

A day in the life of.....a Doctor at Church Street Practice

Patients seen on day: 34		
Male 12		
Female 22		
Age	<18	3
	18-59	20
	60+	11

I arrived at work at 7.30 and was the first one in so had to turn off the alarm, put the lights on and open the consulting room door. I turned on my computer to start the main programmes which are used to detail patients' notes, appointments, e-mail, outside mail and dictation software. Whilst the computer is booting up, I start the day by signing 10 prescriptions left over from previous day. When I get a prescription, it is not just signing it but involves looking up and checking medications, renewing repeats in some cases and dealing with queries that the dispensary staff can't answer (i.e. medications a patient hasn't had for a while, or repeats asked for too early or too late). Some patients I know, some I don't, a few queries to be dealt with later in the day regarding an insulin script.

By 7.45, I start dictating letters for patients I saw yesterday. One is to a local chiropractor and the other may require some investigation regarding an allergic reaction, I am not sure who would be most appropriate to refer to. I will ask the secretaries to look into this.

Interrupted at 7:55 by another GP to discuss a few of the day's issues and also a couple of patients he had seen. In particular, we are at issue with the treatment of tennis elbow and the use of steroid injections!

At 8:00 I finish dictating then load up the blood test results which have been sent from the JR. These are sent electronically to reception at 8am and are distributed according to who asked for the tests. All have to be verified and commented on. It is a tedious process. Some patients I will remember but some of the routine checks, I may not and it often requires reviewing the notes of each patient. I have about 40 results this morning, which is about average. They are a mixture of things from regular screen for diabetes and hypertension to more urgent tests. The comments will range from saying they are normal to asking patients to talk to me. One particular result which indicates low potassium will require me to ring the patient later to make a plan for thinking about dietary increases and then repeating the test. I will do this at the mid-morning break.

Its now 20 past eight and I wander down to talk to the GP who has an interest in eye problems about a girl I saw yesterday. I am not sure what's wrong and have asked her to come and see him today. At the same time I look at some photos of a rash that he has been sent which seems non-descript. We discuss the photo with another GP who has an interest in dermatology.

08:25 Just enough time before the referral meeting to check emails. (I am presently arranging the 2nd meeting of a young GPs group. We meet monthly to discuss the latest clinical, political and personal issues!) I also look up any updates to the management of nocturnal leg cramps, which I saw someone with yesterday (making sure my knowledge is up to date!).

At 8.30 each day we have a referral meeting where the GPs discuss all referrals we are thinking of making. The reason behind this is to make sure that they are appropriate. There are often other ways of dealing with a problem than just getting a specialist opinion and the practice uses each GPs own specialised knowledge i.e. eyes, skin, women's health, paediatrics etc to help decide this. There are often solutions we haven't heard of or a more specific clinic to send patients to. It's a dynamic group that most practices won't have. I think we benefit enormously in discussing things with each other and as a result so do the patients! The patients are getting 5-7 amounts of brain power rather than one!

At 9 am, the appointments start. My first is a lady who needs a chaperone and luckily, I find one of the nurses free before surgery. The use of a chaperone for some examinations is a must but often disrupts the rest of the day, mainly because finding someone to help may mean an extra five minutes or more for the patient. The patient I am seeing requires care jointly between us and the hospital and is reviewed every 6 months. Before the next patient, I need to call the information manager as I can't find right heading for the computer entry. As always she finds the solution quickly!

9:10: See a man of 42 with chronic low back pain and prescribe pain killers. I will review the medication effectiveness by phone. GPs see an awful lot of back pain, and along with other chronic joint problems it is often difficult to manage.

9:20: A girl aged 8 with mouth ulcers. It is nice to talk directly to children rather than parents as they are often good historians!

9:30: See a male, 49, for diarrhoea and vomiting advice. The D+V season started about a week ago. Most of the time the cause viral and is treated with time and fluids. Often with self-limiting viral illnesses the main difficulty is putting across to our patients that they will get better without treatment.

9:40: See a female, 39, with a chest infection which is not improving. Explain giving the antibiotics time to work and discuss worrying symptoms.

9:50: See a female, 27, with ear an infection which is not improving. Again, explain things will take time.

10:00: Male, 50, for review of shoulder pain and movement problems. The patient requires a steroid injection, which is a practical procedure I enjoy doing – and hopefully the patient will benefit from it too!

10:10: Female, 73, who is suffering continued problem with breathlessness. Exercise and healthy lifestyle were discussed. I referred her for a chest X-ray and will review in a month after x-ray, if it is normal. We also discuss her recent blood results. *I'm now running 5 minutes late.*

10:20: Male, 78, came for review with his wife, after having an echo of his heart. He has heart failure and will require changes in his medication and a review by the community heart failure nurse. Apart from this I also reviewed a skin lesion, and gave him the `flu jab. I want to make sure his wife is coping as his main carer and we explore this. I discussed the South and Vale Carers organisation and the case management team who may be of some help in the future. *Now 10 mins late*

10:50: Mid morning break. Fill it with more script signing, a couple of phone calls caused by blood tests this morning and prescription requests. Issue prescriptions and arrange for district nurses to do bloods on the patient with low potassium. At coffee had an interesting discussion with another GP about the moments where as doctors we know the diagnosis is going to be bad and how we discuss this with patients and explore their worries.

Now I have 4 telephone slots. These are each 5 minutes long.

11:10: Continued diarrhoea, in female, 41.

11:15: Medication review for a female, 48.

11:20: Medication review and vomiting in a boy aged 4 after he took the medication I had prescribed yesterday. Symptoms caused by medications we prescribe are often unavoidable but I still worry whether it was right thing to do.

11:25: Check before a visit to a female, 89.

Back to seeing patients.

11:30: Female, 60, concerned with a chronic headache. Headaches are often a difficult problem to deal with as patients often think the worst and we have to reassure them that it is a mostly a benign temporary condition.

11:40: Female, 77, who is tired and has been asked to come in by husband.

11:50: A double appointment for antenatal (pregnancy) check on a female, 41.

12:10: A female, 23, who needed health education about the cervical screening program and symptoms. Public health and patient education - always a worthwhile part of the day!

12:20: A last minute cancellation meant I could catch up with prescriptions. This also meant I was now running on time again!

12:30: Girl aged 5 with allergy.

12:40: Telephone call to elderly patient with blood in urine but a history of cancer who feels weak. I will need to visit him later.

12:50: Started eating lunch, while going through 10 more prescription requests and issuing medications that the dispensary can not issue.

1:10: Interrupted by a GP from Newbury Street practice. He requires a signature on a cremation certificate for a patient who had died. This necessitates a history and then talking to someone who was around at the time of death. In this case, I was able to telephone Wantage Hospital, where patient died, and speak to one of the health care assistants. However, the staff member who knew patient would not be in until tomorrow so spoke to Knapps to inform them that certificate would be done then.

1:20: Filling in two insurance forms for patients either claiming insurance or applying for it. This is a tedious job as you need to sift through a patient's history even if you know them well!

2:00: Visits: First to Childrey to visit a patient recently discharged from Wantage hospital following a hip replacement. Patient very anxious that I may re-admit them but doing well so needed a lot of reassurance and going over safety. Carers and a son close by but I make a mental note that may need to be referred to the case management team in the future.

...Then back to Wantage to visit the patient I spoke to earlier with blood in urine. There are lots of difficult problems which I was able to discuss openly with the patient as they know they have had cancer for some time. The patient was last seen at the hospital 2 years ago, and it's probably time to be seen again. It is encouraging that the patient is open about what may or may not be. Patient choice and frankness are important here. I will be referring him to Urology. Took blood while there. I also need to contact the district nurses by e-mail to warn them, as if continues could lead to the patient needing a catheter. Get back to practice an hour later, run through reception discussing with dispensary about a Nomad tray for a patient's meds. Solve issue and collect rest of scripts (another 20) to check, sign etc! Have to then fill in details of visits into patients notes.

3:20: Check mail - usually letters and other information regarding patients which are scanned in every day. They are generally on the system from 3pm but do get put on throughout the day. The number of letters varies wildly from a few to having 30! Today I have an average of 12. In looking at them I have to high-light and comment for things which need to be summarised into notes or not. There are always extra things to do sometimes doing a prescription, contacting patients or discussing as a team. Today a letter from rheumatologist asks for a patient to have digital retinal screening. I discussed this with a colleague as the investigation is probably not needed, and will discuss it further with the ophthalmologist when she comes to clinic on Friday morning and then e-mail the consultant.

3:40: Telephone appointment not taken

3:45: Telephone appointment not taken

3:50: 41 year-old female with multiple problems. We also discussed smoking cessation and childhood sleep problems in son.

4:00: Female, 24 with issues with pill and its risks. Changed type and gave counselling. Also discussed weight management and referred to nurse team for weight issues – the nurses are more up-to-date with knowledge and better equipped to deal with this.

4:10: Female, aged 60, with dizziness who is worried due to history of cancer, maybe connected. *Now running 5m late*

4:20: Shoulder pain in a female, aged 52. *Now 7m late*

4:30: Female, 41. Double appointment to review low mood which allowed time to discuss all issues. Double appointments are very useful with psychological complaints. The time allows us to explore ideas without being rushed! *Although I am now 10m late*

4:50: Male, aged 62, with problems with medication. *12min late*

5:00: Coffee but really straight into next appointment as running 12 minutes late!

5:10: Urinary problem in a 21 year-old female.

5:20: Male, 64 with tendonitis.

5:30: On going treatment of a female, 47, with acute exacerbation of asthma.

5:40: Fertility problems in a 27 year-old female.

5:50: Male, 61, with arthritis. Discussed complementary therapy. I quite enthusiastically support complementary therapy if it does no harm and doesn't prevent diagnosis. Often will use in chronic musculoskeletal problems.

6:00: 50 year-old male with difficult chronic problem.

6:10 Female, 22, discussing contraceptive safety whilst having D+V.

6:20: Infected bite in a 59 year-old male.

At the end of surgery I always look to see how other colleagues are doing with their appointments. I find that the duty doctor has had to go out on several urgent visits and the other GPs are seeing some of his patients. Another GP is admitting a patient and thus has two patients still waiting, I see one and another GP sees the other. In some practices each GP keeps themselves to themselves and will not necessarily help out in these situations. I am very happy that we all have similar feelings about work and am pleased I work in such a supportive environment.

6:40: 39 year-old male with a throat infection due to be seen by the GP on the visit.

After seeing the extra patient, I chat to the receptionist - who is on until 7 - about an admission last week. Then I finish off a few more prescriptions but some will have to wait for tomorrow morning! Close down the computer and leave at around 7pm.

Another eventful, interesting 11½ hours..... and I am sure the same again tomorrow!