The California Board of Podiatric Medicine began focusing on education and training issues in 1991 as residency directors and its examination commissioners reported concerns about the quality of graduates from the schools and postgraduate training programs. The Medical Board of California, with which the California Board is tied organizationally, soon began participating in this review. The interaction between the two boards led to the jointly sponsored Medio-Nelson study.\(^1\)

Since release of the Medio-Nelson recommendations in 1993, the board has emphasized their implementation. The board’s consumer-protection mandate from the California legislature, which underlies its statutory charges for approving colleges and residency programs, is the chief reason for doing so.\(^2\) But the board also considers its course important to the advancement of the profession and quality foot care. The board believes it would be damaging to the public and the profession not to implement the recommendations. That medical, government, and other opinion leaders are watching in no way lowers the stakes.

Steps taken to date include the following:

1) legislation enacted in 1994 requires applicants for licensure, beginning in 1998, to complete 12 months of residency training that includes at least some surgical training;\(^3\)

2) legislation in 1995 added women’s health, pediatrics, and behavioral science to the required curriculum list for approved schools as of the year 2000;\(^4\)

3) regulations promulgated in 1995 amend the approval criteria for hospitals sponsoring residency programs to require that they designate a director of medical education, provide emergency room rotations, measure and evaluate the progress of participants and program effectiveness, and meet the Accreditation Council for Graduate Medical Education’s (ACGME) general, institutional requirements for all medical residency programs;\(^5\)

4) the board initiated the independent California Liaison Committee on Podiatric Medical Education in 1993 to involve all segments of the profession in implementing the Medio-Nelson recommendations, particularly the negotiations with University of California officials for greater access to state-supported health science teaching centers.\(^6\)

These initiatives are supported by consumers, a large majority of the board’s 2,000 licensees, and, most especially, podiatric residents and students. The California Medical Association and California Orthopaedic Association are not opposing these initiatives, at least not overtly. The medical board has been supportive overall, especially in its public positions.

The leadership of the University of California has facilitated the arduous negotiations that California Liaison Committee’s “U.C. Access Teams” are pursuing with medical school deans and hospital directors. Led by progressive doctors of podiatric medicine seeking higher standards for their profession, the California Liaison Committee for Podiatric Medical Education is nurturing this support to move forward.

The board has repeatedly sought input from the interested public, professional organizations, and educational bodies. It has funded expert reports,
such as the newly released “Podiatry’s Role in Primary Care” by the University of California at San Francisco Center for the Health Professions, which supports the board’s direction. Gragnola and O’Neil\textsuperscript{7} comment:

Though our analysis supports the comprehensiveness of podiatric education and training, we do not conclude that the podiatrist is an independent primary care provider. Podiatric services are an important aspect of overall health care and should be considered an essential part of primary care. The value of podiatry is manifested in the intense knowledge and expertise in care of the foot, something no other profession can avow. We feel that a divergence from this purpose would be a detriment to the future success of the profession. Given the dynamics of the changing health care environment however, opportunities lie ahead for podiatry to integrate into primary care networks and to function as an important member of the primary care team. Primary podiatric medical residencies will serve to further validate this integration, but should take caution to balance the principal objectives of the profession.

The board also amends and distributes its strategic plan continuously, holding it up to scrutiny as to whether it is thoughtful, prudent, and in the public interest.

A number of association and college officials have challenged the board on these criteria. Most recently, the American Association of Colleges of Podiatric Medicine noted that the California Board “has gone beyond the customary role of a licensing board” and raised concerns about the impact on the authority of accrediting agencies, deans, and faculties.\textsuperscript{8}

**Accreditation and Licensure**

The California Board’s primary concern, of course, must be the exercise of its responsibilities to protect the public. Protecting the public includes enhancing, through standard setting, the quality of future foot care in California. This will depend on the quality of training provided to current and future students and residents.

But even given the board’s commitment to being a change agent for higher standards, and desire to counteract pressures on the profession’s national bodies for the status quo, it would still be inappropriate for California to usurp or undermine the appropriate functions of other agencies. Examining the responsibilities of these various bodies, particularly accrediting and licensing agencies, will facilitate discussion of how they should be exercised.

**Accrediting Bodies**

Among the numerous accrediting agencies it recognizes, the US Department of Education lists the Council on Podiatric Medical Education (CPME) as the reliable authority concerning the quality of podiatric medical schools. The Department of Education provides this backdrop:

The United States has no Federal ministry of education or other centralized authority exercising single national control over postsecondary educational institutions in this country. The States assume varying degrees of control over education, but, in general, institutions of higher education are permitted to operate with considerable independence and autonomy. As a consequence, American educational institutions can vary widely in the character and quality of their programs.

In order to insure a basic level of quality, the practice of accreditation arose in the United States as a means of conducting nongovernmental, peer evaluation of educational institutions and programs.\textsuperscript{9}

The education department also comments that “The accrediting agency, in collaboration with educational institutions, establishes standards,” and that among the functions of accreditation is to establish “criteria for professional certification and licensure.” It defines accrediting agency as one that “conducts accrediting activities through voluntary, non-Federal peer evaluations” and defines accreditation as “the status of public recognition that an accrediting agency grants to an educational institution or program that meets the agency’s established standards and requirements.” The CPME offers a similar definition of accreditation:

The recognition of institutional or program compliance with standards established by the profession, based on evaluation of the institution’s own stated objectives. Accreditation is a voluntary process in which institutions seek an independent judgment by peers.\textsuperscript{10}

Levrio\textsuperscript{11} comments:

Accrediting bodies have no legal authority to require or mandate that any institution perform in a certain manner or comply with established standards. As private agencies, accrediting bodies derive no direct authority from public law, as do federal, state, and local governments.\textsuperscript{12} The process, in theory, is considered to be voluntary, but the inextricable link between accreditation and licensure for health professions suggests that health professional schools must be accredited in order to confirm degrees of value for licensure . . .

. . . accreditation can be only partially effective in
promulgating the improvement of educational quality. The Council can evaluate quality and help to enhance it, but the colleges must take the initiative to engage in meaningful self-assessment. The colleges must take an honest look at their weaknesses and limitations and be prepared to make changes.

The American Medical Association defines accreditation as:

A device traditionally used by medical organizations to maintain and upgrade the standards of medical care through the granting or withholding of approval for teaching institutions . . . . Early in this century, the process became more effective as the states began to require graduation from an ‘accredited’ medical school as a condition of licensure.

Physicians must be licensed by the state in which they practice. The qualifications for licensure vary from state to state. In general, however, a physician must graduate from an accredited . . . school.12

The ACGME comments that accreditation:

. . . is the process for determining whether a training program conforms to established standards. Accreditation represents a professional judgment about the quality of an educational program . . . .

Licensure is distinct . . . . Licensure is a process of state government through which an individual physician is given permission to practice medicine within a particular state.13

Licensing Boards

In contrast to accreditation, Schneidman14 states “licensure is public, legal, and mandatory.” Meikle15 states:

Medicine is, for the most part, self-governed . . . . Ultimately, however, government is responsible for ensuring that the various institutions involved in medical education produce physicians trained to provide compassionate, competent, and accessible care. This responsibility to regulate the education and training of physicians is constitutionally reserved for state government; and, in all states . . . . the legislatures have established medical boards . . . . that are broadly charged with protecting the public.

Sigel16 says “State medical boards are agents of the people acting through their legislatures.” Langsley17 writes that “A license to practice medicine . . . . indicates that the physician has met certain standards designed to protect the safety of the public. Though licensure demands only a minimal level of competence in comparison with specialty certification, it does set standards for medical education.”

Licensing boards are beginning to face criticism for their deference to accreditation. A 1995 report from the Pew Health Professions Commission Taskforce on Health Care Workforce Regulation comments:

In virtually every state and for every profession, approval means that boards defer to private, voluntary organizations that accredit educational institutions or programs. Some accrediting programs remain integral parts of national professional associations; others have spun off, but the majority continue to be controlled by professional interests.

Because accreditation means survival for educational institutions, and is required for licensure eligibility, it is a powerful force in shaping educational policies, licensure requirements, and the types of graduates entering the workforce. Accreditation standards and processes also have been criticized for not keeping up with advances in professional knowledge and health care technology, thereby limiting innovation and perpetuating stagnant curricula (Gelmon, 1995). Others note that neither health care employers, payers, nor the public are involved effectively in discussions of these standards (Begun and Lippincott, 1993). Consequently, public trust in accreditation has eroded because of the perception that self-regulation mechanisms are invisible or seem unresponsive to the public (Western Association of Schools and Colleges, 1993).

These criticisms . . . . apply to all professions where educational accreditation and professional licensing are linked informally and state authority is perceived as ceded to private professional interests. This automatic deference to professionally controlled accreditation processes has come under increased scrutiny.18

Discussion

Debate in the literature provides strong support for licensing boards moving to exercise their responsibilities more proactively. Bumgarner19 observes that “Regulatory boards in general, and medical boards in particular, have basked for decades in the obscurity of public invisibility,” but he agrees with Winn20, who states that “State medical boards are under increasing pressure to ensure the delivery of quality health care to the citizens of the state.”

Yessian21 reflects that one response for boards is to:

. . . . hunker down and carry out their traditional licensing and enforcement activities. . . . Such an approach might have value for those who cherish stability and tradition. But I submit it would make boards about as relevant to today’s quality assurance agenda as San Francisco’s cable cars are to
the modern need for rapid intercity transit . . . . The public is likely to hold medical boards more accountable than any other quality assurance body. After all, they are public entities established for the purpose of protecting the public.

Medical licensure authorities:

. . . are being compelled to face a paradigm shift of major significance—from a system grounded in self-regulation by the medical profession itself to one based on protecting the public in accord with its expressed interests . . . . In the public protection paradigm, medical licensure authorities are public, not professional, bodies focused on public protection.22

This shift reflects not a change in state laws, but a better understanding of them.

Bowles23 adds that “the American public and its political representatives in all jurisdictions will seek greater accountability in medical licensing.”

Meikle24 comments:

The curricula of medical schools should be strongly influenced by what state boards determine to be minimal competencies for medical practice . . . . In a sense, medical boards serve as overseers and enforcers of last resort of the social contract between medical education and the public. When there are subjects which are not taught or adequately emphasized . . . and which state boards consider to be desired competencies in practitioners, boards should use licensure as the lever to promote their incorporation.

Meikle15 believes states must act to reform medical education:

The need to change medical education seems to be more widely and more seriously appreciated now than at any time in the past 15 to 20 years, yet many medical school faculties continue to resist change. Identifying individuals and institutions that can effect reform of medical education is a constant challenge to organizations interested in improving the competence of . . . American physicians.

If agencies and organizations outside medicine are to influence the direction of medical education, they must shift their efforts from medical school faculties toward government institutions and agencies responsible for supervising medical education. The government is not fulfilling its responsibilities for overseeing the education of physicians . . . .

These boards have broad powers to shape the medical profession, but for the most part do not fully exercise them . . . . Medical boards establish the requirements that an applicant must satisfy to obtain a license to practice medicine. In many ways, that is the single most potent and underutilized lever for reforming medical education . . . .

Using their authority to control medical licensing, medical boards could help reform medical education. Individual boards are authorized to change the requirements to practice within their jurisdiction, and they could thus stimulate change in the educational programs offered by local medical schools and hospital residency programs . . . .

The boards could accept for licensure the graduates only of those already accredited schools and programs which had . . . . provided specific courses and experiences defined by the board(s) as essential for practice, including perhaps . . . courses in . . . behavioral sciences.

Unfortunately, the current medical licensing system is inadequate and must be revised if medical boards are to be the means for reshaping medical education. Medical boards not only have failed to use their control of licensing to reform medical education; they have not even modified medical licensing to keep up with contemporary medical education . . . .

The continuing failure of medical school faculties to reform medical education is due in part to the failure of state government to oversee properly the education of physicians and to exercise the authority of state medical boards to require needed improvements through their control of medical licensing.

Reforming medical education needs to be made a high national priority and should no longer be left to the discretion of the organizations and institutions controlled by faculty members of medical schools. Government should intervene and improve medical education by pulling the unactivated lever of reform—the state medical boards’ licensing of physicians.

Conclusion

The mission of state licensing boards is to protect the general public. They can responsibly support the agendas of the colleges, accrediting agencies, and associations to the extent those agendas are consistent with the provision of better trained providers and higher quality care. Both state boards acting to protect the public, through standard setting, and professional entities working to advance podiatric medicine, through educational program development, need to look beyond any vested interest in the status quo.

Meikle21 comments that “Faculties have their own interest to protect in maintaining the status quo in medical education.” The status quo, however, is not optimal for practitioners, students, and consumers, given current trends and forecasts. New doctors of podiatric medicine without the cal-
the curriculum to the modes of clinical practice. Finally, in 1986, the American Podiatric Medical Association published the Project 2000 Report, which included these curricular recommendations: strengthening behavioral sciences . . . ; affiliating with academic health centers; and developing more research activity.

With medicine moving forward, podiatric medicine cannot stand still and expect a promising future for new students, applicants, and practitioners. Even established doctors of podiatric medicine will be hurt if leaders resist higher standards.28

Licensing boards cannot sit still indefinitely. Heidt28 states “Boards must move forward while anticipating global, regional, and local changes in order to ensure that the people of each individual state are given the maximum opportunity to receive the best possible medical care.”

References

1. MEDIO FJ, NELSON TL. Report on the General Medical and Surgical Components of Podiatric Residency Training in California, Board of Podiatric Medicine/Medical Board of California, Sacramento, 1993.

2. Section 101.6 of the California Business and Professions Code states that boards within the Department of Consumer Affairs “are established for the purpose of ensuring” that licensed professions “are adequately regulated in order to protect the people of California. To this end, they establish minimum qualifications . . . .” Contrary to views sometimes expressed by some association executives, advancement of the profession is not an authorized activity, and never has been. It is the job of the profession’s associations, the author believes, which must initiate more effective leadership. The role of licensing agencies in state government is to protect the public, eg, by establishing minimum qualifications in regard to training. Development of the training programs is the responsibility of the profession.

3. The California Board’s intent is to push development of a standardized and comprehensive entry-level program as outlined more than 4 years ago by the 1992 national consensus conferences on postgraduate year one (PGY-1). Postgraduate year one was defined as including sufficient medical and surgical training so as to serve as a prerequisite to entering practice or advanced training. However, any residency defined by the Council on Podiatric Medical Education (CPME) as including at least some surgical training, eg, participation in one surgery during the 12 months, will qualify. Rotating podiatric and podiatric surgical residencies are currently so defined by the CPME.

The Board hopes to provide momentum for the Liaison Committee on Podiatric Medical Education and Practice’s goal, as stated in its 1995 Podiatric Medical Educational Enhancement Project Implementation Plan: “Seek to establish a uniform state licensing requirement for all podiatrists by 2005, requiring completion of the PGY-1 experience.”

The Board seeks not to require podiatric surgical
residency training or to make all licensees surgeons, but to ensure that all new licensees have at least some exposure to surgical experience and protocols. The Board is aware that “non-surgeons” perform surgery, and that even those who do not should have some familiarity with procedures for which their patients may require referral. For similar reasons, the Accreditation Council for Graduate Medical Education’s standards for family practice training include general and orthopedic surgery.

4. The Board believes all seven approved schools are in at least technical compliance with this requirement. It hopes this initiative will encourage greater emphasis for these areas in the future.

5. The requirement that residency programs must “in the board’s determination, reasonably conform” with the ACGME’s general or institutional requirements provoked little comment during the lengthy, public review process aside from token opposition from the California Orthopaedic Association. In response to earlier Medical Board inquiries, the Board had compared the Council on Podiatric Medical Education’s standards “applicable to all residency programs” with the standards of ACGME and found no substantive inconsistencies. This requirement is designed to: 1) disarm poorly-informed critics attempting to limit training opportunities for the Board’s licensees; 2) encourage greater commitment to quality by hospitals sponsoring residencies; and 3) advance the Board’s strategic plan for mainstreaming podiatric medicine.

6. The Board initiated the California Liaison Committee in response to a perception among board members and examination commissioners that critical steps needed to be taken by the profession’s organized entities were not being taken and probably would not be mounted effectively, or at all, unless an effort like the California Liaison Committee was initiated. The Board has now stepped back, and is encouraging the profession, with the commitment of state matching funds for a maximum of 3 more years, to keep pressing these program development efforts forward. The Board believes its financial commitment has been justifiable to date, but that sustained program development, as distinguished from standard setting, would be an inappropriate use of state licensing agency funds and a counterproductive assumption of a role for which the profession must be responsible.

7. GRACIA CM, O’NEIL EH: Podiatry’s Role in Primary Care: A Report to the California Board of Podiatric Medicine, Center for the Health Professions, University of California, San Francisco, 1996. (Transmittal letter, Jan. 31, 1996).


17. LANGSLEY DG: “The Use of Specialty and Subspecialty Credentials for Hospital Privileges,” in Hospital Privileges and Specialty Medicine, 2nd Ed, ed by DG Langsley, B Stubblefield, American Board of Medical Specialties, Evanston IL, 1992.


25. Regardless of the “primary podiatric medicine” movement, doctors of podiatric medicine are not licensed to serve as primary care physicians in any of the 50 states. Nor are primary podiatric medical doctors likely to be credentialed by health facilities to serve as gatekeepers for more comprehensively trained doctors of podiatric medicine. A comparison of the CPME-approved standards for primary podiatric medical residencies with those of ACGME for family practice or orthopaedic foot and ankle does not bode well for these young doctors of podiatric medicine hoping to compete for positions and privileges. Reports indicate that plans and facilities often accept only surgically-trained doctors of podiatric medicine in order to ensure broad competence, provider versatility, and constant availability of service.


28. THOMAS L. NELSON, MD, the coauthor of the Medio- Nelson Report, expressed concern in a December 22,
1995, letter to the California Board regarding
the resistance to change that is now becoming
apparent within elements of the podiatry profes-
sion. In fact, I have considered coming out with a
'scare the pants off' type statement as to the dire
possibilities facing the profession if it doesn't
move forward with training standards and
improving professional education. Competition in
the medical field is getting very fierce with more
patients moving into managed care and with what
appears to be an increasing surplus of physicians
in some fields. The primary care fields of family
medicine, internal medicine and pediatrics are
moving forward in quality of care concerns and
relevance of their educational programs to prac-
tice. If podiatry doesn't stay current with these
trends, I see family physicians moving increas-
ingly into non-surgical and minor surgical care of the
foot and orthopedics taking over the major
surgery with referrals coming from these primary
care physicians.

29. HEIDT RS: Regional meeting of boards convenes. Fed