2018 NCSBN Annual Meeting - Learning from Others in the Discipline Space Video Transcript

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2018 NCSBN Annual Meeting

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- [Mark] Thank you very much, Marianne. And thank you for having me. It's been a pleasure over the years. I've been with the Federation for 20 years, and during that time I've worked with many at the National Council of State Boards of Nursing, and it's been wonderful including Marianne, Elliott, Vice, etc…, Jim Fuente, and many others who have been very helpful in collaborative efforts that we've done together, and of course David Benton as well.

So, first of all, I'm just going to make a comment very quickly, that I don't particularly like the term "discipline," and so I will try and avoid it when I can. Sometimes it just slips out because over the years we've used it for so long, and I haven't really found that good replacement word.

But discipline implies punishment, it implies all sorts of things, and I think that's not necessarily the message we want to send to our registrants to our licensees. There are often times when we are supporting them, we are helping them, or doing other things than punishing them. So I don't particularly like the word discipline. But that being said, you'll probably hear me say it a couple of times because it's hard to avoid.

So the Federation of State Boards of Physical Therapy, just a little bit of background, very similar to the National Council. Our mission is to protect the public by promoting standards, and safe and competent physical therapy practice. Our membership is 53 of the U.S. licensing jurisdictions. We developed the National Physical Therapy Exam, which is the corollary to the NCLEX.

And we have an Exam Licensure and Disciplinary Database, the ELDD, which is comparable to Nursys. And finally we've developed a compact that we've been going at for a couple of years now, we've got 21, we're trying to catch up with you on your 31. So watch out next year. But we're very excited about that,

and Jim, and Elliot, and colleagues have been really helpful in helping us with that whole project, describing some of the challenges, and some of the opportunities.

So the issue that I'm going to be talking about is something that we've identified for many, many years, and that's the fact that we're sitting on tons of data that we're not doing anything with. And as we move towards an era of trying to make decisions based on data and evidence, we were sitting on tons of data that we weren't using, and we were making decisions without good evidence.

So, the issue was how can we really use our data, and get our data in shape that we could actually use it to make regulatory decisions. The other challenge with this was that terminology between jurisdictions was different.

Everyone had a different practice act, everyone used different terms, and so forth. Finally, the National Practitioner Data Bank requirements were standard. So here we have the standard, everyone had to report to the National Practitioner Data Bank. And how could we leverage this, and how could we use this? So we started thinking about it, and we started thinking about the National Practitioner Data Bank, and at that point we were complied to report to the HIPDB, the Health Integrity and Practice Data Bank, which has been consolidated with the NPDB.

The problem with that data bank is it's a huge compilation of lots of different stuff, there's no common terms. So they have a whole glossary of terms that you have to use. Glossary is the wrong word, a whole list of terms that you have to use. Often they are repetitive, they're huge buckets, such things as unprofessional conduct, and I've seen some states that listed everything as unprofessional conduct.

That wasn't helpful when you're trying to get at some of the granular issues of what discipline is going on. And no definitions or delineations of when to use one term versus the other when we're talking about basis for actions. So the solution we came up with, a great solution, develop definitions in conjunction with the National Practitioner Data Bank and other professions sounds simple enough.

So we went to NPDB and said, "Can we do this? Would you help support us in doing this?" And we got a…In my first iteration of this I had, "Resounding NO"but I thought I'd just be a little gentler and kinder. They basically said no, they weren't interested in data collection at all. They were interested only in being a clearing house, and so forth; a reporting system.

And so they weren't interested in doing that. So we said, okay, what we're going to do is we're going to create our own. And this gives you an idea how long we've been working on this project. 2008 we established a goal that we were going to create definitions for the NPDB basis for action codes and train our member boards in how to use those.

So we had a task force that came together, and established definitions, and clear definitions for violations, and disciplinary actions pertinent to the physical therapy profession so that we could develop some consistency. The thing is, is that we wanted more than just definitions. We wanted to inform people when to use one term versus the other term, and identify when those terms should not be used.

So if there were repetitive terms, when to use one versus the other, and clarified the differences. And when different terms might not be appropriate for physical therapy, they might be more appropriate for

another. We don't have a lot of drug diversion in physical therapy for obvious reasons. We do have it, but we don't have a lot of it. So there are some terms that may not apply to various professions.

So we did this, we developed our disciplinary action definitions and descriptions, and it's about, probably, an eight-page document. And so, now, that we've got the definitions, we've got all sorts of access to data, we're set, we can start using evidence based regulation in making some of our decisions.

We trained our administrators, we had workshops with cases, we had webinars, we had online materials, staff expertise was developed in how to use them, and so forth. So, problem solved? No. Big obstacles ahead, basically three big obstacles, and I'm going to go through those obstacles.

The first obstacle was member boards not able to use the code or descriptor because it was not in their statute, or it was not in the final order. So they said, "No, wait a minute, we can't do that. Our AG won't let us do that." Now, whether that's a valid reason not to do it, I don't know, I'm not a lawyer, and so forth. So that was a problem.

So what are we going to do about that? We said we got to solve this problem. We've done too much work. So we made a system change in our ELDD, our disciplinary database, basically like Nursys, and we added a dropdown box for the FSBPT code, which would be in other words, you could duplicate codes, you could have an NPDP D code, or the code that the state had to use, and then an FSBPT code.

So, jurisdictions could now put in the NPDP code, and they could put in the FSBPT code, or if that was too difficult for them, we could go in and do it for them. And you can imagine we've had to do that. So we solved obstacle number one.

Obstacle number two: No historical data. So we're starting this, we finished this probably two years ago when we added these new dropdown boxes. And, you know, it's going to take us years to develop enough data to be able to use it. So what we said with that is, we're going to go in and put in the codes for the last 10 years.

So we went through all our disciplinary actions in the last 10 years that didn't have FSBPT codes in them and put them in ourselves. A little bit of work, yes, it would be a lot more work for nursing. I know they have a few more numbers than we do. But it took us two years, and probably about six staff to go through and do that. We read through the orders, we decided what FSBPT code based on our definition should be, and put that in.

So we've got that problem solved. Big obstacle number three: Participation in the FSBPT ELDD, or Exam Licensure and Disciplinary Database. We look in envy sometimes at you in nursing with Nursys, and your level of compliance, and so forth, because our jurisdictions didn't really see it as critical.

And some of that was just using the unique identifier, we've solved that problem, some of it was limited board resources. There were all sorts of reasons why people didn't participate in sending us the data. So what we did on this one is we created a star rating system. Five stars means you are a state that supplies all the data that we ask for in a timely fashion, at that time period we wanted.

And lo and behold that really worked. Set up a little competition and star rating, and people love it. So it is working I should say, we're not there yet, but people start getting competitive, and we started publicizing.

Initially we kept it kind of quiet as far as what other people's star ratings were, and then as people got used to it and so forth, we started publishing everybody's star rating. And people got competitive, and excited about increasing their star rating, and wanting to know why they were one star rating versus another. So that has really worked out well.

So, that's the point we're at. We now have 23 states that are at five-star level, very, very exciting. And so we see lots of opportunities ahead in identifying what the trends are for the basis of actions, how we can prevent harms, how we can identify who's at risk, how we can apply appropriate sanctions, how we are spending our time, and are we spending our time where it's really important, and so much more.

So we're really, really excited, and we're just starting this process. Here are some of the data elements we're currently looking at. I'm going to go through this very, very fast. Actually, I don't need to go quite that fast. But just looking at age, gender, when you're initially licensed, where you were educated, all those sorts of things we're looking at and evaluating.

And here's some of our data. This is the gender of those disciplined, really interesting stuff, because if you look at this you would think, well, males are a little bit more likely to be sanctioned than females. But when you look at the overall population, and how many males there are to females, there are more females, roughly two thirds of the PT population is female, one third is male.

And then when you look at the gender ratio, many, many more males get sanctioned than females. This is not atypical for other professions. And so this was validating what we already thought. The other thing is age. We haven't really looked at, but age tends to be the older 40, and older tend to be sanctioned much more likely.

And I just want to make one caveat, this is again, as I said, only 23 jurisdictions, and we'll get at that, that will become portent here, in just a minute when we talk about the education of those discipline, because some of the professions have said, have found out that those that are trained in other countries have a higher incident of disciplinary action. We did not find that in our data so far in looking at these 23, but when we look at the population and where the foreign educated typically go to practice, they aren't in our 23 states.

So we still need to look at that a little bit more and see what's going on with that. We created a severity scale. I won't go into that, but we really got a basis for action guidelines task force, and they created a whole severity scale, and how do you sanction somebody, what are guidelines for sanctioning somebody? So if you look at this Severity 1, is the highest, the most severe scale, and you can look at the numbers there.

Severity 4 is the bottom, it's the lowest. What's really interesting is when you break it up, and I'm not sure if you can see this or not, but the highest is at the top, criminal conviction is the highest basis for action. The next one is unable to practice safely by reason of alcohol or other substance abuse.

And I think you'll see that in other professions. That's a very high one. So we really do need to be putting some effort into that. When we look at the lowest severity level, the highest by all, by far in all the severity levels is failure to meet continuing competence requirements. And that tells me a whole lot. It says we're spending a lot of time working on something that probably isn't

[inaudible] much related to competence, and we need to look at some other approaches. And this is just not working very well. So right there with that simple analysis we got some great information. So, again, we're just starting, this is preliminary, and so forth. What I'm going to do now because my time is up is to say what the moral of our story is. Don't take no for an answer, big obstacles are challenges to overcome, worthwhile projects take time and perseverance, and there are some big opportunities for inter-professional and international collaboration on terminology and definitions.

Think about what we could do if we were doing this inter-professionally, and looking at basis for action across professions, and even across countries, really some exciting stuff. So with that, I'll turn it over to Suzy. - [Suzy] Greetings. Okay. So this is who I am, etc.

I want to thank the council for inviting me here, because I suspect I may learn more than I impart today. But anyway, I'm very grateful to be here. Hello to the Louisiana people, in particular within, we should talk. Anyway, to proceed, because I want to present, and then I really hope we get some interesting questions from all of you.

Well, so Mark really gave a great conversation, I think about some of the broader issues. I'm sort of the case study in this. I'm going to talk a little bit about our recent study, and the issues I encountered while I was extracting data and thinking about all of this.

So I'm going to talk about the study, but I'm really going to talk about some research issues and tracking issues. And hopefully put it together a little bit, what it all means. I also will hope to add to the inter-professional as well as intra-professional for us, issues, and just things to talk about to help spur this discussion. So the end result of this particular set of research was an article in our journal, the Medical Journalof Medical Regulation, similar very much to the nursing regulation publication.

What I will say is that, we embarked on this study because our investigations people anecdotally felt that physicians who had not completed a residency were far more likely to be sanctioned to people who had. But we needed to really look at it from a statistical point of view and control for various issues.

This was not just a little question they had, we really wanted to change the rules pertaining to full licensure for physicians in Louisiana. And in the end, after the article publication, and a lot of discussion at the board, and listening to the public, there was a rule change passed in February. So, that's a happy end to the…not necessarily end, but at least partial end to that story.

I do want to say that as we were gathering data, I came up with, you know, there's a lot more data that we've gathered than appears in this study, and it will be used to continue in various other parts of research. And right now, I've been adding to it, so we're up to about 2015 I think. Anyway, so our question was, are physicians who don't complete three, at least three years of residency training more likely to be disciplined by us than physicians who do?

We used three years as a proxy only because some of the largest specialties like emergency medicine, pediatrics, and internal medicine require a minimum of three. So that's what we used. Our data, you know, again, the study period was 1990 to 2010. We used 652 publicly sanctioned physicians in the study, and basically a 10 to 1 ratio of physicians who were licensed during the period but not sanctioned compared to those who were.

About 20 some physicians actually who were sanctioned during their residency were removed from the analysis eventually, so it was 624 or something. We did not address physicians who had actions that were not public, like public, you know, letters of concern, and so forth. We used our licensing files, and specifically our investigation files, not just the consent orders, but digging a little deeper, looking at conversations and other events that took place.

We also use the AMA Masterfile which is sometimes problematic but we used it. And then here's what I really want to get at, you know, there was a lot of…that's me, investigator classification and interpretation. So I did look at severity of action, more about that in a minute. I also looked at disciplinary history. I also had to do a lot of reading between the lines, because we, like all the others states have, our Medical Practice Act, they're all a little different, which creates problems here as Mark addressed.

And, you know, it might say on the order what they were sanctioned for in terms of our Medical Practice Act, but there were a lot of other things in there, and I had to create myriad other categories. And one of the things we talk about, you know, and Mark talked about, is this issue of unbundling unprofessional conduct. So someone who turned out to be a sexual predator or have boundary issues, sexual or otherwise, it was just called unprofessional conduct.

I think we probably need to drill down on some of these issues. I don't think anyone would disagree. So I had to do a lot of categorization outside of our Medical Practice Act. So actually it wasn't occasional reading between the lines, it was constant reading between the lines. So in our case, you know, and I'll speed through this, we looked at the likelihood of being a subject of formal disciplinary action. And in particular, we focused or we condensed some of these categories into competency and standard of care issues, crime, whether that was a crime committed in the practice of medicine, or some other crime like Medicaid fraud, what have you.

We also, you know, improper prescribing was a large one, and fraud and lying we included, whether that was lying to the board about the fact that you'd been disciplined elsewhere or something like that, or just fraud, Medicaid fraud, other forms of fraud. And of course we looked at substance abuse. For us, improper prescribing, and substance abuse were the two largest reasons we sanctioned our physicians for anything.

We controlled for various demographics, importantly time period of graduation because training was our specific variable, and there have been such, you know, changes in training requirements, and so forth. Obviously, bigger issues in specialty, some specialties prescribe a lot, some do not, etc. Anyway, we had separate models for just plain years of postgraduate training and also board certification because of the collinearity between those two things.

So talking about this, you know, there's a lot of issues both in research and in tracking, I think one of them we've been talking about, which is the Medical Practice Act, how do you standardize that, is that all you're looking at, or do you have to read between the lines and create other data points basically? And again, the issue of unbundling professional conduct, in recent years, our board created a broader unprofessional conduct law with something like 32 different sub-parts to it.

So we actually, if we start using those in a certain way from a data point of view, we probably already have unbundled it in terms of why we could sanction someone for unprofessional conduct. But it has not been put up into our data formally. So that's something. But some of that work has been done, and presumably in a lot of nursing boards as well.

And, you know, we talked about severity and history. That's next. I do think when you look at, both from a research point of view, and you know, assistance for the public, and assistance for a practitioner, you really do have to think about normative changes in the profession, in the healthcare system, and so forth. And then, I definitely noticed, in terms of reading between the lines, there were normative changes in the disciplinary regime.

Some things, you know, perhaps a certain years ago, something could pass by in the kind of good old boy regime that we now know is no longer acceptable. But I think you do have to look at that and at least talk about it when you're looking at these issues. Hopefully we've advanced in that regard. So in our study, our severity level, you know, had to do with the sanction itself, was it a reprimand, was it a probation or restriction, were they suspended or revoked?

And in this study we coded each action, 1, 2, or 3, and then within the 20-year period we had a final severity, at the end of the 20-year period, which isn't to say if it gets expanded to 2015, something hasn't changed in that final severity within this, you know…So I wanted to be able to track, they had these issues, how did they do years later?

So that's, sort of, where that came from. I'm going to whiz through this because you can read it. It's on the FSND website in the journal. But, again, the big one were, you know, drugs and alcohol, improper prescribing for pain, competency and standards, very rarely was it actual competency.

Sometimes it was, but a lot of times it was just violating standards. One of the other things that I know is of concern to the nursing profession has to do with nurses diverting. And I had a very interesting conversation with somebody from West Virginia about this last night. Most of the time, I had to dig very deeply when I was looking at our data to see was it diversion or not?

And so I created something, you know, was the DEA involved, could I really tell it was diversion when it was a case of improper prescribing or something else? So, again, that just speaks to the need to read between the lines and get pretty detailed in there. And again, as I mentioned, 10% of our physicians who were sanctioned, were sanctioned for sexual boundary issues.

Very sensitive subject of course, sometimes it might have been porn, sometimes it may have been more serious in terms of violation in some way of the patient's person, so... Six percents were from prior actions. And I think a lot of this drilling down really speaks, you know, and looking, for instance, at the disciplinary history type, well, let me just talk about this very briefly.

I had a lot of conversations with Rob Marryat [SP], who was the executive director at the time and is one of my coauthors, and we created a disciplinary history type. One being someone who had an interaction with the board in a disciplinary matter, cleaned it up, we never saw them again. Level 2 is someone who was, you know, was sanctioned, had a lot of issues, terms changing during probation back and forth, possibly still being, you know, still in some form of probation or restriction at the end of the study, but still practicing.

Level 3 was someone who was in and out of issues with the board and at the end of the study lost their ability to practice medicine. Number 4 was the person who had some form of immediate revocation yield surrender of license, was suspended for something egregious, and failed to get their license back. In some cases this might be an older physician who just decided forget it, I'm towards the end of my practice years, I don't feel like going through the lawsuits, etc.

But most of the time it was someone who had a pretty egregious offense in some way, and you know, and either agreed to give up their license or had it taken from them. And people with less training were definitely over-represented in the category 4 there. But talking about this disciplinary history type, you know, whether that's something that's national or just at your own board, I think it's important as we think about not just geeking out for research purposes, but helping our practitioners and helping the public, because I think it's the disciplinary history type 2 and 3 that we really have to think about, what are our interventions and what can we do?

And I think, looking perhaps at who those types are, who they are, any data we can look at, you know, who is more likely to be in that 2 and 3. We're a little bit less concerned with, you know, the first category because they had an issue, and they figured it out, and they moved on, and they kept practicing. So I think for both, you know, again both protecting the public and helping our practitioners practice well we really need to think about who those people are, and what can be done, and what kind of interventions can be enacted.

I'm going to actually whiz through the main findings only to say that there were not that many physicians in our study who had fewer than three years, but they were way over-represented compared to the controls, you know, in who was sanctioned. Interestingly, we also broke it down from one year, and then two and three.

And it was the physicians who completed that first year but didn't complete or had issues in the second and third year that were the real problems and, you know, led to some unpleasant things for their patients and for themselves. I will say that in Louisiana, we require that international medical graduates do a minimum of three years postgraduate training, so they were under-represented in our sanctioned physicians.

So, again, male physicians were more likely to be disciplined and so on. So, I want to talk a little bit about time variables. Again, the issue of how far does your data go, and what changed, and changes in the medical system, I think from a research point of view, you do have to look at this, and look at normative changes.

I'm not sure it matters tracking going forward, but there is some food for thought in there. If you look at our categories of graduation year, our largest group of physicians is internal medicine physicians. And in 1977 the requirements for training went from two years to three years for most residencies in internal medicine. So that's what some of that breakdown looks like.

Anyway, you know, I'm going to move on about this. This is just…But it's interesting to note that 33 states require only an internship year for full licensure. Two states require two years. We now require sort of two years, or if you're going to become fully licensed after one year, we need a letter of good standing from your residency program.

So, we've managed to move the needle a little bit. Obviously, all over the country, a lot of states require three years for IMGs but it varies. So, again, current norms all residency completion board eligibility, board certification with about 87% of physicians now.

That's changed over time, and of course maintenance of certification re-certification. Without education you can't do too much of that. So, anyway, again, I'm going to pass on…You know in terms of things to think about that are not so focused on my study, I do think the issue of every state having different medical practice acts for its physicians, it's nurses, PTs, that's a big problem, and so we do have to work both within our respective professions and across I think to figure out how to standardize that.

There are different issues by profession of course. The issue again of unprofessional behavior is huge, and how to break that out. And, you know, the issue of severity both for the public, which is what Mark was discussing, and then for the individual you're sanctioning, which was really more of the focus of my study. And then I know that Mark went to the National Data Bank.

I am, you know, I am not an investigator at our board, so I've have limited back and forth with them, but I honestly don't think that what they gather is necessarily sophisticated enough for our purposes, is what I would say. You may disagree. So that's all I have to say for now. But we're both happy to answer any questions.

- [Maryann] Well, thank you both very much. I'd like to start off the questioning, and then ask you to come to the microphone with your own questions. So, Mark, I have a question that during your excellent presentation came up, I know you had a task force that developed the codes, and then you had to translate the NPDB codes to your standardized ones.

Did you have a process of validation? Were there questions about the translation from NPDB to yours?

- Well, let me just clarify one thing, and that is that we actually use the NPDB terms and codes, so we didn't create our own terms and codes, we just defined what they were, and when to use one versus the other. So our validation process is basically two years of using them, and getting feedback from our jurisdictions, and looking at it.

So that was basically the validation process.

- Great. Thank you very much. Suzy, I'd just like to turn it to public protection, what are the implications for public protection from your study, and what's on the horizon? What will you be doing next?

- Well, I think there's a lot of work being done out there in the research universe, and in individual boards, and at the FSMB to look at this. I think the biggest emphasis right now that everyone is looking at the FSMB and individual boards is the issue of physician burnout, where that, you know, in general, that's a big question, and also, you know, what to do about it, and how to do what we can when…and a lot of it does come, and they know this now from the health care system, and not from the boards, and not from medical regulation, but we're looking at, you know, and certainly the FSMB's recent Journal talks about this a lot.

So, you know, I think that's the biggest one, and certainly, you know. But in terms of the disciplinary space, looking at how much of it is physician burnout, I will say in our study the average age was about 55, so 24 years in practice give or take, and that does speak to burnout, your life getting more complicated, the environment getting more complicated and so on.

- Thank you. I see we have a question. Microphone number two, Nathan. - [Nathan] Nathan Goldman, Kentucky. I'd like to ask the panel, do you think there's any advantage to having uniform disciplinary terminology at least among the health care professions?

And is that something that could be done through an interdisciplinary compact perhaps?

- I definitely think that it would be beneficial to do that, to come up with some uniform terminology, and so forth. I think that the globalization of the world, and the fact that we're working so much interprofessionally nowadays, and that's being recognized. Interprofessional practice is really critical. So, I think that is a next step, whether or not it's done through a compact or not, that's an interesting…I got to think about that a little bit, but that's certainly a possibility.

- Microphone number 7. - [Erin] Hi. Over here. Erin Tilley, with Ontario. Thank you both for your presentations.

Something that particularly resonated with me was this idea that we sit on a lot of our data and how can we effectively use it to inform our decisions. And I had a question related to the physician discipline research in part to inform how we may use our own data, and that's around the study period that you chose, so I believe it was a 20-year study period.

Just wondering what the rationale was for that, and why not look at all of your data, versus 10 years, versus 5 years, and how can we draw meaningful conclusions from our own data?

- In all honesty that period was chosen because before that the data was terrible and it just would not have been good, honestly, that was why. I will say that I cited a study from Ontario in my research actually, and it was fascinating to me at the time to see what, you know, there were some differences in Canada versus the U.S., and so on so forth. But honestly, it was because, you know, the EDs said, "Look, anything before 1990, the data itself is terrible."

- One of the issues that we have when we look at disciplinary data is the fact that there are multiple codes for sometimes one violation, how did you deal with that?

- Our instructions to our jurisdictions is to use as few codes as you can to really get out what the issue is but you need to cover the issues. So if you need to use multiple codes, use multiple codes.

Now what that's doing is, we're analyzing the data, we've had to create a disciplinary or incidence, and we've got to separate now, multiple codes that are related to one incident from…And it becomes very complicated and very complex. But I think you have to do that. But I think many times, and that comes in just training and so forth, people just assign as many codes as they can or as few codes as they can.

So it's kind of like coming up with a consistent approach to this, to really describe what happened and why the action is taking place, is just part of I think what has to be incorporated into the instructions and guidelines.

- I'd like to add to that. It's a really interesting question I found as we were extracting the data for our study. Certainly, most, you know, if someone had a board action, there were usually several MPA violations involved as I would get in there, and be reading, you know, reading in the lines there.

You know, there were sometimes all kinds of things happening which is why I started creating these separate categories. I think standardization is important, but it's a complicated issue, because for instance I created something, you know, one of the categories I created had to do with mental health issue not related to substance abuse, I mean, which frequently they are, but sometimes it's not, you know, or sometimes it's another mental health issue.

But, you know, there's a lot of things hidden in 525, you know, 5 in our database being, you know, mental health, 25 being, or maybe I have this reversed, I've looked at it so it's been a while, but one is mental health specifically and one is substance abuse, but of course they're usually interlinked. Also in our particular law in the '90s, our pain rules became, we created our pain rules so that any physician who was violating the pain rules could also be cited for violating standards of care, so most of the time they have 6 and 13, or whatever.

So it's complicated. And I think some of it just has to be common sense and what's really going on here. But I don't think it's going to be easy to do.

- Mark, you mentioned collaboration among disciplines which is an excellent idea. What do you think some of the differences are that we might encounter between physical therapy, and nursing, and medicine?

- Yeah. I think there's a couple of really significant differences. One is just numbers. Nursing has huge numbers. Physical Therapy, we've got about under 3,000, probably about 270,000 licensees. So when you compare that to nursing, we don't have the numbers. That creates problems for us but I know the numbers also create problems for you too.

If you were to go in and do what we did, and go back through the last 10 years, and apply a new code system to the last 10 years of data, that would be just onerous I would think. So that would be a real challenge. So there may be some other ways of getting around that. As far as the actual codes are concerned, I think, well, drug and substance abuse was very high on our list, we don't have the diversion as I mentioned before.

We don't have some of those things because we don't have…We only have access to a few drugs. So, most of our things are related to stealing patients' drugs, etc., versus not administering, and that type of thing. So I think there are definitely some differences. And that's why I think inter-collaboration could be so great because we could identify when you use one versus the other, and this one applies to this profession more than it does to another.

And it could really…you could fine tune some of that.

- Great. Microphone number two. - [Louis] Louis Perkins, Kentucky. In the categories that were cited in your studies, how do you see education or an increase in residency solving that problem? And then a second part to that question, if education is a solution, is values and ethics something that needs to be focused on a little bit more?

- Okay. That's a good question. As we say in our study, you know, all we could see, you know, we cannot say, you know, there's a linear relationship between the numbers of years of education and the exact…You know, we didn't have that kind of correlation. What we really saw was, and it's especially true, you know, things have changed over the years, again, those normative changes in physician education.

At this point, if you can't complete a residency, there's probably, I mean, even if you have to stop because you have a sick parent and go back, but if you cannot complete a residency, there's probably something the matter. And your licensing board needs to keep, you know, needs to keep an eye on you, because at this point, you know, it is a real indicator of either a personal problem, a competency problem, or a drug problem.

You know, again, that was not always the case. I need to be, you know, we were very clear about that. But in, you know, in today's, in terms of the norms and expectations, if you know, any licensing board needs to look really carefully at someone who did not complete at least three years post graduate medical education, that's a ding, ding, ding, ding, ding, real problem. In terms of the ethical questions, that's really a question in the medical profession anyway for LCME.

I certainly support ethical education, but that's from the educators themselves I would say.

- We have time for one more quick question. Seeing none, do you each have a final word?

- I definitely do I think. Of course, I do. I just think that as we move into much more of a role of prevention, this data is absolutely critical. We need to know who is a risk, we need to know. And burnout is, I think it's not just a medical issue, it's nursing, it's physical therapy, etc. And we're just starting to look at that, and provide support.

So I think it all gets out all this risk-based regulation, how do we keep people engaged in our professions, keep them from getting burned out? We need this data. It's absolutely critical data. It's not data just for data sake, it's data to really help our licensees and provide access to good quality care.

- I think I certainly concur with what you said. And I also think, in our study, we did not look at practice setting, but I think more work needs to be done there, both as it applies to likelihood of being sanctioned, burnout, whether, it's you know, nurses, PTs, or physicians. I think there's a lot of interesting work that needs to be done.

I do think practice setting needs to be looked at more carefully. And I do think it's exciting that we're having this conversation.

- Thank you both very much. Please join me in thanking them for their excellent presentation.