THE EVOLUTION OF A PROFESSION:

THE FIRST 75 YEARS OF THE AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS 1942-2017

By Kenneth Durr, PhD
with Jerome S. Noll, DPM, EdD, FACFAS

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The project drew heavily upon the series of oral histories conducted by Jerry Noll from 2007 to 2014. Those interviewed included: Cheryl Beversdorf, Ginger Burns, Michelle Butterworth, Joel Clark, Mary Crawford, Gary Dorfman, Jordan Grossman, John Giurini, Ben Hara, Dan Hatch, Don Hugar, Gary Jolly, Michael Lee, Gary Lepow, William Lowe, Chris Mahaffey, Robert Mendocino, Mary Meyers, David Novicki, Marsha Pederson, Harold Schoenhaus, Barry Scurran, Alan Shaw, John Stienstra, Jim Thomas, Lowell Scott Weil Sr., Glenn Weinraub, Bruce Werber, and Howard Zlotoff. Also interviewed by History Associates in 2016 were Gary Kaplan, Chris Mahaffey, Mary Meyers, Tom Schedler, Harold Vogler, and Lowell Scott Weil Sr.

A number of people at History Associates helped launch or bring the project to completion. Mason Farr conducted oral histories, Barb Reed edited the text, and Jen Giambrone and Phoebe McDougal conducted photo research. The index was prepared by Hilgenberg Editorial Service of Fort Wayne, Indiana and the book was designed and printed by Westland Printers of Laurel, Maryland.

Introduction

Like many American institutions, professional associations tend to think short-term, be it solving the crisis of the day, achieving an annual budget, or forgetting the past when governing for the future. And associations also often fail to remember and recognize their heroes—the people who got them to where they are today. That's why this book, and the herculean effort that preceded it, are so important.

The ACFAS story is a classic American tale. A story of modest beginnings, a hard-fought evolution, and a bright future—however contentious things may have gotten along the way. It's a story that needs to be told and remembered as the organization—and the profession—continues to evolve. It's a story every podiatric medical student, member, and future leader should read and remember.

And like many tales in the ACFAS story, this project would not have been possible without one person's passion and commitment. Long-time ACFAS volunteer leader Jerome S. Noll, DPM, FACFAS first expressed an interest in archiving the College's past as the 70th anniversary approached. Oral histories of past presidents were recorded in 2007-2014. Meanwhile Dr. Noll started compiling and assembling 70-plus years of documents. Then, as the 75th anniversary approached in 2017, we felt a professional historian should write the College's story to ensure objectivity and credibility. Thanks to Dr. Noll's research, author Kenneth Durr, PhD has done just that. The citations of virtually every event and statement tell the story accurately and candidly.

Mahatma Gandhi said, "A small body of determined spirits, fired by an unquenchable faith in their mission, can alter the course of history." The College's five key founders (average age 31) certainly showed their faith, as have 10,000 members over the past 75 years. Together you have changed—and ARE changing—the course of American medical history.

J.C. (Chris) Mahaffey, MS, CAE, FASAE
Executive Director

November 2016
Chicago, Illinois

Past Presidents

All individuals are listed with updated titles. In the early years of the profession most foot surgeons earned, and used, the Doctor of Surgical Chiropody (DSC) degree. A few used the PodD degree. Similarly, the title for all Fellows of the American College of Foot Surgeons was abbreviated FACFS. The *Journal of Foot and Ankle Surgery* transitioned to universal use of DPM in 1969. The abbreviated title for all fellows was changed to FACFAS in 1993.

1940s

Douglas T. Mowbray, DPM, FACFAS
1942-1947
Lester W. Walsh, DPM, FACFAS
1947-1949
D. Lowell Purgett, DPM, FACFAS
1949-1950

1950s

Lawrence A. Frost, DPM, FACFAS
1950-1952
Oswald E. Roggenkamp, DPM, FACFAS
1952-1954
Samuel F. Korman, DPM, FACFAS
1954-1956
Ned Pickett, DPM, FACFAS
1956-1958
Ralph Owens, DPM, FACFAS
1958-1959
Earl G. Kaplan, DPM, FACFAS
1959-1960

1960s

William Edwards, DPM, FACFAS
1960-1961
Louis M. Newman, DPM, FACFAS
1961-1962
Lyle R. McCain, DPM, FACFAS
1962-1963
Robert L. Brennan, DPM, FACFAS
1963-1964
Ralph E. Fowler, DPM, FACFAS
1964-1965
John B. Collet, DPM, FACFAS
1965-1966
James Meade, DPM, FACFAS
1966-1967
Robert L. Rutherford, DPM, FACFAS
1967-1968
Samuel C. Abdoo, DPM, FACFAS
1968-1969
Oscar M. Scheimer, DPM, FACFAS
1969-1970

1970s

James O. Tredway, DPM, FACFAS
1970-1971
Ben Hara, DPM, FACFAS
1971-1972
Seymour Z. Beiser, DPM, FACFAS
1972-1973
Howard R. Reinherz, DPM, FACFAS
1973-1974
William Lowe, DPM, FACFAS
1974-1975
Robert E. Weinstock, DPM, FACFAS
1975-1976
Saul Ladd, DPM, FACFAS
1976-1977
Charles L. Jones, DPM, FACFAS
1977-1978
Cecil W. Davis, DPM, FACFAS
1978-1979
Raymond A. Scheimer, DPM, FACFAS
1979-1980

1980s

Donald W. Hugar, DPM, FACFAS
1980-1982
Stuart A. Marcus, DPM, FACFAS
1982-1983
Gary R. Dorfman, DPM, FACFAS
1983-1984
Edward H. Fischman, DPM, FACFAS
1984-1985
Joel R. Clark, DPM, FACFAS
1985-1986
Richard L. Hecker, DPM, FACFAS
1986-1987
David V. Chazan, DPM, FACFAS
1987-1988
Arnold L. Cohen, DPM, FACFAS
1988-1989
James H. Lawton, DPM, FACFAS
1989-1990

1990s

Howard M. Sokoloff, DPM, FACFAS
1990-1991
Gary S. Kaplan, DPM, FACFAS
1991-1992
Alan H. Shaw, DPM, FACFAS
1992-1993
Lowell Scott Weil, Sr, DPM, FACFAS
1993-1994
David C. Novicki, DPM, FACFAS
1994-1995
Harold D. Schoenhaus, DPM, FACFAS
1995-1996
Howard J. Zlotoff, DPM, FACFAS
1996-1997
A. Louis Jimenez, DPM, FACFAS
1997-1998
John M. Schuberth, DPM
1998-1999
Gary M. Lepow, DPM, FACFAS
1999-2000

2000s

Barry L. Scurran, DPM, FACFAS
2000-2001
Robert W. Mendicino, DPM, FACFAS
2001-2002
Robert G. Frykberg, DPM
2002-2003
Bruce R. Werber, DPM, FACFAS
2003-2004
Gary P. Jolly, DPM, FACFAS
2004-2005
John J. Stienstra, DPM, FACFAS
2005-2006
James L. Thomas, DPM, FACFAS
2006-2007
Daniel J. Hatch, DPM, FACFAS
2007-2008
John M. Giurini, DPM, FACFAS
2008-2009
Mary E. Crawford, DPM, FACFAS
2009-2010

2010s

Michael S. Lee, DPM, FACFAS
2010-2011
Glenn M. Weinraub, DPM, FACFAS
2011-2012
Michelle L. Butterworth, DPM, FACFAS
2012-2013
Jordan P. Grossman, DPM, FACFAS
2013-2014
Thomas S. Roukis, DPM, PhD, FACFAS
2014-2015
Richard M. Derner, DPM, FACFAS
2015-2016
Sean T. Grambart, DPM, FACFAS
2016-2017
Laurence G. Rubin, DPM, FACFAS
2017-2018

Chapter 1

"True Professional Status," 1942 - 1955

On March 23, 1942, a new organization was chartered in the state of Delaware.[1] The incorporation was routine—it is doubtful that any of its officers were even in attendance. But the officers were not men to stand on ceremony—they were after results, and they realized that even though this step was the product of several years of work, it was only a beginning. For years practitioners of the treatment of foot and ankle problems—most often called chiropodists—had been seeking respect and the right to practice their specialty on par with other medical men. They had made great strides in recent years, but there was a subspecialty—surgeons of the foot—whose status was even more in doubt. It would take a systematic and sustained effort to build up a profession worthy of the respect and recognition that these practitioners knew that they could attain. And that is what their new organization, the American College of Foot Surgeons, was meant to accomplish. The founders hoped that this organization would long outlast them and accomplish more than they ever could individually. It did.

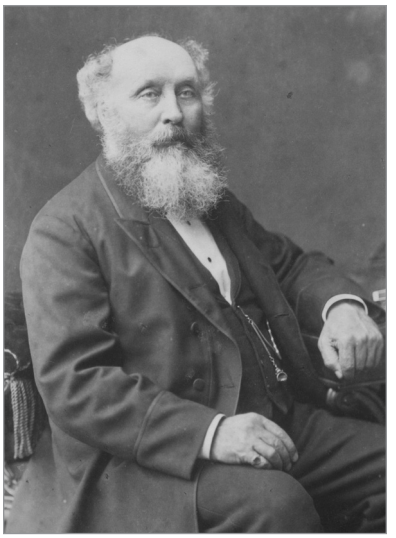
Rise to Recognition

The mysteries and complexities of the internal anatomy had given medical doctors a certain measure of status—indeed even before many had earned it. However, chiropody was awarded no such respect. There was some good reason. It had started in Europe as a trade more than a profession, with its practitioners traveling about, working out of barbershops or from bootblack stands, cutting corns and callouses from the feet and hands. Thus the name of the trade incorporated the Greek chiro for hands and podi for feet.

Transplanted to the new republic, the institution changed little. An early American practitioner had to be willing to perform extremely painful excisions of corns and callouses, usually charging 25 cents or so. Perhaps because of their patients' pain as much as the profit, most practitioners were itinerant, heading to greener pastures after the corns had been cut. Then, during his travels about New England, New Hampshire native Nehemiah Kenison met a Scotsman who had developed a better way of doing things. He used an acid

to soften the corn and then cleaned it out with a dull bone blade. Kenison learned the procedure, settled down in Boston, and in 1840 hung out a shingle directly across from the Old South Church. The practice of modern chiropody had begun. Before long, Kenison was teaching students, albeit informally, and the profession had begun as well.[2]

Progress was slow but steady through the rest of the century, helped along by the efforts of the four-generation dynasty founded by Kenison along with other first families, such as the Kahlers of Pennsylvania. The first American treatise on chiropody was produced in 1862, the same year that Isachar Zacharie, perhaps podiatry's first expert self-promotor, began to treat Abraham Lincoln, who suffered in his size 14 shoes.[3] Within another generation there was growing awareness of the problems caused by flat feet, with a commensurate interest in inserts, arch supports, and special footwear.[4]



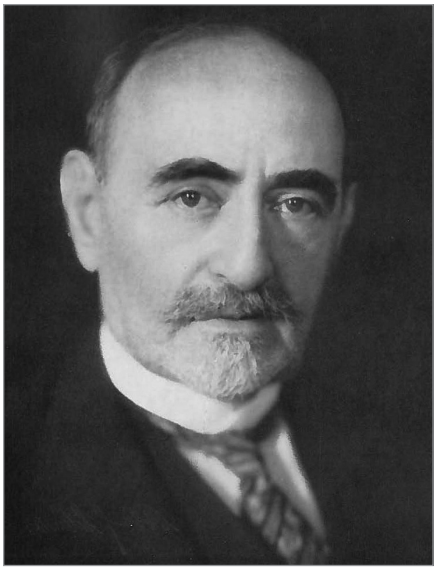
Isachar Zacharie, Lincoln's chiropodist.

Still the maturing practice of medicine shunned chiropody, dismissing its practitioners as mere "corn cutters." But the physicians were willfully missing the point. The most serious of the aspiring chiropodists were not interested in purveying a few moneymaking tricks. They had abandoned their study of hands to focus on a comprehensive understanding of the physiology of the human foot. Most were less interested in performing heroic measures than in making smaller adjustments that enabled them to relieve pain and avert deeper damage while keeping their patients on their feet as much as possible. These serious practitioners started to call themselves podiatrists and began to refer to mainstream medical practitioners as allopathic physicians, a term coined by the originator of homeopathy to denote those who favored drugs, surgery, and other heroic measures over more subtle methods.[5]

There were places where the new profession was taken seriously. In 1895 the state of New York passed a law regulating chiropody, and within a few years a professional organization, the Pedic Society of the State of New York, was thriving.[6] Given newfound recognition, these practitioners began writing papers and aspiring to establish a profession in the academic sense. They asked Maurice J. Lewi, a New York-born and Vienna-trained physician who was Secretary of the New York Board of Medical Examiners, for help. Lewi was impressed by their work and in 1911 helped establish the School of Chiropody of New York. The next year the state established academic requirements and provided for licensing of chiropodists by a board of regents. A few years later the New York school changed its name to the First Institute of Podiatry in recognition of its groundbreaking status. Lewi allowed that it was a "paradox" to be credentialing people who were not licensed practitioners of medicine, but he insisted that "the existing gap must be closed."[7]

Across the country, other states were closing gaps, and other chiropodists were embarking on the journey of professionalization. In 1912 the National Association of

Chiropodists was created, with 225 members. The same year, the Illinois College of Chiropody opened. The California College of Chiropody followed in 1914. That year, *The Text Book of Chiropody*, edited by Lewi, was published. Perhaps hoping that chiropody's critics would be intimidated by the book's 1,183-page bulk, Lewi noted in his introduction that the pioneers in the profession were "today recognized by the progressive element in the scientific world as having labored worthily in a righteous cause."[8]



Maurice J. Lewi helped establish the chiropody profession in the State of New York.

The landmarks kept coming. Temple University established a College of Chiropody in 1915. The Ohio College of Chiropody was founded in Cleveland the next year. By 1919, 23 states had licensed chiropody, and as institutions were new, educational qualifications were minimal—most states required only a high school education or even less.[9] But by 1930 at least one year of college was required and by the end of the decade, two years.[10]

The new profession of chiropody had come a long way by 1939. Although plenty continued to criticize, there was even movement in the right direction in the medical profession. That year the Judiciary Council of the American Medical Association (AMA) conducted a study and reported favorably. Chiropody, the Council insisted, was "not a cult practice" (a category in which it placed osteopathy, chiropractic, and Christian Science). It was "rather a practice ancillary, hand-maiden to medical practice in a limited field considered not important enough for a doctor of medicine to attend."[11] Being referred to as "not important enough" was, perhaps, faint praise. But practitioners welcomed the recognition.

By then, the United States was drifting inevitably toward war in Europe, and the burgeoning chiropody profession sought a role—and the respect—that it felt was warranted. In its first national lobbying effort, the profession pushed Congress to create a Chiropody Corps. It was not without reason. At the time of World War I, the government-appointed Munson Shoe Board had given four years of study to the subject, with little more to show than the Munson Army Last still used in heavy boots. This time the chiropodists expected more.[12]

In June 1941, a Senate subcommittee held hearings on the bill. Some Senators did not fully understand the subject, so Lewi explained that while medical doctors might deal with the exceptional, "when it comes to close study of what is happening every day to people in all phases of life" the chiropodist "is called upon 10 to 1."[13] Dr. William J. Stickel, the executive secretary of the National Association of Chiropodists and president of the Association of Chiropody Colleges, laid out the curriculum which was by then standard at

colleges of chiropody and sought to counter physician resistance by invoking the findings of the AMA Judiciary Council.[14] The Senate subcommittee was not convinced, but by then Stickel was close to winning a different round.

Groundwork for Surgeons

Chiropody had to a great extent succeeded in its quest for recognition because mainstream medicine had deemed the comprehensive treatment of the foot as something not worth pursuing. But allopathic physicians did not feel the same about an important subspecialty of chiropody—foot surgery. Opening the skin and working on tissue and bone—whether on the foot or anywhere else—was a truly heroic measure, and allopathic physicians thus insisted on reserving it for themselves. For that reason, the 1895 New York law restricted surgery by chiropodists to nails, corns, and callouses—no major incisions or general anesthetics. A 1909 revision allowed only what it called "minor" surgery.[15]

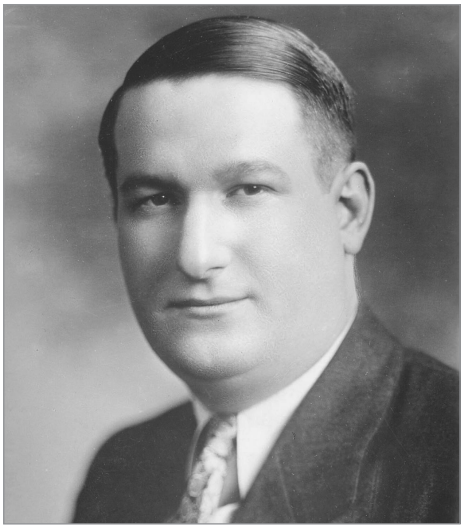
A few pioneers pushed the boundaries, including Otto Kahler, who published *Surgical Chiropody for the Profession and Students* in 1904, but not surprisingly, through the 1910s and into the 1920s, most surgery by chiropodists was limited to remedying ingrown nails.[16] Although top practitioner Reuben Gross demonstrated this surgery in 1922 at the First Institute of Podiatry, he did not consider himself to be on safe ground teaching it.[17] Within a few years, chiropodists had become bolder, mostly in the area of surgical removal of highly intrusive corns. It started when Gross performed a corn removal at the 1930 National Association of Chiropodists convention. Another successful method, resection of the head of the proximal phalanx, was developed by Detroit chiropodist Ralph Fowler in 1934.[18]

That same year, Douglas Mowbray, the director of clinical surgery at the Illinois College of Chiropody, published his first article in the school's academic journal, the *Chiropody Record*. By 1936, Mowbray had published 14 papers on foot surgery, publications that served as the authoritative corpus for another 20 years and established Mowbray's reputation as one of the most accomplished chiropodist foot surgeons.[19]

Although pioneering practitioners like Gross, Fowler, and Mowbray were setting high standards for their contemporaries, on too many occasions surgery was conducted haphazardly, with inconsistent procedures and incomplete sterilization. A greater problem was that even when a chiropodist practicing foot surgery carefully followed precedent and observed the best procedures, there was no way that anyone other than a fellow practitioner who had scrubbed up and joined him in the operating room could be sure. As a result, the surgical progress possible for chiropodists was highly restricted by the lack of access to hospital operating rooms and staff.

William J. Stickel probably understood this better than anyone else. After nearly 30 years on a shoestring, in 1941 the National Association of Chiropodists began to expand and made Stickel its first executive secretary.[20] As he put the wider profession on a solid foundation, he also turned his attention to the problems of its surgical specialists. He put "the need for some measurable standard of competency for approval of hospital privileges" among the top objectives of the organization.[21] What was required, he decided, was a "qualifying organization" that could set the rules and regulations for foot surgery and could

certify practitioners as being capable of meeting these standards.[22] Further, having served as the dean of the Illinois College of Chiropody and editor of the *Chiropody Record* during the mid-1930s, Stickel thought he knew who might be capable of establishing such an organization.[23]



National Association of Chiropodists executive secretary William J. Stickel. He tasked Douglas Mowbray with founding a foot surgeon's organization.

Douglas Thomas Mowbray was born in 1911 and graduated from the Illinois College of Chiropody at the young age of 21. He returned to his home town of Waterloo, Iowa, to set up a private practice, but within months Mowbray was back in Chicago to become director of the school's clinical surgery department, push the boundaries of forefoot surgical techniques, and disseminate his knowledge in published papers.[24] By 1938, Mowbray had set up a private practice in Chicago.[25] Despite all his publications, Mowbray was no ivory-tower intellectual. He was a highly practical man who knew how to work with others to accomplish an objective, and he had the force of personality required to subdue most opponents. As a colleague later put it, Mowbray had "the ability to identify problems and pin-point solutions. He was direct and to the point, and sometimes conclusively overpowering."[26] Stickel asked him to begin laying the groundwork for the much-needed qualifying organization.

Mowbray began pulling together a group to help. Delmer "Lowell" Purgett had been a year behind Mowbray at the Illinois College of Chiropody and was also living and practicing in Chicago. He was on the staff of the Foot Clinics of Chicago and deeply committed to enhancing the reputation of podiatry in general and foot surgery in particular.[27] Oswald E. Roggenkamp practiced in the District of Columbia, where he was also on the staff of Doctors Hospital. Lester A. Walsh had been a professor of experimental therapeutics at the Temple University School of Chiropody during the mid-1930s. He also knew something about qualification and organization having created the Federation of Chiropody-Podiatry Examination Boards.[28]

The men in this group were surprisingly young. In 1938, Mowbray was 27, Purgett 28, and Roggenkamp 29. At age 37, Walsh was the greybeard—the others called him "Pappy."[29] During the next four years, the men set standards and developed a process of written and oral exams. The requirements were tough, based on those imposed by the American College of Surgeons. There were to be two levels of membership in the new qualifying organization, associates and fellows. All would have to be currently practicing and would have to belong to their state organization as well as the National Association of Chiropodists. Associates, the founders decided, had to pass a series of written and oral examinations. To be a fellow the bar was very high—members had to present case records

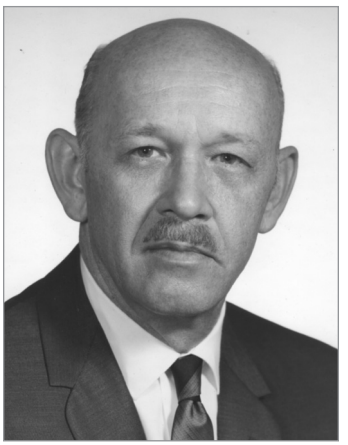
for 75 different surgeries. Twenty-five of these could involve soft tissue, but a like number had to involve bone. Twenty-five of the case studies could be in abstract form, but the same number had to be presented in great detail.[30]

Finally Mowbray and Walsh drafted a constitution and bylaws.[31] Article II of the constitution laid out a broad basis for the organization: "to foster a bond of fellowship among chiropodists who specialize in foot surgery…, to bring to practitioners and students a realization of the results that can be gained…, to teach finished or standard techniques…, to constantly strive to develop additional techniques, and to act as a protective agent for the public and for the profession."[32]

As for the name of the organization, there was no mention of chiropody or podiatry. Perhaps they could not agree. Notably, of the four founders, Mowbray and Roggenkamp had adopted the title podiatrist. Walsh and Purgett still considered themselves chiropodists.[33] More likely, they, like their colleagues, believed that since chiropodists understood the functions and complexities of the foot far better than their medical counterparts did, it was in the best interests of the professions and the patients for the former to take on the role of foot surgeon. The incorporation papers, therefore, filed with the state of Delaware on March 23, 1942, identified the organization as the American College of Foot Surgeons, Inc., later abbreviated as ACFS.[34]

The founders soon met to set their organization in motion. Mowbray had earned the presidency of the organization along with the distinction of being ACFS associate number one.[35] Purgett was named vice president; Walsh, secretary; and Roggenkamp, treasurer. And for four years that was as much as the College accomplished, progress halted due to an event that Stickel and Mowbray could hardly have foreseen in 1938. By March of 1942, the United States was at war in Europe and Asia.

Despite the best efforts of the profession, there was no Army Chiropody Corps for the ACFS officers to join. But the Navy did welcome chiropodists into its ranks, and by January 1943, Mowbray was a lieutenant of aviation medicine in the Naval Air Corps stationed at Grosse Ile, Michigan. By the next fall he had even become a pilot, flying home to Waterloo, Iowa, at the controls of a Navy trainer before reporting to duty at the Naval Air Station in Memphis, Tennessee. Lowell Purgett served in the Navy as well.[36]

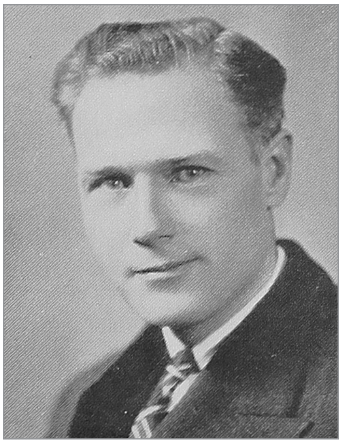


Douglas T. Mowbray (1942-1947)

That did not mean that foot surgery failed to advance during the war years. While Mowbray was in the service, Ralph Fowler was conducting and publishing notable work, developing the standard operation for excision of the plantar nerve to treat Morton's neuroma—a common condition identified as early as 1876 but treated inconclusively for years.[37] But it was in the courtroom rather than the operating room that Fowler made his biggest mark.

As one of Michigan's top practitioners, Fowler used anesthesia, including narcotics, during his surgery. But in 1943, the Michigan attorney general, who may have been influenced by orthopedic surgeons, decided that the state chiropody act did not allow the use of narcotics after all. Fowler would have to stick with procaine, greatly limiting the scope of his work. With support from other Michigan chiropodists, Fowler took the attorney general to district court and

won a ruling that chiropodists could use narcotics so long as they were employed as local anesthesia.[38] The state promptly gave Fowler a way around this highly circumscribed victory by granting a reversal on appeal. In October 1945, in the case *Fowler v. Michigan Board of Pharmacy*, the Michigan Supreme Court determined that even though he was not an allopathic physician, a chiropodist could practice medicine within the limits of the chiropody act. The decision restored the use of narcotics, gave a big boost to Michigan chiropodists, and provided a model for others to follow.[39]



Lester W. Walsh (1947-1949)

Up and Running

By the summer of 1946, ACFS was back in business. The charter members likely gathered again sometime during the annual meeting of the National Association of Chiropodists. Around that time Mowbray earned a rare mention in the national papers, warning against the growing trend of open-toed shoes for women in an article syndicated by the United Press.[40] He also returned to giving seminars. It was at one such event held in Davenport, Iowa, that he awarded the first postwar ACFS associateship to Dr. Lawrence Frost.[41] Frost was an accomplished surgeon in his own right, having performed the first condylectomy using a bone chisel as early as 1933.[42] He was also from Michigan, as were two other distinguished 1946 inductees, Earl Kaplan and Ralph Fowler. Ohioan Samuel Korman joined at the same time.[43] All four would contribute greatly as members of the founding generation that got the College up and running during the late 1940s and early 1950s.[44]

In the immediate postwar years, some of the tasks before the organization were internal: getting meetings scheduled—and attended—on a regular basis; enabling members to provide and receive training; and encouraging them to publish. Far more difficult was achieving the ACFS agenda of external change: gaining inclusion in private insurance plans and access to hospital staffs, becoming defined as physicians under state narcotics laws, and earning participation in industrial accident boards.[45]

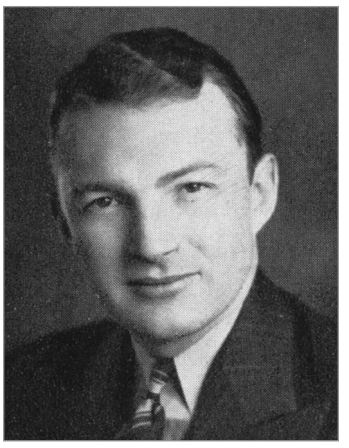
Immediate responsibility for obtaining these objectives fell mostly to the founders. Douglas Mowbray deserves credit as the father of ACFS, but it would be a mistake to consider him an empire builder. The only reason he was president of the organization for five years was because it was dormant for most of that time. And while performing and teaching foot surgery was clearly his first love, Mowbray had other interests. In between conducting seminars for ACFS, he cultivated an inventive streak, filing for a number of patents in the late 1940s and early 1950s. Some, like a touch-free liquid soap dispenser and a rubber sock with inflatable collar, were clearly developed with his profession in mind. Others, such as a fishhook patented in the early 1950s, stemmed from leisure pursuits.[46]

After Mowbray, each of the founders took turns. Although elections were annual, it was customary for each president to serve two terms. Lester Walsh was president from 1947 to 1949. Lowell Purgett served from 1949 until his early death in 1950. Newcomer Lawrence Frost succeeded Purgett to serve from 1950 to 1952, followed by Oswald E. Roggenkamp, who was president from 1952 to 1954. The latter had earned a reputation as a champion

of foot health in a truly unusual way. Back in 1936, Roggenkamp had been among a party enjoying a cruise on the Potomac River (near the site of Reagan National Airport today) when the yacht hit a submerged piling. As the boat began to list, Roggenkamp, a strong swimmer, jumped into the river with his shoes on, swam to the nearest shore, and ran for help. Rescuers credited him with saving 13 lives, but were perplexed as to why, counter to standard lifesaving practice, he had kept his shoes on in the water. "I knew I would have a long way to run when I reached the shore," Roggenkamp explained, "and I didn't want to injure my feet."[47]

When it came to meetings, the nascent ACFS displayed no such unorthodoxy. In common with many other affiliated professional groups, the group scheduled its meetings in close proximity to those of the umbrella organization, the National Association of Chiropodists (NAC).[48] Since their meeting was contiguous with the NAC convention, ACFS leaders expected full attendance—missing two meetings meant expulsion. By the time of the September 1949 meeting at the Drake Hotel in Chicago, ACFS had blossomed to 24 members. When four of them did not attend, the minutes recorded that "none of the excuses given were acceptable," and the absent members were duly informed.[49] But the next year, when even more members missed the meeting held in Boston, ACFS decided it would have to be less draconian. A more tolerant approach was essential, wrote Samuel Korman in one of the earliest typescript issues of the annual *Newsletter of the American College of Foot Surgeons*, "if we wish to develop our West Coast membership, and there are some fine, capable men out there."[50]

At a time when hospital privileges remained hard to attain, clinics held at the established chiropody colleges were among the best ways for ACFS members to demonstrate their capabilities. From 1945 to 1952 the Ohio Chiropody Association sponsored more than 15 postgraduate courses. Held at the Ohio College of Chiropody in Cleveland, each course involved several days of foot surgery. Pioneer practitioner Henri L. DuVries, an allopathic physician working in foot surgery since the 1920s, taught most of the classes, but ACFS leader Lawrence Frost taught ambulatory surgery. Mowbray remained among the most distinguished instructors during these years, regularly conducting clinics at the Illinois College of Chiropody and Chicago College of Chiropody through the early 1950s.[51] By the spring of 1953, John Witte, one of the next generation of ACFS leaders, was teaching postgraduate courses at the Ohio College of Chiropody.[52]

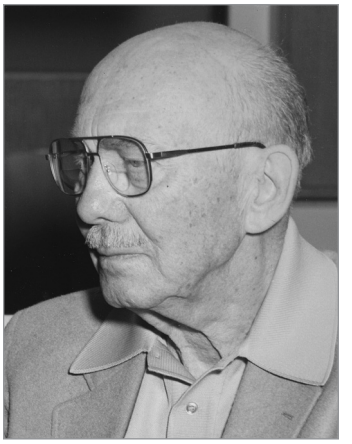


D. Lowell Purgett (1949-1950)

Despite the achievements of a few, ACFS as an institution was seldom satisfied with its academic accomplishments. True, it had high standards. The constitution and bylaws, modeled after those of the American College of Surgeons, required members to submit either a case history or an academic article every year. And although the College regularly approved papers on foot surgery for inclusion in the *Journal of the National Association of Chiropodists*, the leadership constantly had to remind members of their duty to publish.[53]

The governance of the College was conventional as well. The constitution provided for a board of directors made up of a president, vice president, secretary, and treasurer. Early on, it became the informal

practice for members to rotate through the lower positions before assuming the presidency. Just as some of the presidents served multiple terms, however, so did other officers. Sam Korman, for example served three terms as secretary before being elected president in 1954. Convinced that the growing organization required more systematic administration and record keeping, Korman tasked treasurer Ralph Owens to work with a professional accountant to revise and update all ACFS record keeping.[54]



Lawrence A. Frost (1950-1952)

As is inevitable in volunteer organizations, more specialized initiatives were delegated to committees. In the summer of 1951, six committees were in operation: terminology and fee schedule, public relations, proposed school education, professional education, scientific publications, and director of surgical clinics.[55] In the next few years, as the College became more ambitious, the numbers grew. By 1955 there were eleven committees.[56]

Only one of these, however, was required by the constitution. The Credentials Board played the all-important role of ensuring the quality of ACFS membership and therefore the profession. From the beginning, ACFS had been determined to spend less time asking for recognition and more time earning it. This philosophy went back to Mowbray, who insisted that "if podiatrists are to function in areas which medicine controls such as hospitals, we must play the game and follow the rules."[57] Those who evaluate practitioners and control hospital staff privileges, he acknowledged, required a "yardstick by which to judge the qualifications and competence of a podiatric foot surgeon."[58]

It was the duty of a four-man Credentials Board, then, to provide this yardstick—not only to conduct investigations to ensure that aspiring associates and fellows met the constitutional requirements for membership but also to perform examinations to further ensure the quality of the membership. Finally, the Credentials Board recommended candidates to the board, which made the ultimate selections.

In the earliest years, when the Credentials Board and board of directors were largely one and the same, the process of credentialing appears to have been somewhat informal, but in 1949 the Credentials Board adopted a set of examination blanks consisting of four sets of ten questions each.[59] But still the review process was highly laborious and sometimes subjective, so by 1953 an expanded team was utilizing summary grading sheets. Each member of the team filled out standardized sheets and sent them to the chairman of the Credentials Board. To further minimize bias, graders reviewed applicants from outside their region.[60]

But in the end, ACFS could set the highest standards possible and it made no difference if its members were not allowed by law to meet them. In too many states, certification boards were dominated by allopathic physicians who made sure that podiatrists were not allowed to do bone surgery, period. That put some aspiring practitioners in a no-win situation. The ACFS bylaws stated that associates had to attain fellow status within five years or lose their membership. But attaining fellowship involved performing bone surgery, and in the late 1940s only seven states allowed extensive surgical practice by chiropodists.[61] The problem came to a head in 1951 when a highly respected associate member from New

Jersey reluctantly submitted his resignation, pointing out that state law did not allow him to do the requisite bone work.[62] The next year, the newsletter noted that many members received excellent training in surgical hospitals but were denied by law the right to sign charts or admit patients, asking, "Was it the intent of the men drafting the ACFS constitution to restrict these men?"[63] By the time the constitution was fully revised in 1955, the five-year limit had been dropped.

Stretching Out and Reaching Out

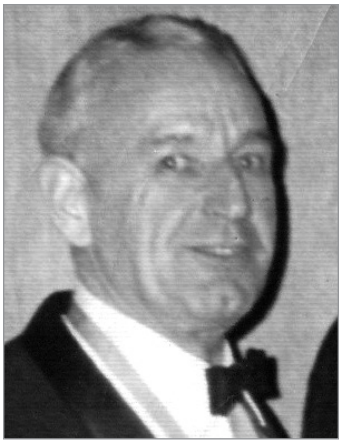
From the very start, ACFS had big aspirations—the 1942 constitution stated that it was "founded by foot surgeons of United States and Canada."[64] But in truth, the organization was founded by, and for several years remained the province of, mostly chiropodists from a few eastern and midwestern states. Geography was part of it, for even in the immediate postwar period, coast-to-coast travel was hardly routine. Still, as Sam Korman noted in 1949, there were some "fine, capable men" out west, and in the next few years ACFS began attracting a few of them. Unfortunately for the budding organization, however, many of those practitioners had already found it necessary to organize outside the ACFS umbrella.

The West Coast group coalesced around the California College of Chiropody, founded in 1914. Abraham Gottlieb, an allopathic physician, was an original faculty member and among the first to conduct postgraduate surgery courses.[65] By the 1930s, Gottlieb's efforts were spurring interest in the creation of a professional organization among West Coast chiropodists practicing surgery, particularly Berkeley-based Robert Rutherford.[66] On September 29, 1944, the West Coast practitioners formed a group of their own—one with national aspirations judging by the name: the American Society of Foot Surgeons (ASFS).[67] The group expanded along with ACFS in the immediate postwar years, but remained a West Coast phenomenon with members in Oregon, California, and Nevada. By the 1950s, it appeared that ACFS had the better chance of becoming a truly national group, and the officers of the ASFS reached out. In the summer of 1951, ACFS member Kenneth Sandel moved to amend the constitution so that ACFS could negotiate with "one or more representatives of the West Coast Group."[68]

Although a few ASFS members hoped to go it alone, there were a number of others in favor of a merger, and they included Robert Rutherford, with whom Sandel wished to negotiate.[69] The discussions took time, but it was fortuitous that the National Association of Chiropodists slated its 1953 annual meeting for Los Angeles, taking ACFS to the home turf of its West Coast counterpart and perhaps helping smooth the way for agreement on a merger in principle. A year later, at the August 12, 1954 annual meeting in Chicago, the ASFS was formally merged into ACFS. "It was a momentous step," noted the newsletter. "The unification of the two societies will add strength and unity of purpose, a first in our profession of chiropody and an example others can profit from."[70]

The easterners got a sudden influx of associate and fellowship applicants into their expanded organization. The westerners got their own small victory. Among the constitutional changes of 1955 was one allowing for the honorary membership of a few select allopathic physicians. Abraham Gottlieb, who had done so much for the westerners and for the profession, was among the first nominees.[71]

The merger did much for the growth of ACFS, but broadening the scope of the organization did nothing to solve the transcontinental travel challenges of the pre-jet era, which ensured that when it came to affinity and education, most ACFS members interacted much more with their regional counterparts than their national colleagues. Accordingly, as the merger talks went on, the College developed a representative structure intended to solve the problem. The first proposal to create regional divisions within ACFS was introduced in 1950.[72] After consideration of a number of permutations, the 1955 constitution provided for the creation of a division by five or more members, one of whom had to be a fellow, "for geographic convenience only."[73] Divisions got a vote at the annual meeting proportional to their membership.



Oswald E. Roggenkamp (1952-1954)

The structure was finalized in the summer of 1955 with the creation of the Western Division, consisting of members from California, Oregon, Washington, Arizona, Nevada, Idaho, and Utah; and the Eastern Division, including members from Pennsylvania, New Jersey, Delaware, and Maryland. The additional creation of the Michigan Division illustrated the outsized importance of the Wolverine State.[74] By then ACFS membership reached 29 fellows and 23 associates. They were from 19 different states and the District of Columbia. ACFS was still lightly represented in the mountain west and the Deep South (there was only one southern member, from Georgia) but it stretched from coast to coast.[75]

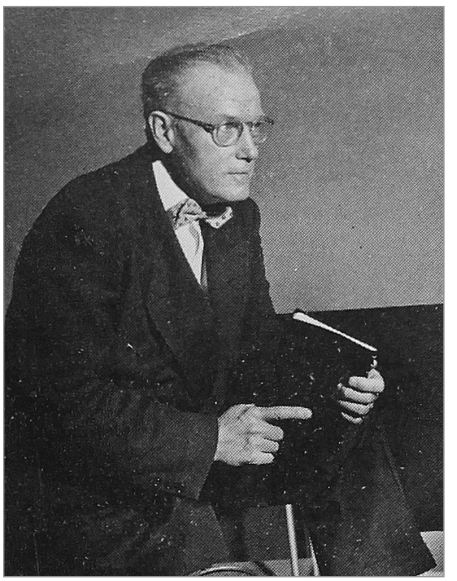
It was one thing for ACFS to expand from its existing base of podiatric surgeons, but it was another to reach across disciplinary lines to obtain the recognition necessary to ensure that the American public could fully benefit from its services. Through the early 1950s, ACFS continued to use diplomacy and advocacy in equal measure in seeking recognition "equal to that of dentistry" for its members. Squarely in the former camp was Lowell Purgett, who served as the College's liaison officer with the American College of Surgeons and the American Hospital Association in the late 1940s.[76]

But among themselves, at the annual meetings and in the pages of the newsletter, some members were less than diplomatic, particularly when it came to the medical profession's intent to keep states from recognizing podiatric surgery. This resistance was all the more incomprehensible given that ACFS members believed that "surgical chiropody is a specialty within the framework of medicine whose aims are to assist the physician in his work for the good of the patient."[77]

More frustrating in some ways was a certain level of resistance by the greater institutional body of chiropody itself. An unattributed piece in a 1951 newsletter took issue with "prejudice and autocratic practice on the part of the parent profession."[78] In 1952 ACFS planned its first surgical conference, to be held at the Ohio College of Chiropody. At the last minute, the Ohio Chiropodist Association, which wished to have the conference held along with its own annual meeting at Cleveland's Statler Hotel, persuaded the Ohio College to withhold its sponsorship. A peevish newsletter complained that "fear and mental immaturity drive men to do petty things."[79]

There were more encouraging signs, however. In Chicago, a few chiropodists had managed to be attached to a hospital clinic under "chiropody staff status." The March 1953

newsletter hoped that it "might be a forerunner of a nationwide movement."[80] And progress was being made regarding insurance. For years, Lester Walsh had been working to get Delaware's Blue Cross affiliate to recognize the services of surgical chiropodists. Since Delaware had been among the first states whose attorneys general ruled that a chiropodist was a physician according to state narcotic laws, Walsh was optimistic that Blue Cross could be persuaded to accept its definition.[81] In 1950 he advised his counterparts in other states to begin seeking similar rulings from their insurance companies.[82] One of the most notable achievements of the era was when, in 1953, the Prudential Hospital Association covering Washington, Oregon, and California accepted ACFS members in its policy plan. It was with barely concealed glee that the newsletter noted that the move "will divert all the chiropody work to us which has been going to MDs."[83]



Lester Walsh, deep in thought, at the Temple University School of Chiropody.

From a present-day perspective, it is tempting to minimize the achievements of the American College of Foot Surgeons during its first 13 years. Four of them had brought war-imposed stasis, and afterward the College continued to pursue the same objectives for which it had been formed—to seek recognition of its particular expertise and acknowledgement of its contribution to the broader field of health care. But those concerns count for only the last of five objectives outlined in the preamble to the College's founding document. As for the other four—teaching, developing the field, underscoring possibilities for practitioners, and fostering fellowship—although there was much more to do, these had in great measure been accomplished. Perhaps the founders knew that attaining these first four objectives would help make the long, hard fight for the fifth objective bearable. Years later, Lester Walsh put it in perspective by invoking the aphorism "If you bargain for a penny the world will pay no more." He continued, "Let us thank the Lord that we refused to bargain for anything short of true professional status."[84]

Chapter 2

To Mirror Medicine, 1956 - 1975

ACFS had gained a measure of respect in the postwar decade and a foothold in the world of health care. In mid-1956 the organization numbered 35 fellows and 33 associates from 23 states and the District of Columbia, with 52 potential new associates in process.[1] Many of those members had hospital privileges and so were allowed to perform surgery unsupervised. That same year brought a landmark—podiatric surgery's first teaching hospital.

But by the end of the 1950s it had become clear just how tentative those accomplishments were. The Deep South was hardly represented at all in the ACFS membership, and there remained marked regional variations in the profession—a patient going in for surgery on the West Coast might receive far different treatment than he got in the Midwest, for example. More problematic, the very success of podiatric surgeons elicited a reaction from allopathic physicians.

As a result, the most pressing responsibilities of ACFS from the 1950s to the 1970s were enabling its members to create new, more formal educational structures; encouraging more and better research; and above all, establishing a method of certification. In short, ACFS had to duplicate the very structures that supported the authority and longevity of the mainstream medical profession itself. As ACFS president Gary Kaplan put it when he recalled the struggles of his father's generation, "they had to mirror the medical profession for us to gain acceptance."[2]

Civic Hospital

Earl G. Kaplan was a force of nature, with foot surgery his life's mission. He first gained a high profile when he helped Ralph Fowler in his successful effort to convince the state of Michigan to restore the right of podiatric surgeons to use anesthesia. He followed that by serving as chairman of the Michigan Division and then president of ACFS. After serving a term as president of the American Podiatry Association (successor to the National Association of Chiropodists) Kaplan returned to ACFS as secretary, then the College's chief administrative position. Throughout that time he also served the public, putting in 18-

Samuel F. Korman (1954-1956)

hour days, most of them at his practice at 14608 Gratiot Avenue in a Detroit neighborhood that, in common with other urban working-class neighborhoods, experienced its share of troubles as postwar affluence drained to the suburbs.[3]

But Kaplan understood better than most ACFS members did that it was the hospital rather than the individual practice that would be the key to professional success. At the most fundamental level, surgeons needed hospital beds, staff, and operating rooms to do their jobs well. As Sam Korman told ACFS in a 1956 presidential address, "The patients' surgical interest is best considered when performed in hospitals and not in offices."[4] For that reason, the Hospital Affiliation Committee was among the organization's most important committees. In 1956 Lawrence Frost chaired the committee, and the next year Ralph Fowler held the post. The hospital was also indispensable as the place where aspiring surgeons did postdoctoral training and residencies. In this as in so much else, Detroit led the way. In 1956, ACFS fellow Russell H. Seeburger established a Chiropody Section at Lister General Hospital in northwest Detroit "to give the best possible care to patients admitted, to perfect surgical procedures, and to assist each other in techniques and procedures."[5]

The record does not indicate how long the Lister effort endured, but it is clear that by far the most influential effort of the year took place about ten miles to the southeast. Earl Kaplan believed that foot surgeons needed more than to gain cooperation from hospitals; they needed to control one. Only in that way could they create the kinds of programs required to build up the profession. In early 1956 Kaplan solicited financial help from fellow practitioners, took out personal loans, and bought a house. Built in 1933, it was a 5,300-square-foot structure with a basement, two main floors, and attic apartments. It was a single family home, but not for long. In the basement Kaplan installed a medical clinic and sterilization equipment. The first floor was fitted out with a surgical area and beds. There were more beds on the second floor, and in the attic, space for residents—real medical residents. On June 4, 1956, Kaplan opened Civic Hospital, the first podiatric teaching hospital in the United States.[6]

Civic Hospital, Detroit. The first podiatric hospital in the United States.

Within months, Civic Hospital, in conjunction with ACFS, had launched postgraduate training programs for practicing podiatrists. The weekend sessions, inaugurated in November 1956, covered primary surgery with training in asepsis, hospital protocol, lab and x-ray procedures, instrumentation, and preoperative and postoperative medication. Two weeks later, an intermediate surgery course was launched, adding review of basic surgery skills and performance of actual surgery under supervision,

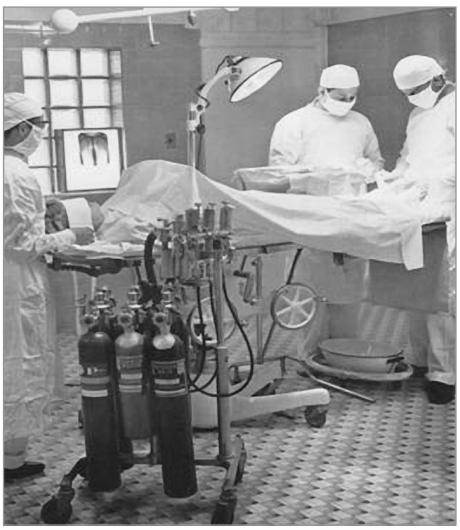
including the treatment of nails, hammertoes, and other minor surgeries. In mid-December came the first advanced surgical course, which culminated in bunion surgery.[7]

Ned J. Pickett (1956-1958)

Although Kaplan claimed that "the surgical and medical set-up at the hospital parallels that of major hospitals in the United States," some aspects remained more of a shoestring affair. Much of the surgery was on cadavers. To attract live patients, it was not beneath Kaplan to visit soup kitchens with offers of free meals and a warm bed.[8] The Civic program was good enough, however, for podiatrists from across the country to attend its regularly oversubscribed weekend sessions. In a dozen years, a preponderance of American podiatrists gained their first exposure to foot surgery at Civic Hospital.[9]

Kaplan's vision was not confined to providing courses for current practitioners; he wanted to train the next generation with postgraduate residencies patterned after the training of allopathic medical personnel. So promising graduates of the nation's podiatry schools went to the house at 610 East Grand Boulevard for lectures, discussions, and to assist in and perform foot surgery.[10] The Civic Hospital residency program began with two doctors, both from Detroit, serving a one-year internship. But Kaplan was soon convinced that a year was too long, so in mid-1957 he established six-month residencies and, assisted by Sol Luft, Irvin Kanat, and dozens of other ACFS members, began routinely training four interns a year.[11] "They start at the bottom," said Kaplan, and worked their way up to assist in, or perform, about 500 surgeries.[12]

By the mid-1960s, Civic Hospital had worked its way up as well, offering six residencies and ten postgraduate sessions per year, each open to about ten podiatrists.[13] By 1965, 2,200 podiatrists had attended either advanced or primary weekend programs.[14] Earl Kaplan's motto, said his son Gary, was "I'm going to make you something. You pass it on to somebody."[15] Accordingly, Civic Hospital was the first link in a chain that when drawn taut, steadily elevated the practice of foot surgery in the United States. By demonstrating that podiatric residencies were possible and popular, Civic Hospital spawned imitators.[16] In 1960, another teaching institution, the California Podiatry Hospital, directed by Robert Rutherford, was established in San Francisco.[17]



Earl Kaplan and Irvin Kanat at work in Civic Hospital around 1956.

It took time, but eventually a second wave of institutions began to expand upon the Civic Hospital example to more closely mirror medicine with multi-year residencies. In July 1969, E. Dalton McGlamry established the Section on Podiatric Surgery at Doctor's Hospital in

Ralph Owens (1958-1959)

Tucker, Georgia. He started with a two-year training program, which, by the early 1970s, he extended to three years. Because of that, Doctors Hospital training became the most prestigious in the profession.[18] Due largely to Robert Rutherford's efforts, the California College of Podiatric Medicine later initiated a three-year program, while former Kaplan students, members of the Civic Hospital Residents Alumni Association, had initiated surgical residency programs in Illinois, Maryland, Texas, and New York.

The movement launched in Detroit had profound impact on the profession and on the College. By the mid-1970s membership applications had increased due to the growing numbers of surgical residency programs and constitutional amendments that made it easier for graduates to obtain ACFS membership. This somewhat ironically created a great deal of work for Earl Kaplan, who was then processing membership applications as part of his work as ACFS secretary.[19]

By then, the house on 610 East Grand Boulevard was once again a home. In 1965 the weekend programs had ceased, and four years later, with Kaplan facing a trumped-up lawsuit brought by a disgruntled intern, ownership of Civic Hospital was transferred to nearby Grand Community hospital.[20] The time when an 18-bed hospital could be profitable had passed, and on September 23, 1973, a brand-new 54-bed facility, Monsignor Clement Kern Hospital (named after a Catholic priest and friend of the poor who was also a friend of Kaplan's) carried on the work.[21] The next year Kaplan had the last word, calling Civic Hospital "a catalyst for a profession striving for maturity by building itself a house in which it could grow, expand its horizons, and refine its skills."[22] Those expanding horizons, however, had already brought on the predictable backlash from orthopedic surgeons.

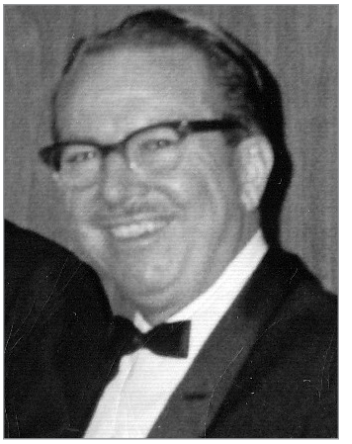
Orthopedic Offensive

Earl G. Kaplan (1959-1960)

In 1963, ACFS founder Oswald Roggenkamp returned from an extended vacation in Hawaii to find that he had lost his hospital privileges. He had been working at Doctors Hospital in the District of Columbia for 28 years, but now the Joint Commission on Accreditation of Hospitals decided that he could no longer practice there unless an allopathic physician was standing beside him. For Roggenkamp, that was the price of his profession's success.[23]

By 1960, ACFS members had privileges at 250 general hospitals nationwide, 47 states granted full surgical privileges to podiatrists, and orthopedic surgeons were worried.[24] A year earlier, the American Academy of Orthopaedic Surgeons (AAOS) had created a Committee on Podiatry that began scrutinizing the profession. To the increase in podiatrist privileges and state licenses, they added such grievances as the growth of podiatry schools, the coverage of podiatry under Blue Cross and Blue Shield, and of course, the establishment of Civic

Hospital. It was with some relief that they determined that most podiatrists still lacked access to hospital staff. But the committee warned that "The podiatrist has 'his foot in the door' of the operating room."[25] The AAOS decided a strong stand was required to keep bone and joint surgery away from podiatrists and to keep ACFS members out of hospitals.



William Edwards (1960-1961)

Until recently, allopathic physicians had done little to serve patients and earn income by specializing in problems of the foot. They had apparently been confident that they would be able to recover the business from the old-line "corn, nail, and callus" practitioners whenever it seemed desirable. Indeed, once the AAOS offensive began, Ralph Fowler noted that "like the mother who gives away her baby, only to come back years later to reclaim it, this medical group has decided it wants its baby back."[26] But by the late 1950s, allopathic physicians no longer considered podiatrists to be pushovers, in large measure because the profession, as the AAOS noted, was increasingly dominated by "fellows of ACFS," like Lester Walsh and Ralph Fowler, both of whom served as president of the National Association of Chiropodists during the 1950s, since renamed the American Podiatry Association (APA).

The AAOS offensive came at a time when the APA was deep in reflection about the status and stature of the profession, having created the Selden Commission to review the state of education and professional credentialing in podiatry. There was room for improvement everywhere, but when the commission looked at the APA specialty groups, the largest of which was ACFS, it was particularly unhappy.[27] True, there were two teaching hospitals with residencies and postgraduate courses, but there was no specified sequence or regularity for continuing education. Research and publishing were even weaker. The ACFS bylaws required members to submit one new case history and one article to a professional journal every year, but this requirement had never been enforced; indeed, to do so would have destroyed the organization—in 1960, only 8 out of 170 ACFS members had submitted articles for publication.[28] Nor were ACFS conventions very heavy on science—they were more focused on fellowship than scholarship—and travel costs kept younger men away. There were also problems stemming from the profession's origins, dual terminology (*podiatry* and *chiropody*), and inconsistent state laws. And there was no official system of hospital certification.[29]

Louis M. Newman (1961-1962)

On August 31, 1960, while the Selden Report was still being drafted, APA president Marvin D. Marr showed up at the ACFS annual meeting at Chicago's Drake Hotel. When he got the floor, he gave the members an earful. All specialty groups, he began, had to promote further education and research, "which, I am sorry to say, has been noticeably lacking." Then he spoke to the larger point, which was the AAOS offensive. "Believe me, we need you," he said. "Let's quell those individuals who are hurting us and who are frustrated physicians." He asked ACFS members to begin the effort by providing better information about their work.[30]

Lyle R. McCain (1962-1963)

When Marr relinquished the podium, the meeting returned to business as usual until Lester Walsh asked for the floor. "Dr. Marr came here today, not only requesting co-operation but actually imploring us to give it to him," he said, "and I am in accord with that thought." Walsh warned that orthopedic surgeons "will want to know, where is chiropodial surgery going to stop and where is orthopedic surgery going to begin?" He recommended that ACFS set up a committee to address, if not answer, the question.[31]

In January 1961 the AAOS announced its position: "The training of chiropodists is not sufficient in basic sciences or clinical medicine and surgery to meet the standards of other surgeons practicing in these hospitals." AAOS sent two resolutions to the American Medical Association (AMA) House of Delegates that would have suspended all hospital privileges for podiatrists, but the AMA equivocated, instead adopting only a single resolution calling only for "a thorough review and study of Chiropody."[32] Douglas Mowbray considered this a challenge, as he told his colleagues, to "put our professional house in order."[33]

By the summer of 1961, Walsh was chair of the committee that he had called for, with license "to attempt to work out the problems of scope and policy of ACFS as related to medicine and that specialty of medicine, orthopedic surgery."[34] He had already met with a committee of the AAOS, which was holding the line against podiatrists doing any joint surgery.[35] He was also meeting with the APA Medical Liaison Committee, charged with resolving this sticky situation. It was a curious arrangement, because Walsh was meeting with himself—he and Mowbray were members of the Medical Liaison Committee representing ACFS.

Walsh and Mowbray both realized that, despite its merits, the group they had founded had not done enough to elevate the status of foot surgeons on par with other medical practitioners. They believed that podiatrists—given a good deal of work and a lot of time—could get their "professional house in order" and gain recognition as highly trained specialists from allopathic physicians on par with what dentists had achieved. But not all ACFS members were in agreement. Some believed that taking a hard line with the AAOS was the best approach, while others insisted that foot surgeons should demand nothing less than full admitting privileges with the ability to conduct admittance examinations and to be responsible for patients under anesthesia.

Robert L. Brennan (1963-1964)

On June 29, 1961, Mowbray and Walsh, representing the APA, attempted to bring their colleagues back to earth, claiming an "urgent need for a complete and soul searching look at ourselves."[36] The *Report to ACFS on the Current Status of Hospital Privileges for Podiatrists* began by dismissing the notion that podiatrists would be getting full privileges soon and noted that when it came to education and training, even in comparison with dentistry, "podiatry leaves much to be desired."[37] It was a tough message. The founders of ACFS were telling their colleagues that the criticisms of their toughest opponents were, in large measure

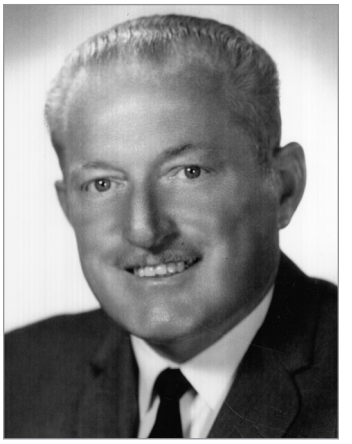
correct, that accomplishments like Civic Hospital were not enough—that in graduate education, publication, science, and research, podiatric surgery fell short. "We have not kept pace in our educational status and time will run out unless we act promptly and in good faith."[38]

Ralph E. Fowler (1964-1965)

The report recommended that in the short term ACFS should do three things: define its scope of practice (many state laws, for example, still gave chiropodists the ability to treat hands); draw up a code of ethics that took a strong stance against practices like fee splitting and ghost surgery; and take a position on certification (under what specific program should foot surgeons be certified to practice in a hospital?). The report also suggested that ACFS pursue a few other priorities in the longer term, such as enforcing its bylaws regarding research and publication and establishing a quarterly journal (or at least including a surgical section in the *APA Journal*). "If we are to attain the professional stature in hospitals which we desire, it will be necessary for the ACFS to develop a coordinated program directed toward meeting the standards required by medicine."[39]

Two decades earlier, Mowbray had hoped that if the bar was set high enough, ACFS membership alone might be enough to open operating room doors. But that had turned out not to be the case. ACFS could never be a certification body operating in the public interest; it would always be a professional association. Mowbray believed that even in that aspect ACFS had fallen short and that the situation would get worse before foot surgeons earned the respect necessary to keep them in hospitals. Because of that, in sharp contrast to his colleagues, Mowbray seemed to harbor no cynicism or bitterness against allopathic physicians. This was all the more remarkable because he had been one of the first foot surgeons to gain hospital privileges, and one of the first to lose them, due to physician influence shortly after returning from the war.[40]

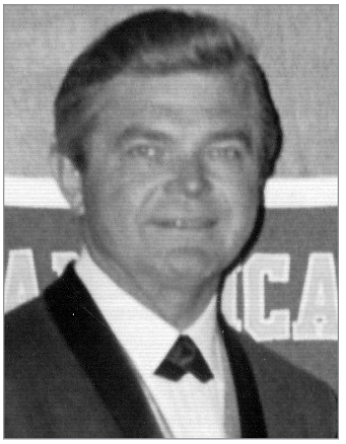
While Mowbray always got respectful applause, it is likely that only a minority of members agreed with him—it was easier to blame those they called "orthopods." Others believed that the courts could be counted on to remedy the injustice, although Mowbray insisted that podiatrists would never get anywhere with antitrust lawsuits—and even if they won a suit or two, the reaction would be hard and swift and "the hospital climate would be frigid indeed."[41] In 1963 Oswald Roggenkamp tested that thesis, hiring Edward Bennett Williams, one of the toughest litigators in the United States, and taking Doctors Hospital and the Joint Commission on Accreditation of Hospitals to court. His antitrust case went nowhere. AFCS was in for a long uphill climb.



John B. Collet (1965-1966)

Fellowship, Reform, and Firsts

Ralph Fowler seemed to have anticipated the challenge when he gave the luncheon speech at the August 1957 ACFS annual meeting at the Drake Hotel, telling the members that "their responsibilities will be many and their privileges few."[42] At the time, however, most in attendance were probably thinking about something else—the very name of



James Meade (1966-1967)

the profession was in question. Doctors tend to be conservative, and although New York pioneer Maurice Lewi had urged practitioners to adopt the name podiatrist for their profession, many clung to the archaic term chiropodist. The vast majority of states did too—by 1957 only New York and Indiana officially recognized the newer term. The movement to modernize was strong, but the issue remained in doubt as the ACFS meeting closed and the National Association of Chiropodists conference began. In the end it took a parliamentary trick to force adoption of the name podiatry.[43]

Through the late 1950s and into the 1960s, as chiropody was incrementally replaced by podiatry, ACFS supplied some of the most enterprising leadership to the APA, including men such as Fowler, Walsh, Kanat, Mowbray, Kaplan, and McGlamry.[44] With ACFS membership having swelled from 25 in 1950 to 125 in 1960, some administrative changes were clearly in order. In 1959, Oklahoman Ralph Owens stepped down as president only a year into his two-year term due to ill health. At the same time, however, he submitted a constitutional change making the one-year presidential term permanent. When the organization was small, he noted, it was necessary for a few to invest a great deal of time working through the officer positions. But now that the organization was larger, Owens said, "men would never have the opportunity of going through the chairs."[45]

The growth also greatly increased the volume and complexity of administrative business, so Jack Kohl, who took office in 1955, was persuaded to remain indefinitely as full-time secretary, becoming the College's first long-term administrative officer. Kohl was associated with the Illinois College of Chiropody, which provided him with space, so through the rest of his service until 1965, Chicago became the unofficial headquarters of ACFS.[46]

ACFS leaders in 1956. From left, Sam Korman, Ned Pickett, Ralph Owens, Jack Kohl, and Earl Kaplan.

The growth in membership did not create organizational affluence, however. In 1957, with funds low and opposition to a dues increase high, Fowler suggested that ACFS hold a midwinter scientific meeting to help raise funds. Kaplan supported the idea, not only in the name of science but also as "an opportunity to go places and have a winter vacation so that we could have some of the privileges like other medical groups."[47] The APA, which wished to keep ACFS close, was skeptical, but gave approval when assured that the annual meetings would continue to be held just before APA conventions. The first midwinter meeting was held in February 1958, with Fowler as scientific chairman. But the delegates were interested in more than science: the event was held at the Riviera Hotel in Las Vegas, and although the schedule included a half day of

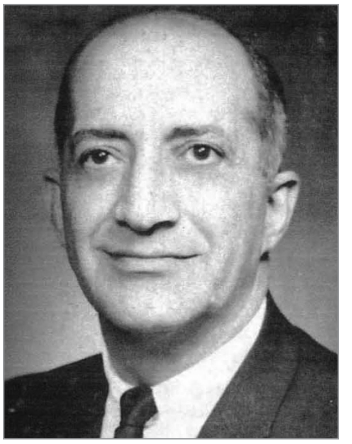
science (which meant that attendance would be tax-deductible) another two-and-a-half days were given over to "sight-seeing."[48] It was, wrote Jack Kohl, "a tonic we all need."[49]

Robert L. Rutherford (1967-1968)

After another year in Las Vegas, ACFS was hoping to go to Cuba. Unfortunately Fidel Castro's revolution intervened, and the 1960 midwinter meeting convened in Mexico City instead.[50] A few years later, ACFS was going even farther afield, meeting in Spain (where members witnessed foot surgery at Toledo's Virgin de la Luz Hospital) and Israel, where ACFS established a liaison "to promote modern podiatry."[51] Mowbray and Walsh harrumphed that "the annual scientific session is by any other name, a holiday session with only enough scientific program to justify tax exemption."[52] The members as much as acknowledged the truth of the charge when they began holding two midwinter meetings—the official scientific one and an unofficial "extension trip" dedicated to fun and fellowship.[53]

For an aspiring associate, there was little that was fun about an annual meeting. Testing was administered by board members, with oral exams lasting until the early morning hours and results announced immediately afterward. Potential fellows sat for the written portion of their exams early in the meeting, waited in their hotel rooms to learn the results, and if successful were invited back for oral examinations the next day.[54] In the mid-1960s, beginning with Samuel Abdoo's chairmanship, the ACFS Examinations Committee formalized (and humanized) its procedures. Examinations were held at different subject matter stations with two examiners at each station. Each examiner had to grade and sign an examination sheet. There was also a mock operating room. Applicants were informed of the results by mail rather than in person, saving the unsuccessful a great deal of personal mortification.[55] While serving as president in the late 1960s, Robert Rutherford tried to reform the process again by removing examinations from the annual meeting entirely, but his efforts did not gain traction.[56]

Other reforms that took place in the 1960s were the direct result of the 1961 Mowbray and Walsh report. In 1962 ACFS produced a code of ethics, adapted from the American College of Surgeons, and created an ethics committee to deal with fee splitting and ghost surgery.[57] Also in 1962 a Committee on Nomenclature was established to resolve the *chiropody-podiatry* confusion and to clarify other terms as well.[58] Another recommendation had been that ACFS institute a program of film and audio-visual learning, and in 1962 ACFS began compiling a library of slides, movies, photos, x-rays, and other resources that could be displayed at conventions and district meetings.[59] Through the 1960s and 1970s, ACFS was ready to supply slides, films, and a projector to all interested parties—except when members failed to return the equipment.



Samuel C. Abdoo (1968-1969)

There was also some organizational adaptation as ACFS grew during the postwar years. In 1958 Lester Walsh moved from the East Coast to Texas and created the new Southwestern Division, which covered Oklahoma, Louisiana, and Texas.[60] A decade later, the Midwestern and

Oscar M. Scheimer (1969-1970)

Southern Divisions were formed to accommodate membership growth in those areas.[61] In 1974 the ad hoc system that had developed over the years was rationalized as ACFS redrew the lines, creating new Western, Southwestern, Midwest, Great Lakes, Southern, New York, New England, and Eastern Divisions.[62]

In at least one case, the divisional structure was incapable of containing the inevitable tendency to splinter that all organizations display. By 1964 a new group calling itself the International College of Foot Surgeons had emerged, claiming to be accredited by an "American Board of Foot Surgery." Some of its 125 members also belonged to ACFS. An APA board of inquiry found no merit to its claims, disavowed the dual organization, and suggested that all of its members join ACFS.[63] It would not be the last time that a dual organization challenged ACFS or the APA.

Meanwhile, from the ranks of ACFS emerged a few notable "firsts." In 1961 Ann G. Rotramel became the first female member of the College. Rotramel was a 1948 graduate of the Illinois College of Chiropody and Foot Surgery practicing in New Ulm, Minnesota. Her attendance at the August 1961 annual meeting led the officers, in their addresses to the membership, to adopt the awkward phraseology "lady and gentlemen."[64] Four years later, ACFS welcomed its first African American member, Peggie R. Roberson, who had earned her doctorate at the California College of Podiatry and Foot Surgery and practiced in Los Angeles.[65]

Ann G. Rotramel, the first female member of ACFS.

When it came to the long-term success of ACFS, however, no first could be more important than the creation of student chapters, a priority for ACFS president William Lowe, in the mid-1970s. Most of the chapters were family matters. The first was founded at the renamed California College of Podiatric Medicine by Richard Reinherz, the son of recent ACFS president Howard Reinherz.[66] The student chapter at the Illinois College of Podiatric Medicine was formed by Mark Feder, the son of ACFS member Harold Feder, and Dale Kaplan, one of the three Kaplan children to follow their father into the profession. Earl Kaplan himself organized a student chapter at the Ohio College of Podiatric Medicine, and members of the Eastern Division established a chapter in Philadelphia.[67] "Our interest in them today will mean their interest in ACFS tomorrow," wrote Lowe.[68]

"A Journal of Its Own"

In 1963, after the high-profile denial of privileges to Roggenkamp, Mowbray and the APA Medical Liaison Committee met with AAOS officials in a nine-hour session. Afterward Mowbray continued his ingratiating ways, telling ACFS members that "we find ourselves

in this situation with our educational pants down."[69] Ralph Owens, an Oklahoman who had been struggling for more than a year to get his colleagues to publish, added, "You are the best in the business, but you're too cotton picking lazy to write these articles up about what you are doing. . . . No organization is an organization until it puts out a journal of its own."[70]

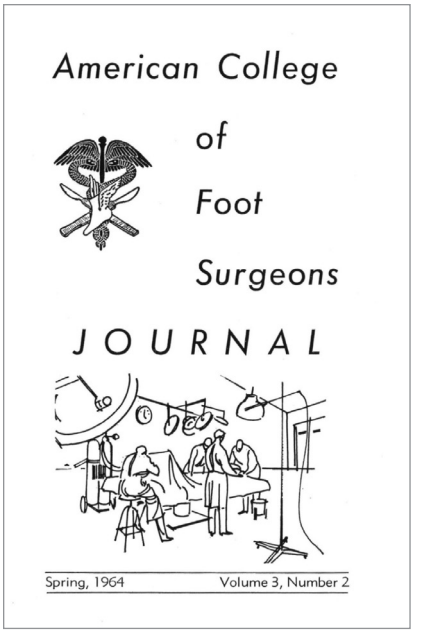
James O. Tredway (1970-1971)

The founders of ACFS had hoped to cultivate a profession enriched by a steady accumulation of knowledge and enlivened by vigorous academic debate. Instead they created a case history bar that aspiring associates and fellows managed to clear well enough, but once over, never revisited. The first attempt to realize the dream of professional publication came in the mid-1950s when the *Journal of the National Association of Chiropodists* provided space between its covers for surgical articles.[71] In 1958, president Ned Pickett decided that the time had come for an ACFS journal. Jack Kohl managed to fill two volumes, which were printed by an academic publisher and sent to all members, state medical journals, and other professional publications.[72] But the effort was premature—Kohl had no time to recruit authors or vet submissions, and the content showed it. ACFS then scaled back its ambitions, issuing a few mimeographed journals, but the APA urged the College to suspend the effort and return to publishing within the confines of its pages.[73]

A second, less ambitious attempt came with the issuance, in 1961, of the *ACFS Bulletin*, which combined academic articles and organizational news. Among the included articles was a paper by president Lyle McCain on Morton's neuroma.[74] At the annual meeting in 1962, Owens told attendees that he was ready to reestablish an ACFS professional journal "if we could only get our men in the profession to write up their case histories."[75] He could not. The next year, the journal published four articles, two of them penned by Owens himself.[76] This slow start was all the more frustrating because new research—particularly the biomechanical approach pioneered by Dr. Merton Root that emphasized not merely treatment but long-term maintenance of correction—was beginning to have an impact in the colleges and the profession.[77]

Finally, in 1964, the effort bore fruit, although the origins of the modern journal remain somewhat mysterious. The first extant copy of the *American College of Foot Surgeons Journal: A Publication Devoted to Foot Surgery and Economics* appears to be the April 1964 edition, which is listed as volume 3, number 2. The previous two volumes may have been the *ACFS Bulletin*. But volume 3, number 1, which was listed as having been published in January 1964, is nowhere to be found—even in the collection of Gary Kaplan, who kept his father's office intact decades later. Congratulations appear in issue two referring to issue one, so it must be presumed that the January edition did exist.[78]

Issue number 2, however, is a publication clearly still on the way to becoming an academic journal. It features a hand-drawn ACFS logo (a winged foot and two scalpels superimposed on a caduceus), and a sketch of an operating room scene. In this and subsequent issues, papers tend to be by the College's most high-profile members, including McCain, Kaplan, Rutherford, and Owens, attesting to a great deal of commitment from the top of ACFS to getting the endeavor up and running. The early journals are also very much an organizational

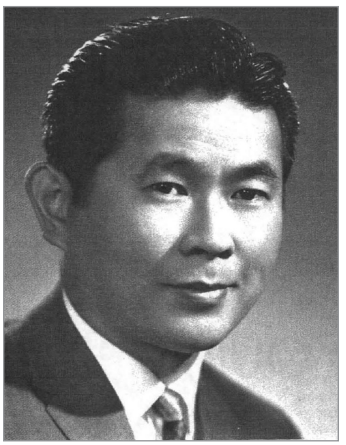


The hand-drawn cover of an early edition of the *Foot Surgeons Journal.*

as well as an academic publication, with a Secretary's Statement, a President's Message, and occasional fee study reports.

Whatever the content and format, the fledgling journal survived. By the summer of 1965 it was paying for itself.[79] In 1966, Birmingham, Michigan, member Don Shubert took over editorship from Owens and expanded the journal.[80] By fall he had four reviewing editors on board, including McGlamry and Rutherford.[81] At about this time, president James Meade exulted that "through the laborious efforts of our Journal staff, our college is becoming more unified with each issue."[82] In 1967 Shubert and Owens traded editorship again, but in 1968 the journal got its first long-term editorial team, co-editors Irvin S. Knight of Ohio and Richard H. Lanham of Indiana.[83]

Knight, in particular, deserves recognition for his persistence at the Sisyphean task of coaxing articles out of a publication-shy profession. In 1969 the co-editors asked every member for an article. Finding that too ambitious, they then personally asked 25 specific members for papers and got seven submissions.[84] In 1972 Lanham resigned and Oscar Scheimer of New Jersey became co-editor. He and Knight announced that "the journal is maturing and becoming a representative of ACFS in which we can be happy."[85] They set goals for bringing the format up-to-date, improving the quality of papers, setting target dates for publication, expanding the bestowal of the Lester Walsh award for papers of exceptional quality, and getting the journal into *Index Medicus*. All achievements remained elusive, and by late 1974 both editors were ready to resign if the board requested it. The officers knew better than to do so.[86] By then the journal had been renamed, redesigned, and gotten a new publisher. "The new look of the *Journal of Foot Surgery* was exceedingly well done and attractive," noted president Howard Reinherz in 1974. "Our problem is still with the material between the covers."[87]

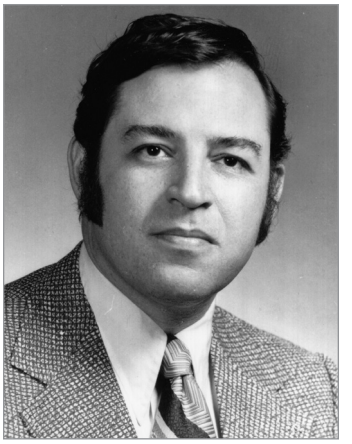


Ben Hara (1971-1972)

There were a few questions about content in addition to the case histories and articles. In the early years, for example, the publications included lists of median fees. A few questioned inclusion of these as being unseemly at worst or purely local or regional matters at best. Isadore Forman of Philadelphia countered that "we use the American College of Surgeons as an example in conducting ourselves. The American College of Surgeons has been talking about fees quite loud."[88] In the late 1960s and early 1970s, the journal regularly included full-page cartoons poking

fun at the day-to-day affairs of foot surgeons by gifted California member Robert Hughes.[89] Although jokes about surgeons forgetting which toe to operate on detracted from the gravitas of the journal and certainly would not have been welcomed by more austere constituents such as Mowbray, the membership clearly appreciated them.

If getting out the journal was a thankless task on the front end, it was also a big job on the back end. In 1965, five years after his stint at the helm of ACFS, a year after serving as APA president, and about the time weekend programs at Civic Hospital ceased, Earl Kaplan found himself with time on his hands. He successfully ran to become the College's full-time secretary, succeeding Jack Kohl. ACFS headquarters shifted to Kaplan's practice on Gratiot Avenue in Detroit.[90]



Seymour Z. Beiser (1972-1973)

From that point on, Kaplan had a hand in nearly every College activity. Like professional association executives today, Kaplan was an ex-officio member of all committees, attended multiple ACFS and APA meetings, and tracked associate and fellow applications, checking in with candidates to ensure that they were ready for examinations.[91] His practice also served as the "back issue department" for the journal, with help from his sons who delivered bundles of journals to the post office.[92] When, in the early 1970s, ACFS set up a speaker's bureau, Kaplan's practice served as the clearing house.[93] William Lowe, who joined the ACFS board as treasurer in 1972, remembered paying a token rent for space at Kaplan's practice. But he considered the real office space to be the "2' x 3' x 2' traveling case that Earl Kaplan sent all over the place."[94] The case contained certificates for associates and fellows along with other official documents that he preferred to keep close at hand.[95]

There were a few things that Kaplan did not do. After Howard Reinherz took over the treasurer's office in 1971 he tightened up ACFS finances commensurate with an organization numbering in the hundreds, creating a budget and issuing a full chart of accounts. ACFS passed its first full audit the next year. After Reinherz rotated out of the office, the ACFS account remained in the bank in his home town of Kenosha, Wisconsin.[96]

Certification

The founders may have hoped that attaining ACFS fellow status would be enough to qualify for hospital privileges, but well before the AAOS offensive began in earnest it was clear that was not always the case. In 1958 Isadore Forman noted that ACFS was getting attention in hospital literature, but "the question has frequently been asked me 'what are the qualifications of the men who call themselves fellows of the American College of Foot Surgeons?'" Forman said that "our qualifications as set forth in the Constitution and bylaws don't mean much to hospital people." He suggested establishing an accreditation committee.[97]

But if foot surgeons were going to mirror medicine, they could not certify their own members—that would have to be done by an independent board serving in the public interest.[98] Because educational qualifications were key to certification, this was among the many pressing points to arise during the course of the Selden Commission's look at the

broader issue of podiatrist training. In the summer of 1960, the APA decided that it was time to come up with a means of qualifying podiatrists for staff privileges and to keep them from being regulated by the allopathic medical profession. Upon the recommendation of Walsh and Mowbray's Medical Liaison Committee, the APA House of Delegates adopted Resolution 21, calling for a full-scale study by the APA Council on Education of procedures for certification and accreditation.[99] In 1961 the APA formed a Joint Council on Accreditation and Certification. That September ACFS president Louis Newman appointed nine members to a new ACFS Committee on Certification chaired by Lester Walsh.[100] For the first time, the College was committed to directly pursuing accreditation.

Why had it taken 19 years? One observer noted that "apparently the ACFS had delayed in promoting the surgical specialty because it was unclear about the goals it wished to promote."[101] In fact, the question seems to have been less one of goals than commitment. Many ACFS greybeards, such as Oswald Roggenkamp, had already obtained privileges and may not have been as concerned with the matter as they could have been. When, in the late 1950s, the orthopedic surgeons decided to "take their baby back," the matter became more pressing for the most influential members of ACFS. The incentive was not all negative, however. Although creating podiatric teaching hospitals to mirror those for medicine had previously seemed impossible, the founding of Civic Hospital and California Podiatry Hospital offered a way forward.[102]

In January 1962, the APA convened a meeting in Washington, D.C., to set policy for all its affiliates. Attending were representatives of the Council on Education, the Association of Podiatry Colleges, the American Society of Chiropodical Roentgenology, the American Board of Chiropodical Dermatology, the American College of Foot Orthopedists, the American College of Hospital Podiatrists, and ACFS. The delegates agreed to follow the dentistry model—that profession had long ago developed accreditation and earned mainstream medical acceptance—and produced the document "Requirements for National Certifying Boards for Specialty Areas of Podiatry Practice." This became Resolution 33 passed by the House of Delegates in August 1962.[103]

By then the Walsh Committee had drawn up an outline for a certification board. It distinguished between a limited certificate and full certificate (conferring what would be known as diplomate status) by length of practice and case studies submitted. The plan also called for a "Founders Group:" nine members who would give the exams and therefore be exempt from the examination process. It was to be called the American Board of Foot Surgery.[104]

Howard R. Reinherz (1973-1974)

When the plan went before the ACFS members in February 1962, they immediately began to pick it apart.[105] Mowbray was not interested in arguing over the details. He warned the members that they would have to be ready to put aside their differences to work with the APA and allopathic physicians. Belligerence and indignation would count for little, he maintained. "If we are going to represent ourselves as an organized medical discipline, then we must expect to be measured by the same yardstick as medicine measures itself."[106] The ACFS members duly approved the mechanics of the system, which, allowing time to get the educational provisions in place, was scheduled to go into effect in 1968.[107]

The Walsh Committee submitted the matter to the APA House of Delegates in August 1962, which withheld approval but allowed the plan to go forward (while suggesting a name change). The American Board of Podiatric Surgery (ABPS) was incorporated by the Founders Group in Delaware on January 9, 1963.[108] On January 18, the Founders Group met and elected themselves members of the ABPS with Walsh as president. Jack Kohl, who as secretary had long maintained the ACFS examination records, took the same position in the certification group.[109] The Founders Group then disbanded and reconvened as the ABPS and arranged for a hospital and medical consultant to review their draft constitution and bylaws.[110] The next day they met with the APA Council on Education and obtained recognition "in intent" of the ABPS.

William Lowe (1974-1975)

That summer the APA reminded ACFS that the ABPS would never gain full approval without a "program of instruction for the individuals who are going to qualify themselves for certification."[111] The colleges and teaching hospitals could do the work, they were informed, but their programs had to be coordinated and consistent with a "level of competency."[112] In the spring of 1964, the ABPS conducted a nationwide survey of graduate training programs both in existence and in the planning stage. The next August, the ABPS gained "initial accreditation" from the APA. "Continuing accreditation" was withheld until the ABPS issued certificates to its first group of diplomates. To do that, the profession had to have a formal training program in place. The plan was for a one-year internship, followed by a one-year residency in podiatric surgery.[113]

Then the threads began to unravel. Lester Walsh died on March 30, 1967.[114] Douglas Mowbray wrote a memoriam in the July issue of the journal.[115] Compounding the leadership vacuum were money troubles. In early 1968, with the first deadline for the full functioning of the ABPS looming, Mowbray asked ACFS for a grant of $10,000 "without any strings," to defray ABPS expenses. ACFS provided $2,500 and told Mowbray to come back after ABPS got full approval from the APA, then expected in January 1970.[116]

Perhaps due to this rebuff, that summer at the annual meeting Mowbray rose for special privilege and in making a motion, proceeded to castigate ACFS for "examining candidates and running junkets" rather than "doing its duty to the profession." This was too strong for even the plain-spoken founder, and a bit later he received permission to resubmit his motion "in proper language."[117] It passed, and a year later ACFS implemented Mowbray's motion to hold surgical seminars for all APA members.

But it was not funding that stood in the way of the ABPS. Instead it was the curriculum, the status of the Founders Group, and the process by which ACFS fellows would be grandfathered into certification. The exemption of a preexisting group is a customary way to jumpstart an organization or provide for a senior cohort capable of inducting others. But it inevitably elicits questions about where to draw the line. In 1968 the APA House of Delegates decided that grandfathering should be delayed until there were enough formal postdoctoral programs to ensure a continuing supply of individuals worthy of certification. In 1971 the APA held more hearings on the same subject and in 1972 it found that there were not enough residency programs "to make certification by specialty boards a viable program."[118]

While the APA temporized about postgraduate training, ACFS members bickered over seats on the board. By 1970 the most polarizing issue was whether the Founders Group would be examined. That summer, Mowbray and former president William Edwards, representing the ABPS, and Reinherz and Kaplan, representing ACFS, pursued a settlement. The ABPS agreed to exempt founders, but insisted that all other ACFS fellows would have to take an oral examination. Mowbray pointed out that the ABPS was only heeding the request of the Council on Education, but the idea was nonetheless insulting to veterans of the College.[119]

In the end, ACFS opposed tests for any of its fellows. Predictably, the Council on Education refused to approve the arrangement, expressing "concern with any decision that exempts fellows of the ACFS from any examination as a requirement of the ABPS certification."[120] Although Mowbray and Edwards had supported the ACFS line, they did not get much sympathy from the members who insisted that if fellows had to take the exam, the Founders Group should have to do so as well.[121] There was also contention between the growing ranks of surgeons who had served two-year residencies and the old-guard ACFS members who had never done residencies at all. In particular, the California Residency Alumni Association wanted special consideration for the 20 or so graduates of that two-year residency program.[122]

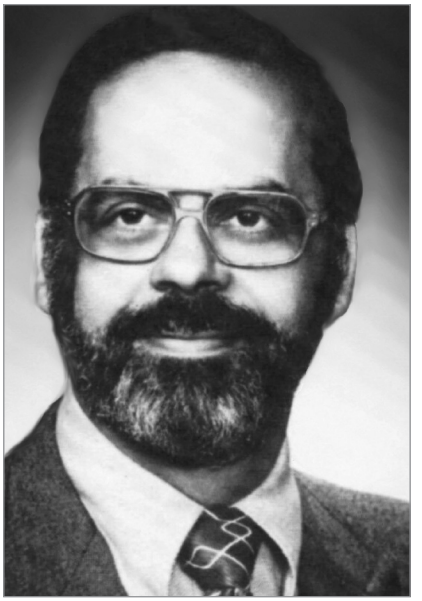
While the contention continued, ACFS began to lay the foundation on which the successful certification body would rest. One of the early 1970s initiatives during the presidency of Ben Hara was creation of a Planning Committee to set some strategic goals for ACFS. A top priority was establishing firm guidelines—the kind the APA wanted—for postdoctoral education in surgery.[123] Meanwhile the orthopedic surgeons kept the pressure on, most notably Robert Samilson who, in his 1973 inaugural address as president of an orthopedic surgeon's group, described training of podiatric surgeons as vastly inferior to that of his colleagues. Podiatric surgeons were stung, but recognized a grain of truth—podiatry had as yet failed to adequately mirror medicine.[124]

By August 1974, both the Council on Education and ACFS agreed on changes to the ABPS constitution and bylaws that, as they saw it, curtailed the ability of the Founders Group to run the board as they saw fit and gave more rights to membership as a whole. In order to yield enough grandfathered members so that there would be at least 100 initial members, they created five categories: fellows with three years of privileges, podiatrists who had completed a two-year surgical residency with three years of privileges, and three different categories of associates. This offer came with an ultimatum: the Council on Education informed the ABPS Founders Group that if it did not agree to this it would "find nine other qualified people or whatever number you find necessary and start another organization."[125]

In the end, that is what happened—it was left to a younger, less inflexible generation to create the certifying board. Over the next year, Irvin Kanat pulled together a new group and developed a good working relationship with the Council on Education. In May 1975, Kanat's group chartered the National Board of Podiatric Surgery (NBPS) in Washington, D.C. The Council granted recognition.[126] The new group included 179 diplomates—a very large proportion of the approximately 485 ACFS members.[127] Howard Reinherz served as NBPS president and Robert Weinstock, with long experience on the ACFS examinations

committee, was among the original members of NBPS examinations committee.[128] It was Weinstock who, as president of the College, put the residual animosity between ACFS veterans and new two-year residents to rest by asking all of them to "please come and sit for the ACFS exam."[129]

To some, the creation of the NBPS called into question the continued relevance of the College, but the NBPS was careful to stipulate that "the National Board only certifies the competency of foot surgeons in the hospital setting. The ACFS provides a mechanism for continued study and for postgraduate education, publishes a journal, and evaluates and examines candidates for membership." The official statement went on to say, "The National Board continues to look forward to a long, close, harmonious and cooperative relationship with ACFS."[130] It could hardly be a less harmonious and cooperative relationship than had existed between ACFS and its troubled predecessor.



Irvin Kanat picked up the pieces after the failed first attempt to create an accreditation group to found the National Board of Podiatric Surgery.

Chapter 3

Complications, 1976 - 1991

In February 1982, the members of ACFS gathered in Houston for the annual midwinter meeting. On the afternoon of the 24th they left the lectures behind and took a bus across town for an evening at the Houston Livestock Show and Rodeo. The surgeons surely expected the usual riding, roping, and ten-gallon hats. They could hardly have anticipated the spectacle of one of their own, Marion Filippone, DPM, taking up an ACFS banner, mounting a horse, and riding a circuit around the Astrodome. In retrospect, Filippone's feat sent a mixed message. For a quarter century, ACFS had been working to prove to the mainstream medical establishment that its members were steady, respectable professionals—anything but cowboys. Gary Lepow did not notice the incongruity, but the young local foot surgeon never forgot this initiation into the professional association of his chosen calling.[1]

During the 15 years after 1975, the American College of Foot Surgeons suffered something of an identity crisis. Its historic function had been to identify and to accredit—through rigorous examination—the most skilled practitioners in the nation. Those examinations and that position as gatekeeper had been central to the ACFS identity. Perhaps it had been a long time coming, but suddenly in 1975, both those functions were ceded to the new National Board of Podiatric Surgery. Two years later president Charles Jones wrote, "I believe that this society, this organization, has been intimidated in the last couple of years over what our role is going to be in podiatry."[2] What was left to be done? A great deal, as it turned out, and into the 1990s the College continually refined its mission and its identity as it grappled with the tasks of producing an esteemed scientific journal; working with, and independently of, the larger podiatric profession to define and improve professional development; meeting a challenge posed by a rival specialty organization; and not least of all, transforming its own management and administration.

Despite the challenges, these were good years for the College. Shortly after Filippone's ride, membership passed the 1,000 mark. Within nine years it had tripled. In the mid-1970s the majority of foot surgeons were still practicing in their offices without sedation or general anesthesia and residencies were rare.[3] By the 1990s, scores of hospitals had accredited one- and two-year residency programs. Although it had taken more than a

decade to create the accrediting body, in the end the timing could not have been better as a more active lifestyle became a cornerstone of American culture. Backpacking and running took off in the 1970s, television workouts and fitness centers in the 1980s. Whether it was Jim Fixx or Jane Fonda, Americans were being urged to get on their feet. "The upgrading of podiatry has fitted into a near perfect timetable," wrote ACFS president Cecil Davis in 1978. "It is obvious at this point that we must make every effort to improve and keep current our surgical podiatric skills—our public needs us."[4] The challenge, then, was for ACFS members to work out the complications created by the establishment of the NBPS, while remaining sharp for the good of the profession and patients.

Publish or Perish

One of the first obligations of any professional is to "publish or perish," and collectively ACFS had felt the urgency of that charge since the beginnings of its journal. A sore spot, however, was that the profession's definitive text, *Surgery of the Foot*, had been published in 1959 by an allopathic physician, particularly since the author, Henri DuVries, once a friend of ACFS, had turned against podiatric surgery after losing the directorship of the California College of Podiatric Medicine to Robert Rutherford.[5] Los Angeles foot surgeon Ben Hara recognized the value of *Surgery of the Foot*, but was convinced that something more was needed. The result was an enduring accomplishment for ACFS.

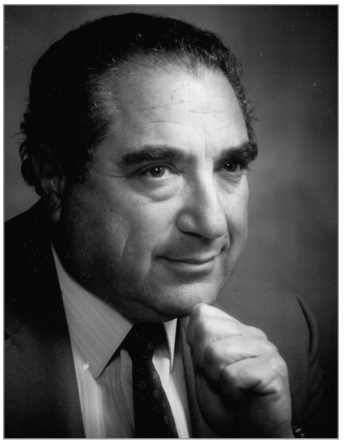
Hara was the kind of expert that ACFS could be proud of. He had served on the Examination Committee throughout the 1960s, getting so good at his work that his 1968 written exam was accepted by his colleagues with no revisions at all. That same year he joined the board as treasurer. At the end of his first meeting, Hara brought up what he later called "a growing personal concern." The profession, he said, needed a new text, one that focused less on specific techniques and procedures and more on complications arising before, during, and after surgery.[6] As Hara later put it, "any surgeon worth his salt is called upon to manage the consequences of complication and resolve them satisfactorily. Surgeons know full well that litigious, ravenous attorneys are waiting for surgeons to make a mistake so that they can pounce on the unresolved complications that ensue."[7] President Robert Rutherford understood completely—and immediately charged Hara with editing the volume.

Robert E. Weinstock (1975-1976)

There were pitfalls, to be sure. Hara's own mentor, former president Robert Brennan, warned that such a book would simply serve as a blueprint for litigators. But the College was willing to accept that risk. The more immediate obstacle was obtaining the required input from ACFS members who, as experience with the journal demonstrated, were reluctant writers. Nevertheless, after a year's worth of cajoling, Hara had articles, data, and diagrams from 132 of them. Unfortunately, about half the submissions were more anecdotal than scientific, so Hara continued to coax. His accomplishment was all the more remarkable since the bulk of the early work was conducted while he himself was ACFS president.

Hara did have help, however, from an editorial board and associate editors William Lowe and Ray Locke. It was Locke who persuaded the

prestigious Baltimore medical publisher Williams & Wilkins to publish the book. The publisher immediately did the editorial team a favor by cutting the anticipated 500 pages back to 250. After four years of work, during which Hara personally rewrote five of fourteen chapters, the manuscript went to the publisher. Weeks later, picking up the publisher's response at the post office, Hara tore open the package to find a caustic cover letter demanding substantial revision—he resisted the overwhelming urge to chuck the entire thing into a nearby trash can.

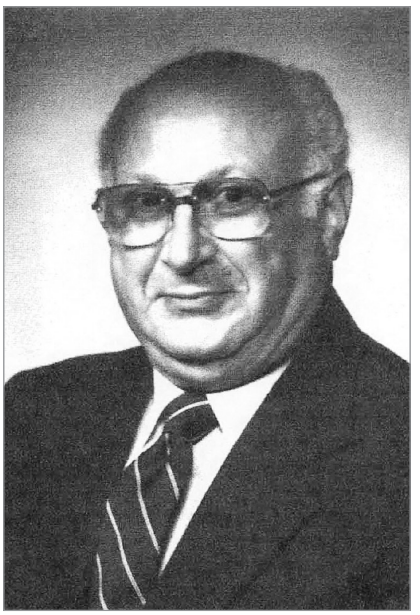


Saul Ladd (1976-1977)

The final work, credited to the American College of Foot Surgeons, reflected the participation of more than 25 percent of all ACFS members, listing a 10-man editorial board, 33 manuscript reviewers, and 118 contributors. Nevertheless, it was "95 percent Ben Hara's work," Lowe later insisted. "He gave his heart and soul to this book."[8] *Complications in Foot Surgery: Prevention and Management* was published in 1976. Within a year, the entire press run of 10,000 copies was sold out, and Williams & Wilkins asked ACFS to begin work on a second edition.[9]

Exhausted from the effort, Hara turned the project over to new editor Stuart Marcus.[10] His work appeared in March 1984, and by midyear the publisher had delivered 3,200 copies, making *Complications in Foot Surgery* the best-selling podiatry text ever.[11] In the end, the second edition sold more than 5,000 copies, so by 1988 a third edition was in the works.[12] That work, renamed *Prevention and Management to Postoperative Complications in Foot and Ankle Surgery*, was published in July 1992, credited to editor Jeffrey Carrel and associate editor Howard Sokoloff.

While *Complications in Foot Surgery* thrived, the *Journal of Foot Surgery* struggled, with editors Irvin S. Knight and Oscar Scheimer continually begging members to submit articles for publication. When that did not work (and it seldom did) the editors resorted to blackmail, regularly printing in the *ACFS Newsletter* lists of fellows and associates who had not met their obligation to submit to the journal.[13] Just as problematic as the lack of submissions was the quality of what did come in, with Knight and Scheimer acknowledging that they "were forced to grasp at straws and print what was available."[14]



Long-time1960s and 1970s journal editor, Irvin S. Knight.

Why go to so much trouble? The explanation stems from the premise that professionals must publish. But it was even more important for a profession seeking to earn respect, as podiatric surgery still was, to produce literature worthy of notice. Earl

Kaplan understood this better than anyone else, and so while Knight and Scheimer strove to upgrade the journal, he worked to get it listed in *Index Medicus*.

In the days before digital databases, scientists, physicians, and other professionals kept abreast of the cutting-edge research of their disciplines through indices—volumes regularly updated and routinely distributed to the reference collections of every major library. *Index Medicus*, published by the National Library of Science, was among the most venerable, founded by John Shaw Billings, librarian of the Army Surgeon General and the first director of the New York Public Library. A periodical with articles listed there was understood to be a publication of record, but unfortunately the *Journal of Foot Surgery* had not made the grade.

Some of the requirements, such as number of subscribers and a regular publishing schedule, were objective. And when Knight and Scheimer managed to assemble four issues in 1975 that could be submitted for consideration, they were encouraged that this would enable the *Journal of Foot Surgery* to be accepted.[15] By the end of 1976, circulation stood at 1,759—two-thirds of subscribers were nonmembers.[16] But other criteria were more subjective, and it required the services of one of the College's greatest persuaders to surmount those barriers.

Earl Kaplan had long hoped to get the *Journal of Foot Surgery* indexed. In 1974 he believed that the time was drawing near and convinced ACFS to set the goal of getting into *Index Medicus* within two years.[17] Meanwhile, he enlisted legal help in Washington, D.C., and began making regular visits to the National Library of Science himself.[18] In late 1976, the journal was accepted for indexing by the *Japan Medical Index* and the *European Excerpta Medica*.[19] Finally, in 1977, the *Journal of Foot Surgery* made *Index Medicus*. ACFS president Saul Ladd lauded Kaplan for his tenacity. "Dr. Kaplan never dropped faith in the fact that the *Journal* would get indexed," Ladd wrote, "and the members owe him a great deal of thanks."[20]

Making the listing did not solve the journal's long-standing problems. Through the rest of the 1970s and well into the 1980s, the journal continued to be short on submissions, and the editors kept begging fellows and associates to live up to their obligations to submit material. During those years, ACFS also required every residency program to submit at least one journal article per year.[21]

Charles L. Jones (1977-1978)

There were some welcomed accomplishments, however. In 1980, worn out from their thankless task, Knight and Scheimer relinquished editorship. The new editor was Richard Reinherz, who had followed his father, former president Howard Reinherz, into the profession. While Richard Reinherz never aspired to leadership, he made an indelible mark on the College through his 17-year stint as editor of the journal, assisted for much of that time by associate editor Craig Gastwirth.

Their first initiative was to completely revamp the size and format of the journal.[22] In 1984, Williams & Wilkins, which had been printing the journal for publication by ACFS, became publisher as well. Through better management and promotion, both in the United States and abroad, the professional publisher began to make more of this ACFS asset, even accelerating the publication schedule to six issues per year.[23] In 1989,

as part of the larger effort to introduce more specificity about the work of its members, ACFS considered renaming its periodical the *Journal of Foot & Ankle Surgery*, just as the title of *Complications in Foot Surgery* would come to include "ankle" as well. But the move was postponed due to legal concerns.

Although the reputation of the College and podiatric surgery rested largely on *Complications in Foot Surgery* and the *Journal of Foot Surgery* in these years, publication was hardly reserved for such august efforts. In the 1980s ACFS undertook a series of unprecedented direct-to consumer efforts. In 1982 the College prepared a brochure simply called *Surgery of the Foot*. By the fall, ACFS had sold some 120,000 copies, largely for distribution by practitioners.[24]

Cecil W. Davis (1978-1979)

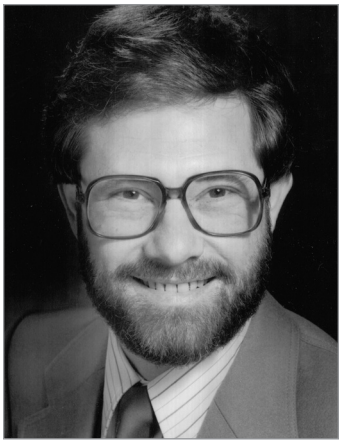
The next year the College went straight to the consumer. On January 9, 1983, ACFS ran advertisements in the *Parade* and *Family Weekly* Sunday supplements promoting the brochures. Some 23,500 respondents asked for one and along with it they got the names and addresses of nearby ACFS members. The effort required a large investment, but the board considered it a "valuable public relations project."[25] In September 1987, the effort was repeated, yielding 7,750 responses within a month. More conventional efforts involved making informational pamphlets available to the membership. A brochure on bunion deformity and treatment sold some 84,000 copies during 1988.[26] In 1991 the ACFS Public Affairs Committee completed an especially ambitious effort, issuing four new brochures on digital, heel, nail, and arthritis disorders and treatments.[27]

ACFS publications of this period were aimed at potential members as well. In 1983 the brief publication *Why ACFS?* went to students of podiatric surgery along with a kit of application materials.[28] In 1991 ACFS produced *Step Ahead—Join the American College of Foot Surgeons* in another effort to convince students and young practitioners to join.[29] But these efforts likely counted for little. A 1980 survey indicated that the vast majority of ACFS members chose to join the College simply for the prestige that came from being a member.[30] Increasingly, that prestige came less from passing tests than from participating in a group responsible, more than any other, for furthering the profession through education.

Qualifications and Foundations

Approval of the original American Board of Podiatric Surgery had been delayed during the 1960s and early 1970s in part because of controversy over grandfathering, but mostly because the APA Council on Education did not believe that there was opportunity for sufficient numbers of podiatric surgeons to be hospital-trained and thus fully qualified for diplomate status. The hiatus turned out to be a constructive one, because it provided time for the proliferation of residencies in hospitals across the country—many of them building on foundations established by Kaplan's Civic Hospital, Rutherford's California College, and McGlamry's Section on Podiatric Surgery at Doctors Hospital.

There was also a briefer hiatus after the founding of the National Board of Podiatric Surgery in the 1970s, which provided time for a name change for the accrediting group. At



Raymond A. Scheimer (1979-1980)

mid-decade, Lowell Scott Weil Sr. agreed to become the second president of the NBPS, but he had a problem. The names of all other accrediting boards began with "American Board of." And if podiatric surgery was truly trying to mirror medicine, why should it stand out? Even though the original founders group had made prior use of that title, Weil simply did an end-run, submitting a trademark and copyright application in Illinois. The state accepted it, and on May 31, 1977, incorporated the American Board of Podiatric Surgery, Inc. (ABPS).[31] If this name change clarified the podiatry picture, the 1984 name change of the APA to the APMA (for the American Podiatric Medical Association) complicated things a bit, but the membership approved the addition of the extra letter to emphasize that podiatrists were in the mainstream of medical practice. Throughout the period, therefore, the promotion of residencies was a joint endeavor of the three four-letter acronyms—ACFS, ABPS, and the APMA. The latter formally approved residencies.

In the early years, guidelines for residencies were in a state of flux, but as of 1975, the APMA Council on Education had approved about 60 hospital programs offering first- and second-year residencies.[32] Over the next few years, the process for evaluation and approval became more formalized largely as a result of input from ACFS. In 1978, the College made "the renewal and opening of resident training programs" a top priority.[33] That year, AFCS instituted a nationwide in-training examination program designed to ensure that residents were meeting the criteria laid down by the ABPS.[34] Another ACFS program, instituted in 1980, conducted more comprehensive evaluations of selected residents during the course of their training and education.[35]

ACFS, working through its Resident Training Programs Accreditation Committee, also joined with the APMA and the ABPS to inspect residency programs as a whole, with different criteria for first-year and second-year programs. Members of the committee routinely traveled across the country inspecting programs at various hospitals.[36] By the late 1970s ACFS had worked with the ABPS and the APA to further standardize evaluation criteria, and its members were inspecting dozens of hospital programs per year.[37] By the mid-1980s ACFS had begun offering financial assistance and participating in a formal training program for residency evaluators. With ACFS and ABPS cooperation, the evaluation program was then spearheaded by the APMA Council on Podiatric Medical Education.[38] The results of this push were substantial. By the fall of 1980 there were 128 approved hospital residency programs—twice as many as five years earlier.[39] Seventy-five of these were specifically surgical residencies.[40]

ACFS also promoted scholarship among the surgical residents. In the late 1970s the College offered subsidies to residency programs for producing "outstanding manuscripts on foot surgery." Qualifying programs received cash awards, with the first-place prize set at $1,000.[41] In the 1980s ACFS began providing research grants to student applicants and making direct research grants to podiatric medical colleges.[42]

As the growing number of residencies made professional certification by the ABPS easier, the College worked to make membership easier by steadily scaling back its own examinations and substituting residency or ABPS qualification instead. A 1976 amendment

to the bylaws enabled graduates of residency programs to submit written evidence of surgery performed in a hospital setting rather than writing up cases in the traditional manner, allowing them "to proceed to fellowship in the American College of Foot Surgeons in a less cumbersome method," as president Robert Weinstock put it.[43]

By the 1980s, with residencies well established and the ABPS fully functioning, ACFS was ready to eliminate nearly all examination functions.[44] Oral examinations for associates were discontinued first.[45] A few years later ABPS certification became a prerequisite for fellowship status, with diplomates invited to join ACFS without submitting to a written exam (although in 1986, after a brief suspension, oral exams were reinstated for fellows).[46]

These were substantial accomplishments for the profession, but the change was not without its complications. Those who served residencies began to see the profession in a new light, and often without the proper sense of perspective. To the veterans who had come of age when residencies were rare, many of the podiatric surgeons emerging from the new programs appeared to be nothing more than ungrateful "young whippersnappers." William Lowe recalled that in these transition years "those without residency were looked down upon," even some of the greats.[47]

In 1976 president-elect Saul Ladd overheard young students and residents at a conference complaining that some of the lecturers did not have sufficient formal training. He used the editorial page of the *Journal of Foot Surgery* to remind the new practitioners that "the pioneers in podiatric surgery indeed are the parents of the young profession of podiatry. It is because we have men like Earl Kaplan, Robert Rutherford, Dalton McGlamry and hosts of other members of the ACFS (and some non-members) that we have the residency programs today."[48] This cultural conflict was probably to some extent inevitable and excusable—the Young Turks never sufficiently appreciate their forebears. But another controversy was much more serious and less likely to go away on its own.

The challenge grew out of technological improvement. By the 1970s, tools had advanced to the point that certain types of surgery to be performed through tiny openings rather than through the traditional incision. The practice, known as "minimal incision surgery" (MIS) or in the case of foot surgeons, "ambulatory surgery," was promoted heavily on its advantages—small openings can produce less operative trauma, fewer complications, and quicker recovery times. But there were drawbacks as well. MIS was then in a highly experimental state with the more serious practitioners still working out safe and effective procedures and the less scrupulous making temporary cosmetic improvements at best. Nevertheless, by the mid-1970s those who performed ambulatory surgery were organized and seeking certification for their specialty.

Donald W. Hugar (1980-1982)

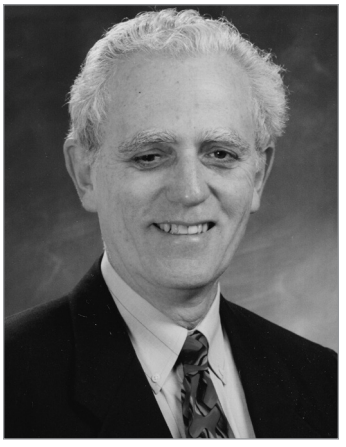
This posed a problem for ACFS. The College's long struggle for what Lester Walsh had called "true professional status" revolved around the premise that its members were as capable of performing the foundational surgical techniques as allopathic surgeons were. As Ben Hara had so well understood, they had to have a sufficient skill set to be ready to prevent or manage any complications that could arise. MIS was, by definition, something of a short cut. Its practitioners used a limited set of techniques, so if complications arose MIS could be of little use.

ACFS members, therefore, took formal recognition of ambulatory surgery to be a "dumbing down" of their profession. Equally problematic, MIS was promoted and practiced as an in-office procedure at a time when foot surgery was finally being welcomed into hospitals on a wide basis.

Practitioners of MIS, some of them ACFS members, shared neither of these concerns, and by 1977 they had formed an accrediting organization, albeit one not recognized by the APA. In 1977 president Saul Ladd, along with Earl Kaplan, met with representatives of the Academy of Ambulatory Foot Surgery to find common ground. "We never discovered what the Academy's goals were or what they really wanted," reported Ladd.[49] In another year the ambulatory group had grown considerably, prompting the New York Division of ACFS to formally inquire of the College "why the Ambulatory Foot Surgeons Group has so many members, what they are doing that ACFS is not doing, and what can ACFS do to improve its position so that we could be on par with them?"[50]

It was fortunate for ACFS that it was the APMA and the ABPS that had to answer the toughest questions—after the ambulatory surgeons sued. Their premise was that their "specialty" had been overlooked during the creation of the American Board of Podiatric Surgery. For a time in the late 1970s the APMA House of Delegates considered a path of least resistance—"Resolution III," which would have allowed more than one area of special practice—but in the end that was voted down.[51] In the early 1980s, it was the ABPS that was ready to cut a deal. ACFS president Stuart Marcus warned, "The ABPS board is mistaken if it believes that differences in technical procedures or removal of the in-hospital requirement would be in the best interest of the profession or the public."[52]

ACFS escaped involvement in what president Don Hugar dubbed the "300 million dollar lawsuit" and in 1984, after legal wrangling and arbitration in the APMA House of Delegates, the American Board of Ambulatory Surgery (ABAS) was permitted to become a section of ABPS. The matter might have been settled outside of ACFS, but California College of Podiatric Medicine professor of surgery Joel Clark, then serving as ACFS president, was not ready to make peace with those within ACFS who sought to "distort or mislead the public." In 1985, he informed the membership, "Your board is as committed to the elimination of these destructive elements within our own College as is possible under current law."[53] Nevertheless, in 1986, 234 members of the ABAS were credentialed by the ABPS.[54]

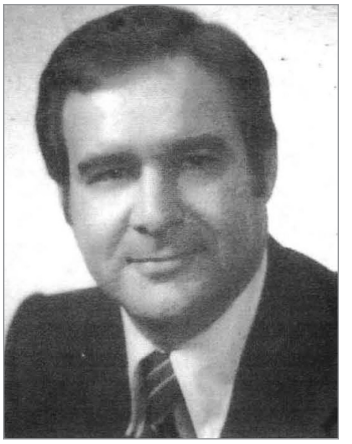


Stuart A. Marcus (1982-1983)

In the end, the subspecialty did not continue to grow exponentially as it had in the 1970s, and ACFS soon acknowledged MIS, even if it did not welcome it. In November 1986, after receiving multiple queries from insurance companies and other entities, the College issued a formal "Position on Minimal Incision Surgery." It allowed that "on occasion, the minimal incision procedure may be the procedure of choice," but warned that those trained only in MIS may employ it in cases where it was not warranted. "It is therefore critical that the surgeon possess the skills to use either technique."[55]

It was particularly nettling that practitioners of MIS seemed to wish to limit the scope of foot surgery even as ACFS was attempting to widen it. In March 1986, the ACFS board held a three-day workshop, facilitated

by management consultants, to consider the post-credentialing role of the College. Without question, the top priority that emerged was for ACFS to become the leader in podiatric surgery research. But as established, the College could never develop the kind of funding required to truly advance the state of the profession. Therefore a secondary priority—launching a nonprofit foundation—became an immediate goal.



Gary R. Dorfman (1983-1984)

The creation was easy. In December, a group of officers incorporated the ACFS Research Foundation in Delaware.[56] Getting the foundation operational proved to be tougher. Board members David Chazan, Richard Hecker, and Arnold Cohen agreed to lead the organizational effort, and by early 1988 they had established a mission: the ACFS Foundation would make grants "to various entities involved in research related to diseases and deformities of the lower extremities," with grants going to colleges and universities, individuals, teaching hospitals, and other foundations.[57] The officers also began searching for lay members of the board, leaders in business with knowledge of finances, grant writing, and foundation support.[58]

Back in 1986, the ACFS board had provided $10,000 for the foundation startup costs, and three years later it was still funding strategic planning efforts intended to develop an effort capable of raising of $10 million in five years.[59] The slow start equaled the pace of fund-raising—the ACFS Foundation had neither the capability nor the contacts to succeed, and by 1990 it was operating in the red.[60] In a moment of optimism, the ACFS board agreed to provide an additional $100,000 over the next five years, but it very quickly reversed itself and the unfunded foundation was terminated in 1993.[61]

A New Approach

With the possible exception of Douglas Mowbray, Earl Kaplan had done more than any other member on behalf of ACFS. He definitely did the most work. During the mid-1970s he pursued the *Index Medicus* objective; compiled two issues of the *ACFS Newsletter* per year; edited, proofread, and printed a new constitution and bylaws; routinely handled membership records and queries; helped put out the journal; returned case studies; and acted as ambassador to the APMA and other groups—all in addition to continuing his practice and his work at Kern Hospital. These were remarkable accomplishments for a diabetic with a history of heart trouble, and by early 1979, the toll had begun to show.[62] Two things were certain: Kaplan could not go on as ACFS secretary, and no one person would ever be able to do the job as he had done it. It was time for a new approach.

Everyone at the February 1979 board meeting knew that Kaplan would be announcing his retirement, effective April 1. Howard Reinherz, therefore, departed from his comments as convention chairman to insist that the administration of ACFS had become too complex to be handled in the old way. "It has to come out of the hands of a doctor and into the hands of a professional," he said.[63] The officers already had a plan—they would offer a new executive director's title to John L. Bennett. Robert Weinstock had a challenging few months filling Earl Kaplan's shoes, but by the summer of 1979 Bennett was ready to go to work.

After retiring as ACFS secretary, Earl Kaplan (center) saw son Gary (left) become president of the organization he helped build. At right in this 1991 photo is Lawrence Harkless who served on the board in the late 1990s.

ACFS had traded a doctor for a professional, but one who was steeped in the culture of the APMA. Moreover, the College had not even obtained full-time help. Bennett had served nine years as director of the APA Council on Podiatry Education, based in Washington, D.C.[64] More recently he had served as executive director of the ABPS as well. Eager to move west, Bennett had resigned from the APMA and was taking the ABPS to Martinez, California, picking up the ACFS portfolio in Detroit along the way.[65] The agreement was that the ABPS and ACFS would split Bennett's services and the cost of the office—although for the first three years Bennett also handled work for the American Academy of Podiatric Sports Medicine as well.[66]

By August 1980, Bennett had moved the ACFS headquarters to a building in San Francisco. He soon obtained IBM office equipment, hired assistant Chuck Grandi, and retained legal counsel Mark Schlussel. Immediately Bennett and his staff began to take care of details formerly left hanging—Schlussel brought a trademark case against some podiatrists who were using the *Journal of Foot Surgery* in advertisements and prepared a suit against a group called the American College of Foot Specialists who were using the ACFS acronym.[67] ACFS prevailed in both cases.

In 1980 ACFS had about 750 members. Four years later, that number had doubled. Bennett's small office was swamped, and his minimal staff overtaxed.[68] In October 1984, the ABPS and ACFS purchased new quarters in San Francisco on a 60/40 basis. The property was a Victorian house at 1601 Dolores Street, southwest of San Francisco's Mission District.[69] During the next year, the ground floor and exterior were completely remodeled, and shortly after the move, made in September 1985, a staff of six was at work at the new headquarters.[70] Seventy-five ACFS, ABPS, and APMA officials attended an open house on March 23, 1986, at which a shiny new brass plaque was unveiled.[71] The very next day the ACFS board of directors convened for the three-day strategic planning workshop with two big goals.

The first permanent headquarters of ACFS at 1601 Dolores Street in San Francisco.

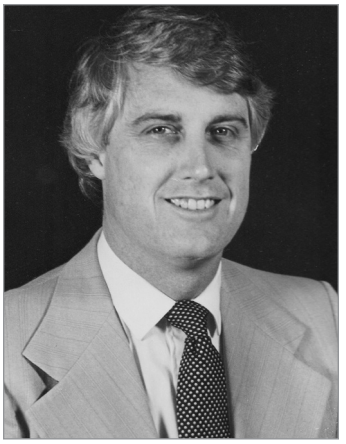
The first, the ACFS Foundation, may have been an overly ambitious objective, but the second, advanced by new president Richard Hecker, was a more modest governance change, best understood as the culmination of a longer process of reforms. In the mid-1970s, after ACFS achieved IRS 501(c)6 business league, tax-exempt status, the governing documents of the College were completely revised. The constitution, not required of such an entity, was done away with entirely, and all governance provisions were written into the bylaws.[72] By the mid-1980s only about ten to fifteen percent of members were attending annual meetings—and thus able to vote on changes in the bylaws. At the 1984 meeting, therefore, the bylaws were amended to provide for mail-in balloting in the future.[73]

Edward H. Fischman (1984-1985)

The next year ACFS scaled back examinations, more and more considered the purview of the ABPS. The written examinations for associates and fellows were done away with, and the size of the Examinations Committee was accordingly reduced. A senior membership category was created for semiretired members, and bowing to inevitability, the requirement that all members had to submit a journal article in order to receive certification was removed.[74] Also in 1985, the board proposed revising the bylaws to allow for special interest committees "so that any new or existing podiatric group having any affiliate with surgery may be established as a special area of interest within ACFS." Here the intent was as much to cut down on the proliferation of specialty groups (such as the ambulatory surgeons) that offered certification without credentialing as it was to foster new areas of practice.[75]

The special interest committees were established as part of a broad set of 1986 reforms. New sections included laser and arthroscopic surgery, with committees on biomaterials and diabetes-related conditions coming later.[76] Aside from the research foundation, however, the centerpiece of the 1986 reforms involved governance. Previously, the board had been a relatively compact six-person group. One new member was elected each year, serving as director before rotating through the offices of secretary-treasurer, vice president, president-elect, president, and immediate past president. In 1986 the College approved a new structure, hoping, as Hecker described it, to "bring more members into the decision-making process."[77] First the board was expanded from six to nine directors with staggered terms. Automatic succession of officers was eliminated.[78] The secretary-treasurer and president-elect were still elected by the board and the president-elect still ascended automatically to the presidency, but members now got the opportunity to nominate new directors and elect them by mail-in ballot.[79]

Two other late-1980s initiatives involved repair rather than reform. As membership surged following the creation of the residencies and the founding of the ABPS, the grassroots—the student chapters and the divisions—withered. The Southwestern chapter had practically shut down for a time and the Western Division went completely inactive in 1985. The College then reorganized the entire structure, helping each new division file for incorporation and tax-exempt status.[80] By 1987, only two of the student chapters established fifteen years earlier were still functioning. The board, therefore, appointed faculty advisors at each of the seven podiatry schools to help students re-establish chapters,



Joel R. Clark (1985-1986)

with directors themselves serving as liaison.[81] These efforts enabled the divisions and student chapters to revive, if not entirely thrive.[82] There was, however, even greater need for repair and reform in the late 1980s.

The midwinter scientific meetings had been something of a pro forma exercise for some time, and newly trained residents were understandably dismayed to encounter rodeos rather than research. Former president Howard Reinherz had begun handling the details of these events years earlier. He was adept at networking with hotel managers and service providers and willing to travel cross-country to seek out commodious quarters and reasonable rates. By 1980 he had been officially made Convention Coordinator and was compensated, even though he had no written contract and no job description.[83] It is not that Reinherz and the scientific chairmen for the midwinter meetings (called seminars during the 1980s) were not committed to science—ACFS, for example, invested heavily in scientific exhibits for some of the meetings—it was just that the meetings usually featured the same routine of lengthy lectures. For a time, the well-meaning board even required that only ACFS members could present, resulting in a fairly predictable cast.[84] For those and other reasons, most members looked forward to the customary post-convention trip to an exotic vacation spot more than to the midwinter meeting itself.

By spring 1986 the board was aware that something was wrong and had begun considering ways of increasing attendance at the seminars.[85] A "Super Seminar" held jointly by the California College of Podiatric Medicine and ACFS had proven popular in 1984 and was repeated in 1988, at which point the board informed members that it was making "long-range plans to improve its future scientific seminars."[86] Lowell Scott Weil Sr. had been disappointed for some time. "The American College of Foot and Ankle Surgeons became a travel club," he recalled, "and I started having less interest in that organization." After the midwinter event in Hollywood, Florida, in 1989, Weil complained to president James Lawton—who promptly put him in charge of the next year's event.[87]

Weil had some good experience and even better perspective. A 1964 resident at Civic Hospital, Weil had decided early to learn not only from the best in podiatric surgery but from orthopedic surgeons as well, going so far as to sneak into their conferences to watch presentations. Eventually he was welcomed at the orthopedic events, and over the years he learned much about how to run a meeting, deal with vendors, and present medical science.[88]

Accordingly, Weil broke precedent in planning the 1990 event. He did away with extended, and often tedious, presentations and substituted a series of more than 100 abstract lectures and six-minute scientific talks.[89] He got permission to invite presenters who were not members of ACFS, to pay a premium for particularly prestigious speakers, and to provide free tuition to members whose abstracts were accepted.[90]

The result, themed "Two Decades of Progress in Foot and Ankle Surgery" and held at the Fairmont Hotel in New Orleans, was the most successful event in ACFS history up to then, drawing an attendance of 527 and netting the College $25,720.[91] It was not just the science that was presented differently: the Friday evening social event, usually reserved for the obligatory awards dinner and speeches, was also jettisoned. Instead, as the newsletter

put it, "Speeches and plaque awards were abandoned in favor of great food, dancing to a live New Orleans jazz band, and other Mardi Gras festivities."[92]

With the New Orleans conference, ACFS had begun to professionalize the management of its scientific meetings. Weil and his successors as Chairman of the Scientific Program Committee began serving two years rather than one, in order to better focus on the content.[93]

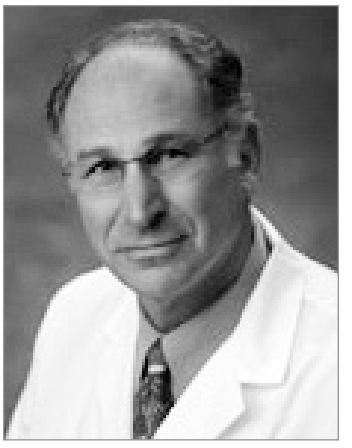
Toward Independence

In March 1986, the cover illustration of *Time* magazine depicted lightning striking a flagpole in small-town America behind the bold letters, "Sorry, America, Your Insurance Has Been Cancelled." The story inside covered a crisis that was then becoming widespread, although ACFS had been grappling with it for years. In retrospect, the insurance initiative can be seen as much as a response to a crisis as part of an ongoing move toward independence on the part of ACFS—one that included the creation of standards of care, a move to Chicago, and an excursion into lobbying.

There are competing explanations for the 1980s insurance crisis, but the one clear cause was the economic result of the Federal Reserve's decision to tighten up the money supply to finally deal with the inflation that had dogged the 1970s. Interest rates began rising in 1979, reached 21 percent late in 1980, and dropped slowly. When rates were high, insurers seeking premiums to invest welcomed new customers. As rates returned to normal levels, insurers were compelled to raise premiums or to go out of business.

ACFS experienced these economic ups and downs through malpractice insurance. In early 1979 a company called Professional Risk Management presented a plan to the board establishing an interim policy and promising special rates if it could obtain coverage from 40 percent of the membership.[94] ACFS agreed to endorse the company, and as members signed up both presidents Hugar and Marcus spent a great deal of time trying to develop a permanent arrangement with Professional Risk Management. Instead, in August 1982, the company began canceling policies, telling Hugar that ACFS members "did more surgery than anybody else and so were a risk."[95]

ACFS felt an understandable obligation to find another solution for its members and persuaded insurance broker Marsh & McLennan to step in temporarily while it sought a long-term solution, even considering creating its own offshore "captive" insurance program.[96] In 1984, Marsh & McLennan found what looked like a suitable carrier, Granite State Insurance, but that arrangement fell apart within a year. ACFS next turned to the Podiatry Insurance Company of America (PICA). PICA had been founded in 1980, created at the insistence, and with the assistance, of the APMA. By early 1985 board members Joel Clark and Dave Chazan were meeting almost monthly with the company in an attempt to negotiate good rates for ACFS members.[97]



Richard L. Hecker (1986-1987)

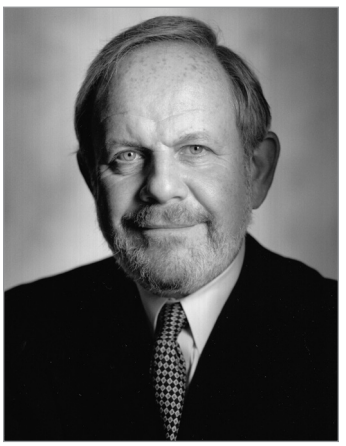
In the summer of 1985, AFCS entered into a Memorandum of Understanding with PICA and formally recommended that its members take out policies with the company.[98] On the strength of its prior arrangement with the APMA, PICA went on to build up its share of

the podiatric insurance market as a whole to 75 percent by the end of the decade, but largely because the surgeons were still considered a bigger risk than the generalists, the arrangement with ACFS lasted only three years.[99]

The fulfillment of another initiative—standards of care—resulted in long-term gains for ACFS. Their establishment could be seen as a greatly delayed implementation of the first recommendation made in the 1961 Mowbray and Walsh report—that ACFS rigorously define its scope of practice. By Alan Shaw's account, however, the initiative was less a response to the 1961 report than the result of rumors that orthopedic surgeons were planning to conduct some kind of inventory of their services. "We wanted to beat them to the punch" recalled Shaw.[100] The effort began slowly in 1984, described by David Chazan as "the arduous and gargantuan task of cataloging what we as podiatric surgeons do, and the parameters in which we work."[101] By 1986 a Standards of Care Committee had been created, chaired by president Richard Hecker.[102]

It was after Shaw, who was something of a perfectionist, joined the committee in 1987 that the effort began to bear fruit.[103] "Alan virtually took that whole job on himself," recalled Weil.[104] The task began in earnest when the committee sent 20 different forms listing diagnostic criteria and possible procedures for each to 60 select members. Similar forms were circulated steadily thereafter.[105] By 1989, a preliminary standards of care document listed 80 different forefoot conditions and diagnostic criteria. The committee had begun collecting information about rearfoot procedures and had obtained the services of a statistician to process all of this information as it came in.[106]

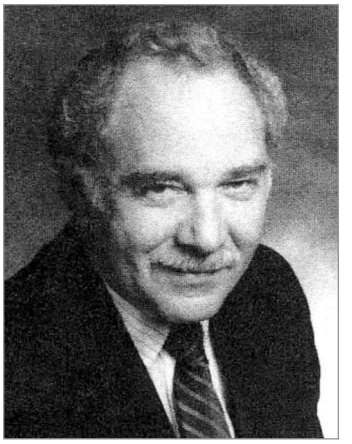
By early 1990, Shaw had formally taken over the Standards of Care Committee. By then it was clear that there was far more to be gained by this effort than merely co-opting the orthopedic surgeons. A year earlier the federal government, as a part of its overall healthcare reform efforts, called for the medical professions to develop "practice guidelines" to help payers identify the most appropriate treatments at the lowest cost. It was becoming clear that as medicine became ever more rationalized foot surgeons would need to provide standards to ensure continued patient access to their services.[107] In September Shaw and president Howard Sokoloff met with the American Academy of Ophthalmology to talk about its own "preferred practice patterns" initiative.[108] The next month, the committee, with the guidance of an expert from Johns Hopkins University, committed itself to developing "preferred practice guidelines that will be acceptable to the podiatric profession and provide entry for the profession into government activities."[109] The group renamed itself the Preferred Practice Guidelines Committee.[110] It had once hoped to complete the work by 1990—in reality it had only begun.[111]



David V. Chazan (1987-1988)

As ACFS escalated its efforts toward independence in the 1980s, one inescapable fact intruded—its administration served two masters, and given the 60/40 split, ACFS was the junior partner. As Shaw later put it, "John [Bennett's] main responsibility was to show allegiance to the ABPS and the College was kind of a step sister."[112] By the summer of 1989, with membership exceeding 2,500, the board was investigating its real estate arrangements with the ABPS and reviewing retirement programs.[113]

In late 1989 the board decided to move to the Midwest. The ostensible reason was to be in a more central location and near a host of other associations that had gathered around the American Medical Association, located in Chicago. Another explanation was that the board wanted to hire a new, full-time director with minimal controversy and knew that Bennett would never leave San Francisco.[114] In October 1989, the board met for two days, again with help from a representative of the American Management Association. It approved hiring a full-time director and offered Bennett the right of first refusal.[115] As expected, Bennett opted to remain on the coast with the ABPS.[116]



Arnold L. Cohen (1988-1989)

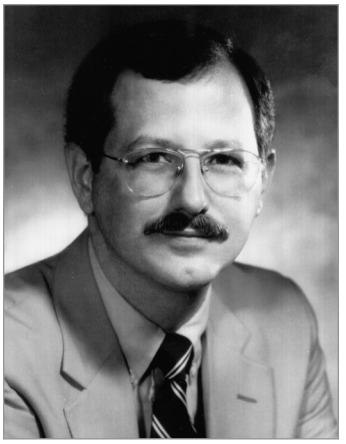
ACFS announced the move to the membership in the May 1990 newsletter, calling it "a means to expand relationships between ACFS and other medical specialty organizations, to increase visibility in the medical community, and to meet the need for full-time office staff to accommodate growing ACFS operations."[117]

The first step was finding staff. A consultant from the American Society of Association Executives narrowed a field of 25 candidates down to five. The board interviewed two of them and chose Cheryl Beversdorf, who had started out as a registered nurse and gotten into association management at the Washington, D.C., office of the American College of Surgeons.[118] Beversdorf started work in July 1990. By the beginning of September she had opened an office at 444 North Northwest Highway in Park Ridge, Illinois, near O'Hare Airport, and hired a secretary. Two more employees arrived shortly thereafter. The entire ACFS legacy from San Francisco arrived as well, contained in eight boxes of records.[119]

It was no coincidence that Beversdorf had Washington, D.C., experience. Even though ACFS had reason to keep quiet about the matter, it had decided to get into lobbying as part of its new push for independence. The same year as its move, ACFS created a Governmental/Political Affairs Committee and began looking for a legislative consultant based in Washington, D.C.[120] There were grounds for this aspiration as the federal government was getting ever more involved in attempting to contain health care costs. Medical practitioners had been watching closely ever since Congress created the Physician Payment Review Commission (PPRC) in 1986.

In November 1989, the other shoe dropped when Congress implemented the PPRC recommendations for reform of the Medicare program. These included, among other things, abolition of a "global fee" for services. Instead, preoperative, operative, and postoperative services were uncoupled, with sharp limits on subsequent surgeries in particular. The legislation also called for a fee schedule based on resource costs that would adhere to Current Procedural Terminology (CPT) codes utilized by the Health Care Financing Administration (HCFA), the sizeable bureaucracy administering Medicare. There was much to worry about in the codes, which could be imprecise and open to interpretation—and the HCFA would inevitably interpret them restrictively.[121]

For years it had been understood that the APMA would handle policy work for all its specialties, and for years ACFS had let it do so. But as the federal knife began to carve the medical dollar into ever more specialized slices, it became unrealistic for the APMA, which had to represent all podiatrists, to effectively serve the then one-third of its members



James H. Lawton (1989-1990)

who were also foot surgeons. And there were other sources of long-term friction between the APMA and ACFS that did nothing to reduce suspicions on either side. Although the orthopedic surgeons might have once believed that the APMA could be dominated by ACFS, there is little evidence that, at least up until 1990, that was the case. When foot surgeons donned their APMA hats, they generally considered themselves podiatrists first.

To the contrary, there were a number of instances in which the APMA seemed unusually concerned that the surgeons were not properly subordinate to the parent organization. For example, when in 1980, in response to member requests, ACFS moved its annual meeting to midwinter instead of holding it just before the House of Delegates meeting, APMA officials demanded explanations and assurances from ACFS.[122]

There were also much touchier long-term troubles. The constitution of the parent group had always made it mandatory for affiliates to require their members to belong to the APMA.[123] This saddled associations like ACFS with the tough task of policing not one, but two levels of dues payments. ACFS already had plenty of trouble collecting dues. In the mid-1980s, president Edward Fischman considered it "one of the few problems confronting our board."[124] There had always been a few ACFS members who let their APMA membership lapse and continued to pay dues to ACFS. When he was secretary, Jack Kohl had not troubled himself much with the problem. At the time, ACFS membership was small, and the APMA was willing to overlook noncompliance. Earl Kaplan, on the other hand, enforced the rule scrupulously, although mostly out of public view.[125] At a 1978 board meeting, however, he read into the minutes a list of ACFS members being dropped due to nonpayment of APMA dues.[126]

During the 1980s, Bennett's office carefully tracked membership status, and the newsletter regularly ran reminders about the requirement to keep current with both groups, stating that either the APMA would be reviewing ACFS membership lists or that ACFS would be comparing lists itself.[127] In February 1986, for example, fewer than 50 of 1,794 ACFS members were delinquent to the APMA. Two months later, 32 members were dropped from the ACFS rolls.[128] Despite these efforts, the continual questions from both sides did nothing to improve ACFS-APMA relations.

Howard M. Sokoloff (1990-1991)

They only got worse when, in 1990, the APMA held a referendum regarding Medicare reimbursements that many foot surgeons, wrote president Howard Sokoloff, believed "did not accurately reflect the feelings of the College membership."[129] A joint APMA/ACFS liaison committee was created to deal with the problem.[130] "Initially, there was wariness on both sides but both believed in the concept and began to effectively work together," Robert Weinstock later wrote.[131] At the time, Beversdorf agreed that "ACFS should make every effort to work together with APMA on government policy issues."[132] Sokoloff insisted that the APMA and ACFS were "marching together," but both

Beversdorf and Sokoloff were planning to get ACFS independently involved in lobbying.[133]

Much of a May 1991 three-day retreat was dedicated to government affairs. That was when the board made the decision to hire a Washington lobbying firm to monitor items of interest to podiatric surgeons arising from the work of the PPRC, the HCFA, and other agencies.[134] By September the consultant was at work; ACFS vowed that he would share all of his information with the APMA, "although at times the two organizations may differ on an issue."[135]

Gary S. Kaplan (1991-1992)

It turned out that the APMA may not have had much to worry about. When Beversdorf and the ACFS officers arrived on Capitol Hill in June 1992, their reception was underwhelming. Lowell Scott Weil Sr. was one of those appointed to lobby. He recalled being tightly scheduled in meetings with senators and congressmen "who fell asleep at every one of my three-minute presentations. Their heads were bobbing up and down—you know, thank you very much, put the check on the desk and then everything will be fine."[136] If ACFS was less than effective behind closed doors, where it mattered most, the "Day in Washington" did manage to generate some press, with Weil appearing before the House Ways and Means Health Subcommittee to emphasize the importance of patients being able to choose their treatment options.[137]

These efforts continued the next year with appearances before Congress by ACFS members Judith Cappello, who discussed research in podiatric surgery, and Eric Lauf, who discussed the Preferred Practice Guidelines initiative and urged Congress "to help our members choose more carefully among available treatment options."[138] Beversdorf orchestrated one last "Day in Washington" in 1993. That year's event had its own damper; less from sleepy politicians than from the APMA itself, whose political action committee refused to defray any part of the cost of the ACFS effort. Meanwhile, with membership sentiment ranging from the skepticism to hostility, ACFS eventually gave up trying to influence Congress, an activity then beyond its skills or resources.[139]

Nevertheless, the brief ACFS fling with lobbying ended well. As soon as ACFS arrived on Capitol Hill the APMA lobbyists begin paying a bit more attention to its requirements. "We sort of pushed them a little bit to get it right," said president Gary Kaplan, "and they got it right."[140]

Just as it was embarking on its lobbying venture, the College decided the time had come to take what it considered to be another long overdue step. In 1986, presumably in an effort to create harmony with the accrediting body, the board had considered, but rejected, the idea of changing the name of the organization to the American College of Podiatric Surgeons.[141] Five years later the board was ready for change and put the question to the members. Less than a third completed the mail-in ballot, but 57 percent voted for no change. This measure appeared to have been as unsuccessful as the lobbying—but it also carried an unexpected outcome: about 30 percent of respondents voted to change the name to the American College of Foot and Ankle Surgeons.[142] This was a complication that ACFS would soon turn into an accomplishment.

Chapter 4

A Clearer Focus, 1992 - 2001

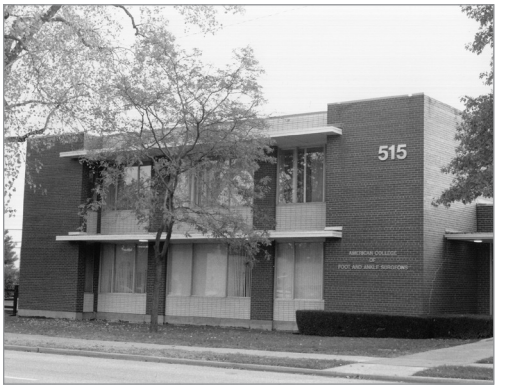
Much depends on how you look at things. By the mid-1980s Harold Vogler had been practicing foot and ankle surgery for more than a decade, teaching and helping others to win hospital privileges. Then, in a moment of clarity, he realized that he and his colleagues had been doing things all wrong, making their case in podiatrist's vernacular rather than more familiar terms, not only to hospital administrators and doctors but also to lawmakers and the public. He started writing letters, lots of letters. He wrote to the American Podiatry Association, insisting that the organization add the all-important term *medical* to its title. And he wrote to ACFS.

Podiatric surgery had begun with the forefoot, but by the 1980s it regularly encompassed the rearfoot. By the early 1990s residencies routinely covered ankle surgery, and 40 percent of the articles in the *Journal of Foot Surgery* were on the rearfoot and ankle.[1] As they approached the knee, podiatric surgeons could be sure of backlash from orthopedic surgeons.[2] "It was absolutely mandatory that we claim our realm," Vogler recalled. "We needed to identify who we were and what we did in name."[3] President Alan Shaw agreed and campaigned for a name change. "Our scope has truly expanded and I believe the ankle is definitely part of everyday podiatric practice," he told ACFS members in a summer 1992 *Bulletin* (the *ACFAS Newsletter* became the *Bulletin* in 1990) editorial. "Why not be proud of it and let the public and the rest of the medical profession know?"[4] Vogler had taken a teaching position abroad—but was still writing letters—when one day in the fall of 1992 he got a call from Shaw, who told him, "Well, it's happened."[5] The board had put the name change before the members, and they voted six-to-one in favor of it. As of January 1, 1993, ACFS became the American College of Foot and Ankle Surgeons (ACFAS).[6]

ACFAS had begun the 1990s hoping to make a new and independent start in Chicago. However, the College faced challenges from within and without that required not only more effective leadership but also a clearer focus on the organization's strengths, weaknesses, and mission. During the 1990s and early 2000s, therefore, ACFAS struggled against custom, skepticism, and fear of change in attempts to complete the revolution begun earlier. By 2002, much had been accomplished, although a few goals were yet unmet.

Bringing Order to Headquarters

It would not be too much to say that ACFAS suffered from an excess of ambition during the early 1990s. Its membership steadily climbing, ACFAS took growth for granted. By mid-1993, with the rolls exceeding 3,500, the staff had outgrown two rented suites at North Northwest Highway and was planning to purchase.[7] In the fall of 1994 ACFAS bought the former headquarters of the American Society of Anesthesiologists, a two-story brick building at 515 Busse Highway, also in Park Ridge, Illinois.[8]



ACFAS officers had big plans for this building at 515 Busse Highway in Park Ridge, Illinois, including a skills laboratory.

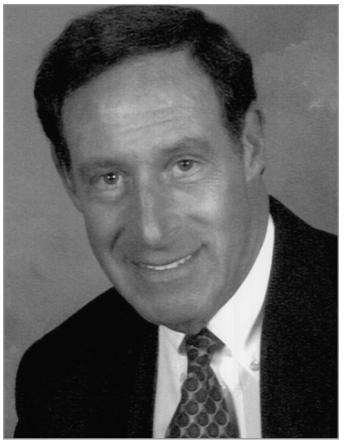
Executive director Cheryl Beversdorf never moved into the building—that same fall she moved instead to another association in Washington, D.C.[9] The board had no trouble choosing a successor. Ronald Bordui had spent years in association management finance, including a decade as CFO of the American Osteopathic Association.[10] Even before Bordui officially joined on November 1, 1994, the board had turned to him on a consulting basis to take a look at its investments.[11] It all seemed too easy, and it was.

Emblematic of the College's ambitions were its international aspirations. "It is the commitment of the board of directors to position ACFAS internationally among all foot and ankle specialists," the board resolved.[12] Members had long been accustomed to international junkets for rest and relaxation, but in September 1991 the College, working in concert with the Italian Orthopedic Foot Society, held a surgical meeting in Milan, Italy. The event proved wildly successful, with more than 1,000 attendees from the United States and about 900 from Europe. It was gratifying that most of the latter were orthopedic surgeons, more willing to work with podiatrists than their U.S. counterparts.[13] That event was followed by a slightly less successful meeting in Bordeaux, France, the next year. Finally, in October 1993 it was the College's turn to host.

Cosponsored with APMA, the World Foot and Ankle Congress held in Chicago in 1993 did not reach the high water mark set in Milan.[14] Just over 300 people attended.[15] In the end, though, this was probably a good thing, because the relatively green ACFAS staff had made a beginner's mistake. "Many Europeans were 'invited' to attend and per European custom they assumed that all of their expenses would be paid for because they were 'invited.' This was an expensive faux pas," recalled staffer Ginger Burns.[16]

There was an ambitious backstory to the Busse Highway building as well. President David Novicki had hoped to build there an ACFAS "skills lab," which was to be the signature accomplishment of his administration. This was a hugely ambitious undertaking. The facility was to contain a full-scale "wet lab" teaching facility suitable for arthroscopy, electro-convulsive therapy, plastic surgery, and cadaver work. It would be expensive, but

Novicki intended to obtain donations and to recoup costs by charging other groups to use the facility.[17] Novicki kept working on the project after turning the presidency over to Harold Schoenhaus, and by the fall of 1995 had obtained an architect. Funding remained the chief obstacle. As a 501(c)6 entity, ACFAS was a "business league" rather than a "charitable organization," so its fund-raising capabilities were limited. Novicki and Schoenhaus set Bordui to work changing that status, and in 1996 ACFAS became an IRS 501(c)3 organization which allowed the College to accept tax-deductible charitable contributions for the teaching facility.[18]



Alan H. Shaw (1992-1993)

By then, however, the project had bogged down. It was probably for the best. The basement of the headquarters at Busse Highway, where the lab was to have been, was too small and leaked—it would have been a "wet lab" in the worst sense of the term. Most importantly, while the ACFAS lab was in the planning stage, the American Academy of Orthopedic Surgeons (AAOS) established its own Orthopedic Learning Center just minutes away in Rosemont, Illinois. In 1996 ACFAS held a two-day course on arthroscopic surgery at the AAOS facility, hoping to build momentum for subsequent courses in its own facility.[19] The success of the event only confirmed how little a second facility was needed. Still, it was not until early 1998 that the board finally dropped the idea after calculations showed that neither ACFAS, nor its members, could afford it.[20]

Changes in the regional division structure provided another example of overconfidence in the early Chicago period. The divisions had been created in an earlier age simply as a way for members to meet more easily. But within a few years jet transport and interstate highways had left them without a mission. In spring 1991 the board believed that it had finally come up with a new assignment—to serve as a training ground for new leadership and to provide "grassroots assistance" in furthering ACFAS goals, particularly by taking its case on a regular basis to the APMA's legislative body, the House of Delegates.[21] In accordance with that mission, in October 1992 ACFAS created a new body made up of representatives of the now 14 divisions, called the House of Councilors. Alan Shaw called it "a grassroots legion of podiatrists who can have impact on a local level."[22]

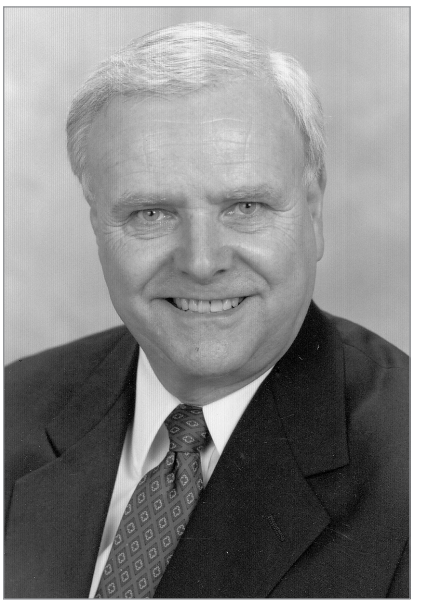
Things looked auspicious when, in spring 1994, New England Division VIII (they all had Roman numerals for a time) sponsored a surgical seminar jointly with ACFAS at Newport, Rhode Island, and hosted U.S. Senator John Chafee.[23] But in the mid-1990s the board asked the House of Councilors to "justify its presence" by stepping up its involvement in the APMA House of Delegates.[24] By the early 2000s the

The first officers of the House of Councilors meet with ACFAS Board members. From left, Gary Kaplan, Eric Lauf, Steven Glickman, Paul Kinberg, David Novicki, and Alan Shaw.

board was considering yet another mission for the House of Councilors, only to learn from a survey that most ACFAS members did not even know that they were also members of a division.[25]

As the grassroots effort stalled, the ACFAS staff descended into conflict and chaos. Perhaps the board had not done so knowingly, but in choosing first Beversdorf (a young association executive who had never before served as CEO), and Bordui (a finance man rather than a CEO), it had ensured that the full-time staff would remain subject to the whims of the doctors. Accordingly, during the early 1990s, the board members continued to work largely as they had before, administering meetings, negotiating with vendors, and regularly overriding day-to-day decisions made by staff. The World Congress faux pas, the skills lab white whale, and the House of Councilors complications were understandable results. By 1995 board micromanagement had brought the office to a standstill and sent morale to the basement.[26] Late in the year, the board hired a consultant to help restructure the staff and began looking for another executive.[27]

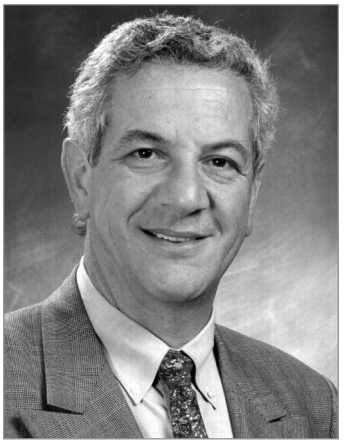
No ACFAS president ever took office under worse conditions than did Howard Zlotoff.[28] In March 1996, the headquarters were in disarray and the members were incensed about the College's expensive initiatives and threatening a dues protest after learning of stipends paid to board members for planning the ACFAS scientific meeting and attending APMA and AAOS events.[29] And Zlotoff's first responsibility after taking office was to fly to Chicago to dismiss Bordui. It was nothing personal, recalled Zlotoff, "he just wasn't the person for that position."[30] Recent events had provided the board with some much-needed perspective. No hands were raised when a short time later Zlotoff asked his fellow surgeon-directors, "Who among us studied for years in preparation to run a business?"[31] By then they had already hired someone who had.



Thomas Schedler was a Certified Association Executive with years of experience when he arrived at ACFAS in 1996.

Thomas Schedler was a Certified Association Executive. Like the foot surgeons he was to represent, Schedler had successfully completed a comprehensive examination devised by the best in his field. He was as prepared by experience as he was by training. When Schedler arrived at the Park Ridge headquarters in May 1996, things looked familiar. He had begun his association management career 30 years earlier in that very building, working for the American Society of Anesthesiologists.[32] Since then he had worked his way up to the CEO position at several national medical associations (while earning the highest honor of the American Society of Association Executives). Along the way, Schedler had established innumerable contacts within the many medical associations and specialty groups—and he had also seen his share of office dysfunction.[33]

Schedler knew what to do. He asked for assurance that the board would not interfere with staff functions, which included administering meetings and other events. The pledge was forthcoming, in part because of Schedler's record and also because the board realized that at this late stage in his career, he did not need the job and would have no qualms about leaving.[34] Next Schedler began rebuilding the staff, letting problem people go and bringing in qualified and capable new hires; most important among them Scientific Director Mary Meyers, who took over planning of the scientific seminars and annual meetings.[35] He also required all of the officers to run their correspondence through headquarters so that he could untangle mixed messages and head off unfortunate commitments.[36] The most difficult of the reforms, however, was helping the board achieve some strategic discipline.



Lowell Scott Weil Sr. (1993-1994)

As the College ballooned from a few hundred members at the creation of the ABPS to more than 3,000 in the early 1990s with little real change in governance, things got complex and hard to control. It was customary, and a matter of pride, for every new president to have his "signature initiative."[37] These piled up, and by the early 1990s the board was overseeing the activities of about 25 committees and subcommittees established to carry out often unrelated and sometimes ill-conceived projects or programs.[38] Worse, the board made the amateur's mistake of spending nearly every meeting mired in the minutiae that turned up in committee reports rather than keeping their focus on high-level and long-term goals.[39] At one 1992 meeting, for example, the directors used valuable meeting time to hash out the differences between, and definitions of, partial and total nail avulsion.[40] The College had created strategic plans in the past, but nearly all had crumbled under new presidents' initiatives and board micromanagement.

In part to encourage a core group of officers to raise their sights, in 1992 ACFAS created an executive committee consisting of the president, president-elect, secretary-treasurer, and immediate past president.[41] With the encouragement and support of Schedler, Zlotoff took more drastic measures. He even had a sign created that he used all too often that read "Committee Work—Shut Up." In 1997 the board resolved that board members could no longer be committee chairmen, thus keeping them out of the weeds and allowing more members to contribute.

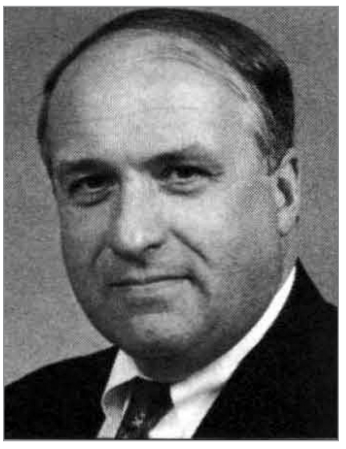
These efforts helped dispel a long-standing suspicion among members that at the top ranks, the College was really just an old-boys club, as Louis Jimenez put it, led by "a few good buddies from Detroit, Chicago, Philadelphia and California" who did not take their charge terribly seriously. Now Jimenez himself was sufficiently convinced that change was taking place that he stayed around to become president in 1997.[42] That year, at Schedler's urging, the board began developing a three-year strategic plan.[43] In an early 1998 *Bulletin* Schedler assured the members that he and the board understood that results had not been commensurate with effort in recent years. "I attribute this, in large degree, to a lack of focus and prioritization on what the organization could do."[44]

Managing Managed Care

The task of reorganizing headquarters and revitalizing the board was not made any easier by the fact that the entire U.S. health care system was in transition during the 1990s. The first upheaval was the political bubble that began expanding when President Bill Clinton made health insurance reform his own signature initiative. This coincided with, and helped give urgency to, the College's brief dalliance with lobbying in 1993 and 1994. In its testimony to Congress and unenthusiastically received legislator visits, the College's chief message had been that podiatric surgery should be included in a national basic health care benefits package.[45] In retrospect, it is clear that such efforts would have accomplished little since the architects of the plan, Hillary Clinton and Clinton cohort Ira Magaziner, kept Congress at an arm's length anyway. David Novicki did manage to get a meeting with Magaziner, but whatever was accomplished died with the Clinton plan in 1994.[46] The next year president Schoenhaus noted that "health care reform" was no longer the phrase of the moment. Instead "the buzzword has evolved into managed care."[47]

Managed care emerged within the context of health care costs that had risen, sometimes precipitously, since the end of World War II. It began to establish a firm foothold after the passage of 1973 legislation that provided for the creation of health maintenance organizations (HMOs) structured by for-profit insurance companies. By the early 1990s, these and other for-profit networks were demonstrating an ability to control health care costs by placing limits on services and demanding cost reductions from "in-network" providers.

As these integrated managed care networks displaced the old decentralized fee-for-service model, podiatric surgeons faced two big challenges. First, they had to qualify for recognition by the networks. System administrators usually knew little of podiatry beyond corns and callouses, so podiatric surgeons would have to convince them of the value of their services and provide ways to measure that value.[48] Second, after they did gain entrance, practitioners within a managed care system would have to be efficient enough to make deep cost cuts yet stay in business. As Lowell Scott Weil Sr. noted in 1993, "The great majority of us will succeed, while some may not survive."[49]

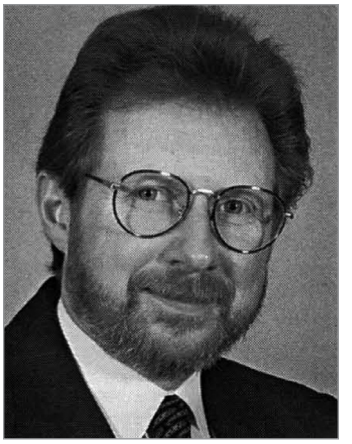


David C. Novicki (1994-1995)

By 1997 the changes had already rippled through the membership. In just the previous three years, gross income from HMOs had doubled while that from fee-for-service arrangements had dropped by half.[50] At the same time, referrals were declining as managed care organizations relegated podiatric surgery to the nonessential category. ACFAS knew this because it had taken a poll of the membership. The same poll revealed that members thought that ACFAS should do more—much more—to help.[51]

The ACFAS response, known for a time as the "Practice Enhancement Plan," reflected some of the old tendency toward an excess of ambition. It promised to solve all of these problems at once. The initiative was begun in 1996 by the Practice Enhancement Development Task Force chaired by Keith Kashuk. The task force worked with marketing firm Tucker-Knapp, the latest in a string of 1990s communications consultants, to develop what it called "one of the most far-reaching and important programs in the history of the College."[52] Approved in February 1997, the

three-year program was to include a communication campaign aimed at managed care organizations, third-party payers, employers, and primary care physicians. It would also include "practice enhancement resources" and tools for members.



Harold D. Schoenhaus (1995-1996)

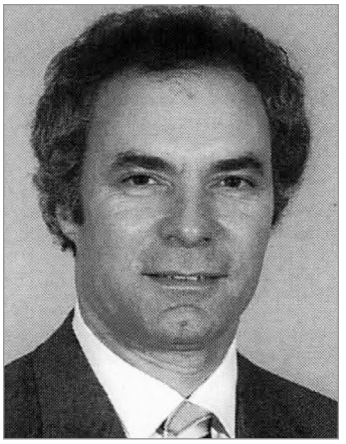
Funded at $250,000, the effort was indeed the largest single expenditure of the College up to that time, although the three branded components it launched—Payor Link (to communicate with company benefits managers and managed care decision makers), Prime Link (directed at primary care physicians), and Patient Link (aimed at the general public) all lost their brands very quickly and simply became individual programs.[53]

Another public-facing initiative, called the Foot Health Institute, was launched quickly. The intent was to inform the public that ACFAS members were the best specialists when it came to treating the foot and ankle.[54] Almost immediately a toll-free number (888-THE-FEET) was functioning. A set of printed brochures came out the next year.[55] Another initiative using soon-to-be obsolete technology included scripted slide presentations and handouts that ACFAS members could use to generate awareness and referrals.

In April 1998, ACFAS launched its first website, which included downloadable versions of the *Journal of Foot & Ankle Surgery* and consumer brochures, as well as a physician search function.[56] Since both the members and leaders remained skeptical about the value of the new Internet, late that year the College launched a more traditional campaign as well, producing Community Outreach Kits that contained prewritten press releases (members could fill in the blanks and send them to their local papers) and placing articles with periodicals like *Diabetes Self-Management* magazine. The College also invested heavily in a film entitled *Oh, Our Aching Feet*, which got some traction in the media—more often in newspaper stories about the film than by airing of the film itself.[57]

It was an honest effort, but by 1999 ACFAS no longer had the financial resources to maintain an ambitious public relations campaign. While the College obtained some corporate sponsorship for these efforts, most notably an early donation from the Smith & Nephew Wound Management Division, the campaign put much strain on the ACFAS accounts.[58] Although some grassroots efforts continued, after 1999 national campaigns ceased.[59]

At the same time board member Gary Lepow, assisted by another consultant, the Jefferson Group, spearheaded a more focused effort. "We developed a story," Lepow recalled, "and we would tell our story as to why we should be viewed no differently than anyone else in the United States who was being reimbursed for foot and ankle surgery."[60] But Lepow, Schedler, and other participants in what came to be called the "Road Show" were not talking to the general public. Instead they called on the largest of the managed care groups. The first visit was to Prudential Health Care in October 1997.[61] By 1999 the road show had played before such professional groups as the Health Insurance Association of America, the Medical Group Management Association, the American Association of Diabetes Educators, and the American Medical Directors Association, among others. Corporate audiences included the Principal Group, Foundation Health, PacifiCare, UnitedHealthcare, Aetna/US Healthcare, and Cigna.[62]



Howard J. Zlotoff (1996-1997)

As the road show, which put ACFAS in touch with the industry, wound down, Schedler began putting another initiative into place to connect the College more closely with its fellow specialty societies. In the early 2000s Schedler called upon his contacts to knit together a loose alliance of national medical specialty groups called the Medical Health Insurance Coalition. The initiative built quickly. By the end of 2002 the group, chaired by Schedler and renamed the Specialty Society Health Insurance Coalition, was regularly meeting with Blue Cross Blue Shield of America, the American Association of Health Plans, and the Health Insurance Association of America, as well as companies like Anthem. At its height, the Specialty Society Health Insurance Coalition represented 18 medical societies with more than 500,000 physician members.[63] While its nominal goal was to bring the specialty groups together with the nation's largest insurance providers, an important secondary objective was to get podiatric surgeons and allopathic physicians on the same side of the conference table for a change.[64] If these efforts helped gain recognition for podiatric surgery, the challenge of helping managed care organizations buy and sell services remained. ACFAS had already done some of the groundwork with the Preferred Practice Guidelines.

Development of the guidelines began in earnest in October 1990.[65] By June 1991, documents on ingrown nail, neuroma, hallux valgus, and hammertoe were nearing completion and heading for review by the APMA and ACFAS boards. These first four were completed in mid-1992.[66] As the initiative grew during the mid-1990s, the APMA helped defray some of the expenses, and by the close of 1994 ten documents were completed and, noted Novicki, "embraced by government agencies, third party carriers, and other key organizations as state-of the-art."[67] Although the Preferred Practice Guidelines were always meant to provide general guidance rather than specific dictation, they were nevertheless exhaustive documents.[68] Too exhaustive, as it turned out. While some were still being developed by the end of the 1990s, ACFAS was soon reformatting all them into more succinct "Clinical Practice Guidelines."[69]

Although third-party payers (insurance companies) could use the Preferred Practice Guidelines to make decisions about the suitability of certain procedures, they also had to have specialists review the documents and make a host of other assumptions about outcomes, including condition of the patient and overall cost. Throughout much of the 1990s, ACFAS was working on the tough task of making this process simpler—and thus making it easier to employ podiatric surgeons.[70]

This "Outcomes Research" effort was launched in 1993 by a committee led by John Schuberth; the immediate goal was to create a database of outcomes and standardized evaluation protocols. A small grant from the APMA funded an initial effort on heel pain.[71] By mid-decade Schuberth's group had produced an initial report and was seeking funding for longer-term efforts, including the establishment of "focused multicentered research projects."[72]

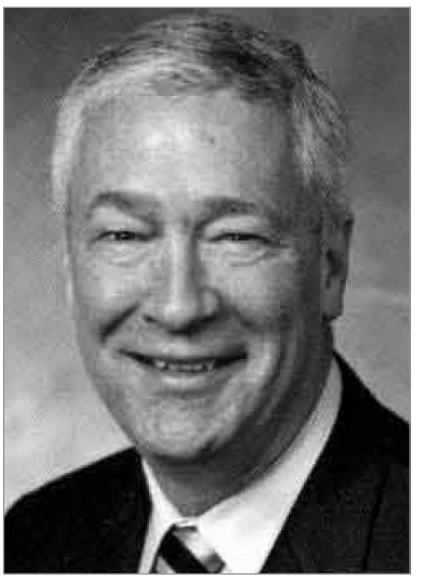
Not until 1999, when ACFAS partnered with the Podiatry Insurance Company of America Service Network (PSN), did these plans materialize.[73] By then the effort was being led by Robert Frykberg, who called the initiative "probably the most ambitious

undertaking in the history of the American College of Foot and Ankle Surgeons."[74] In order to generate data, sixteen research sites were established nationwide, each of which was to study a minimum of 100 patients per year. This huge statistical effort would last well into the next decade.

While trying to encourage managed care organizations to work with podiatric surgeons, ACFAS was also conscientiously helping its members learn to work within the new managed health care system. The chief instrument for this was the *Bulletin*. A series of articles entitled "Managing Your Practice for Managed Care Success" ran through six installments from 1997 to 1998, followed by "Managed Care and the Demand for Data," which came in three installments. In 1999 ACFAS established a Health Care Industry Relations Committee. By early 2000 it had developed the *ACFAS Managed Care Resource Guide*, which designated members with expertise that could be consulted and would conduct workshops.[75]

The late 1990s *Bulletin* also featured a number of articles on CPT coding, the indispensable hieroglyphics of the modern medical practitioner.[76] ACFAS also offered coding workshops, first in two-day and then in three-day sessions, to help surgeons ensure that insurance companies and Medicare would allow claims, particularly in the case of complex or multiple procedures.[77] In 1999, ACFAS created a new staff function, the Department of Socioeconomic and Practice Management, to help members handle not only coding but also contracting and negotiating with managed care organizations.[78] Throughout, the quality and consistency of the college's practice management and coding training was ensured by ACFAS volunteer Douglas Stoker, who taught for, or chaired, the Practice Management Committee for many years.[79]

All the initiatives generated by the managed health care revolution cost money—at a time when members were dues conscious and ACFAS coffers were getting lighter. Increasingly, "non-dues income" was a priority for every president. ACFAS had long welcomed corporate support for its meetings, but in the 1990s the concept was extended far beyond that. In 1993 the College offered gold and silver sponsorships to raise funds for special projects, and nine companies signed up. The next year a bronze category was added.[80]



For years, Douglas Stoker was the ACFAS expert on complex but all-important current procedural terminology (CPT) codes.

In 1997 the board created the Industry Advisory Council specifically to fund the development of materials for the Practice Enhancement Plan.[81] This was an unusual entity in that it included not only podiatric surgeons but also industry members. In 1999 president Gary Lepow reorganized the Industry Advisory Council, providing for an industry, rather than a physician, chairman. The first was Charles Herrera of Wright Medical Technology, Inc.[82] Meanwhile,

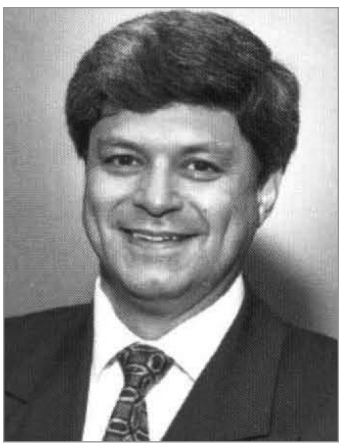
ACFAS paid ever more attention to its corporate partners, including a "Corporate Corner" in one *Bulletin*, and a "People You Should Know" feature on the Industry Advisory Council in another.[83]

Earning Respect, Gaining Access

Managing managed care and boosting corporate support may have been new initiatives for the 1990s, but equally important was the continuation of the long-standing mission of earning respect for the profession and gaining access to hospitals. It was clear that the chief means of earning respect would always be maintaining high standards of skill. Back in the years before surgical residencies, the College had regularly held workshops. In the 1970s and 1980s those events had been curtailed, with more focus placed on the annual meetings and scientific seminars. But in the 1990s the workshops returned.

In 1992 ACFAS held two heavily attended arthroscopy workshops, one in collaboration with the University of Texas and the other in the Chicago suburb of Itasca, Illinois.[84] Another arthroscopy training session featuring lectures and cadaver work was held the next spring in Orlando, Florida.[85] Due to popular demand, the March 1995 annual meeting and scientific seminar included for the first time seven instructional courses and "skills workshop laboratories."[86] Clearly ACFAS members were eager for hands-on surgical training, particularly cadaver and tissue work.[87] Indeed, the board's awareness of this helped drive the headquarters skills lab campaign.

In May 1994 Lowell Scott Weil Sr. and David Novicki met with the directors of the American Orthopedic Foot and Ankle Society (AOFAS) to try to establish some ground for joint efforts. That initiative did not go very far, but at one point during the meeting, one of the AOFAS members suggested that ACFAS consider renting time at the AAOS Orthopedic Learning Center (OLC).[88] Two years later, the ACFAS skills lab was still a dream, and Tom Schedler and Scientific Director Mary Meyers were considering how to get ACFAS skills training out of various hotel suites and into a more sophisticated central location. That was when they approached the AAOS about using the OLC—just to build momentum for their own effort ACFAS members were assured.[89] The November 1996 Arthroscopic Surgery of the Foot and Ankle course was exceptionally successful, so five more two-day workshops—both on the road and at the OLC—were held in 1997, with a full complement of more than 250 participants.[90]



A. Louis Jimenez (1997-1998)

The driving force behind this 1990s training renaissance was John Schuberth. Meyers called him "the person who had the burning desire to move forward with the surgical skills." At the outset, neither Schuberth nor Meyers had a blueprint. "All we knew for sure was that we wanted to provide an unparalleled educational experience," Meyers recalled.[91]

The early emphasis on arthroscopy was likely intended in part to keep ACFAS out in front of the minimal incision surgery movement. Following that, Schuberth and Jeffrey Christensen spent a year preparing a highly complex trauma course. That effort required an unprecedented amount of preparation—the instructors had to create 400 precise

fractures on cadaver specimens, for example. The event was held in August 1998 at the OLC.[92] The next year ACFAS developed a course on the cutting edge technique of external fixation of the foot and ankle.[93]

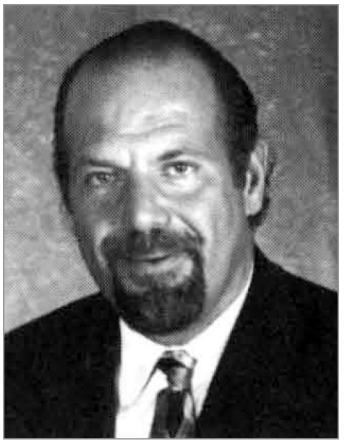
In the early 2000s, the ACFAS workshops hit closed-circuit television when Gary Lepow convinced the HealthSouth Outpatient Division Clinical Education Department and Western Pennsylvania Hospital to sponsor a "satellite symposium." The first installment was broadcast to 1,200 HealthSouth locations.[94] New lab courses, meanwhile, focused on complications arising from the growing problem of diabetic foot. These symposia were developed by John Giurini and Robert Frykberg, for Schuberth had moved on to an equally challenging task.[95]

The *Journal of Foot & Ankle Surgery* (it had finally been renamed along with the College itself) remained a source of great expectations and great frustrations during these years, and the College's solutions to the problem also remained largely the same. The appeals to the membership for publishable articles continued, as did recurring questions about the virtues of various publication options. In the summer of 1994, the board decided to once again bring publication of the journal, which had been handled for a decade by Williams & Wilkins, "in house."[96] Harold Schoenhaus hoped that would "elevate the journal's current stature as a respected scientific publication."[97] But in the end, ACFAS opted only for a new publisher, Data Trace, which took over in 1996.[98]

The next summer Richard Reinherz accepted an academic position, concluding 17 years as editor. Knowing what a difficult and thankless task that the editorship was, the board was profuse in its recognition of Reinherz and his "remarkable legacy."[99] At that point, Lowell Weil Sr.—an ACFAS utility player if there ever was one—stepped in to become editor-in-chief, working with a succession of managing editors. Weil recognized the great progress that the journal had made in the previous two decades but remained disappointed in the low number of submissions.[100]

Richard Reinherz, left, served as editor of the *Journal of Foot Surgery* for more than two decades. Here he presents a plaque to Lawrence Lavery, winner of a 1994 journal award.

In moving the ACFAS skills training program forward, Schuberth had demonstrated a capacity for doggedness required for editorship of the *Journal of Foot & Ankle Surgery*, and in late 1999, after completing a year as ACFAS president, he became the journal's managing editor.[101] In 2001 Weil relinquished the editor-in-chief position. The next year, Schuberth reorganized the editorial board along topical lines. The ACFAS board, meanwhile, brought in a new publisher, the prestigious international firm Elsevier, which also provided state-of-the-art online access the next year. [102] Everyone recognized, of course, that these were just the latest positive developments in what had been one of the College's longest and toughest campaigns.



John M. Schuberth (1998-1999)

Indeed, there was only one ACFAS campaign that predated and exceeded in complexity the task of creating a respected academic journal—the never-ending struggle for hospital privileges, otherwise known as "credentialing and privileging." Somewhat surprisingly, until the 1990s ACFAS had never created a formal mechanism for helping its members through what could be an ordeal. Instead the work was undertaken on a volunteer basis by the indefatigable letter writer with an appreciation for proper definition.

Harold Vogler attended the Illinois College of Podiatric Medicine, receiving his DPM in 1972. He did his residency at a small institution, Harrison Community Hospital, in the Detroit suburbs. This was something of a typical case. Very few large hospitals offered significant surgical privileges to podiatrists at the time. In the mid-1970s, now in private practice, Vogler found it necessary to launch a sustained campaign for ankle privileges, and in doing so began what, in addition to teaching and the practice of foot and ankle surgery, became his life's work.

Vogler began working with colleagues to lobby the state of Michigan to recognize the ankle as a legitimate field for podiatric surgeons. Accomplishing that was only the beginning, recalled Vogler. "Just because it's in the law doesn't mean that you can execute the privilege."[103] As a next step Vogler traveled all over the state, observing surgeries, attending conferences, and finally asking a Detroit orthopedic surgeon if he could "scrub the case." The allopathic physician was hardly encouraging, but he agreed.[104]

Soon Vogler was helping more colleagues on an informal basis. It was not uncommon for even the best, most established podiatric surgeon to one day find—much like ACFAS founder Oswald Roggenkamp had—that his hospital privileges had been revoked. There was often opposition by orthopedic surgeons behind the scenes. The customary response was for the aggrieved surgeon to file a lawsuit, which usually worked out no better than it had for Roggenkamp, who lost despite having one of the best lawyers in the country.

Involving lawyers was almost always a bad idea in these cases, not only because it instantly made enemies of hospital administrators who might otherwise have been willing to compromise, but also because lawyers had a vested interest in keeping the conflict going. Vogler realized that his colleagues could learn much from the law without employing lawyers. He had learned to respect the power of precedent and due process. Vogler found that in bowing to the demands of orthopedic surgeons, hospitals had often violated their own rules. In those cases careful documentation could be incontrovertible.[105]

But in plenty of instances the record was not clear, and so it would be necessary to build a case, not only for what podiatric surgeons were capable of and accredited for, but more importantly, for what they were already doing in other contexts. So the punctiliousness that started with names extended to documentation. Mission statements, position papers, white papers—anything that could serve as record was fair game in the credentialing process. "I recognized the critical importance of having a definitive paper trail," Vogler recalled. When he got a call or letter from a colleague in trouble, he always instructed them to keep good records—and to keep duplicates, because hospitals often "lost" theirs.[106]

By 1991 the College was ready to institutionalize this fight. It began, appropriately enough, by documenting information on what podiatric surgeons were already doing through a survey on hospital privileges. The chief findings were that 47 percent of ACFAS members were active on a hospital staff; 29 percent were members of four hospital staffs. A full 81 percent believed that they had the appropriate privileges given their training and experience.[107] Since only about one-third of the members responded to the survey, the full picture cannot be known with any certainty, but if 19 percent of the members lacked appropriate privileges that was a problem worth tackling. In 1993 the board created a Professional Relations Committee to do so.

Not surprisingly, the Committee began with documentation. The Preferred Practice Guidelines then underway promised to be a big asset in delineating the outlines of surgical practice. The committee complemented them with written guidelines for ankle surgery privileges, ankle arthroscopy privileges, surgical delineation guidelines for foot and ankle surgeons, and guidelines for surgical second opinions. The committee also began producing a variety of other position papers.[108] None of these had legal standing, but they provided all-important precedent and created "pathways," as Vogler put it.[109]

While developing the record on what ACFAS members could do, the committee also compiled information on what members had been prevented from doing, painstakingly documenting credentialing and privileging problems nationwide.[110] By the end of the decade, this effort had become part of a larger attempt to work closely with the APMA in developing a single credentialing document for the profession.[111]

Most of this documentation was going to end up sooner or later with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which accredited more than 19,000 health care organizations nationwide.[112] While credentialing would be pursued on a case-by-case basis for the foreseeable future, ACFAS was hoping to obtain a more universal goal by working with the JCAHO to enable podiatric surgeons to take responsibility for the "history and physical."

The history and physical (H&P) is a record, created upon admission, that memorializes a patient's medical history and documents the conditions or concerns leading to admittance. To the extent possible in an age of increasing specialization, the ability to conduct the H&P confers upon the admitting physician chief responsibility for the patient and the role of gatekeeper. For podiatric surgeons, ability to conduct the H&P would mean that, for the first time, they could actually admit a patient to the hospital on their own rather than "co-admit" with an allopathic physician. Not surprisingly, the H&P carried great practical and symbolic import.

The heart and soul of the JCAHO was its exhaustive list of standards. Standard MS.6.2.2 specified who could perform a history and physical.[113] Allopathic physicians, of course, had been written into the standard from the beginning. Later, dentists, who had obtained a measure of influence in the JCAHO, were able to have their profession included by name as well.[114] In addition to those named practitioners, the standard noted that "other licensed independent practitioners who are permitted to provide patient care services independently" could conduct the H&P.[115]

Gary M. Lepow (1999-2000)

By the summer of 1997, Vogler realized that podiatric surgeons, lacking the level of influence with the JCAHO that dentists had, were not likely to be named specifically in any revised standard. Instead he recommended that ACFAS pursue a "clarification" of the existing standard that would specifically include podiatric surgeons in the "other licensed independent practitioner" category. This involved more than just asking; ACFAS had to build a comprehensive case, with documentation of training, education, and experience.[116]

In 1998 Vogler worked with Dr. William M. Scholl College (formerly the Illinois College of Podiatric Medicine) to establish a strong and standardized history and physical examination certification program that could be replicated elsewhere.[117] He advised his counterparts to denote these "refresher courses," since podiatrists should have been learning how to perform H&Ps all along. Henceforth Vogler insisted that every staff podiatric surgeon put an H&P on the chart—even if it did not count.[118]

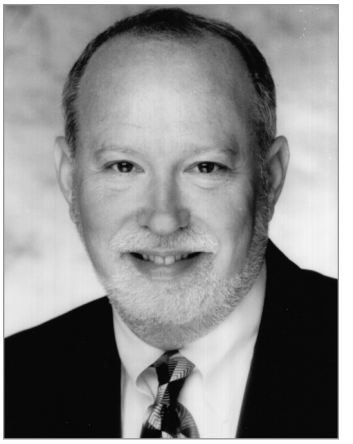
Harold Vogler, left, receives a plaque from president Howard Zlotoff, one of many awards he earned for helping ACFAS members win the right to conduct history and physicals and gain hospital credentials and privileges.

As Vogler built the case for clarification, Schedler worked his connections, especially a few within the JCAHO itself, which eventually got ACFAS a place at the table. After several years of effort and seemingly endless meetings, in November 2000 ACFAS received a "Draft Clarification" from JCAHO. To the question "Can a Doctor of Podiatric Medicine perform the entire history and physical for a patient admitted to inpatient care?" The JCAHO answered yes, finding it "consistent with MS.6.2.2." The clarification became effective December 22, 2000.[119] Resistance hardly evaporated, of course, but in April 2002 ACFAS obtained an additional clarification enabling members to conduct H&Ps in clinics and other ambulatory facilities as well as hospitals.[120] Vogler must have appreciated a small victory for precise nomenclature in the clarification: the JCAHO, which had for years identified only "podiatrists," now referred to "credentialed and privileged Doctors of Podiatric Medicine."

Coming Apart and Pulling Together

Despite the managed care and administrative challenges of the early and mid-1990s, ACFAS had reason for optimism. From the very beginning, it had enjoyed steady growth which only accelerated after the creation of the ABPS. As soon as the College obtained a list of newly minted ABPS diplomates, it sent out invitations and within a few months had scores of new members.[121] From 1992 to 1995 ACFAS grew predictably at a rate of about 300 new members per year.[122]

The curve reached its apex the next year and in 1997 began dipping downward.[123] At the same time, despite continued efforts to upgrade the annual scientific meetings and attract attendees, attendance at the events averaged about 15 percent, half the proportional attendance at meetings of most other medical associations.[124] ACFAS was not the only group under stress. The American College of Foot & Ankle Orthopedics & Medicine (ACFAOM) was having its own difficulties. In 1998, the ACFAOM proposed joint management, and in 2000, a merger.[125] But ACFAS demurred, in part because its finances were in a perilous state.[126]



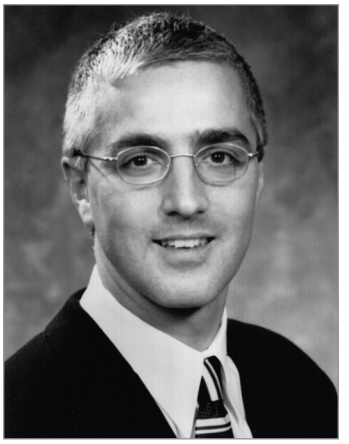
Barry L. Scurran (2000-2001)

Stresses like these would heat up any boardroom, but ACFAS meetings were regularly boiling over. Only part of this, however, was due to external circumstances. The board at the time included a number of men with strong personalities who tended toward overconfidence and away from compromise. On top of that, according to Gary Lepow, "everyone had different political agendas."[127] Things got so bad during the late 1990s that two directors quit in disgust. Lepow had tired of the conflict by the time he became president in February 1999. His first action as president was to announce that he would be governing the meeting according to Robert's Rules of Order.[128]

Although there had been a push to keep the board from doing committee work earlier in the decade, Lepow sought to further lighten director loads by changing the ACFAS organizational structure. Previously, all of the nearly 30 committees reported to the board. Now they were grouped into four "councils" covering governance; professional affairs; education, podiatric practice, and research; and publications. The board would henceforth hear only from four councils rather than 27 committees.[129] Lepow also hoped that the arrangement would liberate and thus reenergize the committees, raise accountability, and improve communications.[130] But parliamentary procedure and reorganization could not solve what was essentially a people problem. The October 1999 meeting began with a professionally facilitated Leadership Training Session and extended over three days rather than the usual one. Those in attendance agreed at the end that "it provided a more relaxed and productive approach to the meeting."[131]

Lepow's efforts to raise the sights and lower the voices of the board members were carried further by Barry Scurran. A senior officer with California's Permanente Medical Group, Scurran had already begun to develop governance experience when, in early 1996, president David Novicki expressed interest in having him serve on the ACFAS board. Scurran agreed to take on the challenge, only to learn that Novicki had expected him to run for office later on. So instead of waiting a year to be slated by the Nominating Committee, Scurran petitioned to get on that year's election ballot (remaining to this day the only board member to do so). By the time he succeeded Lepow as president Scurran had gained valuable experience on other boards of directors and was determined to create a less destructive, more collegial, culture at ACFAS.[132]

Scurran's tenure began with a four-day session which included leadership and planning workshops. Throughout his year Scurran worked hard to foster the development of a set of core values, a sense of mission, and to promote consensus rather than conflict.[133] He insisted that the directors spend part of the time together in team-building activities on the assumption that playing together makes for better working together.[134]



Robert W. Mendicino (2001-2002)

Likely because of the long-running personal and political differences, board deliberations had been public knowledge for years, feeding member concern about such subjects as lobbying, officer stipends, board micromanagement, and conflicts of interest. Lepow, Scurran, and Schedler all emphasized, as recorded in the minutes of one meeting, that "a responsibility incumbent upon the board and staff is unity and professionalism in its message to its publics."[135]

By the beginning of the 2000s, the ACFAS boardroom was a more polite, if not placid, place. That presumably enabled the officers to focus on the fact that, despite the efforts earlier in the decade, the College was still long on aspirations and short on strategic focus. This was to some extent understandable, particularly as the College tried every method imaginable, and some not quite affordable, to help its members cope with the rise of managed health care. In mid-1999 the board came up with a "strategic plan of 36 goals."[136] Those were eventually narrowed down to 32 points.[137] The directors were still thinking as they had when membership was rising and funds were adequate if not plentiful. But the darkening financial picture forced everyone to focus a bit more closely.

As Schedler told the members in early 2000, "Circumstances have changed in our immediate world which now require that we revisit our plan."[138] Later, Scurran put it more directly: "We have had strategic plans with 30 plus goals and have had some great successes, but we have spread ourselves too thin." At the October 2000 meeting the board decided that henceforth, the College would have to sharply limit its activities to one clear, essential, goal—"the surgical aspect of our practice and education."[139] This decision, simple enough in concept, had dramatic implications. By deciding that they were surgeons first and podiatrists second, ACFAS had found a way through the thicket of contention that had once seemed an annoyance but now appeared to threaten the College's survival.

Buried in the middle of the summer 1997 edition of the *Bulletin* was an unattributed editorial noting that "there are hundreds of potential ACFAS members who cannot or will not join the organization due to the membership requirement of also being a member of APMA." The editorial observed that the subject had been "under discussion for some time."[140] It was the natural outgrowth of years of contention between ACFAS and the APMA over the membership count, years of disappointment as ACFAS had been compelled to eject members who refused to maintain dual membership, and years of the dawning realization that perhaps ACFAS and the APMA did not have that much in common after all.

At mid-decade, less than 30 percent of the podiatric profession was board certified or qualified in podiatric surgery.[141] Even if it had wanted to, the APMA could hardly have truly "represented" the surgeons. That reality was brought into ever sharper focus as the APMA and its constituent organizations, including ACFAS, worked through the "Educational Enhancement Project" during the mid-1990s. The project had the admirable goal of ensuring that all aspects of the profession—but particularly residencies, college curricula, and continuing education programs—were matched to the expected demands of the 2000s. In the summer of 1996 ACFAS backed the initiative unanimously.[142]

But by 1997 the APMA had added to the initiative the goal of developing a "single certification model" that would be applicable to podiatric generalists and to all the specialties as well.[143] Almost out of necessity, such a document would hopelessly blur the lines that ACFAS, in its Preferred Practice Guidelines among other things, had been working so hard to sharpen. The next year, the resulting *Blueprint for the Future* was marked by a lack of clarity regarding training in podiatric surgery. When ACFAS called attention to this, the APMA tried to smooth things over, but the concern never went away.[144] By the dawning of the new decade, the board had long been dissatisfied with the Educational Enhancement Project. It had proven that the APMA's need for inclusion conflicted with the ACFAS goal of highlighting its particular expertise.[145]

More than a few ACFAS members had already thought about going it alone. In 1993 the board had discussed disaffiliating when the APMA considered admitting the Academy of Ambulatory Foot Surgery.[146] Now it seemed like the only way to stop the membership slide. In 1998 ACFAS sent inquiries to unaffiliated podiatric surgeons asking them if they would be interested in joining an independent ACFAS with no requirement of paying APMA dues. Seventy-five percent said they were likely to do so. When ACFAS members were polled, however, 60 percent opposed disaffiliating.[147] And that number included a few board members, who dug in their heels.

By the fall of 1999, however, the resistance—at least on the board—was gone. Schedler remembered being in the meeting when the subject came up. "Before I knew it, somebody made a motion," he recalled.[148] It carried unanimously. When word got back to the members, however, they were far from unanimous. But the leadership was more determined than ever—there were, observed Lepow, "Thousands of ABPS board certified/qualified Doctors of Podiatric Medicine who have never been members due to philosophical or financial issues."[149] The next spring, as ACFAS contemplated cutting 300 members due to nonpayment of APMA dues, Lepow wrote that "remaining with the status quo is only losing ground."[150]

According to the ACFAS bylaws, the APMA affiliation requirement could only be removed by a two-thirds favorable membership vote. Accordingly, the board retained a communications firm to develop messaging and launched an unabashed educational campaign intended to change the requisite number of minds.[151] The summer 2000 edition of the *Bulletin* featured an article entitled "Fork in the Road." It pointed out that the American Medical Association did not require its specialty societies to maintain dual membership and that only three state medical societies required dual membership in the AMA. It described in glowing terms the success of the Illinois State Medical Society after it cut loose from the AMA.[152]

The objective was never to disparage the APMA. If it became independent, the article assured members, "the College would encourage APMA membership to an extent that it never has in the past."[153] But those qualifications made no difference to the opponents of the measure—the vast majority of the letters and calls that came into headquarters were opposed to disaffiliation.[154] Schedler, who took many of the calls, remembered hearing few convincing explanations for the refusal to change. "Nobody could really say, except that's the way it's always been."[155]

Soon convinced that the necessary two-thirds of the members would not support disaffiliation, the ACFAS board resorted to compromise. Late that summer, Lepow, Scurran,

and Schedler took their case to the Resolutions Committee at the APMA House of Delegates meeting in Philadelphia, making it clear that the "membership issue was one of the most critical confronting the profession."[156] They were met with hostility and the introduction of three resolutions penalizing ACFAS. Gallows humor suggests that they were prepared for such a reception. As the tumult grew to a roar, one of the officers turned to Schedler and said, "I think this is going well. Don't you?"[157]

ACFAS beat a hasty retreat and tried another front, working with the APMA trustees to keep the negative resolutions from being introduced. Ironically, the APMA president was Gary Lepow's brother Ronald. He agreed to compromise—but only if ACFAS discontinued its "campaign to promote freedom of choice." After a short break, the leaders of both groups were composed enough to hammer out a deal that included the withdrawal of the resolutions and the creation of a blue-ribbon task force with three members from each group charged with maintaining unity and increasing membership in both organizations.[158]

In three meetings between October 2000 and February 2001, the group devised a Pilot Membership Recruitment Program that would not require dual membership.[159] ACFAS accepted the proposal; the APMA rejected it unanimously.[160] In June 2001, the APMA presented a counter proposal: a limited dues waiver program for those wishing to join both groups who could demonstrate "a temporary hardship situation." ACFAS rejected it.[161] The rough diplomacy continued for another year, with the APMA presenting yet another alternative. ACFAS estimated that the original pilot program would probably have yielded more than 2,000 new members—the latest version might have brought in fewer than 200. ACFAS rejected that one too.[162] Both sides stood down.

These events of the late 1990s may have muddied the waters of ACFAS-APMA relations, but they also brought the challenges that lay ahead into clearer focus. The Philadelphia bid had been a doubtful undertaking from the start, demonstrating only that the APMA was bound to resist any change in its relationship with the College. Rather than changing minds, the freedom of choice campaign had appeared only to confirm the findings of the 1998 poll. So long as more than one third of its members wished to remain affiliated with the APMA, there were few options open to ACFAS—under current governance arrangements. The question remaining was what could change, and what would not.

Chapter 5

Keeping the Faith, 2002 – 2017

In the spring of 2002, ACFAS was at a turning point. The College had accomplished much during the previous decade, consolidating its commitment to providing top-quality education and training, not only in clinical science but also in coding and practice management. But ever since membership had peaked in 1997, financial problems had dogged the College, and they continued into the 2000s, aggravated by the post-9/11 economic slowdown. Now the College's cash reserves were perilously low—just 12 percent of revenues.[1] One option was to retrench. The other was to "maintain the momentum," as incoming president Robert Frykberg put it, and seek a quick infusion of funding from the members.[2]

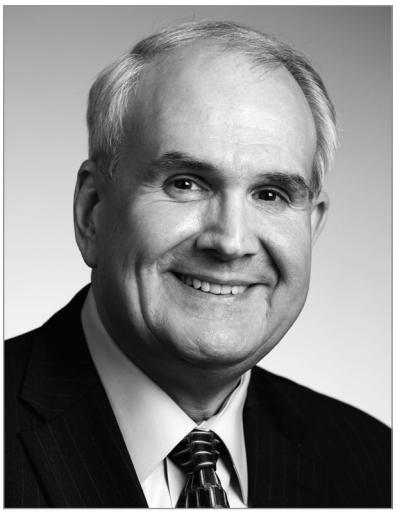
Both alternatives carried risk. The wholesale cutting of programs and services could reverse a decade of progress. A one-time dues assessment would keep the College on mission—but what if the members did not comply? By some estimates, 20 percent of the members might terminate their membership. The board prepared for that scenario, took a collective deep breath, and implemented the $100 one-time dues assessment, payable by the end of the year.[3]

The dues assessment succeeded beyond expectations—98 percent of the members kept the faith with ACFAS, allowing it to get through the tough times with its capabilities intact.[4] During the next 15 years, the College was to use those capabilities to keep the faith with its members, helping them become better, more prosperous practitioners; furthering the quest for parity with the other medical professions; and establishing ACFAS as a strong and, at last, fully independent organization.

Identity

ACFAS came out of the assessment year with much to do, but first on the list was shoring up its administration and management for another period of growth. In mid-2002 Tom Schedler announced his retirement as of March 2003.[5] That gave the board plenty of time to find a successor, and by January 2003 the next executive director was in place to begin a long and smooth transition.

Like Schedler, J.C. "Chris" Mahaffey came to ACFAS with strong association management experience. He was also a Certified Association Executive, and before joining ACFAS had served as CEO of a group representing association executives.[6] Mahaffey had begun his career in health care, however, working for the National Association of Community Pharmacists and the National Association of Boards of Pharmacy.[7]



J.C. "Chris" Mahaffey became executive director in 2003, a period in which the College was recovering from financial straits and learning to follow a new "strategic compass."

Although he had no intention of undermining the capabilities of ACFAS, Mahaffey was determined to increase its efficiency. After careful study, he recommended reducing 25 committees to 12 and made significant internal operational changes.[8] Mahaffey also suspected that the ACFAS headquarters, purchased in the 1990s to provide a home for the ill-fated skills lab, was less a successful investment than a strain on the books. A cost-benefit analysis confirmed this, and in the summer of 2004 ACFAS sold the 515 Busse Highway building and moved to rented space at 8725 West Higgins Road in Chicago, near O'Hare Airport.[9]

At the same time, the efforts begun in the 1990s to gain new corporate support began to pay off. Medical device manufacturer Smith & Nephew, for example, funded a six-week mini-fellowship at Russia's Ilizarov Scientific Center.[10] New contributions not only put the scientific skills training sessions on firm ground, they lent a new air of impressiveness to the annual scientific conferences as inexpensive table displays gave way to more elaborate island exhibits. Cost savings in the office, the sale of the old building, and new corporate sponsorships, coupled with a new accounting system and change of investment firms made for an impressive turnaround. By 2004 ACFAS was back in the black, and by mid-2005 reserves were a comfortable $2.5 million.[11] The College was more capable of serving its members than ever before.

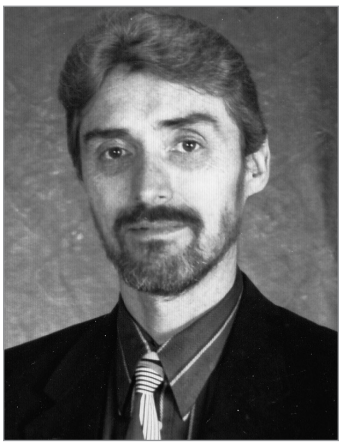
But what did member service mean? What did ACFAS members want? The College had already taken steps to find out. In 2001 ACFAS conducted a survey to learn how its members practiced and to discover how their practices shaped priorities. The same year, ACFAS convened six focus groups that explored member priorities more broadly. In 2002 came the most enlightening effort of all, a member needs assessment survey.[12] That study found that education and research topped the list of what members expected from ACFAS, not only clinical education through the *Journal of Foot & Ankle Surgery*, skills courses, and the annual scientific conference, but also training in insurance, coding, and practice management. A close second was advocacy and public relations. Members wanted ACFAS to work with other organizations, or on its own if necessary, to promote the right of foot and ankle surgeons to practice and to convince other practitioners and the public to recognize—and use—the efforts of highly trained foot and ankle surgeons.

The result was a mission statement and strategic plan that, rather than responding chiefly to external challenges or the enthusiasms of board members, closely tracked with member priorities. As the decade went on, ACFAS conducted member surveys on a regular three-year basis, and although strategic goals might shift with member needs, they would never vary widely. One-time strategic plans gave way to more durable goals, part of what was suitably described as the organization's "strategic compass."[13] As ACFAS president Gary Jolly put it in early 2006, "The board no longer operates in a vacuum."[14]

Mahaffey also urged the College to implement a number of procedural changes that enabled board members to track their course from true north rather than be diverted by the magnetic pull of private agendas and isolated events. In mid-2003, he tightened lines of communication between the staff and the membership, ensuring that all matters of policy went through his office so that staff could not get sidetracked.[15] Not only did Mahaffey encourage the board to delegate more authority to committees, he also recommended adoption of specific governance procedures to allow committees to work more independently.[16] Above all, meeting agendas sharply and clearly distinguished between matters for oversight and issues for action. "We put the committee reports on the consent agenda," said Mahaffey. "If there's a problem, you move it to the action agenda, but that's very rare."[17]

By listening to the members and keeping its leadership on track, ACFAS was able, for the first time, to come up with a simple coherent mission statement: "To promote superior care for foot and ankle surgical patients through education, research and the promotion of the highest professional standards; and to promote our members' professional and socioeconomic activities."[18] The mission was supported by the strong strategic compass that incorporated public relations, education, science, and advocacy.[19] Above all, ACFAS was systematically listening to its members and enabling the directors and volunteers to focus on their priorities unimpeded, which enabled ACFAS to keep the faith with its members during the 21st century.

The surveys had also made it clear that although foot and ankle surgeons had concerns that clearly distinguished them from general podiatrists, the members still wished ACFAS to work closely with the APMA to pursue common objectives. Indeed, starting in 2002, it became the College's goal to take every opportunity to work with—and especially within—the APMA rather than independently.



Robert G. Frykberg (2002-2003)

It was a fitful course, however, particularly since the highly conservative APMA House of Delegates, in the interest of fostering unity and minimizing the effects or even appearance of specialization, was determined to resist distinguishing—both in terms of skill and practice—between podiatrists and foot surgeons. In early 2002, for example, ACFAS introduced in the House of Delegates a resolution on surgical care of the lower extremities. Even though the APMA trustees had approved the language, in the House of Delegates acrimony followed and rejection resulted.[20]

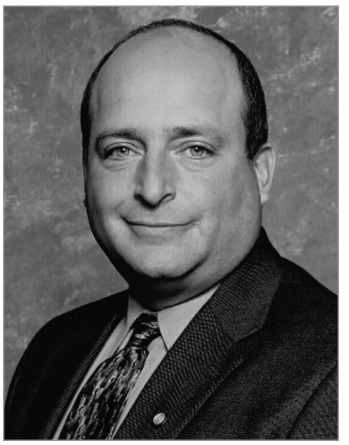
In the spring of 2003, ACFAS and the other six APMA specialties submitted a resolution requesting a seat for each in the House of Delegates. They strengthened their case by pointing out that the House

of Delegates of the American Medical Association (AMA) had granted similar seats to its specialties and that an APMA blue-ribbon task force had already resolved to support this initiative.[21] ACFAS lobbied hard for the measure but was rebuffed by the House of Delegates, which countered that the move was only an elitist power grab.[22] The next year ACFAS tried once again to obtain a seat in the House of Delegates. The idea was that there would be two seats, one surgical (ACFAS) and one nonsurgical (ACFAOM) and that the positions would be nonvoting.[23] This time, in a show of good will, ACFAS pointedly refrained from lobbying the House of Delegates.[24] It made no difference.

President Bruce Werber was committed to achieving rapprochement with the APMA; he acknowledged in the *Bulletin* that "ACFAS is still carrying some 'political baggage' from our past effort" but affirmed that the College had moved on and wanted to be part of the process. He could point to some improvements, noting that ACFAS and APMA trustees were meeting regularly to "discuss areas of mutual concern and to avoid duplication of efforts."[25] This goal was elusive, however, in large part due to the APMA governance structure. ACFAS could negotiate all it wanted with the APMA trustees who were the organization's nominal leaders, but in the end a minority in the House of Delegates could overrule them.[26]

It was advocacy, rather than representation, that most highlighted the differences between ACFAS and the APMA. The surveys had all identified advocacy—appeals to the public and other medical professionals, and work with accrediting organizations, the Joint Commission on Accreditation of Healthcare Organizations, and Medicare—as something that they expected ACFAS to provide.[27] In early 2004 the ACFAS board decided that it could no longer rely on the APMA to serve its interests when it came to public and private insurers. The board vowed to engage directly with the Center for Medicare and Medicaid Services whenever necessary.[28] The APMA, on the other hand, insisted that regardless of specialties and skill differentials, all podiatry specialties should maintain a unified front by relying on APMA efforts alone.[29]

President Lloyd Smith had long been irritated by the College's reluctance to toe the APMA line. In May 2004 he sent a letter to ACFAS pointing out that it had violated an old forgotten rule, Resolution 27-95, every time it promoted board certification. Smith also demanded that ACFAS halt all health policy and consumer education initiatives and threatened to convene an APMA Board of Inquiry into all of these matters.[30] It was a patently incendiary move. Since 1975, the very existence of ACFAS had been premised on board certification—why had the APMA ignored that for 19 years? The APMA soon repealed the archaic rule. As for the demand that the specialties leave all public efforts to the APMA, the ACFAS directors countered that "APMA's 'one voice' philosophy in health policy runs contrary to American pluralism, modern political science, 'coalition politics,' and how other branches of medicine operate."[31]

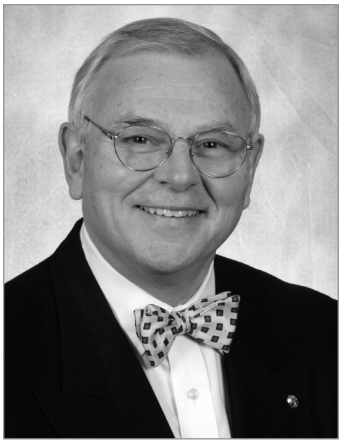


Bruce R. Werber (2003-2004)

Still ACFAS tried to resolve the differences. In July 2004 president Gary Jolly and Chris Mahaffey met with APMA leaders. Instead of considering compromise, Smith threatened expulsion. "Don't do us any favors, Lloyd," Jolly countered, smiling.[32] Afterward the board spent most of its now-customary extended summer retreat trying to come up with ways to stay true to its members yet obtain cooperation from the

APMA.[33] At a meeting of APMA affiliates in 2005, ACFAS noted that there had been a natural evolution at work. As president John Stienstra later put it, "Both APMA and ACFAS have evolved not unlike many medical specialty associations. APMA and ACFAS have common members, yet unique needs."[34] Would it not be best for podiatry as a whole if there were a plurality of voices in the public policy realm rather than just one?

The concern became even more pointed when, in early 2006, the APMA produced a strategic plan that conflated general podiatric medicine and podiatric surgery. In response, president Stienstra and president-elect Thomas encouraged the APMA to tackle "select global podiatric issues which benefit all members, rather than attempting to be all things to all people with mediocre results."[35]



Gary P. Jolly (2004-2005)

ACFAS leadership was acutely aware of the importance of honing a sharply defined identity rather than trying to be all things to all people. It was only in 2003, recalled Bruce Werber, that ACFAS leaders "came to the understanding that we had a brand."[36] The next year, Jolly, probably the most influential leader of the 2000s, developed that notion further, explaining, "We practice our specialty in a 'market place' and in order to distinguish ourselves from other foot care providers, it is imperative that we develop our own brand identity."[37] Experience had suggested, and Jolly insisted, that the foundation of the brand had to lie in surgical skill, that ACFAS fellows had attained the highest possible level of professional skill in podiatric medicine, and that it was the only podiatric specialty organization that required board certification of all its members.[38]

If this branding was guaranteed to disappoint the APMA's "one voice" advocates, it helped energize ACFAS publications. In an effort to provide better information to members more effectively, the College regularly upgraded its website and publications during the early 2000s. The *Bulletin* was complemented by a biweekly e-newsletter in 2002, and was renamed the *Update* in 2004, with more regular departments and shorter, punchier articles.[39] Members welcomed these simpler communications more closely geared toward their specific areas of interest, but they appreciated even more the College's increasing efforts to market their brand—and thus their services—to an ever-growing public of patients.

ACFAS had first taken up the challenge of public relations in the 1990s as part of its Practice Enhancement Plan. While those efforts had led the way, they had also faltered due to the programmatic and financial weaknesses of the era. In the 2000s, as the College got on stronger financial footing and developed a better understanding of its brand, public relations efforts were stepped up. In 2003 the ACFAS Public Affairs Committee launched an expanded national platform. Along with issuing news releases and topical consumer interest stories through wire services, ACFAS began producing video and radio news releases.[40] The entire program, a direct result of the needs assessment and focus groups, was directed by a public relations consultant.[41]

Throughout the 2000s, the initiative became stronger and more diverse, with features on sports injuries appearing on ESPN, articles on diabetes and the foot making it into the pages of *Prevention* magazine, and general interest stories reaching hundreds of millions

John J. Stienstra (2005-2006)

of potential patients through major outlets, such as the *New York Times*, *Forbes*, *USA Today*, and *U.S. News and World Report*.[42] The effort was underpinned by an ever-growing stable of ACFAS experts available to journalists for backgrounders or interviews.

After 2004 all of these efforts were unified by a new public-facing website, FootPhysicians.com.[43] From the start, the site featured consumer opinion polls, trivia questions, feature articles, and most importantly, a physician locator.[44] In June 2004, a few months after launching, the public site had 13,134 visits.[45] By the time it was renamed FootHealthFacts.org in 2009, hits were numbering in the millions.[46]

Most of the stories that ACFAS presented to the public dealt with the timeless challenges of bunions, hammertoe, diabetes complications, or the ravages of high heels. But in the 2000s, the profession found itself ready and willing to comment on a few particularly hot issues. The excessive wear of flat-soled flip-flops among young women was particularly damaging, and as a result ACFAS experts received considerable coverage in women's health and fitness magazines.[47] One study suggested that in the last half of the decade, some 21 million people visited FootHealthFacts.org specifically for information about the ubiquitous flip-flops.[48] When a blessedly briefer public threat—cosmetic foot surgery—appeared in the early 2000s, three of the College's most esteemed experts weighed in. Citing the Hippocratic Oath of "first, do no harm," Frykberg, Werber, and Jolly, successors in the presidency of ACFAS, wrote that "pandering to a patient's vanity is something a responsible surgeon must avoid."[49]

After the College moved to in-house public relations staffing in 2006, a greater push into local markets and ever-increasing use of an expanding Internet resulted in a dramatic increase in media placements.[50] In 2016, in direct response to member demand as established by the regular surveys, ACFAS began shifting its public relations efforts to better reach fellow medical professionals, including nurse practitioners, family physicians, and diabetes educators.[51] The centerpiece of this $1.2 million "Take a New Look at Foot and Ankle Surgeons" campaign, orchestrated by world-class public relations firm Fleishman-Hillard, was, not surprisingly, yet another special-purpose website. The site, TakeANewLook.org, led with a direct invocation of the ACFAS brand: "With more education and training specific to the foot and ankle than any other healthcare provider, foot and ankle surgeons are the leading experts in foot and ankle care today."[52]

Raising the Bar

During a session at the 2003 annual scientific conference, one of the participants made a joke at the expense of another ACFAS member. The incident quickly spread to e-mail and became a matter of contention in online podiatry chat rooms, obligating ACFAS to clarify and reinforce its long-standing code of conduct.[53] Only a few years earlier, the remark would likely have "remained in the room." But the new age of instant and highly public communications brought heightened expectations.

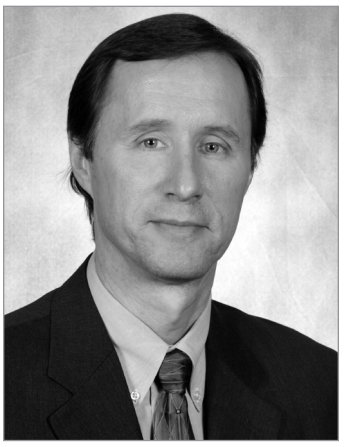
In this case, technology had raised the bar for the personal conduct of foot and ankle surgeons, in other cases ACFAS itself raised the bar, aware that, as Werber put it, "by 'pushing the envelope' in all levels of our professional training, we will all advance."[54] Indeed, in areas from scientific research to continuing medical education, and from accreditation to training, ACFAS relentlessly set a higher standard, not merely out of a commitment to excellence but also from the conviction that foot and ankle surgeons would have to prove beyond a doubt that they had earned the highest levels of respect that they had for decades sought.

As Louis Jimenez had acknowledged as late as the 1990s, there were always members who might suspect, justified or not, that the ACFAS board was something of an exclusive old boys' club. Worse, there were always those willing to believe that board members used their exalted positions to feather their own nests. Mahaffey knew from long experience that even perceptions of conflict of interest could irreparably damage an association and urged the board members to raise the bar for their own conduct. The May 2003 board meeting began with a roll call as usual, but that was followed by another call—for disclosure by all members of potential financial or ethical conflicts of interests with anything on the agenda. That call continues to this day.[55] In 2004 Mahaffey developed a conflict of interest statement and disclosure form for ACFAS which he later encouraged the American Society of Podiatric Executives to adopt.[56]

"In the post-Enron era," the statement began, "it is crucial that not-for-profit organizations keep faith with their stakeholders and the public." It identified two obligations: "duty of care" (the responsibility of using good judgment and management skill) and "duty of loyalty" (the requirement of advancing the member and public interest rather than private goals).[57] In June 2004, the board approved this even tougher conflict of interest disclosure policy and made it mandatory for all staff members, journal editors, and ACFAS volunteers.[58]

The next year, ACFAS put in place another important set of expectations. Too often, malpractice suits had pitted one foot surgeon against another, both serving as expert witnesses. In rare cases, foot surgeons had crossed the line from expert to advocate. As a result, the ACFAS Professional Relations Committee created guidelines for expert witness testimony. In addition, ACFAS requested that any foot and ankle surgeon planning to serve as an expert witness file an Expert Witness Affirmation Statement pledging his or her commitment to evaluate the matter at hand in the context of generally accepted practice at the time and promising to testify only in areas in which he or she had relevant clinical experience.[59] By 2011 more than 1,000 members had completed the statements and committed to the standards.[60]

In 2006 the old code of ethics became the *Principles of Professional Conduct*, revised to cover not only the physician-patient relationship but also to encourage surgeons to act as role models for residents, surgeons in training, and others.[61] A 2013 update included guidelines for navigating the hazards of social media.[62] The next year, ACFAS released the latest in its set of standards of conduct, the *Code of Interaction with Companies*, which mandates that ACFAS should always keep its own programmatic goals separate from those of sponsoring companies and always make company support of programs—however large or small—public.



James L. Thomas (2006-2007)

When it came to raising the bar, however, it was the *Journal of Foot & Ankle Surgery* that now faced the most daunting in a long succession of challenges. For decades, podiatric clinical research had revolved around the case study. Indeed, when ACFAS had served as an accrediting body, membership status had been determined by the number of cases submitted. By the early 2000s, however, most other disciplines had turned away from the case study—which drew lessons from single surgeries—to evidence-based medicine (EBM), which had higher and more clearly definable standards for scientific value. In sharp contrast to the descriptive case study, EBM demanded rigorous randomization, careful control for variables and bias, followed by meticulous statistical evaluation. Five levels of evidence were identified, ranging from the base level of expert opinion to the gold standard of randomized control trials and systematic review of all data.[63]

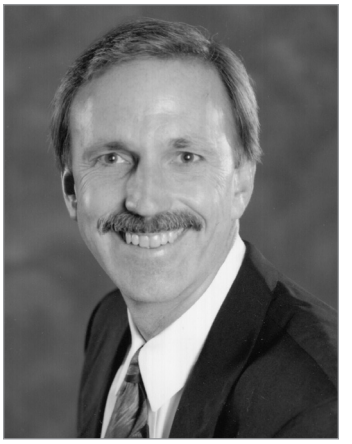
In October, the board's now-routine strategic-thinking discussion revolved around EBM, with president Werber admitting that "the podiatric profession is definitely behind the curve."[64] In pursuit of the longtime goal of acceptance by the medical profession, the board members decided that ACFAS should adopt EBM as quickly as possible, appointing a task force led by then-secretary-treasurer John Stienstra.[65] They realized that this would require a "culture shift" among foot and ankle surgeons, but they wanted ACFAS to lead rather than follow.[66]

In 2006, the year that the journal was expected to transition to EBM, John Schuberth resigned on short notice.[67] A search committee offered D. Scot Malay the interim editorship.[68] Malay was a veteran of E. Dalton McGlamry's residency program at Doctors Hospital in Georgia with an impressive record of clinical research, having earned an MS in clinical epidemiology at the University of Pennsylvania School of Medicine in 2005.[69] Most importantly, he was by nature well-suited to lead the journal into the EBM era. Schuberth relied greatly on his own judgment in evaluating submissions. Malay was dispassionate, systematic, and dedicated to the virtues of peer review. Schuberth's editorials were opinionated and discursive. Malay used his first opportunity to reach foot and ankle clinicians to offer "Some Thoughts about Data Type, Distribution, and Statistical Significance."[70]

D. Scot Malay elevated the *Journal of Foot & Ankle Surgery* to the premier publication of the profession.

Although it was his first year as editor, Malay presided over the rollout of EBM in the journal. Case studies were not excluded (indeed, Malay emphasized that they had their place) but every submission had to identify which level of evidence it could meet.[71] That same year, as part of what Stienstra called a "Johnny Appleseed movement," the College assembled a cadre of EBM experts, sending a delegation of journal section editors and members of the ACFAS Evidence-Based

Medicine/Research Committee to a workshop led by international experts.[72] By one account, they "returned home energized and equipped to begin implementing the precepts and techniques of EBM into ACFAS publications and programs for the benefit of all ACFAS members."[73]



Daniel J. Hatch (2007-2008)

Late in the year, Malay became full-time editor of the journal. At the same time, the board created a larger and more autonomous editorial base, the Council for Journal Management, led by former board member and long-time skills instructor G. "Dock" Dockery.[74] By the 2010s, the disappointing days of the *Journal of Foot & Ankle Surgery* were long gone. In sharp contrast, the journal had become the preeminent publication in the field, ranking high in readership, relevance, and reputation in repeated surveys. By then, the journal was averaging almost two article submissions per day.[75] Many of these submissions were from non-DPMs, and MDs were even serving as section editors.[76]

When it came to continuing medical education (CME), ACFAS focused on raising the bar on two fronts—technology and standards. By the 2000s, the surgical skills courses created during the 1990s had become unshakable pillars of ACFAS educational offerings. As always, sessions rotated among facilities nationwide and the Orthopedic Learning Center (OLC) in Rosemont, Illinois. The challenge was how to make these courses available to more members and to those unable to travel.

In 2013 a group of ACFAS members and outside investors thought they had an answer—buy a building in Chicago and install a wet lab. The board had no institutional memory of the wet lab white whale of the 1990s. Mahaffey had heard about it from Tom Schedler, but he dutifully oversaw a sizeable due diligence study on the subject that the board approved. When the results confirmed that a wet lab promised to be as much of a money-losing proposition in the 2010s as in the 1990s, the plans were again shelved.[77] As before, there was a good lower-cost alternative, a brand new OLC, which opened in 2015.[78] ACFAS also redoubled its commitment to rent wet labs across the country to meet member needs.[79]

But bricks-and-mortar could not solve the problem of bringing training to practitioners who were geographically isolated. More responsive to that requirement was the Distance Learning Initiative undertaken in the summer of 2006. In July, a consulting firm presented a full range of remote learning programs to the board, including elaborate video distance learning technologies and more modest web and DVD offerings. "We decided to take the baby step approach," recalled Mahaffey.[80] Rather than invest in expensive distance learning, ACFAS developed a suite of products aimed at providing CME, practice management, and "privileging management" education online.[81]

The landmarks from that effort included a set of podcasts made available on the website in 2007 featuring noted surgeons discussing various clinical topics. Over the next two years, these generated 50,000 downloads.[82] In early 2008, ACFAS offered a five-CD set on practice management, featuring print-on-demand patient education materials.[83] The same year, videos from annual scientific conferences went online, along with the first installment in a *Surgical Procedures* series, accessible on a members only e-learning portal on the website.[84] The shift to digital also encompassed sessions in practice management and coding instruction,

John M. Giurini (2008-2009)

which retained a full seminar schedule while increasing electronic access through podcasts and videos online and on DVD.

Changes in information technology seemed transformative as late as the 2000s, but in retrospect, far more important were questions about the quality of CME offerings as a whole, and what kind of expectations they would have of foot and ankle surgeons.

In the fall of 2012, the Council on Podiatric Medical Education (CPME) approved changes intended to move podiatric CME closer to that of allopathic and osteopathic physicians. The APMA, more committed to maintaining homogeneity than raising the bar, registered no response.[85] But ACFAS insisted on raising standards higher so that they met or exceeded those of MDs. ACFAS also asked the CPME to provide greater enforcement and discipline, particularly when it came to third-party accreditors who piggybacked on the credentials of another organization. "Frankly," wrote ACFAS president Jordan Grossman in 2013, "this arena needs a 'new sheriff' with vastly more authority."[86]

Naturally the greatest concerns about raising the bar to attain what came to be called "parity" with MDs revolved around the most important course of CME, the residency. Since the days when Earl Kaplan had cut his Civic Hospital residency from one year to six months, foot and ankle surgeons had debated the length and requirements of a standard residency. As late as the 1990s, newly minted DPMs interested in foot and ankle surgery could choose from four or five different options.[87]

By the early 2000s, however, postgraduate training for DPMs as a whole was moving toward a three-year model, with the final year being dedicated to reconstructive foot and ankle surgery. The problem was, by then it already took more than three years to train a foot and ankle surgeon. Nevertheless, when the APMA sought a standard at all, it argued for inclusivity, favoring one model for both generalists and surgical specialists. This created uniformity at the expense of appropriate training, since not all DPMs wished to be foot surgeons and not all foot surgeons wished to practice as generalists. And while many DPMs might gain a full measure of training under the APMA model, foot surgeons would certainly come up short. "As painful as this might be, we must look at our profession objectively," noted president Gary Jolly in 2004. "It is no longer homogeneous."[88] Jolly was skeptical that the APMA would advance standards for surgeons.[89] Instead, he pushed for ACFAS to engage directly with the CPME. "This responsibility is ours and ours alone," he wrote, "and we must be prepared to roll up our sleeves and work with the CPME to develop and enhance surgical education at all levels."[90]

By the fall of 2004, ACFAS and the CPME were working on a strategy for post-residency training.[91] The next year, ACFAS issued a position statement to the effect that foot and ankle surgeons should have, at a minimum, three years of postgraduate training.[92] As Jolly stepped down in 2005, he warned ACFAS members that they must "continuously push the envelope" on postgraduate training "if true professional parity is to be achieved."[93]

In the spring of 2007, the APMA launched Vision 2015, its own effort to establish "full professional parity" based on "equivalency" over the next eight years. In essence, the APMA was, for the first time, undertaking an effort to "mirror medicine"—the same effort ACFAS

had embarked on with mixed success years before. The APMA offered ACFAS one seat on its Vision 2015 task force.[94]

The ACFAS board chose parity as the subject of its 2007 summer retreat. It also formed a Project Parity Task Force to work directly with the APMA.[95] "Parity" remained a watchword in 2008. At the annual scientific conference, incoming president John Giurini pointed out that the curriculum at podiatric medical schools was now equivalent to the curriculum at MD medical schools. He also anticipated that residency would soon be fixed at a minimum of three years (this was accomplished in 2010). "Contrary to our detractors' opinions," said Giurini, "we are much closer to this goal than they wish to admit."[96]

In truth, parity did not come as quickly or as easily as anticipated. There was still distance to travel before accrediting institutions set the bar higher for foot and ankle surgeons than for allopathic physicians, and more still until full recognition and parity between the professions was achieved in spirit, let alone in practice.

In acknowledgment that it had to take primary responsibility for raising the standards for foot and ankle surgery, in 2009 the College began developing its Recognized Fellowship Program. There were then a number of surgical postgraduate fellowships nationwide but no coordination between them, no common yardstick. ACFAS filled this void by developing a set of requirements that residencies had to meet in order to gain full recognition. In 2010 the first list of recognized postgraduate fellowships was posted, with more following the next year. In 2012 a full package of support was introduced, including lower dues for fellows, reduced fees, and certificates for the programs. By 2016, those completing a surgical residency and committed to continuing their training—and doing their part to push the profession farther toward parity—could go to the ACFAS website, choose from nearly 30 ACFAS Recognized Fellowship Programs, and be confident that each met or exceeded a minimal set of standards.[97]

The push for parity had two short-term effects. On one hand it strengthened the ACFAS commitment to becoming primarily an educational association. In reference to parity, president Dan Hatch wrote in 2007, "Our vision is to serve society as the preeminent source of knowledge for foot and ankle surgery."[98] On the other hand, because the APMA was content with a maximum three-year residency and ACFAS insisted on a minimum three-year residency, the quest for parity helped drive yet another wedge into the ever-growing split between the two organizations.

The Road to Rights and Recognition

Even as the gap between ACFAS and the APMA appeared to be widening, differences between state scope of practice laws appeared to be narrowing. But predictably, as more states began to recognize the foot and ankle surgeon's legitimate sphere, opposition by allopathic physicians mounted, leading to tough fights at the state level. Although the road to rights and recognition was rocky going into the 2010s, ACFAS laid foundations for the future, institutionalizing the credentialing and privileging efforts formerly carried out by a handful of individuals.

Mary E. Crawford (2009-2010)

Among the new waysides on the road to recognition were ambulatory surgery clinics. First pioneered in the 1970s, ambulatory surgery clinics became popular during the 1980s due not only to their convenience for patients but also for their ability to control costs. In terms of volume, outpatient operations overtook hospital procedures in the late 1980s and doubled by the mid-2000s.[99] Early in the decade, the members of the ACFAS Professional Relations Committee worked with the American Association of Ambulatory Surgery Facilities (AAASF) to open this booming sector to foot and ankle surgeons. In November 2004 they succeeded—the AAASF permitted accreditation of facilities that included a foot and ankle surgeon on staff.[100]

At mid-decade things looked promising. Foot and ankle surgeons were increasingly recognized as subspecialists in the broader medical world. They were practicing at some of the best academic hospitals in the country, podiatric medical colleges were being integrated into the mainstream, and ACFAS fellows were leaders at some of the nation's most prestigious hospitals.[101]

Still, there was a big task remaining: to bring consistency to the patchwork of state laws governing foot and ankle surgery. Every state had a scope of practice act that set boundaries around the work of medical professionals, and as of 2005, every state podiatry act was different. That year, the Professional Relations Committee developed model legislation to amend state podiatric scope of practice acts. The ACFAS board urged members to take the issue, and the model law, to their state legislatures.[102]

The variability in scope of practice acts nationwide was a potential weak spot—with no generally accepted standard, states would be particularly vulnerable to pressure, so uniformity was an objective for its own sake. But ACFAS had no intention of fighting in 50 arenas to obtain uniformity. In 2005 there were a few specific states that ACFAS particularly needed to reach: the 12 that did not include ankle surgery in their scope of practice. Only a year later that number was down to nine, with Connecticut one of the holdouts.

The resistance there, as elsewhere, was from orthopedic surgeons and the AMA. Weighing in for the profession was the president of the ABPS, who reminded state legislators that when it came to training in foot and ankle surgery, "the requirements for podiatric surgeons far exceed those of orthopedic surgeons."[103] Gary Jolly put it more bluntly: "Orthopedic surgeons argue that their concern is for the public safety, but the reality is that they fear having to compete in an open market with better-trained podiatric foot and ankle surgeons."[104]

Michael S. Lee (2010-2011)

In the fall of 2007, Connecticut allowed "independent ankle surgery" by surgeons who had graduated from a three-year residency program after June 1, 2006, while restricting others to operating only under supervision of an allopathic physician. At about the same time, Illinois expanded its podiatric medical practice act to include certain amputations and moderate and deep sedation. Louisiana's scope of practice law was also expanded to include the ankle and lower leg.[105] The next year, three states were considering bills that would remove discrepancies in insurance reimbursement between podiatric and orthopedic surgery.[106]

The opposition could hardly be expected to stand down as foot and ankle surgeons moved ahead. The year 2008 began with the publication, as part of an AMA "Scope of Practice Partnership Project," of a series of documents unfairly characterizing podiatric medicine and surgery. These were soon withdrawn, but the intent behind them persisted. Later in the year, in only the worst instance in a nationwide trend, the University of Utah Medical School moved its division of podiatry from the Department of Surgery to the Department of Orthopedics, and its chairman terminated the academic appointments of all podiatrists on staff.[107]

Glenn M. Weinraub (2011-2012)

Meanwhile, in New York, California, Texas, and Florida, state podiatric medical associations battled state medical associations and orthopedic societies over attempts to limit scope of practice. The struggle in each state, according to Harold Vogler, was a "surrogate fight for the national organizations."[108] Texas was notable because for years its State Board of Podiatric Medical Examiners had interpreted the law to mean that the foot includes the ankle. When it codified that definition in a 2001 rule, orthopedic surgeons, in an effort to exclude the ankle from the scope of podiatric surgery, argued that the interpretation amounted to an expansion of scope and moved to have text related to the ankle struck from the Texas code. In 2002, facing tough opposition—and volumes of outdated and misleading characterizations of podiatric surgery—Texas podiatrists requested support. ACFAS provided expert testimony, solid statistics, and other information for the Texas fight. ACFAS also began developing policies for handling subsequent conflicts elsewhere and the Professional Relations Committee began drafting a new position paper, released in 2008. The Texas Podiatric Medical Association prevailed in trial but lost on appeal, and in 2010 the Texas Supreme Court refused to hear the case. Accordingly, the legal scope of practice in Texas still includes the ankle because the "foot," consistent with the appellate court's decision, is that part of the body at or below the ankle.[109]

The eventual settlement followed the model that had already succeeded in Connecticut and would later prevail in New York and Kansas: allowing ABPS board-certified podiatric surgeons to practice unrestricted, but setting limits on all others. Unfortunately, this "half a loaf" approach further split the podiatric profession at large as it placed emphasis on the advanced training and board certification promoted by ACFAS at the expense of the APMA's generalist orientation.[110]

Harold Vogler was particularly chagrined when, in 2006, friends of the Florida Medical Association and the Florida Orthopedic Society introduced a bill to roll back a scope of practice law in place since the 1930s. "They assaulted us in Florida because we had one of the best laws in the country," said Vogler. The chief area of sensitivity, according to Vogler, was that the 1933 law contained the word "leg," a joint too far for territorial allopathic physicians.[111] After a three-year fight, the forces for podiatric surgery prevailed, largely on grounds that advocates of the new law could show no harm caused by the old one and that states could not cut back a surgeon's privileges without a fair hearing.[112]

These skirmishes continued into the 2010s. In 2011 the Kentucky Medical Association embarked on a crass public relations campaign attempting to keep patients away from non-

MD practitioners. That July, ACFAS instituted a "Truth in Advertising" campaign providing specific guidance to help members counter such negative and misleading portrayals.[113]

In retrospect, these efforts may represent nothing more than the retreat of the opposition to the last ditch. By 2015 only four states—Alabama, Mississippi, South Carolina, and Massachusetts—did not allow podiatric surgeons to practice on the rearfoot.[114] And the gains were not only in podiatry. Across the country, non-MD licensed health care professionals were battering the AMA's decades-old barriers. As one of 38 member organizations of the Coalition for Patient Rights, a group representing licensed health care professionals, ACFAS was part of that broader movement as well.[115] In 2012, ACFAS president Michelle Butterworth was ready for a new strategy. "Let's call it what it is: We are in an economic turf war—and always have been," she said. Butterworth's pessimism was understandable. She had spent much of her career fighting to no avail in South Carolina, but her terminology suggested that ACFAS and its allies represented the future rather than the AMA, which was still clinging to its "19th century vision of MDs being the only medical providers on the planet."[116]

But ACFAS was not going to win recognition entirely in the statehouses. For every one of these high-stakes surrogate fights, there were many individuals still fighting for rights and recognition in their local hospital or outpatient facilities. Throughout this period, help with discrimination in credentialing and privileging remained the most frequent request from members.[117]

Vogler's emphasis on meticulous attention to documentation and due process indicated, however, that in all of these individual fights, it was context that made the difference. ACFAS had fundamentally shifted that context in 2000 when it obtained the draft clarification from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that allowed foot and ankle surgeons to conduct history and physicals (H&Ps) in hospitals and, in a 2002 extension, in ambulatory facilities.

Despite these accomplishments, a problem remained. Medicare still explicitly required an allopathic or osteopathic physician to conduct the H&P. Although it was a violation of JCAHO rules, this policy was not likely to be reversed without intervention. In early 2003 the ACFAS Professional Relations Committee decided to take on the task.[118]

Michelle L. Butterworth (2012-2013)

Its efforts paid off within two years when the Center for Medicare and Medicaid Services (CMS) proposed a language change allowing a "qualified individual who has been granted these privileges by the medical staff in accordance with state law" to conduct an H&P. ACFAS president John Stienstra called this "a threshold event," stating, "It resolves the confusion. It codifies what is fundamental to practice: independent assessment of each patient with regard to health and risk status."[119] The change became effective January 2007.[120]

Because of its centrality to the admission process, the H&P was the keystone of the broader credentialing and privileging process. But any one of scores of particular rules, restrictions, and issues of qualification could come into play in a credentialing and privileging controversy. The Professional Relations Committee, therefore, spent a great deal of time creating documentation, precedent that individual surgeons and their advocates could use in specific cases.

In 2007 the committee drafted a protocol that codified the approach: "Equality of treatment should be the central theme of all negotiations."[121] The next year, the committee produced a background paper, *Education, Training and Certification of ACFAS Podiatric Foot and Ankle Surgeons*, a document that demonstrated incontrovertibly that board-certified podiatric surgeons had far more training in foot and ankle surgery than orthopedic surgeons, who may have spent 5 percent of their training, at best, focusing on the foot.[122] In 2009 the board approved a one-page "privileging statement" summarizing all the relevant JCAHO and CMS standards and statements promulgated since 2000.[123] At the same time, a "Privileging Toolkit," which contained documentation and a guide for its use, went up on the ACFAS website.[124]

Jordan P. Grossman (2013-2014)

Much of this documentation was obsolete almost as soon as it was created, however, as the JCAHO shifted to "core privileging." In the early 20th century, hospital privileging was general. As specialization grew in the 1950s, the American College of Surgeons recommended carefully delineating privileges. The result was the so-called laundry list approach that podiatric foot and ankle surgeons learned to adopt. But as technology revolutionized medicine, the laundry lists lengthened to the point that they confused more than clarified.

Moreover, it had been clear for years that this was not how doctors or hospital administrators thought about privileging. They assumed that any licensed and certified medical professional should be able to handle most items in a certain category on the laundry list. Particularly complex procedures, on the other hand, clearly required certain specific types of additional training and experience.[125]

By 2010 these categories had been established, reducing scores of laundry list items to a handful of core privileges. Michael Lee had been watching this development, and while he was still president-elect persuaded the board to create a special task force to bring ACFAS practice in line with the new approach. The task force carefully reviewed documentation from a variety of medical specialties to produce two core categories: foot and ankle; and complex rearfoot, ankle, and related lower extremity structures.[126] By August 2010 Lee was president and the ACFAS core privileges were posted online, where they had become the ACFAS documents most in demand, not only by members but also by hospitals and ambulatory centers.[127] The JCAHO recognized the value of the effort by including these core privileges in its *Medical Staff Handbook* published in 2011.[128] As with the earlier H&P achievements, ACFAS leaders saw core privileging as preliminary to full recognition. "It may serve as a key stepping stone to a national scope of practice act," said Lee.[129]

The 2010 work on core privileges was the capstone of a lifetime of volunteer service by Harold Vogler, who was honored that year with the seventh annual ACFAS Distinguished Service Award recognizing exceptional contributions by ACFAS volunteers.[130] Late that year, Vogler suggested creating a team to take up the work that he had done almost single-handedly for so long.[131] In 2012 the ACFAS board created the Credentialing and Privileging Advisors Team (CPAT) to give advice and counsel to members facing privileging roadblocks. The group met for the first time in Orlando, Florida, where Vogler began working with a cadre of about a dozen experienced members. "The old are training the new in so-called due process," said Vogler.[132]

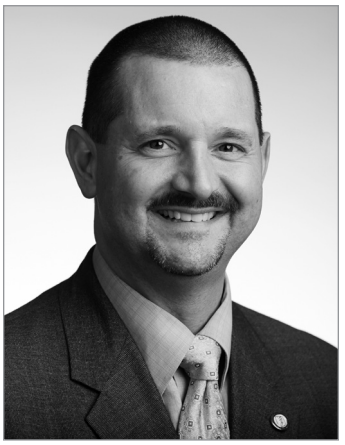
The Old and the New

If there is a theme that runs through the most recent years of ACFAS, it is that of making the most of the old and seeking the best in the new. Some long-standing efforts continue to patiently unfold, one earlier initiative has been reinvigorated and revolutionized, and the College has finally gained sufficient perspective on its past—and confidence in its future—to secure complete organizational independence.

The ACFAS scoring scale project is a good example of enduring effort. The work began in 1998 when John Schuberth and Lowell Scott Weil Sr. became determined to standardize the process for documenting surgical procedures. A structured series of subjective questions and objective data—a systematic way to determine efficacy, judge progress, and compare results—was needed. There were a number of such scoring scales in existence, but they all had limitations. ACFAS therefore launched its Universal Evaluation System Project, with a task force that worked out a 100-point scoring system within a year.[133]

It was one thing to create a system; it was another to ensure that it could be objectively validated, and the former was far easier than the latter. The ACFAS scoring scale remained in question for a decade, until a new task force led by Thomas Roukis undertook the challenge of updating it in light of evidence-based medicine and then validating it.[134] After the additional work and validation, the ACFAS scoring scale was independently tested and then published in the *Journal of Foot & Ankle Surgery*.[135] It was not considered "complete," however; the expectation was that the scoring scale would be a work in progress that members used and improved.

Clinical Consensus Statements had an even longer history and experienced a more profound transformation. Pioneered in the 1980s and early 1990s as Preferred Practice Guidelines, they had been instrumental indicators used by practitioners, insurance companies, and accreditation bodies to help delineate the sphere of activity of the podiatric surgeon. In revised and abbreviated form, they became known in the 1990s as Clinical Practice Guidelines, with new ones being introduced and published in the journal on a regular basis, along with corresponding treatment algorithms. In 2006 the ACFAS Clinical Practice Guidelines were posted on the federal government's National Guidelines Clearinghouse website. By 2010 the guidelines were being updated on a continuing basis, an effort directed by an ACFAS Clinical Practice Guidelines Council.[136]



Thomas S. Roukis (2014-2015)

In 2006 president James Thomas called the Clinical Practice Guidelines "the most comprehensive and effective guidelines available regarding foot and ankle surgery." But within a few years, relentless transformation in health care standards brought more change.[137] In 2011, the national Clinical Practice Guideline criteria were revised to have a strong evidentiary basis that the ACFAS guidelines lacked. Accordingly, the shorter, slightly less evidence based, and more user-friendly ACFAS guidelines were renamed "Clinical Consensus Statements," and the Clinical Practice Guidelines were retired.[138] The most recent phase in this enduring initiative was concluded in 2015, when two new Clinical Consensus Statements were completed and published in the journal.[139]

Another transformed legacy of the past was the regional division structure. Since their establishment during the 1950s the divisions had turned in an uneven and often disappointing performance. There were three chief weaknesses. First, established ACFAS members tended to interact with their organization on a national, rather than a divisional level. Second, as the 14 regional divisions developed organically over the years, they became uneven in size and therefore representation. Third, the divisions suffered from a "neither fish nor fowl" problem—there were always questions about how autonomous they were. In the 1980s the board sought to strengthen the divisions by creating the House of Councilors (HOC) but confusion followed. It was originally intended to provide grassroots feedback to the board, but before long the HOC's mission had shifted to supporting College initiatives at the national level.[140] It was perplexing but perhaps not a surprise when surveys indicated that most members knew little about the divisions and nothing about the HOC.[141]

When he became chairman of the House of Councilors in 2002, Dan Hatch determined to change all of that. He shifted the focus of the HOC to education, particularly education of younger ACFAS members. There was a good reason for this: established foot and ankle surgeons might have the time and finances required to attend national events, but those starting out on a shoestring did not. The HOC, therefore, began developing and strengthening educational programs specifically directed at student chapter members, residents, and beginning practitioners. For years the board had considered doing away with the HOC, but in 2003 it dropped the idea and gave full support to the new educational mission.[142]

Jerry Noll took over as HOC chair in 2004 determined to strengthen the divisions to better carry on this mission. He developed new policies and procedures, set higher standards for financial accountability, and raised expectations for division leadership. Under his watch, the board renamed the HOC the Division Presidents Council. Perhaps most importantly, like Hatch, Noll emphasized that although the divisions were expected to support the ACFAS mission, they had the right and responsibility to determine their own affairs.[143]

Jerry Noll, along with Dan Hatch, strengthened the divisions and reinvigorated the House of Councilors, renamed the Division Presidents Council.

This turned out to be the correct mix of autonomy and expectations. During the 2000s both the divisions and the Division Presidents Council became increasingly effective. By 2006 the divisions had carried out some 30 educational projects. By the late 2000s the list included local surgical scientific events, "sawbones workshops," funding for poster exhibits, and even scholarships enabling young members to attend the annual scientific conference. The members took a final step toward bringing the best out of the divisions in April 2016 when they supported

bylaws revisions changing the "divisions" to "regions" and allowing the board to determine new geographic boundaries to ensure equity in size and revenues.[144]

This new regional emphasis on youth education dovetailed perfectly with a renaissance of ACFAS student initiatives. The historical roots go back to the student chapter effort of the 1970s. But by the late 1980s, nearly all of these had folded. There were few traces left when ACFAS again came to the realization that students represented its future. Efforts to encourage surgeons-in-training had never entirely died out. In the early 2000s, ACFAS offered student summer research grants.[145] Then the divisional efforts—which included direct support and regular visits to the clubs—began to take effect. In 2007, with president Mary Crawford as chief advocate, the College at large began to help sponsor these initiatives, with each board member volunteering to serve as "ACFAS liaison," to surgery clubs at the eight podiatry schools (nine after the Western University of Health Sciences School of Podiatric Medicine opened in Pomona, California, in 2009).[146]

These student clubs offered first- and second-year students their earliest opportunity to gain hands-on experience in surgery labs. They provided guidance to members producing posters for the first time and held unusual yet inspiring events, such as "suture off" contests.[147] The ACFAS liaisons generally attended at least one club meeting per year, while a faculty advisor provided more direct mentoring. According to the students themselves, the chief appeals of the clubs were access to hands-on experience and the ability to network with future colleagues. ACFAS Membership Committee chairman Eric Barp, himself a recent club member, noted that "if those relationships are built early enough, they can be life-long."[148]

By the 2010s ACFAS Student Clubs were booming nationwide. Here, officer Glenn Weinraub presents a club grant check to a Student Club member at the Western University of Health Sciences School of Podiatric medicine.

Why did the new student clubs thrive where the early student chapters failed? In the absence of board certification, the early ACFS culture revolved around skill as defined by mid-career tenure and experience more than early-career education and training. In essence, during the organization's first thirty years, when it alone had been the gatekeeper and protector of skills, ACFAS had developed a culture of exclusivity. Even after the shift to board certification, it took decades for that culture to change, but by the 2000s it most definitely had. In its programs, communications, and especially in the pages of the *Update*, ACFAS was anything but an old boys' club. It actually more closely resembled a young person's organization.

Beginning in the fall 2008 academic term, the College provided students with inexpensive access to its publications through a student "e-access" subscription.[149]

Along with that came discount pricing for attendance at seminars and conferences and purchase of DVDs and other training materials.[150] That same academic year, ACFAS provided free attendance at its annual scientific conference to a select group of ten outstanding students.[151] At the same time, the College introduced a graduated dues structure to benefit young members.[152] Starting in 2009, ACFAS offered complimentary membership to first-year residents, and three years later it issued its first *Student and Resident Update*, a quarterly publication with specific information to help beginning foot and ankle surgeons start up the career ladder.[153] An ACFAS Job Fair held in partnership with PodiatryCareers.org at the 2014 Annual Scientific Conference even helped them find the first rung.[154] By then the *Update* was as likely to include news and features appealing to young and beginning foot and ankle surgeons as it was to cover issues of interest to established practitioners. ACFAS was truly investing in its future.[155]

Richard M. Derner (2015-2016)

This reorientation came at an opportune time, for in the early 2010s there was doubt as to whether student members would even be able to embark on a career—the profession was in the midst of a residency crisis. The mismatch between academic enrollment and opportunities for clinical training was in some respects cyclical. In the 1980s podiatry school graduates had well outnumbered residency slots. By 2001 the situation was reversed, with only 537 graduates to fill 798 residency positions.[156] The cause of the residency crisis that began early in 2010 was no secret. Residencies had been moving slowly from a two-year to a three-year standard throughout the 2000s. After the CPME officially adopted the three-year standard effective in 2010, the majority of the residency programs shifted over, resulting, not surprisingly, in a residency deficit of about one-third.[157]

It was not a problem of demand. Market surveys confirmed that there were ample opportunities for podiatric surgeons. This made finding a quick solution to the problem imperative, because if the supply of foot and ankle surgeons was insufficient to meet demand, the profession as a whole could lose ground to orthopedic surgeons moving in to fill the void. But this was a problem that the College could not do a great deal about.[158] ACFAS did use the bully pulpit early and often, asking every member in position to do so to extend existing residency programs and to start new ones, and urging the rest to support ongoing efforts by the American Association of Colleges of Podiatric Medicine (AACPM).[159] ACFAS created a Post Graduate Affairs Task Force in 2013, and its board members served on the AACPM Residency Balance Committee.[160] As of early 2013, that group had identified 140 potential new slots. Nevertheless, 104 graduates were left without a residency that year.[161]

There were two obvious solutions to the problem: return the residency to two years, or lower requirements for residency programs. ACFAS emphatically rejected both of these options; the residency crisis could not be solved by lowering the bar for podiatric foot surgeons after ACFAS had pushed so long to have it raised.[162] Although the AACPM did lower case requirements in 2014, by then the residency crisis was easing.[163] And while ACFAS had played mostly a supporting role, it was intent on remaining engaged by transitioning the

Sean T. Grambart (2016-2017)

Post Graduate Affairs Task Force into a permanent committee, putting a residency director center online, and hosting residency directors' forums in 2015 and 2016.[164] The residency crisis had been acute but blessedly brief. As it unfolded, ACFAS was recovering from a more chronic condition, precipitated by years of conflict, compromise, and disappointment with the APMA.

The 2004 APMA House of Delegates action threatening the College with expulsion if it did not give up its existential imperatives was still fresh in the minds of ACFAS board members when they met at the annual summer retreat in Santa Fe, New Mexico, in July 2005. The mission then was to work with staff and legal counsel to update ACFAS governing documents to bring them into conformity with current standards and legal requirements.[165] But the retreat also provided the College with the opportunity to revise the rules pertaining to membership which had earlier precluded ACFAS from dropping the requirement that members belong to both ACFAS and the APMA if a majority of members were against the change.

The key modification was to move requirements for membership renewal from the bylaws, which could be changed only by membership vote, to policy, which could be changed by the board.[166] This provided the board with the unilateral ability to drop membership in the APMA as a requirement for renewal of ACFAS membership—giving it an "exit strategy" that it could exercise when necessary.[167] The requirement of APMA membership when first joining ACFAS, however, remained in the bylaws. This distinction gave the APMA one last benefit of the doubt. As an administrative memo later put it, "All ACFAS new member applicants would be required to join APMA. It would then be APMA's job to prove its value thereafter."[168] Approved by the board in November 2005 and submitted to the membership late in the year, the new bylaws were approved overwhelmingly and went into effect in March 2006.

For more than two years after the Santa Fe retreat, ACFAS leadership sat on the exit strategy and wondered if it would ever be exercised. Everyone recalled the resolution to disaffiliate of 1999, the educational campaign of 2000, and then the decision to make one last attempt at conciliation. "We were close to backtracking on that at one point," said James Thomas, president in 2006. He recalled insisting that "we are going to do this or we are not going to do this but it's not going to be a compromise thing again."[170]

By 2007 the APMA's continued attempts to promote podiatric unity at the expense of professional expertise, particularly as presented in its Vision 2015 initiative, had persuaded a majority of board members to agree with Thomas.[171] That summer, president Dan Hatch brought up the exit strategy. It went on the agenda for a full day's discussion in October.[172] In the meantime, the ACFAS leadership took the temperature of the membership. There was still significant opposition, but highly influential veterans and past presidents such as Lowell Scott Weil Sr. supported the move, and that made a difference.[173] As always, there was concern that a sizeable number of those in opposition might resign. But the membership loss following the dues assessment had been low, and ACFAS had since proven its value to its members; it was time for the APMA to prove its value as well.[174] The board voted to exercise the exit strategy.

The move was announced in late November, 2007. Believing that the constellation of issues and events driving the split was too complex for a compelling and concise explanation, the board couched the issue simply—in terms of freedom of choice.[175] Those who supported the ACFAS board's position did so passively. Those who expressed loyalty to the APMA did so vociferously.[176] The timing of the move was unfortunate, because it provided ample opportunity for opponents to join forces. At a New York podiatric conference in January, petitions began circulating.[177] Arguments pro and con drowned out the science at the 2008 annual scientific meeting. Most disturbingly, there was a move within the ACFAS Division Presidents Council to mount concerted opposition.[178] The board acted quickly and assertively to get in front of the issue. On February 20, 2008 the board approved holding a referendum on the question, using the terms employed in the petitions.[179] The referendum went to the members in March, with a voting deadline of April 2.[180]

Both sides were worried about membership loss. Naysayers warned that the College could lose 30 to 50 percent of its members.[181] A staff study suggested something between 3 and 7 percent.[182] By this time, ACFAS accounted for about 50 percent of APMA membership, so if a sizeable number sided with the surgeons, the APMA could be devastated. The APMA launched its own counter campaign.[183] Skeptics appeared to buy the well-worn argument that the podiatric profession was too small to have more than one leading organization. One predicted that ACFAS "will do just fine until a real crisis comes. The real crisis will be when that other non-podiatric foot and ankle club decides to encourage states to limit our scope of practice. When they see our house divided, they will see their opportunity."[184]

A large percentage of ACFAS members took the time to help determine the future of their organization—66 percent of the total voted, with 53 percent supporting "choice" and 47 percent opposed. President John Giurini noted that the vote "confirms what our members have been saying for several years—members want a choice of professional memberships."[185] The vote confirmed choice, but because a two-thirds majority was required to change the bylaws, it did not affect ACFAS policy or governance. ACFAS pledged to honor its standing policy of not requiring APMA membership for renewing members. It also pledged itself to "creating a new relationship" with the APMA.[186]

The APMA's idea of a new relationship was none at all. Less than a week after the results came in, the House of Delegates voted to withhold recognition of ACFAS as a specialty affiliate organization and threatened to recognize a new surgical specialty organization.[187] It considered conferring the status on an outside group but characteristically opted for something homegrown. In late 2008, the APMA created the American Society of Podiatric Surgeons (ASPS)—that group faced a tough uphill fight in prying surgeons loose from ACFAS.[188]

Three paths existed in the aftermath of the referendum. One was to resolve the issue once and for all by removing the APMA requirement for admission to the College—but that still required another vote, and everyone knew what the result would be.[189] Another was for the

Laurence G. Rubin (2017-2018)

two organizations to truly develop that "new relationship." In 2009, ACFAS member and California Podiatric Medical Association president Steven Wan, who was leading an effort to reconcile podiatric surgeons with orthopedic surgeons in California, attempted to bring the parties to the table. His suggestion was that the two groups split the duties for podiatry, with ACFAS being responsible for education. ACFAS president Mary Crawford agreed repeatedly to discuss this option with the APMA—so long as there were no preconditions. The offer was never accepted.[190]

The third path was the one of letting time heal, taking ACFAS through the controversy and into a new future for podiatry and foot and ankle surgery. Known as the Crawford Doctrine for the president who first implemented it, this approach had time on its side. It was telling that a 2009 member survey, for example, revealed that ACFAS members were increasingly identifying themselves as surgeons rather than podiatrists—particularly the younger ones.[191]

Chris Mahaffey had predicted that ACFAS would lose from three to seven percent of its members.[192] A year after the referendum, the loss stood at 2.7 percent. Then, as the ASPS started to splinter, members began to return.[193] ACFAS continued to grow, with membership reaching 6,300 in 2010 and exceeding 7,200 five years later.[194] Despite the sizeable turnout for the referendum, in ACFAS as elsewhere, only a small percentage of members ever cared about association politics. That membership growth meant that by 2015 there was another nine percent of the membership with no memory of the troubles of 2007 and 2008.

In September 2015, the Division Presidents Council, which had previously opposed changing the dual membership requirement in any way, recommended to the board that it resolve the controversy by removing it entirely. In late April 2016, the board put a new set of bylaws amendments before the members for a vote. Among them was provision for "aligning new and renewing membership requirements," namely eliminating the APMA membership requirement for new members.[195] In sharp contrast to 2008, there was no uproar, no petitioning—no one cared.[196] Instead 93 percent of the members approved the package of amendments.

The members may have reacted and voted silently, but their decision reverberated with nearly 75 years of history, validating the efforts of generations of ACFAS officers and volunteers who had shared Lester Walsh's insistence on "true professional status." At the 2009 annual scientific conference, Gary Jolly took a few moments to reflect, the fight with cancer that would take his life early the next year written on his face. Jolly pronounced himself proud that foot and ankle surgery had become a recognized medical subspecialty. "Although there may be pockets of resistance," he said, "hospitals and clinics, including orthopedic practices, are now open to us." Nevertheless, he cautioned that there remained those "who would prefer to restrain us in order to create a more homogeneous profession. Should we roll back our education and experience to achieve their goals?"[197] In April 2016, ACFAS answered a resounding no.

The Compass

Founder Douglas Mowbray had expected every succeeding group of leaders to be as committed to cutting-edge research and rigorous accreditation as he had been. He was

among the first to be deeply disappointed when the College, as it sometimes did, got diverted. The hard truth is that throughout most of its history, at any given moment the ACFAS agenda tacked with the prevailing winds, be they internal constraints, external circumstances, or the temporary enthusiasms of the man in charge. Sometimes, from all the reversals of course, ACFAS lost its way entirely.

But by the mid-2000s, for the first time in its history, ACFAS had developed a strategic plan consisting of six concrete and overarching priorities, in order: promote the specialty to patients, provide superior education, advance scientific and clinical research, improve practice management and conduct public advocacy, enhance use of technology, and employ strategic governance and best management practices.[198] More than ten years later, ACFAS still has a list of six strategic priorities. Today education has been placed before promoting the specialty, use of technology has been removed (nearly everyone was overly impressed by technology in the mid-2000s), and practice management and public advocacy have been divided into two separate items. With these minor differences, the plan remains the same.

History is the study of continuity and change. Usually the change makes the best story, but sometimes the continuity is most instructive. By the mid-2000s, something in ACFAS had changed. By the mid-2010s, those changes had proven their ability to endure. The weather, both within and outside of the organization has been no better; some might even say it has been worse. But by the mid-2000s, it had been a long time since ACFAS was diverted by pet projects or untested assumptions. In a readiness to listen to its members and act accordingly, and in a willingness to subordinate personal imperatives to the good of the organization, ACFAS has found its bearings. It is no surprise that the strategic plan of 2006 became the strategic compass of 2016.

With the orientation of the strategic compass remaining straight and true over the last decade, ACFAS has passed from one landmark to another. One of those landmarks was when "the man in charge" gave way entirely. In March 2009, Mary Crawford became first female president of the College.[199] Michelle Butterworth became the second in 2012. Their elevation is a testament to the fact that as the membership has nearly doubled since 2003, there has been an exponential increase in women, minorities, and young people.[200] Ann Rotramel, the College's first female member, would likely have been pleased that when ACFAS all-time membership reached the 10,000 mark, it was Stephanie Eldridge who put it over.[201]

Although strategic discipline and diversity may strengthen the College, the larger goal has always been to further foot and ankle surgery for the benefit of the patient. Few things will bring this about as effectively as convergence between professions that have spent too long apart. In 2011 there were 6,300 foot and ankle surgeons who were members of ACFAS. At the same time, there were 1,800 foot and ankle surgeons who were members of the American Orthopedic Foot and Ankle Society.[202] In the past, history and chance drew lines between these two sets of practitioners. But increasingly, the passage of time and the desire to serve patients have brought members of both groups together in practices and medical centers across the country. And despite what Gary Jolly called "pockets of resistance," history tells us that if the two groups can learn to work together, they will eventually learn to live together. Today ACFAS has made doing both a priority. As one MD conceded in 2012, podiatric surgeons had "become experts in the field to the point that it is ludicrous to argue that their qualifications do not allow them to cover a wide territory."[203]

Today, following its strategic compass, ACFAS is more capable of affecting change than ever before. But as the College has recognized through its Distinguished Service Award, individual commitment can sometimes make the most difference. Ask Stephen Wan. When it comes to convergence, few have accomplished more. He may have failed to bring ACFAS and the APMA to the table, but to date his efforts have done much to further a California joint licensure initiative that may set a national pattern for bringing about parity between MDs, DOs, and DPMs nationwide.[204] Ask Harold Vogler, comfortably in retirement in July 2014 when his last letter-writing campaign paid off and the American Board of Podiatric Surgery became the American Board of Foot and Ankle Surgery.

Ask Marc Kravette, the former Division Presidents Council chair who spent the better part of his career working for the good of the profession. He recently noted that "The College has grown from a handful of forward-thinking leaders in their field to become the premier organization in education, training and research for today's foot and ankle surgeons."[205] What sounds like a casual characterization is actually an incisive observation. In its early years, the American College of Foot Surgeons was a confederation of exceptionally strong, unusually ambitious, and highly individualistic men. They had made their way to the top of their chosen field largely alone and in the face of tremendous opposition. Used to dominating the room, they could form an organization on paper, but they often had difficulty yielding for the greater good.

Thanks to them, every member of today's generation of foot and ankle surgeons has had an easier time of it. Dedication and hard work are still required, but today's foot and ankle surgeons can all take for granted the structures painstakingly created by their predecessors. And although it may not seem like it at times, resistance has also waned. As a result, today's ACFAS is far better able to cooperate, compromise, and above all, listen—just the qualities required to keep the College on course in the future. Before president Richard Derner took office in 2015, he was repeatedly asked what his agenda was going to be. He countered unhesitatingly, "It's not 'my agenda;' it's the College's agenda."[206] Douglas Mowbray would have approved.

Appendices

Original Constitution and Bylaws (1942)*

CONSTITUTION

Article I. Name

This organization shall be called the American College of Foot Surgeons, Inc.

Article II. Objects

This society is organized not for profit. Its objects are:

(1) To foster a bond of fellowship among chiropodists who specialize in foot surgery. Foot surgery as accepted by this organization means an operation beneath the dermis of the foot which may include either soft tissue or bone tissue surgery, wherein an anesthetic, local or general, is required, and standard sterile technique is employed.
(2) To bring to practitioners and students a realization of the results that can be obtained by foot surgery.
(3) To teach complete or standardized techniques which have been developed for surgical intervention in foot conditions.
(4) To constantly strive to develop additional techniques.
(5) To be a protective agency for the public and the profession.

Article III. Membership

Section 1. Qualification for two types of membership-Fellowship and Associateship.

(1) The candidate must be a practicing chiropodist.
(2) The candidate must be a member of his state society and the National Association of Chiropodists.
(3) The candidate must be a graduate of a chiropody college recognized by the National Association of Chiropodists and acceptable to the American College of Foot Surgeons, and must be licensed to practice in his respective state, province or country, or engaged in the Armed Services of the United States.
(4) All candidates must submit to the Credentials Board their qualifications and case histories sixty days prior to the annual meeting of the American College of Foot Surgeons, which must be accompanied by an application fee of five dollars ($5), which will be applied to the membership fee.
(5) At the annual meeting of the College one day will be set aside to the examination of candidates who desire affiliation.

*This earliest known version of the constitution was published in the *Journal of the National Association of Chiropodists* 32, no. 7, 38-40 and no. 9, 13.

Section 2. Qualifications for Fellowship.

The candidate is required to submit 75 case records of surgical work, 50 case records in complete detail, 25 of which are to be made up of soft tissue surgery and 25 of bone tissue surgery, 25 in abstract (summary of each case). The series of 50 detailed records must be for major work in which the candidate was the responsible surgeon. This series of records should be of comparatively recent work and should not date back more than five years from the time of submission of the histories, after recommendation for Fellowship by the Credentials Board. The series of 25 abstracted records can be for work in which the candidate has acted as assistant. Candidates can submit records of cases (not to exceed five in number) done during internship if the internship was completed within five years of the time of submission.

Section 3. Qualifications for Associateship.

The candidate is required to submit 25 surgical case records in detail, which can be made up of either soft tissue or bone surgery. The series of 25 detailed records must be of work for which the candidate was the responsible surgeon. This series of records should be of comparatively recent work and should not date back further than five years from the time of submission of the histories after recommendation for Associateship by the Credentials Board. Candidates can submit records of cases (not to exceed five in number) done during internships if the internship was completed within five years of the time of submission.

An Associate, in order to apply toward a Fellowship the 25 case records submitted for an Associateship, must complete the requirements for a Fellowship within five years.

An Associateship does not confer the right to vote or hold office.

Section 4. Revocation of membership.

Membership may be revoked by a two-thirds majority vote of the members present at any regular meeting of the College for any of the following causes:

(1) Failure to practice chiropody for a period of one year in any state, except when the member is connected with the teaching staff of an educational institution acceptable to the society, is serving in the Armed Forces, or is unable to practice because of illness.
(2) Revocation of state chiropody license.
(3) Conviction of a criminal offense.
(4) Exploitation of membership for commercial purposes.

Article IV. Officers and Credentials Board

Section 1. The officers of this organization shall be a president, vice president, secretary, and treasurer, who shall constitute the Board of Directors.

Section 2. The president shall preside at meetings and shall perform the duties usually performed by a presiding officer and such other duties as are required of him, and he shall be ex-officio a member of all committees.

Section 3. The vice president shall perform all the duties of the president in his absence or inability to act.

Section 4. The secretary shall keep a record of the proceedings of all meetings, the minutes of which are to be read at the next meeting; shall keep a register or roll; shall notify officers, Credentials Board, and committees of their election or appointment; shall furnish committees with all papers referred to them; shall sign with the president all orders authorized by the organization unless otherwise specified in the by-laws; shall announce all meetings; and shall conduct the correspondence of the organization.

Section 5. The treasurer shall be the custodian of all money and property and shall pay funds out of the treasury as directed by the Board of Directors. The treasurer shall report in full at each annual meeting of the organization and as often as required. The treasurer shall furnish bond if required by the organization.

Section 6. The Credentials Board shall consist of four members appointed by the Board of Directors for a term of one year, who shall investigate all applications of candidates for Fellowship or Associateship, shall study all case records submitted, and shall assist the Board of Directors in conducting an annual examination of candidates. The Board of Directors shall pass on all applications.

Section 7. Any vacancy of office shall be filled by appointment by the Board of Directors until the next regular election.

Section 8. There shall be an annual election of officers. Nominations shall be made by a nominating committee, and other nominations may be made from the floor. Election shall be by written ballot.

Article V. Dues

Section 1. The membership fee, which includes the first year's dues, shall be twenty-five dollars ($25) for either a Fellowship or Associateship, payable upon notification of acceptance to membership.

Section 2. Annual dues shall be ten dollars ($10).

Section 3. The amount required of any member shall not exceed three hundred dollars ($300).

Section 4. An application fee of five dollars ($5) must accompany each application for membership and will be deducted from the $25 membership fee.

Section 5. A five dollar ($5) fee is required for each re-examination of a candidate for membership but may not be deducted from the membership fee.

Article VI. Meetings

There shall be an annual meeting at the time and place of the convention of the National Association of Chiropodists, and any other meetings deemed necessary may be called.

Article VII. Amendments

Amendments may be added or altered by a two-thirds vote of the members present, if the amendment has been presented at a previous meeting or by general announcement to the membership.

BYLAWS

1. When a Member is to be raised from an Associate Member to a Full Fellowship, he must submit the Associate Certificate to the Secretary before the Secretary shall send the Fellowship Certificate to him.
2. In the event of two successive absences from annual meetings of the A.C.F.S. without acceptable excuses, a member shall forfeit his Certificate of Membership and appear at the next annual meeting in person for reinstatement. The Certificate is the property of the A.C.F.S. and may be recalled at the discretion of the Executive Body.
3. Conduct: The conduct of a member of the American College of Foot Surgeons shall comply with the rules and regulations of the local and national Code of Ethics of Chiropodists and Podiatrists.
4. On the use of the title of the Association, or of F.A.C.F.S.:
   a. The title shall not be used on personal stationery or cards, or in any way to be construed as for personal gain.
   b. The title shall be used only in correspondence for official business of the Association.
   c. Members may use the title in the following manner:
      (1) Official correspondence.
      (2) Articles for publication approved by the A.C.F.S.
      (3) Official Rosters or Directories for classifying the profession.
      (4) In catalogs listing faculty when a Member is on the faculty.
      (5) On State and National programs when Member is to speak.
      (6) Others not specifically covered must be approved by the Board of Directors of the A.C.F.S.
5. Articles for publication: Any Member of the American College of Foot Surgeons the presentation for approval to the Board of Review of the American College of Foot Surgeons.
6. It shall be mandatory for each Fellow and Associate Member to attend the annual meeting of the A.C.F.S. unless prior to said meeting a letter of explanation on inability to attend is presented to the organization for action at the regular business meeting. Providing unfavorable action is taken, rejection of membership by the organization may be invoked as provided in the constitution and by-laws. Such Members shall be notified of this action by the Secretary.
7. Surgical procedures NOT acceptable to the American College of Foot Surgeons:
   a. Cauterization of verrucae.
   b. Curettage of nail matrix.
8. A case report shall be on a patient operated upon one day, regardless of the number of incisions made on that day.
9. Each member will be required to send in one case history each year, or one article on some phase of surgery or allied branch each year.

Annual Meeting and Conference Locations

Annual Business Meeting
Held during the annual meeting of National Association of Chiropodists/American Podiatry Association

1942 Hotel Nicollet, Minneapolis, Minnesota
1943 Drake Hotel, Chicago, Illinois
1944 Drake Hotel, Chicago, Illinois
1945 Drake Hotel, Chicago, Illinois (Cancelled per the Railroad Reservation Restriction policy of the U.S. Office of Defense Transportation)
1946 Statler Hotel, Cleveland, Ohio
1947 Hotel Pantlind, Grand Rapids, Michigan
1948 Brown Hotel, Louisville, Kentucky
1949 Drake Hotel, Chicago, Illinois
1950 Statler Hotel, Boston, Massachusetts
1951 Drake Hotel, Chicago, Illinois
1952 Peabody Hotel, Memphis, Tennessee
1953 Statler Hotel, Los Angeles, California
1954 Drake Hotel, Chicago, Illinois
1955 Statler Hotel, Cleveland, Ohio
1956 Drake Hotel, Chicago, Illinois
1957 Drake Hotel, Chicago, Illinois

Annual Scientific Conference (ASC) and Annual Business Meeting (ABM)
The ASCs were held independently in winter. The ABMs were held in summer during the annual meeting of American Podiatry Association/American Podiatric Medical Association

1958 ASC Riviera Hotel, Las Vegas, Nevada
ABM Shoreham Hotel, Washington, D.C.
1959 ASC Riviera Hotel, Las Vegas, Nevada
ABM Waldorf Astoria Hotel, New York, New York
1960 ASC Hotel Del Prado, Mexico City, Mexico
ABM Drake Hotel, Chicago, Illinois
1961 ASC Eden Roc Hotel, Miami Beach, Florida
ABM Americana Hotel, Bal Harbour, Florida
1962 ASC Dunes Hotel, Las Vegas, Nevada
ABM Shoreham Hotel, Washington, D.C.
1963 ASC Royal Orleans Hotel, New Orleans, Louisiana

ABM Ambassador Hotel, Los Angeles, California
1964 ASC Fontainebleau Hotel, Miami Beach, Florida
ABM Statler Hilton Hotel, New York, New York
1965 ASC Flamingo Resort, Las Vegas, Nevada
ABM Chase Park Plaza Hotel, St. Louis, Missouri
1966 ASC Continental Hilton, Mexico City, Mexico
ABM Sheraton Hotel, Philadelphia, Pennsylvania
1967 ASC Dunes Hotel & Country Club, Las Vegas, Nevada
ABM Leamington Hotel, Minneapolis, Minnesota
1968 ASC Plaza Hotel, Madrid, Spain
ABM Palmer House, Chicago, Illinois
1969 ASC Sheraton Palace Hotel, San Francisco, California, and Royal Hawaiian Hotel, Honolulu, Hawaii
ABM Shoreham Hotel, Washington, D.C.
1970 ASC Royal Sonesta Hotel, New Orleans, Louisiana, and Camino Real, Mexico City, Mexico
ABM San Francisco Hilton, San Francisco, California
1971 ASC New York Hilton, New York, New York
ABM Denver Hilton, Denver, Colorado
1972 ASC Riviera Hotel, Las Vegas, Nevada
ABM Sheraton Boston Hotel, Boston, Massachusetts
1973 ASC Americana Hotel, Miami Beach, Florida
ABM Washington Hilton, Washington, D.C.
1974 ASC Marriott Hotel, New Orleans, Louisiana
ABM Marriott Hotel, Atlanta, Georgia
1975 ASC Caesars Palace, Las Vegas
ABM San Francisco Hilton, San Francisco, California
1976 ASC Beverly Hills Hilton, Beverly Hills, California
ABM Fairmount Hotel, Dallas, Texas
1977 ASC Konover Hotel, Miami Beach, Florida
ABM Sheraton Hotel, Philadelphia, Pennsylvania
1978 ASC Fairmount Hotel, New Orleans, Louisiana
ABM Hilton Hotel, Portland, Oregon
1979 ASC Aladdin Hotel, Las Vegas, Nevada
ABM Detroit Plaza Hotel, Detroit, Michigan
1980 ASC Islandia Hyatt House, San Diego, California
ABM Diplomat Hotel, Hollywood, Florida

Annual Scientific Conference (including the Annual Business Meeting)

1981 Hyatt Hotel, Sarasota, Florida
1982 Hyatt Regency, Houston, Texas
1983 Fairmount Hotel, San Francisco, California
1984 Riviera Hotel, Las Vegas, Nevada

1985 Hyatt Regency, Tampa, Florida
1986 El Conquistador Resort, Tucson, Arizona
1987 Hyatt Regency, Los Angeles, California
1988 Riviera Hotel, Las Vegas, Nevada
1989 Diplomat Hotel, Hollywood, Florida
1990 Fairmount Hotel, New Orleans, Louisiana

1991 Fairmount Hotel, San Francisco, California
1992 Marriott World Center, Orlando, Florida
1993 Hyatt Regency, San Diego, California
1994 Fontainebleau Resort & Spa, Miami Beach, Florida
1995 San Francisco Marriott Hotel, San Francisco, California
1996 ITT Sheraton New Orleans, New Orleans, Louisiana
1997 Wyndham Palms Springs Resort, Palm Springs, California
1998 The Hilton at Walt Disney World Village, Orlando, Florida
1999 Westin Century Plaza Hotel, Beverly Hills, California
2000 Hyatt Regency, Miami, Florida

2001 Hyatt Regency, New Orleans, Louisiana
2002 Century Plaza Hotel, Beverly Hills, California
2003 Walt Disney World Swan and Dolphin Resort, Orlando, Florida
2004 Manchester Grand Hyatt, San Diego, California
2005 Hyatt Regency, New Orleans, Louisiana
2006 Mandalay Bay Resort and Convention Center, Las Vegas, Nevada
2007 Gaylord Palms Resort and Convention Center, Orlando, Florida
2008 Long Beach Convention Center, Long Beach, California
2009 Gaylord National Resort and Convention Center, National Harbor, Maryland
2010 Mandalay Bay Resort and Convention Center, Las Vegas, Nevada

2011 Broward County Convention Center, Fort Lauderdale, Florida
2012 Henry B. Gonzalez Convention Center, San Antonio, Texas
2013 Mandalay Bay Resort and Convention Center, Las Vegas, Nevada
2014 Gaylord Palms Resort and Convention Center, Orlando, Florida
2015 Phoenix Convention Center, Phoenix, Arizona
2016 Austin Convention Center, Austin, Texas
2017 The Mirage Resort, and Convention Center, Las Vegas, Nevada

Scientific Journal Editors

ACFS Journal 1964 - 1966

Ralph E. Owens, DPM, FACFAS - 1964 – 1966
Donald A. Schubert, DPM, FACFAS - 1966

Journal of Foot Surgery 1967 – 1992

Donald A. Schubert, DPM, FACFAS - 1967
Irvin S. Knight, DPM, FACFAS & Richard H. Lanham Jr., DPM, FACFAS - 1968 – 1973
Irvin S. Knight, DPM, FACFAS & Oscar M. Scheimer, DPM, FACFAS - 1973 – 1980
Richard P. Reinherz, DPM, FACFAS - 1980 – 1992

Journal of Foot and Ankle Surgery 1992 - present

Richard P. Reinherz, DPM, FACFAS - 1992 – 1997
Lowell Scott Weil Sr., DPM FACFAS - 1997 – 2001
John M. Schuberth, DPM, FACFAS - 2001 – 2006
D. Scot Malay, DPM, MSCE, FACFAS - 2006 – present

Distinguished Service Award Recipients

The Distinguished Service Award is presented by the Board of Directors to volunteer leaders who selflessly donate their time and expertise with little if any recognition over many years in various College activities.

2004
Douglas G. Stoker, DPM, FACFAS
Practice Management Seminars

2005
Jeffrey C. Christensen, DPM, FACFAS
Surgical Skills Courses

2006
John V. Vanore, DPM, FACFAS
Clinical Practice Guidelines

2007
Samuel S. Mendicino, DPM, FACFAS
Surgical Skills Courses

2008
Gary Dockery, DPM, FACFAS
Faculty, Speaker, and Author

2009
George S. Gumann Jr., DPM, FACFAS
Surgical Skills Courses

2010
Harold W. Vogler, DPM, FACFAS
Professional Parity Initiatives

2011
Alan R. Catanzariti, DPM, FACFAS
Education and Residencies

2012
Jerome S. Noll, DPM, FACFAS
Historian, Board/Committee Member, Division President

2013
John Stienstra, DPM, FACFAS
Arthroscopy Skills Courses

2014
Edwin L. Blitch, IV, DPM, FACFAS
Annual Scientific Conference and other roles

2015
Lawrence A. DiDomenico, DPM, FACFAS
Faculty, Journal, Board, and Committee Service

2016
Troy J. Boffeli, DPM, FACFAS
Faculty, Journal, Board, and Committee Service

2017
John T. Marcoux, DPM, FACFAS
Patient Education, Post-Graduate Affairs, Divisions, Education

Leaders and Primary Office Locations

Executive Secretaries (volunteer)

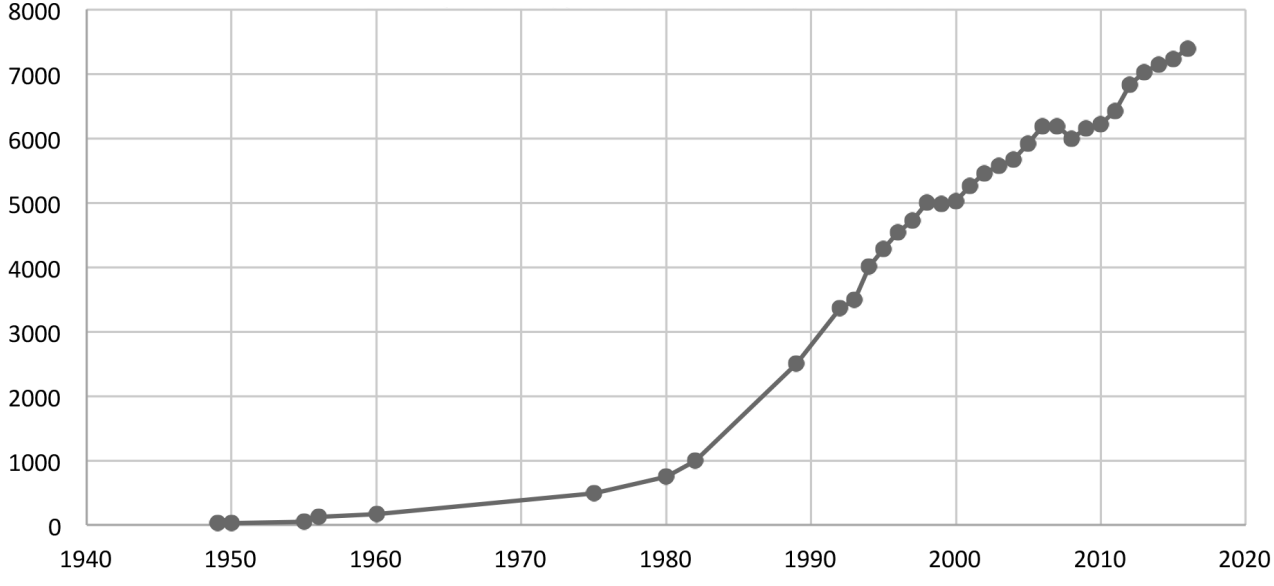
1955-1965	Jack M. Kohl, DPM, FACFAS
1965-1979	Earl G. Kaplan, DPM, FACFAS

Executive Directors (professional staff)

1979-1990	John L. Bennett
1990-1994	Cheryl A. Beversdorf, MHS, CAE
1994-1996	Ronald J. Bordui, MBA, FHFMA
1996-2003	Thomas R. Schedler, CAE
2003-present	J.C. (Chris) Mahaffey, MS, CAE, FASAE

Office Locations

1955-1965	3959 N. Lincoln Avenue, Chicago, 13, Illinois
1965-1979	14608 Gratiot Avenue, Detroit, MI 48205
1979-1980	P.O. Box 991, Martinez, CA 94553
1980-1985	629 28th Street, San Francisco, CA 94131
1985-1990	1601 Dolores Street, San Francisco, CA 94110
1990-1994	444 N. Northwest Highway, Park Ridge, IL 60068
1994-2003	515 Busse Highway, Park Ridge, IL 60068
2004-present	8725 West Higgins Rd., #555, Chicago, IL 60631



Membership statistics were not regularly reported until the 1980s, therefore data points before that time are at uneven intervals. The surge in membership evident during the 1980s is largely due to ACFAS spinning off certification to ABPS, which had different requirements as described in Chapter 3.

Intrayear High Membership Marks

All Known Former or Current Fellows and Associates Since 1942*

Name and State/Province

R Randal Aaranson, DPM	MO	Donald P. Adler, DPM	MI	Kathleen A. Alles, DPM	CA
Harry M. Aaron, DPM	FL	Joan C. Adler, DPM	NY	Paul D. Alley, DPM	IN
Robert M. Abady, DPM	FL	John J. Adler, DPM	FL	Lara M. Allman, DPM	PA
Hummira H. Abawi, DPM	VA	Merwin Adler, DPM	NY	Ronald W. Alm, DPM	ID
Kyle W. Abben, DPM	ND	Philip F. Adler, DPM	FL	Walter A. Alm, DPM	IL
George A. Abboud, DPM	NH	Richard E. Adler, DPM	NJ	Maria del Pilar E. Almy, DPM	WA
Julie A. Abboud, DPM	WI	Steven P. Adler, DPM	NY	Nicholas P. Aloi, DPM	FL
Tarick I. Abdo, DPM	IN	Carl H. Aeby, DPM	TX	Maryanne Alongi, DPM	NY
David C. Abdoo, DPM	CA	Jared S. Aelony, DPM	MN	Joyce S. Alonso, DPM	OH
Elmer Abdoo, DPM	MI	Monica R. Agarwal, DPM	TX	David B. Alper, DPM	MA
Samuel C. Abdoo, DPM	MI	Scott W. Agins, DPM	NJ	Holli Alster, DPM	NJ
Richard R. Abe, DPM	CA	Karen M. Aglietti, DPM	NY	Johnnie L. Alston, DPM	AL
Bradley P. Abicht, DPM	WI	Patrick S. Agnew, DPM	VA	Scott A. Alter, DPM	FL
Timothy C. Abigail, DPM	TX	David Agoada, DPM	MA	Stephen P. Altman, DPM	CA
Paul L. Abler, DPM	WI	Joseph R. Agostinelli, DPM	FL	Bert J. Altmanshofer, DPM	PA
Jossie Saramma Abraham, DPM	CT	Jeffrey D. Agricola, DPM	IN	Richard A. Altwerger, DPM	NY
Suzanne C. Abraham, DPM	AZ	Ryan G. Ahalt, DPM	VA	Dana Alumbaugh, DPM	BC
Thomas J. Abrahamsen, DPM	CT	Kenneth E. Ahern, DPM	CA	Gregory Alvarez, DPM	GA
Steven P. Abramow, DPM	NY	Matt M. Ahmadi, DPM	CA	Michael S. Alvaro, DPM	CA
Eric J. Abrams, DPM	NJ	Clarence O. Aho, DPM	MN	Terence A. Alvey, DPM	IN
Robert A. Abrams, DPM	CA	Irfan Ahsan, DPM	LA	Philip P. Alway, DPM	CA
Robert J. Abrams, DPM	CA	Maurice W. Aiken, DPM	MD	Tiffany H. Alway, DPM	CA
Robert M. Abrams, DPM	WI	Martha J. Ajlouny, DPM	NC	Robert A. Alworth, DPM	NJ
Steven J. Abrams, DPM	AZ	Janet Ajrouche, DPM	MI	Shazia Amar, DPM	NY
Vivian Abrams, DPM	TX	Carol A. Akerman, DPM	TN	Gregory T. Amarantos, DPM	IL
Howard S. Abramsohn, DPM	NJ	Affan Akhtar, DPM	NJ	David L. Amarnek, DPM	MO
Lawrence A. Abramson, DPM	PA	Robert K. Aki, DPM	HI	Thomas R. Amberry, DPM	CA
Pedro M. Abrantes, DPM	FL	Ghadeer Alami, DPM	NJ	John A. Ambrosino, DPM	CA
Alberto Abrebaya, DPM	FL	Hernan J. Alamilla, DPM	TX	Donald L. Ambroziak, DPM	KY
Rafael M. Abreu, DPM	NY	Babak Alavynejad, DPM	CA	Michael T. Ambroziak, DPM	MI
Mak S. Abulhosn, DPM	WA	Johnny Alayon, DPM	OH	Hillarie S. Amburgey, DPM	OH
William J. Accomando, DPM	NJ	Brian J. Albano, DPM	RI	Anne C. Ames, DPM	TX
Anthony N. Acello, DPM	NJ	Virginia R. Albano, DPM	MI	Gina R. AmicaTerra, DPM	NY
Lorelei C. Achor, DPM	CA	Fred G. Albert, DPM	MN	Susan G. Amico, DPM	NY
Omer F. Aci, DPM	NY	Byron S. Alberty, DPM	CA	Arti C. Amin, DPM	CA
Jordan J. Ackerman, DPM	NY	Rickey L. Albin, DPM	NJ	Jyothi A. Amin, DPM	FL
Michael J. Ackley, DPM	CT	Julie K. Albrecht, DPM	IA	Ameneh Aminian, DPM	NY
J Mari R Adad, DPM	WA	L. Todd Albrecht, DPM	MD	Robby A. Amiot, DPM	WI
Richard C. Adam, DPM	TX	Carl R. Albright, DPM	PA	Ronda G. Ammon, DPM	CO
Frank P. Adamo, DPM	PA	John E. Albright, DPM	PA	Kenneth G. Ammons, DPM	MN
Donald J. Adamov, DPM	FL	Justin T. Albright, DPM	OK	Joseph M. Anain Jr., DPM	NY
Ben F. Adams, DPM	IL	Terence B. Albright, DPM	ME	Michelle C. Anania, DPM	OH
Bradley J. Adams, DPM	OH	Thomas R. Albright, DPM	PA	Sunita Anantaneni, DPM	MO
Christy B. Adams, DPM	OH	Chris Albritton, DPM	TX	James J. Anarella, DPM	NY
Donald William Adams, DPM	MA	David C. Alder, DPM	GA	Robert C. Andersen, DPM	AZ
Heiko B. Adams, DPM	KY	Mark A. Aldrich, DPM	WI	Adina-Maria Anderson, DPM	MI
Jenny W. Adams, DPM	FL	Debra J. Aleck, DPM	VA	Ann C. Anderson, DPM	PA
Melissa L. Adams, DPM	OK	Joseph Alencherry, DPM	NY	Blair V. Anderson, DPM	NV
Nicholas Dane Adams, DPM	NC	Kyle P. Alessi, DPM	NJ	Brad C. Anderson, DPM	ND
Richard M. Adams, DPM	TX	Donald F. Alexander, DPM	IL	Charles D. Anderson, DPM	OK
Scott E. Adams, DPM	CA	Jeffery H. Alexander, DPM	IL	Christopher J. Anderson, DPM	IL
Todd M. Adams, DPM	OH	Kirk Alexander, DPM	WA	Dawn J. Anderson, DPM	WI
William C. Adams, DPM	CA	Nancy Alexis-Calixte, DPM	FL	Eric C. Anderson, DPM	OH
William R. Adams II, DPM	KY	S. Jeffrey Ali, DPM	OH	Fred L. Anderson, DPM	CA
Annik Adamson, DPM	VA	Sadia Mahmood Ali, DPM	GA	Gregory S. Anderson, DPM	UT
Annelisa R. Addante, DPM	MA	Nicholas John Alianello, DPM	IL	James C. Anderson, DPM	CO
Joseph B. Addante, DPM	MA	Elaine A. Alicakos, DPM	NJ	Jason B. Anderson, DPM	IA
Jessica A. Addeo, DPM	NJ	Aleisha C. Allen, DPM	TX	Joel R. Anderson, DPM	IL
John G. Addino, DPM	NY	Amanda Lynne Allen, DPM	TX	John J. Anderson, DPM	NM
Christopher J. Addison, DPM	FL	Charles T. Allen, DPM	IL	John S. Anderson, DPM	FL
Adebola T. Adeleke, DPM	CT	David M. Allen, DPM	TX	Karen E. Anderson, DPM	CA
Kenneth A. Adelman, DPM	NJ	Drew D. Allen, DPM	CA	Kerry W. Anderson, DPM	ID
Ronald P. Adelman, DPM	MI	Elaine Allen, DPM	GA	Martha A. Anderson, DPM	OH
Vanessa R. Adelman, DPM	MI	John C. Allen, DPM	LA	Mikol Robert Anderson, DPM	UT
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James S. Adleberg, DPM	MD	Marque A. Allen, DPM	TX	Robert S. Anderson, DPM	CO
Charlton L. Adler, DPM	FL	Richard M. Allen, DPM	ID	Sarah P. Anderson, DPM	IL

*This list includes all names in the College's current database or historical archives. Every effort was made to ensure accuracy.

Seth M. Anderson, DPM MO
Sharon R. Anderson, DPM MO
Stacie D. Anderson, DPM OH
Bijan John Andrade, DPM MT
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David S. Andrew, DPM FL
Scott H. Andrew, DPM FL
Boyd J. Andrews, DPM AZ
Michael C. Andrews, DPM CA
William C. Andrews, DPM CA
Jeff J. Angarola, DPM CA
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Paula F. Angelini, DPM MA
Arush Kumar Angirasa, DPM TX
Robert J. Anglim, DPM IL
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Stevan J. Anselmi, DPM PA
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Patricia M. Antero, DPM AL
Larry R. Anthon, DPM CA
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Louis Aquino, DPM MO
Michael D. Aquino, DPM NY
Rosario Araguas, DPM CA
Saera Arain-Saleem, DPM IL
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Ioanis Arapidis, DPM NY
Robson F. Araujo, DPM AL
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Thomas P. Ashdown, DPM OH
Hisham R. Ashry, DPM FL
Ivan C. Ashton, DPM TX
Roy W. Ashton, DPM TX
Scott J. Ashton, DPM TX
Leonard B. Asin, DPM CA
Jerald M. Askin, DPM CA
Pedram Aslmand, DPM CA
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Kevin G. Bachman, DPM NC
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Tracy Marie Bacik, DPM MI
Bruce M. Backer, DPM CT
Natasha Baczewski, DPM NH
Homam Badri, DPM NJ
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Christopher J. Bailey, DPM IL
Danny S. Bailey, DPM OH
Jason R. Bailey, DPM NE
Lori K. Bailey, DPM IL
Michael A. Bailey, DPM GA
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James A. Baird, DPM IL
William E. Baird, DPM NC
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Caleb R. Baker, DPM WY
Elizabeth L. Baker, DPM WI
Jeffrey R. Baker, DPM IL
John E. Baker, DPM FL
Lora Baker, DPM PA
Michael J. Baker, DPM IN
Michael R. Baker, DPM TN
Richard E. Baker Jr., DPM MA
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Constantine G. Barbounis, DPM FL
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Juan Carlos Barra, DPM PA
Oscar Barreto, DPM FL
Barbara J. Barrett, DPM OK
J. Peter Barrett, DPM PA
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Kathleen M. Barrett, DPM NY
Michael J. Barrett, DPM TX
Stephen L. Barrett, DPM AZ
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Eric E. Barton, DPM ID
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Agnes K. Bartoszek, DPM FL
Kalman Baruch, DPM GA
Paul T. Basile, DPM IL
Philip Basile, DPM MA
Scott L. Basinger, DPM NC
Eric S. Baskin, DPM NJ
David F. Baskwill, DPM PA
Suneel K. Basra, DPM NJ
Fara D. Bass, DPM NY
Javan Shinar Bass, DPM GA
Stuart J. Bass, DPM MI
Barinder P. Bassi, DPM KS
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Jack Bastow, DPM NY
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Natalia S. Batista, DPM TN
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Sireesha Battula, DPM CA
Chad A. Batzing, DPM NY
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Ira M. Baum, DPM FL
Mark L. Bauman, DPM NJ
Christopher C. Bautista, DPM CA
Joseph V. Bava, DPM VA
Jeffrey J. Baxter, DPM TX
Mark C. Baxter, DPM TN
Tamara Whitaker Bay, DPM MI
Frank R. Bayerbach, DPM NY
Ethel R. Baylor, DPM MA
Demencio Isaac Bazan, DPM TX
John Bazata, DPM FL
Lael J. Beachler, DPM WY
Jacob B. Beal Jr., DPM TX
William S. Beal, DPM CA
Aaron S. Bean, DPM CA
Francis J. Bean, DPM IN
H Kim Bean, DPM NV
Jeffrey K. Bean, DPM NV
Andrew S. Bear, DPM NJ
Paul R. Bearden, DPM SC
Bradley D. Beasley, DPM OK
William T. Beasley, DPM KY
William H. Beatie, DPM CA
Richard G. Beatty Jr., DPM OK
Michael C. Beaudis, DPM OH
Jil A. Beaupain, DPM ME
Janet E. Bechtel, DPM VA
Jeffrey C. Beck, DPM CA
Keith A. Beck, DPM WI
Roger G. Beck, DPM FL
Valarie A. Beck, DPM NJ
Kerry A. Becker, DPM MD
Todd R. Becker, DPM GA
Lisa A. Beckinella Gordon, DPM VA
Randall L. Beckman, DPM TX
Gail L. Bedell, DPM PA
Debra B. Bedgood, DPM PA
Michael K. Bednarz, DPM GA
Glen A. Beede, DPM TX
Steven L. Beekil, DPM IL
Genine M. Befumo, DPM NJ
Kasra N. Behfar, DPM FL
Todd S. Behrmann, DPM FL
Thomas C. Beideman, DPM PA
John K. Beighle, DPM MT
Douglas R. Beirne, DPM TX
Ian H. Beiser, DPM DC
Seymour Z. Beiser, DPM FL
Samuel D. Beitler, DPM MD
Steven B. Beito, DPM TX
Jeffrey M. Belancio, DPM NJ
Arthur J. Belanger, DPM TN
Susan L. Belanger, DPM NJ
Ronald J. Belczyk, DPM CA
Joseph Belfatto, DPM NJ
Brian J. Belgin, DPM MD
Andrew M. Belis, DPM FL
Thomas J. Belken, DPM MI
Daniel L. Bell, DPM TX
David A. Bell, DPM GA
Glen Bell, DPM CA
Jason M. Bell, DPM NJ
Jennifer L. Bell, DPM MD
John E. Bell, DPM CA
Larry A. Bell, DPM PA
Robert M. Bell, DPM TN
Samuel D. Bell, DPM NY
Frederick A. Bella NJ
Richard A. Bellacosa, DPM TX
Jay P. Bellias, DPM NJ
Clair L. Bello III, DPM GA
Eunis Bello, DPM AZ
Robert F. Bello, DPM NY
Stanley A. Beloff, DPM NJ
Drew Jackson Belpedio, DPM OH
Gladys P. Bembo, DPM TX
Thomas F. Bembynista, DPM MO
Jay K. Benard, DPM CA
Marc A. Benard, DPM CA
James R. Bender, DPM MI
Mary Ann Bender, DPM IL
Steven R. Bender, DPM NJ
Randall L. Benedict, DPM ID
Anthony V. Benenati, DPM MI
Thomas J. Benenati, DPM CO
David E. Beneson, DPM MI
Jennifer Anne Benge, DPM KY
Kenneth J. Benjamin, DPM MD
Scott M. Benjamin, DPM IN
Mary K. Benjamin-Swonger, DPM OH
Brian N. Bennett, DPM GA
Ira E. Bennett, DPM FL
John D. Bennett, DPM IA
Jonathan I. Bennett, DPM CA
Patricia W. Bennett, DPM NJ
Ricardo M. Bennett, DPM VA
Steven J. Bennett, DPM NE
W. Ray Bennett, DPM OH
Daniel N. Benoit, DPM IL
Nicolas R. Benoit, DPM VT
Daren T. Benson, DPM WA
Stephen A. Benson, DPM CA
Sebastian Bentivegna, DPM NY
Mindy L.B. Benton, DPM MN
Wendy Benton-Weil, DPM IL
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Anthony J. Yoworsky, DPM	PA	Steven M. Zavinsky, DPM	MI	Camille J. Zizzo, DPM	WI
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Ian K. Yu, DPM	BC	Malik Zayed, DPM	IL	Robert A. Zobel, DPM	AZ
Jenny Yu, DPM	CA	John L. Zboinski, DPM	NY	Blake O. Zobell, DPM	UT
Kelly L. Yu, DPM	CA	Alissa Berner Zdancewicz, DPM	FL	Nooshin Zolfaghari, DPM	FL
Song K. Yu, DPM	CT	John S. Zechman, DPM	PA	Robert J. Zombolo, DPM	IL
Neal Yudkoff, DPM	NJ	Vladimir Zeetser, DPM	CA	Larry Zonis, DPM	AZ
Keith N. Yuen, DPM	CA	Walter Zelasko, DPM	NC	Rachel Shara Zorger, DPM	WV
Andrew S. Yun, DPM	HI	Charles M. Zelen, DPM	VA	David H. Zuckerman, DPM	NJ
Jaimie Yun, DPM	OH	Marek E. Zelent, DPM	MN	Arnold J. Zuckman, DPM	CT
Anthony C. Yung, DPM	BC	James E. Zelichowski, DPM	GA	George P. Zuk, DPM	CT
Jeffrey Y. Yung, DPM	MI	Roger L. Zema, DPM	FL	Brandon M. Zuklie, DPM	NJ
Paul G. Yungst, DPM	FL	Christoph C. Zenker, DPM	AL	Caesar A. Zuniga, DPM	TX
Jesse T. Yurgelon, DPM	CA	Todd A. Zeno, DPM	PA	Vincent G. Zuwiala, DPM	PA
Gabriela Yurkanin, DPM	PA	Gerald N. Zeringue Jr., DPM	TX	Thomas G. Zwick, DPM	FL
Mark E. Yuska, DPM	MN	John C. Zervos, DPM	RI	Kenneth H. Zygmunt, DPM	IL
James J. Zaccaria, DPM	PA	Thomas Zgonis, DPM	TX	Michael J. Zyzda, DPM	CO

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CHAPTER 5

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