

# Hospital and Surgical Privileges for Doctors of Podiatric Medicine

## *A Position Statement from the American Board of Podiatric Medicine*

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The Board of Directors of the American Board of Podiatric Medicine approved the following position statement regarding hospital and surgical privileges for doctors of podiatric medicine on February 27, 2019. This statement is based on federal law, Centers for Medicare and Medicaid Services Conditions of Participation and Standards of the Joint Commission, and takes into account the current education, training, and experience of podiatrists to recommend best practices for hospital credentialing and privileging. (J Am Podiatr Med Assoc 109(S1): 1-4, 2019)

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Doctors of podiatric medicine (DPMs) are licensed independent practitioners, classified as physicians in the Social Security Act, who specialize in the medical and surgical care of the foot and ankle and related structures. To provide comprehensive patient care, it is necessary for DPMs to obtain hospital privileges. However, because laws, credentialing and privileging requirements, and policies vary by state and hospital, the process is not uniform.

The American Board of Podiatric Medicine (ABPM) is one of the two specialty boards recognized to certify doctors of podiatric medicine by the Joint Committee on the Recognition of Specialty Boards (JCRSB) of the Council on Podiatric Medical Education (CPME), which receives its authority from the American Podiatric Medical Association (APMA).

The ABPM certifies DPMs in the areas of podiatric medicine and orthopedics if they successfully pass a comprehensive examination process. The ABPM exam focuses on the following major subject areas: podiatric medicine, medical imaging, pathology, public health, internal medicine and medical subspecialties, wound care, emergency medicine, anesthesiology, podiatric surgery, general surgery, and surgical specialties.<sup>1</sup>

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The American Board of Podiatric Medicine created the *Guide to Credentialing and Privileging Doctors of Podiatric Medicine* to assist hospital credentialers in understanding the nuances of podiatric education, and training, and how to use a DPM's experience as a key differentiator in the granting of hospital and surgical privileges. This position statement is based on the aforementioned *Guide*, Centers for Medicare and Medicaid Services (CMS) Conditions of Participation, and the Standards of The Joint Commission.

### **Position #1: The hospital's primary duty in granting privileges is to protect the public by ensuring competency of health practitioners.**

The responsibility for granting staff membership and delineating clinical privileges rests with the hospital's governing board and is discharged through the organized medical staff. This position statement is not intended to usurp the authority of a hospital or medical staff to determine the most appropriate process for judging the clinical competence of providers; rather the goal is to provide the ABPM's positions on the current standards of evaluating the competence of podiatrists.

The Centers for Medicare and Medicaid Services has stated:

*"The hospital's Governing Body must ensure that all practitioners who provide a medical level of care and/or conduct surgical procedures in the hospital are individually evaluated by its Medical Staff and*

*that those practitioners possess current qualifications and demonstrated competencies for the privileges granted.”<sup>2</sup>*

## **Position #2: The podiatrist’s hospital and surgical privileges should be based on their education, training, and experience.**

Criteria-based privileging is a requirement of CMS and all other accrediting agencies with deemed status granted by CMS (ie, The Joint Commission, DNV GL, Healthcare Facilities Accreditation Program, and others). Specifically, the CMS Conditions of Participation *Interpretive Guidelines* state:

*“The process articulated in the medical staff bylaws, rules, or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:*

- *Current clinical competence*
- *Individual training, including residency and fellowship training, post-graduate certification of training and/or preceptorship*
- *Individual experience or ongoing clinical practice in the privileges requested/granted*
- *Individual judgement”* <sup>3 (§482.12(a)(6))</sup>

## **Education**

Podiatric medical education is a nationally standardized, 4-year, graduate-level program offered at one of nine podiatric medical colleges accredited by the CPME and governed by *Document 120*.<sup>4</sup> Upon completion of the program, graduates are given the DPM degree. The American Association of Colleges of Podiatric Medicine (AACPM) curricular guide<sup>5</sup> provides an overview of the didactic curriculum, which includes basic sciences (general anatomy, neuroanatomy, lower-extremity anatomy, biochemistry, embryology, medical genetics, composite histology, physiology, microbiology/immunology, pathology, and pharmacology) and clinical sciences (geriatrics, medicine and its subspecialties, radiology, orthopedics, surgery and anesthesiology, and community health).

Following didactic education, podiatric medical students engage in hands-on, hospital-based clerkships in podiatry and major subject areas of medicine.

## **Training**

Podiatric Medicine and Surgery Residency (PMSR) programs are nationally standardized, 3-year, Grad-

uate Medical Education (GME)–funded, postgraduate training programs in inpatient and outpatient medical and surgical management.<sup>6</sup>

In addition to podiatric medicine and surgery training received during a PMSR, the following rotations are required: medical imaging; pathology; behavioral sciences; infectious disease; internal medicine and/or family practice; general surgery; anesthesiology; emergency medicine; one of the following surgical specialties—orthopedic, plastic, or vascular surgery; and two of the following medical subspecialties—dermatology, endocrinology, neurology, pain management, physical medicine and rehabilitation, rheumatology, wound care, burn unit, critical care medicine, pediatrics, or geriatrics.

Beyond residency training, some podiatrists complete a fellowship in a subspecialty of podiatry. The length of podiatric residency training was uniformly standardized in 2011. The current designation is the PMSR and it is 3 years in length. Prior to that, many designations were given to CPME-approved residency programs including Rotating Podiatry Residency (RPR), Primary Podiatric Medicine Residency (PPMR), Podiatric Orthopaedic Residency (POR), Podiatric Surgery Residency (followed by the length in months—PSR-12, PSR-24, and PSR-36), and Podiatric Medicine and Surgery (followed by the length in months—PMS-24 and PMS-36). All these programs were accredited by CPME, and we recommend that organizations recognize any CPME-approved program in the consideration of membership and privileges.

## **Experience**

An evaluation of a podiatrist’s current experience is the best method to determine competence to perform requested procedures. This experience can be in the form of a log maintained by the podiatrist during training or postresidency or it can be obtained from another health-care facility.

Neither CMS nor The Joint Commission requires that a summary report of clinical activity be submitted at the time of initial appointment. However, both CMS and The Joint Commission require primary-source verification of an individual applicant’s character, competence, experience, training, and judgement. The Joint Commission requires evidence of current competence and expects organizations to obtain information regarding licensure, education, training, experience, and competence; CMS requires an examination of documented experience.

**Position #3: If board certification is a required element for a podiatrist's hospital or surgical privileges, the requirement should be for certification in their primary specialty.**

Neither CMS nor The Joint Commission requires board certification for staff membership or clinical privileges, and CMS specifically prohibits the use of board certification as the sole criteria for credentialing or granting privileges: "Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society."<sup>3</sup>(§482.12(a)(7))

This does not mean that hospitals cannot require board certification, but it may not be the sole factor. Although the certification or lack of certification of the applicant does not, in and of itself, indicate clinical competence, certification does show that the applicant has demonstrated a grasp of the knowledge necessary to perform effectively. Increasingly, medical staffs are requiring that applicants have board certification or are board eligible (as defined by the applicable specialty board) and obtain their certification within a timeframe specified in the medical staff bylaws.

Both ABPM and the American Board of Foot and Ankle Surgery (ABFAS) are recognized by the JCRSB of the CPME to provide certification of doctors of podiatric medicine and should be considered certification in one's primary specialty.

Both CPME-recognized boards have changed their names in recent years. The American Board of Podiatric Orthopaedics and Primary Podiatric Medicine (ABPOPPM) is now doing business as the American Board of Podiatric Medicine (ABPM). The American Board of Podiatric Surgery (ABPS) is now doing business as the American Board of Foot and Ankle Surgery (ABFAS).

**Position #4: If a podiatrist lacks sufficient experience to be granted a requested privilege, a process should be offered as a means to demonstrate competence.**

Podiatrists may apply for privileges for which they lack the level of experience required by the facility. Additionally, technology and medical knowledge is rapidly evolving and a process to evaluate the competence of practitioners to perform new procedures or use new devices should be adopted by the organization. In some cases, documentation of

experience through participation in a course may be sufficient. Additionally, a proctoring process using a focused professional practice evaluation during a provisional period prior to the granting of independent privileges can be useful.<sup>7</sup>

**Position #5: Podiatrists are physicians and should be granted privileges to perform a complete history and physical examination.**

Podiatric Medicine and Surgery Residency standards include the performance and interpretation of comprehensive medical history and physical examinations (including preoperative history and physical examination) inclusive of head, eyes, ears, nose, throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, and neurologic examination.<sup>6</sup>

Furthermore, CMS Conditions of Participation state that a medical history and physical examination is required to be completed and documented for each patient no more than 30 days prior to or 24 hours after hospital admission and prior to surgery and other procedures requiring anesthesia: "The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy."<sup>3</sup>(482.22(c)(5)(i))

Section 1861(r) of the Social Security Act includes a Doctor of Podiatric Medicine in the definition of a physician.<sup>8</sup>

The competence to perform a complete history and physical examination is a basic component of the education and training of a doctor of podiatric medicine and should not require a separate demonstration of postgraduate competence.

**Position #6: Podiatrists should be evaluated for privileges on their competence and not discriminated against on the basis of their degree.**

State laws on the definition of podiatry and the scope of practice are variable. When allowed by state law, podiatrists who are competent to offer the full scope of podiatric care should be given the opportunity to obtain those privileges.

Privileges available to DPMs should include the opportunity to admit to the hospital, supervise hyperbaric oxygen treatments for in-scope conditions,<sup>9</sup> harvest tissue from elsewhere on the body to

treat an in-scope condition, administer conscious sedation, and have full access to prescribe antibiotics for resistant infections. CMS Conditions of Participation state that:

*A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that—*

- (i) Is present on admission or develops during hospitalization; and*
- (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is—*
  - (A) Defined by the medical staff;*
  - (B) Permitted by State law* <sup>3(§482.12(c)(4))</sup>

Thus, CMS hospital regulations do permit doctors of podiatric medicine, as allowed by the State, to admit patients to a hospital. However, CMS does require that Medicare and Medicaid patients who are admitted by a DPM be under the care of a MD/DO with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting podiatrist.

### **Position #7: Hospitals should not exclude podiatrists who completed previously approved training pathways for membership or privileges.**

It is with the understanding that the profession of podiatry has evolved greatly and continues to evolve that hospitals should maintain an inclusive attitude toward podiatrists who completed training under older, but approved, standards by the CPME.

The ABPM recommends the following language be adopted for medical staff membership:

- Successfully complete a residency program approved by the Council on Podiatric Medical Education (CPME), the credentialing body recognized by the American Podiatric Medical Association (APMA); and
- Be board certified or become board certified by a board recognized by the CPME within 5 years (if board certification is required by the organization).

The ABPM recommends that hospitals use a podiatrist's current documented experience as the

key factor in determining the delineation of individual privileges.

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**Conflict of Interest:** None reported.

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