Dr Carek’s Commentary on Training PAs and NPs

TO THE EDITOR:

We are writing to respond to the commentary by Peter Carek, MD, about training of physician assistants (PAs) and nurse practitioners (NPs) by family physicians. As physicians and PAs, and as educators, we believe that much value is added by interprofessional training of physicians and PAs and that the role of family physicians is essential.

The PA profession has worked collaboratively with physicians for 50 years. Physicians at Duke University and the University of Washington developed this profession to recruit individuals with a background in health care and provide them intensive training that enables them to work with physicians in any specialty. The PA profession’s accrediting body has well-established national standards, developed by a group that includes family physicians. PAs complete over 2,000 hours in clinical rotations in a wide range of specialties, giving PAs the flexibility to perform a variety of effective team roles in any specialty, including family medicine. This is particularly critical, as we know that PA role not only varies by specialty but even within primary care specialties and sometimes within the same clinic. Primary care services must reflect the needs of the patient population served, so training for a variety of roles best serves our patients and teams.

Accepting a PA student can add complexity to the training site, and we are grateful to all family physicians who serve as preceptors. We appreciate that adding another trainee could potentially decrease technical medical experiences available to family physician trainees. The overlap in skills taught to PAs, NPs, and family medicine trainees might seem to be an unnecessary redundancy. However, given that 53% of primary care physicians work with PAs and NPs, we believe there is more for family medicine to gain from training PAs than there is to be lost.

Preparing PAs for primary care roles provides family medicine trainees with the opportunity to develop teamwork knowledge and skills. In a time of increasing demand for primary care services, projected shortages of primary care physicians, primary care redesign, and movement toward value-based payment, team-based care will likely become more prevalent in family medicine. Becoming a team requires more than simply calling a group a team. To be successful, health professionals must develop the knowledge and skills critical to team functioning such as developing shared goals, team cognition, communication, coordination, and leadership. Interprofessional training is critical to development of these skills.

Training PAs for a wide range of roles provides practicing family physicians with significant benefits. The evidence suggests that physicians who work with PAs can make more money, reduce the time spent in the clinic, and have greater job satisfaction. These benefits are predicated on the ability of PAs to perform clinical “back-up” behaviors for physicians on the team, which requires redundancy in skills learned. Skills developed prior to entering the workforce will decrease the time practicing family physicians need to invest in their PA team members. Helping PAs learn to serve patients allows PAs to provide value to the health care team and the patients we serve.

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References
3. Hing E, Hoia C-J. In which states are physician assistants or nurse practitioners more likely to work in primary care? JAAPA 2015;28(9):46-53.
TO THE EDITOR:

I appreciate the thoughtful response by Dr Everett et al to my commentary on training physician assistants (PAs) and nurse practitioners (NPs). I agree with their sentiment that physician assistants add to the primary health care team, and interprofessional training is essential. My commentary did not mention anything to the contrary.

As I noted, the current model for the delivery of primary care based on a team-based care approach is fundamental. As such, team members “should be trained to fulfill their unique, separate, and important roles on the health care team.” For this team to be both effective and efficient, these roles should be complementary with the understanding that some redundancy will be needed. Roles that are either overly redundant or significantly separate are not conducive to effective or efficient teamwork.

Further, I stated “Our discipline should work with schools of nursing and physician assistants to provide a reasoned and standardized approach outlining how to best educate these providers in a primary care environment.” While both family physicians and physician assistants have well-established standards for training, the specific skills needed by each member of the team could be more clearly delineated. Additionally, the family medicine practitioners who choose to provide educational experiences will need to balance these numerous requests with their ultimate activity of providing high-quality patient care. I invite Dr Everett and her group as well as other family medicine and physician assistant educators to work collaboratively in determining the specific knowledge and skills required from each member as to produce the most effective, efficient, and diverse team needed to meet the primary care needs of our large, highly diverse population in the setting of a family medicine practice that has numerous other needs to meet. This delineation will allow members of each profession to develop their unique and complementary skills to the fullest extent and the practice site to provide high-quality and efficient patient care.

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References


Looking for Trouble

TO THE EDITOR:

We read with interest the recent editorial by Saultz advocating a long-term look at the performance of graduates of family medicine residency programs to validate educational outcomes in those programs. While we could not agree more with this premise, we do, however, take exception to his suggestion that residency programs need resident-specific, longitudinal American Board of Family Medicine (ABFM) certification/recertification examination data to do so.

We acknowledge that the ABFM certification examination is currently the only objective measure of resident performance and agree with his previously stated position regarding its pivotal role in assessing program performance in the accreditation arena. Nevertheless, using individual resident’s certification examination scores for program improvement is of very low utility for several reasons. First, almost all residency programs suffer from problems of small sample size. This prevents most program-level analysis from having sufficient statistical power to detect actual issues, not attributable to chance, that are related to the program. Second, physician-specific recertification scores for examinations taken 10, 20, or 30 years after residency might provide some useful information about what that program was like 10 years ago, but as the examination...