Podcast Episode 78

Physician Assistants have an increasingly important role in healthcare.

Featuring Dr. Klarisse Mathis.

Physician Assistants are a relatively new specialty created in response to the shortage of primary care physicians in rural areas, and the PA profession is now well established with over 100,000 graduates of accredited PA programs. The training time is a little shorter than that for a primary care physician, which does make the profession comparatively accessible and more cost effective. Dr. Klarisse Mathis is based in Manhattan and sees patients from all kinds of backgrounds, including providing care to immigrant and refugee children – New York City has every aspect of diversity. In today's podcast Klarisse talks about her life as a Manhattan PA, the challenges and rewards, and shares her observations on health disparities and meeting the needs of minority populations. With podcast host Eileen Body.

All views and opinions are the participants own.

Eileen: Welcome to The Health Disparities Podcast. A program of the Movement is Life Caucus, where we have conversations about health disparities with people who are working to eliminate them. I'm Eileen Bodie. I've been a member of the caucus for 10 years, and I'm delighted today to be hosting a conversation with Klarisse Mathis. We'll be talking about the unique and growing role of physician assistants and the health care landscape. Klarisse is an orthopedic physician assistant at Lenox Hill Hospital in New

York City, which is in the Upper East Side of Manhattan. Welcome to The Health Disparities Podcast, Klarisse.

NP Klarisse Mathis: Thank you. Thank you for having me.

Eileen: We're so glad to have you here today. And actually, my very first question is this, a lot of people don't know what a physician assistant does. What do you do?

Klarisse: So that's a great question. A physician assistant is a medical practitioner in which our graduate program, we go to school for about two to three years for most PA programs in which we are trained to diagnose, treat, read x-rays. We can prescribe medications, things of that nature. We're in the operating room. It's pretty much almost a comparison of four years of med school kind of crammed into two to three years. So, we're fully able and capable to see patients on our own. We have a lot of autonomy depending on which sector that we're working in as well.

Eileen: So, at Lenox Hill, as a physician assistant, you're in the orthopedic section of the hospital, is that correct?

Klarisse: Correct.

Eileen: So, are you actually in the operating room assisting surgeons?

Klarisse: Yes. That's like my number one place that I love to work at. So, I'm in the operating room at least two days of the week.

Eileen: So, do you help out with preparation for surgery with the patients?

Klarisse: Yes. So, literally I'm there from start to finish. We'll see the patient as soon as they come in, they're getting dressed, just to get a little bit more background about the patient. I'll just ask about their medical background and things of that nature. I'm actually there with the patient, escorting them in the room with the nurse. I'm helping prep and drape. If an anesthesiologist needs help, I'm helping them give blocks and things of that nature. And as soon as they're put to sleep, I'm there prepping, draping first assisting with the surgeon all the way down to suturing and closing wounds and taking them to the recovery room.

Eileen: Now, you also told us that you're involved in working with migrant children as a physician assistant. Could you tell me a little bit about that?

Klarisse: Yeah, so I have a per diem job that I work on usually every Monday in which I work for a facility called Cayuga. It's pretty much all the children that are crossing the border. A lot of them are crossing without their

parents. Most of their parents are left behind, or some of their parents are actually in the United States. So, what we do as PAs there, we pretty much are frontline with the children. We're making sure that all their medical vaccinations are up to date and things of that nature. So, that they can either go into foster care or they're pretty much teed up that they can also be sent with their parents. So, we're doing everything from sick call, vaccinations, giving TB shots and things of that nature.

Eileen: Well, it sounds like there's a real contrast between what you do at Lenox Hill hospital and what you do for Cayuga. So, let me ask this question. Let's go back to Lenox Hill for a second. What is your patient population there? Is it reflective of people who can afford elective surgery? Are there any healthcare disparities there? What, kind of patients do you have?

Klarisse: I would say because of the location of the hospital. It Is located on the Upper East Side of Manhattan. And if you're from New York, you know, that's a pretty posh area. So, I would say our population is not that diverse, but we do have a lot of surgeons that I feel like are bringing in that diversity, where we're having a stronger reflection on a lot of Hispanic and Latino patients, especially coming in for spine surgeries and joint replacements. We always have construction workers because they're always doing constant construction in the area. And, seemingly that's a strong Spanish population as well, minority population that comes in that

are having, accidents and injuries we will see that population come in as well. But I feel like it depends on the surgeon that are kind of starting to diversify the group. Also, again, it's still New York City. So, we will have those occasional, people that are homeless that break their ankle. We still have to treat them no matter what and trying to help them get into shelters and things of that nature. So, it's not just going to be necessarily the older lady that's fallen and broken her hip in which we're doing a surgery on, or the people that, like you said, can afford the elective surgeries as well.

Eileen: This is a very interesting concept. You have a hospital here on the Upper East Side, which really, if you will services more well to do patients who can afford to have excellent health insurance. And then you've got a beginning patient base who are coming in, who may or may not have insurance. Do you find any kind of unequal care between the two patient populations that come to Lennox Hill?

Klarisse: I can only speak for myself. Especially, if I'm in the operating room, I don't necessarily know your complete background. So, to me you're just a patient and I'm just trying to make sure we keep alive and we do a great surgery on, but I do notice because I'm also on the in-patient side. So, I do take care of these patients after the operating room and post-op care. And once you do find out a little bit more of their background, I do notice that the people who may be, domiciles versus the people that are well to

do, or just at least, like you said, have great insurance are able to have elective surgery. No problem. I feel like it's just a harder transition versus the patient with good insurance. They can just probably progress to go home versus the homeless person or the person that is elderly doesn't have any family at all to help them. Doesn't have great healthcare, Medicare or Medicaid. They may go to rehab or they may not be able to afford to go to rehab. So, I feel like that's where, as a team effort, social workers and case managers have to come in to play to try to figure out what are we going to do with this patient? And we can't just send them back out on the street. We have to make sure that there is some plan in place before we can safely discharge them. So, we've definitely had patients that we call them, they're just live-ins. They have been with us for, almost like 20, 30 days because of their home situation where we just have not been able to practically find a place for them. It's pretty tough. But as far as me, I just, I take care of everybody. There was almost a recent incident where some lady needed a scooter and she couldn't afford one. And my cohorts were literally saying, "Hey, everybody, if we just chipped in $10 apiece. Instead of her just rotting here in the hospital, waiting for a scooter because she can't afford one, why don't we just chip in and just give her the scooter?" Because unfortunately, hospital resources, we only have one scooter in the house, which we use with physical therapy to practice on. So, they were like, we're not giving a patient, our scooter, we need that to train other patients on. So, it was just

like, well, what do you do in this situation? Patient can't afford it. Hospital's not going to give it to them. What do you do in these situations? So, I do feel like there are some caveats, depending on what insurance you have that will determine, where you're going to go home rehab and things of that nature.

Eileen: Well, that's a very interesting concept. I was actually sort of fishing for that. I was trying to get to that.

Klarisse: Not everybody, has a job that will give them great benefits or, unfortunately everybody's going to get older. So, what happens when we're on Medicare or if you have to be on Medicaid, what exactly is prepared for you? And especially Social Security, that's running out. So, a lot of people can't afford to have certain equipment or do certain things after you have your surgeries, and then the caveat behind that too, is like, it's a Catch 22. You didn't know that you were going to fall down today and break, one of your bones. So, you can't just lay there because then, mortality rate increases. Somebody has to do something and we have to intervene at some point.

Eileen: At Lenox Hill, do you find that the care providers are equal in their treatment of, let's say the wealthier patients versus the patients who have limited means?

Klarisse: I don't really see that. I will not say that has probably never happened. I'm sure it has. It's just that maybe I have never witnessed that. I do notice that, certain patients who are wealthier may have more connections. So, I have been in those situations where things weren't going their way, and they've definitely said, well, I'm calling such and such. So, they'll call my attending. Some of them know CEO's of the hospital, some of them know just people, higher ups and admin, and they will definitely try to blow the whistle on us because they know certain people. And for me, it's just like, “Hey, if that's what you have to do, sure. I'm just here to try to provide patient care.” I'm pretty good with bedside manner. So, if I see there's an issue, I always just try to relate to the person. Will just try to figure out what's going on with the patient. I think that's one thing a lot of people don't do which is listen to the patient because deep down in that complaint, or, they're screaming and yelling, there's something wrong. There's something that they're screaming and crying for, and if you just try to find the root of that problem, then you can figure it out and hopefully none of those things will necessarily have to happen.

Eileen: Do you think physician assistants have a role or responsibility in delivering humanitarian health care?

Klarisse: Absolutely. I think just even the basis of what a physician is and where we came from, like we came from military corps men, we came from that background of being out in the front field and developing this position. And our primary role was to be in primary care in rural areas. That was the goal. And still is the goal as a physician assistant. It's just that now we have all these other different specialties, so everybody's kind of branching out, but the primary role for a PA is to be in primary care and in the rural areas that not necessarily all of the doctors will be. So, it is definitely not uncommon that PAs are the first person that you see, which is very common. When I speak to a lot of patients, they don't even see the doctor because they see the PA more so than the doctor or the doctor comes in for five minutes and, just does their thing, and then, it's back to the PA. So, I definitely think we have a lot of responsibility as far as taking care of patients and are definitely most of the time, the frontline person that a lot of the patients are seeing.

Eileen: Sounds like you’re frontline with Cayuga with these migrant children that are coming in. Talk a little bit about that in terms of your role as a physician assistant and the kind of humanitarian healthcare you provide them.

Klarisse: Sure. And actually, when you said that, I just realized that I've been at Cayuga for about three or four years and realize that we don't necessarily

have the doctors on-site there. So, it's just like we have a medical director. So, if there are anything that's happening or an emergency occurs, we can definitely call and reach out to the doctor that's maybe on call that day. But it's pretty much ran by MPs and PAs all day, every day in which, we're pretty much the first medical practitioner that these children are seeing, or some of them, have seen in a very long time. So, it's good because, one, a lot of the PAs and MPs, they speak Spanish. I'm picking up on my Spanish. So, it's great because they can kind of relate to us. We can speak the language and they can feel a little bit more comfortable. Unfortunately, on my perspective, I see the patients as far as giving them vaccinations and who likes needles. So, I make them cry most of the time, but it's just great to know that I'm providing care for children that may not have gotten any care or great care back in their home country, and we're just actually able to be a frontline person to actually continue that care, so that they're up to par. We're providing that preventative care for them that they may not have had in their own country.

Eileen: What happens to these young kids or these teenagers that move on into foster homes or perhaps orphanages. Who continues their health care there?

Klarisse: We see the patients up to age 18. So, I literally see six-month-year-olds that I'm giving vaccinations to all the way up to 18-year-olds. And I figure

probably about 18 either they're on their own or they're still going to be with their foster parents, or if they have been connected with their own family, they're actually living with them at that point. So, I think for us at Cayuga we're at least the first person that's actually able to kind of stabilize that medical care that they're going to get for the rest of their lives.

Eileen: You mentioned something that was very interesting before and talking about a physician assistant they were really originally designed to be in rural areas. And, of course, you work in an urban area. So, how do you see the future, for delivery of healthcare, to rural areas and how it may involve physician assistants?

Klarisse: Just being a PA in general, we are constantly growing. It's still kind of a new profession. We've been around for at least a little over 50 years. So, it's not as well-known as doctors and nurses are, but it's definitely as they say, I think it's in the top three as US healthcare, hot jobs and things of that nature. So, it's definitely something that a lot of people are going towards, instead of becoming a doctor or a nurse. So, I think, as the ball gets rolling and, just as far as reimbursements and insurance and all those other technicalities that come, a lot of times, a PA is going to be the person that people probably can afford to see and will want to see versus seeing a doctor because we're just, there more, we're doing more patient

care with them and we're probably put in those areas more so than a doctor would be. Then, pay comes into play as well. Maybe some of these areas may not necessarily be able to afford having multiple doctors there, but they can have multiple PA's there with one doctor supervising. So, that's how I see the model is for certain rural areas as well.

Eileen: That's very interesting. I certainly have seen an expanded role of physician assistants in Chicago and in orthopedic practices as well as primary care practices, just because of the quantity of people that need to see physicians, and they can't maintain, you don't want to call it the schedule to see all these patients, physician assistants take over.

Klarisse: Correct. Because we're able to, see patients on our own. Like I said, we have a lot of autonomy, especially depending on the type of doctor relationship that you have. So, I think it's just more cost-effective as well. And you can see more patients with a PA, especially some of my friends that are actually private PAs. They literally have their own block time. So, on certain days of the week, they will literally see their own patients, giving injections while the doctor has another day where they are both seeing patients. So, you can increase the load, increase reimbursement. I feel like it just works hand-in-hand, as far as the practice is concerned to have a PA. It's just a lot more beneficial for you.

Eileen: Do you think that, with the increased use of bundled payments that you'll see more involvement of physician assistants to manage healthcare for patients?

Klarisse: Absolutely. Unfortunately, at Lenox Hill, it's just like we've started to do billing, but it's not direct billing where the PA gets reimbursed directly. I'm sure through the system, the hospital is getting reimbursed for every single consult that we've seen, that we're billing for. Every single surgery that we've first assisted on in some sort of way the hospital was getting reimbursed for that. And I feel as though, with all these changes that are happening, a PA is probably, like I said, more, cost-effective more beneficial to have on the front lines than having, specific doctors and things of that nature. And with the reimbursement issue, I hear everybody complaining, Oh, this was on Medicare, total knee. I got $300 for it. And it's just like, wow, that's for maybe like, 20, 30, $40,000 surgery.

Eileen: Relative to, let's say physician assistants, do you see a future for them in terms of, providing humanitarian health care for a vast majority of people?

Klarisse: Of course. That's something that I'm definitely trying to work on as far as just being more diverse. I would say in the medical care in general, even as far as doctors, I feel like the numbers are extremely low. I think it's about 3% to 4% African American representation as far as doctors are

concerned. And it's about the same for physician assistants and minorities in general. So, it's just something that we need to still constantly chip chip chip away at because as you know, the population is becoming more diverse. And to be honest, sometimes a lot of patients when they see somebody that looks like them, can speak the same language, things of that nature, they feel a lot more comfortable than someone who may just not be able to understand that's completely disregarding them. And it's always nice to see, a familiar face. Prime example was when I first started as a PA, I'm green, I walk into the hospital and I'm in the recovery room and they paged me and they're saying, there's a patient, Latino Hispanic patient. And they keep screaming ay, ay, ay and I was just like, okay. And they were like, yeah, this is a case of the ay, ay, ay's. And I was just like, "What do you mean?" They're like, "That's what they do." And I'm just like really, as a new PA, this is exactly what I'm hearing. So, it’s kind of stuck with me. And it's like, now when I see Hispanic patients and they give you the ay, ay, ay which is exactly what they said, it's just like, do I listen to what this, nurse told me is like, “Oh, they're just doing that,” but you have to think about a cultural standpoint. Maybe this is the way that they express pain. And I think it's a snowball effect of how people don't address people's pain issues and how people can die because you're not addressing what they're trying to tell you. So, maybe, the average person who had this total knee or big spine surgery may not scream or yell in pain, but the next person does that doesn't mean that you need to

disregard what they're trying to tell you. So, for me, that was definitely a reality check that Klarisse, you definitely have to treat everybody different. As far as one person may take something a certain way, one person may do things a different way. And as far as pain is concerned with these big surgeries, you have to address everybody differently.

So, it’s just like I just try to relate to the person. I try to talk to my patients at all times and just figure out what exactly is the issue. And I just don't ignore them. I think that's what happens a lot of times, because not everybody is as diverse, they don't know what to do and they tend to ignore patients. And I think that's where our downfall is in the medical field. So that's why as a PA, I'm trying to make strives to hopefully diversify the field. I'm a part of a group from PAEA, which is our educational standpoint from PA associations, called Project Access where we're literally taking a PowerPoint presentation that's literally just telling you what a PA is, where do we work, how to become a PA, what type of schooling you need.
Of course, everybody likes to know how much money you make. So, that's attractive. We make six figures on average and just the steps you need to take in order to become a PA, and we're doing that in minority high schools. And I recently just did that at my friend's high school, and it went great. And especially since I'm orthopedics, I have to throw in some splinting, give them something practical to do, and the kids loved it. And now the kids know what a PA is versus what they know what a doctor is

and what a nurse is. And at least I've planted the seed and might've touched at least one or two kids to inspire them to now, if they are interested in becoming something in the medical field, they won't go with the average, typical doctor nurse route, but they might, just try to look into what, a PA is. So, planting these seeds in the kids, and even, as a youth, I did that. In PA school, we were going to elementary schools, give the kids little white coats, stethoscopes, teaching them practical skills, because again, it just starts from young, so that they can just have more awareness about the field. And that's my goal right now is to try to just make more awareness, especially in the minority population.

Eileen: So, it sounds like what you want to do is become a teacher to try to increase diversity in the physician assistants' field.

Klarisse: Teaching, that's on the backburner. My mentor is definitely trying to get me to teach at my alma mater, Touro University, Manhattan campus in New York. So that definitely is on the wave. I feel like a lot of people are saying, you have a great personality. You're funny, you like to talk and you're good with people, so you should definitely start teaching. So yes, that's definitely on the next step as far as my career.

Eileen: So, let me ask this question. So, do you think it's important to increase diversity in terms of race and gender in the physician assistants' field?

Klarisse: Absolutely. The funny thing is that, as a physician assistant, it's about 60/70% women, so it's pretty much mostly women that are PAs. So, if you're a male PA, it's like, you're a unicorn, so I think we're doing very well in that part of the spectrum. But as far as diversity is concerned, absolutely. It's just very nice to see other people, like I said, that look like you. And literally my friends and I, we call ourselves unicorns of the group. When you see another African American female PA it's just like, “Whoa, hey. High five! Where'd you go to school?” It's like an automatic connection. There are specific groups that are out there, like I'm a part of the African American Heritage PA Caucus, which is affiliated with APA. Again, we have these big groups, that are out there that are trying to diversify the field, but it's just hard. I think there are a lot of boundaries sometimes as far as a minority to even get to these steps, to being someone in the medical field. So, we need to start chipping away at that so that it can be more accessible for us to even just become a PA.

Eileen: Do you think that there's better care by, say an African American PA with an African American patient? Or does it matter you have different races?

Klarisse: That's a great question. That's a hard question. That's a very hard question. I don't think I would use the term better. That's a strong word for me. I think the care could possibly be different. I think, like I said, when

you can relate to your doctor or PA or nurse or whoever, when you can relate to them and they understand where you're coming from, maybe some of the social issues you have, or maybe this is why I'm not losing weight to get the total knee replacement because I have X, Y, and Z going on at home, or I live in this certain area, things of that nature. I think people connect to you when they can relate. And I think that's a big part of the medical field. Besides operating, you have to be able to connect with people and people have to want to like you and trust you. So, if I don't like you, I'm probably not going to trust you. So, I feel like the likability aspect, the trust aspect, those are things that fall into play and I feel like, when you have somebody that looks like you or come from the same background, it might be an easier connection for likability and trust versus someone who doesn't look like you don't come from where you come from. You don't trust them. If I see a white doctor, I might say, Hey, you probably don't believe that I'm in all this pain because you think I'm probably faking. Some people think they're drug seeking. There are so many things that can come up and it's just like, maybe that's not it. Maybe I have other issues going on that you don't know about or medical issues or things that are just going to heighten my sense of pain or whatever else that are falling into place. So, they may not want to talk to that doctor that doesn't look like them and express those things to them. But if they see somebody that looks like them, they might be able to open up a bit more.

So, I think that there is definitely a chance that treatment will be a little bit different like I said, when you have somebody that looks like you.

Eileen: So, do you think that race and gender affect knowledge in terms of social determinants, so you better understand the background, the backstories of African American patients?

Klarisse: I definitely do. I'm not a person that had an extremely traumatic childhood or anything like that, but, if I met somebody that came from my same neighborhood, I might be able to relate with them and know like, hey, if you grew up in this neighborhood, I know that there probably aren't a lot of physical therapy places for you to go to as an outpatient. So, you might want to go to X, Y, and Z place, things of that nature. So, like I said, there's a relatability issue there that you'll be able to understand what exactly is going on versus, someone else that, doesn't know, sometimes doesn't care because if you can't relate with them, sometimes you're just like, okay, whatever, it's just another number. It's just another patient and just brush them off.

Eileen: Do you think healthcare workers, no matter what your race or gender is that there's unconscious bias on the part of healthcare workers towards patients?

Klarisse: Absolutely. Like that example that I gave you earlier about the ay, ay, ay's and they're just like, what, like this is what you're teaching a new PA. This is the bias that you're telling me about Hispanic patients and I'm green. I'm just like, "Excuse me, what are you talking about?" So, yeah, I definitely do think that people will treat people differently based on where they come from and will ignore certain signs because they just don't understand where they're coming from culturally, or this is how they express themselves. So, I definitely feel like it's there. And I think it's a big thing now, unfortunately, that we have to even have these conversations. Or at the hospitals now, they do have these trainings for diversity and culture and things of that nature. It's just like really, we literally have to sit here and teach people how to treat somebody else that may not necessarily look like you or come from where you come from. I think it's pretty crazy, but unfortunately this is the time and age that we're in right now. So, if it has to be done, then let's do it.

Eileen: If you had any goals for the physician assistant field, in terms of improving healthcare and reducing healthcare disparities, what would it be?

Klarisse: I think the first goal that comes to mind is just increasing the number of minority PAs. It's just a huge, huge, huge need. And it's a huge void that we have and it's unfortunate. But that's just something, my goal right now is to just try to start chipping away and just making people more aware,

giving out those resources because I feel like there are a lot of things that come into play as why minorities are not jumping into the medical field. It's definitely a big financial burden. So, the debt is a lot. And a lot of people definitely can't handle that. And a lot of people I've seen have stopped going to school, got into a program, which is one of the hardest parts. Getting into the program is a hard part, but then actually maintaining and graduating the program is the next biggest step because of financial reasons, because they don't have the support from their family, which I find that other cohorts, do. If you have a mom and dad, I know a lot of people that are of Caucasian descent, that they have parents that are doctors and nurses. I had to work my way hard just to find somebody to shadow or, for a PA or I got the job on my own. Whereas I know some of my cohorts, their doctor knows 50 million surgeons in the hospital. They didn't really have to do much of an interview. They didn't really have to go through the application process. They were able to just automatically go in there. And there's not a lot of African American families that are full of doctors. I have no doctors in my family. I didn't even know what a PA was until I got introduced to that by a friend in college. So, it was just like, again, we don't know these things because we're not exposed. So, I think just the exposure, to us and just supplying the resources financially. Right now, I'm getting ready to start letting a lot of people shadow me of all races. But I am a part of certain groups that are specifically for minorities in the medical field for pre-PAs. And I'm definitely going to let them start

shadowing me so that they can get these shadowing hours to apply to school. So, using myself just as an outlet and just encouraging my other friends that we need to just kind of be there for others, so that they can be in the same position for us. So, for me, that's just the main goal is just increasing the diversity in the field because we definitely need it.

Eileen: Well, sounds like you've got your role cut out for you to be a future teacher to attract, African American and Latino minorities, to the field of physician assistants. Well, it's been a real joy to talk with you today, Klarisse.

Klarisse: Thank you.

Eileen: And really thank you for your time. I would like to also thank our listeners for joining us in this episode of the Health Disparities Podcast. We hope you found it interesting, please remember to subscribe on iTunes and YouTube, or you can sign up on our website to receive further notifications of new episodes. I thank you for your time and I'll sign off for today. Thank you.

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