Episode 35 – Avoiding missteps with physician supervision of APPs

Intro music: 0:00

Podcast introduction: 0:09
Late last year, the medical board started a new feature in its licensee newsletter. We call it, *Lessons from the Disciplinary Committee*. Its purpose is to help licensed physicians and PAs avoid the kinds of issues that can upset and inconvenience patients and may even be departures from the ethics of the medical profession but aren't considered serious enough to result in public regulatory action. This is Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board, and this is MedBoard Matters. When a case is resolved privately, there is no opportunity to let other licensees know how to avoid similar problems with their own patients. And our Board Members thought, what a shame to waste all those teachable moments. So, *Lessons from the Disciplinary Committee* was born. The most recent installment of Lessons focused on avoiding missteps with physician supervision of PAs. And it caused something of a stir amongst NCMB's licensees, who were surprised by some of the requirements mentioned in the article. Are you a primary supervising physician? Are you a PA? How sure are you that the supervisory relationships you're in are up to Board standards? And, just as important, are you making the most of the collaborative relationship between PA and physician? On this episode of MedBoard Matters, I am talking with an experienced PA, John Goldfield, who is an Assistant Medical Director with the North Carolina Medical Board. John has worked in different types of supervisory arrangements, some good, some not so good and has learned a thing or two about building successful relationships with supervising physicians. Lucky for us, he is willing to share.

Interview with John Goldfield: 1:57
JFB: John, thank you so much for joining me. It's great to have you on the podcast.

JG: Great to be here. Thanks for having me.

JFB: Of course. I wanted to start just by asking you to tell your story. Could you tell me or tell our audience how you learned about PAs and then decided that you wanted to be one?

JG: Yeah, that's a fun story. It goes back years. I was always interested in medicine but had a completely different career and life for a long time until I found my way into the EMS world as a paramedic interacting with PAs in the emergency department. Realized the draw of that profession and what it represented and what I could do with it. So, I ended up going to PA school in 2002 here in North Carolina at Duke and graduated in 2004. So, I've been a PA since 2004.

JFB: Okay, great. And would you mind giving me a short history of your career as a PA and just talk about some of the things that you've done, some of the settings you've worked in?

JG: Yeah. So, when I first graduated, I didn't have a specific prospect in mind, so, I literally pedaled my resume around town and briefly took a job in an urgent care before finding my way into an orthopedic practice in Durham and worked for an orthopedist there for six years on a one-on-one supervisory arrangement with an MD that primarily did joint replacements and some spine surgeries. So, I got very involved in that process and…and learned a lot about a narrower field of orthopedics and a specialty level of almost tertiary level of care that he was providing, which was really fascinating and amazing.

And then eventually found my way to emergency medicine, which was always sort of my first love and worked at the Rex Emergency Department from 2011 until I started with the Board last year.

JFB: Right. So, you started out in the emergency environment as an EMT and then came back to it. So, sort of came full circle in a way.

JG: Yeah.

JFB: Cool. Great. And then just to fill in the blanks for folks who might not be aware that we have PAs working here on the staff of the Board, could you talk a little bit about your role in the office of the medical director?

JG: Yes. So, I'm one of the two assistant medical directors in the office of the medical director, two of us PAs. And we work with a team that essentially evaluates cases that come before the Board, whether they be investigations or complaints from either the public or other health care providers. We do the research on them, essentially find out all the facts and details and make recommendations to the Board so that when the Board has their every other month meetings, they can review these cases which number in the thousands each year without having to go through every single detail. We've been able to do some of that for them. The other part of what I do is thankfully get to be a part of the outreach programs that the Board has, giving some teaching opportunities to our medical schools and PA schools and even some to the public. And I really enjoy that part of it as well.

JFB: Yes. And you had shared that with me previously. And we are so grateful to have you doing that work. You do a great job at it. So, today you're going to be kind of doing outreach again, you know, for a different audience, not students this time, but really, we're talking primarily today to the supervising physicians in our listening audience and the physicians who may be our prospective supervising physicians. So, as you know, and most of our listeners probably know, all PAs in North Carolina are required to have at least one primary supervising physician. It's not lawful to practice without one. And I wondered if we could start just by you giving your advice on identifying a primary supervising physician. What should you be looking for as a PA?

JG: Right. Well, in the vast majority of cases, most PAs are going to get a supervising physician based on just applying for a job. So, they may not have a lot of choice if they're going to a larger group practice or if they're just wanting to get a job in a specific field. But there's a lot to be said for looking at who your boss is going to be, essentially. And your boss, you know, your sort of technical boss may be the practice or maybe the hospital, the group administrator or whatever, but your supervising physician is going to be the person that you work the most closely with. So, you know, the Board has a website that you can look up a licensee and get information about them. And that's never a bad idea. Just to make sure that there hasn't been any, you know, actions against this person or a lot of malpractice cases. And you can read about them, if so. And that's completely reasonable to ask your MD. When you're interviewing for a job, part of your own duty is to ask questions about the practice, what you'll be doing at the practice, what are your expected responsibilities? But part of that will be, you know, who is the person who's going to be your supervisor? Is it the person who's interviewing you or are they just going to assign you to somebody? I know with my emergency department job, I was interviewed by the group and then ultimately was assigned to somebody in the group as a primary supervising physician. But because it was

a group, it was understood that everybody was going to be available as my supervisors, everybody was listed as a backup supervisor. So, I really felt like all these people that I had met as part of my hiring process were really invested in guiding me through the my…my training in the department. When I worked in orthopedics, I was literally interviewed and hired by the man who was going to be my supervisor. So, we established in the interview if we thought we were compatible, which was really important and ended up being fantastic.

JFB: So, let me flip that question and ask you what should supervising physicians consider when they interview a PA, or they entertain the idea of adding a PA or other APP to their staff? What should they be looking for?

JG: I think it's very important for a physician to know what they're looking for in terms of an extension of themselves. Really, the reason that you'd ever want to hire an advanced practice practitioner, whether it's a NP or PA, is to really expand your practice, to be able to see more patients, to be able to reach out to a different physical location, to be two places at once, essentially. That's the perfect situation is to really be an extension of yourself. So, it's very important to be clear about what your hopes and expectations are for this person. I think it's very important to establish that you want to be able to work well with somebody that you want to be compatible in terms of your personalities. I have worked with MDs that we weren't necessarily "besties". In the group practice in the emergency department, I would say that, you know, some people were more fun to pal around with and some people were more businesslike. And as long as that was all pretty well established in terms of what to expect, that's never a problem. With my individual one on one supervisor in orthopedics, he was really funny. He asked me in my interview at one point he asked me what was really important to him was 'How am I with old people'? Because he's worked with a lot of Medicare joint replacement people. And…and it was going to be an elderly population primarily. And I told him, old people love me. And he laughed and said, that's exactly what I wanted to hear. And that was important to him. And it was that ended up being a theme throughout our collaborative relationship was that I was the guy who would ask all the little old ladies and little old men how their grandchildren were and all that stuff. And he loved me doing that because he could talk to them about the, you know, the risk of surgery and the options for, you know, which type of joint replacement. But I could do some of the more personal approach that that he was looking for.

JFB: Well, it sounds like that was a good interview then. I'm wondering, you know, if you have any thoughts on when somebody is maybe in their second interview or final interview where they're under serious consideration for the job, what should happen during that conversation so that there aren't any surprises or problems when somebody shows up for work and it's like nothing like what they were expecting.

JG: Right. Well, my very first job, which was somewhat short lived because the practice had to declare bankruptcy. That ended up being one of those. I was just so happy to have a job that I didn't question the supervisory arrangement as much. So, it was briefly discussed that the arrangement would be that the physician would be in the office, but very quickly, once he, I think, felt comfortable with me, I seemed to convey some confidence and…and capability. And then he was immediately less accessible and not in the office. And that ended up being stressful for me. So, I…

JFB: I'm sorry, [that was your] very first job. Okay?

JG: Yeah, very first job out of school. And I think in retrospect, it would have been nice to clearly delineate that because I had turned down a job offer where I knew that the supervisor relationship was not going to be adequate. That was it was going to be off site, never onsite, never in person available by phone, maybe a couple of different people that would be available by phone, that might be residents or fellows, not even the main supervisor. It was just very loosey goosey. It was rural practice. It was not a good fit for a brand-new PA and I knew that. So.

JFB: Yeah, so it sounds like you should get all those things out on the table.

JG: Communication is really important, but…but going into those interviews, knowing that, you know, as much as it's there's the pressure to get a job and when a salary is waived in front of you, that seems like you're so excited to be able to start paying off your student loans, you just have to remember that your license is important to you and your comfort level in a practice setting is very important and is not sustainable if you don't have that level of support as a PA.

JFB: Could you talk a little bit more about the difference between working for one physician in a small practice versus working with a team of physicians in group practice like you were when you were in the E.D.

JG: Sure, yeah. When I was working with one physician, when I was in orthopedics, I feel like I really became almost like his mini me, like I was we were two bodies of the same brain. I worked with him for six years, and it ended up being that we were incredibly efficient. It was really sort of an ideal collaborative situation. You know, we would work in clinic together, but separately, like two separate schedules, but literally on adjacent hallways so that we could both bounce back and forth and help each other with something, you know, see one of each other's patients. Or I could consult with him about a patient or one of my patients that I wanted to tell the doctor this or that I could ask, you know, can you pop over that hallway and see Mrs. Johnson, that kind of thing? So, I really came out of that relationship just knowing him well and being a great addition to the team to make him super-efficient. When I went to the emergency department, their goal in a team approach was to make me as autonomous as safely possible, as quickly as possible. So, going in, at first everybody needed to supervise me and to give me as much guidance as I asked for. And so, you know, there would be three or four docs on shift with me and, you know, I would get advice from all of them. And I had one main supervising physician who would then meet with me monthly and say, 'How are you feeling about this, that or the other thing'? But it was really the on-shift supervision that meant the most. But again, the goal was to make me an independent cog in the wheel of this big emergency department, to be able to function well, to not have to need lots of oversight eventually, but to be able to immediately have someone who can answer my questions or give me advice, you know, at a moment's notice on any case. And that's what eventually developed. You know, in the first couple of years, it was a steep learning curve. And I would run everything by, you know, whoever I could. And then eventually it got to the point where I had more experience in certain presentations even than some of the docs that would come in. Somebody actually summed up the team approach to supervision as a little bit more of learning the art of medicine, because you do get so many different opinions and different approaches to treating similar conditions. So, if I had a specific presentation of abdominal pain and I had four different providers that I would run it by, I might get four different opinions on how to approach it. And you learn what people are looking for. You learn how

different physicians need to be presented to and what kind of information they want. Some people want a long dissertation about everything that's going on in your entire thought process. Some of them just want to know the bullet points. Over time, that became really fun, actually, and a really great experience for me. And I made a lot of good friends because of that and felt really supported by a large group of people. But like I said, everybody in a different way.

JFB: That's great. It sounds like that practice had a pretty good system and there was good understanding among the physician partners about how to work with APPs, and that that was going to be an expectation was that you were going to consult with the APPs. One comment that has come up from PAs in the work that I do, is that one of the challenges sometimes can be getting the time with your supervising physician. So, you had a great system, a great group. It may not always be the case. So, I think that's another important thing to highlight, is that the supervisors have to be available, have to be willing to put in the time. Right? How do you [get that]?

JG: Well, interestingly, in the group practice, the individual supervision from my assigned supervisor, and if he ever listened to this, he'll laugh and understand that this is this was true, is that we really never got great amount of time together. It became a really quick cursory check in. You know, in the first six months it was every month, but after that was every six months. And we used to joke about how, you know, we need to try to go out to dinner or have like an actual sit down. And it hardly ever happened just because of schedules, but because that group practice was so, they were very PA friendly. They were very invested in making their PAs feel like part of the team, but also to be really productive and hopefully safely autonomous as much as possible that all of the physicians were very invested in making that happen and trying very hard to supervise as best they could sort of across the board. It really was more of a team effort. It felt like a family. It's a small enough group still and in only a couple of locations that it didn't feel like…you felt like you knew everybody. All of your supervising physicians were people that you had worked with a bunch of times over the years. So, it wasn't like you were just trying to walk up to a person that you didn't know with a chart to talk to them.

JFB: Right. Okay. So, what are some of the things that you think that supervising physicians, whether they're a primary supervising physicians or backups can do to make their PAs and other APPs feel safe approaching them?

JG: Well, there's a lot of things that are sort of the obvious answer of, you know, that you should pay attention to what you're PAs saying, make yourself available, all those things. But there are some very subtle other different things that I've had experience with and have had PAs mention to me. Just the simple fact of turning away from your computer screen in the middle of your charting, putting your pen down, taking a moment to just make eye contact and sort of gather yourself for a moment. Some of the best supervisory moments that I had in the emergency department were with a doc who would say, 'Give me a second', and they would finish what they're doing, and then they would turn in their chair and focus on me and say, 'Now tell me what's going on with your case. Tell me what you're worried about', or whatever it may be. In terms of the routine monthly checks, and then every six months checks that occur, those are in some practices they can be very structured and great. Like you could have a true learning experience. You could say, okay, we're going to pull these five charts and talk about them. When I was working one on one with the orthopedist, we were already doing that constantly. So, we

didn't really have to do that. When we met for our every six-month discussion, we would actually talk about things almost that were not even related specifically to the clinical outcomes as much as the processes. Are you still okay with, you know, which days you're rounding for me? Are you okay with, you know, what's happening with the salary discussions or your benefits or anything like that? Those were really valuable discussions because we wouldn't normally do that on a day-to-day basis. So, that was just another way to really sort of connect with the PA in a way that is beyond just the requirements.

JFB: Yeah, so it sounds like it really gets back to that kind of elements of good communication where…

JG: Absolutely

JFB: Be present, show the PA that they have your attention. That you're willing to engage. So.

JG: Yeah, yeah.

JFB: I know it can be difficult, especially in incredibly busy, intensive practice environments like the E.D., but it's so important for having an actual collaboration.

JG: Right. I think any situation where an MD feels like their PA is always asking them questions or always bothering them for information or feels like they just, you know, they keep having to respond. I think that they need to sort of accept that that's necessary potentially at that moment in their collaborative relationship as a means to get to a point where there will be less need for that. Um, you know, that the PA will feel more comfortable knowing how to treat patients, knowing how to do the things that that physician would do as part of their protocol.

JFB: Right. I mean, I would think that it's a pretty big investment at the beginning of the relationship, but it pays off in the long run, hopefully.

JG: Absolutely. Absolutely.

JFB: Yeah. And the Board has some position statements, I think we've got one on team-based practice, and the need for everybody to be collegial and all that kind of stuff. But it's also true with communication that if a subordinate feels that the supervisor or someone who's above them in the food chain is going to snap at them or be irritated or frustrated with them, it doesn't take too long for that person to learn, just not to approach. And that could actually be really dangerous in a clinical environment. So, it's really important to put in the time to build that relationship, it sounds like.

JG: Yeah, I think that those impressions of non-approachability definitely need to be quashed as quickly as possible, if that's something that may be occurring. I think a supervising physician, one of the things they could do in establishing their relationship is to, you know, if they know that they can get stressed out at work, if they can be a little curmudgeonly at times, if they can just say, look, if you feel like I'm not listening to you, let's have a code word, it's…it's really not any different than a marriage. You know, or a relationship. You've got to have some way to let someone know, and this is what I developed over my years in the emergency department, is that they knew that I was pretty comfortable doing almost everything. So, when I came up to them and…and I would say, Dr. So-and-so, I actually have a concern about this patient. I have a real question about whether I'm doing the right thing. When I would say that after 11 years of working with them, they would drop what they were doing and say, okay, tell me

everything. And do you want me to come see the patient with you? Like, would that help? And it was really nice. In the beginning when I was working there, I was treading water as fast as possible and learning as much as I could, and so everything felt like I needed help, making sure that I wasn't doing the wrong thing until I had some reassurance. And so, in the beginning, everybody was, you know, everybody knew that I was a rookie in the emergency room, and they were willing to give me the extra time. But…but fairly quickly, you learn your strengths and your supervising physician learns that, too. And uh, and it becomes less of an issue.

JFB: As you know, PA supervision specifically because PAs these are the APPs that the medical board regulates has been a topic of discussion at some recent board meetings, and the board members have expressed interest in us doing more to talk about supervision, everything that it entails, the responsibilities on both sides, supervisor, supervisee and as part of that, at the back of almost all of the outreach we do, it's always this idea of how can we help people avoid problems. So, I thought we could talk about some of the common issues that come up in supervisory relationships between PAs and their supervising physicians. What are some of the things that come to mind when I say common problems?

JG: Well, some of the common problems would be a supervisory relationship that is established essentially on paper, but not as much in person. We see that often. Sometimes it's almost necessary, depending on the practice setting. If a PA is working in a practice setting where they're going to be the only provider locally and they just need a supervising MD to provide that legal element, that can be a challenge. We run into situations where supervising MDs have very, very many APPs that are under their license and it gets really challenging to be able to give the proper amount of attention to all of those providers. And while it may seem that they're all functioning very capably and happily out there in the world, all of us with all levels of experience, run into problems here and there…

JFB: I think that's probably a good place to pause for emphasis. That point and point number one is that if you're supervising, this is not just a formality. It's not just a signatory role where you're it's your name on a piece of paper that says you're the supervisor. The medical board expects you to have an actual relationship like the ones you've been describing with your supervising physicians. And then point number two, there isn't a limit in North Carolina, the Board has no rule that limits the number. So, technically, there's nothing wrong with having a whole lot of supervisees under your license. But the reality is, going back to point number one, you're expected to provide actual supervision and to have a working relationship with each and every one of the APPs that you supervise. And the more names you add to that list of supervisees, the more difficult it gets just to do what you need to do.

JG: Right.

JFB: Have you ever been in a situation like that where you felt like you had a supervisor who just had more than they could handle as far as supervisees?

JG: Thankfully, no. I feel that that first job I turned down may have been a situation like that where they had multiple rural clinics that were being supervised remotely from a hospital setting elsewhere. But yeah, I basically only had three jobs in my career and one of them was only for a few months.

JFB: Okay.

JG: But…but yeah, my other two, I had really almost like Goldilocks supervisory relationships and I had the benefit of having one that was a one-on-one and one that was more of a team approach. And they were really good because the supervising physicians were invested in making their practice better by hiring a PA to do that. They weren't just hiring a PA to fill a slot and have a warm body. They really were trying to extend their abilities to provide care to their patients. And that's really, you know, the original purpose of PAs, when they were established back in the sixties, at the Duke Emergency Department was to take these qualified functional medical corpsman and turn them into something that was going to make the doctors in that E.R. more efficient to get more work done and to make the patients happier and treated, you know, more efficiently. So, that's still the role, is that we can really take a practice, whether it's an individual or group practice, and increase the efficiency and the profitability and the satisfaction of the patients by having a good collaborative approach.

JFB: Yeah, you mentioned that job that you turned down where its PAs on their own at rural clinics. And just for the record, there's nothing wrong with a PA practicing without onsite supervision. That is perfectly lawful. But again, there has to be meaningful contact between the PA and his or her supervising physician. So…

JG: Right. Because every day is going to be a little bit different in their prior experience and their current experience. Me looking at that job with 20 years of experience under my belt is completely different than me looking at that job with, you know, I just graduated last week. It's a completely different animal in terms of how I would feel with the level of supervision, for sure.

JFB: Yeah. One thing that I want to do is to make sure that we talked about, and this has been the specific topic of discussion at recent board meetings, and that is of the intent to practice. And if a PA is in the audience and hopefully some of the supervising physicians recognize that term, that is the online form that you submit when you initiate a supervisory relationship. So, the PA submits this form. They use it to identify who their primary supervising physician is going to be. Hit that submit button. The Board receives the information. It shows up on their licensee information page that Dr. So-and-so is their supervising physician. You're actually not allowed under the law to practice as a PA until that intent to practice is filed. So, one of the things that on occasion comes up is that somebody gets the job, they're raring to go, they start to practice and oops, they didn't file the intent to practice. How do you remember to do those things? How do you personally do you have any thoughts on what people should do, what supervising physicians should do, or employers to make sure that those I's get dotted and T's get crossed?

JF: Yeah, I mean, that's a tough one because there isn't a trigger for the PA when we switch jobs. Again, I only switch jobs three times in my career. And I think I was just so intent on making sure that my old supervisors were not listed as a supervisor anymore that it then reminded me to add the new ones and an intent to practice. But that's the really the important thing is that as a PA, we need to remember to make sure we're not listing previous supervisors as active because the MDs don't have any way to remove themselves as a supervisor. We have to do it as the PA so that's a responsibility of our own. And there isn't a trigger to remind you to do that, except to say that when you change jobs just the same as if you change emails or mailing addresses to just make sure you're updating everything with your board

website. It's pretty easy to do, and it's really important because that's the only way to really keep track of that stuff.

JFB: Exactly. And just to clarify for folks, you remove a supervisor using the exact same process. You go online, you access the intent to practice form, and you use that form to remove a supervising physician. So, and again, currently only the PA can do this. The Board is working on some alternatives, some ways for both PAs and their supervising physicians to monitor who's listed as active on their profile and then notify the Board if there's a problem, you know, if something's out of date so that someone can look into it. But you're absolutely right. Currently, the only way to remove a former supervisee if you're a supervising physician, would be to reach out to the Board, assuming the PA has moved on and they're no longer in contact with them, you really have to reach out to the board and say, I don't supervise so-and-so anymore. They need to be removed from my profile. So, we're working on that. We're hoping to make that easier. But for now, keep that in mind.

JG: Yeah, I think when PAs are recertifying, you have to go through and verify that all your information is correct each time. That's something you should be double checking as well to make sure your supervisory arrangements are accurate, that your practice address is accurate, that your choice of mailing address is accurate, your email is correct, work and private email. All of that stuff.

JFB: Yes. Yes, please. Please do that. One of the other things that I do as part of my role is I'm the editor of our newsletter and the vast majority of licensees receive that by email. And every time I send it there are hundreds and hundreds that bounce back because the address has changed and little fun fact under the law, you are required to keep an up-to-date address, email, telephone number on file with the Board, so please do that. In addition to the care of your intent to practice informations. What are some of the best ways to avoid problems in practice, you know, working with in a supervisory relationship? Do you have any strategies that you could share that have worked well for you just to build and maintain a good, productive relationship with a supervising physician?

JG: Well, obviously the most straightforward is just the constant communication. Being able to talk to your supervising physician is critical. When I was in the emergency department, I was also Lead PA for a while, so I dealt with some situations where some assigned supervising physicians didn't communicate as well with their assigned PA. Again, it was still a group supervisory practice. So, the day-to-day, you know, individual patient issues weren't as much of a big deal as trying to address any other issues which came up. And if they didn't get along well, then the PA, at least from my side, it seems like the PA and certainly from the physician side, they need to have some avenue that they can talk to someone else, either in the group or another administrator, to be able to find out either how they can connect better or if they need to be assigned differently to switch to a different supervisory relationship within the group, if that's possible. When I was in my very first job and my supervisor turned out to not really provide the level of supervision that I was comfortable with, I never really got to the point where I could feel confident to say something to that person and to say, you know, 'Hey, you said you were going to be here a lot more than you are.

JFB: Yeah.

JG: By that time, I was already going out the door. But that would have been tricky because I didn't have any other resource except my own bravery to step up and say, 'Hey, you know, can we talk about this'? But that would have been the thing to do.

JFB: You know, you raise an excellent point. We talk about this when we go out and do training and outreach at the PA schools where we talk about the power differential. And that's a huge issue for some PAs, I would imagine, especially for newer graduates, where they may have a question or they may have a concern or they might even think that their supervising physician or a supervising physician is doing something wrong and just not feel it's their place to say anything about it.

JG: Yeah, yeah, I would say that if I was going to give advice to the physicians in order to have a strategy to make these relationships work, one of the things would be to preface this conversation of establishing the relationship by saying, 'I really want you to come to me with any concerns. If you have a concern about how I'm listening to you, how receptive I am, how approachable I am, even a practice pattern that I have that you're unsure about or anything like that', it would be far more beneficial to be directly approached by your supervisee than it would be to have a patient complain or to have the Board get notified because of something…. The other way, the feedback and the insights of the collaborative practice arrangements should go both ways really.

JFB: Yeah. You know, you just made me think of something that is probably really important to mention again, from the supervising physician's standpoint, as I consider the conversation we've been having, we are asking supervising physicians to really invest a lot in these relationships and we're saying you need to put in the work, you need to put in the time, you need to give your attention. So, it sounds like we're asking supervising physicians to do a lot, and we are. But there's a good reason for that. And the reason you've touched on is that PAs are connected to the supervising physician's license. If the PA gets in trouble very often, it will blow back on the supervising physician. And the supervising physician is also going to get in trouble. It depends, of course, on the circumstances, but generally speaking, if something goes wrong in the clinic, the PA does something that is below accepted standards, they're prescribing in a way that is excessive, inappropriate, this is going to be something when the Board looks at it, that the Board expects the supervising physician to know about. And, you know, there shouldn't be any surprises if a PA gets in trouble. And then the Board comes to the supervising physician and says, why were you allowing your PA to do this? And they say, well, gosh, I don't know.

JG: Right.

JFB: So, there are definitely situations where if a PA is getting a public letter of concern, then maybe supervising physician is, also getting a public letter of concern. And in really extreme cases or cases where there's been some sort of really serious issue, patient harm, or just a practice that is completely unsafe and inappropriate that the Board can't allow to continue, there have even been instances where supervising physicians have been prohibited from supervising APPs at all. So, again, as a supervising physician, you should be invested in the success of your and other APPs because you are truly responsible for them in a really meaningful way that could affect your licensure.

JG: Yeah, absolutely.

JFB: Well, John, is there anything else that you wanted to add, or do you have any final words of wisdom for the supervising physicians or the PAs?

JG: I always have lots to say to PAs, but I do think that PAs are always looking for a good supervisor relationship, generally. They want good backup and support, and that feeling of collaboration. And I think for the MDs, DOs, physicians in general, they want to have that collaborative relationship, too, because that's the whole point. Like I said, the whole point in hiring a mid-level provider is to expand your practice, to make you more efficient, to make you reach more patients, to make your life better, essentially. It should make your life better, but it is an investment, and it does take some effort. And in a perfect situation, like I have been so privileged to have been in an investment of six months to a year gives you many more years of a great relationship, a friendship even, and this great collaboration that can really help your practice out. You do have to take it seriously and put the effort in up front. And…and some people are…are admittedly not good managers, they're not people persons. And that's okay. I think if you're not a people person, but you want to supervise a PA, as long as you talk about where your strengths are, how you can be a supervisor, how you can lead or not lead, how you want to be approached with questions or concerns, if you can convey all of that to another human being who is going to be your supervisee, it'll work out. It'll always work out.

JFB: If there's a theme of this conversation, it's communicate.

JG: Yeah.

JFB: Great. Well, John, thank you so much for sharing your time and expertise. It's been a pleasure.

JG: Absolutely. Thank you, Jean.

Wrap-Up: 36:06
I hope you enjoyed hearing Assistant Medical Director John Goldfield's thoughts on physician-PA supervision. Now is the part in the episode when I underline some key takeaways and add some exclamation points. First and foremost, physicians who agree to supervise PAs must understand that this is an active role, not just supervision on paper. Do not agree to supervise if you are not able to meet at least the minimum requirements. What are these requirements? I'm so glad you asked. They are all written down in North Carolina Administrative code, or as we refer to it at NCMB, in the PA Rules. You can find a link to the rules on the medical board's website by visiting www.ncmedboard.org/PAResources. You can find a link to that page on the podcast show page. Another helpful resource is the Board's position statement on physician supervision of other licensed health care professionals. You can also find it on the PA Resources page. In fact, just go ahead and bookmark the PA Resources page and take a look at all of the links. Pretty much everything NCMB has on PA supervision is there.

Episode closing: 37:27
Well, that brings us to the end of this episode of MedBoard Matters. I hope you found it helpful. Find the resources I've mentioned on our show page at www.ncmedboard.org/podcast. And feel free to send your comments, concerns, and questions by email to podcast@ncmedboard.org. Thanks again for listening. I hope you will join me again.