

## New professions ... new solutions

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**Robyn Williams:** The first speaker is Ruth Ballweg, who is the Director of Physicians Assistant Program at the University of Washington in Seattle. She has come an awful long way so we are especially pleased to see you, to talk on new professions and new solutions. Ruth Ballweg.

**Ruth Ballweg:** Greetings. It's wonderful to be here! I've been here a number of times to talk about our physician assistants and nurse practitioners and today I really want to focus on both of them equally. We see each of them moving along in some very exciting, positive ways as solutions to rural health care issues in Australia.

I wanted to go back and talk a bit about why both professions started in the United States and, again, with the understanding that, as they're both developed here in Australia, they will be adapted to fit the needs here. But I think there are some similar issues that have to do with how they started. They felt: "We've got to do it differently." While it may not seem like such a radical thing to people in Australia—but in the US it was a big deal. At the same time, we had a Civil Rights Act saying that people of all ethnic backgrounds should have equal access to care. We haven't completely succeeded in that area. There are still many examples of disparities—but the sense was there had to be some different solutions.

In 1967, when we saw the NP and PA careers developing, there were major issues with rural health access and with physician burnout. At the same time, we had returning military medics who no one quite knew what to do with. They had lots of great experience but they didn't fit anywhere in the health care system. Again, it sounds pretty familiar to what we have now.

Nursing was also going through a lot of changes. The feminist movement was supporting nurses in achieving the power that they felt they should have. There were expanded roles of nurses based on new technologies. There was the development of family practice as a specialty. Most of all, there was new technology from wartime, from the MASH units in Vietnam and the Korean war that was used as the basis for the emergency and trauma systems we all now benefit from everywhere around the world.

Nurses were concerned about some specific issues. They were unhappy about shift work and whether or not there were jobs that allowed them to have a balanced life. They were worried about pressures to move to administrative roles. There was increasing emphasis on nursing creating its own freestanding profession with emphasis on their own degrees, research, nursing language and theory.

So I want to talk a little bit about the PA movement and then I'll go back and talk more about nurse practitioners, but I think it's important to set the stage for the history of this movement toward new professions.

The program that I direct was founded by Dr Richard Smith, a famous international health expert who was the first Medical Director for the Peace Corps. He's an African American—trained at Howard University. He really believed physicians were not the only solution to health workforce issues. Thinking only about physicians was just too expensive, but it was also not reasonable because many patients really didn't want to hear things—and couldn't hear things—from people who were dropping in and didn't stay.

Dr. Smith looked at the international history of non-physician clinicians. In Russia, Peter the Great created “feldshers” to accompany his troops. In China there were “barefoot doctors” primarily serving the agricultural workforce. In the US there were many informally trained assistants—as I’m sure there are in many rural communities in Australia—that physicians felt could do more if they were given the opportunity.

Strong and well-connected physicians were the founders of the first five PA programs in the US. The key point here is that PAs exist because “physician champions” made this happen!

As PAs and NPs, developed there was tremendous interest in the media. It’s interesting that in the year that the first PA program began at Duke University there was more coverage about PAs than there was for Duke and North Carolina basketball. This gives you some idea about how captivated Americans were by one of the few examples of “good news” to come out of the Viet Nam war!

Stories about physician assistants were in the Readers’ Digest, America’s most popular magazine and in Parade Magazine, the Sunday newspaper supplement with the nation’s highest circulation. There were a lot of mistakes about how PAs and NP were both promoted. You can see that here in this article in Look Magazine that’s titled “More than a nurse, less than a doctor.” You couldn’t infuriate more people if you tried to! So, as we see, both professions moving ahead internationally, I think paying attention to language is important! I’ll get back to that later.

There were also PAs and nurse practitioners in well-read cartoons! This is Gasoline Alley, the most famous US cartoon in the 1960’s. In this case there was an old style doc—you can tell it’s in the 1960s because the doc’s often smoking a cigar, which would never happen now—and he’s recruiting a returning local corpsman—the a son of a patient of his—to become a physician assistant.

So here’s the information about PAs right now. You can see there are quite a few of us, almost 80,000. What a lot of people do not know is that a large percentage of PAs are female. It’s interesting that the PAs that are here for the Queensland pilot project, initiated this week are all female. Two of them come from nursing backgrounds. Ninety-one per cent of PAs all PAs ever trained are in clinical practice. I think one of the things you find about both PAs and NPs is that both groups feel they have very rewarding and satisfying roles!

In terms of geography—the largest number of PAs per state live in New York, but the highest number per capita is in Alaska where PAs provide care in small villages, and supervise community health workers. Many small villages and small sized towns are too small for a hospital and that is really the cut-off point for many places in the US. Physicians don’t want to work where they can’t use their hospital skills and so a PA or an NP or a NP/PA team may be the best “deal” for a small town. Both groups have been acknowledged for being among the best jobs in America.

So, on to nurse practitioners—there are quite a few of them, too—125,000. Many of them work part time and see that, by the way, as an advantage for being a nurse practitioner. The message for nurse practitioners in their newest website is that they emphasise “care and cure.” They really want to differentiate the fact that nursing brings some additional skills. There is a movement to the nursing doctorate—very controversial in the United States.. NP leaders want to promote themselves as being the primary care providers of the future—and that’s the idea of retail clinics. I don’t know if you have them here yet, but the idea would be that there be a primary care clinic for acute problems in department stores, pharmacies, grocery stores, and shopping malls. You can imagine there can be some advantages and some disadvantages to this model.

So, in 2009, our list looks pretty similar to the list of 1969. Health care access. New diseases. New treatments. It is interesting to know that in the US, PAs and nurse practitioners are often the continuity

clinicians in HIV and AIDS clinics. Technology-driven developments create new roles for PAs and NPs. We're also looking at international developments, of which the Australian example is just one.

So what I really want to emphasise—and I've talked about this every time I've been here—is that the goal is not to take the US model and superimpose it on any country or delivery system. It's simply to see what was the original idea and figure out how it can be adapted here. I know that the people that are working on the development of both PAs and NPs really want to make sure these the Australian models and not someone else's.

I want to review some principles for creating a new profession. These came from Dick Smith, the founder of the MEDEX program and they apply to any new profession. I know you're going to be talking about some other professions as well and these are some basic principles.

It's not just about creating the training programs. Sometimes that's what people think you do, but you have to really do more than that. Until you do all of these steps, the project won't be successful. So you need a "collaborative model". You need to ask community people about new roles and then you need to include them in the planning. You need "competency-based training," thinking about what you want these folks to do and then working backward from that to design the curriculum. You want to focus on "recruitment and selection", and not just take all comers. I think as rural folks, we're particularly interested that we choose people from rural communities to be PAs and NPs because we know that those are the people that will go back and stay there. That, in fact, is what we've learned in the US.

The "receptive framework idea" is that you have to build the reimbursement strategies, the pharmaceutical strategies, all those, before you choose the first students. You have to allow them to be fully utilised, You need an active "deployment strategy." In the US, we are very directive about where we send our students for rotations, with the idea that we want them to stay in those settings. Once they sign on to be in PA and PA programs, they buy the idea that the programs are going to actively direct them in ways that meet social needs. It's hard to do that with physicians. And of course "continuing medical education" is needed to keep clinicians current and to build new skills sets.

Thinking about "the collaborative model", consider all the people you need to include in planning and implementation. "Competency-based training: What is it you want people to do? Eliminate competition as a strategy for working with 2nd career adult learner. We put a lot of emphasis on recruiting second career versus first career folks. I know that you've already heard that the new PA program at the University of Queensland has 20 students, the average age is 41 years of age and the average years of experience is 11.6! So these are paramedics, military medical people, nurses and a wide variety of people who have a broad range of clinical experience. A rigorous selection process not only chooses students but also determines, where they'll be going. It's about underserved communities and also about primary care.

So here are some of the students in the program that I run at the University of Washington. You might be less familiar with this professions—Alaska Community Health Aides—although you do have a model similar to this, the Aboriginal health workers who serve in indigenous communities in bush Alaska.

So when you think about choosing people for rural practice or primary care, I like to use these pictures—and I'm sorry they're all men. ( I don't have any women's pictures. ) But what we really want to do is choose people who have a broad open mind. You all know people like this—with closed minds—who have ended up in your communities for some strange reason and we remember them for all the things they refuse to do. They don't want to learn, they don't 'want to mix with whomever! in fact, we want the opposite—a broad, open-minded person.

We want somebody in primary care who really is excited by learning and who can never get enough—because there's such turnover of information. We all know that five years from now everything we know in medicine will be obsolete! So successful clinicians have to have a curious point of view and a commitment to life-long learning. Most of all what I notice about people who are PAs and NPs is they're curious and they're full of good ideas. They're older students. They know why they're there. They can sometimes drive faculty crazy because they're so opinionated. You get a lot of pushback from them, but they're fun to work with, they know why they're there, and they know the communities they're going to back to work in.

This slide describes the receptive framework, the things that need to be done ahead of time. I know that various groups have been working on this in Queensland as well as at the national level. It's important to make sure that sure people go to where there is an area of need, not just where they're wanted, and not based on income possibilities.

Let's go back to the original concept of PAs and NPs. It has really morphed a lot over time. The idea was originally that the physician's role was the big circle and then the plan was that NPs and the PAs would do a just little bit of it. Well, you won't be surprised to know that that's not what happened. This slide shows what happened instead. The slide shows the overlap in functions that the three groups have. Nurses bring to the mix their nursing background as well as their new skills as nurse practitioners. PAs bring their past roles—I always like to mention that I'm a good example of this because I was a social worker before I was a PA. So in a primary care practice I would deal with all the mental health issue in addition to the broad range of primary care problems. The physician has his or her medical training as well as their specialty background and individual interests.

Where we sometimes disagree—or where there is always the potential for misunderstanding—has to do with different ways that PAs and Ps talk about “supervision. PAs are supervised by physicians. They legally are required to work with a physician. There's a very broad definition of supervision. Nurse practitioners choose to talk about independent practice rather than supervision by a physician. In some settings they'll talk about “collaborating physicians” but goal is always for autonomy on the part of the nurse practitioner.

By the way, one thing that we try to do as PAs and NPs is never to speak for the other group. This custom eliminates a lot of difficulties! So my comments today have been vetted and approved by my colleagues at the Nurse Practitioner Program at the University of Washington. They're “OK” with what I'm saying!

This slide provides a quick comparison of PAs and NPs. It's s interesting to see that as countries develop both roles, the understanding of each comes into a little better focus. Nurse practitioners are nurses of all different kinds. PAs are a wide range of different people—which makes it both good and sometimes difficult to understand. They both have standards which, for nurse practitioners, are degrees and for PAs a national certifying exam. Licensure is by different groups; regulation is by different groups: nursing boards regulate nurse practitioners and medical boards regulate physician assistants. They both bring a little bit different culture, with nurse practitioners bring in the practice of nursing and PAs bringing the physician role.

So I want to talk quickly about the delegatory models. There is a lot of conversation going on here in Australia about delegated practice. That's really how this is supposed to work for PAs. The physician decides what the role is that the PA will have, based on both their experience and how they plan to work together. Physicians like this. Rather than having a laundry list, they like the fact that it's individually decided based on the individual PA, the years of experience and their relationship.

So what that means is there are three levels of supervision. This is instructive not to just think about PAs but also as we think about other new kinds of health providers currently being developed. People are interested in the supervision model and what that means. It doesn't mean just hanging out, and dropping in occasionally. For PAs there are three aspects of supervision: "prospective", meaning you decide ahead of time what the role will be. The physician and the PA and the clinic system work that out. "Concurrent" describes how the physician and the PA work together. Simultaneously. That could even be with distant supervision, by telemedicine, or telephone. The idea is that the physician will be available to the PA or sometimes the nurse practitioner if they are in a supervisory role. They have to agree to take their call! They have to agree to answer the exam room knock, and they have to be there to work side by side. "Retrospective" involves quality measures like chart review, review of patients at the end of the day shift and monitoring of patient outcomes. There's a lot of flexibility to the PA supervision model.

Nurse practitioners want to emphasise their potential for independence. They feel that this is a high priority based on nursing culture. They like to emphasise that nursing is different than medicine. Both groups really believe in team practice. Unfortunately when people think about team practice, they often think: "Well, one person is going to do one thing and one person is going to do another thing and one person is going to do another thing and they never overlap." In fact, in a dynamic team, the activities need to be delegated to people's strengths and then the team should teach to people's weaknesses. So, in a particular practice, the physician might be an expert on one thing, the nurse practitioner another thing. T

They pick up on each other's passions and experiences! This creates an environment that's fun to work in!

Both NPs and PAs have a long history of working with under-served populations in, geographically isolated areas. There's a lot of emphasis on cultural competence and on dealing with the disparities of the uninsured—a huge problem we have in the US.

PAs see them see themselves as generalists. Their curriculum is very broad. They have a general certification exam, a re-certification exam at the end of six years. There's also a lot of emphasis on diversity in the PA programs. In the US there is less diversity in nursing in general so, when you think about nurse practitioners, it's hard to extend diversity that's not there. PAs, because they come from many cultures, particularly the military medics—contribute high levels of diversity to the health workforce.

PAs value community involvement. It's built into to our admissions process and it's built into the training. There is also a major emphasis on communication. PAs and NPs have been extensively studied since our beginnings! When you ask patients in the United States what they think about PAs and nurse practitioners—patients have said they really feel like they can talk to the PA and the NP. "They're real people and they have time for me," which at least in the US is an issue that comes up for physicians. Patients often feel they cannot connect with physicians—whom they often feel are required to see too many patients to encourage quality conversations!

These are some common roles for PAs in primary care. The next three slides show the distribution of health care encounters in Washington State—one of the most progressive states in terms of PAs and NPs. And here you can see the actual numbers for physicians, PAs and NPs. Relatively speaking a high percentage of encounters in rural communities are provided by PAs and NPs in Washington State. Everybody is very happy with this. They're well accepted by most consumers, by physicians, and by other health care providers.

This slide looks at the FTEs—full time equivalents. We have headcounts compared to FTEs and the number of visits performed by all groups. The distribution is pretty similar in urban and rural areas. PAs are moving into speciality practices as physicians find they can improve their efficiency. Those of us in primary care don't like to publicise this but, in fact, specialty practice is a growing rapidly growing area for PAs. In terms of rural care, we're particularly interested in new roles for PAs and NPs as hospitalists in small hospitals and teaching hospitals.

Right now nurse practitioners are emphasising their roles in community based primary care, residential care, and practices dealing with chronic illnesses. In the military, nurse practitioners stay in hospital-based care and physician assistants are on the front lines working with the troops. Almost all the health care in US prisons is provided by physician assistants. It's interesting to know that the people who take care of the President and his family and his staff in the White House are a group of 12 military PAs representing the four branches of the service. One of them travels with him on every trip, one does advance work. So we're sure that the President knows quite a bit about PAs!

We feel that the strength of the PA role is that physician supervision gives us a lot flexibility that we might not have otherwise. The credibility of that relationship makes a difference to physicians and it allows us to be rapid responders and niche fillers. Nurse practitioners have that same flexibility but it comes from a different origin because it has to do with their independent practice in a nursing—a different discipline. NPs feel the independent practice allows for greater flexibility and mobility. Both models work! There are advantages and disadvantages to each.

Looking back on 40 years of the PA and NP movement, what have we learned? What mistakes could you avoid? The first one is this idea of partnership, not competition. When I wear my "great conspiracy hat" I think that there were political leaders and medical leaders who actually felt that the way to get rid of PAs and NPs was to get them fighting with each other! There was a lot of wasted energy spent on this competition and it wasn't helpful to any one! I think that's maybe an important lesson for any sort of new professions as they're developed. There are people that are opposed to any new role for a variety of reasons—but it's usually economic!. We've really gotten past that and thankfully it's not the case any more.

We also need to pay attention to language and title issues. The reality is that both physician assistants and nurse practitioners hate their names! They're too confusing! People say to nurse practitioners, "When are you going to stop practising and actually do something?" And they say to PAs, "When are you going to stop becoming an assistant and really do something?" The reality is that the both have too many syllables, they're hard to pronounce, and they're confusing to people. Fortunately people increasingly call us by our initials—NPs and PAs—and people are a little happier about that.

Most of us think if we were to do it again that there be more shared learning opportunities. I think this is true for all health professions. How you work together is by learning together in the first place! What we like to emphasise is that both groups actually allow us to use the best of human capital! So, for example, people that want to be PAs may be paramedics, and if they don't become PAs they'll be lost to the health workforce because it's impossible to be an old paramedic. You've hurt your back or you've hurt your knees. We all know people like that. We're wasting a huge amount of valuable experience! Many nurse practitioners will say, in answer to the question, "You're leaving nursing and joining nurse practitioners. You're sort of a traitor"—their answer is, "I wouldn't have stayed in nursing if I didn't have a new role. I wanted this expanded role. I wanted something new." So these two roles are actually keeping people in health care.

I'd also like to point out that both the PA and the NP professions have been known for recruiting some unusual people. These individuals are "high risk" people with complicated past lives They've been able

to provide unique care to patients because they really understand that person; they've also come from a very difficult life; they're somebody who's "lived." So the people who are PAs and NPs are often very unusual people who have taken a risk to go back and to have a second career later on in their life. They bring a lot to the community!

So our goals should be getting the right people with the right skills in the right places doing the right things. In almost every health care delivery system in the world, this is where there are huge problems. People are really have work assignments and job descriptions that don't allow them to fully use their skills. PAs and NPs demonstrate that. Of course, these are decisions that need to be made in a country-specific way to figure out what works best.

I was asked to come up with some recommendations, so here are some ideas. I would suggest that NPs and PAs be promoted equally. I think that's happening in many places. I think it is important in thinking about both of these professions—or the Australian equivalents—as a strategy for improving rural health care access. Think about who in your community could, in fact, be the PA and NP to be trained and returned to your community and then be the continuity person who doesn't leave because your community is their home.

I haven't talked a lot about it but it's interesting to think about configuring clinical sites for team practice. We've had some Australian physicians visit us in the US and come to see clinics and, "Say isn't it interesting? Instead of bringing the patient to the physician in his or her consulting room, they have multiple consulting rooms and the clinicians move around between the patients and they actually see more patients." Interesting observation!

Lastly, is this idea of "delegating to strengths" and "teaching to weaknesses." This is a pretty good idea in any workplace situation, not just clinics with PAs and NPs. What can you learn from the others? What do you have to share with them? How do you constantly do this as a way of building people's skill sets and job satisfaction?

So this is a slide I use a lot and I think you can probably agree with this. When you have any kind of new idea it's "ridiculous" We can all think back when some of the new careers that we have now, were thought of that way. "Controversial," I'd say, is where we are with respect to PAs and NPs in Australia. We want to move to the place where they are an "obvious" strategy for improving rural health care and I look forward to your comments and discussions for the rest of this meeting. Thank you for your time.

## Presenter

**Ruth Ballweg**, MPA, PA-C is a physician assistant, Associate Professor and Director of MEDEX Northwest Physician Assistant Division at the University of Washington School of Medicine. Ms Ballweg works extensively with national and regional leaders of the nurse practitioner, family medicine and physician assistant communities and regularly serves as a consultant for health care organisations on the issues of interdisciplinary primary care teams. As an author, Ms Ballweg has written on primary care training, the professional roles of women in health care, on the training of community health workers and on the composition of the primary care workforce.

