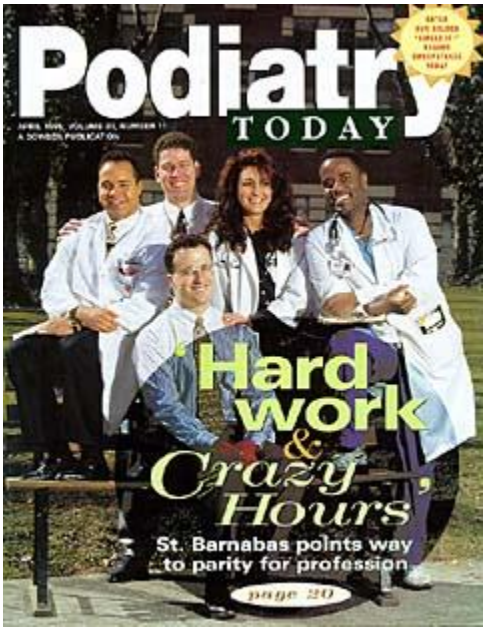
Some Residents Are More Equal Than Others

A Bronx teaching hospital broke through prejudice to train podiatric residents as equals in the OR and ER - but at a price.

By Judith A. Rubenstein



St. Barnabas Hospital is a refuge at the end of Arthur Avenue in the heart of Belmont, the "Little Italy" of the Bronx. Subsidized low income housing abuts another side of the voluntary hospital; southward lie increasingly indigent neighborhoods that are home to an underprivileged population of the working poor, welfare recipients, and Medicaid eligibles. New York's battle scarred Bronx is a patchwork of ethnic enclaves - Hispanic, Italian, African American, Irish, Jewish, and Albanian. Many area residents spend a lifetime waiting to escape from the Bronx. Many also wait too long to see a primary care physician. Even longer to see a podiatrist. When it's too late, they're wheeled into St. Barnabas 'emergency room or clinic for medical care.

Late one February night, a 54 year-old man ended up at St. Barnabas with a foul smelling, draining foot that was swollen to three times its normal size. A diabetic with hypertension and a history of previous bypass surgery to his leg, he had a fever of 104 degrees and a 23,000 white count. X-rays revealed gas in the tissue.

The podiatric residents on call were urgently summoned to the emergency room. Quickly, the team moved into action, checking the history, reviewing the radiographs.

Robert N. Piccora, DPM, chief of podiatric medicine and surgery and director of podiatric medical education at St. Barnabas, wasted no time in using the near crisis as a learning opportunity for his residents. Pointing to a specific area on the film, he asked, "What's that?"

"Fracture of the first metatarsal," volunteered one resident.

"But the patient reports no history of trauma," countered the residency director. "Why do you think he has a fracture in that foot?"

The residents were stumped, so Dr. Piccora continued his lesson in the frenzied emergency room: "Doctors, that's a Charcot foot. The x-ray shows a pathological fracture secondary to his diabetes."

Throughout the night the residents stood by, diagnosing, treating, learning. Just before dawn, the patient was wheeled to the operating room, where a surgical team that included the weary residents amputated his foot. The emergency surgery saved that patient's life.

The podiatric residents at St. Barnabas - two in PGY2 and 12 in PGY1 - experience such scenes every day and far into every night. But before last August, they would have completed their duties by mid-afternoon and gone home. When other medical residents were at their busiest in St. Barnabas' ER, they would have been asleep, dreaming about the clinical experience that is denied to most podiatric residents.

Running the Medical Gamut

Though podiatric residents and students have always ranked the St. Barnabas experience high, it was not necessarily exceptional until Kenneth Schwartz, MD, FACS, a vascular surgeon and director of surgery and director of the general surgical residency program at St. Barnabas, made a decision in August 1994 that had far reaching ramifications.

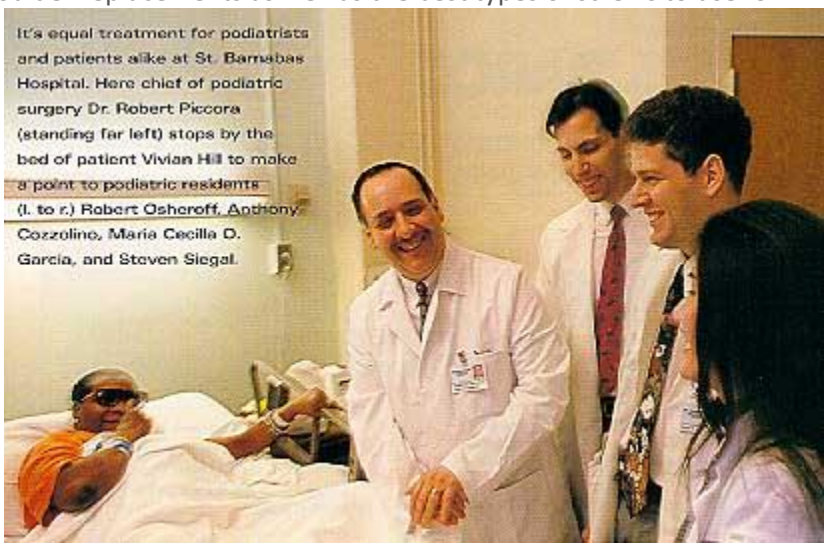
Since 1982, when he joined the staff at St. Barnabas, Dr. Schwartz had been observing third and fourth year students and residents from the New York College of Podiatric Medicine rotate through the

hospital. For the most part, he says, the program worked well. But recently, when he became more involved in teaching the fourth years, he realized something was missing.

"I recognized that in the inpatient setting the students had some weaknesses," he says. The residents did well with the young, healthy people who came in, for instance, with a hammertoe, had their procedure, and went home with no problem. But they weren't so successful with the other set, the ones Dr. Schwartz refers to as "the sicker patients" - those with diabetes or peripheral vascular, heart, or lung diseases.

"What was missing was a higher level of surgical involvement on the case," states Dr. Schwartz. "But who was going to teach these podiatric residents the best way to take care of somebody with diabetes who is in the hospital and who has an infected foot? What's the best way to teach people who are one month or even one year out of podiatry school?"

Dr. Schwartz concluded that these residents "would benefit greatly by being with a set of attendings and residents who could teach them the best way to take care of these patients. Orthopedic surgeons, hand surgeons, vascular surgeons, neurosurgeons, and podiatrists interact all the time. Orthopedic surgery and podiatry, for instance, have a lot in common. We're lucky here in the hospital that we don't have any rivalry among them. The podiatric surgeons here have learned a lot from our orthopedic surgeons." The "lot" includes knee, hip, and shoulder replacements as well as the best types of screws to use for different procedures.



It's equal treatment for podiatrists and patients alike at St. Barnabas Hospital. Here chief of podiatric surgery Dr. Robert Piccora (standing far left) stops by the bed of patient Vivian Hill to make a point to podiatric residents (l. to r.) Robert Osheroff, Anthony Cozzolino, Maria Cecilia D. Garcia, and Steven Siegal.

"All that is useful and applicable even if they never operate on a hip," declares Dr. Schwartz. "I think the surgical techniques involved in dealing with bones and joints are applicable from top to bottom and can be learned not only from the podiatry attendings but also from the orthopedic attendings. And then, the hand and the foot are definite parallels and learning from the attending hand surgeons will add a different set of skills."

Similarly, podiatrists often work together with vascular surgeons. Dr. Schwartz rapidly sketches a different scenario: "The patient has a lesion on the foot. The podiatrist will be involved with the lesion. But it turns out the patient needs a bypass because of circulatory disease. The key is: does the podiatrist, does the internist, does anybody realize that even though it's a big toe lesion, the problem isn't the big toe ? The problem is that the patient has bad circulation. The podiatrist needs to recognize it and call the appropriate consult. Yes, I could teach them that when you see this, call for that consult. But I thought it would be even better if the podiatric resident were involved in the total care of that patient even though he won't ever do a fempop bypass. Even though I'm a vascular surgeon, it's very important for me as a physician to know about cardiology, endocrinology, pulmonology, et cetera. I don't have to function as an endocrinologist, but I have to know their strengths, their expertise, when I should call them. And the best way to learn that is to be involved with them."

Indeed, through exposure to a gamut of medical diseases, the podiatry resident would learn not only how best to treat a myriad of conditions but also how to get patients into the hospital, safely through surgery, and out of the hospital - alive. "When podiatrists are involved with inpatient care on patients with multiple medical problems," says Dr. Schwartz, "they need to be educated on how to take care of patients with multiple medical problems. That's for the good of the patients and, it turns out, for the

good of the residents." Dr. Schwartz had this ambitious graduate education all designed in his head, but what his plan didn't take into account was the timing.

Parity Is Not As Parity Does

This year's residency program began typically enough in July 1994. NYCPM residents assigned to St. Barnabas had signed contracts. The salary was $16,500 for PSR1s and $21,000 for PSR2s. According to the agreement, the residents expected that they would be responsible for the hospital's podiatric clinic and podiatric inpatients, podiatric inpatient and out patient surgeries, plus emergency room call every sixth night. They also expected that once their clinic and surgeries were done, they would have light afternoons. In that way, their rotation at St. Barnabas would not differ from that of their predecessors. But almost overnight, the rules were changed.

In August, Dr. Schwartz created a "Silver Team" of subs-specialists in podiatry, orthopedics, neurosurgery, hand surgery, and vascular surgery, structured along the lines of other hospital teams. Subsequently, plastic surgery was added to the mix. St. Barnabas, it should be noted, has no orthopedic or neurosurgery residents.

"Our residents are now doing vascular cases, general surgical cases, orthopedic surgical cases," reports Harold L. Goldstein, DPM, an attending at St. Barnabas. "They do ankle arthroscopy and knee arthroscopy, ankle fractures and hip fractures, shoulder arthroscopy, knee replacements. They are doing whatever the orthopedists are doing if they need help. They're doing skin grafts with the plastic surgeon."

And they're doing more than just a few cases. St. Barnabas and its sister hospital, Union, log 6,000 clinic visits a year. By last fall, the current first and second year residents were overwhelmed with additional responsibilities.

"They were working as hard as the surgery residents, no doubt about it," affirms Dr. Goldstein. They were spending more and more time at the hospital. While they relished the expanded clinical exposure, they rebelled at the financial inequities of their situation. After all, they were putting in the same 70 to 75 hours a week as the general surgery residents, but first years and second years were being paid $16,500 and $21,000 respectively while the comparable gene al surgery residents were earning $38,000 and $41,000.

On the other hand, argues David H. George, DPM, NYCPM assistant dean of graduate medical education: "The graduate years are experience and exposure, and residents should want to get as much experience as they can. They shouldn't complain about how many hours they put in or try to do as little as possible."

Nonetheless, most observers agreed that the podiatry residents were being shortchanged. The residents took their concerns to Dr. Goldstein, who advised them to put it in writing. A petition was drafted, signed by all the firstyears, and presented to Drs. Piccora and Schwartz and NYCPM. Dr. Schwartz met with the residents and told them they could go back to the easier schedule for less pay or put in the time for parity. "Everyone at the meeting concurred that they would rather do every fourth night for more pay," recalls Dr. Goldstein, "because basically throughout the day the work would have been the same."

All well and good but, as with many similar college administered residencies, St. Bamabas paid NYCPM for the services of its podiatric residents. The college set the actual salaries and paid the residents.

"Graduate medical education in the United States is funded essentially via the Medicare system," explains Michael J. Trepal, DPM, professor of surgery and NYCPM senior vice president for academic affairs and dean. Hospitals with accredited training programs receive reimbursement both directly and indirectly from the federal government to offset the costs of training. That is, a "direct" medical reimbursement of a set amount per resident plus an "indirect" medical reimbursement that translates to a higher reimbursement for such items as supplies used by the trainees. The logic is based on the knowledge that residents will use more gauze, for instance, than an established practitioner.

"When I made this change, I discussed it with NYCPM," recalls Dr. Schwartz. "I told them I was going to assign podiatry residents to function just like all other PGY1 residents. They are going to work the same, and I am going to teach them the same."

When the first year residents decided to make a pitch for parity, the college had already finalized its budget. The stage was set for a showdown between NYCPM president Louis L. Levine and St. Barnabas president Ronald Gade, MD, spurred on by Dr. Schwartz.

The two institutions had enjoyed amicable and mutually beneficial relations for several years. And, ironically, Levine had already fought for - and secured - pay hikes of 175 percent for his residents. That's up from $6,000 in 1991, when Levine assumed his position, to the current $16,500 for PGY1. Plus, the fringes were increased to include medical, dental, long term disability, and group life insurance.

"I'm still not happy with the salary," says Levine, "but it's a matter of mechanics and the ability to raise money from the hospitals. When I came here, some hospitals owed us as much as 200,000 to 300,000 dollars."

The college demurred from matching the salaries of podiatric residents with those of the other medical and surgical residents at St. Barnabas - $38,000 for PGY1s and $41,000 for PGY2s. But Dr. Schwartz had already determined that "all the first year people coming into training, regardless of race or creed or degree - MD, DO, or DPM - will be treated alike." From his position, "alike" included stipend. Consequently, St. Barnabas opted to put the podiatry residents directly on its own payroll.

"If St. Barnabas doesn't pay us the $16,500 per resident," confides Levine, "it will amount to a shortfall of $160,000 to $175,000. Obviously, that impacts negatively on our budget. It changes the method by which we are doing a residency program.

"Under the graduate medical education (GME) pro gram," he continues, "the hospitals, depending upon their classification, were collecting between $50,000 and $90,000 per resident, but we were collecting very little from the hospitals. To administer the whole program for our 51 residents runs somewhere between $1.5 and $1.6 million. For the fiscal year from July 1, 1994, through June 30, 1995, we might collect about $1,750,000. The profit center would be less than $200,000 if every hospital paid us what they owed us. But we do not collect it all."

'The Most Beautiful Thing'

Currently, NYCPM's residency budget must cover residents' salaries and fringe benefits, professional insurance, a residents' dinner, and administration by Dr. George and a staff of four. But St. Barnabas' move has made Levine and others directly involved with graduate medical education at NYCPM rethink the whole program. "We're going to every hospital now since St. Barnabas has opened up a floodgate," says Levine. The idea is to convince the hospitals to take on the residents directly - supervise them, pay them, provide the benefits - while the college will still administer the program.

As an outspoken advocate of more comprehensive clinical training for podiatry students, Levine is enthusiastic about St. Barnabas' new program. "There is now a lot of movement by the APMA to get podiatry included into primary care approval patterns so podiatrists can act as gate keepers in HMO programs," he explains. "The training of today's podiatrist is far more extensive than ever, so they should be allowed to do a physical and history and to refer out to the appropriate specialist when disease is detected. In New York State, for example, nurse practitioners and physicians assistants can do these things, although they have to do it under MD supervision. It's ludicrous that podiatrists can not do anything above the ankle, but a two year physician's assistant can. Yes, podiatrists should be primary care people in a community that desperately needs more primary care."

St. Barnabas may bring podiatry a step closer to that goal. "Being exposed to all these problems gives us a more diverse background," says second year resident Anthony D. Cozzolino Jr., DPM. "We learn different techniques. Plastic surgeons do the same skin graft in a totally different way from general surgeons. Just to be able to pick up these differences will help us a lot in the future so that when we run into mile stones in treatment, we have something to fall back on." "The most beautiful thing about St.

Barnabas," declares Dr. Piccora, "is that all the residents are treated equal no matter what their profession - whether MD's, DO's, dentists, or podiatrists. You work the same crazy hours; you get all the same benefits. The politics is not there. From administration down, we're treated equally."