

Can't Get No Satisfaction

Patient satisfaction and PA autonomy are this year's hot topics, judging by the contents of our mailbag. Here are responses to recent editorials—plus a word of caution about the “kissing bug” associated with Chagas disease.

WHEN DID I START CONSULTING FOR DR. GOOGLE?

I have witnessed firsthand the evolution of patient satisfaction (2017;27[1]:13-14). When I became an NP in 1986, I worked in rural areas as the primary provider. My patients trusted that I cared for them and in the best way possible. A lot changed with the internet—Google became the primary care provider, and I became the consultant. Expressions of gratitude and respect from patients have been replaced by entitlement to services mandated by them. I have had patients bring in requests for diagnostic studies and further work-up for which there is no clinical evidence of need. They have their minds made up; if I am noncompliant, there is something wrong with *me*.

I have been reported to administration for being rude, insensitive, and incompetent. Now, I am not perfect, but most of these complaints were a result of me saying “no.” I was initially shocked by these demands and complaints, but they have become the new normal. Precious care time has been replaced by explanations and discussions about why I can't do what patients want me to do.

Many providers give in to patients' desires just to keep them happy and coming back. Unnecessary antibiotics, misuse of controlled pain medication, and pointless diagnostic studies have drained insurance and kept providers from just doing what is right. Big corporations run many medical practices, and unfortunately their main goal is to keep the doors open—even if that means compromising evidence-based medicine.

We have a generation of entitled people who become offended when you disagree with them. Many administrators transfer patient complaints to providers so that they

will toe the line but fail to include pertinent information, such as what the complaint was and who filed it. This is a control technique; the provider is now automatically guilty, without a trial or defense.

I am blessed to work for a company that agrees that if concern is expressed, I have the right, as the provider, to know the details. If I am perceived as rude or abrupt, then knowing who feels that way can help me improve. Upon that patient's next visit, I will adopt a gentler attitude and make an extra effort to pick up on cues that I may have missed.

Sometimes, patients express dissatisfaction because I will not dispense a controlled substance for pain upon request. My administration allows me to respond to situations like this in writing, and they can then verify that the complaint is unwarranted, and it will not be held against me or used as a control tactic. This approach has been so helpful. The company I work for also informs providers when patients express gratitude and thankfulness, which creates a great balance.

Surveys can be useful, but only if they are used as a tool to help the provider excel at his/her job—not create compliance for maintaining the patient head count. Providers should not have to worry about pleasing administration; they need to give quality care without fear.

Sue Beebe, APRN
Wichita, KA

PA AUTONOMY LEVELS THE FIELD

I can't tell you how refreshing it is to read an editorial that portrays PA autonomy in a positive light (2017;27[2]:12-14). I live in Michigan, and the physician I worked with for years is relieved to finally see laws changing for PAs. Physicians want less account-

continued on page 20 >>

>> *continued from page 11*

ability, as they are carrying so much already. The phrase “supervising physician” can feel burdensome, particularly because of its implications in a court of law. When I took time off to spend with my kids, the physician I worked with hired two NPs; he said that their increased drive for autonomy made him feel less legally responsible. The new bill passed here has altered his thinking about hiring PAs versus NPs.

I believe eventually, with increased practice authority, a title change is inevitable for the PA profession. According to my 14-

without supervision.

Personally, I would appreciate this flexibility. After 10 years of working in orthopedics, I am now solely in urgent care and locum tenens. Independent status would give PAs the ability to compete with NPs for locum positions where independent practitioners are needed, as well as increase their negotiating/earning potential and range of volunteer opportunities.

Robert Feinberg, PA-C
Bryn Mawr, PA

➤ *After a decade in practice, I find myself occasionally wishing for the ability to hang out a shingle and run my own practice.*

year-old niece, “PAs obviously can’t do anything by themselves, or their title wouldn’t be ‘assistant.’” This is truly a misnomer that doesn’t reflect the PA scope of practice.

Diana Burmeister, PA-C
Southfield, MI

A NEW MODEL FOR PA PRACTICE

Throughout my 12 years of practice, I have struggled with my delegated authority as a PA in relation to the autonomy of my NP colleagues. Most of the time, I enjoy the PA-physician relationship and see it as a mentoring program, not unlike residency. But after a decade of practice, I find myself occasionally wishing for the ability to hang out a shingle and run my own practice. I often feel taken advantage of by physician employers who reap surplus value from my labor without much appreciation.

So, what could a new model look like? Upon completion of a 5- to 8-year residency, PAs would be eligible to take a post-residency board exam and gain independent practice status. This would be limited to nonsurgical practice and might include family medicine, urgent care, dermatology, and emergency medicine. After passing the board, PAs would gain the ability to practice as an independent entity and treat patients

STRONG REACTION TO CHAGAS DISEASE

Having experienced the devastating effects of the “kissing bug” in September 2016, “Chagas Disease: Creeping into Family Practice” (2016;26[11]:38-45) was a timely article for me. I am writing to thank the authors for giving my case more credence and to issue a note of caution: People may have a strong reaction to the bite of this bug and therefore assume it to be from a spider. In some cases, including my own, bite-related anaphylaxis can send a person to the emergency department. After being bitten, I lost consciousness, fell down a flight of stairs, and sustained a bimalleolar fracture of my right ankle that required surgery. I later found the bug and submitted it to the CDC for testing; it was infected with *Trypanosoma cruzi*, the parasite that causes Chagas disease.

I want others to be aware that severe allergic reactions can result from the bite of a beetle-like bug, such as the kissing bug. I am taking it upon myself to educate my patients and colleagues and have also employed an exterminator for my home. If a person is bitten by this cone-nosed, prehistoric-looking bug, it should not be touched, but it should be collected and kept in the freezer until it can be sent to the CDC. If the bug is found to be positive for the parasite, an antibody test should then be performed on the affected person. I am lucky that my antibody test came back negative for the disease. **CR**

Constance Wylie, RN, MSN, FNP-C
Sacramento, CA