INTERVIEWEE: Peggy R. Robinson

INTERVIEWER: Sasha McEwen, David Hong

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00:05 David Hong

I'm David Hong.

00:06 Sasha McEwen

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00:10 Peggy Robinson.

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00:15 Sasha McEwen

What motivated you to become a PA?

00:18 Peggy Robinson

Well, this is an interesting story. I actually wanted to be a doctor.

I was very young when I finished high school. I skipped a grade in elementary school and I was only 16 when I graduated from high school and was going to go to college.

My father was a dentist and he actually went to dental school back during the time of segregation. So if you were an African American, you could only had two choices to be educated professionally as a doctor or dentist-- Meharry or Howard. I honestly think that if my father had been 10 years younger, he might not have been so opposed to me trying to be a doctor.

But I think he saw what few women were in medicine or dentistry at the time and what a hard time they had. And I think he tried to shield me from that especially and I think being so young played a large part in that, so he really talked me out of going to medical school. I love to write and so he really encouraged me to do journalism. because I was always writing poems and plays and things like that.

but I was worried about majoring in journalism because I was erratically creative and I couldn't imagine depending on that for income. I mean, what if you just didn't feel it, what were you gonna do that month for money? But I loved science and so as a compromise I went to undergraduate at Springfield College in Springfield, MA. I majored in biology. My junior year of college I took Microbiology and loved it. I actually teach microbiology to our first year students and so I went on and got a Masters in microbiology. I actually worked a year on my PhD at MCV in Richmond.

I kind of never got over wanting to do medicine and so after I got married and had my second child, I decided I was going to go to medical school then. My husband said he wanted to go to graduate school, so we couldn't both go to school at the same time.

I said OK, and so he went and worked on his Masters and then unfortunately he decided... you know my personal life kind of fell apart. He left me and we had two small kids at the time and so I knew medical school wasn't an option. Then one Sunday I was reading in the paper. At the time I didn't even know about the PA profession so this was about maybe 1983 or 84.

I was reading an article and in the Sunday section... you know how they have the lifestyle section in the Sunday paper. There was an article about Joyce Nichols. She was the first woman to finish this program. She was an African American woman and she was the first woman to finish the program and at that time I had never heard of the PA profession. But I read about it and I thought, well, this is something I could do. The training was two years and so I waited a couple of years until my children got a little bit older, and so that's how I became a PA. And now you know, I'm fond of telling people now you know, because a lot of you know students will ask, MD or PA and why should I pick one? I always tell people if there's something about being a doctor or some of the intangible things like so when people just put doctor in front of your name but just kind of makes your heart race. You just see love of that kind then you should go to medical school because this is a dependent position. You are always going to be a dependent practitioner as a PA, but if all you want to do is practice medicine, if your whole focus for this is I want to take care of patients and I want to practice medicine, then why would you be an MD? I think that PA is a wonderful profession.

03:52 David Hong

Well then could you walk us through a typical day as a PA then?

03:56 Peggy Robinson

My job is probably a little unusual in that I both teach and I sometimes think you know this is such a great job. You know nobody should have to pay me for this and everybody says that's how you know you're doing the right thing when you would do this for nothing because I have a great job. I love teaching students.

Because I want them to be thoughtful practitioners and so you know if they're out 5, 10, 15 years from now and they hear my voice in their ear... that's the greatest reward. I get to teach them and instill some things I think are important about taking care your patients and then I get to see patients myself. So the one good thing about my day... as in many academic centers, I have both a clinical and academic part to my position. I see patients three half days a week and then the rest of the time I'm teaching. And then there's administrative stuff, so we were interviewing for the next class and all of that. My days are probably a little atypical.

And no day is like the other... some days I teach. But you know, certainly PAs are across the spectrum of medicine. So probably about 50%... there are close to 80,000 PAs now in the country. And as a little history, I don't know how much you know about this, but the profession was founded at Duke in 1965. When I went to PA school, I finished in 1992. At the time I started here, there were only 50 some programs in the country.

Now there are close to 140, so this is a profession that has really grown in the last [years]. Originally the profession was founded to do primary care and so most PAs did primary care. Now a lot of PAs specialize, and very much like medical school. .. PAs are taught in a medical model.

Much like medicine, there are some residencies that are postgraduate. A lot of those are in orthopedics, emergency medicine, those kind of things... you don't have to do one like you do with medicine. So probably there's about a 50/50 split... probably about 50% of PA do specialties. So things like orthopedics, cardiology and then probably 50% of us do primary care.

There are certainly PAs who see patients every day. If their primary care oriented like me, you probably see a lot of things. On a given afternoon when I'm in clinic, I'm in a family medicine clinic, so I see anything from newborns to 80 year olds... 90 year olds.

You're seeing everything right on everybody. You see a lot of chronic disease, a lot of diabetes, hypertension. I do a lot of well child exams. We take your families. You start seeing these kids as babies. I've been in this practice now for 12 years and so you see them grow up, go to college. You know you're treating whole families, and so that's very rewarding. I like that, but some PAs like specialty care.

A lot of times we have students who come in that have been athletic trainers, maybe got their undergraduate training and now they decided to be able to do more things and so they may go into orthopedics, but they're doing what they like. So you have PAs who are in specialty care, PAs who arein primary care, and then you have PAs, like me, who sort of do both academics and patient care.

07:11 Sasha McEwen

Have there been any, especially defining or challenging moments in your career that just stand out to you?

07:17 Peggy Robinson

Woah, that's a tough question.

I can't really say that. I'll probably think of some later, but off the top of my head, I can't think of anything. I think my role in the medical board has been challenging, interesting, and very rewarding. In 1994, the state decided to put a seat on the medical board for what's called mid level. PAs and nurse practitioners are sometimes referred to as mid level practitioners because they are midway between a nurse and a physician, so a lot of times you'll hear us referred to as mid level providers. In 1994 the state legislature decided to put a seat on the board for a mid level practitioner. The seat is always been held by PA and so I'm the third one. A term is 3 years. You can do two 3 year terms. I was appointed in 2006. That's been really rewarding to be involved with legislative changes and to impact how PAs across the state practice. That's been very rewarding. But you know, as I said before, I think teaching is very rewarding to me.

The impact and the influence that I hope to have on students who are going out to practice in all kind of arenas. I want them to be thoughtful and take care with what they do. I certainly see a lot of medicine practiced the wrong way and I want them to practice medicine the right way.

So just being in this position is inspiring every day because you're not only affecting the people that you take care of; you're affecting generations of people who are going to go out there and do the same thing.

I think every day is kind of inspiring.

09:10 David Hong

How do you think your background as a PA influenced how you approach being on the medical board?

09:20 Peggy Robinson

Well I think it certainly gives a good perspective. The board has eight physicians, a mid level and then three public members. I think it really helps people who are not PAs. The public perception of what a PA is all over the place. I think for physicians, especially physicians who don't work with PAs is kind of all over the place as well. And so I think it really is helpful to give them a perspective of what it's like to be a PA.

For example, how a PA functions in a day to day basis and and the responsibility that you have or don't have is very much regulated by your state medical board. There is a common expression among the board that if you've seen one medical board, you've seen one medical board because every state does it so differently. For example, the progress has just been [in North Carolina] a lot for two reasons.

The profession was started here and the state organization of PAs is very proactive and very involved in the legislature. They go to legislative meetings. They know what rules are coming down the pipe. So for those reasons, North Carolina is a great state to practice in. For example there are very few things here that a physician can do that a PA can't do.

You can prescribe for narcotics. You can see patients independently. You're supervised, but because North Carolina has a lot of rural areas and if you put a lot of restrictions on supervision, you really cut access to care and the state and the board don't want to do that. If you're my supervising physician, you don't have to be in the room when I'm seeing patients.

My supervising physician isn't even in clinic sometimes when I'm in clinic. When you are a PA at Duke for example the 1st six months all of your clinic notes have to be signed by your supervising physician. After that they don't. When I'm in clinic I have a fair amount of autonomy. I have my own rooms. I see my own patients. I make my own decisions. I order my own tests. I write my own prescriptions, so you have a lot of independence. I think helping people who don't do this get the right perception of exactly what you do and what's required is really important.

I think that's my big role on the board- [to] give them a real focus on what it's like to be a PA, what you can, and what you can't do because some of the physicians there have worked with PAs. One of the physicians on the board now was a PA. Many years ago North Carolina used to have [a program where] if you were PA and you decided you wanted to become a physician, you had a sort of shortened down course.

You could do two more years and be a physician. All of those programs have sort of phased out, so if your PA now going to physician, you still go in and go through it like everybody else. For the physicians on the board who have not worked closely with PAs, I think it's a valuable resource. Certainly a lot of forethought into creating that seat because even though we've been around for 47 years now, there's still some people who really don't know what we do and what it's like.

12:40 Sasha McEwen

Okay, you mentioned that you want to make sure that your students practice good medicine. So what do you think it takes to be a good PA to practice good medicine?

12:49 Peggy Robinson

You know probably the biggest thing-- and I say this all the time when I'm lecturing to them is to be a thoughtful clinician. You know, I think too much of the time we see knee jerk medicine. Or we make decisions... you know a lot of medicine is now algorithm driven, so I think there's been this sort of movement that now a lot of thought is taken out of medicine-- what's called the art of medicine. You know, we've sort of lost it. You don't need to do a physical exam anymore because you can order a test.

Sometimes now clinicians don't even put their hands on patients. So just kind of going back to basics and being thoughtful. Not so much following algorithms or kind of figuring out what's wrong.

Sometimes you'll pick up a sheet and very often the nurse will bring the patient back, put him in the room, will get the vital signs, and will tell you why the patients here. You sort of look at it and maybe look at some old notes and you sort of decided all this is nothing... this is a complaint or you've already kind of put your... and that's why you know you go in with an open mind. You take your time, you talk to your patient and you think about it.

You don't just come up with an answer. Your goal isn't so much to get the patient in and out in just a few minutes. Your goal is to think about everything, and then to look at your patient's social situation. Can they afford the medicine? They always tell students the first question you should ask about prescribing medicines is do you have any allergies? And the second is how do you pay for medicine?

Patients won't tell you they can't read, or they can't afford medicine, and if you're not in tune with your patient and empathetic, you'll miss that. They'll take the prescription, they won't fill it because they can't afford to. You'll have them come back for follow up. They're not better and then what's the first thing you think is a clinician? Oh, they're non compliant. They're not doing what I say.

But you never took the time, so you have to see where your patient is coming from and look at their perspective. So those are the kind of things that are important.

14:53 David Hong

How good a job do you think the current PA educational system does of instilling these concepts?

15:00 Peggy Robinson

Well I hope we're all doing it. Certainly, the rapid expansion of programs has really left PA educators in high demand and not enough because we've got all this proliferation of programs. Certainly a lot of the programs now are encouraging students to do academic things.

Our program has a teaching fellowship, and so we take PAs with a few years of clinical experience and bring them in. They stay for a year; they learn how to teach. PAs get together. We have an educational forum every year and so PA educators across the country get together and talk about what we do in our program. So I think there is a good healthy exchange of ideas and hopefully we all have the same outcome in mind.

15:47 Sasha McEwen

On the Duke Med website, you mentioned some specific interests and one was topics related to obesity. Can you tell us why that interests you?

15:57 Peggy Robinson

I think obesity is a major public health problem and I always tell the students this. When I first started practicing medicine 10 years ago, it was unusual. I would have a few patients who weighed like over 200 pounds, not many. Now that's kind of my norm. And then I have several patients who weigh 300 pounds, some over 400 pounds, and then all of the health problems associated with obesity. So diabetes, hypertension... Now it's it's such a struggle.

And then you know what's really sad is that we now we're starting to see it in the pediatric population, and so I think it's on everybody's radar screen. But it's a touchy subject. Now we start measuring BMI's for kids who are two or older. And so as a kid, anytime you are heavier in pounds than the number that you are taller in inches, your BMI is going to be like over. Sometimes it's hard to tell parents that your child is overweight. It's really interesting because I was telling the students this-- there was an article that came out about how to tell the cultural... What's the word? I'm trying to think... delicacies of telling a parent their child is overweight and they were phenomenal. Certainly African Americans and Latinos are really overweight. I think this is where I have a good advantage of being an African American provider in our clinic. You can imagine this scenario: an African American family, and this really thin white woman who comes in and who is very slender and saying, oh, you're overweight.

You can imagine how that's received if you don't say it the right way, and so I had told them to go and look at the article, which I haven't read myself, but I plan to read it soon. But certainly in the South where so many favorites or things that are just bad for you. We really have to get patients to make the connection between obesity and a lot of health problems and get him to eat better, exercise more. A lot of the barriers-- I mean things that are healthy are very expensive. Again, that goes back to understanding where your patient is coming from. Fresh vegetables, fresh fish they cost a lot of money. Unfortunately, bad things are cheap and so there are so many things to think about.

That's a real interest of mine. So many of my patient population is overweight, diabetic, hypertensive. And then you know, it's generational and their kids are the same way. So starting that conversation, having a discussion about healthier eating habits, those kind of things are really important.

18:45 David Hong

So you're saying that the population has changed in terms of how how common obesity is?

18:53 Peggy Robinson

Oh absolutely and I think one of the things that I really found interesting was it's not just a US problem. Obesity has become a worldwide health problem. I read an article in The Lancet, which is a British medical journal that said the only place in the world where obesity is not a public health problem is sub Saharan Africa. I think we're sedentary. We push buttons, video games. One of the things, especially in terms of pediatric obesity, is just getting kids to be more active. That's the one intervention that has been shown to make the most difference.

I have to say that the community and Duke are very engaged in that. Duke has a program for kids called Healthy Lifestyles and I refer a lot of my kids there. They work intensively with parents. They have a lot of websites and games kids can play and match up meal, so these are a lot of things I've taken advantage of. [The school system] had a coupon, so kids could go if they were overweight. They actually extended

it to everybody in the school system because they didn't want to sort of target overweight kids. You know with the stigma, but you could get a free subscription or whatever-- the fees for some type of athletic program so they could be in a dance club or anything to encourage physical activity. Certainly there are a lot of opportunities out there that you can take advantage of, both within the community and within Duke itself, but yeah it's a real problem.

A few years ago, obesity wasn't even a billable diagnosis, so you couldn't put obesity on your checkout sheet and and the clinic would get reimbursed for it. So I think we're making a lot of strides and realizing this is a problem that everybody has to tackle.

20:38 David Hong

So the field has kind of adapted a lot...

20:40 Peggy Robinson

Oh absolutely. There's some discussion Blue Cross Blue Shield announced a few weeks ago that patients who had a BMI greater than 40 were going to have to pay a higher premium.

I'm not sure how I feel about that. I agree there is some self responsibility. Certainly it's very hard.

It's getting everyone's attention right, and I certainly think that's going to really get a lot of people's attention.

21:16 David Hong

Do you have any ideas about the ideas about where it's going in the future?

21:20 Peggy Robinson

Hopefully to a leaner, healthier country.

That's where I hope it's going, but I think it's gonna be a slow process because there are so many parts of it. Patients that live in neighborhoods, and that's part of one of the things you do as a health care provider. You get people to get creative. If you tell people well go exercise, you know joining a gym is expensive. I think we need to think of a way that being healthy isn't this idea that costs so much that you can't obtain it. Eating is so expensive. If you want to join a gym, that's expensive or if you live in a neighborhood where you can't go outside and walk. So helping your patient come up with ideas where they can get some exercise. I ask my teenagers "well do you like to dance?" and of course they do. Well I go put on some music and dance for 30 minutes without stopping. So sort of brainstorming with patients about what can you do with your resources that'll help.

22:13 Sasha McEwen

Alright, and you mentioned your other interest was population based medicine...

22:17 Peggy Robinson

Yeah, sort of the same thing.

22:26 Sasha McEwen

Oh, OK. Back to your position on the NC Medical Board, has that at all changed the way you think about the PA program? I know you said the PA program affected how you think about how you work on the medical board. But did it work in reverse at all?

22:41 Peggy Robinson

So that...

22:42 Sasha McEwen

Like the things you learn[ed], experiences from the NC Medical Board. Did you take those back to the PA program?

22:48 Peggy Robinson

Oh, absolutely, absolutely. In fact, we just incorporated that. This year during orientation we had a panel on professionalism because some of the things you see people get in trouble with start very early. In fact, there was a a pretty landmark study a couple of years ago by a group of physicians, and apparently the physicians and you can extrapolate this to PAs, who get in trouble as professionals these behaviors started in training in medical school. Things like not coming to class, can't get along with your classmates and faculty, can't accept criticism. These unprofessional behaviors are things that get you in trouble down the road. I have been in the position where I've seen graduates of our program come to the board. You know, these are our cases that I have to recuse myself from, but certainly.

I kind of wish... we talk about this at the board if you have a chance to just be there much less sit on the board, it certainly changed the way you think about medicine in terms of being more careful, being more professional. That's always what your goal is, but sometimes you fall short for whatever reason.

You've had a bad day, you have something in your personal life and unfortunately spills over into your encounter with patients. And patients can be trying. I mean, people can be demanding and my daughter and I laugh sometimes because when I have patients like that and she go well, "why didn't you just say..." You can't say that! So remember that you have to be the professional, even when what's coming at you. I had a patient [say], "lady, you're crazy" because she wasn't getting a controlled substance that she wanted, but you have to realize that you have to sort of stay kind of above it and then that can be certainly hard to do.

I often think that if everyone had the opportunity to come, and you certainly can come to board, a lot of the sessions are open, some of them were closed. But I think if anyone, I can't imagine that not having an impact upon how anybody practices in terms of being more professional, being more careful, paying attention to detail. Some of the things you see or are simple things like patients will complain to the board because a doctor didn't get their records transferred or they didn't hear about a test. Just, you know, simple things. And so I think if you practice medicine, having watched that for a while will certainly affect everyone. But then some of the other issues about professionalism and giving students, not accepting gifts... and some of them sound like no brainers. But some of that stuff you're like what were they thinking? There's always the classics, you know sex, drugs and rock & roll. And it's always the relationships, personal relationships with patients, things you just can't do. Certainly if you're a professional and you meet a patient and you want to pursue and then you have to remember to sever the professional relationship. You can't do both. You know you can't prescribe for friends and I tell

students just say no. You know because that's an awesome responsibility of a prescription pad and a DEA number, and you can write for anything under the sun.

But you have to remember those guidelines and you can just get into trouble. One of the things that I tell students that really amazes me [is that] those people that you go out on a limb for are the very ones who will call the board and report you when the relationship goes south or something bad happens. It's like they have the board on speed dial and they want to remain anonymous when they report you, but you know who it is and so just think about it.

Now is the time to start thinking those things. So this year we decided to have a professionalism panel the first week because sometimes you don't think that those things like not coming to class, turning in assignments late and in a sort of wordy exchange when a faculty member is trying to give you some criticism.

When you're in professional training, that's when you start to sow the seeds of good professionalism. It's never too early and so yeah definitely. I brought a lot of that back. I don't want to see them over there.

27:16 David Hong

I guess you mentioned earlier the history of the PA program. But do you think you could go a little bit more into that?

27:27 Peggy Robinson

So the profession was founded here by doctor Eugene Stead, so he was a physician here at Duke- very well known. [He] saw corpsman coming back from Vietnam who had medical skills but didn't have the actual classroom training and thought that this is a trained professional that we could use or could mold into to sort of assist a physician with some of the simple things. A lot of things in medicine are routine. I always tell the students this how you learn medicine by repetition you see the same thing over and over again. So in its infancy the idea was that this would be a trained professional who could assist a physician in some of the more common things, and then that would sort of free up the physician to handle the more complex things.

That's traditionally how this started. You know, the first class was three Navy corpsman. In 19 they started in 65, graduated in 67. And from there we just progressed it. I think early in the probably first decade or so, being a PA was pretty much a second career, so you had people who had some health related profession and were older.

Being a PA was a second career and I think that's how it went for a quite some time. We're starting to see a shift now. Much like medicine, more female predominance. Males are pretty scarce in our program. For our classes in the past several years, we've been probably 70/80% female. And we're starting to see a shift to a PA being a first choice career.

Sometimes I'm amazed at the things that students have done. They start being EMTs in limited capacities like maybe as part of their undergraduate experience. Most programs will require because this is such an accelerated program. In medical school you have a long window before you're going to be independently taking care of people. You have four years of medical school and at least three years of residency where you're very closely supervised, so at least seven years from the time you start until you

may actually be responsible yourself for a patient. In PA school, that's very different. PA programs are generally somewhere between 24 and I think there there are some that are three year programs, but around 28 months is sort of the national norm.

So you're going to have somebody who could be in a relatively... even as I said, even though this is a dependent position, you could sort of be in a position where you're making decisions yourself, because supervision doesn't imply somebody directly in the room.. in a relatively short period of time, so that's why all paid programs require some hands-on experience before you come. Ours is six months. Because you're going to be in that position pretty quickly.

As I was saying, I'm sort of amazed [as] some of our students have done some really incredible things and we tend to see some common themes. So a lot of our students have EMT training. As I said before, some of them were athletic trainers, some of them have done a lot of EMT training. Every year we may have some RNS, some dietitians, and that's one of the things that sort of creates.

We want it to create cohesiveness and helping among the students. We try to deemphasize competition and that the idea is that this is a room of people with all kinds of experience across the healthcare spectrum and for them to be a help to each other. So when we get to nutrition someone who's been a dietitian can help. When we get to emergency medicine, the students have been paramedics, have a perspective to sort of learn and share and support each other.

31:06 Sasha McEwen

OK, back to your history. Was there ever a moment where you questioned your decision to become a PA?

31:14 Peggy Robinson

No, this is great, and I think that's universal. I remember a student. I think she's graduated a couple of years ago, so of course when students come... when applicants come to interview, we sort of get a feel for how much they know about PAs and she was at a medical center and she said clearly the happiest professionals were PAs. And that was one of her reasons... I've got to find out what's going on... and I think you find very few PAs who are not just think it's the best thing they've ever done. It's just sort of this universal kind.

You know one of the things that surprised me when I was a pre major advisor was the lack of knowledge of PAs. A lot of the students came and I think that's understood we come to Duke, you're going to go to med school, but a lot of students didn't know, never heard of PAs, didn't know Duke had a PA program. And Duke has been consistently, we try to not put a lot of stock in rankings, but the best PA program. It's always in the top. They'd never heard of PAs, didn't know Duke had a PA program.

It always surprised me; it was right here.They don't know anything about it, but we have had a few Duke undergrads who've come to PA school.

32:34 David Hong

Do you think as we go into the future that's going to shift?

32:37 Peggy Robinson

Oh, absolutely, one of the big things in medicine, and certainly healthcare reform has driven this, is that there aren't going to be enough primary care positions. There not a lot of dollars in medicine. Medicine has sort of shifted to a focus on primary care, I mean on specialty care. And so if you did a specialty, you got big bucks.

32:56 Peggy Robinson
The more procedures in your specialty, the bigger the bucks and not many procedures in primary care… incising an abscess. I mean the procedures are pretty mundane, and so no physicians were going into primary care, and so now you have all of these patients. Potentially, the public option and now all of these uninsured people are going to get insurance. That's what happened in Massachusetts when they mandated everybody have insurance. Who's going to take care of them then? And so the current thinking is that mid-levels are going to be the primary care providers in this country. Certainly there is a move afoot to get more medical students to choose primary care which is a fascinating specialty. I think it's really underappreciated. You have to know something about everything. If you were a specialty physician or specialty PA, you just need to know this.... so you need orthopedics or you need to know GI or you need to know...But if you're a family medicine person, if you're the gatekeeper, the first person that someone sees you have to know some of everything and it is really tough.

But yeah, certainly, I think we're being looked at as mid-levels, both nurse practitioners and PAs. PAs got a little upset because I think when Obama goes at TV he says physicians and nurse practitioners, sort of forgets these 80,000... so I think that he got inundated with "hello, we're out here." But we're going to be the primary care providers. For the country.

34:30 Sasha McEwen
Any more questions?

34:32 David Hong
I can't think of anything off the top of my head.

34:35 Sasha McEwen
OK, then thank you so much.

Peggy Robinson
Alright, no problem.