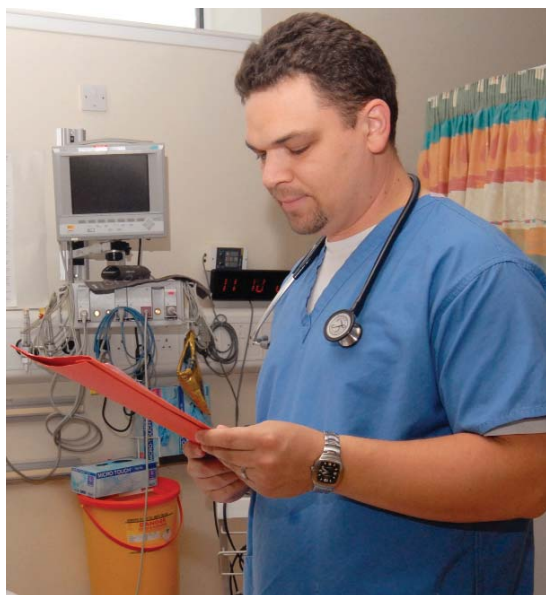


A Day in the Life

Zachary Hartsell, MPAS, PA-C;
Keith Kehoe, PA-C



Coauthor Zach Hartsell

It is spring in Scotland, and we are both part of the pilot project run by the National Health Service (NHS) exploring the use of physician assistants. The project is scheduled to run from October 2006 until October 2008. Initially, 12 PAs were brought to Scotland to enter practice areas including emergency medicine, family practice, specialty care (COPD, diabetes), rehabilitation, and *GP OOH* (general practice out of hours, which is similar to urgent care). Zachary works day shifts in an *A&E* (Accident and Emergency) in East Kilbride, a suburb of Glasgow. Keith works the overnight shift in a *GP OOH* practice in Aberdeen. The following represents a typical day for us working as PAs in Scotland.

The authors are American PAs working in Scotland as part of the UK's National Health Service pilot project exploring the use of physician assistants. They have indicated no relationships to disclose relating to the content of this article.

GLASGOW, SCOTLAND

■ 8 AM

From the moment I get up, things are much different in Scotland. The most noticeable difference is the weather. Having lived previously in Arizona, I find that the frequent rain and cool weather make for a nice change. My first patient is someone with a wrist injury. A 9-year-old girl fell while playing outside the night before. There is tenderness and ecchymosis over her distal radius, without snuffbox tenderness. Her x-ray shows a greenstick fracture, and her arm is placed in a short arm backslab (splint). She is referred to the fracture clinic, where all patients with fractures are seen by the *Consultant* (attending) orthopedist the next morning.

■ 11 AM

I remind myself that even though my patients and I speak the same language, some words have very different meanings. My current patient is a 63-year-old male with right lower leg pain. Six days ago on holiday in Spain, he hit his right leg on a folding chair at the airport. The pain has worsened since he returned to work, and he notices more swelling. I get strange looks from him and his wife when I ask him to lower his pants to examine his leg. Then I realize my mistake. *Pants* in Scotland is a word that means *underwear*. The Scottish word for *pants* is *trousers*. I quickly explain my error, and he and his wife get a good laugh at my expense. His exam is normal except for minimal swelling of the leg. I am concerned about a possible DVT, however, so I refer him to the DVT nurse for evaluation. In this case, the nurse checks the D-dimer level and performs impedance plethysmography. Both tests are normal, and the patient is discharged to follow up with his *GP* (General Practitioner or PCP).

■ 2 PM

A 45-year-old patient presents with substernal chest pain that lasted 30 minutes. The pain occurred when he was walking back to work after lunch and resolved after 5 minutes of rest. His ECG is unremarkable. Heart disease is very common in the west of Scotland. My patient has a typical story: he smokes 20 cigarettes a day, and he has hypertension, hyperlipidemia, and a significant family history of heart disease. The patient already received an aspirin from the ambulance crew. I place a saline lock and present him to the medical team for admission. In Scotland, the medical team, not the nursing team, is responsible for drawing labs and placing IVs. Another difference is the cardiac rule-out protocol. Cardiac enzymes (troponin T) are not measured until 12 hours after the episode of pain. If a single troponin is negative at 12 hours, patients typically get a treadmill stress test either as an inpatient in the morning or through an outpatient nurse-led chest pain service within a few days. Positive troponins are treated similarly to how they are in the States, with an immediate cardiology referral.

■ 5 PM

A 24-year-old male presents with abdominal pain that has lasted for 6 hours. The patient felt a general discomfort this morning, and by noon, the pain had localized to the lower abdomen. He is afebrile and his *observations* (vital signs) are normal. On exam, the lower abdomen



“I work steadily into the early morning, seeing an array of patients of all ages.”

—Keith Kehoe

is tender, more on the right side than the left, but there is no rebound tenderness. Labs are drawn and the surgeons are called for an evaluation. In Scotland, patients present similarly to the way they do in the United States. Moreover, the end results of treatment in Scotland and the States are very similar for most diseases. But the way we get from patient presentation to final outcome is often quite different. For example, CT is frequently ordered for US patients with abdominal pain, but in the UK, ultrasound and observation are frequently used instead to determine which patients need to go to *theatre* (operating room) or require further testing.

■ 7 PM

My shift is over, and a quick check of the *rota* (schedule) says that I am on again tomorrow. My drive home tonight is more like it was in Arizona, with dry, sunny skies. I am looking forward to the challenges that tomorrow's shift has to offer!

ABERDEEN, SCOTLAND

I have been in Aberdeen for 9 months. I work at Grampian Medical Emergency Department (GMED) providing medical coverage at night.

■ 7:30 PM

I arrive to a fully packed waiting room. I and up to two physicians work steadily into the early morning, seeing an array of patients of all ages. GMED addresses acute illness and management with a “treat and street” approach to care, encouraging patients to follow up with their GP. For those needing direct admits, a tertiary care center, Aberdeen Royal Infirmary, is located across the street. I have the ability to instantly consult with a specialist there and set up an admission. Despite the perceptions that many in the States have of socialized medicine, I am amazed at how easy it is to consult and get patients admitted. There was one night when I spoke with a dermatologist at midnight! That was not a luxury I had previously at my clinic in rural Alaska.

■ 11 PM

It is an especially busy night. Most folks have relatively benign conditions, but some are very ill. One of those tonight is a very pleasant 88-year-old woman with a recently diag-

nosed UTI. Two days ago, she was started on trimethoprim by her GP. The daughter adds that she has become increasingly confused and reports a similar episode a year ago when she was admitted to the hospital for urosepsis. Her medication list is extensive, and of particular interest is that she was recently also started on fluoxetine. Her observations are normal and she has a benign physical exam, but she scores poorly on a mental status exam. Her urine dipstick is remarkable for trace leukocytes and hematuria. Because of her age, history, and new onset of confusion, she warrants an admission. A quick call to the admitting house officer, and she is sent across the street for further care.

■ 12:30 AM

My next patient is on the other end of the age spectrum, a 2-year-old with a runny nose, low grade fever, and a barking cough. He coughs as I call his name in the waiting room, and it sounds like the classic cough of croup. The patient's exam reveals minimal inspiratory stridor and no signs of acute respiratory distress. Due to the lack of prescriptive rights for PAs in the UK, to get an oral dose of dexamethasone for this patient, I have to step out to briefly consult with a GMED doctor. I then obtain and dispense the medicine myself. However, I spend most of this visit providing education and reassurance to the parents. By the time they are ready to leave, the child is already improving.

■ 2 AM

A 45-year-old female presents with acute onset of right upper quadrant abdominal pain after eating fish and *chips* (French fries). The history and exam support a differential diagnosis that includes cholecystitis. I give the patient an NSAID injection and check in on her over the next 60 minutes while seeing other patients. Her pain is fully relieved, and she is released with strict instructions to promptly see her GP to get the further workup she needs.

■ 4 AM

I get a moment to eat and talk to the medical traffic dispatchers housed in the same building. They take phone calls and send out doctors to do home visits. Within GMED, there are always 2 additional doctors solely available to these visits. They treat patients who have no means to get to the clinic or are too ill to travel. The “car doctors” have a full medical kit, including medications to treat anything from simple colds to end-of-life palliative care. They too have been busy with minor illnesses and complex patients tonight. I am really impressed by this service that the NHS offers.

■ 6 AM

I am *knackered* (British for very tired) and head home. I walk outside into the morning light. Birds are singing and the city awakens. It was a good night, and I feel fulfilled once again being a PA and part of this project. [JAAPA](#)