ABPM
The American Board of Podiatric Medicine

E-Mail Addresses

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October 7, 2014

Alan R. Tinkleman, Executive Director
Council on Podiatric Medical Education
9312 Old Georgetown Road
Bethesda, MD 20814-1621

Dear Mr. Tinkleman,

In response to your communication of June 3, 2014, the ABPM Board of Directors is making a formal request of the JCRSB for an "emergency" review of CPME 220 for the purpose of possibly inserting language into the document allowing the JCRSB to consider alternate pathway requests from existing boards. While the directors dislike the term "alternate pathway" because of its negative association, if that language will accommodate the needed action, so be it. The intent of the Board's request, however, is specific to bringing closure to an issue that was unintentional in the profession's attempt to improve and solidify resident training. The chronology is as follows:

a. In 2000 alternate pathway closes.
b. Recognition of RPRs as a qualifying year, along with other "certification pathway programs" is phased out by ABPS in 2003 and by ABPM in 2004.
c. Residents who graduated in 2000-2003, unlike their predecessors or successors, are locked into the certification pathway defined by their training sequence (+/- the RPR). If they happened to have a PMR-PSR sequence, or POR-PSR sequence they were eligible for either board's exam. If they had a PSR, only, sequence (or RPR-PSR sequence) it relegated them to ABPS only. Likewise other sequences could relegate them to the ABPM only.
d. In 2003 the PMS-24 and PMS-36 are initiated, eliminating the limitation to a specific certifying board, HOWEVER:
e. Some programs converted "early", and residents were given the option of receiving certificates under the "old" designation or the "new" designation. If residents chose the old designation, they were locked in to the certification pathway specified on their certificate.
f. In addition, programs were not obligated to convert to the new designation until their next scheduled on-site. That means that hypothetically programs were out there "unconverted" through 2008.

Reiterating the premise on which the ABPM directors feel the students and two cohorts of residents were placed into a scenario beyond their control, and which is now impacting more and more DPMs as time goes on, is the following:

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1. Students participating in the CASPR match could not be expected to comprehend the significance of which programs were certification path specific. Their priorities were, understandably, obtaining a program. The credibility of the COTH and CPME in the establishment and accreditation of programs would be sufficient information, as well as their perceived quality of the program itself.
2. In any case, the match was computer-mediated and the program obtained was largely out of their control. Nor could their practice patterns/preferences have been expected to be predetermined at that early stage of their training.
3. However, by the otherwise well-intended regulatory circumstance imposed by others, many of these people have been predetermined to one certifying board's pathway only.

Residents who graduated with ABFAS pathway-specific training sequences, who then became board qualified with the ABFAS enjoyed, in large part, protection from the negative consequence of health care industry/hospital limitations for the duration of their board qualified status (regardless of what their practice patterns were). As more and more realized they did not wish to, or couldn't, acquire the volume and diversity of surgical cases to sit for ABFAS certification, they began turning to the ABPM, or perhaps the non-APMA recognized boards.

As a result, there exists a population of DPMs who completed their residency training between 2000 and 2008 who have two or more years of CPME-approved training, and wish to attempt certification with the ABPM, but cannot do so. Whatever "alternate pathway" language is written, its implementation should also account for another factor, which is the phasing out of two-year training sequences in 2018, which would impose yet another proverbial nail in their coffin, if the issue referenced is not addressed by the JCRSB/CPME.
The ABPM directors feel that a narrow but reasonable window of access should be provided for these two subgroups of DPMs (i.e. graduates from programs between 2000 and 2003, and graduates from programs that did not convert their designations after the PM&S delineation was rolled out). That would weed out the mere complainers from those that truly want to become certified. A two-year window, and in no case more than three years from the time this access is created should accommodate the cohort groups equitably.

Furthermore, the ABPM directors are aligned on the idea that successful passage of case submissions would be mandatory as a precursor to access to the certification examination, regardless of duration of residency training of these individuals. That requirement would parallel the current ABPM requirement for regular-pathway candidates with only two years of training. Approved case documents would remain on file only through the final year of the window created to accommodate the cohort groups.

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The essence of the situation has been set forth. To the extent that the potential number of individuals affected, as well as the testing methodology, is worth review and discussion at this stage, the following is provided:

Number of individuals between years 2000 and 2008, by residency type, who completed a sequence accessible only to the ABFAS (i.e. they did not complete programs subsequently that relegated them accessible to both ABPM and ABFAS):

RPR/PSR-12 = 288
PSR-24 = 828
PSR-36 = 382
Total = 1498

While we have no information on those who subsequently went on to become certified by the ABFAS, if as few as 20% failed to acquire the volume and diversity of cases for access to their "designated" certification pathway, we would be looking at 300 individuals.

Depending upon what the ABPM and JCRSB mutually regard as "reasonable", the implementation could be as follows:

1. Passing case documentation mandatory for all applicants (already covered)
2. Cases on file would terminate with the final year of access
3. Window of two (or three) years to complete the process
4. Application process could coincide with the 2015, or 2016 examination year
5. If implementation is delayed until 2016 and a three year window of access is created, then candidates with RPR/PSR 12 and PMS-24 sequences would sunset in 2018, as with all other candidates with two-year sequences
6. If implementation in made in 2015 (or the window of access is two years) then item #5 would not apply, as this resulting end date pre-dates that in item #5.
7. Candidates with PMS-36 training sequences would be subject to the methodology in place for "regular pathway" candidates, with the exception of the need for mandatory case documentation (currently waived for regular pathway candidates).

Sincerely,

Marc A. Benard DPM

Marc A. Benard, DPM, Executive Director

c. ABPM Board of Directors