Foot Notes From Seattle

Claresa Levetan, MD

Editor's note: *In the "Practice Profiles" department of* Clinical Diabetes, *we spotlight clinicians who have chosen to dedicate a significant portion of their time to the care of patients with diabetes. Suggestions for clinicians to interview in the future are welcome and can be e-mailed to* levetan@juno.com**.**

Who? William A. Boegel, DPM

What? Staff podiatrist

Where? Department of Orthopedics, Virginia Mason Medical Center in Seattle, Wash.

Where are you originally from?
I was born and raised for 10 years in Santa Monica, Calif., but then moved with my family to Bethesda, Md. I went to high school and college locally (University of Maryland, College Park) and worked at the National Institutes of Health for 7 years, from 11th grade through 5 years of college.

Were there any podiatrists in your family?
I do not have any podiatric family connections and had never met one before applying to school.

How and why did you get interested in podiatry?
I learned about podiatry from the national executive director of the American Podiatric Medical Association, which is based in Chevy Chase, Md. He had learned that I was a pre-med student and had immunology research experience and told me that I would make a great podiatric medical student.

I decided to take a look at the podiatric medical school in San Francisco (one of seven schools and the only one in the western United States). I fell in love with the school, the curriculum, and the location.

I believe that choosing your medical specialty early still allows you to obtain a thorough medical core background, but it also helps you focus on securing appropriate clinical rotations and residency experience. So after earning my bachelor's degree in biological sciences, I went to San Francisco for 4 years at the podiatric medical school. The school is affiliated with the University of California, San Francisco and offers an excellent academic curriculum.

After third- and fourth-year rotations in Bay-area hospitals, I was accepted for a 2-year surgical residency in Seattle. After that, I served a fellowship in orthopedic foot and ankle surgical reconstruction at Harborview Medical Center, a University of Washington teaching hospital.

You had extensive training. Where did you finally decide to work?
After my residency, I was directly hired into the Department of Orthopedics at Virginia Mason Medical Center in Seattle. I like to think of this 400-doctor institution as "the Mayo Clinic of Seattle." It has a strong diabetes emphasis, including a freestanding diabetes research institute. Our hospital functions as an academic teaching center, and I am a staff podiatrist here. In 1996, I moved to the Kirkland satellite branch clinic, and many of my downtown diabetes patients followed me.

Describe your current practice.
I practice in a large team. We all are salaried and have some time to get involved in clinical research. I manage patients who come to us from both inside and outside the clinic. We are a regional tertiary care center. I do not run a business or get involved in most staffing and insurance issues like many of my podiatric colleagues in private practice. Also, when we travel, our team of seven podiatrists can easily cover for each other.

How many podiatrists are there in the United States?
A podiatrist is a physician and surgeon of the foot and ankle. There are about 16,000 of us in the United States.

What are some of the recent breakthroughs in podiatry?
Breakthroughs in surgery include more accurate and effective internal fixation techniques and better, more accurate rehabilitation of surgical patients. Podiatric medical breakthroughs have been largely in the areas of diabetes management.

Throughout the country in the 1980s and '90s, it was clearly established that podiatric-run diabetic foot clinics at major medical centers, including Virginia Mason, reduce diabetic amputations and hospitalization days by more than 50%. These focused clinics work best when they employ the entire diabetic team management concept, including

podiatrists, orthopedic and vascular surgeons, endocrinologists, primary care providers, nurses, pedorthist/orthotists, plastic surgeons, physical therapists, and so on. We use this team approach here at Mason, and it works very well.

What is new in the field of podiatry?
New topical platelet-derived growth factors have been proven to help close difficult diabetic ulcers. New bioengineered skin grafts are now in use to close large defects. These can be applied in office settings to keep patients out of the hospital.

Legislative changes here in Washington, such as the Diabetes Cost Reduction Act, now mandate coverage of all foot appliances, such as shoes and orthotic devices. Insurance companies now must also pay for all pharmaceutical supplies for diabetes patients and for all diabetes education classes.

I believe that the more proactive and cost-efficient we are in treating the diabetic population, the less money we have to waste on avoidable inpatient hospital costs and surgeries.

What further improvements are needed in diabetic foot care?
Despite all of the breakthroughs, our national patchwork medical system is seeing an epidemic of diabetes-related amputations. In 2000, the number of amputation surgeries in this population reached an all-time high of 100,000. Foot-related pathology is the number one reason for hospital admissions of diabetic patients in this country.

I truly believe and have personally witnessed that great benefits can accrue for all physicians when we train together. Historically, the general medical community has not always done a thorough job of treating foot pathology, and podiatrists are vital team members for diabetes management. Seattle podiatrists have an excellent relationship with other members of the medical community, and most of this is because we share mutual training through the University of Washington residency programs.

What has changed the most in your field?
The one worrisome change in the past 10 years has been the insidious, eroding insurance coverage provided under managed care and what it has forced our patients to go through. I believe that managed care has affected this population is mostly negative ways, forcing patients to change doctors and, until our legislation passed, to navigate through highly variable coverage and receive generally poor reimbursement for high-risk diabetes foot and ankle care.

Even as an endocrinologist, I use a tuning fork and 10-g monofilament and inspect my patients' feet. Can you offer some cardinal ABCs of foot care for physicians like me who have never spent even a day with a podiatrist?
For ABCs of diabetic foot care, readers can refer to the article "Expert Diabetic Foot Care for the Primary Care Physician," which I wrote for *Clinical Diabetes* in 1999. (*Clinical Diabetes* 17:37–41, 1999). It offers lots of pointers and it summarizes how we work in concert with many specialists.

I believe that all diabetic patients need to be accurately screened (not necessarily by a podiatrist) for extremity complications. If any risks at all are identified (neuropathy, peripheral vascular disease [PVD], foot deformities), the patients need podiatric care. Cost-efficient office care of these high-risk patients is essential to keeping patients out of the hospital.

Generalists should know how to detect neuropathy and PVD and, more importantly, need to know about functional demands on feet. Such simple things as corns or calluses go unnoticed and untreated in "silent," painless diabetic feet, but did you know that most diabetic foot admissions are for infected corns and calluses? Podiatrists are experts at reducing stress, shear, and overall risk in these patients.

What is the one thing about caring for patients with diabetes that you find most rewarding?
The single most rewarding thing about diabetes care for me is the hope and empowerment that patients take away from their visits to an excellent diabetes team care, such as the one here at Virginia Mason Medical Center.

What is the one thing in the current health care system that you would like to change?
I would like to see an improvement in coordinated diabetes care in the highly variable medical community at large. This is especially important for high-risk diabetes extremity care.

In your free time, what do you enjoy doing?
I enjoy the active outdoor Northwest lifestyle, including biking, skiing, hiking, and golfing with my family. I volunteer quite a bit for the American Diabetes Association and am now on its Pacific Northwest Region Board of Directors as the next President, Health Care and Education. I am very active in my Catholic church and have performed prison ministry for the past 5 years.

In all honesty, I am 99% happy with my choice of podiatric medicine and surgery. I hope for a healthy eventual retirement and to remain active in the community and with volunteer programs.

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