Jarrod Shapiro: Good day to all. My name is Jarrod Shapiro, Editor of the Practice Perfect blog. As many of you know, the joint task force of orthopedic and podiatric surgeons composed of the American Association of Orthopedic Surgeons, the American College of Foot and Ankle Surgeons, the American Orthopedic Foot and Ankle Society, and the American Podiatric Medical Association, have brought a resolution, J21-303, to the American Medical Association. This bill proposes to investigate if the accreditation, education, and certification processes for podiatry are comparable to those of MDs and DOs. This obviously has the potential to create controversy in the podiatric profession. So, I'm speaking with individuals well-placed to understand its potential effects. I'm here today with Dr Stephen Wan. Dr Wan recently retired from a distinguished podiatric practice in Los Angeles, California after about 42 years, if I have that correct, where others stop working when they retire, Dr Wan's version of retirement is to become a faculty member of Western University College of Podiatric Medicine, where he continues to educate students, residents, and in fact, our faculty as well. He's been a past president of the California Podiatric Medical Association, a statesman and leader in the region and nationally, and is an integral member of the California Physicians and Surgeons Task Force that has been looking into podiatrists obtaining a physician and surgeon license in California. The California Task Force is obviously the forerunner of the current joint task force. Dr Wan, thank you very much for joining me today. I appreciate you taking the time.

Stephen Wan: Thank you for inviting me. I look forward to it.

Jarrod Shapiro: Good. So, can you tell us a bit about your experience with the California Physicians and Surgeons Task Force?

Stephen Wan: Yes, in fact, this started about eight years ago. And at that time, the California Podiatric Medical Association took a look at the bigger picture of DPMs licensed to practice in the State of California, and by extension, DPMs quest around the country. And it became very apparent that of all the rules and regulations that we've had to face over the decades, a lot of that had been what we call a whack-a-mole. What do I mean by that? It means that for every subject that came up, we would have to spend quite a bit of time and also financial resources and personnel resources in order to address a situation. I'll give you an example. About 20 years ago, then Senator Teddy Kennedy had proposed a bill, a national bill at the U.S. Senate, addressing that physicians were entitled to do certain things and should not do certain things. And by and large, that bill was very positive. But when that bill came out, we had to go to Senator Kennedy, who was a friend, really, a legislative friend, and say, don't forget us podiatrists. And he was absolutely taken aback. He said, what do you mean? You're one with the physicians. We said, no, we're not. We're not licensed as physicians. So, if he had to amend that and put in, and podiatrists, okay? That's just one example. The other examples are discrimination. You take a private insurance company, they are freed to pay DPMs in certain states, and certainly in California differently than they pay an MD or DO for the same amount of work, okay? And when we would contact those insurance companies, some would just say, alright, so we understand we should not discriminate, et cetera, et cetera, et cetera. And after a certain amount of time, they will

invite us back in. But other companies will just very openly and blatantly say, no, you are not physicians, you're not licensed as physicians so we don't have to pay you as physicians. Well, we don't name names here, but they are some very big insurance third-party payers. And they are big players, too, on the national scene, and they practice that day in and day out. So, no sooner will we address one issue, another issue would come up. We had just had that issue; a third issue will come up. So, this really has become what we call a whack-a-mole, circling back to what I said earlier. But the heart of it is the fact that we are licensed to practice as physicians. We have a limited licensed called a podiatric licensed, okay? We're licensed to practice podiatry in the State of California. So, we said, alright, what does it take? What it takes is for us to ask for the physicians and surgeons' licensed. In order to do that, we would have to make sure that we get to showcase our education, curriculum, as well as our residency training competency so that the House of Medicine, the MDs and DOs, can take a look at how we currently educate and train. And then, be able to say, yes, you're there with us, we're okay with that. Or no, you're still lacking in this, show that up and come back, and we'll talk some more. So, at that time, we came up with this project, we call it the Physicians and Surgeons Project. And we knew that if we're just going to go to the state legislature by ourselves and launch it, you can just imagine the pushback coming from all sides, right? So, we say, okay, since we have developed a good working relationship with the California Medical Association as well as the Osteopathic Physicians and Surgeons of California, we said, alright, let's just go talk to them, and see whether or not this is even doable, alright? If it's not, then we know exactly what kind of resources we have to invest in order to do it alone. But if they would help us, the pathway is certainly a lot smoother. So, with that in mind, we sat down with them, I think, in 2011. And they said, yes, it's very doable. What you want is a plenary license or what is called unrestricted license or universal license, whatever term you want to use it, but the proper term in California is called a plenary license, okay? They said, alright. And you want to do it by proving that you are there? They said, we are very much on board of it, simply because CMA, California Medical Association, deposition is it has to be about education and training. And their executive director said, well, since you're coming and you're calling us on that, we will be very hypocritical if we don't go with you on that, at least take a look. So, with that we will launch the task force in 2012. And we sat down, California Medical Association, Osteopathic Physicians and Surgeons of California, California Podiatric Medical Association, and also the California Orthopedic Association. Now, some people will say, well, if the COA, Orthopaedic Association in California is part of CMA, the Medical Association, why do they need to come particularly be represented at the table? Well, for lack of a better term, now, if we are going to take on this project, what better way than to convince our biggest naysayers or turf battle competitors, so shall we say, and the orthopedist. So, can you imagine if the orthopedist were to say, we can find no fault in the education and training, then very few other people can find a fault with it. So, with that in mind, it became a full-on organization project. And we sat down and we identified what we needed to do. Since this was in California, they said let's start with looking at those schools and look at the curriculum there at each school, and then we want to go visit some of your residency programs. So, we outlined our residency programs. And they said, alright, we want to take a look at the programs that are affiliated with teaching institutions. So, they picked out the full

programs. And those were our best. And they had a reason for that, is that if those are your best, we want to take a look at your best. If your best doesn't measure up, there's no conversation to follow. Because if I go to a restaurant, I want the house special. If the house special is crappy, we don't have to change anything else, right? So yeah, so after I think about a four-year process, we all came to all four recommendations and came to the conclusions about education and training in school as well as in residency are really comparable, okay? And they also took a look at how we accredit our schools and our residency programs. And they found that the process by which CPME, the accredited schools and residency programs are very much in line with how they accredit their medical schools and their osteopathic medical schools, as well as their residency program. So, they said, your education, your training, your accreditation, are really very much on par and parallel with what we use, respectively. Therefore, what's lacking and what's missing then is just the exam. So, if you, guys, will take our exam, the USMLE or COMLEX and you can pass, the rest is just a matter of putting the letters on a piece of paper at 50 states and recognize you as a physician. So, that's how this project got launched. And that was a quick summary on what it is to date. So, when we reached that point in California, where even the ortho said, three out of four things are done. The final thing is, see if you guys, can take our exam and see how you do. That became a national issue, because as one state, we could very well go to National Board of Medical Examiners and say, open up the process to our students only. So, we handed it off to APMA. And at the same time, the orthopedist handed it off to AAOS. And so, ACFAS, AOS, and APMA all got together. And within AAOS, the orthopedic surgeons, they also said, well, the biggest naysayer is coming from their ranks would be AOFAS, the foot and ankle orthros. And they said, well, let's have them at the table as well. If they say, they don't find an issue with it, the rest is easy. So, after two, two and a half years on a national level, after multiple meetings, they finally came to this resolution. And it's the first time ever in orthopedic history that they have become a sponsor of a resolution to the AMA, to ask them to actually look at our accreditation process. And because they didn't say, they don't have to look at education and training anymore, because we've already done that for them. All they have to do is make sure that CPME is comparable to LCME and ACGME. And then, they ask AMA to petition the NBME to open up the USMLE forms. So, that's the logical sequence, okay?

Jarrod Shapiro: So, I have a question I was going to ask you later in our discussion, but I think it's appropriate now. I'm sure you could imagine that there are podiatrists that disagree with the process and the idea of having them examine us in this way. I've heard individuals argue things like, our students will pass the USMLE or some argument that this is somehow a backdoor way for podiatrists to become MDs or somehow this is going to destroy podiatry. I heard somebody say that this was like, we're giving the orthopedist the ammunition that they need to try to diminish us in some way. What would you say to the people who are making that argument against this part of the process?

Stephen Wan: Well, first of all, I think we should look at those colleagues who are "naysayers" to this process, not as the enemy or not as the stupid or whatever, all the negative adjectives and adverbs should not apply to them. I think we are all discussing

and debating what is best for us and if each party, whether it's a yay or nay is just coming from a different angle. We, as DPMs, I would like our DPM colleagues who are anxious about this to follow us through on this. This is about DPMs being licensed as physicians. So, that limited licensure goes away. But if you don't look at DPMs in the traditional limited license framework, but you look at it as a physician ophthalmologist, then we may have a better understanding of it. An ophthalmologist is a licensed physician with all of the rights and privileges attached to it. But the ophthalmologist chooses to specialize in eyes and associated structures, okay? So, with DPM being licensed as a physician is the same thing. We are fully licensed as a physician. And we choose to specialize in foot, ankle, and related structures of the lower leg, okay? That does not mean that we can we should do cardiology any more than half than ophthalmology does cardiology. No, ophthalmologists are not interested in doing cardiology and does not want to do cardiology, and the ophthalmologist malpractice insurance does not cover the practice of cardiology by an ophthalmologist, right? So, the same with us. So, usually, in the early days, when this subject came up, around the room, there always be a couple of hands that said, does that mean that we can practice cardiology? No. If you want to practice cardiology, then you have to go back to a cardiology residency. But the DPM can go back and do a cardiology residency without having this to start medical school all over again, a new one, which is what we have to do at the present time. Okay? And then, colleagues will follow up and say, if that's the case, then we lose our esteem to MD or DO schools. No, we wouldn't because you cannot imagine how many MDs and DOs have approached DPMs and say, with what you do, I wish I had known about you guys. When I first applied to medical school, I would have gone to Podiatric Medical School and be a podiatrist, okay? Because with the exception that we are not recognized as a physician. On the clinical level, on the hospital level, all of our obligations are those of a surgical specialist. We are held to the same standards. We have the same exposure. It's just that we don't have the rights and privileges of a full-fledged physician. We may have 90%, even 92%, even 95%, but we don't have a full, so to speak, to be called and licensed as a physician.

Jarrod Shapiro: So, I have a couple of, I guess, scenario types of questions that I'm wondering if this might affect. So, as an example, your podiatrist doesn't currently do endovascular work, we're not revascularizing. But if we were fully licensed as physicians in the way you describe. And we did obtain training, maybe, for example, during a limb-preservation fellowship, and there was a vascular component where they taught the fellow how to do endovascular lower extremity procedures. Would this allow something like that or is that still in the same realm as, no, you're not a cardiologist at that point. Is it the same as that or somehow different?

Stephen Wan: No, I think you brought up a very good scenario. And I think that would have to be taken up hospital by hospital, right? And just like in the early days of endovascular surgery, who's realm does that fall into? That there was no such thing, not even 10 years ago as an invasive radiologist or a radiologist who did endovascular procedures, right? That's so-called specialty was really a recent addition to a subset of radiologists. And if you remember, there was a turf battle between the vascular surgeons and the interventional radiologists, right? And still, to this day, there are some

states that enable that to happen. There are some states that don't. Even in the State of California, the greater majority of hospitals recognize interventional radiology as having the training to be able to do endovascular work. And there are some hospitals that still say, only though those with vascular surgery training can do endovascular work, right? So, I think that your question is best answered by, can the DPM take advantage and go get trained? The answer is yes. When you're licensed as a physician, any physician can be trained for that, okay? So now, once you're recognized as a physician, all your privileging is really based on training and experience, right? So, if you have the document to training, technically speaking, yes, you can apply to the hospital for endovascular privileging whether or not it is granted based on the hospital's protocol, that's a local issue. I imagine that will be a new frontier, because now they have to add in DPMs to do certain types of endovascular work in the lower extremities, in that it still fulfills our specialties, the specialization in foot, ankle and lower leg.

Jarrod Shapiro: So, I would wonder if that might also be beneficial in states where maybe our license is more limited regionally. So, for example, some states would allow you to do, say, a tibial osteotomy or maybe even ORIF a tibia, whereas maybe a larger number of states don't necessarily allow that. But if we're fully licensed as physicians in that same way, I would imagine that it would give those podiatrists a maybe a stronger leg to stand on, no pun intended I suppose, to fight that type of thing. Maybe supramalleolar osteotomies might not be within the scope of practice in a particular state. But if you're going to fight them as a podiatrist, maybe this type of thing also gives you a little bit more sway or strength for that argument. Would you agree with that?

Stephen Wan: Yes, in fact, you brought up a very good point in that once we are licensed as a physician, then a limited licensure goes away. And then, you are judged by your education, your training, as your annual experience just like any other physician is, right? So, it's like, a general surgeon will not apply to do a supramalleolar osteotomy. That person is not trained to do that, right? And if they want to, they have to go back and get a training for it. However, a DPM, let's say for you and me, were already licensed, but I say tomorrow, this thing comes to fruition. And you and I are licensed as physician, if I do not have the experience and I was never trained to do a supramalleolar osteotomy, I should not have the ability to do that. Because then, our area of expertise specialty becomes foot, ankle, and related structures of the lower leg. So, if by a supramalleolar osteotomy, you are turning around an internal tibial torsion or whatever it is you need to make the foot and ankle function better. And you, Dr Shapiro, has the documented training and experience to do that, why should you not be allowed to do it? Correct? Right now, the frustration is that even with an ankle law in the greater majority of states, if that pathology is two centimeters above the artificial line of the ankle, then that DPM either is not allowed to do it even with the training and the experience, or they would have to change the state law to allow that DPM to do it. With the physician category and the license, that goes away, okay? Now, there are some colleagues who also say, well, within Medicare, we are already physicians, so what's the problem? Well, there are different grades of physician definition in Medicare. MDs and DOs are Category R1. Dentists are Category R2 as physicians within Medicare. We, as DPMs are in Category R3. So, yes, R1 is definitely the ticket to ride, okay? We are in R3, so

no, we are not really true-fledged or full-scale level one physicians like we believe that we all.

Jarrod Shapiro: Yeah. I can definitely see where there are other areas where there might be questions about scope or, yeah, I think of things like plastic surgical procedures, where you might have island flaps that come from other parts of the body, somebody who has that training as a podiatrist could apply that to the lower extremities. Things like, I know there are some people who do leg lengthenings, but yeah, there are others of us who were concerned about, say, putting on an extra fixator approximately on the leg, because they're concerned about that whole idea. In California, a podiatrist can't do a below-the-knee amputation, which seems silly, has always seemed silly to me, especially since nobody in California seems to want to do it. So, why not have your podiatrist be able to do it? And it seems like there are a number of those kinds of things that are, at least, as long as, like you said, the training, the experience is there, the education is there, that this potentially opens that up, at least these possibilities of expansions into other areas that could be helpful for our patients in the profession. I think it's a very interesting statement about Medicare. I've heard that same statement, podiatrists or physicians in Medicare, but a physician isn't always a physician, it seems. Do you know any other areas that this could be advantageous to podiatrist and the other places where the definition, this global definition of physician might be helpful to the profession?

Stephen Wan: Yeah, well, two things come to mind right away. One is the reimbursement question, especially within the private sector. No longer than, no longer should DPMs suffer the indignity of being paid less for the same amount of work, right? From the integumentary system all the way down to the osseous system, and everything in between, you do the same amount of work, you should have the same amount of pay, because your liability is not going to be less, right? And the blood, sweat, and tears that go into it is not any less. Your exposure is not any less, right?

Jarrod Shapiro: Right.

Stephen Wan: So, that's one. Secondly is also the ability to hold certain offices within the governance circle of either big multispecialty group or even in a hospital, okay? Currently, the law is pretty gray in terms of, because Medicare has chosen not to clarify it beyond the shadow of a doubt. Are DPMs allowed to be Chief Medical Officer of a hospital or Chief of Staff at a hospital or the President of the Board of Trustees of a hospital. MDs and DOs don't have that issue because they are fully licensed physicians, okay? But the DPMs, it's very… some of the big multispecialty groups because they are self-regulated. They just say, "Well, we feel that the best candidate to hold these offices position is a DPM," and they'll go ahead and do it. And they have the clout to do it. And they self-regulate it. But in community hospitals and in proprietary hospitals, or the religious hospitals, that is still a gray zone and is not very clearly defined, okay? And then, on top of it, there are also discrimination or extra hoops that some DPMs have to jump through, I know at least in California, that has become a decreasing issue. But in other states, that has not yet. And what is that? And that is private insurance companies

can erect extra barriers for DPMs to go through to get a preauthorization. It wasn't so long ago that a very big private insurance company in California, up to about two years ago, they subsequently abandoned their practice. But up to about two, three years ago, they could deny DPMs a request for MRI or CT scan for the very reason that providers of this category are not entitled to order these tests, okay? And so, each time we ask for preauthorization from patients covered by their insurance company, we've had to get on the phone and do all of that. And then, even some of their medical reviewers would chuckle and say, that doesn't make sense. Well, it doesn't make sense. But the clerk denied it on the first round so we have to spend extra time. I'm not saying anything new that we haven't come across, right?

Jarrod Shapiro: Right.

Stephen Wan: But it wasn't until the last two, three years that that insurance company, because of CPMA's intercession has basically just really backed off.

Jarrod Shapiro: So, it seems to me that this type of thing is not necessarily saying, podiatrists are illegitimate as a physician or that we're not qualified, in that sense. It sounds to me, the benefits of this are more like, we've proven that our capabilities are the same as all other physicians. And then, when we are coming to these circumstances, these situations, like what you're talking about, Steve, that an insurance issue where maybe they're trying to rip us off, or they're just trying to make the most money that they can by denying us things that we're requesting, that this gives us this more power, I guess, to stand up to those who are potentially trying to take advantage of situations. It doesn't seem to me that we're really hearing, oh, you're not qualified to take care of patients. It's really more, we recognize that you're one of us, and that you should be treated the same. Or at least, you have this influential power to accomplish those things that we want. Is that a fair way to look at this type of thing?

Stephen Wan: I think, on the first question, it's about right, but I'd like to put a couple of finer points in that. Don't forget that, we all have to remember that a substantial amount of the rules and regulations from the federal level, down to the state level to the private level were all written some decades ago, right? Medicare rules and Medicaid rules, now, came up in the '60s, right? And then, a lot of state rules were treated along the way, et cetera. And private insurance companies, some of their rules were written and modified as time went on. But now, podiatric medicine and surgery really did not come to any national recognition as a player, so to speak, until probably the '60s and '70s. So, a lot of these rules and rights that we are currently laden with started around that time when we were included into the insurance world. And so, these might have been appropriate at that time, but no longer applies to today. And to your point, it gives us more power. I think it's a matter in that what we are saying is the looser rights that were written from that time and carried on to the present regulating the practice of podiatric medicine and surgery no longer apply to the present day where we're practicing high-end, well-trained, well-educated DPMs, because we are now a totally different animal. We have evolved so much that the practitioners in the '60s will not even recognize that what we are practicing today was what they could dream of back then. And so, it's a matter of

bringing the rules and regs and the statutes up to date in line with what we are providing in terms of value to the patient and for patient's safety, and also to their well-being, right? Because at the heart of it is what can we do to make our job easier so that we can serve our patients better, right? Because ultimately, without patients, all providers are out of a job, right? We cease to have a reason to exist, right? So, anything that we can make streamline for the benefit of the patient and to make our practice life easier, plus also to bring everything in line with the way we are educated and trained and the way we practice. That is what this quest is ultimately about.

Jarrod Shapiro: So, do you see that, I guess we should maybe move forward a little bit and create this maybe hypothetical scenario that we are then considered physicians and maybe this task force, it's currently going, whatever this happens, not only are they successful, but it is determined that we are considered comparable. I think that's their terminology, comparable rather than equivalent. If it is then comparable, and we are then, I guess, voted in as physicians, would you see effects for how podiatric education occurs? And I guess that obviously the two major areas are schools and residency programs. I wonder if, for example, would podiatric residency programs, maybe they would have an intern year that includes maybe more medicine. Although there are quite a number of our residency programs that have a very heavy medical emphasis. Do you think that that type of thing would change in some way with us being considered physicians in this larger realm of things? Or do you think this is really just an enhancement of what we're already doing currently?

Stephen Wan: Well, I think it's a validation, and there has been an enhancement of what we are already currently doing. A greater majority of residency programs strike me as falling into the two aspects that are really important. One is, the greater majority of our programs, DPM programs, are really embedded within what they approved in hospitals, okay? And those are already existing teaching hospitals or major academic medical centers, okay? And so, the greater majority of our programs are already within the hospitals already, okay? So, that does not really require our programs or anything different. So far as the second thing is our exposure to medicine and the principles of surgery, and other surgery for other parts of the body in order for us to become better in the understanding of medicine, that is already being taught and trained up to the great majority of programs, especially within the first year, okay? And the internship year has, really, basically, gone away for those individuals who know what they want. If somebody who wants to go into ophthalmology, they don't have to do an intern year because they have been to ophthalmology residency by and large. A lot of the previous years are those who really don't know what specialty they want to go to, and so this is really their journey to do different things and try and find what specialty they want to put on, okay? So, that is really the so-called old-fashioned intern year. Once they pick their residency or area of specialty, that would attribute as well to their residency training. So, the so-called traditional intern year has really by and large gone away. But what we are doing in terms of declaring a very clear pathway of specializing. 00:40:02 So, ours come in right away knowing that they're going to be able to do foot and ankle and the related structures of the lower leg. So, their education and their training is more focused on that. You know what? The allopathic and osteopathic world is embracing that in

incremental rooms. UC Davis already has had over the last four or five years, UC Davis have a medicine track where their students go to medicine and especially for primary care, they do a three-year education. And during those three years, they are in fact to really primary care. Now, by the third year of that, if they really don't want primary care, I want to walk out of primary care program, and they'll come back out and try their hand, a shot at other residencies such as general surgery or oncology, that person can drop out of primary care. But that person will have to back full a couple of the courses that they lacked, and some of the hours that they lacked because they will try to work as primary care, okay? Now, change the word primary care to podiatric medicine or surgery.

Jarrod Shapiro: Yeah, the same thing.

Stephen Wan: Right? The same thing. And Duke University Medical Schools would probably put the same thing for their students. Somebody who's coming in to medical school, if he or she knows that that person wants in fact to focus into orthopedic part of the three-year program also in medical school and are related too goes into orthopedic residency that way. But if they avoid and didn't want to go to surgery, they drop of that, back full some hours and some courses, and so they can compete for other residencies as well. So, our model is also by the allopathic and osteopathic board for subspecialties. So, despite the fact that we do not come from the same pedigree that our method of, our mode of training, it's more as much of an alien animal as it was once.

Jarrod Shapiro: Right. Okay, so I see what you're describing that the idea of us trying to adopt what had previously been the model for medicine is potentially even going backwards, I think, in some ways, from the way you describe it. So, it's definitely not in our best interest to look at it that way.

Stephen Wan: Well, at the heart of it is still, I think we, as time goes on, medicine and provider education training continue to evolve, I think the time has come for us to recognize that we are physicians first and specialists second. I don't care how you justify and how you seek the education and training. At the end of the continuum of medical school and residency, the finished product should be no different than any other physician specialty, right? And that's what the California Task Force found out. That the only difference and what really is different is our sequencing. We start off with a focused product. And then, we allow that product to branch out. And at the end of our seven-year continuing education and training, our end clinical product is not differentiable from any of the surgical subspecialties of the House of Medicine, okay? Whereas, they train at a more specific product at the end of their program, and they defer it to different pathways using weighting.

Jarrod Shapiro: I think it's a ...

Stephen Wan: But our clinical product and their clinical product are not equivalent or comparable in terms of our expertise of knowledge within the endovascular surgery and medicine.

Jarrod Shapiro: I think you have a much more optimistic view in comparison to some doom-and-gloom people who have been maybe contrary to this whole idea. So, as a way to close out our conversation today, I'm wondering if you, given your experience over these years with the Physicians and Surgeons Task Force in California, what advice I suppose would you give to those who are currently leading this Podiatric and Orthopedic Task Force. Are there suggestions that you would give them to help make this a healthy process for everybody?

Stephen Wan: I think what they have outlined and how they have been… regarding **…** if it would be, it has been previously spot on. The National Task Force colleagues have not been in argument. They've laid out the process in a very remarkable and persuasive manner. But for the colleagues on the other side of the table, as you said, they are doing... I don't blame them, simply because they… what their personal experience has, right? If their personal experience with the House of Medicine has been at loggerheads, a very contentious atmosphere, I can see why they argued about this approach, and say, does this give license to destroy us and take away my privileges. Somehow, maybe unless we're**…** No, they don't. I've **…** National Task Force colleagues, as well as myself, we've had the good fortune of being able to… for people within the House of Medicine and the orthopedic organization, pretty high level. And you'll find that at that level, the quest is essentially the same. But if I put on a mercenary hat, what's in it for the house of medicine. It's a very simple thing. A lot of people want a piece of their pie, right? Because when you have the full pie, your entire life depends on your pie. Everybody else can come and take bites of it. And they understand that different people also want to come by and say that they are also physicians, and this and that. So, we have provided them a good pathway in order to use education, training, and experience as the benchmark and as the milestones. 00:48:04 So, once we go in to the House of Medicine, they can say to the rest of the outside group, so shall we say, alright, we have a model here. It really is about education, training, and experience. If you do the same thing as the DPMs have done and willing to invest and upgrade your education, your training, and take our test, you too can be a physician. That's exactly how I would play it if I were in their shoes. And so, once that was laid out, you can see them just understanding and grasping that concept. Very well. And so, on that kind of a level, I don't see there are other nefarious agendas and items on there. But the thing is, even if we don't take it, even if we, shall we say, we can do better on their test. Let's say the first couple of years our students take the USMLE, we find that we still have a little way to go to close the gap. Well, you know what? Look at those as practice games, right? Those are pre-season games. When the season comes is where it counts. So, what better way to gauge ourselves as to where we are than to do a couple of practice rounds and say, okay, we still need to show our peer, show the international medical graduates coming from medical schools from other countries, they have a similar obstacle. We don't see that the Royal College of Medicine is anywhere negated, simply because their students may not do as well as us, our MD or DO students on the USMLE.

Jarrod Shapiro: Right. Well, I think that is a fabulous place, very positive place to end it. So, Dr Stephen Wan, thank you so much for taking the time. I think you've provided a really educated perspective, a reasonable one. I'm sure this process will be going on for years. It seems like it's one that takes a very long time to finish up. I'm looking forward to seeing where it goes in the future. So, thank you, again, for participating in the conversation. I think our audiences will find it really educational. Thank you very much.

Stephen Wan: Thank you for the opportunity. I appreciate that.