depicted in the initiative were not accurate. This opened the door for us to discuss with organized medicine the actual education, training, and experience of podiatric physicians which, as we were able to confirm, were not identical, but were quite similar to those of MDs and DOs. The original Vision 2015 has now transformed into the Path to Parity. To achieve true parity in the near future, there can no longer be confusion or disagreement among DPMs as to whether the issue is degree, licensure, or scope of practice.

Ten years ago, the profession defined parity as being designated as physicians, and having unrestricted licensure. Unlike seeking an MD degree—which would require podiatric medical schools to “convert” to medical schools—this goal is achievable through a unified strategy with our existing schools. What is critical to understand is the difference between degree and licensure. MDs and DOs have different degrees but they are both recognized as physicians in all relevant statutes because they both hold the same license—a plenary, or unrestricted one. Because they have a plenary license, they can “legally” provide any type of medical or

type of ankle surgery, but I did not receive the training and education to perform ankle surgery in my residency; therefore, I do not perform ankle surgery, and no hospital would give me those privileges if I applied for them—even though I could legally perform them.

Still, at a later time, I could receive the relevant training and education and could then perform ankle surgery without needing to change the law. Another example: many of today’s DPMs are well trained in wound care; however, a DPM in California can treat an ulcer at the ankle—but not on the leg, even though s/he is probably more capable and better trained than most MDs to treat that ulcer. To gain this one privilege, a DPM would need to change the law because s/he does not have a plenary license, and this would involve convincing attorneys and other non-physician members of the legislature, instead of simply documenting his/her training and education as is the process through which all other physician specialties gain new privileges.

### **CPMA’s Definition of Parity**

CPMA’s definition of parity is not focused on degree because parity does not require a degree change; rather, it requires a licensing change. Being

*Continued on page 78*

## *Path to Parity (from page 76)*

a physician and holding a plenary, or universal, license is based on training, education, and experience. The education and training of MDs and DOs is not the same, but the common course work that makes their training and education comparable, or equivalent, is what makes them physicians and qualifies them both for plenary licensure. In every statute, both state and federal, MD = DO, and each is considered to be a physician with the same rights and privileges. DPMs are, instead, lumped with allied health, which includes all limited licensed practitioners. At the same time, only one of this group of limited licensed practitioners has comparable training and education to that of MDs and DOs—the DPM.

Today, DPMs have four years of podiatric medical school and three years of residency, including all medical and surgical rotations, side-by-side with MDs and DOs—and with the same level of responsibility and the same expectations. Throughout training, DPMs, MDs, and DOs all have a plenary license. Imagine, a DPM in training has a universal license, but upon completion of training, his/her license is “down-graded” to a limited one because s/he is not “actually” a physician. In spite of the curricular changes and the expanding of residency training programs from “optional” to required three-year, comprehensive programs (perhaps, even followed by a fellowship), today’s DPM graduates still receive the same limited license that I received 45 years ago.

While Medicare considers us physicians for purposes of reimbursement, we are in a “lesser” category than MDs and DOs, and we are still fighting to be physicians in Medicaid. In fact, no matter where you look, no matter how much progress has been made—even under the best of circumstances—DPMs are always slightly “less than physicians.” Moving towards parity is like Zeno’s paradox. If we keep getting halfway to the goal, we get closer and closer—but never cross that goal line. Even in those states in which DPMs are listed in statutes as physicians, in most cases, this is not true par-

ity because it is usually in name only and not in licensure. The only way to get true parity is to cross the goal line and reach the point where MD = DO = DPM, with these three degrees all holding the same universal license, regardless of specialty or focus of practice.

### **Three Degrees, Same License**

The concept of three degrees that all receive the same license is one that is gaining traction and momentum in the medical communi-

ty at a number of California residency programs. Our goal is the attainment of a Physicians and Surgeons Certificate, which is the same unrestricted license that MDs and DOs hold in California. This is the natural extension at the state level of the national goal of Vision 2015 and the Path to Parity—that goal being that “Podiatrists be defined as physicians who treat patients in the physician’s specialty without restrictions.”

We have been fighting scope and discrimination battles forever.

---

**A successful outcome is achievable  
in the near future through use of this collaborative  
process that involves all stakeholders agreeing to, and  
working towards, the same goal.**

---

ty because today’s podiatric medical education and surgical training are observable and objectively measurable, and are something that can be supported by organized medicine as being equivalent. This was made particularly evident at the recent APMA House of Delegates at which Paul Phinney, MD, the immediate past president of the California Medical Association (CMA), spoke about the Physician and Surgeons Joint Task Force in California. It is through this collaborative process that CPMA is working towards our goal. Instead of “going to war” over what could be viewed as a major “scope expansion,” CMA is supporting—even expediting—the process, based on clear demonstration from us that podiatric physicians have comparable education and training to that of MDs and DOs. This “demonstration” is the path to parity that California is taking through the efforts of our Physicians and Surgeons Joint Task Force.

This group is made up of representatives from the California Medical Association, The California Orthopedic Association, the Osteopathic Physicians and Surgeons of California, and the California Podiatric Medical Association. Site visits have been conducted at the two California podiatric medical schools as well as

We have won many of them, but we never win the war because we have been focused on symptoms rather than on the underlying cause—which is that we are not considered to be physicians and do not have the same license as MDs and DOs. Reaching this goal will not require another forty years of fruitless effort with no end in sight. A successful outcome is achievable in the near future through use of this collaborative process that involves all stakeholders agreeing to, and working towards, the same goal. If this outcome is achieved in just one state, it is something that could subsequently be duplicated in any state. Ultimately, parity is not dependent on a degree change; it is achieved at the moment when DPM = MD = DO—the moment we all hold the same unrestricted (plenary) license with the same rights and privileges associated with that license. **PM**



**Dr. Hultman** is Executive Director of the California Podiatric Medical Association, practice management and valuation consultant for Vitera Healthcare Solutions, and author of *The Medical Practitioner’s Survival*

Handbook (available at [www.mbagurus.com](http://www.mbagurus.com)).