



COTH eNews

Volume 2019, Number 2

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We Need You at the World Scout Jamboree



The AACPM needs DPM volunteers to assist with the Podiatric Medicine career exploration exhibit tent at the 24th World Scout Jamboree. The Jamboree is at the Summit Bechtel Reserve in West Virginia from July 22 to August 2, 2019.

Volunteers from Ohio, Virginia, Kentucky and other surrounding states are invited to participate in this exciting recruitment event. The exhibit tent seeks to engage young students, showcase the

profession in a “hands-on” manner, and demonstrate the state-of-the-art technology currently in use by podiatric medical professionals in their day-to-day practices. We are partnering with industry leaders to offer engaging workshop sessions. Questions can be directed to Mandy Nau at the AACPM by email: mnau@aacpm.org

The following link guides you to the Volunteer Sign Up Forms and additional information: <http://www.aacpm.org/becoming-a-podiatric-physician/events/>

News from the April 13 COTH Meeting

COTH welcomed the new Region 4 and APMSA representatives, Dr. Danae Lowell (DVA Cleveland) and Justin Garver (Temple) respectively.

COTH also thanked Drs. Lowery, Davies and Dei for their service to COTH and its residency programs. On June 30, 2019, Dr. Clinton Lowery will wrap his term as chair of COTH and hand the gavel to Dr. Kerry Sweet. Dr. Lowell becomes the chair-elect. Dr. Lowery will remain on COTH as a regional representative. On June 30,

Dr. Davies concludes 10 years of service to COTH as a regional representative and COTH’s representative to the NBPME board. Dr. Dei will complete 8 years of service as a regional representative including 2 years as chair of COTH on the same date.

COTH approved the following recommendations to the AACPM board for its upcoming July meeting: inclusion of class rank and a section on activities related to professional advocacy on the CASPR application, an inflationary increase in CRIP applicant fees, an increase in CRIP meeting room fees, and a scheduling fee for callback interviews at CRIP. You will find your representative and contact information on the last page of this newsletter.



Seeking Volunteers for COTH Regional Representatives

COTH has two vacancies for regional representatives starting July 1. Dr. Dei completes two terms and 8 years of service for Region 3 (AL, IL, IN, KY, LA, MS, TN, WI) and Dr. Davies winds up two and half terms and ten years of service for Region 8 (NY).

If you are a program director or faculty member from either of these regions and have interest in serving on COTH, send your CV to scloffey@aacpm.org. For more information about the requirements of the position, please reach out to either Dr. Dei or Dr. Davies. Their contact information is on the last page of the newsletter.

Are You a Mentor?



DPM Mentors
Network

You can help build interest in careers in podiatric medicine by becoming a mentor with the DPM Mentors Network. Mentoring is a simple, easy way to become involved in career awareness in your community. Every practicing podiatric physician is needed to mentor; however, podiatric physicians with practices within 100 miles of a college or university are especially in demand. You may register as a mentor [here](#) and if you have any questions, contact mnaa@aacpm.org.

2019 NRMP Main Match Fills Record 34,727 Positions

The National Resident Matching Program® (NRMP®), the system utilized by U.S. and international medical school students and graduates to obtain residency positions in the U.S., announced its 2019 Match included a record-high 44,603 registrants and 35,185 positions.

When the matching algorithm was processed, 33,417 positions were filled, and of the 1,652 positions offered through the Match Week Supplemental Offer and

Acceptance Program® (SOAP®), 1,310 were filled. Only 458 positions remained unfilled at the conclusion of SOAP, resulting in an overall fill rate of 98.7 percent.



Other Highlights

First year (PGY-1) positions rose to 32,194, an increase of 1,962 over 2018. The jump was due, in part, to the number of osteopathic programs joining the Match as the transition to a single accreditation system for graduate medical education programs continues.

Osteopathic programs contributed 1,764 positions in 2019 versus 764 in 2018.

The match rate for all 2019 PGY-1 applicants was 79.6 percent, the highest since 1993 and 1.3 % greater than in 2018. Osteopathic applicants matched to first-year positions totaled 5,076, an increase of 1,305 over last year and the percent matched increased from 81.7 to 84.6, another all time high. The PGY-1 match rate for U.S. allopathic medical graduating seniors was 93.9, consistent with the historical 92-94% match rate.

For the third year in a row, the number of registered non-U.S. citizen medical graduates declined to the lowest since 2005; however, more non-U.S. graduates matched to PGY-1 positions than any other year in history. This year, 47.1 percent of U.S. allopathic seniors matched to their first-choice program, 1.4 percentage points lower than in 2018. Among all other applicant types, the percentage of first-choice matches was 33.1, up 1.5 percentage points from 2018. [View and download the 2019 Results and Data reports](#)

Changes in ABFAS ITE Fees, Effective for 2020

Because of increased Pearson VUE exam time associated with all ITE exams, ABFAS will be changing its ITE exam fees effective July 1, 2020. These fees do not cover all of ABFAS' ITE examination expenses and ABFAS does not make a profit on its ITE examinations. The new fees are detailed below. For more information, contact Kathy Kreiter, Executive Director, at 415-553-7806.

| Examinations | Current Fee | Fee Effective July 1, 2020 |
|--|---|---|
| In-training (PGY 1&2 and PGY 3 for 4 yr. programs) | Examinations <ul style="list-style-type: none"> • Foot Didactic - 90 items • Foot CBPS – 8 cases Residency Program Fee - \$200 | Examinations <ul style="list-style-type: none"> • Foot Didactic – 80 items • Foot CBPS – 8 cases • RRA Didactic – 80 items • RRA CBPS – 8 cases Residency Program Fee - \$240 |
| In-training (Final Year) | Examinations <ul style="list-style-type: none"> • Foot and RRA Didactic – 90 items • Foot and RRA CBPS – 4 foot cases/4 RRA cases Residency Program Fee - \$200 | Examinations <ul style="list-style-type: none"> • Foot Didactic – 80 items • Foot CBPS – 12 cases • RRA Didactic – 80 items • RRA CBPS – 12 cases Residency Program Fee - \$300 |

News from the Colleges

The Provost of Barry University announced that Dr. Bryan Caldwell will be the next Dean of Barry University's School of Podiatric Medicine (BUSPM). Effective August 1, Dr. Caldwell succeeds Dr. Albert Armstrong and Dr. Armstrong will return to full-time faculty status.



Dr. Caldwell currently serves as Assistant Dean, Director of Clinical Education and Clinical Operations, and Professor at the Kent State University School of Podiatric Medicine. He earned a bachelor's degree from the University of South Florida, a master's degree from the University of Notre Dame, and a Doctor of Podiatric Medicine degree from the former Ohio College of Podiatric Medicine. He completed a hospital residency at Florida Hospital in Orlando, FL. Dr. Caldwell is certified by the American Board of Podiatric Orthopedics and Primary Podiatric Medicine. In 2013, Dr. Caldwell returned to medical school and earned a Doctor of Medicine degree in 2017 from the International University of Health Sciences.

First-year Doctors Spend Almost 90% of Their Time Away from Patients

A new study from researchers at Penn Medicine and Johns Hopkins University found interns spend 87 percent of their work time away from patients and half of that is spent with electronic health records. Of the 13 percent of their time spent with patients face-to-face, most of that is spent multitasking.

This is largest study to look at how young doctors spend their work day while in training and the study was published in JAMA Internal Medicine. "This objective look at how interns spend their time during the work day reveals a previously hidden picture of how young physicians are trained, and the reality of medical practice today," said lead author Krisda Chaiyachati, MD, an assistant professor of Medicine in the Perelman School of Medicine of

the University of Pennsylvania. "Our study can help residency program leaders take stock of what their interns are doing and consider whether the time and processes are right for developing the physicians we need tomorrow."

This study is a part of a larger effort known as the Individualized Comparative Effectiveness of Models Optimizing Patient Safety and Resident Education (iCOMPARE) research. iCOMPARE is a multi-year study, funded by the National Institute of Health (NIH) and the Accreditation Council for Graduate Medical Education (ACGME). Its goal is to better understand the impact of shift lengths on young doctors and their patients.

Last month, two additional iCOMPARE studies published in the New England Journal of Medicine demonstrated that first-year doctors do not experience chronic sleep loss and patient safety is not affected when doctors-in-training are allowed to work longer shifts than ACGME had previously permitted.

The current study used data from six different internal medicine programs participating in the national iCOMPARE study. The activities of 80 interns were recorded over three months in 2016 covering 194 shifts and 2,173 hours. Activities were classified into categories of direct patient care, indirect patient care, and education. Direct patient care included time directly speaking with patients or their family; indirect patient care was time spent on things like working with medical records, communicating with other clinicians, or viewing images; and time spent studying and being taught while in the hospital was classed as education.



Chaiyachati noted that it's too early to tell "whether or not how interns allocate their time is 'good' or 'bad.'" Further research is needed into how time spent on these shifts affects patient care or physician well-being. Researchers also found multitasking was common in all activities. Roughly 25 percent of interns' time with patients occurred in conjunction with time spent coordinating care or updating medical records.

Researchers note that this study can serve as an important baseline for training programs and hospitals to use when adjusting programs, shifting responsibility for tasks to other health care providers, or automating processes. The iCOMPARE team continues to analyze its data to find clues on how the work day could be modified so that doctors in training experience less burnout and improved professional satisfaction during training.

3D Printed Feet Employed for Training

At the University of South Australia, 3D foot models will be playing an important role in teaching fourth-year podiatry students how to treat and manage high-risk foot conditions.

A recent press release on the 3-dimensional feet noted that a gooey mixture is added to the newly printed feet to mimic infected and non-infected diabetic foot wounds. The mixture, a blend of icing sugar, chicken stock and flexible resin, creates realistic foot ulcers, as part of a world-first podiatric training initiative at the University. The 3D printed feet are formed with wound-like cavities in place and composed of thermoplastic polyurethane (a plastic with many properties, including elasticity, transparency, and resistance to oil, grease and abrasion). Each foot takes a week to print, and costs less than \$ 4 AUD (\$2.80 USD) to produce. The University's podiatry team adds the life-like ulcers and effects that encompass anything from dry gangrene to oozing pus.

Treating severe foot conditions is an essential podiatric skill, particularly given the

continued increase in type 2 diabetes within the population. Foot care is very critical for diabetics as one small cut can potentially have catastrophic consequences that include foot ulcers, lower limb wounds, or amputations. Diabetic foot disease is one of the leading causes of disability across the world and has a mortality rate worse than many cancers.

Medically removing dead or damaged skin exposes the healthy tissue underneath and encourages healing. However, learning the necessary scalpel skills to do this is challenging due to the risks of 'practicing' on such a high-risk population. The 3D foot models, plus the mock injuries with which they are enhanced, enable the University to provide a realistic but safe learning tool and allow students to practice their scalpel skills before treating a real patient. To augment the training, ulcer debridement and management videos are being created in partnership with the high-risk foot clinic at the Royal Adelaide Hospital.



New technologies are opening doors every day. Students may be, pleasantly or unpleasantly, surprised by the models but the University believes they will be gaining confidence, techniques and critical skills that will put them steps ahead of their competition.

The Value of Health Systems Science Education

More and more frequently, awareness of factors outside the clinic or hospital has compelled changes in medical education. A recent article by Davis and Gonzalo published in the AMA Journal of Ethics, enumerated the values of health systems science (HSS). Since the 1990s, greater emphasis on medical errors and a movement to improve care delivery models resulted in systems-based practice being included as 1 of the 6 core competencies in undergraduate and graduate medical education. In recent years, many medical colleges have also included HSS as a part of their curriculum. In the article, the authors outlined ways in which HSS competencies are valuable in a medical education and how they can benefit physicians and patients outside the medical school setting.

The authors sees the shift toward incorporating health systems science in medical education as a new professional identity for physicians. They believes physicians must move beyond serving as diagnosticians and caregivers to embrace roles of leader and collaborator on healthcare teams. Mastering HSS competencies--such as teaming, leadership, and healthcare structures, processes, and collaboration; allows physicians to become "citizens of the healthcare system." This reimagining of physicians' identities, the authors assert, is a part of this "citizenship" and requires determining how social factors impact patients' lives and examining strategies, such as providing patients with cheaper alternatives to medications, assisting patients in enrolling in medical assistance programs, or identifying and rectifying inefficient clinical processes; to improve health care delivery and patient health.

Embracing opportunities to address the needs of patients' daily lives and their communities is a role for medical schools in the health systems science framework to the authors' thinking. Collaborations with outside institutions, such as social work or drug rehabilitation programs, could give medical colleges the opportunity to align physician training with assisting patients to meet day-to-day needs. If these types of ideas were incorporated into the role of medical schools, Davis and Gonzalo believe it would naturally lead to better

health outcomes from more interaction between physicians, community workers, and patients.

Many medical schools are starting to adopt HSS topics into their curricula and educating their students on the relevance of health systems science topics to patients' day-to-day lives. The Penn State College of Medicine, for example, encourages students to pursue activities in accordance with the health systems science curriculum. A benefit coming from this approach was a student-developed program, funded by the institution, to provide fresh produce to at-risk patients. As healthcare continues to evolve, the authors believe that medical education must also change. By including HSS competencies in medical education curricula, they think medical colleges will help ensure that future physicians are ready to be competent systems citizens who can provide improved patient care.

Reference: Davis CR, Gonzalo JD. How medical schools can promote community collaboration through health systems science education. *AMA J Ethics*. 2019;21(3):E239-E247.

Why Do Doctors Overtreat? For Many, It's What They're Trained To Do

After her family practice residency, Jenna Fox signed on for a yearlong advanced obstetrics fellowship to learn to deliver babies. She knew she would need to practice as many cesarean sections as possible. The problem was, she also knew C-sections aren't always the best thing for patients and doctors are working to decrease C-section rates in hospitals around the country. "I want to avoid primary C-sections. But also in this one year of my life I want all the primary C-sections in the world," Fox says. She feels that the more C-sections she does during her fellowship, the better prepared she will be to practice independently. "It's me feeling conflicted, internally, all day, every day," she says.

Medical education is built on the notion that the more procedures or treatments doctors see and do increases their competency when they're independent. It becomes tempting to do more rather than less. But excessive medical tests and treatments have financial and personal costs, contribute to rising health care spending, and subject patients to



anxiety and the risk of unnecessary procedures. A group of medical educators thinks this epidemic of overtreatment, as they call it, begins with habits that doctors form during training — habits the group hopes to break with new approaches to medical education.

There's some evidence that patterns learned in residency are hardwired for a physician's career. For example, a 2014 JAMA study showed that doctors trained in regions where patients experienced more tests and procedures went on to independent practice in a similarly aggressive style. Academic medicine is often criticized for emphasizing an overly thorough workup for ordinary problems. In the name of learning, young physicians may be

drawn to order lots of tests, a trial-and-error approach that has real implications for their patients. But more isn't necessarily better and it's not news that U.S. health care costs are out of control. The U.S. spends more on health care, per capita, than any other developed country. Unnecessary tests and treatments may contribute to those high costs. A 2010 estimate from the Institute of Medicine (now known as the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine), projected that medical interventions could be reduced by 30 percent without sacrificing quality of care.



There can be a disconnect between that abstraction and deciding how to treat a patient. "Nobody went to medical school to treat the GDP," says Christopher Moriates, a physician and dean at Dell Medical School in Austin, Texas, who designs medical school curricula to teach appropriate use of tests. Instead, medical educators must focus on a different argument to teach prudent use of tests and treatments: the human costs of overtreatment. Order enough medical tests and eventually an abnormal value results. Doctors may feel obligated to treat that abnormality — even if the patient would have lived a healthy life without knowing about it. "It's totally natural to think more information is just going to be better," says Moriates. "Eventually it leads to patients feeling less well than they actually are, if you uncover things that are meaningless but abnormal."

Moriates and other medical educators are trying ways to teach this model early in medical education to help medical students and residents curb these instincts before they become habits. One area that seems to have some promise is using doctors' competitive spirit and demonstrating how they compare to their peers. Internist and Columbia assistant professor Joshua Geleris published a study in 2018 that looked into the number of tests that internal medicine residents ordered during the 2016-2017 academic year at a New York residency program. Geleris and his co-authors didn't distinguish between tests ordered on different types of patients, since all residents spend equal time in intensive care units and regular hospital floors. Their findings were that some residents ordered seven to eight times more tests than their peers. While it's hard to say what number of tests is the correct one, the variability is concerning.

At Johns Hopkins Hospital in Baltimore, a group of professors is trying to provide similar, real time data to their residents in hope it might encourage doctors to think more carefully about what tests are truly necessary. Johns Hopkins radiologist Pamela Johnson, an associate professor who teaches residents about appropriate use of tests, gives out personalized reports showing how individual doctors rate against their peers. She's currently analyzing whether the reports are effective in decreasing the number of CT scans ordered to check for blood clots in the lungs. Clear guidelines exist for when a CT scan is the right test to check for clots but she says they're often ignored, partly because doctors are afraid of missing a life-threatening condition. "The best way to avoid a diagnostic error is to avoid an unnecessary test," Johnson says.

This kind of peer pressure may be useful for fully trained doctors too. Internist Adam Cifu, a

professor at the Pritzker School of Medicine in Chicago who has written about medical overuse, recalls his personal experience with an infectious disease physician charged with decreasing unnecessary antibiotic use in the hospital. Cifu was told he was one of the worst offenders when it came to using broad-spectrum antibiotics for ordinary urinary tract infections. Knowing that he was over-treating compared to his peers, made him cutback on his prescribing almost immediately. "We're all ridiculously obsessive high achievers," Cifu says. "Seeing that I'm not in the 90th percentile or above kills me."

Medical school professors hope to further exploit this competitive spirit when teaching students and residents to test and treat responsibly. Johns Hopkins associate professor Lenny Feldman says he's hopeful these "report cards" will help normalize more judicious ordering of tests. "We have to break the cycle somewhere," Feldman says.

Podiatrist Creates Orthotic for Alan the Wombat

A Queensland Australia podiatrist and a prosthetist branched out from their usual profession of treating humans to help create an orthotic for an injured wombat.

The Rockhampton Zoo approached a local podiatrist about an ulcer on wombat 'Alan's' back leg. Fate, it would seem, lead them to a podiatrist of the same name, Allan Harwood, who was instantly interested to see what he could do for the furry marsupial. "Alan was a wombat that the zoo picked up quite some years ago," Mr Harwood said. "He was hit by a car, which injured his right rear foot and left it misshapen.



"Alan was a wombat that the zoo picked up quite some years ago," Mr Harwood said. "He was hit by a car, which injured his right rear foot and left it misshapen.

"Standing on that foot, there was a pressure point that kept breaking down and while his health was good, in his later years, he needed some extra help and the question was asked whether the podiatrist could do anything to help this spot and help heal the ulcer." Harwood said they attempted to take a plaster cast of Alan's foot but he didn't enjoy sitting still for too long.



They did manage to take a print of his paw using foam, from which they were able to derive measurements. Marcus Wood, a visiting prosthetist who makes artificial legs, was brought in and he was able to create an orthotic to off-load the pressure point. But Harwood said the wombat was a 'bit of a Houdini'. "It was lovely to see how that would fit on his foot but it wasn't always staying in place, so we had our staff here sitting behind the front counter stitching pieces of leather and velcro on to make it work a little more effectively," he said. "It was a labour of love — it was a bit of a pleasure to try to create something that was going to off-load this pressure but still leave his claws sticking out because a wombat still needs to scratch."

Sadly, Alan passed away this March from old age. He had been at the Rockhampton Zoo for 20 years.

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We welcome your comments, suggestions, and submissions for inclusion in future editions.

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COTH Regional Representatives Want to Hear From You

The Council of Teaching Hospitals oversees the administration of the COTH, CASPR and CRIP programs and associated websites. Your COTH Regional Representative wants to hear about your activities and concerns. They are a resource for you to get answers to your questions, raise issues, and available to listen to your suggestions.

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