VIRGINIA FOWKES

November 7, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: What is your date of birth?

Fowkes: It's April 5, 1942.

Mullan: The date is the seventh of November, 1996. We are in the San Francisco Hilton Hotel, in, as it turns out, a non-smoke-free room, Ginny Fowkes and I, on what is a nice afternoon outside, a long way from her place of teaching and practice and enterprise, but wanting to talk about her and her background. Why don't you tell me a bit about yourself. I couldn't tell from your C.V. where you grew up, where you started.

Fowkes: I grew up in New Jersey, in a suburb of New York, North Plainfield.

Mullan: What was your youth like? Tell me about your family.

Fowkes: Well, just a small family. Two sisters, three and a half years apart, who both wound up on the West Coast within six months of each other. My sister is Director of Mental Health for San Mateo County, and we actually live on the same street, twenty

minutes apart on Skyline Boulevard in the rural Santa Cruz Mountains.

I left home when I was eighteen, and wanted to go far for new experiences.

Mullan: What had your parents done?

Fowkes: My father owned a small embossing and die-cutting business in Plainfield, kind of a self-made man. My mother was a homemaker and suffered from chronic disease (rheumatoid arthritis) a good part of her life, although not so much when I was growing up, but intermittently, and at critical points in my life.

Mullan: And the desire to strike out on your own when you were eighteen was based on wanting to leave New Jersey, wanting to leave the family, wanting to see the world? What was it?

Fowkes: All of the above. I wanted to live somewhere else, find out what life was like, and to study nursing.

Mullan: What influenced you on wanting to be a nurse?

Fowkes: Well, in those days, women were slated to be either teachers or nurses, for the most part, if they wanted a career. I very much wanted an academic program, and there were few

nursing programs that offered a strong four-year academic program.

Mullan: Were there nurses in the family at all?

Fowkes: My mother's sister was a nurse.

Mullan: Was that incidental?

Fowkes: That's incidental.

Mullan: How about physicians?

Fowkes: No. My grandfather was a well respected pharmacist and "general practitioner" in town when I was very young. I always had an interest in health care. Did volunteer work in the hospital when I was in high school.

Mullan: How about other values or other institutions? Was religion, for instance, a factor, in your views at all?

Fowkes: That was very much a presence in my youth. My folks were Methodists, and their church was their social community. That didn't fit for me and wasn't my social network. I took different paths exploring who I am and what I needed to be. That took me to North Carolina, Washington, D. C. And eventually to California where I found my place.

Mullan: When you chose Duke, was that because of the nursing program? Did you know that's what you were headed into?

Fowkes: It was because of the type of program, but also because I wanted to live in a different area of the country. I knew New England and the middle states, and knew nothing about southern states.

Mullan: And so decided you'd go explore?

Fowkes: And I found out, right.

Mullan: What was it like?

Fowkes: I spent ten years of my life at Duke, which was a very important part of my formative professional years. A lot happened. I guess I'm one of these people who feels fortunate having been in the right place at the right time. I finished the undergraduate nursing program, did traditional hospital nursing for a year or so. About that time Drs. Andrew Wallace and E. Harvey Estes were interested in starting a CCU. I signed up to help and trained for it.

Mullan: Tell me a little more about this. Harvey Estes I know as Duke's family medicine mentor.

Fowkes: Right.

Mullan: But he was into cardiac care?

Fowkes: Before that Harvey was an internist/cardiologist. He wrote the textbook on vectors, many years ago. He is one of the numerous internists at the time who "converted" to the specialty of family practice.

Mullan: And Andy Wallace is the Dartmouth dean now?

Fowkes: Right.

Mullan: With whom you co-authored a number of papers?

Fowkes: Yes and we co-authored a book. I worked very closely with Andy and the CCU team. He was the director of the CCU. Became very involved in the technology and innovative procedures. I was good at it. In fact, I held the world's record at one point for number of defibrillations. I defibrillated ninety=six times during the second year in the unit, mostly on one patient whose pacemaker kept triggering the arrhythmic.

I also became involved very quickly in teaching, and became a self-styled clinical specialist, teaching both nurses and house staff coronary.

About that time Kay Andreoli and I wrote the book, Comprehensive Cardiac Care which became a national bible in cardiac care. Dr. Andrew Wallace and Douglas Zipes backed us up as co-authors. I stayed with the book for six editions, until

many years later when I decided that I knew less and less about cardiology and withdrew.

Mullan: Because you'd stopped practicing?

Fowkes: Yes and because my focus was in primary care.

Mullan: To get into Duke required a fair amount of success academically in terms of your high school training. And to go on to what, arguably, is a very cerebral and, at that point, kind of ground-breaking element of the practice of high-intensity nursing, obviously meant you had a certain set of skills. Even knowing you as I do now in the area in which you've focused, this seems quite different from what were your moorings or your original proclivities. Tell me about that. Was there an epiphany, or something that happened, that decided you, and how do you square who you are now with, clearly, what you were at that point? I may be making it too polar.

Fowkes: I think it was a natural growth process for me. Initially I was dissatisfied with the role I had assumed in hospital nursing. I had major responsibility, very little patient contact, and did not feel good about my patient care. I was disappointed in nursing leadership and looking for something else to do that was quite different. The CCU experience offered me an opportunity to e on the cutting edge of developments in medicine.

At the same time, I watched another important development at Duke. Dr. Eugene Stead, the founder of the PA concept, was conducting a very innovative nursing project with Thelma Ingles, who probably was the first nurse practitioner in the country. Dr. Stead and Thelma, as part of the graduate nursing faculty, were training master's level nurses on an in-patient unit to use these "sacred" tools like an otoscope and ophthalmoscope that no one but physicians had ever used and to take a new kind of responsibility for patients.

The NLN site-visited Duke on several occasions and refused to accredit their graduate nursing program, because they reportedly said that nurses should not be doing what physicians do, and nurses should not be under physician supervision. Dr. Stead became so alienated by that posture, as did Thelma Ingles. I'm told she left the country in professional exile. I only met up with her years later, when we both were part of a site visit. Dr. Stead, turned off by nursing turned his interests at that time to the Vietnam corpsmen returning to civilian life, a ready pool to implement his idea of starting a physician assistant program.

Mullan: What dates would this NLN disapproval and her exile have been?

Fowkes: That was just before the PA program started. Of course, this was acted out in national forums as well, between national

nursing and national medical groups, and it would have been in the early 1960s.

Mullan: '65, the PA program started.

Fowkes: Right.

Mullan: So, in other words, Dr. Stead was--the base instinct might well have been to start a physician extender program with nurses, but he was sort of scared off, or forced off, and therefore he created the next idea to come along, a non-nurse PA program.

Fowkes: Right. And there was a ready pool coming from Vietnam, highly-trained people seeking places in health care. So I had a role in both the CCU and PA program developments.

Mullan: And which years were those? You graduated in '64?

Fowkes: I graduated in '64, and I guess I started with the CCU in late '65, and did that for a year. Then I was employed by the Department of Medicine half-time and nursing service half-time, with the idea that I would develop a teaching program in coronary care and would also help Kay Andeioli, who was engaged to assist Dr. Stead in starting the first PA program.

Mullan: Who was a physician, a nurse?

Fowkes: Kay is a nurse. The nature of my duties with the first PA program was to help with the admissions, and to teach a cardiology section. In those days, we hardly knew what primary care was, and we taught people what we knew, whether it was needed or not. And these poor guys, who were supposed to be doing primary care in rural North Carolina, eventually, were learning all of their skills in in-patient care and often high-tech areas like these. Looking back it all seems so inappropriate. But that's what you do when you start a new thing. You teach people to do what you know.

Mullan: Well, not only that, that's in the tradition of medical school.

Fowkes: Right. Absolutely.

Mullan: I mean, the hospital-based training, and then you somehow retrofit or backfill the ambulatory experience.

Fowkes: And that was a pivotal experience for me, because I was involved with the first two classes of PAs at Duke and I watched what happened to them afterwards, and I was very aware that they didn't go into rural North Carolina to practice. They were hired in Duke Medical Center. They weren't doing what Dr. Stead's original vision was. So that was a very important hit for me in terms of what I did when I came to California.

While I was doing the CCU experience, primary care was a whole new concept getting started. There weren't books about it. I also was doing a research project associated with the CCU, on patients that I took care of, comparing catecholamine levels with daily psychological assessments that I completed. I became very close with these patients and their course of disease. Through changes in levels of catecholamines, we could actually predict if they would have another cardiac event. I also became aware that every person on the unit, prior to having a heart attack, had had some major personal event in their lives.

The type of studies that I was participating in were leading me to think more and more about people and disease. There was a study about that time in England showing that patients with myocardial infarction treated at home did as well or better as those in hospitals. I wanted to know more about primary care, what the PAs were supposed to do, and how we were going to get there.

About that time, I had to move and start over again. I joined my husband at the National Institutes of Health for a year.

Mullan: You had married someone from Duke?

Fowkes: He was doing an internship at Duke when we met. So I joined him in Washington and had to pound the pavements looking for work. What I found to do was, of course, what I knew how to do, and what was needed. I got a job for a year at the D.C.

General Hospital and helped them set up a coronary care unit and educational program for their physicians and nurses. That was my ghetto experience.

Mullan: Which year was this?

Fowkes: I think it was '67-'68. That was the year that Martin Luther King, Jr,] and Robert Kennedy were assassinated, and the city was under siege. Some of my colleagues were black professionals whose children were out in the burning streets. It was just a horrendous time for everybody, and for me. Everyone had to do extra things to help out, amidst horrible feelings of being at war, the city burning. That was somehow a very important year, I guess the great leveler, about all the things that you think are important, and you learn what's really important in a hurry.

When my husband returned to Duke, I did a research activity there for a year, and more CCU-type teaching. He then planned to work with a Nobel Laureate either at Stanford or Boston, and gave me a choice (since I'd have to start all over again), where I wanted to be. I chose Stanford because I'd never even been to California. I was hired by the medical school to run a portion of the heart program in Regional Medical Programs. We had an eleven-county area that we were responsible for at Stanford. Soon after I was hired, RMP funds were decreased. I had this job to do, and no resources other than my salary. So I did what anybody would do. I hit the road and traveled these eleven

counties, setting up community-based educational programs, visiting hospitals and community colleges and county institutions, doing on-site training, and mainly teaching people how to do what I knew. I had my book and lots of other resources and taught people how to set up educational programs, and if they needed help to set up CCUs. That took me into a lot of rural California. It was a wonderful way to get to know the state.

I did other things in Regional Medical Programs as the heart program became smaller. RMP was a great training ground for me. Community-based education engaged me solidly with the community. I got to know lots of people. I had always felt that it was important to bring resources of the medical school, or medical center, out to the community, and RPM provided a bridge to do so. So I loved that job. I mean, I just thought, "This is great. This is what I believe should happen. You know, bring the wealth of the Ivory Tower out to the community." I valued the opportunity to do grassroots community work.

Mullan: Was Stanford accepting of that? One doesn't usually think of Stanford as a community-oriented institution, particularly.

Fowkes: Right. Individual faculty enjoyed being engaged in community teaching projects. They found it stimulating and it enhanced referrals.

As time went on I assumed a broader role and helped develop other programs. That's really where I got in touch with the architect part of me, creating programs for people and making things work. I helped to get a nurse practitioner program started in the state, and we actually did, as far as I know, the first nurse practitioner program for four nurses in RMP at Stanford. It was very informal.

Mullan: What year was that?

Fowkes: Around 1972. I also developed a variety of other programs in RMP, based on community needs. At that time, I had an opportunity to do an evaluation of education via satellite to nurses in remote areas of Alaska. That took me to Alaska and a new frontier.

Mullan: But through this period, it sounds like your interest evolved towards the community.

Fowkes: Definitely.

Mullan: Your technical expertise gave you the passport to the community.

Fowkes: Right. I had something to give the community that they wanted, and really became involved.

Mullan: And yet it wasn't until the late seventies that you actually decided to take the plunge and become a nurse practitioner yourself?

Fowkes: Not so. While I was in Regional Medical Programs, informally trained as a nurse practitioner. There weren't any formal programs. I certified later, but I never went through what you know of now as a nurse practitioner program. The other thing I did from this RMP base was to help obtain resources to begin a PA program at Stanford.

Mullan: Spend a bit more on your auto-education, since that's atypical. At least today it's atypical. Were others becoming nurse practitioners simply by acquiring skills, or was that something you did yourself?

Fowkes: There were a number of people who were informally trained, who then challenged programs on the certification process when it became available. You had to prove what you'd done at the time we finally obtained legislation in the state.

Mullan: Which was 1979?

Fowkes: Well, it was really late. The PA regulations came forth in 1971. This was a very conservative state. When I came here, I heard a member of the Board of Medical Examiners, stand up and

say, "PAs will exist in this state over my dead body." I always say to my students, "Only a portion of his prophecy came true."

The nurses, then, in 1974, revised the Nurse Practice Act, with this broad definition of nursing. That was done because they were afraid that physicians were going to take steps to control nurse practitioners.

Well, that worked for just a few years, until it became a reimbursement issue. Agencies like MediCal starting asking, "How can we reimburse nurse practitioners? There is no such definition in our state." So the nurses created what was called "holding-out legislation" in 1978, which specifically defined what a nurse practitioner was in this state. It was kind of an awkward way to do things, very defensively.

Mullan: In terms of your acquisition of skills, were you conscious that you were setting about developing a set of skills that would allow you to be more clinically directly active? And were you? Did you practice?

Fowkes: I practiced only briefly and quickly became overwhelmed with other responsibilities.

Mullan: But it got you the credentials to sort of establish--

Fowkes: It got me the skills. I wrote a book with my now husband of twenty-five years, on Clinical Assessment for Nurse Practitioners. We wrote that while in the Regional Medical

Programs. I was learning the skills and then writing this book and then began teaching it.

Mullan: You went from Kliner, to Hunn , to Fowkes?

Fowkes: Yes. Kliner was my maiden name. Hunn was my first married name.

Mullan: And that was the Duke--

Fowkes: Yes, that was the Duke connection.

Mullan: That marriage did not endure?

Fowkes: No. This is my second marriage.

Mullan: And he's also a physician?

Fowkes: Yes. We have been personal and professional partners in many ways.

After the first year of the PA program, RMP funds were impounded and I went over to the PA program full-time, to develop that program.

Mullan: Which years were these?

Fowkes: 1973. I started with the second class. There was no curriculum, and so I developed one and I taught everything that I could teach, started gathering the resources--people and facilities--to make the program happen.

That was another pivotal decision for me. I was very involved in the beginnings of the primary care movement in this state, helping to develop legislation for physician assistant, nurse practitioner, and family physician training and working on the evolution of the PA and the NP legislative efforts in California. I was very attracted to the PA concept.

About that time, too, Stanford discontinued its Department of Nursing which functioned under the Dean of the School of Medicine. Had there been a School of Nursing at Stanford, or had there been one at University of California, Davis, we never would have been able to do what we did in terms of combining NP and PA training.

Mullan: In a sense, you were trained as an NP, but you were training PAs? When you say, "combined?"

Fowkes: Basically, I was training primary care generalists. Having traveled a good bit of the state and looked at the needs, my philosophy was that it was very important to get new primary care generalists to where they needed to be, and to not get hung up on the professional ticket and professional turf issues. That was not a popular view, but nonetheless, I had resources to do that and did.

The second year at the PA program, I became its director. As I mentioned earlier, the Duke PA experience was a recent memory, and I wanted to do something different. I noticed that the first graduates of our PA program practiced in the Bay Area, and I didn't want to be training more providers where they were not needed. So I provided the leadership to decentralize the program statewide, and develop a series of satellites that then could be changed if we saturated a given area with program graduates. We developed satellites in Humboldt County, Shasta County, Kern County, Monterey County, the Central Valley and most recently San Diego County where there was no PA training program. The latter expanded recently to Imperial County, where there's no PA or NP training. We also closed some of the early satellites after providers saturated the areas.

Mullan: Saturation in the sense that that community had enough--

Fowkes: PAs and NPs. Right. And there wasn't the demand because of our graduates or those from other programs.

Mullan: But you did have success in training people in an area, and having them stay vocationally?

Fowkes: You bet. We recruited locally, built a local faculty, worked with local institutions, and partnered with family practice residencies as they were developing. They were major partners in our efforts statewide.

The community-based PA/NP faculty in these different communities recruit and select students who live and work in the surrounding areas. We bring students to Stanford for classroom work and very little time. All of their clinical training is in their home communities where they remain for practice. That's really worked. The vast majority of graduates practice primary care and most in underserved sites.

Another significant event happened as we kept bumping into the UC-Davis faculty in many communities. I collaborated with Dr. Hughes Andrus, who was chairman of Family Practice at UCD at that time and Mary O'Hara Devereaux, both co-directors of the NP program there. We obtained a Robert Wood Johnson Foundation grant, from 1977 to 1980, to combine PA/NP training in three of our programs' satellites. We compared our nurse practitioners and physician assistants. We looked at their test score, endpoint scores on national certifying exams, and employment records. It was an opportunity to look at both process and outcome measures, in terms of similarities and differences between PAs and NPs. Of course, as you might be shocked to know, there were not any. What was important was the kind of clinical experience that people had before they came into the program, and how fast they built on those skills.

After those three years, we formalized a nurse practitioner track in our PA program at Stanford, meaning that our nurses could be nurse practitioners or physician assistants, and UCD, which had started as a nurse practitioner program, developed a PA track. We have been the only two programs in the country that

train PAs and NPs together in the same curriculum. And as you might imagine, nursing leaders were very upset with this approach.

Mullan: And the term you use for it at Stanford is "primary care associate program?"

Fowkes: Right. To include both.

Mullan: Which is generic.

Fowkes: Right, but has not caught on as a title.

Mullan: And what kinds of numbers have you trained over the years?

Fowkes: Well, we have 720 graduates to date.

Mullan: Wow.

Fowkes: We have expanded recently. We now have fifty-three students per graduating class.

Mullan: What's the breakdown in between--

Fowkes: Approximately one-third of our student body has had a nursing background, although one year we had a class half nurses and half PAs.

Mullan: That describes what they come in with. So you're saying that--

Fowkes: Whether their background is a nurse--

Mullan: Right. Or not nurse. So that's distinct.

Fowkes: Or from some other health care field.

Mullan: What about out the other end? Do they get to choose which they graduate as?

Fowkes: Well, if they're nurses, they're eligible to practice as an NP or PA. They take the national certifying exam for PAs, and in this state, they also qualify to be nurse practitioners. Students who are not nurses become physician assistants.

Mullan: So do most nurse graduates take the PA exam?

Fowkes: Yes, they do. We require that, because if they go to another state to practice they have to have a master's degree in nursing to practice as a nurse practitioner and they wouldn't be able to practice. So we make it very clear at the front end that

people are coming to a certificate program. I think it's important to have this academic diversity, for people to have a variety of options, rather than just one path. However, my views about this, as I'm sure you imagine, have been criticized by nursing leaders.

Mullan: Tell me a little bit about the growing awareness of primary care as a concept. As you pointed out, when you were back in Duke, in school and so forth, in the sixties, that the concept really wasn't there yet. But somewhere between 1965 and 1975 it went from a non-concept to a fairly fully developed concept. Just give me a little bit about how you experienced that, particularly in your work in California.

Fowkes: I think mainly through the development of the family practice movement. In many respects, the family practice residency era paralleled the PA and NP growth. In the late sixties after the unfortunate beginning at Duke, nurses observed what was happening with PAs and began developing nurse practitioner training.

In developing the PA program in California, it was very important to stay close to the family practice movement. We developed this concept of team training, so that residents would be trained with our students, and our graduates would practice as faculty in residency programs and role-model for residents what PAs and NPs were all about. So my education in primary care

really came more through the family practice movement and being very much a part of that.

The other thing that happened in 1977 my husband developed a family practice residency at San Jose Medical Center, on leave from the Department of Medicine at Stanford. He's boarded in internal medicine and family practice, and is now additionally certified in geriatrics.

Mullan: Hold on a second.

[Begin Tape 1, Side 2]

Mullan: This is tape one, side two, continued.

Fowkes: The PA program had been developed in the Department of Surgery at Stanford, believe it or not, because it was started by a plastic surgeon. So we took our two programs--the residency and PA-- and we merged them to build a Division of Family Medicine in what was then the Department of Family, Community, and Preventive Medicine. We used the resources of these two programs to build a program in predoctoral family medicine for medical students. I became very involved in developing undergraduate medical education and creating opportunities in family medicine for medical students.

Another key event in my training occurred in 1977 with my appointment to the Bureau of Health Manpower's--Medical Education Review Committee--of the Division of Medicine. There were twenty

of us, and I was, I guess, the token non-dean and non-department chair, and the youngest person in that group. In those days, we did grant review for all of the Division of Medicine programs, and spent like five weeks a year in Washington. It was a horrendous job with cartons of materials to review. So I learned about fast reading and the Bureau's programs, and had some wonderful mentors on that committee. Because we spent so much time together in Washington, I got to know these folks very, very well, people like Drs. Marvin Dunn and Marion Bishop, Harvey Estes, and Jack Colwill some who have been leaders in establishing academic family medicine The Committee worked with consultants from each program area to help us with whatever we were reviewing. If it was family practice residencies, there would be experts brought from those programs. If it was AHEC, we'd have AHEC leaders. It was an incredible educational experience for me. That continued for a number of years and I've continued to be a consultant to the Division of Medicine.

Mullan: What was it called? MERC?

Fowkes: Well, it was originally called the Medical Education Review Committee (MERC), and then the authorization changed and we were called consultants. But they kept this group of twenty people for several years.

Mullan: Through the eighties, a number of things are sort of peppered with division and bureau. Why don't you take me quickly

through the eighties, because I want to get up to the present, and then go back and pick up a few themes. The AHEC concept was important?

Fowkes: Right. In 1980, Bill Fowkes and I developed an AHEC, one of the first inner-city AHECs, in San Jose. He used his San Jose contacts to help with that in the formative aspects, and he and I were co-directors for the medical school in developing the programs. Subsequently, I took over as regional director. Esperanza Garcia Walters to this day, continues as Director of the Community AHEC. She and I continue in partnership together.

In the AHEC, we developed a number of programs for the residency. San Jose is the largest city in Northern California and we focused on a number of multi-cultural programs in the community and some that had lasting impact at Stanford. I continue to sit on the board of the AHEC, although the AHEC is now funded by other resources, and only a small part is federally funded. The AHEC does considerable health education with minority communities in the greater San Jose area.

The AHEC program is something that I am very fond of. It was a natural for me because of the bridge idea between the medical school and the community, making the resources in the school work in the community. San Jose is a city similar to what Los Angeles was twenty years ago, exploding in every direction. So I have loved working with AHEC and do believe we have had one of best partnerships in the nation, as I've looked at many AHECs. Ours is a very strong one, and has been sustained.

Mullan: And that's been a theme, I gather, of your work. The AHEC has sort of woven in and out of it?

Fowkes: Right. I also had the opportunity to co-direct the national evaluation of the AHEC program, and have been consulting with a variety of states since that time. I've developed over the years considerable expertise in evaluation, and used that to help AHECs, either in their process or outcomes analyses. In Florida, for example, I helped the program set up a statewide database. I like helping people build AHEC programs, and helping people decide how to evaluate them.

Also, in 1988, I was invited Botswana for a summer to evaluate that country's nurse practitioner program, which was another grassroots kind of activity. That was right before AIDS invaded the country. People hadn't even heard of AIDS then, or seen it, and yet half of their population were infected.

Along with developing AHEC, I've also assisted in developing academic family medicine, and essentially co-managing our Division. The architect side of me continues to build programs in academic family medicine programs at Stanford and recruit faculty. Family medicine has been my academic home and my academic network. That's where I have felt most comfortable.

Mullan: You obviously have been enormously creative in terms of sewing together disparate threads, starting with CCU.

Fowkes: Seems crazy, doesn't it?

Mullan: No, it doesn't. It seems incredibly inventive and creative, in this world of rather cookie-cut career paths. But a couple of questions come to mind. First of all, Stanford is not an institution that is noted for the areas in which you have prospered--family medicine, generalism, non-physician training, etc.--and you seem to have brought that to them. It seems like an odd place for you to have ended up, as opposed to institutions that might well have valued, or plotted to develop programs that you have seemed to have brought to them, notwithstanding their general reputation, anyway. Do I have it wrong about the reputation?

Fowkes: Of course you don't.

Mullan: How do you characterize this twenty-year underground career?

Fowkes: I've thought about that, and one of the things that I really feel I've been blessed with is being in a private university. I don't know that I could've done what I've done in a public university. I've existed at Stanford, as long as I have paid my own way, and that of others in my programs. But a private university encourages that kind of creativity. If you can figure out how to do it, and build programs that do make some sense with whatever else is going on--

Mullan: They'll tolerate it, or accept it.

Fowkes: Yes. It's tolerated, and it's a wonderful base from which to do all kinds of things in the community. You're absolutely right. Family medicine at Stanford has been counterculture, just like it has been nationally. It really is a reform movement.

In the last two years, one of the most important things we did at Stanford, with the support of a new dean of education, was to establish a required family medicine clerkship. I helped write the federal grant to put it in place, and one of our family practice residency graduates, formerly a psychologist, was hired to direct the required clerkship. The clerkship has been the most popular one in the school. It has become a model for reforming the other clerkships in the school. Our dean of education feels this is one of the most important things that's happened to the school. She was very interested in developing an ambulatory clerkship. We came along with the idea of how to do it, and made it happen in family medicine. And, in fact, Dr. LeBaron, the clerkship director received (unprecedented) all five teaching awards last year in medical education. There are other things. Dr. Ron Garcia, who's been a colleague of mine for years in the PA program, branched out to develop a COE at Stanford.

Mullan: Center of Excellence?

Fowkes: Yes. Through the AHEC resources, he developed an Ethnicity in Medicine course at Stanford that has become a very important course. So there are a lot of things that these

programs have done to fit into and change the mainstream of undergraduate medical education at Stanford.

Mullan: And yet in terms of your academic status, it's always been a kind of quasi-academic status?

Fowkes: Right. Absolutely.

Mullan: Why is that, and how do you feel about that?

Fowkes: I feel fine about that. Academic accolades have never been important to me. It may sound strange, but I don't need that kind of recognition. It is more important to me to feel that I am making a difference.

Mullan: I ask this not as a personal challenge, but I think it relates to an interesting element of your career that I'm aware of, which reflects a national debate. That is, your advocacy of certificate programs, which do not take their principal identity and validation from a master's, say, level degree, which, of course, takes the educationalists and drives them up the wall, as in nursing. I do want to talk about the vision you've had and the role that you've played, and the flak that you've gotten over that. But I observe that your ability to sort of run on your own smarts, and not acquire tenure track, educational bureaucracy to identify you, is a singular feature of yours, which is terrific. I guess lurking beyond all that, is that a commodity that others

can exist on? In other words, if you're creating a certificate approach to life, which is much more evanescent, as opposed to an academic structure, which is much more planted and replicable, and bureaucratic, even, can you build programs in the more evanescent way, as opposed to a more bureaucratic way?

Now, I've asked about six questions in there, starting from personal and going to the national, but develop for me a little bit your thinking in this area about the importance of creativity and the importance of stability. I can take those as the two poles.

Fowkes: Like I said to you earlier, I think I'm somebody who's been in the right place at the right time, and had opportunity to do things, and grabbed that opportunity to do what I and others with me feel is important to do. I tend to be a very goal-oriented kind of person, that there are needs out there, this is the best way to meet those needs, and stay focused about that.

The type of students that I'm working with, at least in the PA/NP program, are people averaging in age around mid-thirties. They're mostly women and have done other things. They've been nurses, or they've been in the health field somehow, or maybe they've raised children and they're coming back to seek a new career. Men the same ways making some kind of a role change, or a career ladder. Most of the students are post-baccalaureate. They already have academic experience, and they're looking for the ticket to practice.

I feel that this fifteen-month certificate program is a very important option. It's mostly focused on California and targeted to California's needs.

There are people who can't afford either money or time for the long hurdles required to get a baccalaureate and a master's in nursing. There remains no evidence in our state that any kind of degree helps one to get any better job in primary care as a PA or NP. The certificate program is an important alternative, particularly where there is a focused mission, e.g., training for underserved populations. It will exist as long as it meets a need.

Mullan: When you say, "in our state," that's because you've studied it. There's not contrary evidence in other states?

Fowkes: Other states have imposed requirements such as a master's in nursing or ANA certification to practice. It's different from one state to another. I feel that the efforts of my program and the UC Davis program both having PAs and NPs trained together have done much to bring both sets of educators and practitioners together. We have had at least two Statewide committees which I chair to bring nurse practitioner and physician assistant educators together to do things--either politically or programmatically. And generally, even though I may differ with the views of some of my nursing colleagues, we do good work together.

Mullan: Let's just focus on the certificate versus the degree concept, in nursing in particular. Tell me your views of that.

Fowkes: In this recent study that I did for the Bureau, I had the opportunity to site-visit a number of nurse practitioner programs throughout the Nation that were training for underserved areas. The nurse practitioner directors that I talked with indicated that when they converted from a certificate program to a master's program, they had to give up clinical time to plug in nursing theory, research components, or other curricular elements. They felt that they were really losing something in terms of the clinical training of their students. Our students come out being very good clinicians. Sometimes it takes the master's graduates a little bit longer to catch up, because they haven't had as much intensive clinical experience during their training. Most of our program graduates practice in underserved areas. To practice in areas of high need strong clinical skills are a must. There is some evidence that nurse practitioners with advanced degrees are less likely to be in underserved areas than those from certificate programs.

Mullan: I don't want to put words in your mouth, but I'm sort of stumbling with that. Move back to the bigger picture about what are the dynamics going on within the society at large, including the nursing hierarchy, in regard to certification versus non-certification, or certification versus degree.

Fowkes: The national nursing organizations, which I am not a part of--again, my grounding has been in a medical school--have made it very clear that they expect nurse practitioner training to be done at an advanced level, in master's programs. That is their posture. We are not an accredited program for nurse practitioners. You can't be, unless you have a School of Nursing and a master's program. That is the position of national nursing. I recognize that. I don't agree with it, but I don't think that that's anything to fight. That's a reality.

Mullan: I believe they do argue that without firmly rooting the nurse practice concept in an academic degree, you will not (a), train people adequately; and (b), not achieve sufficient recognition for both clinical and reimbursement purposes to maximize the nurse practitioner movement. What's wrong with those arguments?

Fowkes: In my experience, "adequate training" means a lot of clinical hours. Certificate NP programs (the few that are left) and PA programs have substantially more clinical hours than master's level NP programs. The competency issues--I have observed that the graduates from our program and the Davis program are much better prepared clinically, for reasons that I spoke to. Again, any nurse practitioner as any PA who enters these programs is clearly building on other skills that they already have--clinical skills, academic skills, and life

experiences. There's no evidence in this State that there's a better salary or a better job, with a degree.

Mullan: So neither vocational nor competence issues can be demonstrated to be better if based on degree-granting hierarchies?

Fowkes: Not in my observations or experience.

Mullan: So why does the nursing leadership cling ever more tenaciously to this?

Fowkes: Well, to me, that has to do with issues about professionalism, and nursing's struggle to be a profession. Our society is a very degree-oriented society with the premise that the more degrees you have, the more capable one must be. We're training so many people with all kinds of degrees, and keeping them out of the workforce, and when they come out, what really counts is experience. No matter what field you're in, employers want to hire people with experience. I have always valued that in terms of people that I hired, in teachers. What I look for first is the kind of experience that they have had, and do have, in their communities, rather than the degree that they have. I've hired associate-degree-level PAs or NPS as program faculty who are excellent clinicians. To me, that's what's important. I think people get their education many different ways, through a

variety of experiences, life experiences, for one. It just doesn't have to be in a formal academic setting.

Mullan: You've observed the PA and the NP movement up close, virtually since their inception. I'd be interested in your thoughts about the difference in both what they have accomplished thus far and where they're both headed.

Fowkes: The most important difference, and I think the reason I stayed interested in physician assistant training for so long, is the opportunity to have a multi-disciplinary faculty as well as a variety of students with differing health care backgrounds. There's this whole thing in not only nursing, that nurses should be educated by nurses, but also in medical schools, physicians should be taught by physicians. Part of the family physician reform movement, as you know, in the Society of Teachers of Family Medicine is a multi-disciplinary group of educators of graduate training in family medicine has benefitted from this as I think the PA movement has. I also believe it has been important to bring people with a variety of health care backgrounds, not just in nursing into primary care roles as the PA movement has done.

Our program offers students a multi-disciplinary faculty which complements the multidisciplinary student body. To me, that is what a real education is about and certainly that's what my education has been about, being exposed to many different people, many different walks of life and backgrounds. As you're

learning professional training, that seems to me to be the greatest gift of education. So I see that as a major difference.

Mullan: A major difference between PAs and NPs?

Fowkes: Between their educational processes. PAs are exposed to more of a multi-disciplinary faculty and fellow student body.

Mullan: Whereas NPs are kept within the nursing structure?

Fowkes: Yes.

Mullan: Just a simple, sort of man-on-the-street question, personal history question. Are the two professions going to continue in parallel, into the future, or are we going to end up with a single profession?

Fowkes: I had hoped for that in the early seventies in California. Several of us proposed combining them and calling them primary care associates in this state. The horse had left the barn. And I do not think that is realistic now. Nurse practitioners and physician assistants have developed separate professional organizations. They come with different professional identities. They have different licensure umbrellas in every state. And yet there are many similarities. Studies that have looked at their functions in a single setting aren't

able to show any difference. For example, NPs and PAs functioning in a community health center have the same job description, same ways of supervision, and they're hired interchangeably. So, functionally there are a lot of similarities. The curricular content that they need to learn is similar. I believe we should respect their differences, and acknowledge their similarities.

What I hope will happen is that there will be more collaborative efforts, for example, through these Robert Wood Johnson Foundation initiatives that are now funded in several areas of the country to combine aspects of PA, NP, and CNM training. I hope there will be more collaboration, like there has been in California. Because of the UC Davis program and our program at Stanford, there are many local professional organizations around California of PAs and NPs where they support each other in their communities. I hope we could rid ourselves of the "holier-than-thou kind of attitude that I think nursing has more than the physician assistant group. I'm reassured to see that there's now a national organization of PAs and NPs that actually produce a journal. It's called *Clinicians Review*. They have a combined board. The two state organizations in this state, CAPA and CCNP, are collaborating. My hope is for more and more collaboration. The way that happens naturally is through program graduates working side by side, and kind of minimizing the assumptions of some educators who are stuck with their biases.

Mullan: What about the role of gender in all of this? Obviously, gender has been a key identifying issue for nursing, much less so for PAs. And, of course, once upon a time, the distinction between nursing and medicine was, medicine was male and nursing was female. On the medicine side of that, that's changing rapidly. You've watched this as a savvy, up-close observer for more than twenty years. How do you see gender playing into all of this?

Fowkes: A big issue. I think the PA movement followed the women's movement in this country. The first PAs were all men. And then as the women's movement started and more and more women wanted roles in health care and needed meaningful work, they entered the PA profession which now has become majority women.

Mullan: What percentage of women?

Fowkes: Our program enrollment of women is about 65 percent over the last few years. National enrollment is about 60 percent.

Mullan: You've described the demographics of it. What does that mean for the politics, substance, sociology, and future of the movements?

Fowkes: There's one more issue in the demographics that I should mention. The PA movement opened doors for underrepresented minorities in health care. There are relatively few minority

nurses to create an eligible pool for nurse practitioner programs. Many PA programs took on a focus to recruit minority candidates successfully, and I think that's been a very important feature of the movement. Certainly in this state it is a feature of most PA programs. Many PA and NP programs have made substantial progress in teaching cultural competence.

In terms of the gender issue, how that impacts on the future, it's hard to say. We see more and more women entering medicine, and it may be that eventually the primary care providers, whether they're physicians, nurses, nurse practitioners, or PAs, are practically all women, like in some other countries. Men may not be as satisfied with the lower salaries that are inevitable in health care and may seek other careers or other things to do, in addition to practicing medicine. That's something that I've wondered about in the evolution of health care in this country.

Mullan: Nurse practitioners make the point frequently that the care they render is different than physicians, because it's more caring, it's more psychosocial, it's more educationally oriented, features that are prominent in nursing and nursing education, and features that, arguably, are somewhat more feminine, on the feminine to masculine spectrum. Do you think that's true?

Fowkes: I think that every single person has a masculine and a feminine side. I know many men whose feminine side is more developed than their masculine side, in terms of their

personality features. There have been things written about this. I have never, frankly, understood what nursing attempts to articulate as the difference. When I look at what we teach in behavioral science in medicine, and I look at what nurse practitioners are taught in psychosocial areas, the content is very similar. There are different labels, but we're teaching the same kinds of principles. So I'm not someone who can help you understand what that means. It has never made sense to me. I think we're all doing similar things with different labels and different faculty with their own professional assumptions.

I facilitated a support group for medical students for six years with a couple of other people, and that's one of the issues we explored, the masculine and feminine sides of each person and how to develop those aspects further.

Mullan: Let me ask a numbers question. Obviously, the number of physicians is rising, continues to rise. The number of NPs and PAs is growing, not only being a younger population, you have relatively fewer people with hiring at the top, although you will, but the programs have expanded. I saw figures recently from the Kellogg-funded National Organization of Nurse Practitioner Faculty study that showed the number of grads, nurse practitioners, about tripled over the last four or five years, from about a thousand to three thousand. Do you foresee a glut of primary care providers, and, particularly, do you see problems with NPs and PAs not being easily employed?

Fowkes: I don't know. It seems like the questions that we're asking now about surplus and looking at the surplus of primary care physicians in the early 2000s are similar to issues raised in the 1980s. Then and now, I think the issue is about distribution. We know that if you use different models of training, community-based models of training and you take the training programs to people who already live in areas of high need, that PAs and NPs will be retained to practice. Even if there is a surplus, I'm not convinced that market forces will take providers to places where are needed. There are other social factors at work. Physicians that I know finishing residencies are very concerned about lifestyle issues, and don't want to work sixty, seventy hours a week; they want to have a life. And they are people who have been trained with PAs and NPs, and who think of partnerships in the managed care delivery systems they are forced to join.

I do think there's a need to hold the development and expansion trend for PA and NP training to present numbers and watch and see what happens. There also is a need for different models of training that address gaps in services. PAs and NPs can be rapidly produced to fill special roles or provide special services.

Mullan: How about NPs and PAs, their proclivity to do primary care versus specialized care? The figures show that PAs are considerably more specializable, more specialized. What do you make of that?

Fowkes: I think that one of the fortunate things we have about PAs as a professional movement in our country is their flexibility and adaptability to a variety of service needs.

Mullan: PAs?

Fowkes: Yes.

Mullan: More so than NPs?

Fowkes: Yes. The reason I say that is because nursing, like medicine, is entrenched in academic schools that take a long time to change tradition and educational principles; whereas PA programs nationwide tend to bend and flex very quickly, based on service needs. Certainly, in this state, that's the way they have operated. That is another reason why I've stayed with PA training, because it's an opportunity to change. For example, with the AIDS epidemic, we quickly revised curriculum for all students in classroom and clinical settings and encouraged deployment of graduates to HIV/AIDS clinics. You can quickly make a change to address a major public health problem.

Mullan: Let me change the tape.

[Begin Tape 2, Side 1]

Mullan: This is Ginny Fowkes, tape two, side one.

Fowkes: I think that is a very important concept, to have a flexible group of providers so that if you need more house staff in inner-city hospitals, you can quickly train PAs to do that. That hasn't been a need on the West Coast. The emphasis here has been primary care. The legislature's commitment to training PAs has been to fill the gaps in primary care. That is what we've focused on. Our training strategies have been built around that priority, but can change if there are other needs.

Mullan: The flip side of what you're saying is that much of our educational establishment is quite locked into institutions and institutional tracks and tenure and identity that is quite inflexible.

Fowkes: Right.

Mullan: Would you dismantle, dismiss much of that in favor of more flexible training programs?

Fowkes: I think you need both. If I could wave my magic wand and start over, I would change a lot about our educational institutions and their structure. But I think there needs to be alternative approaches.

Mullan: Let me ask about your fascinating career.

Fowkes: Strange.

Mullan: What do you feel about it? As you look at yourself now, what are you most satisfied, enthralled by? What are you most dissatisfied and disgruntled with?

Fowkes: The past, you mean? Or future?

Mullan: Well, as you look at the present and looking back.

Fowkes: What I want to do when I grow up? Looking back at the past?

Mullan: Assessing yourself now, looking back over all that you've done, including what you're doing now. I'm just looking for a way to ask you to talk about your joys and your disgruntlements, if you want to know why I'm asking. I was trying to be clever about it.

Fowkes: I feel very privileged, actually, when I think about that question, very privileged about the opportunities that I've had, the things that I've been able to do, and the other people that I've been able to partner with, to make things happen. As I look back, I just feel that that's what's been there for me, and that I've been able to do a lot because of things.

Another good thing is that my jobs have been different every year, and that I've had the opportunity to build on past experience, to always be doing something new. The place where I want to be now is doing more policy research along with the other

basic responsibilities I have. That aspect of what I do, I would like more of. I also like helping other people do things, build their own programs or helping them get published.

One of the places I'd like to end my career is being on the other side of things, and I've thought of being with a funding agency. Rather than always having to get money. I would like to be able to give it, and to guide people in building programs. It's entirely different. So at some point a foundation role might be appealing. I don't know whether that occasion will ever arise.

Mullan: Difficult if you don't want to leave the Santa Cruz hills.

Fowkes: Perhaps.

Mullan: Battle Creek, Michigan. Philadelphia, Pennsylvania. Great place to go. But let me just goad you a little bit. Are you sorry you weren't a doctor, physician?

Fowkes: No. As a matter of fact, my colleagues at Duke encouraged me to take a short-circuit through medical school. For a variety of reasons, I think I have been able to do more by not being tied into any single profession. For example, I am not "owned" by nursing or nurse practitioners. They do not see me as a part of their club.

Mullan: That was going to be my next question. Are you sorry you're a nurse?

Fowkes: Am I sorry I'm a nurse? No.

Mullan: Are you glad you're a nurse?

Fowkes: I learned from my nursing background, and built on that. That is valuable for what it helped me do. I am also not "owned" by the PA movement, and I'm certainly not a family physician, and so I don't really have professional turf. This has been useful for me to make different things happen. No, I don't really feel badly about any of the choices that I have made in the past. I've always felt that they've led to something useful I've learned a lot along the way and hopefully given a lot in the process.

Mullan: And partnering with your husband, I gather, is very important?

Fowkes: Yes, we think so. We are good together.

Mullan: You've not had any kids?

Fowkes: We have a combined family of seven children. Adult children, six boys and one girl, and four grandchildren.

Mullan: Holy cow.

Fowkes: Two nine-year-old little girl twins. They're very much a part of my life.

Mullan: Whose are what? Where are the kids from? Whose are which or where?

Fowkes: Well, I inherited six stepchildren, and then had one child of my own, and helped to raise some of these other children, in different ways. They're all very much a part of my life. I've always said that I grew up with my children, inheriting these children of different ages.

Mullan: What's your son's name?

Fowkes: David. He's in the media, the radio, in Santa Cruz.

Mullan: Good. The future. What do you see as the future of primary care?

Fowkes: I see primary care as the basic guts of medical practice, and also as the gap-filler.

Mullan: What about technology that's going to make for capabilities of doing all kinds of things at distance, and it's going to give all kinds of printouts to doctors and patients?

Are those going to be innovations that make for more, or less, demand for generalist skills?

Fowkes: Probably more. I don't think anything really substitutes for the human relationships. Patient care will continue to change in different ways, and practitioners will have to be educated accordingly. In California, we revamped curricula everywhere to address the changes with managed care. But that's of what primary care has been about all along.

I anticipate that the nation's health care will eventually be managed by several large integrated delivery systems that rely heavily on networks of primary care physicians, PAs, and NPs. My hope would be that increasingly these providers would work in co-practice models with perhaps two or three physicians teamed with several PAs or NPs where collaboration and case conferencing about patient care are rich experiences for both groups.

Mullan: Are there things we haven't touched on that you'd like to comment on?

Fowkes: I can't think of any. You've been very thorough.

Mullan: When you get your transcript back, you can add. Thank you. It was terrific.

[End of Interview]

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