THERESE HIDALGO

Dr. Fitzhugh Mullan,
interviewer

Mullan: Please give me your name.

Hidalgo: Therese Hidalgo.

Mullan: You're in the Presbyterian Medical--

Hidalgo: Family Health Care in Belen.

Mullan: In Belen, New Mexico, on the morning of February 21, 1996, in the conference room facility.

Therese, would you tell me a little bit about your background, where you grew up, and how you got interested in nursing to begin with?

Hidalgo: I was born in Las Vegas, New Mexico, but I grew up in Phoenix, Arizona. I went to Catholic schools and Catholic high school, then I moved back to New Mexico to go to college at the University of New Mexico in Albuquerque, with nursing in mind. You're probably wondering why I thought about nursing. First of all, my mom was a nurses' aide and raised eight children on that income, which was difficult, but I think she always wanted to be a nurse and so I thought, "Well, I can fulfill her dream and mine, too." I at one time thought about medical school, but in those days, in my cultural background, family was first, being

married and having a family. I remember making that decision as a sophomore in high school that I needed a family and the two wouldn't work, and so that kind of helped me fulfill the decision about nursing. So I went to UNM, got a bachelor's degree in nursing, and practiced in Santa Fe for about seven years.

Mullan: When did you graduate?

Hidalgo: I graduated in '79. I started as a general nurse on a med surgical, and then my love was for obstetrics.

Mullan: In Santa Fe?

Hidalgo: In Santa Fe, at St. Vincent Hospital. Then I moved towards maternal child areas, and that was labor and delivery. I did several years in labor and delivery. Then I did some education. I was an educational coordinator for the staff for about a year. Then I moved to Belen to work in a small hospital.

Mullan: Was that a family move?

Hidalgo: Family move. My husband was born and raised here, and we have property here, and we decided to make our move back to raise our children. I have to tell you, I was very fearful. I became very specialized in my career early on with maternal-child, and to come back and work in a small hospital where an RN was responsible for an emergency room, I had no experience in

that, back on med surg, newborn intensive care, the whole gamut. I had geriatrics. Then I had to take care of men patients again after taking care of primarily women. So I was a little bit nervous, because I was comfortable in my role, but I did it, and it was probably the best thing that could have happened in my development in my professional arena, because I became much more broad in my scope, and I was a lot more challenged with the diversity.

So as I came here, let's see, I probably started in 1986, August of '86, and then again, I quickly kind of was driven or pulled toward labor and delivery again. I became head of that clinical department for labor and delivery and postpartum, and pediatrics, actually. It was maternal-child. And served in a supervisory role as well as a clinician.

Then in '80--

Mullan: Tell me a word about this hospital then.

Hidalgo: It was Eastern Valencia Hospital, owned and operated by Presbyterian. It was a satellite hospital for that organization, and they had several satellite hospitals around the state. We are thirty-five miles south of their main headquarters.

Mullan: Which is in Albuquerque.

Hidalgo: Which is in Albuquerque. It was about a thirty-four-bed hospital, closely affiliated with their mother hospital

thirty-five miles away. We did have some acute-care-type patients, but for the majority, let's say for an MI, those would be transported to Albuquerque. But we did full obstetrical services; we did surgery in those days, C-sections. We had a surgeon here, we had an OB/GYN here, and family practice docs, and a pediatrician.

Mullan: That was pretty much the medical staff of Belen was all on staff here?

Hidalgo: Yes. There were physicians outside of the ones we are currently employing today that also admitted to the hospital, that were mainly family practice. There was an internist. At the time of the hospital, there were actually two internists here, and a general surgeon, an OB/GYN, a pediatrician, but there were other family practices.

Mullan: It was, I gather, or became a troubled, rural hospital in the sense of could it make it.

Hidalgo: Yes.

Mullan: Tell me a word about that. It must have been tough for the town and tough personally. As you saw the rural hospital move towards closure, what took place?

Hidalgo: There was a lot of community discussion and some division, even among the community about supporting the hospital, because the issue became that Pres [Presbyterian] made a decision because of continual financial losses, which was the trend around the country for rural hospitals, that they were going to need some support from the community. We have a large Medicaid population here and that's what our hospital served, is a lot of Medicaid. Because of reimbursement issues and things like that, I think that's what drove the decision to make a change. So a mil levy [phonetic] was petitioned to the community and it failed.

Mullan: That was proposed, put on a ballot and didn't pass?

Hidalgo: Yes. Right. It was an election.

Mullan: This would have been like an add-on to the sales tax or some such thing?

Hidalgo: Yes, and I can't remember exactly how much.

Mullan: But it would have raised a fund to support the hospital.

Hidalgo: To support the hospital.

Mullan: And the community didn't pass it.

Hidalgo: They didn't pass it.

Mullan: Was it close even?

Hidalgo: No, it wasn't close. It was countywide. The county is divided into areas that, and I could understand, a large population that is right next to the county line where Albuquerque is. As a matter of fact, it was closer for a lot of those people to go to Albuquerque hospital--

Mullan: So they weren't interested in supporting it.

Hidalgo: Supporting it. So I think some of that had to do with it. There was some campaigning, and I hate to speculate on tape what I think happened, but there were some other providers in the area, I think, who were campaigning in opposition to it.

Mullan: The opposition because they would just as soon see the hospital close?

Hidalgo: Yes.

Mullan: By providers, you mean physicians or not?

Hidalgo: Yes. Physicians.

Mullan: Why? What benefit was it to them?

Hidalgo: The reason why I say that is, I think, in a personal level, I heard negative--well, I think they didn't want Pres to continue to run it with taxpayer money. They really wanted an active board that was elected by the community. The community felt if they were going to pay--and this was one of the positions of this physician--that the community should actually have more control over it than what it had in the past, or what it was intended to have. It's interesting that after it didn't pass, the physician resurrected, or attempted to resurrect, another coalition to bring another hospital to the area.

Mullan: Unsuccessfully?

Hidalgo: Unsuccessfully, right. And that issue stayed at a simmer for a while, for I would say a couple of years, with some key people supporting it, some politicians and some other health care providers and nurses who were very forthright in their opinions about this. It was more of an issue between the organizations whether it was Lovelace or Pres, so it wasn't like an individual type of endeavor, it was trying to hook up with another organization like Lovelace. There was a lot of talk about Lovelace bringing a hospital here at one time. I'm not privy to all the meetings they had and what was said behind the scenes, but as it appeared and what I knew, that's where I came up with that opinion that I think that there was some opposition.

Mullan: How did the community respond to the closing of the hospital? Was it accepted? How did you feel about it, too?

Hidalgo: People were very opinionated about their loss of a hospital. They were opinionated about the need for twenty-four-hour, especially emergency, care. It affected me, because I felt that those were the same people who wouldn't support it financially on the ballot, obviously. I didn't ever hear anyone say that they were happy it closed, put it that way. So a lot of people did feel free to express their disappointment in it, and I really believe that they were angry at Pres and not at themselves, for it not being here, that they felt, "Well, why shouldn't Pres keep it open?"

Mullan: When was it closed finally?

Hidalgo: It closed in 1990.

Mullan: I want to pick back up on your story, but tell me a few more things about your youth. What did your parents do?

Hidalgo: My mom worked as a nurses' aide in Phoenix, as a single parent, because my father died when I was in third grade.

Mullan: She raised you?

Hidalgo: She raised all of us. There are a lot of us.

Mullan: How many?

Hidalgo: There are eleven children in my family. She remarried later and we have three half-sisters.

Mullan: Did anyone else go into nursing?

Hidalgo: Yes. My brother became an LPN, and then did get his RN. We used to have these long battles about LPN and RNs, and he used to get my goat. So I just said, "Go back and get your RN." And he did, and I was so proud of him. I have a sister who has an LPN and is still struggling with trying to go back to school for her RN, in the administration track.

My mom did start RN school. She's probably sixty-five years old, and she switched out of RN school and is still in college, has an associate's degree in early child development in the bilingual program, and is about to get her bachelor's.

Mullan: Good for her.

Hidalgo: Yes. Who else? Those are all the nurses in our family.

Mullan: When were you born?

Hidalgo: December 11, 1955.

Mullan: So I guess there was general enthusiasm and your mom's support when you went into nursing?

Hidalgo: Yes.

Mullan: Good. Well, we got up to the mid-eighties and you were describing your work here heading up the obstetrics unit. I wanted you to take your story forward from there. Before we do that, give me a little bit of a side on family. You got married and started a family, right?

Hidalgo: I got married before I finished my RN school, two years before, and then we had our first child in '80. I was already working as an RN in Santa Fe. It was when I was pregnant with my third son that we decided to make the move to the rural area. It's so different from Santa Fe, but appropriate for our family goals, for raising the boys in the country, and we have a ranch. We raise cattle and are Santa Gurtrudis breeders.

Mullan: What kind of breeders?

Hidalgo: Santa Gurtrudis cattle. It's a pure breed. I think they've got Brahma and Shorthorn, but they've been bred as a pure breed. They're registered--Democrats. So we do that with our boys. They enter in state fairs and we show them and we travel and it's a lot of fun.

Mullan: In the early years of having kids, having a growing family and working as an RN, was that tough? How did you juggle that?

Hidalgo: What I will say about nursing is it's been good to me, especially raising a family, because I've had a lot of leeway in choices of shifts, taking a negative and making it a positive. People think working graveyards and evening shifts can be a real downer on family life, but actually, I used it to my advantage. When I'd have a baby, I'd work night shift three days a week, so I didn't need babysitters. I really felt I was there with my children in their early years. Then when they got to a certain age, then I worked three to eleven part-time.

I primarily worked part-time, except for when I entered into the administrative-type roles, then it was more demanding. I prefer to work part-time, and I'm still working part-time. I finally got back to part-time in my role now. That's how I balance. That's how I balance, because as I was mentioning to you at the beginning about why I decided to go into nursing, I knew I wanted medicine, because it's challenging, it's exciting, and it's a very caring field. I've been able to keep my career and make that balance with family, and that's how I've done it, the part-time business, and being creative with my shifts and the type of jobs that I'll do. So I felt great that I'd been able to do that, and the profession's allowed me to do that, even as a nurse practitioner now. I feel like I've expanded my role, and I can care for my patients in a more fulfilling way than when I

worked in a hospital, and yet I can still be part-time. So I feel very fortunate that I achieved that personal goal.

Mullan: Nursing has worked well for you, in both pre- and post-advanced practice. Let's pick up the story in the mid-eighties. You were here as the obstetric nurse director.

Hidalgo: Right. In around--it must have been '89, I needed some personal goals. I served on a lot of organizational committees, both here and in the local hospital, and also in the larger organization in Albuquerque, and was giving a lot of my time and commitment. I decided to do something for me, so I decided to go back to school and get a master's degree in nursing. I'm not so sure what I expected to do with a master's degree in nursing, although it was always my dream to get a master's degree.

When I graduated in '79, there was a nurse practitioner program, but it was run by the medical school, and in '80 was the last year that they had that program. So actually, even though I was getting my RN back in the seventies, I knew I wanted to be a nurse practitioner. But what happened is that in '80 was the last year they had that program, so there was no opportunity in New Mexico for ten years. I tucked that away and I never let that dream die.

So in '89 I started to look around. I knew I wanted to get a master's, and I said, "I still want to be a nurse practitioner." I didn't have much of an opportunity for

encounters with nurse practitioners. It was a role I learned in school, in the RN school, that I knew I really would like to do.

Mullan: There weren't role models in the community to look to?

Hidalgo: There were none. I met one in Santa Fe, and I'd asked her to come and talk at some of my educational things, and she was probably the only role model I had, but I never worked directly with her.

So back in '89 I started looking around. I was going to go to Arizona and Texas, thinking about relocated myself and being a part-time mom.

Then as I was calling Arizona, they said, "Well, you know, New Mexico's thinking of having a program."

I said, "Really?" So I went and I started asking questions.

They said, "Well, we don't have the grant money yet. We are planning it, but we're not funded. So go ahead and enroll," and I enrolled in just the general graduate program for nursing.

It's interesting. We'd go around, you know how you orient in a new class, a new semester, and people go around and say, "This is my background and these are what my educational goals are for this program." Mind you, there wasn't a program yet, but I would say, "My name is Therese Hidalgo. I work in Belen. My area of expertise is maternal-child, and I'm going to be in the nurse practitioner program." [Laughter]

I think they felt sorry for me, so I was one of the first--there were seven of us who were chosen for the pilot program, and

so that next year I was accepted to that program and finished in '91.

Mullan: What was the program like?

Hidalgo: Oh, it was haphazard. I can't compare it to any other program, personally, because that's the only program I went in, and I had my undergraduate there, so I had a lot of the same instructors. But there was a lot of room for growth, and there were a lot of suggestions that our group as a whole made towards improving the program.

There were still no role models in our preceptorships, but that's changed, because I serve as a preceptor for the college and we assist students as a team, physicians and nurse practitioners, because I think you need both, to help with that role identity. I had not much of an idea in actual practice with a role model or mentor, and I don't know how I knew, but I came away to my sites thinking I knew what a nurse practitioner should be and what our roles were, and some of it was just ingraining in our minds, this area of independence, because that was the movement at the time in clinical areas.

The physicians I came to work with in my last preceptorship, which was here, they didn't know either. They hadn't really worked with nurse practitioners. I think one of them worked briefly in the family practice center at UNM when he was going through his residency with a nurse practitioner, but they didn't really know. And the scope of nurse practitioners has changed

over the years here in New Mexico, with the changes in the Nurse Practice Act, so I think all of us evolved the role together.

Mullan: Would you characterize it as more limited and modest when you were in school and leaving school, and it's expanded five years later today?

Hidalgo: Yes. My last year in school, the Nurse Practice Act changed with sunset review. But prior to that, nurse practitioners worked under the supervision of physicians and they worked under protocols. That was how they were monitored and what have you. They could prescribe, we've always been able to prescribe, but it was under supervision.

Mullan: Limited prescription authority?

Hidalgo: Right. There were no narcotics, no scheduled drugs at that time. In '91, the Nurse Practice Act was reviewed, and there were some changes. We were moving more towards independence. At that time there was language, independent, trying to describe the different roles that were out there already, because we knew that supervision was really inappropriate to label what we did. Because we're a rural state, nurse practitioners were working in very rural sites, with only phone consultation, so it wasn't really direct supervision. So what they wanted to do is they wanted to address all the different levels of independence. They had one that was still

supervisory, and there was one that was interdependent, and one that was independent. There was still a connection with a physician, and those affidavits had to be signed and determined what level your relationship is.

At that time, that revision of the Nurse Practice Act did not include scheduled drugs yet. It was two years ago that the Nurse Practice Act was amended again, or regulations, I'm not sure exactly whether it was--it was the Practice Act. They got rid of all that language about discrepancies between interdependent, independent, and supervised, and cleaned it up, and I was really happy about that, because that was a hassle, trying to explain.

Mullan: How did they leave it?

Hidalgo: We're independent. The language is "independent in primary care, chronic and acute, and will consult as needed." And the opportunity to apply for a DEA number was also changed two years ago. So we have that now.

Mullan: So that's been an evolution in the scope of practice.

Hidalgo: Right.

Mullan: In terms of the nursing school, what size classes have they been producing?

Hidalgo: Oh, we were seven in our class. I think they accepted eight, but we ended up with seven, and the next year I believe they had, I would say, twenty. This year I think they've got thirty-some. So that they've been increasing the size of the class.

Mullan: Are they most New Mexicans to begin with or do they come from around about?

Hidalgo: I can't tell you what ratio they are, but they do accept people out of state.

Mullan: Mostly New Mexicans?

Hidalgo: I can't say that for sure.

Mullan: How about where they go to practice? Do most people stay in New Mexico? Can you tell?

Hidalgo: In my class, I can tell you that most of them stayed in New Mexico, or at the border with Colorado and New Mexico. The goal of this program is for rural health.

Mullan: Is that an explicit goal?

Hidalgo: Yes. That's how they got their grant money. It was out of a task force that looked at health care in New Mexico and

the shortage areas. So a lot of their money was linked to that. I'm considered in a rural area. I would say out of my class, 50 percent ended up in a rural area. One of them in rural Colorado, right at the border. I still consider her within the New Mexico area. I know that the most recent class, it's probably about 50 percent. It's probably still 50 percent where it's urban--

Mullan: 50 percent are--

Hidalgo: In the rural areas. Some did go to other states, back to their home states. One of them I know in the subsequent class to mine, came from Arizona, the Public Health Service sent some from Arizona, and their obligation was to go back and finish there.

Mullan: Tell me about entering the practice again, now as a nurse practitioner, coming back to your same hospital or your same community. How was that?

Hidalgo: Positives and negatives. It was comfortable on one respect to know the physicians. I worked with the same physicians when it was a hospital, as a nurse, and some of the nursing staff, the LPNs, were left over from the hospital staffing.

Mullan: When you came back, it had now gone from a hospital to being--

Hidalgo: A clinic. It had been a year history of a clinic.

Mullan: When you got back.

Hidalgo: When I got back. But at the same time I felt a lot of pressure, even when I came from my preceptorship, I thought, "Well, they knew me as a nurse," and like I said, I felt comfortable in my role, especially in OB. Matter of fact, I felt like I taught them a few things, because they were rural, and I had been in a larger institution doing OB. So I brought a lot of experience with me, but coming back, then I felt the pressure of, "Gosh, I'm supposed to know a heck of a lot more," and I don't know if you remember your residencies and internships that you think, "I don't know anything." So I put expectations on myself that I thought they would have for me. They'd been very nurturing, the physicians here.

You talk about evolving the role, I think I tried to teach them about the role. I was blind, mind you. I didn't really have any true role models. I came in with a clinic need. They needed someone to help them with urgent care, so that's how I started. It was a very welcomed addition to the clinic staff, because our physicians were doing appointment care and taking turns doing urgent care or non-appointment coverage as well during the week and in the evenings. That is very, very difficult. They weren't real happy with that.

So when I was about to finish, and it was Steve, actually, while he was out running on this area that I also ride horses and stuff, asked me, "Are you almost done with school?"

I said, "Yes, I'm almost done. I'd like to come over and work back at the hospital."

He says, "Well, you go talk to so-and-so," the administrator at the time.

So I felt welcomed when I came. I think I helped a lot. It was hard for them at first because I was a new graduate, and I did need a lot of time at first. They made a great investment in me for their future benefit.

Mullan: This is in terms of consultations?

Hidalgo: Consultations. Yes. Right. So I did the urgent care, that really freed them up. They still did the evenings and were available for consultations during the regular working hours. I worked Monday through Friday. I'm trying to remember how long I did that. It might have been for two years.

I had the goal to not just stay in urgent care. I wanted to--this is my phrase I use--it wasn't fulfilling for me. It was challenging and exciting, and I loved coming up with those differentials and the diagnosis and treatment, but I didn't have any continuity. I wanted to know how they did afterwards. And although this was an ideal setting for getting as much as you could, being an urgent care provider, I could ask the docs and get the chart, I had access to the charts, but I didn't have the

time. It was constant patients from the minute you got here until way after you were supposed to leave. So the volume was really a lot for one person.

But I didn't feel fulfilled, because I wanted to develop relationships with patients, and that's why a lot of us go into it, this Marcus Welby, as you mentioned, relationship. I felt working in urgent care was like loving and leaving them. It didn't feel fulfilling, so I proposed to the staff that I would like to move into primary care, and we could hire the nurse practitioner student that I was precepting. I sort of had it all planned. We did that. They agreed. Again, I think it's because I was trying to teach them what my role could do, and I pushed it, pushed it, pushed it. They went along with it. I felt at that time I was really the only one in the system that was really having her own patient load. I mean, officially on insurance forms, I can't, and that's one of the barriers, is I still am not listed as a primary provider for billing and through HMOs yet, but I do have my own patients, and pretty much they're exclusively mine, unless they go to urgent care or can't get an appointment.

Mullan: This has developed.

Hidalgo: This has developed over time.

Mullan: How did you select or did they select who became your patients?

Hidalgo: It's self-selection. Patients and myself, and I've learned a lot. I've learned how I need to, for my own level of skill and experience, need to know that I don't really want to take care of this type of--I don't feel like I'm the best provider for this patient. I can think of some pretty complicated ones. They really wanted me, because they wanted that role. They wanted that person that they felt that they could talk to and wouldn't talk down to them. One I'm thinking of is this COPD female who has a lot of health problems, and had polypsythemia [phonetic], and she had a lot of things, depression, a lot of things. She was fed up with the traditional providers that she's had in the past, and she's talking about physicians. I'm not sure if it was a gender thing, but she wanted me desperately, and I knew at the time that she was very, very complicated, and I would work with an internist, a female internist here, and we'd consult a lot on her.

Then the internist retired, and so I felt like I didn't have that link, and that was the type of patient that I've learned that I need to direct patients to another level of care, and it can be through a specialist or it could be to one of the family physicians here. So up until that point, patients would self-select, and I'd try to refer, but that really became apparent to me what some of my limitations were, and that's just part of the growing process, the learning curve.

Mullan: Over time, has that been comfortable? Are there people who discover you're a nurse practitioner say, "Well, I want a

doctor," or contrariwise, are there people who say, "I want you because you're a nurse practitioner"? I gather that's the case in some of these.

Hidalgo: Yes. Because they know I'm a nurse practitioner.

Let's go back when I first started in urgent care, because see, of course, they're not selecting me when they come through urgent care. So that was a different scenario than what I'm doing now. When they make an appointment, they're selecting. So it's a lot easier. But I'll tell you, when I first started, it was hard, because the physicians didn't know quite what a nurse practitioner was, the public surely didn't, and, of course, you have to think about their health-care-seeking behaviors. Very interesting in this town. They use a lot of non-appointment; that's just been their tradition. So there was a lot of learning that needed to take place as far as that.

But then having a nurse instead of a doctor, that was really hard. I got a lot of older people especially, that would say, "I want to see the doctor. I thought I was seeing the doctor." They would say it in so many ways. Some were point blank that, "I don't want to see a nurse." Some would say, "Oh, I thought I was seeing my doctor." Before I came, that's what they expected. If they came on that doctor's urgent care day, they wouldn't bother making an appointment, because they would see him through urgent care, and it would be their provider anyway, their doctor.

But that changed, and I can say that after the first year, that was probably the roughest, I still had a number of people

say, "I don't want to see you, I want to see my doctor." By the second year it dramatically declined, and by the third year, I hardly ever see it. But that's because I also moved into primary care, so that may be just a skewed representation as to what really was the attitude out there.

Mullan: At the outset you're talking urgent care setting?

Hidalgo: It was urgent care setting. But now we have a nurse practitioner in urgent care doing it primarily, and we get your occasionals, but those are those who never worked with a nurse practitioner before, so they don't know. They see this mental picture of a nurse and a physician, and how they've been socialized into those roles through television, through their experiences in hospitals years ago, and so their whole frame of mind about a nurse is totally different.

I did an experiment. I did a talk at the high school. I believe they were freshmen--no, they were juniors. It was a Career Day, and they had different guest speakers, and one of my patients wanted me to go talk about nursing, and the advanced practice role as well. So I went, and what I did, I went around the room and I asked each of them to give me a response to the word "nurse," develop a mental picture and just tell me the first thing that comes to your mind. And our societal opinions or attitudes about nursing haven't really changed much, and that was disturbing, although I expected that. They're still looking at soap opera types, handmaiden, assistant. I didn't hear anything

that let me believe that people at this point are seeing nurses as independent care providers with their own little bag of tricks. So that confirmed it. I could see that in the adult world as well, what I was saying before, is that you just said the word "nurse," that just kind of blew any credibility that we could be totally responsible for their care. I had co-workers who would say, "Therese, can't we call you something? Like the doctor is called a doctor, and that makes people feel comfortable. Can't we call you something instead of your name?" Because people are used to not calling the doctor Rick--

Mullan: Yes, a title.

Hidalgo: Yes. We joked around about that, but those were probably very valid points about how the public sees us, when they've not had much exposure to us. They want something to hang some security blanket on, and they thought maybe a title would be appropriate. But I go by my first name, probably as most nurse practitioners that I can think of, and that's the down side, is that security that a title makes people feel more secure. But at the same time, the flip side is, people feel more comfortable.

Mullan: The title puts a distance.

Hidalgo: Right. I think that's what we market to people through ourselves.

Mullan: Well, let's pursue this. This is very interesting, and in Washington, a much debated point, far away from the actual laying on of hands. In your judgment, do nurses bring to the primary care arena, and let's focus on primary care, which I also want to get your thoughts on, but I've skipped over that for the moment. Do nurses bring to primary care qualities that are different than physicians bring to primary care? Is the product a term that you offer ultimately now a well-trained, experienced, nurse practitioner substantially different than or even different than what a physician brings?

Hidalgo: I'll answer it more directly, but let me just give you a little example on that issue. When Ford brings out the new Power Stroke truck, which I'm going to go pick up in about a week, that's why that one comes to mind, when they're advertising this new model, they put it on this little revolving table for the cameras, and they show you pictures from the side, and they show you pictures from the front, pictures from the back, so that you can get a feeling for the whole vehicle.

I see health care providers in our different domains, seeing the patients from different perspectives, that the physician may have a perspective of the patient and their needs different than the profession of nursing. I know that's been said and debated over the years, and it's probably getting more blurred, but I can tell you from my early nursing experience, physicians were more the medical model, a disease perspective, and nurses have always seemed to have always seemed to be health perspective.

Now because of the market change in health care, we're all trying to work towards disease prevention and health promotion, and so those lines are getting more blurred, because I do think primary care physicians are better at it than specialists and subspecialists as far as looking at the patient with more than the disease, the organ, the organ system, and looking at it more as a complete person. But what nursing can bring is educators and communicators with their patients. I think that that's one of our strongest points, is that we will educate, and I believe that more money needs to be spent on education and the services that can be rendered and billed for, to prevent disease.

So I'm not looking at it so much from a person who's already got COPD in stage and focusing a lot of our energies and attention on medicines to help them and treatments to help them, but more to prevent them from getting there, number one, with spending a lot of energy and time educating, but also, when they are in that level of disease stage, that we work and focus on how does that affect their life, their daily living things. How does the medicine affect that? More of a case management type of a perspective.

Mullan: So your answer would be, yes, that nurses bring--

Hidalgo: Something different.

Mullan: Something different. Is that measurable, in your judgment? Is that scorable?

Hidalgo: I once read an article about how most of us measure things with financial reimbursement and things like that. They were talking about how does a nurse practitioner bill, I guess, for some of these functions that I mentioned a minute ago. Right now there's not a system in place to do much of that, and that's what I'd like to see change, if everybody really put their money where their mouth was. We all talk about disease prevention and health promotion, but no one is willing to pay for it.

On a personal level, I can tell you that I do a lot of counseling and weight management and diabetic education, and this is the arena that's separate from what the physicians are doing. Matter of fact, they refer to me for those. I can see two patients that with weight management and nutritional advice, consultations on a regular basis, were able to be taken off their medicine. That's always like the buck talks. So we don't have to pay for medicines repetitive screenings and things like that. I think that's a victory. I don't have any hard core, bigger studies, but I can tell you from my practice, I've seen a difference.

Mullan: I like your image of the Power Stroke truck from the different perspectives. If a patient has those different perspectives, and a nurse can see a somewhat different side than a physician can see, in the primary care domain, how does one rationalize having one set of patients seen by a person with one perspective, and another set of patients seen by a person with another perspective?

Hidalgo: I'm glad you asked that, because part of the talk that I did for a site visit from an organization in Atlantic City, this was my point, too, I used the Power Stroke as an example.

Mullan: I'll have to find out about the Power Stroke truck. It's a good truck, I gather.

Hidalgo: Oh, yes, it's a diesel.

Presbyterian has a logo that looks like this, and these are supposed to be mountains, and this is supposed to be a sunrise. Okay? What I did is I talked about nursing and medicine, and how we worked together as a team, and I used the logo. The way I see it is this is medicine, this is nursing. There are a lot of things--and there might be more overlap there--there's an area of overlap in tasks that we do. That's why I wanted to focus on a perspective of a patient. This is the patient up here. What I added also is these are the rays of the sunrise or sunset. This is family and community, and this is an area that's been nursing.

The nurse practitioner program has developed out of the community nursing tract in our school of nursing. So this is very, very important from where we come from, where our perspective is, because we don't just want to look at the patient, we want to look at how that patient is affected or affects the family, and then the family within the community. Those are different levels of care, but that is part of our perspective on a patient.

Anyway, so these are the areas that we share certain tasks, but these are areas that are distinct. This is where that different perspective comes from. I'd looked at it as a team, and that was what I was alluding to earlier this morning, is that I would like to see it in this kind of a model, where you have both of us looking at a patient that we share, and we bring our different perspectives for the betterment of the patient. This area where we share some tasks can be done by either, but if we want to look at cost effectiveness, why don't we let the nurse practitioner do some of this, and free up physicians for some other things.

Mullan: Which would be high level of acuity, by and large?

Hidalgo: Higher level of acuity. I always say you don't need a bazooka to shoot a rabbit. A BB-gun will work just fine. Not that one is better than another, but only in terms of acuity. You don't need that much velocity to get the rabbit. So when we're talking about health care shortage or access to health care, especially--and that's one of our biggest issues here, when patients who are prepaying for health care cannot get in to see their primary provider, because that's just the way our model is being set up, you have a primary care provider, but they can't see that provider for two weeks, something's wrong.

As a consumer, I'd be really upset, and I've been in that situation, and I have been upset. That we could improve access with looking at a model like this, where you actually have the

health care provider team, and that we could market it, but it has to come from the marketing standpoint when they're selling HMOs to people, because just like we need to change people's idea of what a nurse can do, it's not Bobby what-ever-her-name was that was on "General Hospital," but that they really are trained and have expertise in areas of health care that you never thought of in the past, that if our marketers can go out there and market that, that when you sign up, you're signing up for a provider, but not a provider, you're signing up for a team of providers that are sharing the responsibility of your care. That's how I'd like to see it evolve.

Mullan: Do you see yourself as more of a nurse or more of a doctor?

Hidalgo: Oh, I'm a nurse. I do some of the things that doctors do. If I didn't believe in a different domain of perspective on health care, then I guess I would say I was more like a doctor. That's why I can't say that, because I do believe that we bring something in addition to what medicine offers patients, but I do some of the things that doctors do.

[Begin Tape 1, Side B]

Mullan: This is Therese Hidalgo, side two, continued.

Is this because of your schooling in the sense that you are acculturated as a nurse, your identity was a nurse, your maternal

identity was a nurse? Obviously that's a powerful influence on anybody, how they get to where they are, it's certainly true of physicians. Or is it because of what you do daily is substantially different than what you're co-practicing physician is doing? If I came from Mars and walked into that pod where you and Steve Cohen [phonetic] work side by side, would I say, "These are people from two different traditions, two different histories, two different educational systems," would I conclude that, or would I conclude, "These are two variants on a theme"?

Hidalgo: This is the essence of how it's so difficult to measure the differences. I think it lends itself--I'm not sure, to answer your question, that a person from Mars could tell by dropping in on our pod that these are two different perspectives and ways to treat a patient. It's more subtle than that. I think it gets more subtle depending on the individual who's providing care, number one.

I've seen some physicians who my impression is nursey, and I will do that to help acculturate not only that physician I'm talking to, to my perspective, that it's a value--I think we're talking about value perspectives, that I wanted him to know that I value that in him, even though I don't feel that the community, because we can't see such distinctions, and we don't place any value, well, where it counts, the pocketbook, on some of these subtle distinctions. But I remember telling a physician, "Gee, that was just so nursey, the way you intervened on that patient.

I'm really impressed." I'm just trying to shed some of those old stereotypes and visions of who we are in our professions.

Just like today, I got a letter from Presbyterian Health Care Services, who I work for, addressed to T. Hidalgo, M.D. The same physician--I've been working at this same physician--is that when he saw something in my door that had Therese Hidalgo, M.D., and this was his bias, he said, "Oh, my, look at that Therese. Gosh, doesn't that make you feel good?"

I said, "Absolutely not." You know what I'm getting at, is that I have to train people that I don't feel that what I'm bringing is lesser and that I am continually trained to achieve the role of an M.D., that I'm happy being a nurse doing what physicians do. That goes back to telling you my perspective on that question you asked me, do I consider myself a nurse or a doctor.

Mullan: Let's pursue a little bit the political side of it. Have you been involved with that as well to some extent?

Hidalgo: Yes.

Mullan: First, on the political side, physician acceptance of your work here, as well as nurse practitioners in New Mexico. How much resistance, how much support? What has that been like in general?

Hidalgo: On the state level, because it's a rural state, nurse practitioners are very well accepted. They are, I would say. Most recently, being part of the organization, not in our clinic per se, I think we're accepted here, but I've been told that as far as the Presbyterian organization, not the other clinics are as accepting as ours, and I think part of that's because they didn't know. But I'm a nurse practitioner and I did. I admit it. I went full force. I saw an opportunity to help the role, and I saw some naive physicians who were not tainted with maybe some of the resistance that I'll share with you, with some of the nurse practitioners in Albuquerque within our system. Money has not been attached to that as far as our positions are concerned here, that what I do doesn't take from their piece of pie per se, because these are employed physicians. So that has an undertone, too.

Mullan: That makes it easier.

Hidalgo: It makes it easier for us to be accepted.

Mullan: In a salaried setting.

Hidalgo: Yes, in a salaried setting. In Albuquerque, I went to a meeting within the Pres organization, and I did hear a physician who's family practice, sounding very resistant to the role of nurse practitioner within her practice as a team, because, I think they're trying the team concept, sharing

patients, not in the level that I'd like to see, but to a certain degree, but compensation as being attached to that position, and she's feeling threatened that her numbers are being affected by having a nurse practitioner. So it's not the nurse practitioner per se that she's being resistant to, it's that her numbers are dropping because people are seeing the nurse practitioner when they could be seeing her, and her paycheck is based on that. There's different levels of agreements in the organization.

Mullan: That's an economic competition.

Hidalgo: That's an economic competition.

Mullan: What are nurse practitioners recompensed in the Presbyterian, roughly?

Hidalgo: Right now, the twenty-fifth percentile for a nurse practitioner is $50,430, something like that.

Mullan: Twenty-fifth percentile of all in New Mexico?

Hidalgo: No, of their range within the organization.

Mullan: Within Pres.

Hidalgo: Within Pres.

Mullan: So that means the fiftieth percentile might be up at $60,000, and you might have people make $70,000, $80,000?

Hidalgo: Currently not in our Pres system, but that's the potential for growth. We don't have anyone in those. Of course, nurse practitioners are new to Pres. I was the first one, and that was in '91. We have probably ten mid-levels total within Pres, and now I'm talking about some PAs. I'm trying to think. I think we might have six nurse practitioners in the system. So for four years' time, I guess I would have expected it to be a lot more expanded, but I think we're on the brink of that. I think we're on the brink.

Mullan: What are the economics in terms of volume seen? If you're sitting in the Pres front office talking primary care coverage, traditionally, nurse practitioners see less patients than physicians?

Hidalgo: That's what the literature says, and that's probably true with certain physicians and certain nurse practitioners, that probably is true. I've read the literature where they think we're more economically advantageous, but yet we don't see as many patients.

Mullan: The calculus I've seen is, in simple terms, if you put a primary doctor at 100,000 and a nurse practitioner at 50,000, the

nurse practitioner sees half as many patients, their economic pulling power is equivalent.

Hidalgo: Right.

Mullan: Then you get to the question of quality and acuity and so forth. I think it's those kind of formulas that are ultimately going to have a reality in the employment pattern, particularly when you have managed organizations. But I think they're in their fairly primitive phases most places as people explore this. But it's certainly inexorably true as the nurse practitioner salaries rise, they will make themselves a less attractive commodity in the sense that the gap, the putative savings become less.

Hidalgo: Well, you're right, and I agree with that statement, because that's a risk. That could be our detriment in the next few years, because the salaries really have changed.

Mullan: Well, it's kind of a Catch-22 for the nurse practitioner.

Hidalgo: It is, and that's why I think we need to change a few things here.

Mullan: It also may medicalize her, in the sense that if the doc is spending less time doing education and counseling and moving

the patients quicker, if the nurse practitioner wants to be economically more successful and be seen as such in an organization, then they've got to have similar productivity, the nursey qualities that do take time often and may fall by the wayside.

Hidalgo: That is really, really true. That's why some things have to change. With managed care, I think, and this is where we're at in this clinic, is that we need to have appropriate appointments. I've worked urgent care, and I know that if I had a thoroughly complicated patient who has a big chart, it's going to take me a lot longer to sift through that problem. At the same time, when you have a physician filling up his schedule with ear checks and otitis, I'm not saying that that's all theirs, but that sure helps the numbers, if we're playing a numbers game.

I think we need to get away from the numbers game and I think that we all have to be committed to getting the right patient in the right appointment slot, because we're talking about access, too. For all those little ear re-checks that's filling up a pediatrician's schedule, you have four people who probably have a higher acuity type of problem, maybe a little more urgent, who can't get in to see their provider, because he's tied up with that, and they're coming through urgent care and that's affecting the nurse practitioner's numbers, because it's more complicated. Besides, the patients aren't even known to us. It's more start from square one to really do a thorough job. So I think we need to get away from the numbers.

If how we're going to measure productivity--and that's what this article was about, I couldn't think of that word earlier--are we going to measure productivity by the number of encounters, or do we need to weight the encounters that we have? An ADD exam is very time-consuming, so the pediatrician will be penalized for an ADD evaluation when it's done right with family and everything. It takes a long time. But that's his expertise, and he should be the one doing the ADD assessments. But his numbers will be lesser.

It's still the same thing as I mentioned earlier about if we can get away from actual numbers and putting people in the right slots, triaging them--to me, that's a program we're going to embark on probably at the beginning of the summer, hopefully, to help with our own access issues, and that is to utilize either a nurse or a nurse practitioner that have a set of protocols, and it's a computer system that can actually be more responsible for triaging. Does this appointment have to be done today? Can it be done two days from now? Should this appointment really be home care instead of taking up a slot? Because in managed care, if we're not available to give the product that people have already paid for, we're going to have problems, and spend the money that doesn't need to be spent with capitated services. Think of all the colds that waste our resources. They waste them. We had an internist here who worked here. I could only feel her frustration, working even in her appointed care and urgent care, she still does urgent care on the weekends, the number of colds that come in.

Mullan: Let me go back, if I could, on an issue between the nurse practitioner and physician. With medicine becoming more feminized as in the number of women doctors entering the work force, certainly what--let me not say certainly--it has been characterized by some that one of the things that nursing brings to the health care work place is a more feminized, more caring model, built into the profession, but a profession that's always been close to entirely women. I mean, nursing, the very concept, relates to mammaries and nursing. As medicine moves towards 50 percent women, does that bring into the field of medicine more qualities that would be nursey in the sense that you've raised them, or not? Do women doctors work more comfortably with the nurse practitioner model in your experience, or not?

Hidalgo: I think it's the male physicians, in my experience, that have a more compatible relationship with the two roles, and it's the male physicians that I see doing more of the nursey things, at our clinic, and they were all trained in the same school. It's interesting. I found that it was more the males. Since I've been here in this clinic, there have been three male physicians that actually had more of the nursey art of medicine, nursing, whatever. And it's been the females, except for this one female internist, but she was motherly to a lot of patients by nature of her age and what have you. But I can tell you that the other female physicians that I've experienced, I don't think they brought that to the role.

Mullan: Would you conclude, and I realize this is highly anecdotal, but would you conclude that a woman entering medicine and moving through the process of medical education moves to a different model or has some of the feminine qualities suppressed?

Hidalgo: I think that's it right there. I think that there's a potential to bring feminism to the role as a health care provider, but I think it's squelched because of the competitiveness and the nature of the medical school and acculturation.

Mullan: Let's move, if we could, to Santa Fe. Tell me a bit about what sounds like a very positive evolution of the Nurse Practice Act. You mentioned before that elements of moving towards more definitive practice, more prescriptive authorities. How does that come about, and with what supporters and with what resistance, and what is your role in that?

Hidalgo: The Nurse Practice Act that evolved to the point of independent practice was voted unanimously by the Congress.

Mullan: By the legislature.

Hidalgo: Yes. By the legislature. So that was really interesting. There was a lot of lobbying on the part of our state Nurse Association, and unfortunately that lobbyist is now in Washington, for future issues we may be at a standstill.

Mullan: Who was that?

Hidalgo: Deborah Walker. She was also a nurse practitioner. I'll tell you that I think the nurses took the AMA [American Medical Association] by surprise, is what happened.

Mullan: This being the state Medical Society.

Hidalgo: The state Medical Society, yes. There have been some responses that were not positive to what happened here. What happened here? The osteopathic society, I'm not sure what it's officially called, has written some letters that felt that the legislation that was passed was, in a nutshell, was done not up front, didn't give enough opportunity for rebuttal and things like that. It slipped past them. So they've made a formal letter regarding that. I believe the state Medical Society also has made some comments. Pharmacy--you know pharmacy is trying to evolve, too, into health care primary care providers. They, too, have raised a lot of flags.

We're preparing for this next coming legislature session, because this one was primarily financial, but the long session coming next year, because I'm not the Advanced Practice Committee for the Board of Nursing, and we're trying to decide what issues we want to raise in relationship to advanced practice. We're worried that we made a lot of headway towards independence as a profession, but I think we're not going to be surprised if there

are some bills that will come to take back, three steps forward, that may bring us back. I don't know.

Mullan: Have there been any incidents or issues that have provoked that medicine is saying, "Here is a situation where a nurse practitioner botched it"?

Hidalgo: No, there has been no complaint as of my last meeting with the Board of Nursing Advance Practice Committee. There have been no complaints about care issues that require any kind of--

Mullan: To your knowledge, it's been the osteopathic community that's raised some issues.

Hidalgo: Not about care, but just about--

Mullan: Principles.

Hidalgo: --the legislative--

Mullan: Principles.

Hidalgo: --legal.

Mullan: The family physician group in New Mexico hasn't--traditionally, those are the people who feel the most heat. They have not, to your knowledge?

Hidalgo: Not formally. Not that I know of.

Mullan: Let's talk a bit about primary care as a concept, which we really haven't, and that's the theme of what I'm exploring, actually. With a nurse practitioner educated as you've been, and as nurse practitioners as I understand it are in general, primary care is at the focus of what they do. When interviewing physicians where primary care there's been this sidebar or this much maligned part of medicine, it's more important to kind of tease out how a person chose one way or another. I would presume, as a nurse practitioner, the concept of primary care came naturally to you and you're comfortable doing it. How do you see it? What is primary care in your view as practiced by a nurse practitioner or a physician?

Hidalgo: Well, primary care is the entry into health care. It doesn't always come the way we expect it, and that's how we use urgent care, especially in our facility and our community here. Sometimes people will access what really is primary care through urgent care because it is--

Mullan: Is this facility devoted to urgent care?

Hidalgo: Yes.

Mullan: There's no specialists?

Hidalgo: There are visiting specialists that come, that we have just for referral purposes. That's what it's for.

Mullan: Or on occasions you'll refer out if somebody needs a specialist?

Hidalgo: Right.

Mullan: But basically what you've done here in primary care.

Hidalgo: Yes. Primary care and non-appointment urgent care. So some people may enter the system through the urgent care mode, or they may do it through appointments. Let's talk appointment and non-appointment. So I see primary care is a person's entry into health care for whatever reason. Then primary care, as opposed to what we're calling urgent care, which is a role I was in, and that's where I can make the difference, is that this is ongoing, a relationship type of care where you develop that relationship with the new patient history and physical, and the relationship where both of your are identifying needs to maintain or improve health care health of that patient, and this is the ongoing surveillance of that. We're talking about health promotion things, we're talking about screening, and along with that is the episodic care in between, but it's more than just having a relationship with somebody just every time they get a sinus infection. It's more than that. And it's more than just coming in for an annual pap. It's looking at other areas of health care

needs, other than cancer screening. The pap smear encounter is not just a cancer screening, but it's really looking at all their other health care needs as far as promoting health.

Mullan: Is that model comfortable in terms of this community? I would presume people come here understanding that.

Hidalgo: I think it's a learning process. As I mentioned, the population here, and I don't know how different or how similar it is to other places, I think the older residents have had a different type of health, because that's what's changed over the years. People would show up at a doctor's office, I can say for Belen, and they just want the medicine. They've been acculturated that way that you've got a cold, and that's why we're dealing with it, if you've got a cold, you go in and get a shot. They don't know what the shot was, but they got a shot, and that's going to take care of them. But they didn't go in for screenings, consistent follow-up for a particular problem like hypertension, that sometimes requires labs, depending on what some of the health care issues are. So there's a big population here that is very episodic, and that's all they want out.

Mullan: But they're not particularly specialty oriented?

Hidalgo: What do you mean by that?

Mullan: That they want to see a cardiologist because they have a chest pain, or they want to see a dermatologist because they have a rash. Do you encounter that? Actually, let me back up. The people you see are either part of the Presbyterian Health Plan or Medicaid, or other?

Hidalgo: Medicare, Medicaid, and part of the plans that we've got contracts with.

Mullan: "We" Pres, or "we" this facility in particular?

Hidalgo: Well, it would be Presbyterian. So there is a certain population that doesn't come here, if it's a different health plan that we don't service.

Mullan: Having passed two other facilities on the way here, the private offices next door, and the Belen Health Center. What is it called?

Hidalgo: There is a Belen Center there that's a nursing home. There's a private practice here with two physicians and I don't know how many mid-levels, but I think they have one or two mid-levels there.

Mullan: What kind of physicians, primary care?

Hidalgo: Family practice.

Mullan: Who comes to you as opposed to them or other doctors in town? Are you seeing an economic cross-section of the community? Are you seeing poor folks, better than poor folks?

Hidalgo: No, we're seeing a cross-section. We have a lot of Medicaid, they have a lot of Medicaid. Medicaid asks people to pick a primary care network where they maybe picked for that office even though they're Medicaid and it's not a HMO, so to speak. At one time they were the only Lovelace providers here in town, and I think they still may be. Lovelace went to them, but they also have Health Plus, and they also have Blue Cross/Blue Shield. Actually they had more of a cross-section because they had FHB Lovelace, that we didn't have.

Some of it is choice of providers, because before all this happened, that's why it's exciting to have been part of this, because when I first entered in the picture here, there may have been Health Plus and that kind of stuff, FHB. Yes, there was, it was the hospital. But what I was able to observe about the community was that it's not so much economic background that made them choose a different physician as their primary physician, it had a lot more to do with the style of care. I would say, and honestly speaking, the physicians that I work with here are more primary care oriented, and more of a gatekeeper type, and primary care meaning screening, ongoing continuity care, not just episodic type of care and referrals to specialists. I think that they do more of that, and that was the style before we really kind of got into this picture of HMOs and referrals and all this

stuff. Then there's one other physician who spoke of retiring but hasn't retiring, who is strictly--I think his type of care is really archaic, the old model.

Mullan: But you don't have a lot of specialists in Belen to make that an issue. The core issue is practicing primary care as you do here, does the negative side of gatekeeping, the perceived negative side, are people concerned because they have to go to you and they can't go straight to the dermatologist or the gastroenterologist, etc.?

Hidalgo: I think that is an issue. Actually, I've seen a change in the behavior in the referral process over the last couple of years. I can see it as a consumer before I got into this picture and before it got so tight with managed care and all this stuff, that I felt it was a barrier. I know I need an ophthalmologist. Why do I have to go to a primary care provider first? I can tell you as a consumer before, that was my perspective, and I do believe a lot of people still share that. But I've also seen the practice of some of these physicians that they've kind of rolled with the punches, too. I think at the beginning when they were given that responsibility of gatekeeper, they took it very seriously, and it was to keep costs down and really not use a bazooka when you can use a .22, for the same problem. But I think their actual practice and referrals is multiplying. I think the gates are looser, put it that way. That's just my perception.

Mullan: Because?

Hidalgo: Because I think it's the demand of the patient.

Mullan: As opposed to there are certain kinds of things that they are now comfortable sending through? For instance, in many cases it's been argued that dermatology is best seen directly, that a dermatologist is so efficient and so quick that if somebody calls up and says, "I've got a rash," and if there's a dermatologist available, it's more efficient to send him to it. At least some primary care docs and others are concluding that. That's different than patient demand saying, "I want to see a dermatologist," or whatever. But as primary care sort of sifts itself out, there are reasonable arguments even in an efficient mode that direct access to certain kinds of specialists makes more sense.

Hidalgo: Maybe that's it.

Mullan: But it's certainly the former, that is that there is a steady demand, a steady patter of patients to want to see specialists.

Hidalgo: Oh, yes.

Mullan: And the primary care docs are getting a little more relaxed about that after initial tough stance.

Hidalgo: I think so. I mean, as I told you this morning, my medical assistant helps Rick Madden's nurse with referrals, because it's just too much. I'm talking stacks of referrals, multiple referrals for the same patient. That's so different from what I was told when I first entered into the picture of primary, when they were acculturating me to the system. When I came as a nurse practitioner student, if I wanted to make a referral, I was taught very early on that, "Oh, no, no. We need to keep those down to a minimum." That's what was communicated to me by the same providers. As I got to working here, I began to say, "Well, I don't refer but it seems as though for the same problem you've changed your tune." I think. I think it would be interesting to look at that.

Mullan: Let me ask about your view of the future, where the primary care portion of the system is headed. Much speculation about will it become more prominent, less prominent, the role of non-physicians working with physicians, will they capture the field, will they be squeezed out of the field, will there be multiple types of primary care providers in the future as there are today, some coming out of medicine, some coming out of nursing, some coming out of PA?

Hidalgo: Pharmacy.

Mullan: Pharmacy. If you look twenty years down the road, what do you think's going to be out there?

Hidalgo: I don't think primary care is going to be squeezed out, because I think even though consumers feel that there are barriers to get the level of care they think they need, I don't think they want to be seen as a liver, as a skeleton, as a heart. They want to be seen as a whole person. And I think that's what primary care and the health care team, with physicians and non-physicians as a team, I don't like the hierarchy, I think that's old stuff, and I think that if we can sell that concept to the consumers, they may feel better cared for, and not feel this need to reach for the specialist after they've had the time for education of the system.

I think we need to spend more time in community education projects to help people understand their perception of illness. For instance, in working in this other committee on the organizational level, it's an access care team. One of the loop process with feedback, and the issue is access. How do we improve access? Why are we feeling that it's a negative right now?

Mullan: Access is a negative?

Hidalgo: That patients are viewing access negatively, that they are not feeling we are accessible to them as their primary care providers.

Mullan: This a Presbyterian committee?

Hidalgo: This is a Presbyterian committee. One of the things is that they feel that it's the patient's perception of level of illness that needs education. Of course, that's us the providers wanting to tell them, but I think a lot more time needs to be spent on that, educating people, appropriate access, so that we don't plug up the holes with things that are inappropriate. I think if we could spend more resources on educating communities on different things. For instance, how many holes are plugged by me doing diabetic education one on one? It's expensive. That's very, very expensive, when programs should be initiated that you're out in the community hitting larger groups of people for less money, actually. So I think community education needs to be a seller for a plan. If we're going by plans, the plan's got to sell to employers, and I think these are some of the things that they should be investing in. I think triaging the appropriate level of access of a patient into the system is going to save a lot of money and actually provide better care for these people. I still feel that the health care team, as a team provider, needs to be marketed.

Mullan: So you would think that twenty years from now we will see people practicing primary care whose origins are medical school and medical concepts, and people whose origins are nursing school and nursing concepts?

Hidalgo: Yes.

Mullan: How about PAs?

Hidalgo: PAs, well, actually, we're going to start a new PA program here. I'm not sure if it actually started yet.

Mullan: At UNM?

Hidalgo: At UNM. They're bringing back a PA program. I think we're going to see PAs, too, because there's a lot of controversy over who's more efficient, a PA or a nurse practitioner, lumping us together.

Mullan: I think the margin again would have a hard time distinguishing. In our minds, the PA who doesn't come out of nursing tradition and is also a latecomer to the medical tradition is kind of neither fish nor fowl, and yet by all measures when properly trained and put into the situation, works pretty well, with a slightly different spin or twist or attitude or world view.

This is your interview, not mine, but I'm struggling with this question. I don't think primary care is going to be a potent part of our system, that the multi-headedness of it, currently--you've got pediatricians, family physicians, and internists just within medicine, and then others like OB/GYNs claiming the same, too, then you've got a set of nursing traditions, you've got PAs, and then you got the pharmacists. If you were marketing toward cars or trucks, you'd consolidate. You

wouldn't have five different pickups that essentially did field work, you'd have one or two.

So that historically one understands how these various streams have fed into the health care work place that we have today, but it seems to me that the market and reasonable educational approaches of things will work to achieve some kind of consolidation or simplification. I don't know what it is, it's instinctive, so I'm sort of plumbing people's ideas trying to figure out what they think. Because we sort of funny-fit different traditions into a work place which is okay, but if it really is going to be a constant foundation of our health care system, an important element of the whole system, it's a little wobbly when you've got all these different things feeding into it. I suppose you can make the argument that it's also rich, because it has different traditions, but it's wobbly.

So you don't see any driving forces that NPs are going to take over and primary care physicians are going to disappear or vice versa?

Hidalgo: No, that won't happen. Nurse practitioners have been in New Mexico a long time.

Mullan: I told you, my nurse, in 1973, Gloria [unclear], went to the first generation of the program at the medical schools, so that's twenty years.

Hidalgo: Did she work for Allison Thel Gonzalez, too?

Mullan: Was she in Albuquerque?

Hidalgo: Yes.

Mullan: She might have. She went to Albuquerque and went to work.

Hidalgo: I think you must have shared the same nurse practitioner. This other proponent for--she's within our system, came from Lovelace, she's a family practice doc, and she's working with the same--I almost feel like you had talked to her, because we talked about the very same issues when I met her.

When I was schooled in nursing for the nurse practitioner program, those people in the ivory tower were moving me in the direction to be very independent, almost in a competitive sort of manner, but over the last five years, I have changed my viewpoint. I've developed my own, put it that way. I've realized that I don't want to compete with a physician, because in this state a nurse practitioner could, and have, developed independent practice. But of course, physicians aren't even in independent practice anymore. They're being employed because of economics, and that would be foolish to do that. Although that was one of my original goal. But over the last view years, I've developed the team approach and feeling very comfortable with it, with is totally different from how I was set free from school. So I think there's a mind-set changing.

Mullan: That's interesting.

Hidalgo: I think it's, to be honest, for survival, because I agree with what you and Allison said.

Mullan: One sees in Washington a fair amount, particularly during the health care reform, I thought, when there was a good deal of opportunism on all sides, people saw the opportunity to make leaps ahead, and particularly since nursing politically was well positioned with the [Bill] Clinton White House, there were enormous demands made about independent nurse practice and the new efforts to make a national law to just sort of preempt state laws, which I think state laws, to use your word, are archaic practice acts, but they are very much a part of the texture of the countryside. States wouldn't take kindly to having the federal government preempt those laws. But there was this effort.

One had a sense, and I speak, I suppose, as a physician, a little defensively, nowhere near as defensively as some of my colleagues, that this was nursing's final revenge on medicine, or final effort to kind of get medicine back. "We're going to be doctors of our own sort and have our own, etc.," which looking at the history of medicine and nursing and the way medicine both historically and interpersonally has been an overbearing colleague or non-colleague, one could understand that.

Functionally what it means for nursing, advanced practice nursing, in a tighter marketplace, somehow physicians and nurses

are going to have to work out a combination to where there are professional benefits or professional distinctions that allow for more effective or salubrious delivery of services, is where I think the gain is to be made. But the irony of nursing both pushing its scope of practice and its cost ahead, is going to run right into the buzz saw of physicians' salaries coming down, more physicians in the country, and it's going to be, I think, a very difficult situation.

Hidalgo: I think you're right. I think even at the state level, I felt like that's what I was pursuing when I came here, and I wasn't making a lot of headway for the role, kind of blindly taking opportunities. I wanted to carve out something before it was carved for our role, and I think I took a lot of opportunities.

But now I feel that I'm at a level and I think our role should be at a level where it's not worth it to try to compete. It doesn't make any sense. You're going to lose a lot more opportunities and that to figure out how we're going to work together but still maintain an identity and not go back to, "I'm your boss and whatever medical order I give, I'm the only one who can give the orders and you carry them out." I don't think nursing needs to go back to that. They don't, because they're intelligent professionals who can make decisions based on their level of education and experience. I would like to see that continue.

Mullan: What do you see yourself doing twenty years from now?

Hidalgo: Well, I don't know about twenty years from now. I won't be practicing twenty years from now, but in that interim I see a lot of opportunity to provide care not necessarily on an encounter level as we're seeing it traditionally today, people coming in for this and that. That may be part of my practice. I'd like to develop educational programs for, say diabetics, in an entrepreneurial sense, and I'd like to hit the market of HMOs to recognize that as something that they're willing to pay for and to be able to demonstrate cost savings. I still have my love in prenatal care, I love it. I tried to stay pretty general for the first few years out of nurse practitioner's school, but I'm drawn to it. I also see developing programs in that level, community-based.

Mullan: Teaching?

Hidalgo: Teaching, yes. I see teaching as an area.

Mullan: The final area and final question. We talked a little bit about your family to begin with. How has your career, as it's developed, intersected with family life? Do they understand? Does your husband understand what you do? Is he supportive? How about the boys, how do they see it?

Hidalgo: And how about extended family. Yes. What I'm trying to sell, what makes me different or how much alike, because that's what all people know, is what a doctor does. Okay? Teaching my family what I did was hard enough, and teaching the distinction between a nurse practitioner and a doctor, it's just so much easier to say, "She does what a doctor does." Well, that gives you a focus point to start from, and I don't like that focus point. I would rather be described as what I do, but not using a physician as a reference point. That's what I meant, a reference point. But they still do that. They do understand what I do, and my husband has been the biggest promotor of what I do and what I can do--this is his family here, his extended family--about how exciting my job is, and how elevated it is from what they see as a nurse. It's taken time for them, just my own extended family, to gather--"Well, what does that do? How much does she really have authority to do?" It goes to both issues. But I think they understand, the younger generation.

My mother-in-law, God bless her soul, I think she's just now figuring it out. Attitudes are hard to change. They see a nurse is a nurse is a nurse. That's why when you get people's perspective is, "What's the first thing that comes to your mind when you think of a nurse?" it hasn't changed that much. It's changing, hopefully, and I want to be the influence to help that along, not to be a doctor, because I'll be the first one to tell you, "No, I'm not a doctor," but to promote nursing in and of its own entity. My mother-in-law will still say things like, "Well, heck, I saw the nurse practitioner," at some other clinic,

because of her health care plan, "and shoot, I wanted to see the doctor, and I told them, well, I could have just seen you."

"Yes, you could. There's nothing wrong with it."

[Laughter]

So some of those attitudes do come through. But they've been very supportive, and they sacrificed a lot when I went to school. So I think they've had just as much commitment to this change that I have. They really have. They've been very supporting.

Mullan: Another question. Hispanics in nursing in the United States are at a low number, something I actually studied in my last job and worried about. The numbers are very, very low. You've obviously gone that route and gone that route fairly well. Any observations about what motivates or doesn't motivate young people, particularly women in the New Mexico community or the Arizona community to not get into nursing or to get into nursing? How's it been being a person of Hispanic origin going through the system?

Hidalgo: That's a real good question. I'm glad, because I want people to know this. I went to a Catholic high school in Arizona. There were a lot of barriers, and it's because of our ethnic origin. It was interesting. I have to tell you a little bit of this background, because I think it's pertinent. My original last name was Lopez. I was adopted by my stepfather and I was Bloyd, but looking at me, I am Hispanic. Coming from

Arizona, the Hispanic population is different and treated differently than in New Mexico, and I've had the opportunity to feel both, and it's been very rich.

Mullan: New Mexico is more long-term part of the land, whereas in Arizona there's much more transience?

Hidalgo: Discrimination is what I'm talking--and prejudice. When I went to this Catholic high school, it was mostly white, middle-class, very few Hispanics. But the rest of the Hispanics came from--I don't know, they had other barriers that they had, well, they had Spanish last names, they had accents--

Mullan: Which is a barrier?

Hidalgo: Which is a barrier. In Arizona it's very discriminatory. They had accents that stereotyped them. Well, I was a good student, and I didn't have an accent, I didn't even have a Spanish last name, but I was Hispanic. People would always ask me what I was. When it was time for me to make a college decision, or a decision after school, after high school, I had an Anglo, white nun, who was the career counselor, told me, "No, don't go to college."

[Begin Tape 2, Side A]

Mullan: This is Therese Hidalgo, first side of the second tape.

Hidalgo: So I was at the point where I was being counseled on what my after high school decision should be. She knew I wanted to go to college, and she said, "Oh, Therese, I don't know. I think that college wouldn't be right for you. I think that you ought to be a secretary." Well, she said that to the wrong person, because as soon as she said that, that made the hairs on my neck stand up. So that was a barrier. That was one of the barriers that is probably not affecting me, but affecting a lot of other Hispanic women and men.

So I went to school, and when I was in my undergraduate program, you're right, I can count the number of Hispanics, and this is in New Mexico. It was interesting. Then in my graduate program, there were eight of us originally, and two of them were Hispanic. That's such a small size. That may not be a fair statement, because I don't think that--I can tell you in the rest of the graduate school level nursing, that was a big percentage of the whole graduate program, for that one class. But that was because this was a federal grant for rural New Mexico. They wanted Spanish-speaking people, and I think that's why the percentage was actually higher in my nurse practitioner class. I don't really know what the statistics are for the most recent classes are as far as the makeup of the ethnic background.

Mullan: Do you have a sense that that's changing, that more Hispanic people are getting into nursing and health professions or not?

Hidalgo: Just a guess, I would think that more of them are getting into it, but getting to the advanced practice level, I still think is going to trail. It'll come. My guess is that the undergraduate levels is accepting or cultivating more Hispanics. At UNM, there's a lot of opportunity once you get there, but having somebody put an obstacle before you before you even get to that college, maybe that's still going on at the high school level. I don't know. Because there are a lot of minority studies there at UNM, and a lot of minority programs. I can remember this, tutoring programs for minorities at UNM undergraduate level.

Mullan: The affirmative action concept and/or programs, did that have any bearing at any point along the way on things that you did?

Hidalgo: I always wondered, and I don't know that for sure, but my hunch is it probably did, getting accepted to the nurse practitioner school. I hate to think that, because I would like to know that I got it on my own merit, but there were hundreds of applicants. Or maybe they just felt sorry for me because I already said I was in the program when even that was going on, with my charm. I thought maybe that was it. [Laughter] I always wondered if that was really an issue when I was in that program, when just eight people were selected out of hundreds of applicants. So I'm not sure.

Mullan: How about in terms of role modeling? Have you done any work on high schools or elsewhere trying to get young women interested in nurse practice careers?

Hidalgo: Any patient that walks in my door. [Laughter] And it's not a matter of what their ethnic background is, but I do a lot. I have done guest speaking at the high school level for their Career Day. I have been asked to be their mentor for a day. They have a program where they mentor with someone they are interested in their career, here at the clinic.

Here's an interesting one. This one young woman asked me to mentor her in my role. This is interesting. I said, "Oh, so you're planning in going into nursing. This is what nursing can do."

"Actually, I want to go to medical school," she told me, "but I feel more comfortable if I would mentor around you at the clinic." She knows this one other physician here very well. It's a small community, so we all know each other real well outside of the clinic. But that was a very interesting remark. Still talked about values of the different professions. I still think there's that attitude, and that kind of hurt my feelings, because I thought I made such headway with, "Nursing is valuable, too." So I know I kind of took that a little personally, but we got through that okay. And I also took it as an opportunity to really show if she should become a physician in the future, that she could see the value of our roles together. She is in college

right now out of state. This is probably her second or third year undergraduate. So I'll be curious to see what happens.

Hidalgo: What about your boys? What are they going to do?

Hidalgo: They're really ranch oriented. My oldest still feels like he wants to be a professional baseball player.

Mullan: He's thirteen?

Hidalgo: No, he's sixteen. He's playing for the high school. But ranching and farm science. I'd like to help direct him in that way, to work in the economics business of ranching and farming. He wrote a paper when he was in eighth grade that, "I'd love to be a rancher, but I know that nowadays you have to have a degree, and I feel that business and agriculture together would be a good combination." That was really pretty good.

My second one still wants to be--they still are in the sports arena, of thinking that--their dreams. But none of them have talked about medicine. None of them have talked about health care. I'll be interested to see. I thought I could get one of them to be a vet, because things are changing in medicine of veterinarians, as far as use of drugs. This would be a good investment.

Mullan: Yes. I bet you as they reach maturity, when they have to start making those decisions, their mind at least passes by

you as a role model, I'm sure. Well, you've been terrific. Anything else you want to say or you'd like to leave with me?

Hidalgo: No, I think I gave you a lot. I'll just look forward to seeing your book.

Mullan: Thank you.

[End of interview]