PA Certification, PA Education & Reform

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A lot is happening in PA-dom these days. Previous columns have discussed each of the following topics. Here are some updates and further thoughts.

Specialty Certification

The NCCPA’s bold announcement that it would offer five specialty certification exams has led to continuing controversy and concern. Certification in one of these specialties—emergency medicine, orthopedic surgery, cardiovascular surgery, nephrology and psychiatry—would be voluntary, time-limited and not linked to licensure.

The outcomes and ultimate effects of specialty certification examinations remain uncertain. A key point is that the AAPA has existing policy that clearly states its opposition to PA specialty certification examinations. The AAPA position is based on the concept of preserving PA clinical mobility among specialties and discouraging the creation of what have been termed barriers to the entry of PAs into clinical specialties.

Despite its official anti-specialty certification examination policy, the reality is that the AAPA can do little to halt the progression of specialty certification. The hope is that at the formal organizational level, the NCCPA and the AAPA will try to work together to design a certification system in such a way that maximum clinical flexibility is maintained.

A challenge to this effort is that specialty certification’s ultimate impact is uncharted territory and will not be evident for years, until its value is tested in the medical marketplace.

Doctoral Education

While the profession’s organizations have held a PA Clinical Doctoral Summit from which was issued clear and bold conclusions, the discussion on the entry-level doctoral degree for PAs has only begun.

Leaders in PA education are weighing in on this debate, with a few prominent authorities calling for an entry-level doctorate. Maintaining equivalent status in the health system with perceived a few prominent authorities calling for an entry-level doctorate. Maintaining equivalent status in the health system with perceived

While attaining this highly desirable policy objective would be a plus on one level, the downside could be the strings that likely would be attached to the awarding of such funding. Federal health workforce policies for PAs almost certainly would aim for the achievement of longstanding workforce policy objectives—specifically, more primary care providers, more care in medically needy areas and more workforce diversity. PA programs would be called upon to develop strategies to respond to these funding targets—a task that many programs have not given high priority. Thus, with the influx of additional federal funding, PA programs will face the challenge of ramping up efforts to address these workforce policy priorities. Are programs and their faculties up to the task?

Solving and reversing the anemic state of PA scholarship (e.g., 74% of PA faculty have no peer-reviewed articles published over their entire career) and that insufficient doctorally prepared faculty are currently in place. With so few doctorally prepared PA faculty, it likely is not even realistic to consider the notion of a legitimate entry-level PA doctoral degree.” Such an impediment, however, may not deter some institutions, and there is a sense of inevitability about the initiation of such degree programs.

Health Workforce Policy

While some see the prospects of Congress passing a health care reform bill diminishing, there is still strong anticipation about the enactment of legislation that would strengthen the health care workforce. Such legislation almost certainly would be aimed at strengthening the primary care workforce and would include incentives designed to attract more providers (including PAs) into primary care and general practice. This could result in substantially increased funding for PA educational programs through the Health Resources and Services Administration.

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Coping With Hot Flashes in Menopause

As a woman ages, her ovaries produce less and less estrogen and progesterone. When a woman hasn’t had a period for 12 months—and when there’s no other reason for this change, such as pregnancy or illness—she has reached menopause and can no longer become pregnant. For most women, this happens after age 45.

Menopause can affect women in many different ways. Sometimes, the only symptom is that periods stop happening and she otherwise feels fine. But some women experience other symptoms such as hot flashes, trouble sleeping, vaginal dryness and mood swings.

If you’re undergoing menopause and are having hot flashes, here are some tips to deal with them.

Symptoms & Triggers

Hot flashes can occur at any time of day. At night, they’re called night sweats and they often awaken women from sleep. Hot flashes are quite common—as many as three of four women going through menopause get them.

Hot flashes vary in frequency. You might experience multiple hot flashes each day or a few a week. Some last as long as 30 minutes, but most go away in just a few minutes. During a hot flash, you may experience:

- Feelings of pressure in your head when the hot flash starts
- Mild warmth to intense heat that spreads through your upper body and face
- A flushed appearance with red, blotchy skin on your face, neck and upper chest
- Rapid heartbeat
- Sweating, mostly on your upper body
- Feelings of dulls as the heat flash subsides
- Less common symptoms such as weakness, fatigue, faintness and dizziness

Some women associate triggers with their hot flashes. Common triggers are feeling stressed, being in a hot place, eating hot or spicy foods or drinking alcohol or caffeine.

Women who smoke, are overweight or don’t exercise are more likely to have hot flashes. African American women also tend to be more susceptible to hot flashes.

Change Your Lifestyle

If your hot flashes aren’t particularly bothersome, you don’t need to treat them. And if they’re mild, you can manage hot flashes with lifestyle changes. The first step is to avoid triggers. Another strategy is to keep cool—dress in layers so you can remove outer clothing if you get warm, sip a cold drink if you feel a hot flash coming on and wash hands in cold water during or after a hot flash.

If you experience night sweats, sleep in a cool room, use a fan and try using special sleeperwear and pillows that pull moisture away from the skin. Put an ice pack under your pillows, and if you wake up with a night sweat, flip the pillows to the cool side.

Some women find that symptoms improve with relaxation. Yoga or meditation are popular choices. A breathing technique called paced respiration, which involves inhaling and exhaling at an even pace, also may help.

Smoking is linked to hot flashes, so quitting should be a priority. Quitting also decreases the risk for heart disease, stroke and cancer.

Other Treatments

Your PA might prescribe medications to help relieve hot flashes. Options include hormone therapy and other medications such as antidepressants, gabapentin and clonidine that aren’t specifically indicated for hot flashes that can provide some relief.

Some women use alternative medicines to curb hot flashes, such as supplements containing black cohosh or phytoestrogens such as soy. There’s no strong evidence that these supplements relieve hot flashes, but some women report success. Make sure your PA knows you’re taking alternative remedies, because some can be harmful when used with other drugs.

Sources include the National Institute on Aging, the Mayo Clinic, the Office on Women’s Health and the North American Menopause Society.

Notes

Your physician assistant has given you this patient education handout to further explain or remind you about an issue related to your health. This handout is a general guide only. If you have specific questions, discuss them with your PA.

References