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EPs, NPs, and PAs

Historically, emergency physicians have been quick to embrace and adapt innovations in health care delivery. But over the past 4 decades, as EM developed and matured as a specialty, few changes have had a greater positive impact on patient care than the addition of nurse practitioners and physician assistants to the ED team.

I was first exposed to these remarkably talented and energetic professionals as a medical resident in the early 1970s, when Bert Bell, MD, then director of ambulatory care at Albert Einstein's Bronx Municipal (Jacobi) Hospital Center, and his ED director, the late Shelly Jacobson, MD, began to train and employ nurse practitioners and physician assistants to work alongside the few emergency physicians, nurses, and rotating residents.

Under the direction of these two pioneers, NPs and PAs helped diagnose and stabilize patients with new or acute medical problems such as hypertensive urgencies, and afterwards, continued to care for them during regularly scheduled clinic visits. In some cases, the follow-up lasted until the patients returned to the care of their personal physicians; in others, it continued for months or years.

The reason for turning to NPs and PAs for help in the 1970s was the almost total lack of qualified emergency physicians able to provide acceptable emergency care. Today, because of an unprecedented demand for that care driven by hospital closings, reduced residents' hours, new health care legislation, and a rapidly aging population, the need for NPs and PAs in emergency departments is even greater than it was originally. In our ED, NPs working with attending emergency physicians and treatment protocols initially evaluate and manage patients with acute abdominal complaints, community-acquired pneumonia, and the chemotherapy-related problem of fever with leukopenia. Our PAs participate in triage and rapid treatment, suturing and other surgical procedures, and expediting the management and discharge of "treat and release" patients.

There are many similarities in the roles of emergency department NPs and PAs, and although their responsibilities frequently overlap, NPs tend to concentrate more on diagnostic evaluations and medical treatments, whereas PAs typically handle or assist with the ED surgeries and procedures. In writing about the unique characteristics of their profession, NPs usually point out its evolution from the "nursing" model, referring to both a holistic approach to patient care and some degree of autonomy from physician supervision. In many parts of the country, however, physician supervision is mandated by state health code or law.

The modern physician assistant—sometimes referred to as a physician *associate*—evolved from the military medic or corpsman, and many of the first PAs of the 1970s had made invaluable contributions to healing soldiers and assisting physicians and surgeons in Vietnam. Afterwards, their skills and experiences were adapted to the needs of the large numbers of civilian patients beginning to crowd the nation's EDs. From the origins of the profession to the present time, PAs have been closely allied with and responsible to physicians.

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In a sense then, if NPs are RNs with additional skills and responsibilities, PAs are MDs or DOs with shorter training and less extensive hospital privileges. Either way, NPs and PAs bring an incredible array of talent, energy, and skills to the bedsides of ED patients, even if after 35 years, it is still difficult for most of us to describe the differences between them.

I hope that my physician colleagues in emergency medicine and other medical specialties will find ways to express our gratitude to all NPs and PAs during National PA Week (October 6-12, 2010) and National NP Week (November 7-13, 2010), and throughout the year. □