ROBERT T. SMITHING

Dr. Fitzhugh Mullan,
interviewer

Smithing: The appropriate initials that I use after my name are MSN and ARNP, for Advanced Registered Nurse Practitioner.

Mullan: Good. And what's your date of birth?

Smithing: February 5, '56.

Mullan: We're in Bob Smithing's office in a converted formerly Sir Speedos or Speedy Copy Center?

Smithing: No, Sir Speedy's actually the landlord who's next door. This office was at one point originally a lumberyard, and ultimately got subdivided into offices and we took over some space that an archery shop used to occupy.

Mullan: How long have you been here?

Smithing: We've been in this place since July first. We had been down the building since April of last year, and we moved there planning to move into this space when it became open.

Mullan: Which leads to the point that it is the ninth of August, 1996, and we're in Kent, Washington, south of Seattle.

I want to hear more about your current pursuits, in terms of the business in the building. But let's go all the way back to the beginning. Tell me a little bit about Robert T. Smithing, where he was born and where he grew up.

Smithing: I was born in Queens, New York, and spent most of my youth growing up in a little town called Williston Park, which is in Long Island, New York. A typical suburban town. I went to elementary school, junior high, high school there through the public school system. Upon graduation from high school decided to attend the State University of New York at Buffalo for a degree in I wasn't quite sure what, but technical theater seemed to be the appropriate thing at the time.

Mullan: Technical theater?

Smithing: Tech theater. Correct.

Mullan: Which means the--

Smithing: The folks in the background that put the sets together. It was a degree that seemed to be a unique degree, but would enable me to pursue a pre-med curriculum at the time. Somewhere in my first two years--

Mullan: Let's step back and talk a bit about Queens, New York. I was in New York to begin with myself. What are Queens and Williston Park--is Williston Park far out?

Smithing: Williston Park is in about the middle of Nassau County. So it's certainly within the suburban sprawl, but at the time it was simply suburban community. It was not big city.

Mullan: What did your family do and what was your dad?

Smithing: My dad was a bursar at the Academy of Aeronautics, which was a technical college. My mom initially was a hausfrau, and ultimately became a secretary then administrative assistant, assistant treasurer in the Williston Park local government.

Mullan: What sort of youth was it? How would you characterize your growing up?

Smithing: It's a difficult question, one that I don't really want to discuss in detail.

Mullan: Brothers, sisters?

Smithing: One brother, one sister. Sister four years younger than me, and brother five years younger than me, both of whom still live on Long Island. She's a legal secretary, and he is a fire marshal.

Mullan: You went to high school in Williston Park?

Smithing: Went to high school in Mineola, actually, which was the school district that we were in. That was the next town over.

Mullan: I gather there was some connection to medicine. You mentioned the pre-med.

Smithing: Sciences were interesting and, of course, the traditional thing that you wanted your oldest son to be was either a lawyer or a physician at the time. So I was being pushed in those directions, not forcefully, but subtly. Science was definitely an interest, although I was dual tracking in the academic track and the vocational track in high school, and went through the vocational electronics, plus the regular academic track. Built my first computer while I was in high school. Didn't do much. It was an amazingly useless machine, but it could add up to 2047, if I remember correctly, in binary, which wasn't real helpful. But it was perhaps indicative of future interests.

But having graduated from high school, I did pick the State University of New York at Buffalo, which was within the state university system, so that it was affordable.

Mullan: Do you have medical experiences? Were you hospitalized, you were taken care of? Were any mentors, or role models, or

people that influenced you vis-a-vis nursing medicine, or anything else [unclear].

Smithing: No. An interest in emergency services, and that was evolving. I worked as a lifeguard during my high school years and my first couple of years at college. During that time became certified as an emergency medical technician. They were only beginning to develop the paramedic programs then. Did a fair amount of teaching related to First Aid and CPR, and was also part of a disaster action team for the American Red Cross. On Long Island they did have hurricanes. So we ended up being called out to do that sort of thing. Fire service was probably the biggest influence in terms of pushing me in the direction of emergency services, and pushing in the direction of sciences, but also just a general inherent interest in that sort of thing. I can't say what the trigger was to have made me want to go pre-med, but one always sets one's sights high, shoots for it, and that seemed to be the appropriate place to put mine.

Mullan: So you went to Buffalo.

Smithing: Went to Buffalo.

Mullan: How was it?

Smithing: It was great. A little cold, the winter. I was there during one of the major blizzards, but I really liked it. While

I was there, I did go back to Long Island and sat in on one of my friend's nursing lectures. Somewhere in talking with her and sitting in on this lecture, I realized that maybe there was a difference between medicine and nursing that I hadn't appreciated, and that it wasn't quite what it seemed on popular TV and in the popular press. That, plus some sabotage of an organic chemistry lab, where a partner and I would work on experiments together, split the unknowns, run them in parallel, compare notes, make sure we had done everything right. Perhaps we split them more because there were rumors going around that experiments were being sabotaged, and if you walked away to pick up a chemical, get a reagent, you had best have somebody watch your Bunsen burner, because if you didn't, you might come back, and things would be boiled away, which did seem to happen, more often than you would think could happen by random chance. Having completed organic chemistry, this side of it, I wasn't sure that this was the approach to the world that I wanted to take. And that perhaps the approach I wanted was not the science of disease, but more the caring for people who may or may not have illness.

That's what I think is the key differentiation between the professions of medicine and nursing, is that nursing focuses more on people who may or may not have an illness, and their responses to those health conditions, and medicine focuses on the science of the diseases, and the care of people with those diseases, which while certainly as a stereotype is a broad generalization, helped me to say that I was more of a people person than a

science person, and got me into nursing. Now, subsequently, I have to say that there's an awful lot of overlay, but if you've got to narrow it down to one, what's the difference there, I rather think that that may be the essential difference betwixt and between. Without a judgment of one being good or bad, both being essential, just if you're trying to figure out where you're going in your career that might be a way to look at it and decide where you want to end up.

Mullan: This happened in which year in college?

Smithing: I was a sophomore, at which point I changed declared majors, sort of got entry into the undergraduate nursing program, and ultimately graduated from Suny at Buffalo.

Mullan: Now, we're talking early seventies? Or where are we at?

Smithing: I graduated in June of '79, which means that this would be '78, '77, somewhere in '76.

Mullan: Did you do something between high school and college?

Smithing: No. I did spend five years in college, though.

Mullan: Because if you were born in 1956--

Smithing: Born in '56, graduated from high school in '74. Freshman year would be '74-'75, sophomore would be '75-'76.

Mullan: That works out.

Smithing: Actually, it would have had to have been my freshman year that I started thinking about it, and sophomore year that I made the change. Because in sophomore year is when I met my partner, who ultimately ended up as my anatomy teaching assistant, and after that semester was over, the following fall we got together, started dating, and ultimately got married. So I met my partner in the anatomy class. I had also met her prior to that in a pharmacology class aimed at first responders which focused at the detail of pharmacology of overdoses. It was probably a graduate-level course, but the people teaching it didn't think so.

Anyhow, my partner and I got together. That's a significant part of my history, because she's also a nurse, and also a nurse practitioner.

Mullan: She was not then, I presume. She was a student.

Smithing: She was a student then when she was a teaching assistant. She graduated from undergraduate school 2 years ahead of me, and from graduate school a year ahead of me.

Mullan: But she was headed towards nursing, too.

Smithing: Yes, as an undergraduate she was already a nursing student.

Mullan: How much stigma, or challenge, or issue was there for a guy going into nursing in the late seventies?.

Smithing: At the schools that I was in, none. It was certainly an interesting experience, made you very sensitive to feminist issues, but in terms of discrimination, there was none that I could identify. I suspect that had more to do with my instructors making sure that everything went for me as it would for any other student, and we had a fairly large contingent of guys in the class.

Mullan: This was at--I know I'm jumping in the story. You stayed in Buffalo, or you--

Smithing: Yes. Stayed at the University of Buffalo--the State University.

Mullan: No, actually, I'm confused, because when you're talking about the class, it's still an undergraduate. It's a bachelor.

Smithing: Yes.

Mullan: Both the BSN level.

Smithing: Correct.

Mullan: Once you declare a nursing major, then you're basically with nursing students exclusively, or largely?

Smithing: Not in the University of Buffalo. They believed that you stayed with your nursing students for your nursing core classes, but for everything else, all of the distribution credits--you could take some science classes that were health care specific, but not limited to nursing students. Or you could go for the regular sciences, which is what I had already done with organic chemistry, with undergraduate chemistry, with all of those other odd courses that you might take, because you like the sciences.

So my nursing classes, that time was spent with my classmates, but the rest of it was spent at the university at large, and that is a very large university, so we were quite intermixed.

Mullan: The clinical work, that was done clearly with nursing students--

Smithing: Yes.

Mullan: --at the university medical center?

Smithing: There was no university medical center in Buffalo at the time. We were distributed through a variety of local hospitals, local community health agencies, local what at the time were nursing homes, and ambulatory care centers. So we were spread out very much across the area.

Mullan: How was that?

Smithing: It was very diverse, which I think was ultimately helpful. I think the program that they had was extremely successful in preparing me to be as successful as I am at this point in time, because they did not focus--they focused on nursing where it was appropriate, but they forced us to look at other things.

One of the required courses was a course in deductive logic, which is certainly a bizarre course to start with, especially when you take it with engineers and mathematics types, and they don't have a clue as to why nursing students suddenly infiltrated this course and had to take it. But it gave you different points of view than you would have ever obtained if you had simply stuck with the traditional math and sciences that go along with a health professional career. They required courses in communication from the School of Communication, as opposed to being taught just within the department of nursing.

So where nursing was good, they taught it. Where there were other departments that were better, they had them teach it. Our physiology course was taught by professors of physiology, the

same professors who were teaching the different health professionals, and they targeted the courses for the health professionals that they were teaching.

Mullan: Tell me, I'm still working the deductive logic, and I remember the deductive-inductive. Deductive is where you start with a broad base of material and deduce from it a truth, whereas inductive you start with a little bit of something or no. Have I got that backwards?

Smithing: At this point I'm not sure that I could tell you that answer. As I recollected, deductive logic would be if A, if B, if A and B, then C. If I remember correctly, it was a set of rules where you followed from the smaller set, and then generalizing out, or not generalizing out, as it was appropriate.

Mullan: So the presence of you as a male was not really prejudiced, was the opposite the case? Were you given preferential treatment, either--

Smithing: Not that I can identify. We were treated the same as everybody else. The only difference that I can remember was that we were not offered the options of wearing nursing caps. Of course, nobody was required to wear nursing caps at that point in time, in that particular school.

Mullan: Were some wearing it?

Smithing: There were some who felt that that was an important part of being a nurse, part of that identity, and did, but they were the exception rather than the rule. But that's the only area that I can think of that there was any differentiation that was made.

Mullan: As you approached the end of nursing school, what sort of notion did you have about what kind of work you wanted to do? Where were you headed?

Smithing: Well, as I approached the end of nursing school, initially I thought that I would pursue my high tech, interventionist, emergency response background. As I got more into it, I found that there was this interesting piece called primary care. What was interesting is that it was diverse, that it was a focus that required generalists, and in all senses of the term, that's my approach to the world is as a generalist. I ended up learning more about that. My partner was also interested in that field. So we explored the options that were out there, ultimately decided that if one was going to go and become a nurse practitioner, if you became a family nurse practitioner, you had the option to practice with any of the population group that you wanted to, and there was always available additional education with the continuing ed, or through working with college preceptorships that could get you the additional content that you needed. But what it would not ever get you is solid grounding in the basics, which is what you

needed to build on. We felt that a family nurse practitioner program would be the best way to do that.

So in 1979, we moved to Philadelphia, and Maddy [Wiley] entered the University of Pennsylvania's family nurse practitioner program. At that point, the plan was that I would wait until she was out, established, and we could afford to have a second person going to graduate school.

Mullan: Were you married at this point?

Smithing: Yes, we got married September 9, 1978, two years after our first date.

Mullan: And before you graduated.

Smithing: Yes. Fall semester.

Mullan: You referred to her as your partner as principal issue, that that's how you approach marriage?

Smithing: It's how we approach life. But it's the only term that would adequately describe her. Plus there's some interesting biases that can arise when you refer to your spouse as opposed to your partner, especially when you're in business together. We have never hidden the fact that we're married, but we do enjoy watching people figure out that we're married.

To that end in our exam room, we have pictures of each other, pictures together, pictures holding our child, and it's remarkable how some people will pick up on that right away, and say, "Oh, that's Maddy. You guys must be married."

And other who will come into the practice literally for years, and years, and years, will not figure out that we're married, until at one point something clicks, they'll go, "How long have you guys been married?"

"Oh, let's see now. Sixteen years."

"Really?"

So it's interesting, and in terms of dealing with businesses and whatnot, it gives a clearer representation to the relationship than spouse would. Spouse wouldn't as clearly indicate that it's a full partner, and that's exactly what it is, it's a partnership, at home, at work, across the board.

Mullan: My initial hit was that this meant your partner was male.

Smithing: Aha!

Mullan: Because the term "partner" has been pre-empted, or at least broadly used, in the gay community because it isn't a wife or a husband, obviously.

Smithing: Right.

Mullan: And given the state of law, it's not a spouse in the original sense. So I'm most familiar when somebody says "My partner," I think same sex. You give new depth of meaning to it.

Smithing: There's that part of it, too. We do enjoy trying to break traditional stereotypes when we can, and demonstrate that you can't prejudge somebody just based on your preconceptions. Partner certainly does have that implication in some settings, although in a primary care setting it's what you have to say when you're inquiring, because you never know if it's same sex, different sex, they married, not married. What is going on here? It's a term that will cover all of it. So it certainly has multiple meanings, there's no doubt about that. Your point is well taken that--

Mullan: Well, your point is well taken. So we're back in 1979. She's entered the family nurse practitioner program.

Smithing: Right.

Mullan: At Penn?

Smithing: The University of Pennsylvania, correct.

Mullan: You go to work?

Smithing: I go to work. I'm working at a local hospital in a stepdown unit, and we had a difference of opinion on a required course. So I ultimately, because of that opinion moved into a different field, and worked as a community health nurse. Somewhere in there we had identified the National Health Service Corps as having scholarships available. So I applied for one and got a scholarship in the last year of that program at that time. That enabled me to go to school about a year and a half earlier than I would have otherwise been able to, which is really quite wonderful. I ended up, after completing the University of Pennsylvania's program, ended up working in Camden, New Jersey, at a public health service site there.

Mullan: [unclear]

Smithing: It was an urban inner city site. Camden at the time was in the bottom ten of the worst cities in the United States, and if you were to drive around the area, there were sections that looked like they had been bombed out, just burned out shells of buildings. That was the section we were adjacent to. Maddy actually was working in a small clinic a couple of blocks away, and I was working in a large clinic called Camcare, which was distantly related to Cooper Medical Center.

Mullan: It was a community health center?

Smithing: It was a community health center established in the area that had gotten some National Health Service Corps providers to come in.

Mullan: Which--

Smithing: That would be January of '82 through December of '83. We had two docs who were National Health Service Corps funded and myself. The two docs were both career, and I was fellowship payback, with no option to become career. Indeed, at the end of two years they said, "We can't renew you. You're out of here."

Mullan: Were you actually in the commission corps or in the civil service?

Smithing: Yes. No, I was in the commission corps. But that was just the way the funding was going at the time, they weren't letting anybody else come into the career corps. So it wasn't an option, which was a shame. It seemed like there would be some interesting places one could go, and people one could meet, and things one could do. But that's neither here nor there.

Mullan: What sort of practice was it? What were you--

Smithing: The clinic originally was a two-sided clinic with internal medicine on one side, pediatrics on the other side. I came in and functioned in family practice. I forget the exact

breakdown, but two or three days a weeks I would do internal medicine types of practice, adult care, and two or three days a week I would do pediatric practice.

Mullan: So you generally weren't seeing families together. You might see the same family, but different days and different sides of the clinic.

Smithing: Although, my staff was, and the head nurse that was there, the two of them used to roll their eyes at noon, and say, "Yes, I suppose we can find you an exam room to look at Mom." It was an experience. But I think that for the community, which was predominantly poor, many Spanish speaking, that a chance to get some continuity of care, and to get the clues that you can pick up when you take care of the kids, and the clues that you pick up when you take care of the parents, were helpful in putting together care for the family group. The teaching that you did when you saw the kids could be reinforced when you saw the parents for something else, and you could inquire and do that continuity of care stuff that we in family practice like to try to work into our encounters.

Mullan: Was it a good experience?

Smithing: It was a good experience, yes. Very good.

Mullan: Did you learn? Since your internship you--

Smithing: Oh, absolutely. Yes, it was. I was working with some terrific providers. One who was a doc at the end of his career, who never saw patients really fast, but was just an incredibly astute diagnostician, and was a terrific teacher, and could give--his clients knew that when he was in the room taking care of them, that was the only person that he was taking care of at that point of time. They had twenty people backed up outside, folks over in the hospital waiting, they were getting the care that they needed at that point in time. That's part of what he taught us was that type of focus, and that speed isn't everything. He was very good. Despite the fact that he was somewhere in his sixties at the time, he was still going back every five years for week-long review courses to make sure that he kept up with internal medicine, something that seems to be the exception rather than the rule. But his point was well taken. That's what you have to do to stay current is you have to go to continuing education, be it once every five years, or an extended course, or yearly. Then there was another doc who was the medical director who was one of the career Health Service folks, and he ended up trying to meet the medical needs of everybody who walked in the door. He was definitely the faster of the two. Also a good diagnostician, but probably not the same, certainly not the same approach to the world as Pete Lippencott [phonetic] had, who was the other guy.

On the flip side, we had the head pediatrician was a Public Health Service career doc, who was transferred out my second year that I was there. It was actually a big loss for the clinic. He

was not replaced by a Public Health Service doc, and the civilian doc took over had a clear dedication to the community, or he wouldn't have been there in the first place, but a different perspective on the world. It wasn't that it was a bad perspective, just different in terms of how one did things, how one ran things. There were two other civilian pediatricians, one a gentleman near retirement, who--

Mullan: There were only two other docs?.

Smithing: Two other Public Health Service docs. There were a number of civilian docs.

Mullan: Oh, I see. It was a big operation.

Smithing: Yes, it was, with, as you can imagine, all the administrative staff required to support that.

Mullan: Was it an efficient operation? Did the community get well served by it overall?

Smithing: I really don't have access to the data that I would need to make that judgment. I was a new provider at the time. Really, people came in, people were seen, people were taken care of. Did the community get all the care they need? I don't know. There wasn't any formal outreach to the community that I was aware of at the time, but--

Mullan: It was pretty much a medical model.

Smithing: Very much.

Mullan: Was the community board active?

Smithing: I'm not sure that there was a community board.

Mullan: So the answer was it wasn't very active. You didn't even know if it existed.

Smithing: Correct. Well, now, again, my focus at the time was on learning to be a clinician. I've gotten into administrative things subsequently, but at the time, it wasn't something near and dear to my heart. I'm not sure I would have noticed.

Mullan: I've leapfrogged over the nurse practitioner program. Let's go back a moment and just tell me how that was. Was that a year, year and a half? How long was it?

Smithing: It was four semesters, but we ran through the summer so that we got out in about a year and a half. It was a master's of science degree, and it focused on clinical issues rather than academic issues. The minimum required time for clinical experience during the week was about two-and-a-half days, and more than that would be good. You were not expected to write a thesis, you were expected to do a series of smaller documents to

teach you the appropriate research related skills that you might need, and you did your research on a data base that was set up that enabled you to avoid the time-consuming necessity of going out and picking up the data. You learned about designing tools and that the implementation was done on a data base.

Mullan: So there was a fairly heavy academic component to this.

Smithing: It was, but it was set up so you could focus on the clinical and still meet the academic requirements. It was clearly focused on the clinical elements of being a primary care provider, rather than focused on academic elements. The best I can tell it's not to its detriment. I think that it is one of those programs that one would do well to emulate. I see a lot of graduate students spending an inordinate amount of time collecting data for a research project that would be better spent doing other things.

Mullan: It was a short tack from the stuff you had to do to do research from the ground up. For learning purposes it's fine.

Smithing: Right. I mean, I don't think that we have to clean all the glassware to know that we need to have clean glassware. Years ago that was one of the things that was done.

Mullan: You had a year and a half there. You felt it prepared you pretty well?

Smithing: I don't think anybody coming out of a program feels that they are prepared really well at the time. I think they're scared to death that they're going to make a mistake and that they're going to do inordinate harm despite the fact that their teachers don't feel that way, and I think it's only on reflecting back after several years of experience that you can make a judgment as to whether or not your were prepared adequately in a program. I'm just not convinced you can make that judgment ahead of time.

Mullan: Looking back on it are you pleased?

Smithing: Looking back on it, I think that we were well prepared, and at the time I graduated I was less than enthused with the program because I felt that we didn't get as much as we needed. The reality is that they couldn't give us as much as we needed. You never can. But what they gave us, again, were the basics that you can build on. The skills that were required to get additional information, the skills that were required to evaluate the information sources that you were looking at, that reading *People* magazine is not a good source for your latest medical information and, indeed, part of our curriculum was taking and analyzing studies to see if this is a study that you want to base clinical changes on, or you really want to question how well the study was done. Did I get as much on the day-to-day management of common primary care concerns as I would have liked? No. But again, I think that was a function of time.

Mullan: Did the next National Service Corps assignment help that? [unclear] fair amount of experience.

Smithing: It did, and it did. I think that it was a function of experience that I needed.

Mullan: So what happened next? Although you might have considered staying with the Public Health Service, that wasn't an option. They weren't--

Smithing: It wasn't an option. The group that we were with, Camcare, wasn't hiring, money was an issue, so when National Health Service Corps folks left, there wasn't replacements that were available. So I left and my position went unfilled for about a year and a half, and then they found a nurse practitioner to put in there. They did in my second year there, actually, get in a public health nurse from the National Health Service Corps as well. She stayed for a few years and then left.

Mullan: What did you do?

Smithing: What did I do? I went back over to Philadelphia and started looking at what we wanted to do. Took a job, very briefly, at an HMO. The position that I thought I was hired for, and the position they thought I was hired for, were two different positions. They wanted me to work as an urgent care clinician without any continuity of care. I was looking for continuity of

care, and carrying my own caseload of clients. We decided that this wasn't going to be working. Subsequently, I went looking for different employment.

Mullan: What did you do?

Smithing: Looked at the possibility of setting up a practice in Pennsylvania. While I was doing that, taught part time at a School of Nursing, found that while the laws would allow you to practice in the state of Pennsylvania, you were required to have a doc as a consultant, which actually wasn't a difficulty, until we sent off the inquiry to the malpractice company.

They turned around and sent back a letter saying, "If you do this we'll cancel your insurance."

Further querying, they backed off of that position and said, "Oh, we've made a mistake. We're sorry. We can't do that."

Both the docs that we had gotten, they said that they would work with us were spooked, understandably so, and so that fell through. As a result, Maddy, who had lost her position because her clinic was funded by the city of Camden, and it was staffed from multiple agencies. The visiting nurses in Camden provided the nurse practitioner. Well, the city administrators really couldn't understand why they had this high-priced nurse there when they could hire an LPN for much less money. So they let her contract go, and she worked with the Visiting Nursing Association filling and at some pediatric clinics in Philadelphia. But we decided this was not where we wanted to be. This was not what we

wanted to do. It was too hot, it was too humid. Let's go find a part of the world we were interested in, and we moved out to Seattle.

Mullan: This would have been '83, '84?

Smithing: This would have been in 1984 that we made that decision, and we moved out here arriving on December 31, 1984. Spent six months up in Seattle while we figured out where we were going to live and where we were going to set up a practice, and in July of '85, opened up our family practice in Kent.

Mullan: This was the continuation of the concept you had of an independent nurse practice?

Smithing: It was actually the continuation of a concept that in the traditional medical model you were very constrained from practicing as a nurse practitioner would like to ideally practice. The only way that we were going to make progress is to demonstrate that the model would work. The model was that where you integrate health promotion, where you integrate teaching, counseling related to primary care issues, where you got a real family practice. We could not find a practice that was looking at primary care in that manner, and at that time that really wasn't the way primary care was being looked at. So we decided, "Well, let's try it on our own." We decided further to, "Let's set this practice up in a competitive, suburban community,

because if we can make it work there, it can be made to work anywhere.

Just one of the issues being thrown at nurse practitioners was, "Oh, yes, people will like you in a rural setting where there's nobody else, but will they like you where there are doctors around."

The answer, "Yes, they will." But nobody had demonstrated that.

Mullan: Was there a model or someone who was doing this in Pennsylvania or elsewhere that you were sort of keying off?

Smithing: There was in Canada a proposal, and I think it came out of McGill University, but I very honestly can't recall, that I read during my undergraduate time. It was a little article on nurse-managed center. I'm not sure if it ever got off the ground. But that was probably more of what it was modeled off of than anything else. There's no one specific practice that came to mind that I could say, "This is how it should be. This is what this person is doing." But rather the concept of, "This is what nurse practitioners are educated to do. This is the way that we want to practice," that were not able to practice that way in general, the way the health care system is right now.

[Begin Tape One, Side 2]

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

Smithing: We weren't able to practice the way that we wanted simply because the system didn't know what to do with us and wasn't set up that way.

Mullan: There are, I'm aware, in more recent years nurse managed clinics here and there, but at the time there really weren't any that you were keying off, or had worked in.

Smithing: Hadn't worked in any. Had worked out the concept of them with another nurse practitioner that Maddy and I knew back in Philadelphia. But it was not--no specific practice. I think there were probably, there was some discussion of it in the literature at the time, and we may actually have met some folks that had talked about doing it, or knew somebody who might be doing it.

When we came out here to look for positions, we did bump into some nurse practitioners up in Marysville who were running urgent care clinics.

Mullan: Marysville is--

Smithing: Marysville is a small city, large town, about forty-five minutes north of Seattle. These two NPs had been staffing the emergency room of a small little hospital, but ER docs who were looking for some new hospitals came along and underbid them. So they got the business. So these guys were left without a place to go. So they set up some urgent care centers and

ultimately developed a chain of urgent care centers that also subsequently began to deliver primary care.

Mullan: Nurse-managed urgent care.

Smithing: Well, they were nurse-managed to start with, but they did on occasion hire physicians when docs were willing to work with them, and when there was enough of a demand to add additional providers. So they would also work with PAs. They weren't looking for a pure nurse-managed center, they were looking for a way to deliver quality urgent care when it was needed.

Mullan: At the time you moved to the state of Washington, were you aware of the status of laws that were [unclear] the scope of practice?

Smithing: Absolutely. Washington was one of the States that allowed NPs to practice independently.

Mullan: Was that a factor--

Smithing: Absolutely.

Mullan: --that this was an environment in which you knew you had--

Smithing: Yes.

Mullan: --a good shot at doing it?

Smithing: Yes. We moved to this state because we assessed, at the time, that it had the best laws anywhere in the country, with the possible exception of Alaska, and if we didn't like Washington, we would go look at Alaska. But we had some friends out here, and thought it was a wonderful part of the country, and so decided to come out here and settle.

Mullan: So what happened ultimately? Opened the doors [unclear].

Smithing: We came out here. Maddy worked with Group Health establishing their geriatric nurse liaison service which went out and serviced the Group Health nursing home patients. I worked for about a year at Country Doctor, which is a small inner city clinic up in Seattle. We renovated and opened Health Connections, which was the practice.

Mullan: Which was your practice.

Smithing: Which was our practice.

Mullan: In Kent.

Smithing: In Kent. I worked there solo until the practice established--

Mullan: Tell me more about Kent. What sort of community is it and why did you pick it?

Smithing: Why did we pick it? It has a good school district. It seemed to be a community with nice people in it. From the sense that we could get from driving around and talking to people and interacting with people, it did not have the traffic congestion north of Seattle, nor did it have the--it's a different milieu. It's a different--

Mullan: What sort of community? Is this a bedroom community?

Smithing: Well, yes and no. It is a bedroom community of Seattle more than Tacoma, but it has its own base of industry at this point, and that was where it was developing at the time. Yet, there are segments of this community that is still a farm community. It's very much a small city, and very much a small town. It's Kent.

Mullan: Did you check out the medical community at all before coming? Was there a sense that this was a community in which you could function better or not?

Smithing: Washington was a state in which we could function better. There was no clearly identifiable overt animosity that was identifiable. It's not that it wasn't there, it just wasn't identifiable at that point in time. We knew that there would be difficulties no matter where we settled. We also knew that you've got to get into a system to start to try to change it. At that point--

Mullan: You started to tell me about the practice. You started on your own.

Smithing: I started on my own.

Mullan: How did you present yourself? What kind of shingle did you hang out and what--

Smithing: I hung out the shingle as a family nurse practitioner doing family practice with an emphasis on health promotion and health counseling. People didn't have a clue. So we went back to family practice and introduced them to the concepts of health promotion, health counseling, as we took care of them. People were surprised that we would do teaching--not unpleasantly surprised. They liked it. They were surprised that we would teach them about peak flowmeters, and surprised that we would not only teach them about their asthma medication, but expect them to know their asthma medications and to begin to identify what it is you do if your asthma's getting worse. What medication do you

reach for? How do you do it? There was a great deal of influence from a doc, a pediatrician, and I think he's in Amherst, Massachusetts, Thomas Plaut. He's done wonderful work on managing kids with asthma, which is as good with kids as it is with adults. I heard him talk at an NPACE conference. That's where that came from. But he's got very much nurse practitioner orientation to that sort of teaching, which clearly indicates that it's not specific to NPs. But I think is what's needed in primary care.

Mullan: Did you need a physician backup or consultant or not? How does that work in Washington?

Smithing: I don't think there's anyplace in the country that primary care providers don't work without backup and consultation of specialists. In our case, the specialists were generally physicians. But there wasn't any requirement in the state of Washington for a paper contract, which makes it actually much easier to get up and running and get started.

It also enables you to earn your reputation when you send patients into a specialist and say, "I'm sending this person to you for thus and such a reason."

They go back and say, "Yes, you were right."

You do seem to know what you're doing after you've sent them several cases like that, so that you can require a reputation of knowing what's going on.

Mullan: Was the medical community receptive to your consults?

Smithing: Some were, some weren't. There were those that asked their patients why they wanted to come see us, and said that they should go find themselves a real doctor. They never went back to that specialist. Patient's choice, not ours. They had chosen their primary care provider and they were very comfortable with them. We never referred to that specialist again, although we would normally try to reach out and endeavor to talk about this, but--

Mullan: Some were receptive.

Smithing: Several very receptive. Some reached out and tried to help, judging us not on our professional degree but rather on how we cared for our clients and what we were trying to do. Part of what we were trying to do was to set up a practice that, one, was--we had both been in the public sector and knew that funding was just abysmal there. So we felt that setting it up as a non-public sector clinic would work better, because there would perhaps not--if it was self-sustaining, you wouldn't have the vagrancies of funding, which means that you could continue to provide care for that community. That was an important issue.

Issue two was that you have to take care of the medically indigent.

Mullan: Indigent.

Smithing: Thank you. Dyslexia is coming through again. As a result, we were one of the few providers on the East Hill of Kent for ten years that took medical coupons, which is the local--

Mullan: Medicaid?

Smithing: Yes. Exactly. Our referral patterns reflected specialty providers who would take Medicaid patients. If you would only take our insurance-covered patients and not our Medicaid patients, you wouldn't get any of our patients. However, if you would take both sets, then we would refer to you. I know that we were able to influence some specialists, if not to open up to the Medicaid population as a whole, we were able to influence them to open up to at least the Medicaid population that we saw first, and said, "Yes, they really needed to see a specialist." So were able to get them some access to care that they wouldn't otherwise be able to get. That was important to us. We did not refer to folks that would only take our insurance-based patients.

Mullan: How did your practice develop? Who came and what sector?

Smithing: We developed, I think, much the same as any other practice develops. You initially start with folks who have tried everybody else in the area, and here's a new person who might give them narcotics. But you learn about those real quick. Then

you get the folks that just have not really connected with anybody, or folks that are new to the area, or, in our case, a lot of folks with Medicaid, because nobody else in the community would take them.

Mullan: What percent of your practice was Medicaid?

Smithing: It generally ran about 50 percent. They, as a whole, are a challenging group to deal with. As are our insurance patients, as a whole, a challenging group to deal with. It's just different types of challenges.

Mullan: How did insurance work in terms of reimbursing?

Smithing: Well, one of the nice things about the state of Washington is a law that says, if an insurance company covered a procedure or a visit, and it would be paid if performed by an MD, then if it was performed by a nurse within their scope of practice, they had to pay for that, too. So you couldn't discriminate based on licensure.

Mullan: What did it mean "within the scope of practice"?

Smithing: If an RN was trying to treat strep throat and prescribing medications, that would be outside of their licensure, so outside of the scope of practice. That's not something that the insurance company would have to cover. But it

wouldn't be an issue, because they would lose their license. We have a very--I don't want to say aggressive, but we have a State Board of Nursing that makes absolutely certain to the best of their ability, that all nurses practice the way that they should.

Mullan: Treating strep throat is outside of the scope of a nurse practitioner?

Smithing: Not a nurse practitioner's practice, but a registered nurse's practice.

Mullan: Right.

Smithing: So in our state we have a second licensure we have to get as an advanced registered nurse practitioner. The way the law was written, an RN could get paid for diagnosing, treating, and prescribing for strep throat. But since that was not within the practice that they could perform, they wouldn't get paid for it. And indeed the Board of Nursing would get real cranky about it.

On the other hand, diabetes education, if covered, is within the scope of a nurse who is a CDE, and they could be covered for that.

Mullan: The advanced nurse practitioner degree license, once obtained, gives you an expanded scope of practice.

Smithing: In this state, that's the way that they phrase it, yes.

Mullan: That would allow you to perform and go for the diagnosis and treatment of strep throat, for instance.

Smithing: Right.

Mullan: Would it allow you to do sigmoidoscopy? How is the line drawn?

Smithing: A subject of some controversy, with the Washington State Medical Association having a very different viewpoint from the nurse practitioners in the state. The line is drawn legally in that we can perform--we can do diagnosis, treatment, prescription writing, although prescription writing is actually an additional licensure on top of the ARNP. We can perform minor surgery, which is not defined in law. There is one more--we can prescribe only up to classified narcotics. We can not prescribe classes two through four, which is fascinating. I can give somebody medication that will kill them in a flash, but I can't relieve their pain with Tylenol with codeine. The stated issue, of course, is concern about controlled substances, addiction, etc., etc., etc., which are concerns certainly that are very, very valid, but it's being played out in a political environment. We've been fighting to get that changed for six and one-half years now, and have been blocked left and right.

Mullan: The scope of practice boundaries are covered, at least in theory, by the state ARNP certification, but where those boundaries are drawn precisely is a little bit open to nurse practitioners' experience and what the payors will reimburse for?

Smithing: What our boundaries are is not what the payors will pay for. It's the law is open enough to allow for different types of experience, different preparations, and it allows you to do what you're capable of doing. For example, if you were an adult nurse practitioner, then you wouldn't be doing well child exams. That would be outside of your scope of practice. You won't find that in the law anyplace, but the law does refer to your scope of practice by your certifying body.

Mullan: That makes sense if you're involved [unclear] with your pediatric nurse practitioners. If you're a family nurse practitioner, and if you follow in the shadow of a family physician, who in fact follows in the shadow of medical licensure, which is sort of nuts, you're licensed to practice medicine and surgery, which means if the patient will let them do it to them, you can do most anything. That's where our situation [unclear] has been, for better for worse.

Smithing: Right.

Mullan: But again, being in that line of command, or that line of authority, the adult registered nurse practitioner, in theory,

it would seem to me, and I'm just asking to learn, to understand, would be in a position to practice such things as he or she felt were established competencies in their training, or in their experience. It's not a list of things, you can do this, this, and this, and you can't do that, that, and that.

Smithing: That's correct.

Mullan: It's individualized. The definition of the individualization is somewhat in the hands of the individual of the practitioner, him or herself.

Smithing: Correct. And their peers who would review them should the issue arise.

Mullan: Realistically, in terms of your own practice, how are those boundaries set?

Smithing: Realistically is we took care of folks in the out-patient setting, and we ultimately--we had to expand our skills. We found that it was difficult to get our Medicaid patients in for specialty care. We found that people would bring their, typically, their kids into the office injured with a laceration. We'd have to say, "Well, we don't lacerations." Or they would have a lesion that would need to be removed.

The program we had gone through did not cover procedures. In the state of New Jersey, you didn't do procedures. So that's

a skill we had to obtain, and we did. We recruited a surgical nurse practitioner to teach suturing, wound management, lesion removal. We got her to teach that, and to this day, she teaches it twice a year up at Bellevue Community College. We, Maddy and I, taught with her for--I guess, me more than Maddy--taught with her for a number of years, and now Maddy and I teach suturing and wound management. So we developed that area of competency, because it's an essential element of primary care. Probably more so for the removal of lesions to evaluate what they are than anything else.

So that was an example of we came into the state, it wasn't something that was within our scope of practice because we didn't have the knowledge to do that. By obtaining the continuing education, and since this was a colleague of ours, talking her into coming down to the office for several days and precepting, or scheduling things so that she could come in and precept us with hands on until we had mastered techniques. We were able to gather the skill, and add it to our scope of practice.

Mullan: Was that done in a formalistic way with the State Board?

Smithing: There's no formal way to do that with the State Board.

Mullan: But you knew you had documentation should t he issue arise now that you had this training.

Smithing: Yes. We had the training and we had the precepting. For some of the hands-on stuff, the education--

Mullan: Do issues like that arise?

Smithing: Yes.

Mullan: By insurance companies, or by docs, or by patients? Who?

Smithing: Anybody can raise them. The State Board of Nursing is one that is inclined to raise the issue. It's not uncommon for nurses and nurse practitioners in the state to be called in for review. Insurance, as a secondary, can also call question on that.

Mullan: For instance, when you started billing for suturing, did anybody raise any questions?

Smithing: No, they didn't.

Mullan: Are there areas in which insurance companies chronically have raised questions?

Smithing: Insurance companies raise questions anyplace they can, in order to avoid paying their bills in anyway way that they can. One of the reasons we sold our practice was that you never knew

what was going to get paid for. It was becoming more and more difficult to get a straight answer out of an insurance company. They would change the rules on a regular basis, and they can withhold payment four or five months just because they didn't get around to it, and there was nothing you could do about it. But if you didn't bill in the appropriate time frame, you weren't going to get paid.

Mullan: Certainly, these are issues that physicians as well as nurses--

Smithing: Yes.

Mullan: --are suffering with insurance companies these days. Did you have a sense that there was anything discriminatory in regard to your practice? That is, they were giving you a lot higher, harder or more arbitrary standards?

Smithing: Initially, yes. Initially, some of the local insurers would refuse to pay us, and then state law was presented to them and they would pay us but begrudgingly. They wouldn't let us become part of their provider panels, and then ultimately they decided, in part, I think, because one of the large local employers had a number of employees who saw a nurse practitioner and brought some pressure to there, although we can't clearly verify that, we could become preferred providers with their group, or their initial stance was, "We'll pay the nurse

practitioners as if they were preferred providers, but we won't let them become a preferred provider, meaning we don't have to list them in any of our brochures."

The ultimate outcome of all of this, was that they developed a special program where they look at in-house statistics, they look at outcomes, I presume, they look at all of the interesting things to insurance companies, and create a list of cost-effective providers. That list of cost-effective providers has an over representation of nurse practitioners in it. If you based that on the total number of providers in their preferred provider book, versus the total number of providers in this--

Mullan: Nurse practitioners are overrepresented.

Smithing: --other program. Now, one could argue that we simply don't spend the money, and we don't do all that needs to be done. Those that were not in the program were arguing it was just because we didn't--the people in there weren't good providers. It didn't matter, doc, nurse practitioner, weren't good providers, because they didn't [unclear] they were. Yetta, da yetta, da yetta.

Those of us in it felt that we were clearly competent providers, we just were cost effective. We wouldn't order a CT scan because somebody had a hand that was achy. On the other hand, if we couldn't figure out what it was, and you needed high tech, then high tech is what we would order, because that's what was indicated.

Mullan: Did you order CT scans?

Smithing: I have ordered CT scans; I've ordered MRIs; I've ordered some very expensive testing. Initially, when they were first available, one would order them after consultation with a specialist. Ultimately, you would figure out that, "Okay, this is now a primary care thing. This is the criteria for when you're going to do this." Sudden onset of an unexplained headache, worst in a lifetime, no prior history of this, it may be the first onset of migraines, but you had best rule out some sort of intercranial process there. So for that you get a CT scan.

Previously what we might have done is sent them to a neurologist. Interesting, the neurologist now doesn't want to see them without a CT scan in hand, because if there's nothing there that's going on, and there's no neurologic happenings, they don't want to see that patient. They've got other patients they've got to take care of. So some of it we have taken on because the system has changed, and it's something that primary care has to do, and some of it we've taken on because our clients needed that service.

An example is colposcopy. Getting our patients on Medicaid into someplace that would do colposcopy at one point was a six to eight-month wait, which seemed excessive to us. If for no other reason than the anxiety that this could conceivably provoke. This was at the time when Pap smears were still being reported in the old class one, class two, class three. So you really didn't

have a lot of information other than class three pap smear. What is going on here? We don't know.

So again, went out and found continuing education programs. Went into an office where they did colposcopies, brought in fifteen patients, or five patients, or whatever you could get into the schedule that day, and did your colposcopies in a preceptorship. Only instead of referring the patients in, you now came in with them, until you became adept at doing that. Colposcopy has become a primary care procedure.

Mullan: So you'd have you and you partner do them, or they'd come in and practice?

Smithing: Yes. We still have a practice, and we still do them.

Mullan: We need to get that [unclear]. Let me ask on other thing on insurance companies we were talking about. Were Medicaid and Medicare more even handed with you than the commercial insurers or not?

Smithing: No. Medicaid initially--in this state, Medicaid has always chosen, for as long as we've been here, have chosen to pay us. Initially they paid us at 85 percent of the rate that they paid physicians. That was somewhere around 30 to 40 percent of the rate that they were billed at. Nurse practitioners made the case that you're not paying cost in some instances, you might as well reimburse both groups equally. It would be the reasonable

thing to do. The medical director at the time, and the folks that were involved with the administration at DSHS which administers Medicaid in this state, agreed, and made that change. Initially, when Healthy Options, which is a waivered program in this state to make Medicaid into a managed care system, initially they were not clear on their desire to include nurse practitioners in that. We advocated for this in many, many meetings and, indeed, had a nurse practitioner sitting on the advisory group who oftentimes went head-to-head with the then president or past president of WSMA, the medical association, and some of the insurers over the issue of nurse practitioners, and should they be allowed to be primary care providers in the system or not. We did win that one and were able to be primary care providers.

As a general answer, usually they treated us similarly to the way that they treated docs, but there are some notable exceptions that required some finessing, which is the nature of life.

Mullan: How did the practice develop? You had it from 1985--

Smithing: From 1985 through 1996.

Mullan: More than a decade. Was it just two of you or were there others?

Smithing: No, actually for many years we had a third nurse practitioner in the practice. One of the challenges of going into practice with your spouse is that it's very difficult to get away and take a vacation together if there's only two of you. What we were able to do when we were smaller was to have somebody come in as a locum tenens. But as we got bigger, we needed to have somebody there who knew the patients through the process. We hired a third nurse practitioner. I believe that our first one was somewhere around 1989, 1990.

Mullan: How do you measure the size and the growth of your practice? Do you do it in patients or revenues?

Smithing: We had an active caseload of approximately 4,000 when we handed off the practice. That's the charts that were active in the past two years. We actually had more folks that--adult guys don't tend to come in for health care a lot. So we had a number that were considered inactive, but if they came in for health care they were going to come into us.

In terms of income, well, our third nurse practitioner took home a competitive salary, my partner and I did not. It's the nature of a small business. It's not necessarily the nature of the practice we chose to make sure that our staff got paid competitive wages, because we felt that was a very important thing. We figured that ultimately it would catch up.

It was growing nicely, growing very well, and then health care reform came along. One of the things that happened during

health care reform was some of the insurers decided not to pay for several months. They just didn't pay, which wreaks havoc on one's practice, capital reserves, forces you to get loans in order to continue to provide the care, because you've got the money there in receivables, but it's not coming in the door. Large insurers can do that. There's nothing you can do about. They did not discriminate against nurse practitioners in doing this, they did it with every practice that was out there. We talked with docs, both primary care and specialist, and it was happening across the board. They were just sitting tight and seeing what happened. Then there was a shift to managed care, Healthy Options, which was not as devastating immediately, but had long-term problems, because the way that the law in the state of Washington was written, nurse practitioners were not mandated access into any managed care programs. They weren't around at the time the law was--

Mullan: Healthy Options is a euphemism for Medicaid managed care.

Smithing: That is the name of the program in the state. I don't know that I'd call it a euphemism.

Mullan: But for that, one had to be then an enrolled managed care provider.

Smithing: Correct.

Mullan: If you weren't an enrolled managed care provider you'd lose patients because they had to go to someone.

Smithing: Correct. That impacted both docs--it probably impacted docs more than nurse practitioners, because if you were a doc with just a couple of Medicaid patients that you were following, many of them chose not to go through the process to become a managed care provider. Many of them didn't even know you had to do it. There were all these rules related to, if you didn't see your primary care provider, and they didn't authorize a visit, you didn't get paid. Initially, the insurers were absolutely adamant that there would be no retroactive--after a certain number of months of allowing for learning curve, you didn't do any retroactive authorizations for care. If somebody did not come into your office when they had a corneal abrasion that was something that could be handled in primary care, and instead went directly to a specialist, didn't call your office, didn't come in, then what would happen is that that payment would be denied. The insurers were saying, "Deny them. There's no leeway here anymore."

Now, two years later, we've got some patients saying, "Wait a minute. I didn't know about this. Explain why you denied this primary care provider? Why was this your policy?" It wasn't my policy. I would have authorized the darn thing. However, this was the policy of the insurer at the time. Those changes created a great deal of challenging times for those in primary care.

The promise to those of us in primary care was that this would impact specialists. There would be lost income on the specialty side that's really not going to impact the primary care side. Indeed, you might even earn more money. We had our doubts. I think that in actuality they were right, that if you managed your caseloads, you didn't have adverse selection, you had a large enough size of a caseload, so that one catastrophic patient wouldn't wipe out the reserves, that primary care providers could do well, especially if they did not treat in an episodic mode, but looked to take, for example, your patients with diabetes or with asthma, teach them the management strategies they need to keep them well, keep them out of the hospital, could make them do as they could, that it would pay off in the long term. But getting to that long term was very challenging, because the feds were unwilling to grant a waiver to the state that would keep people in a practice for more than a month at a time.

Mullan: In other words, the standing Medicaid policy is that a patient can switch providers monthly, and the waiver was the state wanted some policy in effect where that kind of switching and swapping couldn't go on, but you didn't get the waiver.

Smithing: Right. The request was for, if I'm remembering it correctly from the committee meetings, the request was for six months in a practice, but if you got in there and found that it wasn't the right place, you could switch once in a month. So you

could make a second choice, but you'd have to live with the second choice.

Mullan: That didn't go through.

Smithing: No, it didn't. As a result, there were some clients that would benefit from having continuity of care, and one provider coordinating that care who jumped from practice to practice to practice. Most folks didn't do that.

Mullan: For the sake of sort of getting sort of onto the business at hand as it were, eleven years starting management practice went pretty well, not really a financial bonanza, but adequate, but a lot of work, I'm sure, went into it. A lot of [unclear], so forth. What happened then?

Smithing: We realized that the way health care is today is not the way health care was eleven years ago, and that in order to do what we wanted to do, which was to practice, we needed to make some changes. We were spending more and more time arguing with insurers, dealing with contracts, doing business administration. Insurers were more and more wanting to contract only with larger groups. They didn't want to deal with a practice of three people. They wanted to deal with thirty-five people. Faced with a larger move into managed care settings, where if you weren't part of that system you would get patients who would say, "I'd like to see you but I can't afford to," who you may have followed

for five years, whom their company would change insurance plans on them once, and then change it again and change it again, and they might come in and go out.

Mullan: Given the adverse and worsening environment, you did what?

Smithing: We sold the practice. We looked at and negotiated with a number of potential groups. We were looking for a place where we could continue to provide the type of care we had been providing. We were looking for a place that--

Mullan: Looking for a place, looking for a purchaser who would continue to provide the same kind of care.

Smithing: The intent was not to leave the practice, but rather to find a home within a larger institution for that practice, in all likelihood with more providers, so that there could be some shared--make vacations easier, make coverage easier. It would make on call easier. For most of the time that we were in practice, we were on call one out of three weeks. When you're married to your partner, that means two out of three weeks, which is a lousy call schedule. The good news is that we didn't often have to go into a hospital. So it was mostly phone call.

Mullan: Did you have privileges?

Smithing: That's a whole other interview. Succinctly, yes. If you want to go into it I'd be more than happy to do that.

Mullan: I'd like to, but there were places where you could see your patients on an emergent basis?

Smithing: We did have privileges where we could go into ERs to see our patients, although it got to the point where most of our patients that ended up in the emergency room either needed to be there, and needed the expertise that ER providers bring, or weren't really our patients. They just picked us out of the phone book and said, "Oh, Health Connections. That'll work." Somebody we'd never seen, and they went in for a URI in the middle of the night, which managed care helped us move over. We had occasional patients that needed the continuity of care, and those are the ones that we would occasionally go in to see.

Mullan: So anyway, you were looking for a purchaser who would allow you to continue to practice as you had, or continue in the practice.

Smithing: As practices go, we were actually a very successful practice. We had a superb reputation, a reputation better than many of the other local providers, and part of that reputation was that we would not put on our door, "Left for vacation. Go to the ER." Which apparently some folks at Auburn like to do. So yes, we were looking for a whole--

Mullan: Who were the suitors?

Smithing: The suitor that won us was Valley Medical Center. Interestingly, an institution that wouldn't consider, historically, working with us for hospital privileges, an institution whose Valley Radiology initially refused to take our orders, although they were valid legal orders for X-rays. We subsequently found a different radiology group which was very good, because the radiologists were just superb. With a note of irony, Valley Radiology did subsequently years later come courting us to get our X-ray business.

Mullan: Valley Medical Center is the local hospital?

Smithing: Yes, they are.

Mullan: They're buying up practices and you're not the only one, perhaps.

Smithing: Ours is not the only one. Ours may actually have been the biggest primary care practice that they've purchased, although I can't say that with certainty.

Mullan: So what kind of range [unclear] with you?

Smithing: They purchased the practice and some of the equipment that went with it. They got our patients. They put us on a

standard provider contract. We may be the only two nurse practitioners in the system with a provider contract. We are now practicing on a par with three family practice docs at Valley Medical Center Kent.

The precipitating cause of this may have also been the fact that they were building this thirty-exam room clinic across the street from our practice. The likelihood of surviving that with a Group Health Virginia Mason office having gone in down the street, PacMed, another local HMO coming into the area, Kent Medical Center, a large local provider down the hill, and being there.

We've always said that if we were going to change something we had done, what we would have changed was going to a competitive suburban setting to demonstrate our viability. Next time we would pick a place with less competition. It worked, but it was not the best of the business decisions.

Mullan: Right. Well, the competition, too, has changed over the decade, because there are more docs in the field, and the system is squeezing down on practitioners in a way it hadn't before. So what was a good business decision, or reasonable business decision in 1985, given the evolution of things, which by the way is happening in the outback, too. Having just come from Alaska, things are getting tighter in communities that were praying for docs a few years back.

When they purchased you, your patients become theirs, you go to work for them,.

Smithing: Right.

Mullan: Do they actually--

[Begin Tape 2, Side 1]

Mullan: This is Bob Smithing, tape two, side one.

When they purchased you, they actually offer you a premium? How does that work?

Smithing: When they did a practice acquisition, they're a public hospital district, and apparently there are constraints on how they do this sort of thing. They paid us for our hard assets, and paid us for our charts, and that was all we got paid for. There was not--

Mullan: When they pay you for the chart, it's sort of a had fee--patient fee? I mean, they're not just paying you for the paper. Well, actually, part of it is that they're paying for the paper, the physical record. It may also be thought of as practice good will that's being purchased. I believe that the health care administrators have some verbiage for what this is, but I can't, off the top of my had, I don't know the appropriate terminology for it. My understanding is that in comparing notes with others, that we have done about as well as can be expected given the current health care economic environment.

Mullan: Well, you have continued to practice.

Smithing: Yes.

Mullan: Seeing your same patients, or some of your same patients in any event?

Smithing: Right.

Mullan: In a different setting. You've moved into the hospital constructed facility?

Smithing: Correct. We're in a brand new facility that was put together. We're merging two practices--a family practice that was started up several months before the facility started, plus our practice. Currently, there are three family practice docs, which is about two FTEs, and three family nurse practitioners, which is about two FTEs, and an internal med doc, and the plan is that there will be a different pediatrician rotating through the clinic every day, Monday through Thursday, which ought to be quite interesting.

Mullan: You've started in that practice?

Smithing: We've started in that practice. Yes.

Mullan: How long have you been at it?

Smithing: The transition was July first.

Mullan: So very new.

Smithing: Very new.

Mullan: How is it going thus far?

Smithing: As well as can be expected. One of the reasons that they were interested in acquiring our practice is that we collectively have a great deal of experience, both clinical and in practice administration. That was perceived to be of benefit, and one of the reasons why there was a great deal of interest. The implementation of that is not going quite as smooth as we would like. That is probably true of any new merger of groups, and on a day-to-day working with the other providers, it's just fine. The problems that are there are universal to the provider population. We've all got the same things we want to see fixed and changed. The providers we're working with are new out of their programs, one to two years of post-residency experience, and don't have the practice administration background. That's perhaps where some of our--we perceive some of the biggest challenges is in how one sets up and administers a system like this. But our role is clearly not an administrative role.

Mullan: The Valley Medical Center's handling that ultimately, right?

Smithing: Yes. Were clinicians. That's what we do. Our input is accepted and hopefully, at some point, will be acted on.

Mullan: I want to come back and ask you some sort of overview questions about your experience, but let's just, to bring the story up to date, you've started a new business?

Smithing: No. No, this is an old business.

Mullan: It's an old business. Tell me about the business.

Smithing: After Maddy and I started our practice eleven years ago, and both of us are actively involved in nurse practitioner organizations, politics, and have been facilitators with the development of national organizations, and local organizations, and publishing newsletters, and all that sort of good stuff.

As a result of that, we had many, many people calling us requesting information. With the formation of the American College of Nurse Practitioners, that increased. I was on the original what was initially referred to as the SWAT team, whose task was to evolve the college, but also make sure that nurse practitioners were involved in health care reform, that we weren't left out of it. That took up a remarkable about of time.

I found that I could not carry a full clinical load as well as continue all of this additional stuff that we had been doing. To put it in perspective, at that time, I was an officer in the State Nurse Practitioner Group publishing the state newsletter

for nurse practitioners, plus doing this other formative work for the American College of Nurse Practitioners. So I cut back my clinical hours dramatically, and went to first two full days a week, and then two half-days a week, which is where I am clinically right now.

We evolved out of that Nurse Practitioner Support Services, which was giving a formal name to what we had been doing, which is providing information for and about nurse practitioners. Primarily we provide that information to nurse practitioners, who want to be nurse practitioners, non-nurse practitioners trying to figure out who we are, what we do. We fill a gap that organizations don't, that they don't take on.

Mullan: It's Nurse Practitioner--

Smithing: Support Services.

Mullan: It's national or local?

Smithing: It's national. Very active in the state of Washington, but definitely a national phenomenon.

We collect information such as salary information, mailing list information. There's no central repository of information on who nurse practitioners are. You cannot generate a list of nurse practitioners in this country. We feel that this has to be fixed. This is not a good way to do any type of research. You miss so many people.

Mullan: The issue, though, is the irregularity of the credentialing of nurse practitioners. Irregularity, I don't mean in a judgment way, but you've got academic degrees, you've got certification in certain areas and not other areas, you have specialty credentialing in some and not others. It's a--

Smithing: Patchwork quilt.

Mullan: Patchwork. I was going to say hodge podge--

Smithing: Yes.

Mullan: --where everyone agrees it's a terribly valuable activity, but it's so irregular that it's hard to get--I've been active from a sort of scholarly point of view, or governmental management point of view, trying to figure this area out, and it's very--I know the history, I know how it developed, but unless there's some discipline, small D, but disciplinary covenant agreed to within nurse practitioners that defines and regularizes the field, data acquisition's the least of the problems. The whole field is so irregular that it's really hard to talk about in a sensible fashion.

Smithing: You're right. And I think that some of those problems have been addressed and are being corrected. The National Organization of Nurse Practitioner Faculties are taking steps to identify and mandate core curricula that are much more extensive

than they have been in the past. But the biggest problem at this point is that--I'll skip the histories--that you simply can't identify all the NPs in the country to do anything with them. When organizations collect that data they consider it proprietary, and don't want to release it to any of their competitors. While I understand that, it does nothing to facilitate research. Also, most of the time those are members. Members are not the whole population you need to deal with. So that's one of our long-term goals is to collect that.

Mullan: How is this a self-supporting or profitable business? I don't understand what you sell.

Smithing: We sell information. We facilitate communications. One of the down sides to the nurse practitioner world of not having people find us, is that they can't tell us about things. This continuing education topic that might be of interest, they can't send us information because they don't know where to go.

Mullan: There's no AMA master file for nurse practitioners.

Smithing: Correct.

Mullan: Somebody could buy and mail to all the docs, or all the dermatologists, all the whatever.

Smithing: Right. But there is a master file of 10,000 nurse practitioners that we have--that we have accumulated over the past six years.

Mullan: You can sell that or use that.

Smithing: Yes. We ask our nurse practitioners to tell us what information they want to receive. If they don't want information on continuing education, they'll never get a CE mailing from us, because we flag it, and we'll only send to them what they want. If they don't want anything, that's what they get.

Mullan: Them in the sense that individual nurse practitioners join up, or subscribe to your service, or give you their names, or what?

Smithing: Yes.

Mullan: Give you their names.

Smithing: All of the above. We get our names from individuals who contact us and say, "We heard about you. Tell us more." We get names through the Internet. We get names through organizations who want their membership to have access to the mailings that we facilitate. We get names anywhere we can find them, that is a legal way to get names. We'll purchase names from a state. Like Arizona has a caveat that you cannot reuse

their mailing list. But we can send a mailing to them saying, "This is who we are." We can piggyback it into a continuing education offering which covered the cost on it, and those that respond, then we add it into the data base.

Mullan: So who are your clients? Is it a growing business? Where do you see it going? What's you ideal?

Smithing: That's a small part of the business. That's part of--the underlying caveat here is that we've got information, and information is useless if you can't find it and return it when you need it. That's what we're doing.

The other piece that we're doing is facilitating communications. A larger part of our business is what we do on the Internet. We've got the largest nurse practitioner web site in the world. We have found that one of the best ways to fund this is by making "position available" announcements, getting them out to nurse practitioners who are looking for jobs. By doing it across the Internet, there's not the traditional four-week lag that you get doing it in a journal. We get it to a targeted audience of individuals who want to get a job at that point in time. And we facilitate recruiters, employers, finding nurse practitioners looking for positions.

Mullan: Who supports that? Who pays for that?

Smithing: The recruiters do or the advertisers do. The service is free to nurse practitioners. So it becomes a win-win situation. The NPs found the jobs--

Mullan: I guess you sell the space on the web site.

Smithing: On the web site, on a list serve, and on a printed "jobs available" bulletin, all of which started out as an informal, "Bob, do you know where a job is." "Bob, do you know where a nurse practitioner is?"

Mullan: So it's basically a placement service or similar to [unclear].

Smithing: It's not a placement service. We do not do that. It's a job publication. It's a newsletter for jobs.

Mullan: Is that developed? Where is that?

Smithing: Yes. It's when you walked in, there was a recruiter I was on the phone with who was just intrigued because she can't find the nurse practitioners for positions in rural America that she's looking for. I've had other recruiters who've said, "Bob, I've got to cut back. I have too many nurse practitioners contacting me from utilizing my service." While I know that I've got roughly 30,000 hits a month coming into my site, and I know that probably a good 25 percent of that is related to the jobs

information, we also set this up so that we facilitate discussions among nurse practitioners, and we've started in run NPinfo, which is a discussion group for nurse practitioners. That was an evolutionary process. We had originally started a news group, alt. practitioners.

Mullan: Give it time. I think you'll [unclear] pursuing this, which you'd surely teach me, because I'm not very savvy.

I'd like to go back and ask some sort of big picture questions of where you see it coming from, where you see it all going.

Smithing: Okay.

Mullan: You had, as I say, a fascinating, from my point of view, set of experiences with sort of riding the crest of the oncoming wave of the nurse practice movement. If you look at your experience in independent practice, particularly, and the recent acquisition of your practice. How do you interpret that in the big picture? Is this the way of the future. Is independent nurse practices not going to be a thing of the future even to the extent they were a thing of the past? Or what wisdom do you draw from what has happened with your practice?

Smithing: I think the analogy is that of the small mom and pop grocery stories, that in our youth perhaps were much more common than they are now, and that there's the large chain grocery

stores where we tend to go at this point for convenience. But interestingly enough, 7-11s and other stores like that have popped up to replace those mom and pop operations. I think that we're going to see something similar occur in health care. I think the acquisitions are going to continue, but acquisitions typically imply large bureaucratic groups which just by nature of that beast, will not be able to flex and do what needs to be done necessarily for a community. So there's still going to be room for the smaller--and I would not limit it to nurse managed centers, but to smaller providers, be they docs, NPs, what have you. I don't think that the independent practitioner will be as common as it used to be. I do think that what we may find is that large institutions will say, "Yes, big is good, but big has its own set of problems, and we need big as a central facility that you can feed into for specialty care."

Mullan: Maybe franchises and chains.

Smithing: Yes.

Mullan: On an 7-11 model--

Smithing: Right.

Mullan: --which has some level of ownership and some level of local character. It's got a standardized franchise quality to it.

Smithing: Right. I probably wouldn't have used those words, but that's the concept. You've go the quality assurance, the quality control, but you've got the flexibility to meet the needs of the community, be they in a storefront, a church, a community center, or wherever you might have them.

Mullan: Let's go back to the bigger picture of nurse practitioners in the swim. and the ebb and flow of the overall work force. Many people now are arguing we have too many physicians. Some are even arguing there are too many primary care physicians, or a little short [unclear] given the changes in the market, and the continued growth in the physician supply. Those arguments are also being applied to non-physicians, nurse practitioners, PAs. Golly, even though the market's brisk currently for employment, it isn't likely to continue, because we're going to have too many people. What's you reading?

Smithing: As you probably have, I've sat through many reports of impending crises in manpower, and excessive populations of providers, nurses, docs, whatever. I think that we're not going to find--I have my doubts that we're actually going to materialize enough excessive primary care providers to put everybody out of business.

Mullan: You describe right here in Kent an evolving marketplace, this strip of Virginia Mason, and there's a lot of medical muscle, primary care muscle, muscling each other right here in

Kent. Is that not going to be increasingly the way of the future? I don't mean to dispute it, I'm just playing your own tape back to you.

Smithing: Right. But that tape's missing the data that Kent is in a rapidly growing community. On that particular area that I'm discussing is probably the most rapidly developing part with dramatic increases in population. I think that your point is well taken that more and more folks are getting into primary care, but to get into primary care, I think it requires a certain commitment, personality type. I think primary care generally brings with it on-call hours. It impacts on your personal life. It's hard to do primary care and not be available. I think that that is cross profession. I don't think that that's specific to any one group. In specialty care, I think that it's somewhat easier to put some limits on that. Now, I'm not a specialist. I certainly have a different perspective, and that may not be right. So we've got to first make sure that we've got the group that wants to come in and do primary care. The primary care providers need to have a generalist point of view. They can't be narrow focused, and the generalist point of view, I believe, means that you've got to be comfortable with knowing that there's much that you don't know in great depth, but you know well enough to be able to say, "Okay, this is outside the norms, and this is where we need to send you for further evaluation," which is a very different perspective from specialty care. I'm not certain that that is--it may well be learned behavior, but in dealing

with the primary care providers in nursing that I've seen, there seems to be personality types that are more comfortable with that, and those that are not end up in specialty practice.

Mullan: Well, let me ask, pursuing that. Certainly the physician numbers are growing, as are the nurse practitioner numbers as best we can tell in practice, or the schools continue to produce large and increasingly numbers. [unclear] increasing them. MDs, because of our continued production, as well as importation of international grads who are continuing to graduate more, there seems to be a trend towards primary care. There's also a trend downwards in terms of physician salaries, primary care salaries it isn't quite clear, they're not growing, maybe they're not shrinking. Nurse practitioner salaries, what data I've seen, have grown. What is your reading of the intersection between more people in the marketplace, physicians and nurses, physicians' salaries stabilizing or coming down, nurse practitioners' salaries having gone up? Is this a threat to one of the clear attractive points of nurse practitioners, which are they're cost effective?

Smithing: You can't judge cost effectiveness simply based on salary. It doesn't begin to take into account all the variables that are there.

Mullan: We can have a discussion about the softer elements of primary care delivery, and I'm privy to that, and I think it's

good we have, but let me just bore right through the heart of it. If you're a manager of one of these systems, be it a chain or a franchise, and you're hiring folks, and you're one of the major players in this emerging marketplace, you're going to be interested in primary care providers, how many people they can see, and what they cost. I'm asking you this question, because I get often asked this. The mathematics are pretty simple. If nurse practitioners see half as many patients as family practitioners, and that's just a point of departure, you can run that anyway you like, and they cost half as much, well, you can argue it's a reasonable deal, or at least a wash. When they make three-quarters of what a family physician makes, it gets to be a little more questionable just from a point of view of how many people can you move through your system. At some point those lines reach a point that the managers of the system are going to be less inclined to hire nurse practitioners or PAs, it would seem to me, if they can get a physician for the same cost, including units of productivity. Is that strictly a business school exercise, or does that have reality in the marketplace?

Smithing: I think it's both a business school exercise and something that has reality in the marketplace. I think those that use that model dramatically over simplify primary care, and really do not have a good conceptualization of what it is that makes a nurse practitioner cost effective. Ultimately, I think what is going to happen is that we will have a discipline of family practice. I think that that discipline of family practice

will be fed in from nursing and from medicine. I think there's more in common in family practitioners within that group than there is with others of their same profession in many cases, who are in different specialties. I think that ultimately that may be where we head, although I think both professions are going to kick and scream and try to prevent it. But it would be fascinating to take the best of both worlds, which is what the theory was behind nurse practitioners, and pull it together into a provider.

But going back to your question of what's cost effective here, if we're paying the same salary to a doc and a nurse practitioner, cost effective is going to depend on not the number of people that you turn through your clinic, but cost effective is going to be the number of people that you keep from requiring hospitalization, the number of people that you keep from requiring increased doses of medication, the number of people that you keep healthy. That is where the professional training of nurse practitioner differs, I think, from docs, in that we focus on--or we're supposed to focus on, and there are exceptions to everything--in an encounter trying to teach you modify--get that teachable moment to keep you well down the road. I think that when we talk about family practice regardless of profession, family practitioners try to do that. That's part of family practice.

But if we're looking at non-family practice folks coming in, what are we going to find in terms of long-term cost effectiveness? That insurance company that I told you about that

picked up on nurse practitioners and disproportionately represented them in their preferred provider group, they didn't make that judgment based on we're nice folks, they made that judgment based on the cost effectiveness of the way that we practice, the cost effectiveness of the outcomes of those patients, and we did good.

Mullan: They really tell a lot.

Smithing: Yes. I'm firmly convinced--

Mullan: It seems to me that cost effectiveness, you're measuring hospitalization, is going to be overwhelmingly by the age of your population. In other words, if you're seeing more Medicare patients, they're going to be in the hospital much more than if you're seeing healthy young adults.

Smithing: Agreed. Totally agreed.

Mullan: So the nature depends who you're recruiting into your practice, if you're just from the insurance company's point of view.

Smithing: But if you look at the reports that they hand back to you in managed care populations, they've got all that data captured. They're looking at it--

Mullan: They can compare an apple to an apple.

Smithing: Yes. They're correlating it back, and that's exactly what they're doing. They're matching it based on age breakouts, based on gender breakouts, so that you capture pregnancy and childbirth versus non-pregnant. They seem to be controlling for those factors. We could get into a long discussion of whether the controls are adequate or not, and I think there's a lot of refinement that's needed, but I think that yes, they are beginning. They have set up systems to capture that data so that they will be able to make decisions that are reasonable economic decisions for them. I don't think that we're going to be comparing apples or oranges long term.

I think the challenge is that administrators will look at this and say, "Hey, that provider there, who may be a doctor or nurse practitioner, can turn out twice as many encounters as that provider there." But that doesn't mean they're most cost effective. However, an immediate look at them says that they are more cost effective that way. But another administrator up the road has got a better sense of primary care, better sense of managed care might say, "Well, no. You have to look at a bigger picture than that. It's not just salaries, it's also how you practice." You also have to factor in there are those docs going to be required to manage patients in the hospital. If they are, if they're on call for OB and deliveries, does that mean that they are then going to not be in a clinic so that while on a good day that they're there they can see folks, but if they're not out

of the clinic, then they're not being productive? I don't think there's a simple answer to the question of who's going to win, docs or nurses, and I don't think the question should be asked that way. I think the question is, how do we shape the primary care system so that the winner is the client who gets the care that they need by the provider that they want to see, whose personality will sometimes match that of a doc, sometimes match that of the nurse practitioner, and may be a function more of their social upbringing than their professional licensure.

To answer the question will NPs have a role in the future, absolutely.

Mullan: I want to ask you to come back from the trees up the forest now to look forward and look back. We'll go back particularly in your career looking forward in terms of your, first of all--actually, if you could, let's look back first. As you look over a fascinating two decades or so work in this area, and the kind of pioneering work you've done as well as the breakdown of the [unclear] that you and your businesses are involved in now, what wins and what losses do you see? What do you derive most satisfaction from looking back, and what you wish you could do over again, and what would you have done differently?

Smithing: Tough question. Like I said, I think I would have changed exactly where we set up the practice. What else would we have done differently? Essentially, not a lot, some small things

that in retrospect had we known, would have been helpful. But nothing that would significantly impact how we approach the world. We might have moved to Washington earlier. We might have done some things differently. But would we still be nurse practitioners? Yes. Why? A somewhat different philosophy of how you look at the world. Good? Bad? No, just different. It fits with the way that we look at the world. Was it a success? Clearly. We've gone from people not having a clue as to who you are and what you do, and challenges to is what you're doing legal with calls to the boards of nursing and medicine, to a fascinating acceptance that we are mainstream health care providers. There are others out there that are not mainstream, and perhaps we could work together to deal with this, which I'm not sure I expected to see in my lifetime. We're clearly--

Mullan: As an alternative therapist of various sorts--

Smithing: Right.

Mullan: --say, chiropractors?

Smithing: Yes. And there are those that consider them mainstream and--

Mullan: [unclear]

Smithing: I've had the wonderful distinction of encountering a physician, who, in her youth, had been cared for by a nurse practitioner, and knows who we are and what we do, and can articulate clearly that our strength is in part our teaching and education that we do, and that we fit into encounters, and that she is very concerned that we not lose that, that that's very important, which I find fascinating, coming from a family practice doc. I never really expected to run into that, but I did.

Mullan: What do you feel best about [unclear]? In terms of work. I'm talking about in terms [unclear].

Smithing: I was taking it professionally.

Mullan: Well, in that side that's true, but that's not the distinction. I'm not meaning to evoke a specific happening, but what part of you. For instance, clinical work, business work, political work. What is, if you look back, with the greatest sense of gratification?

Smithing: The facilitation of communication amongst my peers, and the building of the infrastructure that's required to move nurse practitioners forward.

Mullan: In terms of categories I was putting--some of that's political, some of that's business, some of it's educational.

Smithing: I don't think that there's a clear-cut category I can lay it into. That's the generalist in me. It's taking the different parts of this and weaving them into a tapestry that works. There's a thread of politics, and this thread of clinical activity, and another thread that is a business thread. But when they all come together, they give you a useful tapestry that you--

Mullan: Let me ask you about politics, because you've been involved in that. As we referenced a while before, nursing in general, and certainly nurse practitioning in particular, is in something of a wild west phase, by which I mean the forces aren't so solidified and codified and regularized like in the twentieth century they were as compared to the nineteenth century, and you've been involved in that. Has that been satisfying, frustrating? Do you think that's maturing or not maturing in terms of its role representing nurse practitioners?

Smithing: It's been both very satisfying and extremely frustrating. It's definitely maturing. It is not yet at its end point.

Nursing as a profession is a very diverse group. It is a group that believes that consensus means unanimity in decision making. We're still struggling with the issues of you don't have to have everybody agreeing 100 percent to move forward and do something. We're much further ahead than we were a decade ago. With the changes that have occurred, I think we will continue to

move ahead. Codifying the way nurse practitioners practice is something that scares the dickens out of us, because historically, whenever we have opened up a Nurse Practice Act, which is what's required to do this, there have been unrelenting attacks to take back that which we have so laboriously won. So nursing is very gun shy of opening up any Nurse Practice Act. As a result, that's going to change only slowly, unless, something came out of the federal government that took health professions as a whole and set up standard criteria, so that you no longer are limited to practice in a single state, and this potentially could benefit all of the health professions. It's also a nightmare that I'm not sure that anybody's going to want to take on, and I'm not sure that I'd be willing to support, but it's an interesting approach to the world. Until that time, we're stuck with a state-by-state negotiations, and we're slowly making progress.

Mullan: I see this as a good topic to sort of transition to your view of the future. What do you see the future of nurse practices being? What will things look like ten or twenty years from now, say?

Smithing: I think that you'll find us practicing in family practices. In many cases, owned and operated by institutions who have the administrative backup to keep them going. I like to believe that the clinicians will be free to do their clinical things, which will include allowing time to develop programs for

education, health promotion, to be working with clients, and will look at long-term outcomes and not just short-term treatments. How much of that we're actually going to see, I don't know.

Mullan: What you're saying, it'll be an integrated future. Nurse practitioners will be working in and amongst family physicians and others.

Smithing: Nurse practitioners have held for years, and the studies, I believe, will back this up, that clients get the best care when they work with an NP MD or DO team, because they bring different strengths into the relationship, different information from their professional training--

Mullan: That's what you envision.

Smithing: Yes.

Mullan: You mentioned the possibility that there might be a melding of disciplines, nursing and medicine under the roof of the family practice. Realistic? Likely? Possible?

Smithing: There is a study that is being funded by one of the major health care researchers, possibly Robert Wood Johnson. It's looking at the tasks, for lack of a better term, of what components there are in health care. It's taking a look at that, and it's proposing a licensure system that authorizes you to do

things based on demonstrated education and demonstrated competencies, regardless of professional licensure. Now, I expect this to be fought tooth and nail, and in truth, I'm not sure that I'm willing to support it or not support it, but it's a fascinating concept. If that follows through, we might well see an emerging discipline of family practice that draws from more than just medicine, or more than just nursing. Indeed, we may well find that family practice has to also draw from naturopathy, and other disciplines to give the best of family practice to a client. We're generalists, and hopefully, open minded enough to believe, and any of us with experience, I think, have to be, to recognize that nobody's got all of the answers. No one discipline has all of the answers. But there's some truth here, and there's some truth there, and there's some truth there, and if we can just figure out what they are, we can move folks to a better state or health, or at least give them the information to help them to move, because we can't really move them. They've got to move themselves. But we can at least enable them by providing them with the information to make informed decisions. I'll never get a smoker to stop smoking until they're ready to do that, but I can let them know what resources are available, what works the best, how to do it, and when you're ready, we'll help.

Mullan: Tell me about your family. I've heard a little bit about Maddy. Tell me about her and her career, and then you've got two kids, three kids.

Smithing: One kid. With all of this, one kid. Maddy's--her birth date's May 25, 1955, so she's about nine months older than I am. She grew up in Syracuse, New York. Ended up at the University of Buffalo. Always wanted to go into nursing. From that point, our careers run parallel. She's better as an administrator than I am, and she's very astute politically and dealing with large bureaucracies.

Mullan: Is she in the current situation? Is she working the two days a week, two half-days a week?

Smithing: No, she's doing full-time clinical practice, which is thirty-two clinical hours, or four clinical days a week, plus a fifth day allegedly to catch up, but in reality you may up seeing people. We have a ten-year-old, whom is certain that health care may be okay, veterinary school is of interest, but he's certain he's not going anywhere near computers. "Dad spends too much time with the computers." He's a very active, athletic fellow, who's just having a grand old time being a ten-year-old, plus one dog.

Mullan: A final question. Back to one I asked early on, I believe it's something like 4 percent of nurses are men. That figure about right?

Smithing: Yes.

Mullan: Nurse practitioners, I don't have percents at all. Is that different at all?

Smithing: I think it's higher, but I don't have a sense of it either.

Mullan: My sense is not greatly higher. It's not like all men in nursing suddenly rushed into being nurse practitioners.

Smithing: No.

Mullan: But in both fields, you're the exception, not the rule, a small exception [unclear] be the male. How is that? We talked about getting into nursing as it was like then, but if you walked through the rest of your career, has that been an asset, a hindrance? How has it played into your clinical, political, business world?

Smithing: It's probably done both. Certainly people know my name more often than I know theirs, although I'm not sure I can attribute that to my gender. But it is easier to pick me out in a crowd.

Mullan: Of nurses.

Smithing: Of nurses, which is where most of my crowds are. Has it been a liability or an asset? I think in different points in

time it's been both, when you're dealing with somebody who's extremely sexist, old school, than being a guy that's helpful. If you're dealing with somebody who is extremely gender sensitive who wants to facilitate and promote women over men, then it's a disadvantage. The good news is both of those were exceptions. Most of the world seems to judge you on what you do rather than what gender you are. I think if you ask my partner, she would give a similar sort of answer, although there may have been more negative discrimination, because I think that the good old boys still out number the rest of the world in decision-making positions. But I don't think that it's been a major asset or a major liability.

Mullan: Is there anything else you'd like to touch on? We've covered a lot quickly here, and you'll get a transcript, actually, you can add any--

Smithing: Oh, great, a twenty-five-page document to edit.

I had a very interesting experience applying for hospital privileges. We went after hospital privileges buying into the concept of continuity of care, but also with a major access to care push because insurers were now going to not let you--nurse practitioners have broken through all the barriers insurers have thrown up in terms of why we can't let you be a preferred provider. The most recent one has been, you have hospital privileges, but you don't have admission privileges. So we were breaking down the barrier of admission privileges. If you think

about it, why do you put most patients in the hospital. You put them there because they need the nursing care. You don't put them there because of the medical care, generally. I think I see these are an exception to that, where you need very intense care from both disciplines, plus many others. But if we could do it just with medical care, we do it out patient. We wouldn't put them in the hospital. We need observation; we need watching; we need that sort of stuff. We would have patients such as a kid with asthma, and he needed to be hospitalized. More so because his mom wasn't going to nebulize him because of problems with drugs or alcohol, and that we needed somebody to make sure that this kid got nebulized. But I couldn't do that, I have to transfer his care to somebody else. Or interestingly enough, in this particular hospital, I could not admit him, but I could write the orders--

[Begin Tape Two, Side 2]

Mullan: This is tape two, side two, of Bob Smithing continued.

Smithing: So working with a family practice preceptor at this particular hospital, we decided to go for admission privileges, since it was--we had privileges that granted us the right to write orders, granted us the right to follow our patients, still had to have a doc coming through and signing off on it, and we had preceptors willing to do that. It was advanced to the final phase of the hospital committee's signing off on this and,

indeed, the word we had was that it was going to be signed off on as a routine right of passage, and we would have privileges as of that night.

As luck would have it, I had a patient that needed to be hospitalized that night, and so we hospitalized them. It hadn't passed the appropriate committee, and it never did. It was fascinating, the degree of animosity and the absolutely negative interactions that we had with many of the docs, most of whom didn't know us, some of whom we had referred to, some of whom consulted on this particular patient, and who couldn't figure out what in God's green earth was going on, and wanted to have a pathology consult from the University of Washington, because nobody'd ever seen what this patient was doing before. It's relevant only in that it was a very medically complex individual, and had I had my druthers, I would have sent them directly to specialty care, if we could have figured out what specialist was the one to take care of them.

They got the appropriate care, but we had the occasion to sit through a medical staff meeting for an hour and a half, where the chief of staff tried to control the meeting, where the handful of docs that were supporters were trying to make things a little bit less wild, where we got apologies from some of our docs that we knew, that they couldn't believe that their peers had acted in this way, and apologizing on their behalf. They were screaming at us; they were calling us all sort of incompetent--

Mullan: These were some of the other docs.

Smithing: This was the medical staff in the medical staff meeting in the general meeting.

Mullan: At which you were present.

Smithing: At which we were present. Oh, yes, we were very much present. I think it's a very, very touchy subject--

Mullan: Were you speaking up, or were other docs speaking up on your behalf.

Smithing: Other docs were speaking up on our behalf. They wouldn't let us speak up. They were afraid that we would be attacked too viciously, and they wanted to buffer us as much as they could. We had the chief of staff on our side. This is unusual.

Mullan: The ultimate--

Smithing: The ultimate thing was that after all of that work, after all of the--everything that had been gone through to smooth the way, it was shot down by some very old-school folks. The informal observation was if you were to split the group based on levels of competency as rated by their peers, those that were rated as competent qualified providers, who people would refer

to, were supporting us. Those that people wouldn't refer to wouldn't. It was fascinating. But I think that there's a great deal of threat perceived in the medical community from nurse practitioners. Somehow we've got to get the message out that we're not a threat. We've got to work together. We're all in this mess together. We've somehow got to find a way for everyone to be successful in providing quality patient care. It's not an us versus them, it's not a one way is right. Clearly, we have a lot to go to get there.

Mullan: You and the profession have come, my sense is that it's not the end of the story. But thank you for your story. It was a terrific one.

Smithing: You're right. It's not the end of the story, hopefully.

[End of interview]