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Switching Surgical Specialties: Preparation, Can-do Attitude Are Key

By Bonnie Darves

One of the key attractions of PA and NP practice for many advance practice clinicians is the inherent flexibility in the field and the ability to explore different clinical areas and move among practice settings—from the ambulatory to the inpatient realm and to growing practice areas such as urgent care and retail clinics.

For APCs who work in surgical practice, the notion of moving from, say, cardiothoracic surgery to orthopedics, to follow a newfound (or long-held) interest might seem somewhat daunting. However, thanks in part to the fact that their skills are in high demand, PAs and NPs with good experience who want to explore a switch are mostly finding that it's do-able with solid planning and a can-do attitude.

Scott Cackler, PA-C, MBA, who manages the advance practice provider team at Ohio State University's Division of Thoracic Surgery in Columbus, has managed to move between thoracic surgery and neurosurgery with relative ease. After working in thoracic surgery for several years, he decided to pick up some additional work (two days a week) in neurosurgery—out of both professional interest and to supplement his income. "Although there are some big differences between the two types of surgery, making the transition between the two wasn't as difficult as I expected because, essentially, tissue is all the same," he said. "In my opinion, if you have good surgical skills, you can move between specialties if you find someone who's willing to train you."

That's just what happened in Mr. Cackler's case. He connected with a solo-practice community neurosurgeon who was willing to teach him the basics because he was confident that Mr. Cackler's existing skill set was readily transferable to the new arena. "He figured he could help me learn the nuances because I had solid OR experience, but he was also looking for someone who would interact well with the patients. It ended up being a good fit," he said, adding that he kept the part-time position for three years.

> **"In my opinion, if you have good surgical skills, you can move between specialties if you find someone who's willing to train you."**
>
> – Scott Cackler, PA-C, MBA

For Justin Brooks, PA-C, the transition—from bariatric and general surgery to neurosurgery—was a challenging but welcome change, and he felt equipped to the task. A former critical care nurse before going to PA school, Mr. Brooks now practices with Carolina Neurosurgery & Spine Associates in Charlotte, N.C., where he works in complex

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Switching Surgical Specialties

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spine. "I knew I wanted to make a switch, but I wasn't sure exactly what I wanted to do," he said. "But when I learned about a new neurosurgery opportunity through a PA I'd met a few years earlier, I decided to pursue it in part because I had done a neurosurgery rotation during school and it was a very positive experience for me. I also thought that neurosurgery was a bit sexier than bariatric, and I was excited about learning something new."

Although the learning curve was admittedly steep at first, the combination of solid OR experience—in a fast-paced, high-stress environment in which 60-hour weeks and back-to-back cases were the norm—and his critical care nursing background provided a solid basis for making the transition. "The surgery and tools are different, but I've found that everything I've learned in critical care and general surgery has helped me out—and I think that most PAs with OR experience would find the transition manageable," said Mr. Brooks, who is on the board of the Association of Neurosurgical Physician Assistants. "We know a lot about medicine, so it's a matter of trusting that you can make the switch and having an open mind."

Some PAs have taken a more stepwise approach to switching among specialties. Chris Kottenstette, PA-C, CPE, spent several years as a primary care PA and athletic trainer before moving into pain management, and from there into the primarily procedure-based practice he enjoys now: treating patients with debilitating spine pain at the Colorado Spine Institute in Johnstown.

"I think it's easy to adapt within surgery, because you can learn the mechanics and post-op aspects pretty quickly, with the exception perhaps of neurosurgery. It would be harder, I think, to go from surgery into the medicine realm," said Kottenstette, who founded and is current president of the PAs in Pain Medicine special interest group of the American Academy of Physician Assistants.

"When you get to the interview, don't be afraid to be very specific about your skills and the responsibilities that you've had."

– Justin Brooks, PA-C

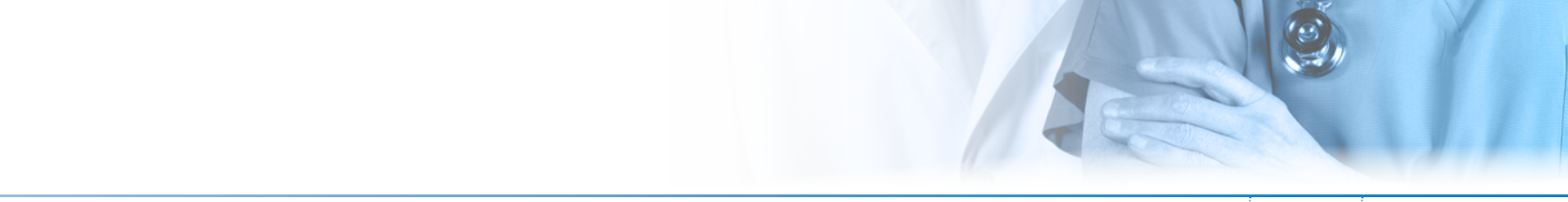
Self-confidence: a must-have

His recommendation to PAs and NPs who want to switch surgical fields is to do as much research and "book study" as they can initially to familiarize themselves, and then talk to PAs working in the field they're considering, to learn out about the environment. Subspecialty chapters and special interest groups are very helpful in that regard, Mr. Kottenstette said. Beyond that, PAs need to be prepared for the learning pains that go with any career shift and face those positively, he suggested. "People who are open and willing to learn will do well, and they'll find opportunities because there are plenty of good jobs out there. But I think it's important to have confidence and a thick skin if you're considering a career-path switch," he said.

When contemplating a switch to a different surgical specialty, a major dose of self-confidence is a key prerequisite for PAs and NPs, several other sources also stressed. Sarah Recupero, PA-C, RRT, who works locums as a surgical and critical care PA and has practiced in dermatology, trauma, general

"Many organizations are expanding their OR schedules these days to accommodate greater volumes, which means there will be increasing demand for OR-skilled PAs and NPs."

– Alyssa Bostock, Provider Relations, Wilmington Health



TIPS FOR MAKING THE SWITCH

Advance practice clinicians who want to move from one surgical specialty to a different one should prepare well in advance and ensure that they document the skills and accomplishments that equip them to succeed in a new surgical environment, sources concurred. Following are their tips and guidance for making the switch:

Quantify your OR experience—in detail—and do up-front research. Justin Brooks, PA-C advises PAs to take the time to log their case volumes and procedure types and be prepared to present that information to a prospective hiring organization. "The extent of your on-the-job training and experience is hard to put on a resume, so make sure you're prepared to present that level of detail," he said. "And when you get to the interview, don't be afraid to be very specific about your skills and the responsibilities that you've had. Of course, it's also helpful to have your supervising physician write a good letter, if circumstances permit."

It's also important, in Mr. Brooks' view, to reach out to other PAs in the surgical specialty you're considering, so that you have a sense of what practice will be like. "Take the time to get out and talk to people in other practices—not only to get a sense of what it's like but also to be better prepared to ask questions during an interview," he said.

State as specifically as possible what you're seeking in a switch. This is the best opening move, according to Scott Cackler, PA-C. "Don't just say, 'I want to practice in another surgical specialty.' Say that you want orthopedics, for example, and talk about why the specialty appeals to you and why you expect to be successful in the field."

Consider taking an online course or workshop in the field you're considering, to bolster your skills. That shows motivation, several sources mentioned, and it's an indication that you're not just looking for a new job—it also demonstrates commitment to a new field.

surgery and acute-care surgery, advises her colleagues to keep in mind that their skills are in high demand and that a positive can-do stance goes a long way.

"Once a PA understands the basics and has gotten some good OR experience, making a switch is very do-able if you have the right attitude. My work in trauma, for example, because in that field you deal with all the tissues, prepared me to practice in a range of surgical specialties and environments," she said. She noted that her previous experience as a respiratory therapist has also been an asset.

The ability to switch environments comes in especially handy for a locums PA, where highly variable environments come with the turf. Ms. Recupero practices locums by choice because she likes to travel, enjoys variability and appreciates the opportunity to meet new people. "I've definitely had some challenging assignments, but when you know that you're really needed, that helps," she said. "And besides, I figure I can do anything to three months."

Mr. Cackler urges his colleagues who want a change but worry about whether they'll be welcomed to keep in mind the key asset for any PA: their comprehensive training. "If you're trying to sell yourself, remember that what PAs have proved over and over is that we're broad based by nature of our education," he said. "That makes us more able to switch fields than some other clinical professionals."

Will there be jobs?

Understandably, the key concerns for PAs and NPs who want to make a switch is whether they'll find somewhere to land and, specifically, how willing prospective employers will be to bring an APC into a surgical specialty where she or he hasn't practiced before. Judging from their email inboxes, several sources noted, there's a high demand generally for surgical APCs. That suggests that in a high-demand market, employers might be more than willing to consider candidates who have good skill sets generally and some OR experience.

"I seem to be on everybody's recruitment list for pain management, but I also get a lot of inquiries from people who are looking generally for surgical PAs," Mr. Kottenstette reported.

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LEGAL CORNER

Looking at Non-competes, Quality Clauses in Employment Contracts

By Bonnie Darves

Andrew Knoll, MD, JD

In this series, Surgery PA Market Watch speaks with health law specialists about contractual issues and trends related to PA and NP compensation and performance. In this article, physician and attorney Anthony Knoll, MD, JD, a partner with the Syracuse, N.Y., firm Cohen Compagni Beckman Appler & Knoll, PLLC, who specializes in physician and advance practice provider contracts, offers a perspective on restrictive covenant clauses that hospitals, health systems and other hiring entities use to prevent clinicians who leave the practice from providing their services to nearby "competing" practices for a specific time period.

He also talks about the relatively new trend toward connecting quality-metrics performance and annual compensation in employment contracts.

Q: In an environment in which some states are moving away from enforcing restrictive covenants—or "non-competes," as they're frequently called—and the health services marketplace is changing rapidly, how prevalent and how important are these agreements? How should PAs and NPs view such clauses in the overall context of the contract?

A: We're still seeing these clauses, and they're not going away. Advance practice clinicians should consider them enforceable from the standpoint, at least, of the cost—in money and time—to defend themselves if they leave a practice and the employer decides to launch a lawsuit to enforce the agreement.

For the most part, these restrictive covenants are still structured to prevent the departing employee from practicing within a certain radius of the hospital or practice—which might be 100 miles in a rural area, 25 in a suburban one or just a few miles in an urban area. Most are fairly standard and relatively reasonable, but I occasionally see something unreasonable, like a 50-mile radius in a suburban area.

However, we're seeing some shifts in these clauses in certain urban areas that PAs and NPs should be aware of. In some markets where a lot of consolidation has occurred and health systems are gobbling up smaller hospitals, for example, the restrictive covenant, rather than spelling out a geographic distance will instead cite a specific competing hospital or health system. It might state: *within x years of leaving the practice, the employee cannot work for health system Y or hospitals A, B or C*. Others I've seen might restrict the clinician from going to a particular large health system, but not to smaller hospitals or systems in the same urban area.

Of course, this isn't a scientific sample, but it's interesting because it's something we weren't seeing before—these clauses tended to be pretty vanilla. And the fact that these are cropping up might mean that non-competes matter more now than they did five years ago. It's a byproduct of this mega-merger trend.

Q: To what extent are quality-metric performance clauses that affect actual compensation showing up in employment contracts, and should PAs and NPs be concerned about them?

A: Organizations are moving in this direction, but it's still early. My general feeling about this is that if the provider gets a bonus out of it, it's found money. What we're not seeing much of yet is potentially punitive quality structures—that the provider earns $120,000 a year, for example, but 10% of that amount is at risk based on performance in, say, five particular areas.

I think this is a tough area for practices and hospitals. They're trying to use a mechanism and some objectivity so that when the hospital is going to allocate a pile of money [for quality performance] to a group, there's some defensible way to give more of the bonus money to the stellar providers who perform well and have a great reputation than the ones who just scrape by. But the differentiation I've seen to date is still somewhat minimal, which is why I advise providers not to get overly concerned about these clauses in terms of their compensation. Psychologically, if you're not betting on it, you're not going to worry about it.

> **"The fact that these clauses are cropping up might mean that non-competes matter more now than they did a few years ago."**

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Organizations seeking surgical APCs would probably prefer same-specialty experience. However, many likely will consider APCs from one surgical specialty for a position in another provided the clinician has ample OR experience and a demonstrated track record in acquiring new skills, according to Alysa L. Bostick, director of provider relations for Wilmington Health in Wilmington, N.C. "The selection criteria will always be same-specialty on the first tier, and then candidates who have OR experience—ideally lots of first assist time," said Ms. Bostick.

"There really is a lot of commonality among procedures, so I think most PAs and NPs adapt easily to another specialty, from what I've heard." Wilmington Health's surgeons are willing to work with experienced clinicians from other specialties, she added. "And I expect that's the case in many practices. Many organizations are expanding their OR schedules these days to accommodate greater volumes, which means there will be increasing demand for OR-skilled PAs and NPs."

"Once a PA understands the basics and has gotten some good OR experience, making a switch is very do-able if you have the right attitude."

– Sarah Recupero, PA-C

Ms. Darves, a freelance healthcare writer and editor based near Seattle, is editor of Surgery PA Market Watch and Neurosurgery Market Watch.

IN BRIEF

Medicare PA Direct-Pay Legislation Introduced

The American Academy of PAs (AAPA) has been instrumental in the recent development of new national legislation that seeks to authorize PAs to receive direct payment under Medicare. The bill, the Physician Assistant Direct Payment Act, H.R. 1052, was introduced in February. The legislation is intended to address an inconsistency in the current reimbursement environment, in which PAs have become the only clinicians who are authorized to bill Medicare but not permitted to receive direct payment.

Proponents of the legislation claim that the inability to receive direct payment not only prevents payment reassignment—something physicians and advanced practice nurses are permitted to do—but also prevents PAs from participating fully and openly in the numerous existing and emerging value-based payment programs. AAPA President and Board Chair Jonathan E. Sobel, DMSc, MBA, PA-C, maintains that the current payment structure renders PAs unable to work for staffing companies and group practices because they can't reassignment Medicare payments to their employer.

"When enacted, this legislation will improve access to care for patients. By removing unnecessary administrative burdens and restrictions, it will enhance the ability of PAs to bring their proven clinical competence and skill sets to patients in need," Mr. Sobel said.

AASPA Annual Meeting Registration Opens

The American Association of Surgical Physician Assistants has opened registration for its 19th Annual CME Meeting and Surgical Update, to be held Oct. 17-20 in Lake Buena Vista, Fla. The event will take place at the Wyndham Lake Buena Vista Disney Springs Resort. The registration fee is $650 for AASPA members and $800 for nonmembers; single-day rates are also available. For PA students, the registration fee of $125 includes a $25 student membership.

Members of AASPA who are PA students, PA residents or PA fellows who plan to attend the conference are welcome to submit a poster presentation application. The poster presentation is intended to provide new PAs an opportunity to meet with residency and fellowship program participants who also submit poster presentations.

For more information on the conference or poster/abstract submission, go to https://www.aaspa.com/events/aaspa-cme-meetings/19th-annual-cme-meeting-and-surgical-update.

How to Improve Your Marketability as a PA or NP

By Katie Cole

As a PA or NP, you know that you have solid experience and skills, and a good working relationship with your current practice. But if you're ready to move on, how do you best convey this "professional package" to another potential practice--especially when the first impression you're able to make is typically via your resume or CV. What makes a candidate marketable, and how can you maximize that marketability?

Start by displaying your best cards prominently; in the eyes of a potential employer, the two things that stand out are experience and job stability. If you have been with your current employer for several years, ensure that those dates are highly visible. If you have a shorter job in your history or any gaps, explain them briefly on the CV or in a cover letter.

Which skills to highlight?

Many advance practice clinicians (APCs) aren't sure which skills they should stress in the CVs, especially if they are considering switching surgical specialties. Physician assistants in particular often have a lot of crossover potential among different surgical specialties because of their skills and OR experience, so it's important to be detailed about your experience as a first assist, the types of procedures that you've worked on and your role and responsibilities in the OR. Ensure that this detail is clearly listed both within current/previous job descriptions and that related skills appear prominently in your overall "Key Skills" list, which should appear near the top of your document for easy accessibility.

If you are seeking a job in the same surgical specialty you are currently working in, be sure to include on your CV the specific types of cases you did as well as the clinical vs. OR responsibilities you had. Any first assist procedures should be specified, such as total knee replacement or anterior cruciate ligament reconstruction within orthopedics, or laparoscopic colon resection or appendectomy within general surgery, for example. Finally, ensure that your total procedure numbers (ideally captured in your ongoing log) are highlighted, if you have extensive experience.

If you are applying for a job in a different surgical specialty, your experience is still likely very marketable to other surgical specialties if you highlight the procedures correctly and make it clear to potential employers that you have experience in multiple procedures. By the way, it's helpful to use bullet points when highlighting types of cases and procedures, so that both recruiters and potential employers can skim the document easily. If you've had intensive responsibilities, such as the following, consider bulleting those as well:

- Endoscopic vein harvesting
- Central line placement

Highlight "soft skills" too

In the current market, where quality measurements and both patient and colleague satisfaction are becoming increasingly important (and sometimes separately compensated, for individuals with high scores), be sure to note good marks or accolades you've received. This is a highly marketable trait today, when healthcare organizations are focusing on avoiding Medicare penalties for poor outcomes and building strong teams to ensure better, more consistent performance.

Employers are looking for a good fit technically as well as personally. After you have made your clinical experience clear in your CV, add in your cover letter a few brief personal statements that demonstrate how you work with your current staff, both APCs and surgeons. Share how you collaborate with your current surgeon(s), and if you take call or work independently be sure to make note of that as well.

If you are looking to make yourself more marketable in the future but aren't interested in changing jobs right now, consider approaching your current employer to help identify ways that you can expand your skill set. In many cases, your superiors might not approach you but will be highly amenable to giving you more responsibility if you take initiative. Along the same lines, take advantage of any CMEs that you can attend or complete, above and beyond those required annually. And always take full advantage of any employer-paid CME and major conferences. It not only builds your CV but also shows that you're committed to "career-long" learning.

Ms. Cole is a Denver resident and publisher of Surgery PA Market Watch and Neurosurgery Market Watch.

CONTRIBUTIONS WELCOMED!

Help shape Surgery PA Market Watch by contributing opinion articles that address issues affecting surgical APC practice or that provide guidance on career matters. We also seek ideas for articles on topics of potential interest to our readers.

To discuss an idea or to propose a coverage topic, please contact Surgery PA Market Watch editor Bonnie Darves at **425-822-7409** or **bonnie@darves.net** or publisher Katie Cole at **303-832-1866** or **katie.cole@harlequinna.com**.

PERSPECTIVES

Doctorate Degrees for PAs: The Next Step for the Profession?

Thomas Colletti DHSc, PA-C

Although residency programs for PAs have proliferated in recent years, to an estimated 90 programs covering 25 specialty areas, the terminal degree for the profession has remained the entry-level master's degree. Some in the field contend that it's time to expand the options for PAs by implementing a clinical doctorate-degree path for PAs who want expand their knowledge and skill sets to better position themselves to play larger roles in the fast-evolving healthcare system.

Surgery PA Market Watch recently spoke with Thomas Colletti, DHSc, MPAS, PA-C, associate professor at the University of Lynchburg School of PA Medicine in Virginia, and Interim Director of Doctoral Education for the Doctor of Medical Science degree for PAs. He shared his thoughts on the rationale for the degree itself for PAs and for more widespread availability of such programs.

What prompted the discussion of doctoral degrees for PAs?

The master's degree became the standardized entry-level degree in 2000, but a lot has happened in healthcare since then that has prompted the field to look at the doctoral degree as another option beside the master's. For one, several other fields, including pharmacy, physical therapy, occupational therapy and others have endorsed the doctorate as the entry-level degree. That development prompted a PA summit in 2009 to consider making the doctorate the entry-level degree.

Summit participants generally opposed the idea of a PA-specific doctoral degree, with some stating that PAs are already excellent clinicians and that a doctorate is not needed for PAs to practice high-quality medicine. Participants did, however, support the concept of PAs pursuing non-PA-specific clinical doctorate degrees such as Doctor of Medical Science (DMSc) and Doctor of Health Science (DHSc). Since then, a growing number of universities have begun offering such degrees and a few, including my institution, now offer PA-specific doctoral degrees. In many cases, these programs are structured to enable PAs to continue working while they pursue their doctorate degree.

It is worth noting that the nurse practitioner profession had made a decision to adopt an entry-level doctoral degree by 2015, but that effort was put on hold because of factors such as nursing shortages, the recession and healthcare reform.

Why do you think that it's time for the doctoral degree to become more widespread for PAs?

For several reasons, but the key one is to support expanded career opportunities for PAs. The Institute of Medicine's report on health professions education in 2003 called for better educating and equipping all health professionals to work within interdisciplinary teams, with an emphasis on evidence-based practice, quality improvement and informatics. However, even though the team approach to medical practice is instilled early in PA training, not all master's level PA programs teach valuable skills such as healthcare administration, health law and policy.

A professional doctorate for PAs would enable those interested to obtain those skills, and to learn research techniques and health systems administration—better positioning PAs to assume leadership roles within healthcare organizations and the industry as a whole. A post-graduate program that teaches those skills may be a better approach than adding them to the master's curriculum, which is already overburdened.

I think the doctoral degree also offers a way to enable our field to gain parity with other advance practice professionals that have adopted such degrees and used them to move into upper-level administrative, health systems, educational and industry positions. I'd like to see PAs as leaders and administrators, up into the C-suite, as some advanced practice nursing professionals have done, so that we can impact healthcare systems and the industry as a whole. PAs should be able to enter the board room on parity with other health professionals, and a doctoral degree would help enable that development.

Finally, I think there's a sense that PAs are getting left out of some of the policy advancements that are occurring in the country. Having more doctorate-educated PAs would help the field play a larger role in influencing the health system changes that are taking place. PAs, as experienced and increasingly valuable members of clinical teams, are well qualified to help remedy a lot of the systems issues that organizations are trying to address.

You mentioned that there's been some pushback on the concept of a doctorate for PAs. Why is that occurring?

There are some parties who have argued that a doctoral degree is a push for practice autonomy, but that's not the case. PAs are committed to team practice—in fact, the Optimal Team Practice (OTP) model that the AAPA is proposing focuses on collaboration, not only with physicians but also with other healthcare professionals. A doctoral degree isn't going to affect that commitment. What is needed is to change regulations in order to allow PAs to practice at the top of their licenses more effectively.

FEATURED OPPORTUNITY

Michigan Cardiothoracic Surgery PA or NP

A hospital in southwestern Michigan is seeking a cardiothoracic PA or NP. Call for the incoming advanced practice provider (APP) will be 1:4 on weekends, which amounts to about 13 weekends annually. The work schedule hours are the typical 8 a.m. to 5 p.m. Monday to Friday, depending on the surgery schedule and clinic days.

The practice currently consists of three surgeons and four APPs. This position will be full-time, hospital employed, with an inpatient focus on surgical assisting, and with approximately 1/4 on-call obligation. Experience and facility in cardiac surgery assisting and endoscopic vein harvesting is an absolute requirement.

The hospital will offer a competitive compensation package with comprehensive benefits that include generous PTO and CME allowance, profit sharing, paid relocation and a sign-on bonus. The facility is a verified Level 1 Trauma Center, accredited Chest Pain Center and a Joint commission-certified Primary Stroke Center.

The area offers a community environment with big-city amenities and excellent school systems. The climate is pleasant with four distinct seasons, ranging from fall's vibrant foliage to spring's lush greenery. The area enjoys lake-effect weather, which is cooling during the warmer months and provides for milder temperatures during the cooler months.

SURGERY PA AND NP JOBS

Kalamazoo, MI: *Hospital Employed - Cardiothoracic PA/NP*

Greenville, NC: *Hospital Employed - Neuro-ICU PA/NP*

Long Island, NY: *Private Practice - Neurosurgery PA*

Raleigh, NC: *Academic - Neurosurgery PA/NP*

Trenton, NJ: *Hospital Employed - Neuro-ICU PA/NP*

Stuart, FL: *Hospital Employed, General/ Vascular PA/NP*

Fresno, CA: *Priva-demic - Neurosurgery PA/NP*

Las Vegas, NV: *Private Practice - Neurosurgery PA/NP*

Macon, GA: *Private Practice - Neurosurgery PA/NP*

Greenville, NC: *Hospital Employed - Orthopedic Trauma Surgery PA/NP*

Stuart, FL: *Hospital Employed - Cardiothoracic PA/NP*

SURGERY PA EVENTS

2nd Surgical Oncology Advanced Practitioner Conference
❏ April 26-28
Houston, Texas

Extremities in the Carolinas—Trauma for General Orthopaedics
❏ May 17-19
Charlotte, North Carolina

AAPA 2019
❏ May 18-22
Denver, Colorado

Society for Vascular Surgery Annual Meeting
❏ June 12
National Harbor, Maryland

2019 Vascular Annual Meeting
❏ June 12-15
Washington DC

20th Annual Conference--Orthopaedics in the Lone Star State
❏ August 26-30
San Antonio, Texas

Perspectives in Thoracic Oncology
❏ October 18
New York, New York

Association of Neurosurgical Physician Assistants
❏ October 20
San Diego, California