Primary Care Cures

Episode 152: John Canion

Ron Barshop:
Welcome to the only show dedicated to a new way of delivering healthcare. This new model has no name, but let's go ahead and call it direct contracting or digital first care. The new way centers on opting out of the games bigs play with their rigged dice, their crooked game board and their purchased referees. And if you're looking for a future where everyone wins, that's the doc, the consumer, the employer, and with assured amazing outcomes and measurably lower costs that are ranging up to 60%, you're in the right place. I'm Ron Barshop, your host. I'm glad you're here. Welcome to the new healthcare economy.

Ron Barshop:

Today, nurse practitioners, which we'll call the NPs, have full practice authority in 22 states plus DC. Now, the states are mostly lightly populated states, but not Maryland, not Colorado. And what does that mean? That means that they can assess, diagnose, and interpret diagnostic tests and prescribe medications independent of docs in those 22 states and DC. In addition, in 36 states and most territories, there's some form of equivalency between nurses and docs, but there will be supervision involved with 36 minus 22 states. So 14 states have some doctors' supervision, okay? So basically what they're saying is both white coats are equal in a couple of dozen states, and in another dozen states they're not exactly equal but they're working towards it.

Ron Barshop:

Why is this happening? Well, private equity and bigs that own a lot of primary care practices and telehealth companies, et cetera, are pushing this equivalency because NPs are 30% lower cost than primary care doctors, and over half opt into primary care. So they fill the slot very nicely, and we aren't producing enough PCPs to replace a third of the 400,000 for age 58 plus years on the tail of their career. I know a lot of them that work into their 70s and 80s because they're in such high demand as local tenants, but this is all happening as the silver tsunami of Medicare enrollees is growing by 10,000 people a day. So, that's going to go on for six more years.

Ron Barshop:

So we're having doctors age out as Medicare enrollees are aging in, big problem. So here's the big issue we've discussed on the show recently, if you're paying attention is, we have 30,000 nurse practitioners graduated from 570 schools last year. One in six of these programs are online only, and what some students report, not all, but some students are reporting is that the classes are a joke, because they're self-paced PowerPoints.

Ron Barshop:

There are no guidance counselors or admission officers at some of these online only schools. So basically, the problem is bigger than just these diploma mills that are not bricks and mortar, it's

much bigger because 85% of the folks that are graduating from the other 30,000 I was talking about, are not clinical tracks, they're not prepared in other words to go see a patient, they're more of a what they call practice or academic track. That's a big problem. That's really the big problem here. So there are also no national standards for teaching these clinical tracks. They're all over the board and their clinical skills are basically scary to nonexistent in basic assessment, pharmacology, and soap notes to get paid by insurance.

Ron Barshop:

I would say that's a problem. May you might say so too, if you're listening. So two nursing programs, one in Tampa and another in the Bronx last year were decertified and a few more are being looked at if they have, let's say a 100% passing rate, because a matriculation rate nationally is 80% or maybe they have super low state licensure passing rates. So the bigger issue is bigger than these crooked diploma mills. The bigger issue is that 85% are getting their nursing white coat without really clinical training that's proper. And what we have today as a guest, you heard from doctors how they're upset about this on this show, but you're going to hear today from a guest who taught at nursing schools, is a nurse DNP and has a lot to say, and he's very brutally honest with himself up with his profession and with the other side of the story here.

Ron Barshop:

So, the problem with these crooked diploma mills and with this low clinical training is that it doesn't happen in medical schools, you never hear about a medical school getting decertified or getting kicked out by a state. Now people will say, "Well, what about Hahnemann in Philly?" Well, they closed, but they weren't closing their residency program, they were closed because they got beat by the competition in Philly, which is a street smart place to do business. And, frankly they did sell the residency slots for 107 grand each slot, so they must be pretty profitable to be selling for that rate in an open auction. So what else? The hours of clinical training are as some of these like nursing schools we'll call them, 500 hours total clinical training.

Ron Barshop:

They're 1500 hours at the better schools that are more bricks and mortar and not so much online that I would call the more serious and thoughtful matriculation programs. So, again remember 80% versus a 100% at the better schools and they even think that's a problem, they wish they could graduate a 100%, but it's just not possible, not everybody makes the grade. Okay, so let's talk about again, 500 to 1500 hours of clinical training compared to MDs and DOs will get 15,000, 20,000 hours non-specialists. If they're a non-specialist but they're a specialist and have a fellowship, it's more, but that's the rub with scope equivalency is docs hate this equivalency in these 36 states. It's not fair.

Ron Barshop:

They're going to do all of these hours with their last two years of medical school in a couple of three years with residency and boom shakalaka, the nurse gets in with 1500 and they're equivalent in all these states. So you get it?What the problem is?. Now, the other thing doctors will tell you is that anybody can apply to nursing. A liberal arts major or a history major because they got a college degree can get in some of these advanced programs and the final insult that

docs love to say, and this is the going away smack down is that nurses would never pass the MCAT, which I don't believe that, but that's what they say.

Ron Barshop:

So should the public be concerned? They aren't. The Gallup polls that come out for decades, now put nurses and doctors in the number one or number two slot for most trusted profession in America. Thank God politicians are at the bottom of that list, but here's the numbers. 85% trust nurses, 84% last year trusted doctors, nurses outweigh doctors in the trusted department with Americans, 56% of Americans trust the government and health matters. And then the low 30s comes in last place, big pharma and big systems, big hospitals. So again, we talked about all this in the show with Dr. Neuron Alagba who wrote a book with their partner about the problem here, but here's the rub and where this is where we have to be fair is 100,000 of these medical school residents, salaries are funded by $5 billion in cold hard federal cash.

Ron Barshop:

So they're subsidized. The nurses have exactly $0 in residency cash from the federal government. So there's no funded residential apprenticeship like medical students, their last two years or residents for several years of hospital and other rounds. So the nursing boards themselves are pushing for this equivalency because docs have been profiting off of them too long. Previous guests of mine have said, it's just not fair. So one final issue before we meet today's guest, you're really going to enjoy I promise. Half of all nurses that matriculate drop out within five years. And there's a lot of reasons for that. There's a giant burnout, much worse than doctors in nursing. And we'll talk about that too. I'm excited to introduce you to John Canion today. He's a DNP. He's also an [inaudible 00:06:57] practice RN and he taught at Hardin-Simmons in Angela state for many years. And now he's an ER nurse. He's super passionate and a super deep and wide wealth of knowledge about this subject and matters of nursing in general and his ideas I think are important on improving nurse practitioner education. John, welcome to the show.

John Canion:

Thank You. The first thing I'm going to add to you is I'm not a DNP. Okay. I'm just a nurse practitioner. I don't have my doctorate in nursing. Okay.

Ron Barshop:

Okay. I understand.

John Canion:

And there's a significant difference between a DNP and a nurse practitioner. They're not synonymous at all. A DNP is an academic role or an academic degree. It does not confer any clinical training at all. So someone has a DNP does not necessarily have the white coat training of a nurse practitioner or a CNA or whatever other advanced practice nurse role you have. So you can obtain a DNP and not be advanced practice. So there's a significant difference there. Whereas you think of an MD or a DPT or a PharmD all of those people have advanced clinical training, a DNP, not necessarily, okay. Doesn't necessarily have advanced clinical training at all.

Ron Barshop:

And I'm not trying to be cute, but I can tell you the alphabet supp, if I'm confused, there's a lot of other people very confused with all the alphabets.

John Canion:

It's horrible. And nursing is really, really, really, really bad about alphabet supp. Their answer to problems is just add another letter to the end of your initial conundrum.

Ron Barshop:

Yeah. And some of these nurses that have maybe 12 or 16 letters, does that mean they're a lot smarter than the rest of us?

John Canion:

No that means that they paid for an additional certification, which not may or may not have any demonstratable benefit to the degree that they already have. For instance, the nurse practitioner say the nurse practitioner like me, if you go back and get a DNP as well, then you have your NP&, and your DNP because they're not the same. Okay. And that literature does not show any... There's no literature that shows any benefit for nurse practitioners obtaining a DNP at all.

Ron Barshop:

And before we unpack all these issues, I brought up. Is there anything particularly that stuck with you that we want to talk about first?

John Canion:

No, I can go down the list of just any way you want to.

Ron Barshop:

Okay.

John Canion:

I mean I have a lot of thoughts on a lot of this. I want to-

Ron Barshop:

This is a big gulf of water before we go into the subject because the subject I think if we're producing way more academics than clinicians, what the heck is going on?

John Canion:

Well, I don't have an answer for that outside of, in 2010, there was an IOM report that came out that said we were significantly under producing primary care providers in the United States. And that everybody knows that, that's not a secret. And so nursing's answer to that was to increase the number of nurse practitioners coming out at a rate that's alarming. And there's not been a lot of control over quality in that time.

Ron Barshop:

Okay. So I've heard you talk about a bunch of subjects that I think unpacked this really nicely. You talked about a consensus model. That's 10 years old now. That has literally failed us because what the nurse practitioners generated was to guide the states on how to legislate your profession and the scope of practice. But it's just a Swiss cheese full of holes, isn't it?

John Canion:

Yeah. It's horrible. It's by far and away, the worst document ever produced by nursing. And that says a lot, but there are some good parts to it, right? There's some excellent pieces of it that are good foundational things that we could use to revamp the entire consensus model. And the idea behind the consensus model was to teach states what we can and can't do and who can do what and who can't. Because again, our scope of practice is exceptionally confusing. So I want to break that down real quick. Before we move on the scope of practice for nurse practitioners, very simple, it's three things. It's their population focus, their education and their training. Okay. So a population focus, for example, you have pediatric nurse practitioners, so they can only see pediatric patients. You have adult nurse practitioners who can only see adult patients, et cetera, a neonatal nurse practitioners.

John Canion:

So they have a specific population that they can see. And then on top of that, you add their education and training. So the problem comes in is when, for instance, I'm a family nurse practitioner and an emergency nurse practitioner, but we're going to talk about the family part right now as a family nurse practitioner, I have specific population group I can see from cradle to grave that's the population, but the education and training part is the part that becomes tricky. So if you are a business owner, let's say you own a clinic and an urgent care. So a family practice clinic in urgent care, and I'm working in your urgent care and in doing an exceptional job for you, right? I do lots of procedures. We do hormone therapy. We do, let's say we do IV therapy to, and you hire another family nurse practitioner and put them in the urgent care and spectrum to be able to do the same things.

John Canion:

And they say, wait a minute, I can't do that. And your thought as a business owner, well, that's a family nurse practice history. Your family nurse practice history should be able to do the same things. The problem comes is it's all about the education and training portion. So if I've been educated and trained to do that stuff, then I can do it. If I haven't, then I can't. It's not based off of the degree alone. And that's part of the problem with the consensus model is it's they try to focus the degrees and limit them based off of nothing. There's no specific description in the consensus model of what one can and can't do. It's very, very vague, which by design a good thing. But the problem is people are trying to interpret it however they want, instead of based of those three things.

John Canion:

So you have your population, your education and your training. Well, now people are trying to add in other adjectives, like it has to be academic training, right? Which is just silly because if I've been out since 2005 and it's over the last five years, emergency medicine has transferred into using ultrasound extensively. Now, do I need to go back to school to get training and ultrasound

to do that? No. I mean, I can learn through CME and through on the job training, how to use ultrasound. It's not a difficult process, but the problem is they're trying to add additional adjectives in trying to change scope of practice without understanding what the base scope of practice is. So there's this big disconnect from our academic community and the actual clinical practice.

Ron Barshop:

Is there a 2.0 coming out? Is there going to be a consensus improvement, a consensus model?

John Canion:

Not yet.

Ron Barshop:

Okay. Is anybody talking about it? I mean, is there a need?

John Canion:

There's been a couple articles in the literature. Very, very few because our academic side course believes in the consensus model wholeheartedly, so they don't understand the problem with it. And when you try and talk to them about it, they get very defensive about the consensus model when they don't understand what the problems are. I mean, here's a really, really good example. When you look at the consensus model who can work in an inpatient setting or who can work in an emergency setting, right? According to the consensus model and the academics, only an acute care nurse practitioner can work in an emergency department. The problem is an acute care nurse practitioner only can see adult patients. And if you look at the number of emergency departments that are adult only, it's less than 1%, right? Whereas the family nurse practitioner can see from cradle to grave and can be trained to take care of critical patients. So the vast majority of nurse practitioners working in the emergency department, depending upon which study you look at is 85 to 92% are family trained.

Ron Barshop:

Okay. So do you agree or disagree with Dr. Alagba, who we referenced earlier and I'm sure you're familiar with her book that talks about it's called patients at risk, the rise of the nurse practitioner in the PA. So what she argues in her book is that patients are at risk. Do you agree that that is a possibility or a probability?

John Canion:

I think the literature has not shown that to be true, right? So the literature is pretty strong on nurse practitioners giving safe care. Okay. So I don't think that there's not any literature that actually substantiates those claims at all that I can find.

Ron Barshop:

Okay.

John Canion:

Now there might be some out there, but I can't find it. What I do know is that to me, we need additional hours of education and training before we get out of school, because what's happening is people are now and businesses now are understanding that nurse practitioners need additional hours of training when they come out, say 10 years ago, when you decided to go from nurse to nurse practitioner, you had to have extensive training as a nurse before they would even look at your application, which as we know is not the case anymore.

John Canion:

So you have the ability to recognize sick patients and understand when you are missing something. And that's kind of absence. So it takes these people several years to catch up 6, 12, 18 months to catch up. Right. And a lot of businesses are recognizing that. So they are now doing what they call orientation models, where they orient nurse practitioners for extended periods of time before they left them see patients on their own. Okay. And the places that I've looked at have anywhere from three to 18 months worth of additional education and training prior to letting them work by themselves.

Ron Barshop:

Okay. So you have said in a previous interview, John, that the nurse practitioner students that you're seeing that are career completely wet behind the ears are exceptionally weakened pharmacology. And there's 24,000 FDA approved drugs. I could understand that's tricky pathophysiology, which is a physiology of a normal states. You said, complaint charting is a problem, a solid physical exam, where they're just doing simple palpation of the chest, et cetera. And then billable notes getting paid on notes. Those are pretty five big areas that are-

John Canion:

Yes, I think it's the foundation of the whole profession. In fact, you could argue that is very weak, which is why. This is the problem, academia moves exceptionally slow, right? So academia has not responded to that yet. The business world has, which is why you're seeing these additional hours of training required by businesses. When they hire a new nurse practitioner or businesses refusing to hire a new grad, they only want to hire somebody who has experience. So if you look at, for instance, I'm going to give you an example here. I worked in an urgent care. I was brought into open and urgent care. So we opened urgent care and got it up. Got it running. And we were competing with another urgent care in town which was under the same umbrella corporation. Okay. So they wanted the second urgent care we came in and opened it.

John Canion:

The difference... Are you familiar with RVUs?

Ron Barshop:

Very.

John Canion:

Okay. So you know what an RVU is. The one that they opened averaged one RVU per patient 0.97, actually. So they averaged a level three, right? So 0.97, we'll call it one for maths sake. And for the listener's sake, say average one RVU per patient. When we opened ours, we average 2.3

per patient, because we understand how to document and how to bill appropriately, okay. I call it maximizing revenue generation. If you understand how to bill appropriately and how to document appropriately, you're going to get more revenue per patient. And because of that, we were making more money. We were getting paid exceptionally well at that urgent care versus the same NPs on the same contract at a different urgent care who could not make couldn't generate as much income. So they couldn't require the same salary requirements. So when you come in and you can do things like that, you can get a higher salary requirement, which makes you more productive and encourages your staff to be more productive and encourages your NPs to be more productive. And the business ends up being more successful.

Ron Barshop:

Yeah, I think it's very important what you're saying, but then the family doctors that are really the most experienced and the most respected in my purview are those that are never through learning. Like you talk about abnormal states getting out of medical school, nobody gets out of medical school as an expert of normal states or-

John Canion:

Nope.

Ron Barshop:

Even pharmacology. It's something you're constantly learning, because it's always ever changing. Maybe there's only 60 approved every year, but you got to learn them especially if they're different. So if they're coming out of school so green and so fresh, and they're getting that bad foundation, they may never catch up. It's like, if you skip algebra, you may never get to the trigger in the calculus.

John Canion:

That's what concerns me.

Ron Barshop:

Okay.

John Canion:

But I mean, the literature so far has not shown that to be the case. So it seems to me, people are being successful in spite of their training. Not because of it.

Ron Barshop:

I'm wondering if the medical air problem they say is somewhere between 250, according to John Hopkins, but as high as 410,000 by others. And I'm not putting that on the nurses for sure. But I am saying that they're not charting exactly who's doing it because they don't want to dig too deep into that subject because it's the third leading cause of death in America after cancer and heart. It's way like COVID replaces number three this year, but it's way ahead of number four, number five and number six. So I don't know if medical [inaudible 00:21:07], if let's sweep it under the carpet and we don't really care who's doing it. We don't care if it's nurses or doctors or MAs that

type something wrong. But I think a doctor who's angry at this, all of this equivalence, you might say, well, it's all the nurses of course, they'll say that.

John Canion:

Sure. And I mean, you can point fingers all over the place, but I mean, one way that you can view this and see what's going on is by monitoring the malpractice industry. Right? So that's a good way to get your finger on the pulse of where that is from a lawsuit perspective. Now of course, as we know the vast majority of those don't ever see a courtroom or get a lawsuit filed, but you can keep your finger on the pulse of the lawsuits and the malpractice claims and have a decent idea of what's happening in that regard.

Ron Barshop:

I'm going to just read you this interesting DG investigation. This is going into the sea, me and dark side. I talked about earlier, and this is again, no reflection on nurse practitioners. It's a reflection on the criminals that are allowed to open up these schools and these three guys in Virginia. And by the way, they pulled up roots in 2013 when they got investigated and opened up a new school in Maryland down the street, but they coached unqualified individuals to pass nursing board exams.

Ron Barshop:

They help them obtain employment of various healthcare providers in the district of Maryland. They would allow them to purchase backdated, illegitimate, registered nurse, or licensed practical nurse transcripts and certifications, even though they hadn't attended school. I mean, this is criminal we're talking about here and then these guys moved to Florida and then they sell illegitimate nursing degrees. I mean, it's the Florida school nursing found them because they had a crappy pass rate in their licensing. So again, I don't want to talk about that, but I'm just indicating that there are some really bad characters that are attracted to this business because apparently you can get really good loans.

John Canion:

Yeah. Well, the unfortunate reality is every profession has bad actors and you can't always predict someone's future behavior and you can't always predict based off of a interview or lack thereof.

Ron Barshop:

Yeah.

John Canion:

What moral compass somebody has. Now, a lot of times you can get a good feel for that but there's sometimes you can't and sometimes people's moral compass change after they've graduated and after they've gotten out. And you know, I mean, there's a lot of Medicare fraud cases and I mean, it's that's you don't like to see stuff like that. People that do stuff like that need to go to jail, it's what needs to happen.

Ron Barshop:

Now, if we made you king for a day, I've heard you give some very interesting proposals. You would make the boards less basic. You think they're a little too easy?

John Canion:

Well, it's a basic entry to practice exam. Okay. So it's not an expert exam for nurse practitioners. The board exam is a basic level entry to practice. So they want to make sure you're safe to practice. They're not saying you're an expert when you pass the board exam. So yeah, I would pump up the difficulty on that as well. I'd also increase the number of hours. I would increase our training requirements to require actual clinical doctorate, as opposed to the academic DNP that you have now. I think that if you do that, you get somebody who comes out, who's physically able and ready to take on the role and walk in and start working that day.

Ron Barshop:

So you said 2000 hours for a generalist and about double that for a specialist?

John Canion:

Yes. So you'd get the idea is very similar to what PA school is doing with their generalist at the master's level. And the idea is to eliminate the scope of practice issues, right? So we have so many scope of practice issues where people don't understand what we can do, what we can't do and why I can do one thing. And somebody with the same initials can't do it. They just don't understand because our training is not like a residency trained MD, right? So if you have a board certified residency trained MD in emergency medicine, you know what they can do, right? If you have board certified MD in general surgery, you know what they can do, right? If you have a board certified family nurse practitioner, well, it's kind of muddy because I can work in the ER, I can work in urgent care.

John Canion:

I can work family practice. I can do end of life care at hospice. You know, it's kind of muddy. I can work with an orthopedist. I work with a general surgeon. I can work with a nephrologist. I can work with, it is just so people don't under understand what we can do and can't do. And it's, I mean, it's even at the academic level and at the nursing board level, people make this mistake, right? They want to add setting as a scope of practice issue. Well, setting is not a restricting on scope of practice. As we discussed earlier, it's population, education and training. Setting is not a limiting factor, but that's what they like to do is try and use setting as an example, when you're using that, you're not following the basic premise of the whole profession.

Ron Barshop:

And then king John would also add pediatric family practice, oncology, cardio radiology, ortho electives for every nurse practitioner?

John Canion:

Well, every well. So that'd be a basic requirement for everybody. So everybody would have to do that.

Ron Barshop:

Okay.

John Canion:

And I think as understanding what goes on you in the profession, no matter which field you work in, if you end up understanding what those subspecialists do or sub-specialties do, it makes you better understand what you are dealing with and when to refer and when not to refer. So there was a study that came out that showed that no practitioners typically order more diagnostics and refer at a higher rate than their MD counterparts in family practice. And I think part of that is because those guys have had those rotations through general surgery and orthopedics. And so they've seen what to refer and what they can hold onto and take care of themselves. Does that make sense?

Ron Barshop:

Yes. You have to unpack one last thing for me, because we're running near the end of our time. This has gone so fast by the way, but I don't understand the difference between a DNP and a master's of NP and a PhD. What the heck is going on there?

John Canion:

Okay. So a nurse practitioner is a master's level training. That's it. You get trained at the master's level as a nurse practitioner and you're able to be certified. Okay. The PhD is an academic doctorate, just like a PhD in any other field.

Ron Barshop:

Okay.

John Canion:

So research based doctorate. Okay. The DNP, the doctor of nursing practice is not clinically based at all. It is in fact, an interpretive research doctorate.

Ron Barshop:

Wow.

John Canion:

So it means from a clinical standpoint, it has zero value. And I say that because the literature has not shown any value addition from a master's level, NP to a DNP. And it makes sense when you look at the curriculum, there's no clinical addition there. You're not gaining any benefit from adding a DNP to a master's level, NP. It's just not beneficial. The only thing that it has done, which is beneficial for the profession is increased the number of doctorally prepared nurses, because then 15 years ago, we were running desperately low on PhDs because people were going to NP school and CNA school and midwife school and stopping because there was no extra money involved.

John Canion:

So they weren't seeing any value.

Ron Barshop:

Okay. So, there's tons of advertisements, improve your life, single mother join a nursing. And they're not really clear in they're advertising for students that they're going to graduate with basically no clinical skills or minimal clinical skills. So there's this, "Come on in, join the army and be all you can be." And then they're like, sorry, "You can't earn a living as a nurse." You just got a little extra schooling there. That seems unfair and actually false advertising.

John Canion:

Yeah, I agree. And I think that there is something to the advertising there. They're trying desperately to get people into NP schools, because the way NP schools currently are set up, they are money makers for schools. There's very minimal overhead costs, and you can pump as many students through as you can. And, there's some issues with accreditation where the accrediting body or accrediting people who probably shouldn't be accredited because of the way they have their complaints set up, you have to buy file a complaint with a name attached to it in order for them to take on the complaints. And if I'm a student at your school and you see a complaint from the CCNE with my name on it, what's going to happen to me?

Ron Barshop:

Yeah.

John Canion:

I'm going to be running out of school. I'm going to be out of money. Right? I'm going to fail no matter what.

Ron Barshop:

Yes.

John Canion:

Right. So, and part of the problem is, we've switched from our education style from a clinical style of 15 years ago, to a more academic style where they're focusing more on writing papers and doing-

Ron Barshop:

Almost busy work.

John Canion:

Discussion boards, instead of focusing on the meat and potatoes.

Ron Barshop:

Yeah. And everybody that goes through these programs say they love the clinical best. They love doing the rounds best just like every MA loves doing phlebotomy best. Okay. So I have a question on insurance panels do, but first of all, since we're on the subject, how do I know if my daughter or son wants to go into nursing, which programs actually are legit? And which ones are these? The diploma mills is too derogatory, but they're not going to get the best clinical training.

John Canion:

They're not getting the training that you would expect. I would find a program that sets up your clinicals for you.

Ron Barshop:

Okay.

John Canion:

If the program does not assign your clinicals, do not attend, which means 95% of the program's out there right now I wouldn't go to.

Ron Barshop:

So many crickets. Wow.

John Canion:

Here's the thing say, you're my instructor and I'm your student. I'm going to your school. I'm setting up my own clinicals. You're not showing up to verify what I'm doing because it's not required. So I'm going and setting up my own clinicals and completing my clinical hours. How do you know that I'm getting any adequate training in those hours?

Ron Barshop:

Well, like a judge, if they assign a juvenile delinquent to go work in the homeless shelter, they got to get somebody to sign off. They did their hours. You're saying that doesn't happen?

John Canion:

No, there's somebody signing off that they did their hours. But the question is, what's the quality of the education?

Ron Barshop:

Oh, got it. Okay. Were they quality hours or were they sitting around chatting?

John Canion:

Or were they in somebody's office that they paid so they could get hours just doing nursing work instead of learning how to do the advanced practice part?

Ron Barshop:

Sure. Wow. That's scary stuff.

John Canion:

So I mean, that's the question, right? And the problem is there's no academic control of clinical training. So if I'm your professor, I can't guarantee that you are getting adequate clinical training.

Ron Barshop:

Wow. Interesting. There's so much to talk about here and we just don't have the time, unfortunately, but if people want to find you John Canion, how do they do that? I found you on LinkedIn.

John Canion:

Yeah. LinkedIn, Facebook, John Canion. I'm pretty easy to find, on YouTube JC the NP. You can find, I've talked about some of this stuff on there. I mean, you just look at... There's so many problems here, man. And if you want me to come back, I'm happy to come back anytime and we can go over whichever part of it you want to.

Ron Barshop:
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