

# Sharing the Mantle of Primary Female Care: Physicians, Nurse Practitioners, and Physician Assistants

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**Objective:** to examine the role that nurse practitioners (NPs) and physician assistants (PAs) play in women's health care as part of a larger study assessing the use of NPs and PAs as primary care practitioners.

**Methods:** We conducted qualitative key informant interviews with providers and administrators at nine managed care organizations and multispecialty clinics.

**Results:** Respondents indicated that although there were a number of reasons these institutions began to hire NPs and PAs, the shortage of women health care providers was an important contributing factor. Many women patients prefer to see same-sex providers, but there are not enough female physicians to meet this demand. NPs and PAs were more interested in preventive care than physicians were. For these reasons, NPs and PAs came to play a central role in the delivery of women's primary care within these institutions.

**Conclusion:** Although the number of female physicians is increasing, there is no indication that the importance of NPs and PAs is waning. Rather, they have become valued members of the health care team. Women physicians will most likely be expected to provide primary care in teams with NPs and PAs.

The shortage of primary care physicians, especially women, and perceived limitations in the availability of primary care in the United States have stimulated a broad change in how the health care system meets the nation's primary care needs. Many women patients prefer to see same-sex providers, but there have been insufficient numbers of female physicians to meet this demand.<sup>1-4</sup> These factors provided an opportunity for two distinct health professionals, nurse practitioners (NPs) and physician assistants (PAs), to join physicians on the front line of primary care.<sup>5-12</sup> In recent years, NPs and PAs have come to play a significant primary care role in many areas, including women's health care.

As part of a larger study assessing the use of NPs and PAs as primary care practitioners, we examined the role that these providers play within women's primary care delivery. We also examined the relationships among NPs, PAs, and physicians. We report our findings here and speculate on how collaborative practice among these three groups may affect what our results suggest regarding collaborative practice, women medical school graduates, and residents.

## Methods

We conducted a qualitative study in five managed care organizations (MCOs), two multispecialty group practices (MSCs), and two hybrid centers (which had elements of both MCO and MSC practice).<sup>13</sup> We chose sites that had experience with NPs and PAs in primary care practice after extensive discussions with knowledgeable experts. We interviewed 107 people, including physicians (22), administrators (13), NPs (36), and PAs (36). Some personnel who were not available during the on-site visits were interviewed by telephone. No facility we contacted and, to the best of our knowledge, no individuals refused to

participate.

We constructed and pretested a semi-structured protocol (available on request) to ensure consistency across the interviews. Questions were open ended, however, so that respondents were free to respond in their own words.

The practitioner interviews focused on: the type of care NPs and PAs typically provide; management style; level of NP and PA clinical autonomy; NPs' and PAs' scope of practice and practice limitations; how the care NPs and PAs provide differed from each other and from physicians; and working relations among NPs, PAs, and physicians. The administrator interviews focused on: the ways NPs and PAs were integrated into the institution; the rationale for using NPs and PAs; management style; level of autonomy NPs and PAs assumed within their practices; how the scope of NP and PA practice and authority were determined; working relations among physicians, NPs, and PAs; and the extent of institutional planning with respect to NP and PA utilization.

We ensured reliability by pretesting the interview protocols at two local sites not included in the final study and by using the same protocols for all interviews. To ensure validity, we used comparative analysis to evaluate the data. Comparing organization types, for example, permitted us to determine how informants from the same type of organizational structure responded. Our data reduction method provided a second form of validation. A member of the team who did not conduct any of the interviews performed the initial data analysis, essentially serving as a blind, independent analyst. First, the independent analyst listed all the topics that informants discussed and then reviewed this list with the interviewers to determine both its completeness and its accuracy. Second, the independent analyst con-

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ducted the initial thematic coding of the data, searching the content of the interviews for common concepts and themes. The analyst and interviewers evaluated the resulting report together, sorting out disconfirmations and confirmations in the original texts and coming to agreement about the accuracy and completeness of the report.

## Results

As described more fully elsewhere,<sup>13</sup> we found that most of the NPs and PAs at our MCO and hybrid sites provided care that meets Starfield's<sup>14</sup> criteria for primary care (first contact, comprehensive care, continuity and coordination of care). This was especially true for well-woman care, in which NPs and PAs perform an extensive range of primary care tasks, including Pap smears; fitting diaphragms; infertility, contraceptive, and abortion counseling; breast examinations; treating menstrual syndromes; and assessing fetal well-being. The range of tasks was generally narrower in MSCs than in MCOs, although the limitation was more likely to be in the scope of authority than in the specific tasks performed. Most of our respondents indicated that NPs and PAs were interchangeable for primary care tasks. Even though most NPs or PAs in our sample who worked in women's health were also women, gender did not appear to play a role in assignment or scope of practice. A number of respondents believed that patient preferences help to explain this finding.

**Evolving Roles.** NPs and PAs fulfilled two functions in women's health care: satisfying female patients' increasing demand for same-sex providers and freeing physicians to perform more complicated tasks. In the words of one clinic director, "At one time, there were no female MDs here . . . But there were women who only wanted to see female providers. This was one factor that encouraged [the] use of NPs." Similarly, an NP stated that patient satisfaction surveys

find [that] one of [the] highest areas of dissatisfaction is [the] lack of female providers for women's health. This has become even more of a demand over the last 20 years. [It] made a big difference to bring in women and this

means NPs because [we] can't get enough female MDs.

Women obstetrician/gynecologists at a staff model MCO and at a hybrid indicated that they had shifted primary care to NPs and PAs, while they focused more on surgical functions. Although the NPs and PAs in the MCOs in our sample were originally hired to perform a limited set of tasks, their roles and responsibilities expanded over time and continue to evolve in response to both patient and physician acceptance. Our interviewees noted, however, that although NPs and PAs fill a large number of women's health care needs, they generally do not assume the care of seriously ill women. More complex cases are generally referred to physicians, and the range of primary care functions is generally narrower in MSCs than within institutions with a larger managed care patient population.

There was a pervasive sense among NPs and PAs in our sample that women's health care has passed from physicians to NPs and PAs. Even at our MSCs, which operated on a more traditional physician-dominated model, NPs and PAs shared primary women's health care with physicians. Our results also indicate that many physicians were willing to share well-woman care with NPs and PAs because it is routine. One NP described this sentiment succinctly:

In primary care the internist doesn't like to do office gyn exams. They are looking for interesting disease processes, not maintenance. Many MDs didn't go to medical school to do Pap smears all day. They don't like to do the "oil change and tune up." So in some teams NPs assume the bulk of women's health care.

More importantly, we found considerable convergence of practice styles between physicians and NPs or PAs, especially in the MCOs. As one gynecologist put it, "There is a natural tendency for practice styles to converge. Guidelines to NPs work well – each encounter need not be monitored." Some physicians noted that consultations between NPs and PAs and physicians went in both directions.

Interestingly, our results were less clear regarding the use of clinical nurse mid-

wives (CNMs). CNMs at one MCO were fully integrated as primary care practitioners, focusing on prenatal counseling and other well pregnancy care. But CNMs at a hybrid facility had a much more limited scope of practice and were focused more on performing a particular technical task than on providing comprehensive care.

**Relationships.** Perhaps the best description of the relationships among NPs, PAs, and physicians is collaborative. This was especially apparent in obstetrics/gynecology departments at all institutions. In obstetrics/gynecology practice, both NPs and PAs had considerable independence in performing their tasks, and for many patients they were the primary care provider. At one of our hybrid sites, for instance, an obstetrician noted that, "the majority of physicians view them as equal and valued members of the team in the obstetrics department." NPs and PAs were more integrated into women's primary health care than any other department we examined at that site. At all sites, however, patients could request to see a physician.

The collaborative nature of the work was one of the most attractive aspects of the job for NPs and PAs. Physicians, especially those providing women's health care, also valued this collaboration. In women's health care settings, NPs, PAs, and physicians frequently commented that the collaborative approach allowed them to manage more comprehensive patient care and that this, in turn, resulted in better primary care. Sharing the burden of care may result in a less exhausting practice for physicians. As one physician noted,

Because of the complexity of health problems, including violence issues and socioeconomic issues, it can lead to burnout for clinicians. Collaborative practice allows you to unload and defuse. It is good to have a second opinion.

Another obstetrician/gynecologist added that collaborative practice resulted in "the seamless delivery of care within teams."

Although we found that settings with a strong focus on women's health (such as obstetrics/gynecology departments) were generally more receptive to an integrated NP and PA role, we did not break

down our physician data by gender. Thus, we cannot determine whether the physician's receptivity to collaborative practice with NPs and PAs was related to the amenability of women's health care to NP and PA involvement, physician gender, or other factors, such as age.

Our interviews indicated that physician acceptance was a critical determinant of the extent of NP and PA practice, and that physician acceptance was a function of both time spent working together and the NPs' and PAs' demonstration of competence. Most of our respondents suggested that experience with NPs and PAs was the most important factor in physician acceptance, and that developing trust between the NPs/PAs and physicians was the key to expanded practice.

The level and pace of physician acceptance was closely related to organizational type and institutional culture. Physician acceptance was considerably greater in MCOs than in MSCs, but even in MCOs that reported the most extensive scope of NP/PA practice, physician acceptance was hardly uniform. All NPs and PAs reported that physician attitudes had improved over time, however. At least three sites now ask physician applicants about their comfort level in working collaboratively with NPs and PAs. The medical director of another MSC added, "Physician resistance to NPs and PAs is likely to drop as MDs become salaried."

## Discussion

Physicians in the United States have always delegated some primary care tasks to allied health professionals such as registered nurses.<sup>15</sup> Formal degree and certificate programs for NPs and PAs have existed for only three decades, however.<sup>16-20</sup> From this study, it is clear that physicians are increasingly sharing the mantle of primary care, especially well-woman care, with both NPs and PAs. Even with increases in the number of female physicians, none of the institutions we visited foresaw any reversal in the trend toward hiring NPs and PAs. In fact, the trend was toward expanding both their numbers and the tasks they perform. Perhaps more significantly, evidence from our hybrid sites indicated

that women's health care is at the forefront of integrating NPs and PAs as primary care practitioners. More research will be needed to confirm or refute this finding.

The shortage of female physicians was one reason NPs became involved in women's health care; this was less true for PAs, however, because, at least at the outset, most were male, having been recruited from the ranks of medics who served in Vietnam.<sup>16</sup> Regardless of gender, many physicians in our sample indicated a lack of interest in well-woman care or in psychosocial issues and preventive medicine. NPs and PAs have gladly filled the gap and are likely to continue in this role.

In some states, PA/NP scope of practice is curtailed legally by referral and supervisory requirements and lack of or limited prescribing authority.<sup>6,10,21</sup> But even where the legal scope is broad, NP/PA practice may be limited by physicians' lack of understanding about the extent and quality of PA and NP skills.<sup>5,22</sup> Although the physician and the medical model remain dominant within US health care, the number of NPs and PAs is growing rapidly. The early history of animosity among these three providers, referred to by one author as "confusion's masterpiece,"<sup>23</sup> has given way on the front line of care to accommodation. Medicine will make increasing use of such professionals in the 21st century,<sup>24</sup> and NPs and PAs will be an important factor in planning for the future health care work force.<sup>25</sup> The literature indicates significant opportunities for increased physician substitution and physician task delegation.<sup>26,27</sup>

Other nonphysician clinicians also function as autonomous providers, and they must also be factored into any equation about the effect of NP and PA practice on women's health and primary care in general.<sup>28,29</sup> Whether these professionals will complement physicians or compete with them is still open to debate.<sup>30</sup> We suspect that in either case, they are likely to make major inroads into women's health care.

The major limitation of our study is its sample size. Given that interviews lasted as long as two hours and that qualitative data are extremely labor

intensive to analyze, it would have been prohibitively expensive to include more institutions. Therefore, these results are neither generalizable to a broader range of provider settings nor conclusive about NP and PA practice nationwide. Rather, this sample includes providers in large institutions that have already had varying degrees of experience with NPs and PAs as primary care providers.

We did not interview a random sample of individuals, but selected key informants specifically for their varied experiences. Because of resource constraints, it was essential to obtain a sample that represented the broadest range of views with the fewest possible individuals.

Finally, our study was limited to self-reports. Because we were not able to observe actual primary care delivery, we cannot definitively validate our informants' descriptions of NPs' and PAs' work.

## Conclusion

Our findings suggest that future women medical graduates will be expected to practice collaboratively in teams with NPs and PAs, especially those in obstetrics/gynecology. If our findings hold true in other settings, physicians hired into MCOs will be selected partially on their willingness to practice collaboratively with NPs and PAs. And if patients continue to report satisfaction with such arrangements, and NPs and PAs continue to provide high-quality primary care, their role is likely to expand. Indeed, we have every reason to believe that primary care responsibilities for women's health care in managed care settings will increasingly shift from physicians to NPs and PAs. ■

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