David Lewis Glazer

Q: …1st of January, 2008. My name is Reginald Carter, and I'm going to be interviewing David Glazer.

Good morning, Dave. David, would you go ahead and give us your full name for the transcriber?

A: Sure. David Lewis Glazer.

Q: David, when were you born and where?

A: I was born in 1936, New Haven, Connecticut.

Q: Could you give me your month and day?

A: November 7th.

Q: Tell me something about your family. Where did you grow up and what did - your mom and dad's occupations?

A: I spent the first nine years of my life in New Haven, and at the age of nine moved to a suburb of Washington in Montgomery County Maryland, which really was home for me. My dad was born in Latvia, and came to this country at the age of six, one of - youngest of 12 children. My mom was born here, one of - middle child of five, she grew up in Bridgeport, Connecticut. Dad was in the clothing business for most of his life. I went to high school, graduated from Bethesda Chevy-Chase High School in Bethesda, Maryland, graduated from the University of Maryland with a Bachelor of Arts degree, and did subsequent graduate work, got my master's at the University of Connecticut in Psychology, with additional graduate work at Georgetown and the University of Michigan.

Q: What year did you graduate with your baccalaureate degree and with your master's degree?

A: Baccalaureate was '59, I believe, and my master's was '61.

Q: Did you have a particular career ambition at that time? I know you went to graduate school so you must have been thinking something.

A: (Chuckle) Yeah, I was interested in research psychology and to some extent in counseling psychology. I ended up actually moving into the defense industry doing research in human performance, human reliability studies, in weapon systems, and in space systems. I actually worked on Apollo.

Q: What years was this and where were you when you did this work for them?

A: Yeah, I worked for a company called Martin Marietta in Baltimore, and I was part of a group that was participating in the development of the Apollo mission itself, and we did a major… We manufactured in our lab a simulator simulating the lunar landing, and actually the lunar mission, and we as subjects worked with the astronauts, we'd bring the astronauts in for five weeks of training and one week of mission, and we were studying the effects of confinement and the effects of - actually, reliability. The extent of human error that might occur in a complex mission. And by the way, these people were extraordinary, there (Chuckle) were no errors to speak of, and none of them critical. It was a pretty interesting study.

Q: So with that background how did you become involved with PAs, physician assistants?

A: Well, my project officer on this project was a psychologist at NASA named Robert Jones, and Bob left… We became pretty close friends in working closely on this project, and Bob left NASA to become director of Biomedical Communications for Baylor School of Medicine, and was doing some consulting work Emory University School of Medicine on a statewide medical education program, both inservice and continuing education, and suggested that what they needed to make this statewide program work was somebody with a background in systems work, really, who could marry the [Inaudible] needs of practitioners with realistic needs that were identified through research, and recommended me for the job.

Q: And this was at Emory University?

A: Yeah, totally unbeknownst to me.

Q: And what department was that?

A: This was the Department of Allied Health.

Q: And you got a call from them?

A: Yeah, I got a call from them, and I came down to… Actually, I was living in Connecticut at the time, I was… I left out a portion of my résumé here. I had left Martin Marietta and gone to work for a company out of Austin, Texas, called Tracor, and I was with them in Connecticut four or five years doing research in human audition in sonar systems, studying the ability of sonar detectors to be able - the sonar operators to be able to detect signals and noise, that's the major unknown in the sonar equation, and that's when I got the call, when I was in Connecticut.

Q: And what year was this, do you recall?

A: Oh, my. (Chuckle) You mean when I got the call? It would be probably 1969.

Q: And so apparently you ended up taking the job and moving to Atlanta.

A: I did. Actually I was housed at Grady Memorial Hospital where we had a statewide medical television system that actually distributed tapes and also broadcast in off hours on Georgia Public Television, worked closely with those folks, and we would produce tapes and secure tapes from

an organization that was affiliated with the CDC called NMAC at the time, which was the National Medical Audiovisual Center - NMAC - and we were able to get [Inaudible] from them here in Atlanta, I worked closely with them, and we were funded by the - gosh, I'm blocking on the name - but it was a federally funded state authorized program, oh, the Regional Medical Programs.

Q: And how long did you stay in that role?

A: I was in that role for I guess about 2, 2 ½ years, and I was teaching part-time out on campus and got friendly with a fellow named Bob [? Juet] who was associate executive dean of the Medical School. Emory had a program training coronary care technicians, and the foundation came to Emory and said that they would like to give Emory some money if Emory would be willing to convert its program to a PA program, a full-fledged primary care PA program. Bob [? Juet] actually became the program director and asked me to come out to campus and work with him as the associate program director, working with students, helping to develop the curricula, and also doing some studies evaluating the effectiveness of this new class of midlevel health practitioner.

Q: And what year was this, Dave?

A: That would be ’72 I think.

Q: And so you were there when the program was just getting off the ground, getting started?

A: That’s correct.

Q So you became the associate director.

A: Yeah, and in fact, about the time the Academy and APAP were beginning to get started as well.

Q: And I believe Dr. [? Juet] then became a president of the Association of PA Programs.

A: That is correct. And I was involved with the [? R&D] Meeting, which is where I met you, [Inaudible] me right, and Don Fisher and Dan… Now I'm blocking on some names. (Chuckle)

Q: Dan Fox or…

A: No, no, no, this preceded Dan Fox. See, you don’t remember, either, do you. (Chuckle)

Q: Okay, you were in that position and I got to know you and then about that time is when accreditation certification came about, and they formed something called the National Commission of Certification of Physician Assistants.

A: Actually, there was one thing in my career that happened before that. Bob [? Juet] left Emory to become the dean of the new Medical School at East Tennessee in Johnson City, and during

that period I was acting program director and I ran the program for about a year. I was recommended as the new program director with a plan to have a medical director working closely with me, but Emory, in its classic tradition wanted a physician to run the program and so it wasn't clear whether I was going to stay or not, I figured I probably would, but then the Commission was formed and Tom [? Pim] asked me if I would be interested in submitting my name.

Q: How did you get to know Tom, or did he know you very well at that time?

A: I did not know him well. At this point, a year earlier, Don Fisher, of course, had become the CEO executive director of the Academy in [?APATH], and Don… I knew Tom and I knew the Sadlers, of course, I knew Don quite well. Coming in as somebody with a background in testing as a psychologist, I was not a nurse, I was not a PA, I was not a physician, I had a background in performance measurement and testing, and I had published some stuff on the evaluation of the PAs and nurse practitioners in practice, so I didn't bring a lot of political baggage to the job.

Q: So Tom [? Pim] was the one that suggested that you put your name in?

A: Actually, I think it was…

Q: Or Don.

A: Honestly, I don't remember. It was either Tom or Don, or both of them.

Q: And you submitted your name and I assume there was a search group and you were eventually then hired as the first director of the Commission.

A: That's correct.

Q: When did that come about, what year was that? Do you recall?

A: Yeah, I sure do, 1974.

Q: What was the mandate? There was some funding that was going to coming or had been secured?

A: There was already funding. There was funding from the, then, of Department of Health, Education and Welfare through the Allied Health Program, a fellow named Bob Conant, was the project officer assigned to us from the government. There was also some funding from the Robert Wood Johnson Foundation. Now none of this funding was directly to the Commission, it actually went to the American Medical Association's Educational Research Foundation, because it was money geared for not for profit. The Commission, at that point, didn't even have a tax status, much less a not for profit tax status, nor did it have a track record, so there was no money funded directly to the Commission.

Q: Now, the National Board of Medical Examiners, by the time you got there, had already produced one exam?

A: That is correct. The National Board of Medical Examiners was funded separately to develop the examination, and a first exam I guess was in 1973.

Q: And that was Barbara Andrews, primarily - responsible?

A: [Crosstalk].

Q: The idea the Commission had been somewhat formed and there were certain groups that had already met to discuss establishing the Commission at the time you came on board?

A: Yeah. Of course, I wasn't a part of this, but my recollection of the history as it's been related to me was that the National Board and the AMA were concerned that although the National Board was an appropriate agency to give this examination… The National Board had *never* certified a health professional and was uncomfortable in that position, and so argued, along with AMA, for the need for a separate independent body, independent from both the National Board and, in fact, from the profession, to attest to the knowledge base that the PAs would require.

Q: Do you recall the first formal meeting that you were at and who was at the table?

A: I'm not sure I understand what you mean by formal.

Q: Well, the meeting where I guess the Commission was actually formed, and you were hired, and you met for the first time, and said, "This is what my job description is, and what needs to be accomplished."

A: As I recall, the first actual board meeting that we held was in Atlanta and was approximately five or six months after the Commission had secured space in Atlanta and I had been hired and put together a staff.

Q: Where did you operate out of beginning, 'til you hired your staff?

A: One of the fist things we did was get space, and that was at 3384 Peachtree Road.

Q: And how much staff were you able to hire?

A: I hired an assistant director, what we would call today a CFO, I think his title was business manager at the time, and three administrative people to help with [? development of the examination, the administration] of the exam, shortly after that meeting I hired a registrar as well, so we were a total of, I think, seven people.

Q: How long before you got your staff on board was the next exam to be administered, how many months did you have?

A: One other point. When I was hired it was the commitment to ultimately move the Commission to Washington, but it felt it was a more appropriate place for the Commission. We had such a successful first board meeting that one of our members actually stood up, one of the board members stood up, and recommended that we remain in Atlanta because we had accomplished so much in such a short period of time. And one of the things we had done was take over responsibility for the examination, we had produced all of the material for the next administration of the examination.

Q: That was the announcements, and getting programs set up and those things?

A: Right. And all of that was in draft form presented to the board. In addition, we generated a mechanism for certifying the people who had taken the exam in 1973 so that they would automatically be part of the certification process and be certified retroactively. We designed a certificate. We also laid out some plans for possible re-registration recertification, and those were very preliminary at that point.

Q: Now when you got started, your board included how many different member organizations?

A: If memory serves me right, there were 21 directors, including three representatives from the Academy, two public members, and 16 representatives from other organizations, one of which was [? APAP].

Q: How quickly did you take over the - coordinating the test writing committees and those things, or did that stay under the National Board of Medical Examiners?

A: Well, it stayed under the National Board of Medical Examiners but we had the ability to come in and identify any additional capabilities that were needed and any time anybody cycled off a committee we selected, with the National Board, the replacement.

Q: Would you say in the early days that most of what you did was around the certification and registration, and selling the concept to states, and not so much in testing?

A: I don't know what you mean by not so much in testing.

Q: It seems like you had your hands full of just getting the logistics down and the Board of Medical Examiners was doing the testing. I guess I….

A: Yeah, yeah, yeah. The National Board of Medical Examiners continued throughout my tenure to be the primary focus of the examination.

Q: And they did the analysis and reliability and all those things?

A: Oh, always did, always did.

Q: Was there much question about eligibility in those early days and how hard was that to determine? It seems like a number of other people besides credited PA program graduates were able to sit for the exam.

A: Well, there were basically three issues. One was in terms of eligibility was… The focus of the examination was primary care or, if you prefer, core, so there was concern among those programs that were training specialty PAs, and there were a number of them out there at that time. So those are two of the issues. The third issue was what we called FMGs at the time, foreign medical graduates, who were ineligible to take the FLEX Exam administered by the Federation of Licensure Boards of the U.S., or had failed it, and felt that their training qualified them to be PAs. And so they were not organized, but we constantly were approached by foreign medical graduates to take our exam and become a PA.

Q: Within about five years of the requirement to leave the exam open for informally trained PAs and nurse practitioners ended - correct?

A: Yeah. Let me back up. I said three issues, there were four issues. The fourth one was informally training physician assistants, and that's the rubric under which the foreign trained physicians wanted to come in. And the criteria for taking the exam was to be *either* a graduate of an accredited physician assistant or surgeons assistant program, *or* to meet the strict qualifications of an *informally* trained physician assistant. And those qualifications included working as a physician assistant under the supervision of a physician and attested to by the physician, or a minimum of… You know, it's been awhile since I thought about this, but I think it was a minimum of four years. And there were some specific criteria that the PA had to meet in terms - that the candidate, I should say, had to meet in terms of job description.

Q: In reality, not many informally trained or FMGs were able to pass the exam, is that correct?

A: Yeah that's true, Not many took it, either. We did not have a lot of people who could meet the criteria. We never made a distinction between foreign medical graduates and PAs. We took the… The Commission took the position that a foreign medical graduate, to be eligible for the exam, had to meet the *informal* training criteria. To this day I don't know if we ever certified any foreign medical graduates, but if we did they were indistinguishable from any informally trained people.

Q: Recertification. When was that decided and do you recall any of the issues that came up about that? This is in the early days.

A: Oh, yeah, there were several issues. Let me start with re-registration. The Commission decided that in order to keep the certificate active physician assistants had to obtain a certain amount of Category 1, Category 2 continuing education every two years, and re-register the certificate. Every six years they would have to take a recertification exam in order to be recertified. The issues that arose over recertification were varied, ranging from, "Physicians don't have to do this, why do we have to?" to, "I've spent my entire career working on oncology why do I have to take a general examination?" Those were the kinds of issues we were dealing with. The answers to those that the Commission determined were 1) to the first question, "But

physicians are a licensed profession, they're not certified, and while there are no formal requirements for physicians to recertify, there are many in planning," including the American Board of Family Practice which was about to institute their own recertification exam at the time. But there were informal sanctions operating on physicians that did not operate on PA's. For example, physicians… The vast majority of physicians in this country are board certified and while they don't have to necessarily recertify to maintain their board certification, they are dependent upon referrals, they are dependent upon hospital privileges, so there are sanctions operating. In terms of the specialty exam, physician assistants are, like physicians, are admitted to practice in every state at that time, irrespective of the kind of practice they went into. So a PA could go to work - graduate from a primary care program, be certified, go to work in a highly sub-specialized practice for six year or five years, and then decide they're going to change their jobs and go to work in primary care. Now we know the half life of medical information, at least at that time, was five years, which means that by the time they were due for recertification, had been working in a specialty practice, 50% of their knowledge base disappeared, had been obsolete. And that was a requirement, by the way, that was stringently recommended by our funding agency in the federal government, by the way. That wasn't the reason we did it, but it certainly spoke to the direction the federal government thought we should be going in.

Q: So the PAs were, I don't want to say guinea pigs, but they were on the cutting edge of thought at that time about certification, licensure, and re-registration, and those issues?

A: Absolutely.

Q: Tell me a little bit about… Do you recall the first states that actually adopted the National Commission and the certification mechanism as their requirement for certification or licensure in a sate?

A: You know, I don't. (Chuckle) That was such a hectic time. I can tell you that within two years 33 states had recognized PA practice and had established regulations requiring a currently valid certificate for PA practice.

Q: Now this was something that Don Fisher with the Academy, and you with the Commission, were interested in seeing happen. Did you guys team up and go to any states to sell the concept?

A: We were invited to speak at a variety of states at the same time. We were *not* a team, (Chuckle) we usually sat on opposite sides of the room. Don would get up and speak to what the profession wanted, which was appropriate, he was representing the profession. All we would speak to was… Don would speak to various aspects of training, number 1 and number 2, what tasks PAs should be permitted to perform, and what limitations should be imposed on them. We, the Commission, never made those kinds of presentations, all we did was stand up and say, "Look, here's the way PAs are trained. Here's what we know the existing job description might be, here's an examination that tests for the appropriate knowledge base to perform those tasks. An example would be that if state regulatory board asks me as a representative of the Commission, should PAs be permitted to write prescriptions, Don's answer to that would be, "Yes." The Commission's answer to that would be, "It is not appropriate for the Commission to state what PAs should be permitted or not be permitted to do. What I can tell you is that as part

of their training PA's do go through pharmacology programs and there are a significant number of items on the examination to argue that PAs are competent to write prescriptions." And it was a very effective kind of horse and pony show.

Q: So the academy tried to get the regs in favor and worked on reimbursement issues, and you worked on national certification and selling that, and it seemed to work.

A: Yeah, it was unprecedented, the recognition and the examination.

Q: How important do you think having all those different health groups involved in the accreditation and the certification process? Was it an easy sell because you had backing from such a wide audience?

A: Absolutely. There were two things that made it effective besides, of course, our excellent presentations. (Chuckle) The two things were, look, this certification process has strong input from the profession but it's not controlled by the profession. It has input from the public and from all those groups in *organized* medicine, of course, we're talking to medical regulatory boards, so we're talking to people from organized medicine, representation from organized medicine involved in the training and/or employment, and/or regulation of physician assistant practice. That was number 1. Number 2 was everybody we talked to knew who the National Board of Medical Examiners was, and that brought a certain cachet to the examination. It was a quality examination but even if it weren't, just the imprimatur of the National Board of Medical Examiners went a long way to help sell the concept at the state level.

Q: What about nursing in all this, they were at first part of the group and then they withdrew. Did you get many questions out there about nurse practitioners, were people confused about the direction they were taking?

A: Sure. And the position we took was that there are several programs in the country where nurse practitioners and PAs train side by side, such as George Washington University, and where that occurs, from the Commission's viewpoint, those programs are undifferentiated. We were very fortunate. While there was a lot of antipathy toward the PA profession from organized nursing, we had a representative from the ANA on our board who was extremely articulate, bright, and liberal in her interpretation of what nurse practitioners should be permitted to do, and her posture was if nurse practitioners are trained well enough, and if they can pass the certification exam for PAs and if they're willing to call them a PA, and it's to their advantage because they have more practice opportunities in a given state to function as a PA, then they ought to be allowed to be PAs, and the American Nurses Association should not be opposed to that. That was her posture.

Q: What was her name, do you recall?

A: I can remember her first name, and I can see her, but I can't remember her last name.

Q: We can add that later.

A: It was Barbara. I want to say Curtis, but I'm not positive about that. She was a terrific lady.

Q: Were there other issues came up like that when you were out there that you can recall, or pretty much as we discussed?

A: Well, the only other issue, of course, was the surgeon's assistants who wanted a specialty examination. Now particularly those groups that were in subspecialties. There was a very good urological PA program at - I think it was Cincinnati. There was also an anesthesiology assistant program at Emory, which was an excellent program, in fact, a master's degree program. They both came to the Commission and asked, number 1, to make sure their people were eligible to take the exam, which they were not, and number 2, to then develop examinations that only tested in a specialty, which we did not. Ultimately, of course, we redeveloped the examination into a core exam with two tracks, one primary care, one surgery.

Q: This question of adding surgeon assistants and additional exams and those kinds of things, it really has been off and on over the years. Now that you reflect back on it is there anything could have been done different, or you think it's worked its way out pretty much?

A: I just don't know, Reggie, I'm completely out of touch with the profession, and there's… I just can't speak to what's happened since I've left.

Q: That's fair. Tell me a little bit, the years that you were there, how did your role change over time from the administrative part of it, and then how did the certification process change over time?

A: I mentioned that the certification process in one regard changed, and when we went to - from a single exam to a core plus two specialty exams, primary care and surgery, that was a major change. One of the real concerns we had, and the profession had, and the programs had, was one portion of the examination called the clinical skills problem. That was a hands-on examination… Let me describe it. The PA candidate was presented with five separate - gosh, was it five or was it three, I don't even remember - it may have been three, I think it was three - three separate vignettes and asked to perform an appropriate physical examination based on the information supplied in the vignette. There was a checklist that the observer used to make sure to check off those essential steps, and there were anywhere from 15 to 30 essential steps in each of the problems. In order to pass this portion of the examination, and people could fail on the basis of this component. In order to pass this component, one had to answer a minimum of 50% - sorry, had to select a minimum of 50% of the correct responses. The concern expressed from both the profession and the programs was it was cumbersome and expensive to administer, which was true, that it only identified a handful of people who might pass the other portions of the examinations but fails solely on the basis of clinical skills, and that because it was based on observational techniques it was subject to human error, and finally, the concern was that it wasn't really a test of clinical competence. Well, it was never expected to be a test of clinical competence [Inaudible] it was rather a mechanism to identify those people who did not possess minimal skills in performing a physical examination. Every year there were five, seven, 10 people who might fail the entire exam on the basis of this CSP. There were always complaints about how the exam had been administered, but almost inevitably, the people complained about

the problem they did the best on. The Board, and particularly the Executive Committee, took the position that anyone who can demonstrate to the Commission that this is not a valid examination technique the Commission would drop it in a heartbeat, but it was continually proving to be valid, and in fact was being studied by various groups in organized medicine as a potential approach to measuring clinical competence for physicians. Because of its cost, and because of its difficulty in administration continued to be a sticking point.

Q: I think with computerized testing that really kind of moved it away.

A: Absolutely. I guess the last thing I was involved with in the Commission was generation of a white paper, sort of, and it was a plan to move… And by the way, here's another concern that was expressed by everybody, including staff and the Board, and that was the exam was given only once a year, so that anybody taking the exam and failing it had to wait a full year before they could be reexamined. And that was a concern to all of us, but there was a cost involved in generating a second examination, and sites that [Inaudible] beyond the ability the Commission to handled given the number of candidates we had for the examination at the time. As the test population grew, however, it became clear that we ought to move in that direction. With computerized examinations it became a much easier thing to implement, and that's what the white paper was. The white paper basically talked about how to move to computerized medicine, how to move to two examinations a year, and how to modify recertification with a second approach that might be a take-home type examination, and what would be involved in increasing staff and cost to accomplish all of this. This was written with the input from the National Board of Medical Examiners, that's kind of the last thing I did before I left the Commission.

Q: Let's backtrack a little bit about Pathway 2, do you recall how that came about and where the…

A: I think it developed from representatives from the Academy, [Inaudible] serves me right. I think they came to us with a recommendation for this, came to the Commission, and the Board looked at this as a possibility and decided it was an excellent approach, and charged me with putting it together. That's my recollection.

Q: And that consisted of completing certain CME requirements and then taking a take-home exam?

A: That's my recollection of it. It was implemented after I left the Commission, so how it was finally implemented I don't know. Although I can tell you I know a young lady here in Atlanta who is a PA, I see her every now and again, and every six years she swears at me. (Chuckle)

Q: Yeah, the six-year recert has always caused PAs to be very anxious and concerned.

A: I was originally certified as a psychologist in the state of Maryland. In order to call yourself a psychologist, or use the term psychology in your title, you had to be certified in the state of Maryland, that involved taking an exam every two years, and I did it twice, I think, many, many, many, many years ago. Here I was doing research in aerospace and in order to be certified I had to take a totally irrelevant examination towards my career in counseling, basically. This was

basically a counseling exam and it was to protect the public, it was to keep me and people like me from hanging a shingle up and calling myself a psychologist and seeing patients, so it's not unlike the kind of thing we faced with the specialty people in the PA profession.

Q: Well, there's tradeoffs I guess for the profession, one is maintaining that flexibility you talked about, by keeping the certification process, recert, the same way, so it does have added benefits. To how many people, I'm not sure, I guess the research still needs to be done. Tell me a little bit about what you consider to be the… If you could say, "There were three major success during my administration," what would those three be?

A: I can first tell you that I think the major successes that we had was to keep 16 groups around the table focused on the same issue, some of these groups having been at each other's throats from time to time over 70 years, without breaking out into these internecine kinds of warfare. The second thing I would say is that [Inaudible] keeping the Commission apolitical, keeping focused on one goal and that goal was protecting the public. Those I would say are philosophically the things that I'm proudest of. In terms of actual events, I think we had an extraordinarily qualified examination that was ahead of its time. I think that the certification process was growing at the same time the PA profession was growing. The exam was able to keep pace with the PA's role, and at the same time give PAs an opportunity to practice almost anywhere I… I really think one of the most important things that we did was the recognition of the PA profession at the state level, and that was really based on three - four things, I'll say. The quality of the education and the accreditation process, the presentations by the Academy and the Commission at the state level, and most importantly the quality of the PAs that are out there providing health care. We all like to take credit for a lot of successes, but the real measure of success I think goes to the members of the profession who are out there seeing patients all the time. You'd year stories about how nurses who are totally opposed to PAs being in the hospital until the PAs [Inaudible] pick up a bedpan and work closely with the nurses, and get nurses on the floor the answers they needed, and the decisions they needed when they needed it, in a timely fashion. So I think we sometimes forget how important the folks in the profession were.

Q: You're totally correct.

A: Well, that was pretty self-serving, wasn't it? (Chuckle)

Q: Tell me now about what you've done after you've left the Commission. You were there from '73…

A: I actually started in '74, in December of '74.

Q: And you ended in…

A: Beats the hell out of me. (Chuckle)

Q: We'll look it up. You were there a long time.

A: Twenty-one, 22 years at a job I expected to have for four or five years, but it seems like there were always interesting challenges developing. Working closing with the National Board, I'll toot my horn for a minute, the National Board folks I worked with once told me that I was, from a testing viewpoint, the most knowledgeable CEO they worked with, and that was nice to hear. I could talk the testing talk with them.

Q: So when you left the Commission what did you do next?

A: Well, I actually became president of a startup company that was developing some equipment for use in bilingual education, actually for parental involvement in bilingual education. I'm still somewhat involved in that activity. Then 1998 I became the southern regional director for the American Medical Group Association, and I work halftime. Well, I work more than halftime, I get paid halftime. (Chuckle)

Q: And you're still in that position?

A: Yes I am. I guess you know, our CEO's Don Fisher, and AMGA is a trade association representing multispecialty medical groups of roughly 25 docs or more, and my role is… I cover an 11-state area, basically put on regional programs and educational programs for administrators primarily, administrative issues. I do some recruiting, I assist our members often with inquiries they might have, and I staff some committees, so I keep busy.

Q: Reflecting back over the time you were involved with PAs, and keeping up with that profession, what's been your overall impression about PAs?

A: I think the PA profession has made a tremendous impact. I see a large number of our own members, AMGA, utilize what they choose to call midlevels, both PAs and nurse practitioners. So they made a huge impact on the delivery of health care in this country. The impression I get was that the role may have changed somewhat from what you and I originally thought it to be, and that was, at least this is my impression, I don't know if this is accurate, but this is what has been my impression, that there's been an increasing movement of PAs into specialty practices, and into urban settings. The original concept, as you will recall, was to take advantage of exiting corpsmen who had significant health training, retrain them to apply those skills and increase those skills for application in the public sector, and get them to medically underserved areas for primary care. It seems to me there has been a shift, and there's also been a shift, from what I understand, educationally. My understanding is that most PA programs are now master's degree programs, and originally we looked, as educators, at people who had formal health training, who didn't have formal health training, like previous college, who didn't have previous college, who were ex-corpsmen, who weren't ex-corpsmen. We looked at a broad spectrum of people and brought them into our programs because we didn't really know what it would take to be a PA and what was the best mix of experience and education. I'm not sure that we ever did do a as thoroughly systematic evaluation of those kinds of entry level criteria nationally as we might have done, and I'm not sure I understand, at least based on my ancient knowledge of the profession, the need for master's degrees. Now, apparently, the profession has evolved to a point where the educators think it's required. This is the same thing we've seen happen with organized nursing historically. I'll get off my soapbox.

Q: I think you're correct. I think the pressures are there from nursing that's gone to master's, and the qualities of people, since we don't have the corpsmen and the LPNs anymore as feeders into the programs.

A: I might also add one other point. There were a number of people, and a concern to all of us in the early days when we were looking at candidates for training as to whether people were looking at this as a circuitous way into medical school, that people who were [? becoming physicians, becoming PAs,] some of them, really wanted to be physicians, and there was at least, a fundamental difference between PAs and physicians, and it is that the buck stops with the doc. He's the final decision-maker, at least that was the case when I was involved with this. And anybody who really wanted to be the final decision-maker might not be a good candidate for a PA program.

Q: I think you're right, and I think the autonomy now, for the PA, has grown to the point that there's a lot of job satisfaction, so you're totally correct. We're getting close to the end of a 60 minute tape, Dave, is there anything else you can think of for the record that you'd like to add, or do you think we've covered it all?

A: I think we've covered it all. I'm just very grateful for the time I had working with PAs and for the job I had. It was challenging, it… It's always nice to leave a career feeling that you made an impact, and I feel like I did.

Q: Well, you certainly did, and we all thank you for getting the Commission up and running and keeping it to what it is today. So with that, I'll end the tape.

[END OF AUDIO]