DIANE DREW

July 16, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: Your date of birth?

Drew: 3/31/47.

Mullan: We are sitting in New London, New Hampshire. The date is the 16th of July, 1996. We are sitting outside of the New London Hospital, specifically next to the Medical Office Building, on a beautiful July afternoon at a picnic bench, Mrs. Drew and I. Tell me about yourself. Where were you born? Where did you grow up?

Drew: I was born in, actually, Lewiston, Maine, and I grew up in Fryeburg, Maine. It's a very small community right on the border of New Hampshire. It has this small, semi-private high school, so I was exposed early to different cultures and kids from all over the world. I have two older sisters and a younger brother. My parents were both uneducated people. My mother finished high school. My father finished eighth grade.

Mullan: What did they do for a living?

Drew: My mother did everything, and actually her main thing is a baker, and she continues to bake every day at the school, at age seventy-six. My father was basically a salesman and died three years ago, actually. He had coronary disease. My two sisters, one lives in Pennsylvania, one in Florida, and my brother still lives in Fryeburg.

Mullan: Growing up, what did you have in mind what you might like to do with yourself?

Drew: Well, I can remember on my fourth birthday getting a nurse's cape and a nurse's hat and a white uniform. So I guess I always wanted to be something in the health care. Actually, when I started applying to schools from high school, the only program really that was available at that time, that was not clerical, was a medical assistant course. I took that at Fisher Junior College in Boston and then actually became a dental assistant when I came home from school. Then I was subsequently married, and we have a now twenty-seven-year-old daughter.

Mullan: When you left high school, you went directly to Fisher, thinking you wanted to do something in this area.

Drew: Right. They had medical secretarial courses everywhere else, but I really didn't want to type. I couldn't type very well. So they had a medical assistant course, which was really more clinical than clerical, so that's what I did.

Mullan: And that was a year?

Drew: Yes.

Mullan: Good course?

Drew: Yeah, I would say so. I worked in a dental office for about two years, and then actually took time off when I got pregnant and stayed home with the baby for a couple of years. Then I started working for Dr. Yuskaitis, who's here in this building, who is a family physician.

Mullan: Where were you located then?

Drew: Here in this building, actually. He's still there, upstairs.

Mullan: So you got from Boston--

Drew: Back to here.

Mullan: Back to here. That was following the marriage?

Drew: Yes, that was after the marriage.

Mullan: Play that a little slower. How did--

Drew: How did I end up back in New Hampshire from Fryeburg?

Mullan: Yes.

Drew: Let me see. How did I? I guess that job, the dental job, came up, so I took it.

Mullan: The dental job was here?

Drew: No, actually it was in Franklin, which is a little south of here.

Mullan: Your husband is from here?

Drew: Right, he was from here originally, and then I met him through a colleague. Then after the baby was born, and I had stayed home, and I was ready to go back to work, Dr. Yuskaitis was advertising. I lived within reasonable distance, so I came up and took the job. That was at the time that the Dartmouth Medical School was training physician assistants.

Mullan: What year are we in?

Drew: This was in '72. I went back to school in '74, so I had worked here for a couple of years as a medical assistant. We trained PAs through our office, and neither one of them that we trained worked out so he said to me--

Mullan: Worked out in terms of--

Drew: Well, in terms of coming back to practice. So Dr. Yuskaitis asked if I would apply to the program, so I did, and I got in. I worked with him for the next total of thirteen years.

Mullan: Tell me about the program. What was it like?

Drew: The program was good. It was short. We had a three-month didactic and a nine-month preceptorship, so that we were out in clinical practice basically in three months. The training was such we felt that we were learning certainly for the whole year. Everything was reported back to school that we did. All of our experiences were reported and critiqued and graded and all of the above, but basically my real hands-on experience was in practice.

So I graduated from that program in 1975, and I worked in family practice for the next ten years and then decided that internal medicine would be fun for a change, so I came down and worked for Dr. Catino [phonetic] in internal medicine.

Mullan: I do want to get forward to the current period, but spend a little more time on what it was like, if you can think back to first going in the practice as a PA, and how equipped did you feel, what was it like. This was the early days of its existence.

Drew: Oh, very early. My PA license number in New Hampshire is twenty-five. [Laughter] It was in the early days. First of all, I just had to fight being a woman. That was not very accepted either, unless you were a nurse. So we worked through those issues and just worked through that whole concept of having somebody that could do a lot of the things that a doctor did, but not as much as, and more than a nurse. It was real education of patients as well.

Mullan: What was it like? Were there patients that wouldn't see you?

Drew: Oh, sure. Oh, absolutely. That just said, "No, we're going to see the doctor, and that's it." And that was perfectly okay. That's their choice, and that was fine. So I felt actually like I had to prove myself a lot.

Mullan: Was that more common in those days than it is today?

Drew: Oh, absolutely, absolutely. I think that the public has been much better educated about PAs and nurse practitioners and the role that we play, and the importance of our role basically and especially in primary care and especially in this day and age of managed care. I think our role certainly has evolved and is much better than it was, but it was hard in the early days. You know, everybody always said, "Well, what's a physician assistant?" So it was like every time you had to kind of go

through the whole thing again and explain again who you were and what you were and how you got there, but that certainly is much better. I think the longer that you're in practice, and especially if you're in the same place, you know, my role certainly has been accepted and is well known.

Mullan: How about in the medical community? We've talked about patients' early resistance. Was the medical community resistant?

Drew: Sometimes, sure. I think the older physicians at the time who were on staff, first of all, didn't want a woman here at all. Secondly, there were a few who were totally resistant to the whole idea of a mid-level, if you will, practitioner. I think as time went on and I was able, I guess, to prove indeed I was competent and I knew what my limits were and lived by the rules, I think that I did prove myself. I actually now, certainly, have a wonderful rapport will all our physicians here. I think the surgeons are very supportive and always have welcomed my referrals and that kind of thing. So I think now it's very good.

Mullan: Tell me about the resistance to a woman in practice then and now. What form, what shape did that take?

Drew: I think initially, again, there were older doctors on staff here at the time when I graduated in 1975. Certainly they didn't treat any woman with respect, basically. I can think of one doctor in particular who was very anti-woman, basically, and

if I would make a referral, he would say something to the patient like, "Well, she doesn't know what she's doing anyway."

I had one physician say to one of my patients, "You should have somebody look at her ear that knows what she's looking at." So it was that kind of thing. I haven't experienced that in twelve years, I think partly because I learned a lot. Actually, my boss at the time wrote that other physician and said, "You know, she's looked at more ears than I have."

Mullan: It's hard to disentangle that one, whether it's feelings about PAs or feelings about women in practice. Were there incidents or people that were definitively off-putting or discourteous or uncooperative with you because you were a woman?

Drew: I think there was a feeling of that. I don't know that I could give you a specific--

Mullan: Were there male patients who didn't want to be examined by you?

Drew: Oh, sure. Oh, sure. And sometimes that's still the case. It kind of depends on age, you know, whether they're accepting of that or not.

Mullan: Which way?

Drew: Older.

Mullan: Being more--

Drew: Older than me.

Mullan: Being more resistant.

Drew: Men in their sixties, seventies, don't necessarily want to be examined by a woman. Most of my younger patients, certainly, and patients my age, they don't think one way or another about basically. That's not an issue anymore, as far as I'm concerned, but it wasn't always easy in the beginning.

Mullan: And there were no other women physicians or other practitioners in New London at that time?

Drew: At that time. There had previously been a woman family physician. She actually delivered my baby. She left to go teach midwives in Kentucky. She recently came back to the area, chose me as her provider. She had a mirror in her baby's room in her office, and she brought it to me to put in my office, so that sense of continuity was wonderful. It was really special.

Mullan: Have there been other women physicians in New London since then?

Drew: No, but we have a new one coming in September.

Mullan: Good. On the matter of the training and competence, a one-year PA programs is, at least by today's standards, fairly short.

Drew: Oh, very short. Very short.

Mullan: How did you feel about that at the time? How do you feel about that now? Is that sufficient?

Drew: No. No. I think almost all PA programs now are four-year degree programs. I think those are probably fine. But I think, at the time, you certainly had to have some requirements before you got into the program. Originally those programs were designed for returning corpsmen from Vietnam who had had quite a lot of experience. You had to have a fair amount of experience before you went to the program. I think that was good. I think that made up for a lot of things that we didn't learn at the time. I think the biggest drawback that I can see was that we didn't have a lot of pharmacology. I really have had to learn pharmacology outside. We learned it as we came along and did it that way.

Mullan: This is in terms of prescriptive activities.

Drew: Sure. Right. We do have prescription privileges, and I do have federal DEA number, but it was hard.

Mullan: Does that represent a change in New Hampshire law?

Drew: Yes.

Mullan: Your independence level of prescriptive authority and practice independence is higher now that it was?

Drew: Absolutely, absolutely. But we are still dependent practitioners. We do have to have a registered supervisory physician, and we all do.

Mullan: As you look back, to pursue this theme of how it was when you were initially trained and went in practice, as you look back at your clinical competence, your clinical not only range of skills but depth of abilities within the skills you have, how would you characterize that from your date of graduation from the PA program on to today?

Drew: First of all, I think I should say that I have had wonderful, wonderful teachers. Dr. Yuskaitis, Dr. Catino, Dr. Kirk have all been excellent teachers, so I have learned a tremendous amount. Also, by law we have to have 100 hours of continuing medical education every two years, so certainly that has been helpful as well. I think from what I know now and what I knew then, certainly the depth of that is many times more than it was. I think that's true of anybody who goes into practice. Until you're in practice, you don't know who to be a

practitioner. It's like you don't know how to be a college president until you're college president, so I think the depth certainly has been deepened a great deal.

Mullan: Was there a rapid learning phase in earlier years which, in your judgment, has plateaued, or is it a linear growth?

Drew: Oh, I'd say it's growth every day. I learn something every day. I think everybody who's in practice learns something every day. I don't know how you could not learn. If you've got a patient with a new symptom, you've got to find out what that means. I feel like I learn every day. That's why it's still so exciting after twenty-one years, because you do learn something new every day. That's the great part of doing what I do.

Mullan: You were giving me the chronology of doctors. Why don't you spell out a little more and why--

Drew: Why I made the change?

Mullan: Yes.

Drew: Well, I worked in the family practice for a total of thirteen years, actually ten as a practicing PA. We did everything. We did obstetrics. We did pediatrics. We did the whole range of services, actually even to the point of Dr. Yuskaitis did his own Caesarian sections. He got special

privilege to do that and had special training, because we were the only ones that did obstetrics at that time. There was not a gynecologist here. That was a very exciting time. It was fun. It was a great sense of satisfaction to deliver babies. Then we had fairly large pediatric practice.

Mullan: You were delivering them, or you were assisting?

Drew: With him. He was there. We were also the only pediatrician in town at the time, so we took care of all those babies that we delivered as well. Then I guess the reason that I changed was that I thought I was ready to move on to maybe a higher level. I was ready to stop doing obstetrics. I thought that not getting up in the middle of the night would be nice for a while.

Mullan: So you'd go in as team, the two of you?

Drew: Basically, yes. Usually I would labor with women, and he'd come in, and either I'd catch it, and he'd be standing behind or whatever. Don Catino had been my alternate supervisor for all those years so we had talked about maybe going into internal medicine would be a new challenge. So I did. I switched and came actually downstairs in the building and went into internal medicine, which was different. It's still primary care basically, but with a lot of different focuses. We didn't do any pediatrics. Our youngest patients would be fourteen or

fifteen. It was a challenge to kind of re-learn how to do primary care in an adult setting and go from there. It's been fun. I've really had a great ride.

Mullan: What year did you make that switch?

Drew: '85.

Mullan: Then you started working with Dr. Kirk as well?

Drew: Yes, at the same time. Then Dr. Kirk offered to be my alternate supervisor.

Mullan: Also an internist.

Drew: Also an internist. He said, yes, he'd be happy to do that as long as I'd work for him one day a week, so that's how it's worked for the last eleven years, almost twelve. So I work for him on Wednesdays and I work for Dr. Catino on Monday, Tuesday, and Thursday and Friday morning.

Mullan: How do you decide who's going to see who within the practice? There's a great deal of discussion of levels of competency in terms of dealing with more complex problems. How does that work out on the front line?

Drew: In practice?

Mullan: In practice.

Drew: Very well, actually. We both are very comfortable with my judgment of what I'm comfortable with, basically. We try very hard for all of us to see all of the patients, so that when he's away on vacation or at a meeting or whatever, all of the patients have seen me, they know what I do and what I can't do, and they're comfortable with that. So we've tried to alternate visits as much as we can. Still we have some patients who want to only see him. We have some patients that only want to see me. It just kind of works out when you know who wants what. But basically we try to, for both of us, myself and Jack and the other office, to see everybody so that they're comfortable with both of us.

I have chosen not to get hospital privileges, mostly because when our daughter was home and growing up, I didn't want to have to come in early and I didn't want to have to stay late to do rounds. That was okay with everybody. That worked out okay. I actually now have privileges for the Urgent Care Clinic, and I go in and take call during the summer, especially when it gets very busy in the ER. I will go in and help out in the Urgent Care Clinic. That's worked out very well.

I'm thinking now that I'm probably going to end up getting some privileges to do work in the Extended Care Unit. I think that would take a fair burden off the docs, and I'm pretty comfortable and familiar with geriatrics.

Mullan: Essentially the nursing home.

Drew: Yes, yes. This is a retirement community basically, so over half of our practice is over sixty-five, so that's going to come eventually, I'm sure.

Mullan: Again, the level of clinical function, have there been situations in which either because of happenstance in the office or because perhaps the physician is away, your function level that you're uncomfortable with, you realize it at the time, or you realize it afterwards?

Drew: If that happens, I always have an alternate supervisor, so I always have somebody available for me. If Don's away, then Jack covers it. If Jack's away, Don covers, so I always have a supervisor's position available. So if I did get into something--I mean, I can tell you quite frankly I had a patient that was scheduled to see me--this is a very weird case. He came in because he thought he broke his ankle, and actually he was in congestive heart failure from cardiomyopathy. He was a thirty-nine-year-old man, and it was alcoholic cardiomyopathy. Obviously I would know how to get an X-ray of a broken ankle and splint it or do whatever had to be done to it. When I realized that this was a lot more serious, I did what I thought was appropriate. We did an EKG, we did a chest X-ray, I got some lab reports, and then I said to Dr. Catino, "This is what I have.

What do you think?" So he was there. But that doesn't happen very often quite, frankly.

Mullan: This is a hard question, but there's a situation which you realized that what you were seeing was more than what the patient was into it. Are there situations where you don't see that except in retrospect? I'm asking as not because I'm anything other than interested, but this is a public perception if we have non-physicians functioning, they will get in over their head.

Drew: I have to say that I can't think of a time when that's happened, but again, I've always had a supervisory physician available to me. If there was any question or doubt in my mind, they've always been there to ask the question. No, it has never happened to me, even in retrospect. I just can't think of one time.

Mullan: That's good.

Drew: Yeah, it is good. This is a very unique situation here, I think it is. This is a small community hospital. We're thirty miles south of Dartmouth-Hitchcock Medical Center. We're thirty miles north of Concord Hospital, which is also a regional center. We have the best of all possible worlds. We also have an affluent, educated community that wants to be well. This is like utopia for medical people. Not that we don't draw from areas

that aren't as affluent or aren't as educated; we do, and we certainly have our share of patients that are indigent. But basically our main patient pool is educated people that want to be well, so this is a wonderful way in which to practice.

I think the fact that we're so small, we have a thirty-five-bed hospital with a fifty-bed extended care unit, and when I say that to colleagues around the country, they all think, oh, you know, wow! [Laughter] I think that that's part of the reason that we've never had a problem, is because there's always somebody available to me. Even under the worse scenario, an ambulance could take them to Hanover in twenty minutes. This is an ideal situation. It truly is.

Mullan: Tell me about the population. One population is either the retirement community or the summer community?

Drew: That's right, and we also have Colby-Sawyer College which is a younger but still affluent, educated people. The surrounding areas, there are probably seventeen towns that we draw from, and they're all very small communities mostly under 1,500 people. Some are industrialized. Newport has Stern-Reuger [phonetic], which is the gun manufacturer. Some have no industry at all. They're just little kind of isolated communities that people commute from. I live in one of them.

Mullan: Which is that?

Drew: I live in Washington, New Hampshire, which is actually a forty-five-minute commute. It's got a voting population of 400-and-something, has a one-room school.

Mullan: I've been through Washington.

Drew: It's just beautiful. It's just beautiful. It was a wonderful place to raise our daughter. She got a very good, basic education there. It was great.

Mullan: In these communities, I presume there are people who are poor or working class?

Drew: Oh, absolutely.

Mullan: How do they relate to the health care system as you see it, and how do they relate to you?

Drew: I think they relate very well. I think they're grateful for what we have here. Newport had a small community hospital, as well, that closed probably six or seven years ago.

Mullan: Newport, by and large, is a poor, it's a working-class town?

Drew: Right.

Mullan: And do they have a medical community there at all?

Drew: The New London Hospital has a clinic in Newport. Also the Valley Regional Hospital does something over there. I'm not quite sure what. That's in Claremont.

Mullan: But there's no physicians or PAs resident in Newport?

Drew: Well, yes.

Mullan: They're in the clinic.

Drew: Yes, they're in the clinic. There's a nurse practitioner over there, and there are three doctors--two family physicians and an internist, I believe. They all have privileges in our hospital and are part of our hospital. Actually, that clinic is owned by the hospital. So there are people there, and I think they are very well accepted and appreciated.

We have the Visiting Nurse Association, the Lake Sunapee Region VNA, also is a wonderful, cohesive group. They are just a wonderful organization.

Mullan: So, good resources.

Drew: Oh, we have wonderful resources.

Mullan: Do you see Medicaid patients in your practice?

Drew: Yes.

Mullan: And is there some limit to that or do you just take any Medicaid patient that comes?

Drew: We've never refused one, so I don't know. I don't think there's a limit.

Mullan: And how about folks, the working poor, who are uninsured? Do you see them?

Drew: Absolutely.

Mullan: And what happens when they come in? Bills, is that a problem?

Drew: Well, it's always a problem, of course, but if somebody does, you write it off. And we're still able to do that. I don't know what will happen under managed care, but so far we're able to do that.

Mullan: What kinds of incursions has managed care made in New London?

Drew: Paperwork. I mean, paperwork. [Laughter] Oh, you can't imagine the amount of paperwork, just tons of materials that have to be--everything has to be documented. Referrals have to be

made for everything. If one of my patients gets pregnant, for instance--and I deal with a lot of young healthy women, of course--if one of my patients gets pregnant, they're going to go to the OB/GYN person. Just the amount of paperwork involved in the referral, and how many visits they can have, and all that kind of stuff, it's time-consuming.

Mullan: So it's a burden that way.

Drew: Oh, absolutely.

Mullan: Has it impacted on your practices in any fashion, in terms of [unclear] of who you see, what you do in the way of diagnostic work-ups?

Drew: Absolutely not, and we talked about that from day one as a practice, as a group, and I'm talking mainly about Don and Jack and I. We have said that we practice good, quality care, and we're going to continue to practice good, quality care because we don't know how to do it any other way. I mean, basically, we just don't know how to do it any other way. I cannot imagine having to think about, "Gee, should I really get this CBC or should I just take a chance?" There's no way we could do that, so we don't.

Mullan: So you think really it's had no impact?

Drew: I'm sure financially it has. I'm sure that we lose because that comes out of our, whatever it is, pool or whatever term they call it.

Mullan: But in terms of clinical activities, it hasn't changed it at all?

Drew: No. We still practice quality care.

Mullan: Are there a number of managed care organizations with whom you are signed up? Is that the way it works coming in?

Drew: Yes.

Mullan: Know any names?

Drew: I don't know. Carol could tell you that, though.

Mullan: A handful?

Drew: Probably. Yeah, a handful.

Mullan: Each with a separate system.

Drew: Each with a separate system. Actually, that's going to change now, because New Hampshire has just legislated that they can be opened now to competition, because it was basically two

HMOs that had all of the state, and nobody else was allowed to come in. For some reason, they got that somehow. Now it's open, so there'll be tons more coming. And you know Medicare is going to go managed care, so I'm sure that's going to have an impact. I'm not sure how it's going to impact.

Mullan: Let's talk primary care. When you graduated from PA school, the term "primary care" probably was in its infancy, and today the term is used, bandied about all over the place. How have to seen that develop both conceptually and in terms of practice?

Drew: I always thought that family practice was primary care, so I always felt that I was in primary care. I think now anybody who sees patients that is not a specialist--whatever that means--is primary care. I think that's how the public perceives us, as the primary care. I believe that we do primary care in the internist's office because we do see everybody. We don't limit it to cardiology. We don't limit it to anything. We see all patients except for pediatric patients or obstetrics. Those are the only two people that we don't see. I don't know how it's evolved. I think the media has evolved it more than anything else or anybody else, probably.

I work with the Dartmouth Co-Op, which is a primary care research group. That started just about the time I was finishing school, so I've been kind of with the group since its inception. They've probably had more of an influence on my thinking of

primary care than anybody. We've done many studies with the group in patient outcomes, how to do certain treatments, that kind of thing. So it's been pretty fascinating and fun to work with the group.

Then ASPN--A Sentinel Practice Network--is the other primary care research group in the country. Actually Jack just had his year of presidency of Aspen, and he's now retired officially, I believe. So I've been involved with that one not quite as much as I've been involved in the Co-Op. But the Co-Op has done some pretty extraordinary things, as far as outcomes have done. A lot of the things that they published have been adopted. Some of our flow charts, some of our questionnaires now are being bought by other countries. That's pretty exciting actually to have that kind of impact from a small community in New England.

Mullan: Under the "primary care" banner, has the relationship between generalists practitioners, including the family docs and the internists, and the specialists, either in town or at Dartmouth or elsewhere, has that changed over time?

Drew: Again, I may live in Utopia here, but I don't think it's changed. I think we've had a very wonderful relationship with both systems. I think it's worked very well. We have physicians from Concord who come and practice in our community one day a week. For instance, the orthopedic group comes, and they're here one day a week. They share space in the new part of the

building. The cardiologist comes down from Hanover once a week, does consults, does stress testing, and that kind of thing.

We're all teaching medical students through our office, so we're all involved in that. I say that we're involved because I am part of that as well, but not in official capacity, although I do sit in on committee meetings sometimes. One of our retired doctors is on the longitudinal clinical experience for the medical students. He'll call me up and say, "Can you go to the meeting this month? Because I'm going sailing." [Laughter] So I do in that sense. Always when medical students come through the office, we spend time together and teach.

Mullan: Are there more specialists practicing now than there were when you started in practice?

Drew: I think there are more specialists here in this community that come to this community so that our range of referral sources are much greater. Yes.

Mullan: The distinction you're making is there are not more living in New London practicing full time, but their availability is greater based on circuit riding and how many visits and so forth.

Drew: Right. Yes. We do now have a full-time pediatrician. We do have a full-time obstetrician/gynecologist. One of our internists is an infectious disease specialist. Our ER doc,

who's the head of our emergency room is qualified in to do stress testing and that kind of thing, so he does a lot of that as well. The ENT people come from Hanover. We have orthopedic people who come from Concord. The psychiatrist comes, and he now has a full-time psychiatric nurse practitioner that is available to us. She's a woman. Podiatrists. We now have podiatrists available that has been in the last ten years. We never had a podiatrist here.

Mullan: Are family physicians, the one that you worked with, is he still here?

Drew: Just the one. He's still here. The new woman that's coming is a family physician. She's finishing her residency program.

Mullan: In a community that has at least a modestly rich hand of specialists and sub-specialists now, does the family medicine model fit in? Are the people still willing to go to family docs?

Drew: Oh, I think he's got a large practice. I think patients love him.

Mullan: Enough to expand to a second doc?

Drew: Obviously.

Mullan: Will she be in practice with him?

Drew: No. One of our docs is retiring who is an internist, and she's taking over his practice. So that will be interesting to see how that operates.

Mullan: Where is she from?

Drew: She's from the Dartmouth program. She's just finishing her residency now, and she'll be here in September.

Mullan: PAs, more than nurse practitioners, have tended to specialize or work with specialty physicians.

Drew: To work with specialty physicians?

Mullan: Yes. In other words, if you look at the practice patterns of PAs in practice, over 50 percent, at this point in time, are working as specialists or with specialists.

Drew: I think that's only changed recently, though. I don't think that was the original trend of things. I think most of us actually worked with family physicians and internists initially. I suppose the teaching programs have changed. I know there are a lot of surgical PAs now.

Mullan: The facts are that as we track more carefully in recent years and as the Academy of PAs has tracked the number of PAs in what could be called--let's turn the tape over right now.

[Begin Tape 1, Side 2]

Mullan: This is Diane Drew, tape one, side two.

The number of PAs who were identified as practicing primary care has dipped under 50 percent, and those that are identified as practicing specialty care is higher than that. In the last several years, I think the PA educational community has attempted to push in the other direction, but there's clearly been a market factor at work pulling PAs, whatever their schooling, into more specialized and specified and narrow kinds of practice. Have you sensed that, can you intuit that, or does that make any sense to you, or is that just foreign to your experience?

Drew: It's foreign to my experience, but I've been in the same place forever. My concept of the original programs were that, indeed, we were going to be trained, and were trained, in primary care with the hope that we would be in areas that needed health care. I do think that, of course, that has evolved, very definitely. I think what I can do now and what could do then are two different things, basically, as well. I think there's a lot of things, and I think that's just from experience. I don't have a doubt in my head that if I wanted to learn how to do assisted surgery, they'd all teach me. It's not one of my desires, but I

think they would all teach me how to do that, and I think I could learn it very easily. They could probably teach monkeys to do assisted surgery and hold retractors. [Laughter] So I think that is a matter of experience.

Mullan: Are there other PAs in New London?

Drew: We have one other physician assistant. He's with Steve Jordan, who's an internist, and they're employed by the Dartmouth-Hitchcock Clinic.

Mullan: And he functions in a manner similar to you?

Drew: Absolutely. They do basically the same things. He covers the practice when the physician is gone, and has an alternate supervisor. He basically sees all the patients and all the patients see him. It's the same thing with him, he has a following that just wants to see him, just like there are some patients that only want to see Dr. Jordan. I think the numbers are small in comparison to the overall number of patients that we have, the ones that just want to see him or just want to see me, pretty minor.

Mullan: What do you like best about what you do? What's most fun?

Drew: I just love my patients. I love taking care of people. I love being able to help women in crisis, and I like the continuity of care that we give. Right now I'm taking care of a nineteen-year-old girl whose grandfather just died from cancer that we took care of. There's something about knowing all that family history that gives you a great deal of satisfaction in knowing that you've done everything you can for that patient, including helping the granddaughter grieve. I love that. I love doing what I do, and I still say that after twenty-one years. I don't think a lot of professions do that, quite frankly, so there's a great deal of satisfaction in knowing that you've helped somebody.

Mullan: Are there particular aspects of it that you don't like? Are there people or circumstances or days that you sort of say, "Yech, I've got to leave"?

Drew: I think we all get overwhelmed some days, and if you've had to see twenty patients, you always feel like well, "Geez, did I do everything that I would do if I'd had another half hour with that patient?" I think we all have limitations, certainly, in what you can do in a day. I think we get overwhelmed. I think sometimes it's overwhelming in the ER when there are a hundred patients sitting out there waiting to come in. I always worry about that. Mostly I just worry about patients. There's not a lot I don't like about it.

I miss pediatrics. I do miss pediatrics, and I didn't think I would. I debated for a year, because I thought it was obstetrics that I was going to miss the most, and it's been pediatrics that I've missed the most. But I do like the continuity. I think that's wonderful.

Mullan: Is there HIV disease in the community?

Drew: Nope, not yet. I mean, there's a few isolated things like maybe a summer person here. I had one person came that was visiting his friend, and I took care of him. But very little, very little.

Mullan: Is there nervousness about it in the community?

Drew: I don't think there is yet, because I don't think there's been a great deal of it. We try to educate the kids as much as we can. I do a lot of sports physicals at the high school, so I always try to make sure that the kids understand what it is, how you get it, that kind of thing. But I do the same with breast exams for women and testicular exams for men. I try to teach them that as well. I think it's just a matter of education.

Mullan: What about teen pregnancy in terms of rates, attitudes, and intersection between the medical community and the larger community?

Drew: I think it's probably the same as every other community, and maybe more so because we're isolated, and you have to drive two hours to go to the theater in Boston, and most families can't do that. So you're kind of up here, and that's what they do. I think a lot of the kids have birth control option here because mothers and fathers are educated, and I think that's a great deal of it is if they know what their options are. The gynecologist did have two nurse midwives with him. Neither one are still here, actually. I think they helped a great deal in education. I don't think he has the time to spend educating like they did. I think that's the value of our role, is we that we indeed have time to educate our patients. I think that's the biggest asset we provide to a practice, is that we educate.

Mullan: Why is that? Are the docs unwilling?

Drew: Because we have time. Oh, no, I don't think it's unwillingness at all. I think it's time constraints, and I think that time constraints are going to be more so under managed care.

Mullan: Is it that their time is worth more in terms of billable minutes?

Drew: Sure, absolutely. Although some days I see more patients than he does, it still can be different. I think that it's the education that's the key.

Mullan: In terms of being able to talk to and explain to teenagers and others.

Drew: Absolutely. And let them know their options. I think HPV is the biggest problem we have right now, and it's rampant.

Mullan: HPV? Herpes--

Drew: Human papilloma virus causes atypia, the increased incidence of penile cancer in men because of the HPV virus. You know, there's sixteen genotypes that cause cervical cancer in women. I bet you every third pap smear I get back is atypical because of HPV. Then again it's education, and it's kids have to know that they have to protect their bodies.

Mullan: How about abortion? Is that an issue in the community?

Drew: I don't think it is. In two years, I bet I haven't referred two women for abortions. We just really don't see it much.

Mullan: With the teenagers?

Drew: I think with the teenagers, I don't get to see it much. I think the school nurse actually does a lot of that kind of counseling, and they would tell her. I don't know how much the GYN person does. I quite frankly don't know.

Mullan: But it has not been a hotly contested community issue, for instance?

Drew: No.

Mullan: A moment on the question of PAs and nurse practitioners. What, in terms of your experience over the years, has been the relationship between the nurse practice community roundabout and the PA community, and personally, what's been your experience?

Drew: I think roundabout it's come a long ways. I think it was felt to be direct competition initially, and nobody knew what to do with it. Then I think over the years we've really come together on it and understand that our roles are very similar. I personally trained a nurse practitioner from Simmons College through our office. I did a lot of preceptorship with her in their primary care rotation. I go to nurse practitioner conferences a lot of times if they've got subjects that are more interesting to me. So I think that we've come a long way, actually.

We now do have a nurse practitioner that works--her husband is a physician. She is going to be on staff one day a week. She is also teaching at Colby in their nursing program. I think that that basic difference in PAs and nurse practitioners is that we are dependent practitioners, and they can be independent practitioners. They're licensed by the Board of Nursing; we're

licensed by the Board of Medicine. I think those are the only two differences. I think now the training programs are very similar.

Mullan: That's arguably a big difference, the degree of independence and the nursing profession's desire to have nurses function more independently. How do you see that?

Drew: I think that is going to be the one drawback when we're all competing for patients under HMOs. I think the docs are going to want the PAs in the practice that have to be dependent, and they can get a cut of, to put it right down to dollars and cents. I don't know if that's going to turn out to be true or not, but I can see that as a potential.

Mullan: Are nurse practitioners in this area practicing independently or higher degrees of independence?

Drew: I don't think so. I think the nurse practitioners are all working with doctors. Certainly all the nurse midwives that I know are working with OB/GYN people. Lay midwives are independent, but not certified nursing midwives. They are all practicing with an MD. I know one nurse practitioner who practices independently.

Mullan: Whereabouts is that?

Drew: In Franklin. She's the only one I can think of.

Mullan: And what sort of practices is it?

Drew: Family, basically, she does family. I think she's probably pretty successful. I think people like her.

Mullan: Franklin is West of here?

Drew: Yes, lakes region, kind of south and east of here. I have to take that back. I did meet another lady from Laconia, which is in the lakes region, that also practices independently. She has a mammography center in her office, she does primarily women's care, and she's got a very good relationship with her hospital. That's the Lakes Region General Hospital. I think she practices very well.

Mullan: So the Nurse Practice Act in the state provides for more independent practice than the PA Act.

Drew: Yes.

Mullan: With a few exceptions, your sense is that the pattern of practice isn't all that different?

Drew: Right, I think that is probably true.

Mullan: As you look to the future, what do you see for the system as a whole, and what do you see for PAs in particular?

Drew: I think our role is going to be much more appreciated, because we can provide quality care in a dependent practice that's going to allow better access to care. It's going to allow better quality because there are going to be two providers, especially for me because, again, I've been here for so long, everybody knows me, they know what I can do, what I can't do. I think that makes a huge difference. So I think it will be a way of the future that more practices will probably have a PA or a nurse practitioner, because it's going to improve the quality of care and improve the access to care.

Mullan: Two notions that are thrown out that might run contrary to that, just to see what you think about this, one is that as we have more physicians and the number of physicians available are steadily rising, the market niche, the opening for the non-physician clinician will be smaller. At least that is a scenario one can spin out. What do you think? Likely or not?

Drew: I'd say unlikely. I think there will more primary care physicians and less specialists. I would think that would impact it in a different way, that there would be actually more call for PAs or nurse practitioners, because people who are in primary care need that other provider. How many times have we heard there's a physician glut? [Laughter] And how true was it then?

An interesting thing that I just read recently, and I can't tell you where I read it, I don't remember, was that the foreign medical grads were trying to take the PA exam, and 50 percent of them failed the practical session. Couldn't do it. So if they're including FMGs in that survey of physician glut, then they may not come anyway to be.

Mullan: The other idea that is bandied about was that as the salaries for PAs and NPs rise, their relative benefit to the physician or the system will diminish, the simple mathematics being if a physician hypothetically sees twice as many patients as a PA, the PA salary rises to the point of being half the physician salary, their draw on the system is equal. At which point, the physician may say, "Why should I pay for a PA or a nurse practitioner when I can see as many myself? It's getting too expensive."

Drew: Sure. That could be a problem. That could be a problem.

Mullan: Have salaries climbed?

Drew: Again, here I am from Utopia. I get 50 percent of the income I generate. So, yes, it's grown because my patient load has grown, and the number of patients I see in a day has grown, but I have never cost the practice a nickel. I've always made money for the practice.

Mullan: And do you bill it the same rate as a physician for given service?

Drew: Yes.

Mullan: It's billed under him.

Drew: Right. Which is what a dependent practitioner is. It works for me.

Mullan: Would you tell your daughter to become a PA?

Drew: Well, that's very interesting, because my daughter is a paramedic dispatcher. [Laughter]

Mullan: It's close.

Drew: Yes, oh. very definitely I would. If she wanted to go back to school now, I'd tell her to go. She loves being a paramedic dispatcher, and she's happy doing that. I couldn't do that. That would be way too hectic for me, but she loves it, so she's happy.

Mullan: Would you tell young people, in general, to go into the PA profession?

Drew: Yes, very definitely. I can't think of another job in the world that would give you this kind of satisfaction. I mean, I really don't. I have the best of both worlds. Basically I don't have to worry about the business aspect of the practice, more because I don't have a whole lot of control over it anyway, but I don't have to worry about all that stuff. I get to see my patients, and that's all I have to do. That's my job. Who could ask for anything more? [Laughter]

Mullan: Good question. As you look at the next five, ten, fifteen years, what do you see doing?

Drew: I'll stay with this for as long as I can.

Mullan: You don't have other ambitions to--

Drew: Patients often ask me that. "Why don't you become a doctor?" I think the role that I play is invaluable. I think that the fact that I can spend time educating my patients, that I can take care of them, I don't want to be a doctor. They can't do that. There's something in the water at medical school, I think, that makes them not able to do that. I don't want to do that. I just want to take care of my patients. [Laughter] And I can.

Mullan: As you look at the future of the system, do you have any wisdom about where you think it's all headed?

Drew: I do think we're going to be under managed care. I think there's going to be probably three or four companies that are going to have the whole country in managed care. Medicare is going to be one of them, and then there will probably be three or four other major players, and they are all going to call the shots. I think the challenge to us is to find a way to provide the quality under managed care. I think that's what our challenge is.

I think there are a lot of physicians right now who are very disgruntled about that whole thing. They don't want to be told what to do by some insurance man. [Laughter] I understand that, and there's a great deal of frustration with that, but I think that's what's going to happen. I think they've got their foot in, and I don't think they're going to pull it out. I think the can of worms was opened, and now we've got to deal with them.

Mullan: What is the pink ribbon you wear?

Drew: Better breast care, which is certainly one of my primary interests.

Mullan: Do people ask about that?

Drew: Yes, which is why I wear it every day, because any time I can educate somebody about better breast care, I do.

Mullan: So is there anything else you'd like to add?

Drew: Let me see. I can't think of a thing that I didn't cover, I guess, other than if this is going to be in a book someday, I have to say that my husband supported me through school and took care of our daughter and was totally wonderful and supportive.

Mullan: That's a good question I didn't ask. How has that been?

Drew: He literally took over everything. I was commuting 100 miles to school, and he took over child care, home care, just totally everything. It's been wonderful. He retired last year, he's sixty, he's a few years older than I am, so everybody chides him about being retired so early.

Mullan: What had he done for the balance of his career?

Drew: He was a master tool and dye maker, worked on some of the Apollo projects and that kind of thing. I always say to him, "You know, it's okay. You can take the chiding because you did it all in the beginning, and it's my turn now." And that's exactly right. So we've been married for twenty-nine years, and he's just a great guy, not involved in medicine in any way, shape, or form. Hates it when he gets a hangnail even. [Laughter] He's been great.

Mullan: Thank you.

Drew: Thank you very much.

[End of Interview]

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