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A Day in the Life of a British General Practitioner

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Abstract

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General Practitioners are key providers of patient related services in National Health Service (NHS) in United Kingdom. The general practitioner have enjoyed enormous trust from the general public. Author shares his day today work giving an interesting insight into the model of care general practitioners engage with in UK

Keywords: National Health Service (NHS), general practice, family medicine training, general practice education, patient centered care

The good General Practitioner (GP) will treat patients both as people and as a population.[1]

General practice is a key element of all healthcare systems in Europe and is recognized by health service providers as being of ever-increasing importance.[2] International evidence indicates that health systems based on effective primary care, with highly trained generalist physicians (family doctors) practicing in the community, deliver care that is both more cost-effective and more clinically effective than in systems that place less emphasis on primary care.[3]

Primary care is described as the "jewel in the crown" of the National Health Service (NHS) in the United Kingdom. The GPs have enjoyed enormous trust from the general public. The Department of Health (England) issued a really positive story recently when it launched the results of the latest GP patient survey, showing that 88% of patients rate their overall experience of their GP practice as good.

I feel this on-going mutual trust and continuity of care plays a very great role in the health and wellbeing of the patients. As Heath[4] describes "primary care doctors offer continuing relationships with individual patients and families, which allow therapeutic interaction to extend over time in a context of trust and solidarity."

GPs in the UK carried out 261 million consultations in 2001, or 741,000 each day. On average, patients consult their GPs five times a year. In the words of Alec Logan, Deputy Editor of the BJGP, "……where doctors and patients meet most face to face, in general practice. Where the science that is medicine bumps thrillingly against human fear, passion, despair and hope".[5]

There is nothing like a typical GP and there is nothing called a typical day in a GP's life. I work as a full time GP in a multi-partner teaching and training practice. The practice caters for a population of about 11,000. The practice is situated in a highly deprived area of Luton and caters mainly for a young population, which predominantly consists of black and ethnic minorities [Figure 1].

Figure 1
Blenheim Medical Centre, Luton, UK

I start my day around midday on a Monday and usually finish my work around 8 pm in the evening. This allows extended hours access to office workers/commuters who can see me after finishing their work at 5 pm. On a Tuesday morning, I run a Walk-in Clinic with my registrar where patients can walk in and will be seen without previously having made an appointment. My Tuesday afternoon is devoted to Clinical Commissioning Group work. Wednesday morning is usually devoted to tutorials for foundation year doctors and GP trainees placed within the practice. Wednesday afternoon is supposed to be protected study time for me to be devoted to my personal development plan and I use the evening to play cricket with other GPs and local hospital consultants. Thursday is usually an on call day for me. On a Friday morning, I usually run a special clinic devoted to women's health. Friday afternoon I am in the branch surgery with a GP registrar. I will now describe a so-called typical day in my life, say, on a Thursday.

I get up around 7 am and have a cup of tea with my wife who is also a doctor. This helps to plan the day. We watch BBC Breakfast News together, which usually highlights the major political or world events of the day.

I reach my surgery in the morning and greet my staff. I turn on the computer and look at the pile of repeat prescriptions. I am usually greeted by my staff with a cup of tea, which unfortunately I hardly get the chance to drink, but this routine keeps me happy.

It is time to call in my first patient. Each patient gets allocated 10 minutes slot. As the complexity of cases that are being managed in the primary care increases, the duration of consultation is becoming more debatable.

My first patient enters. “I was not coming, but it was my wife who said I must see you Doc. I am having a problem during sex. It is not as easy as it used to be Doc”. Mr. Brown is a 50-year-old man who hardly ever comes to see his doctor. You therefore have to explore and investigate further. I am probably already running 5 minutes late by that time.

The next patient is an Afro-Caribbean child who has developed Tinea Capitis. His infection is back and his mum is here to discuss treatment.

Daron James works part time. His manager is saying that he is not performing very well and I complete the occupational health questionnaire for him. He has ran out of his antidepressant and wanted to keep me updated.

The patients continue.

“I made this appointment to talk about discharge from my eyes, but I just wanted to mention that my mum has died. I teach in university and my students think I am crying, but this is embarrassing.” I have got to address her bereavement as well as her allergic conjunctivitis. What about my feelings? I had just seen her mum a few days ago.

“The pessary you fitted doctor is working fine. However, I am going to the toilet so often.” The Hyperactive Bladder of a 56-year-old woman.

“I am back from my holidays. My hospital appointment is ten days away, but I am still not sleeping. I would like to know my blood and X-ray results. Another doctor has told me it could be cancer. Could you please explain a bit more to me.” This patient is a 40-year-old woman who has been a heavy smoker but gave up smoking a year ago. She was visibly upset and was accompanied by a friend.

“My back Doc is no better”. This 40-year-old man is a smoker who is separated from his family and has not been to work for several years. On one occasion he used foul language because my colleague refused to give him a sick note. I knew that he was adding depression to his list so that he could score more points.

“I got this letter, Doctor, to make an appointment.” This 60-year-old diabetic gentleman had a urine test for

microalbuminuria. He has been recalled to discuss the results further.

My next patient is an 80-year-old carer. She has settled in her new home with her daughter-in-law and is finally planning to retire. She has gained some weight but still does not feel quite right.

Mohamed is three years old and has bat ear. His mum is worried that he will be bullied in school. She wants him to have plastic surgery. I have a difficult job in explaining to this concerned mum that the NHS is unlikely to fund this operation. I also know that she cannot afford this privately.

And this carries on for the rest of the morning after which I have seen about 20 patients. Not forgetting also the interruptions from other learners, “Dr. S, could you please have a look at this rash for me” says my registrar. There could also be a phone call from a colleague asking a quick question about women's health issues or even “could you please sign this prescription urgently Doc” request from my receptionist.

At the end of the surgery I have to debrief the registrars, complete my dictation, look at blood results and complete the paperwork. We then have a look at the visit/message book. Since we have many doctors in the practice, particularly registrars, I usually have to deal with one message and one home visit at the end of my morning surgery.

Mrs. Jones had been to hospital for her abdominal scan and the hospital said they would send her results to the GP. She would like to know the results. I have sort the problem out.

My home visit was for Mrs. Khan who always demands to be seen by me. Mrs. Khan has been bedbound for a long time and has never been happy in her entire life, at least not since I have known her. She thinks her husband never wants to sit down beside her or speaks nicely to her. She has children who are too busy with themselves and turn up to see their parents only when they need some money. Whenever I visit Mrs. Khan it is mostly due to a headache, earache, abdominal pain or cystitis. The physical examination is usually over soon and then I have to sit down listening to her moaning. She has never found someone who loves her, understands or even listens to her. I am not sure if I understand her language. Honestly, I hardly do, but all I can do is lend her a listening ear and give her some extra time. After the session we part with me giving her my promise to deliver some medicines via the chemist and that I will return to her service as and when she summons me.

After the home visit I usually return to the practice and try to make some time to eat my sandwiches. There will be some queue of tasks for the on call doctor, taking messages, signing prescriptions, answering queries or even responding to a late request for home visit.

It is 3.30 pm now. It is time to start my afternoon surgery.

My first case is Mr. Patel who always comes with Mrs. Patel. He speaks Gujarati and Hindi, but understands very little English. His wife helps in translation. He is diabetic, hypertensive and had MI in the past. He is on several medications. He has to tell me all the symptoms, discuss all his last appointments with the consultants and has to have his blood pressure measured as routine. He has to get my second opinion on what the consultant has already explained.

My next patient is a patient with chronic back pain. She has been suffering from back pain for quite a while. She is on morphine patches and uses crutches to walk. She has already had an epidural injection. Her husband has given up his job to be her carer and also that of children. She wants to discuss her pain management, “Nothing seems to be working Doctor. I can’t take this anymore!”

My next patient is Maggie. She is a middle-aged Caucasian woman with pain in the ribcage. She needs pain relief since paracetamol is not helping.

Gagan is an autistic child, separated from his dad who lives away in Manchester. Mum is his main carer and lives in a first floor flat. Gagan runs around in the consultation room, all the time touching almost every object he can put his hands on. Mum is at the end of her tether. She needs something done.

Mr. Mia is a middle-aged Bengali gentleman who always smells of incense sticks. He suffers from COPD and hypertension. He is on four types of antihypertensive agents and his blood pressure is still very high. He is still short of breath and bringing out sputum more than usual.

Now I have to phone the District Nurse. She wants to start a morphine drip for Mrs. Watson who has terminal cancer. She wants the prescription faxed to the chemist with an instruction sheet completed and faxed to her as soon as possible.

Tom is a 9-year-old boy to a single Afro-Caribbean mum. Tom had three courses of antibiotics in the last six months and has been missing school. Mum wants Tom to be referred to an ENT specialist since Tom is falling behind at school.

Mrs. Bayer had stopped her period two years previously. She saw her period on one occasion a month ago and has seen this again. She has consulted the internet and is anxious thinking that something sinister is going on in her body. Is this cancer Doc?

I am sure you got an idea. The list goes on.

The people in my extras list could be, for example, someone who has had a road traffic accident and now has whiplash injury, possibly a child with asthma or woman who has bladder infection and needs antibiotics.

This list is coming to the end. It is 6.30 pm and any more phone calls are unlikely now. It is time now to debrief the registrars who have been seeing the patients independently. They may volunteer to discuss a case or may raise some queries about the management of their patients. At other times I will randomly check some cases and give constructive feedback.

Some days there may be a local evening GP educational meeting, which is usually sponsored by a drug company. If I am in the mood I might attend. Otherwise at 7.00 pm it is time to head home. As I drive home I feel how privileged I am and how proud I am to be able to do what I do.

As Roger Jones puts in his editorial, quoting from an article by Wilfred Treasure, “an attitude of compassion and measured confidence; knowledge of science; and skills that help us to help patients both by our relationship with them and by using appropriate technology”. That really is primary care for the 21st century.[6]

I will have a meal with my wife. After that it is usually couching around in front of the TV. At about 10 pm or so, it is time to go to bed. While my wife reads a novel, I will spend another hour or so catching up with emails, face book, etc.

As I finally go to bed I thank almighty how fortunate I am. In the words of Donald Berwick,[7] “But, still, we are fortunate. Still, it is our privilege to enter into the dark and tender places of people's lives, where, still, trust abounds when human beings turn to us in their pain. Still, there will come the middle of the night, and, with it, we still have our duty to meet and our quiet promise to keep: To bring comfort. And, in the morning, still, there will be thanks.”

And life goes on…….

Footnotes

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