



Providing a forum for PA authors practicing in surgery

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When I heard the news that *JAAPA* is now considering manuscripts on surgical topics and will include these articles in the *Journal* on a regular basis, it gave me pause. I thought, why is this such big news? Has being a PA in surgery for the past 31 years relegated me to the outskirts of the PA profession? Am I some kind of maverick? Those who know me must laugh at either possibility. I have been active in multiple PA professional organizations over my career, which has certainly ensured that I remain committed to the profession and all its missions, visions, and strategic directions. As for being a “maverick”—well, let’s just say that I am no James Garner. But still, this announcement about *JAAPA* did cause me to revisit why I ended up in surgery.

A surgeon mentor

The PA program at Alderson-Broaddus College started shortly after the one at Duke and was the first 4-year degree program for PAs. The first class graduated in 1972. This program, like Duke’s and others to follow, offered a curriculum intended to train PAs to help physicians in order to improve the ability of patients to access primary health care. The difference, for me, was that the program at Alderson-Broaddus took shape through the efforts of Dr. Hu Myers, who envisioned the PA program, promoted it, and acted as its first medical director. He was a surgeon.

He and his physician brothers had a long history of bringing health care to rural West Virginia. He even had a residency training program at the Broaddus Hospital located on the rural college campus. My respect for Dr. Hu (there were too many physicians in the Myers family to use their surname) grew from the knowledge and skill he was willing to share—and from the gentlemanly manner in which he conducted himself among students, faculty, staff, and patients. I became adept at positioning myself so that I could make rounds with him. I grew skilled at finding avenues into his operating suite.

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Despite my interest in surgery, the job interviews I was offered as I approached graduation were similar to those offered to most PAs in my class. There was a well-paying and interesting job on the Alaska pipeline construction project. There was a job at a rural clinic in Beckley, WV. I was not seriously looking for positions in surgery, and few were being offered. One day, though, while I was walking down the hall of the administration building, Mrs. Myers, Dr. Hu’s wife and the program director at that time, called me into her office. All I remember is that she said to me, “Hu thinks you should stay in surgery.” This was all the encouragement I needed to pursue a job as a PA practicing in surgery. Standing across from Dr. Hu in the operating room was where I had first felt comfortable. His guidance proved most valuable, as I have had no regrets.

Why, however, has it taken the PA profession this long to recognize the valuable contributions to patient care made by PAs in surgical specialties? Why has it taken this long for the *Journal of the AAPA* to actively promote surgical topics? Those questions still beg to be answered.

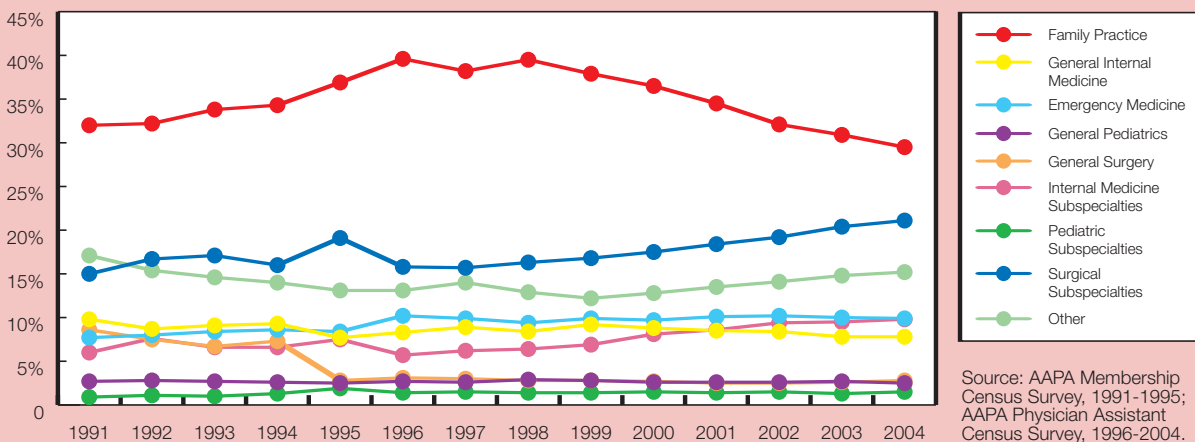
Catching up to reality

Although surgery-related subjects have appeared in *JAAPA* from time to time, this issue, with the appearance of the article on endoscopic vessel harvesting (page 40), announces the regular appearance of articles focused on topics of surgical consequence. Since *JAAPA* is the official clinical journal of the AAPA, it is only fitting that it embrace the Academy’s goal to represent all PAs and recognize the diversity of specialty interests in the PA profession. The AAPA has endeavored to represent PAs without consideration of their area of practice. Its recognition of specialty organizations, special interest groups, and caucuses; representation of surgical and medical congresses in the AAPA House of Delegates; multispecialty CME sessions at the annual conference; and ongoing dialogue with specialty PA and physician organizations are appropriate given the diverse nature of the PA profession.

Recent AAPA census data indicate that PAs in surgical specialties—including general surgery—now make up

FIGURE

This chart shows the percent distribution of clinically practicing respondents to AAPA census questionnaires by the type of specialty practiced in their primary job.



Source: AAPA Membership Census Survey, 1991-1995; AAPA Physician Assistant Census Survey, 1996-2004.

25% of all practicing PAs. According to Kevin Marvelle, Vice President, Data Systems and Analysis, at the AAPA, the percentage of PAs in surgical subspecialties rose from 16.2% in 1994 to 23.2% in 2004, making surgery one of the fastest-growing areas of PA practice. There are multiple reasons for this change, including the limits placed on the hours residents can work; decreases in the placement of foreign-trained physicians; lowered reimbursements for surgical services, which has led surgical practices to limit the number of physician partners but maintain case loads by utilizing PAs; hospitals enhancing support services for reimbursable surgical patient care; and historically higher salaries for PAs in surgical specialties. All these factors have contributed to the increased number of PAs practicing in surgery.

Reaching our full potential

In a profession where the emphasis has always been on primary care, the perception may indeed be that by embracing increasing professional diversity, we are losing our focus on and appreciation for the founder’s concept that PAs should help physicians provide primary care in underserved areas. Certainly we could debate this point. Some evidence would indicate that at the start of our profession, the emphasis was on primary care because the government saw that as the area of greatest need and provided funding to PA programs for that purpose. Meanwhile, physicians involved in developing the curriculum for the profession recognized early on the utility of PAs in all specialties. After all, PAs are educated to diagnose conditions requiring surgical intervention, and PA students continue to have surgical clinical rotations. Perhaps it is only now that our profession is reaching its full potential. The commitment of *JAAPA* to include

a surgical forum completes the ongoing educational experience of PAs that first began and continues on in the standards of PA education.

As professionals, PAs are all involved in some type of specialty practice. Those of us who work in primary care enjoy offering a continuum of care for patients, while those of us in other specialties provide the consultation and services needed before patients return to their primary care provider. The *Journal* now offers us an avenue to share our collective knowledge. As those of us in surgical specialties elaborate on the whys, whens, and hows of our surgical interventions, perhaps our primary care colleagues will learn things too—such as when to request a surgical consult, how to better educate patients on what to expect from the consult, and what patients and PAs should expect postoperatively. In return, we in surgery will be reminded of the intricacies of ongoing care for our patients before, during, and after they leave the operative suite and the surgical floor.

The inclusion of surgical information in *JAAPA* will certainly not eliminate the need for each of us to study the information we have always found in the literature more closely associated with our chosen area of specialty. The complexity of medicine in general, much less that of a specific specialty, cannot be addressed by any single journal. However, as a profession, we now have come full circle in completing the essentials of our original educational experience. It was an experience that addressed all aspects of the needs of our patients. It continues to be an experience that demands that we not act in isolation when considering what is best for our patients.

Why has it taken this long for our professional journal to include surgical information? Maybe because no one there knew Dr. Hu. □