



James M. Taft, PA-C

When I was in PA school at SUNY Stonybrook, I always thought I would practice ER or family medicine after I graduated. I never envisioned the combination of clinical practice and research in neurology that currently fills my days. In 1984 (now I really date myself), there were few jobs for PAs in emergency medicine, so I took a job in neuromuscular research at New England Medical Center in Boston. After a few years, I managed to find a position in ER medicine, where I stayed for over 10 years. Then the ER started to change, and all the PAs headed to the new fast track. I knew I wouldn't be happy doing that too, so I went back to neurology.

My site collaborates with Massachusetts General Hospital in Boston on a number of different research studies in patients with amyotrophic lateral sclerosis (ALS). As part of the project team, I troubleshoot the pulmonary function machines and oversee other outcome measurements for all 27 study sites nationwide. My clinical duties include ALS clinic, headache clinic, and general neurology. My time is divided equally between research and clinical medicine. Here is a day in the life of a clinical and research PA.

The author practices at SUNY Upstate Medical University, Syracuse, NY. He has indicated no relationships to disclose relating to the content of this article.

0730 hours

I arrive at my office and sift through my e-mails and voice mails. This morning, there are a few from study sites having problems with their pulmonary function machines. There are also a number of e-mails from patients in regard to medication refills and problems or questions they have. This has become a popular method of communication for my patients and is especially convenient for those with ALS because most of them cannot talk. The easy exchange of information via e-mail has enhanced patient care. After I answer each patient's message, I print off a copy to go into the clinical record.

0800 hours

We currently have four research studies ongoing. Today I'm seeing three ALS patients who are enrolled in clinical trials. All the trials are double blind and placebo controlled, which can be tough on the patients. These studies focus on slowing disease progression, which is why outcome measures are so important. We do not have a clear enough understanding of the pathophysiology of the disease to look for a cure, but hopefully we will soon. Each study has a unique protocol, with scheduled visits for vital sign and vital capacity measurements, blood and urine collections, ECGs, and quality-of-life measurement. Each visit also includes physical and neurologic exams, which take 1 to 2 hours per patient. Even though these are research visits, I go over clinical issues too, including medications and physical therapy equipment such as walkers or wheelchairs.

Study visits with ALS patients usually require attending to their social needs as well as to their physical condition. One patient I see has a vital capacity of 20% even on BIPAP. We talk about death and dying, and I go over all the options, from life support to hospice care. The patient and his family choose hospice, and I will call them later to make the referral. I give them a script for lorazepam and will mail one for liquid morphine. Air hunger can be very distressing, and these drugs can ease symptoms and make the patient more comfortable. I have been caring for this patient for 3 years now, and I know him and his family well. I experience the emotional rollercoaster of their situation along with them.

My patients with ALS are dying, and I do my best to get in some laughs and goofy jokes during their research visits. I have a weird sense of humor—patients and fam-

ilies often tell me that it helps them through this dark time. All my ALS patients get hugs. Even the men. Even during difficult conversations, patients and families can be crying one minute and laughing the next.

I occasionally make house calls to see patients with ALS. I find house calls interesting because the families invite me into their home and treat me like one of the family. The visits usually take about an hour but can last much longer if I let them. Patients and families love it when I make a house call, and they shower me with food—especially cookies. I never refuse, of course! We talk about current problems and issues, and I examine the patient. I try to have the hospice nurse at the visit to make sure all of us are on the same page.

Recently, I saw an ALS patient at home who was having difficulty swallowing but who had decided against a feeding tube. The hospice nurse had advised her not to eat potato chips, but this was the patient's favorite food. I took out my pad and wrote a prescription for her to have one bag of potato chips per day. This was a big hit with the family and is now a standing joke with the hospice nurses. Sometimes it's the little things that make the patients' and families' difficult times a little easier.

1130 hours

The research patient visits are complete, but I have a few hours worth of paperwork and data entry to complete. Most studies are Web-based, so after filling out the clinical research forms, I enter the data on the study's Web site. As I do this, I multitask, simultaneously making a few phone calls or answering e-mails.

1210 hours

I eat a quick lunch at my desk as I review the latest headline news updates. I sometimes search for articles on patient safety for the AAPA Quality Care Committee, of which I am a member.

1245 hours

I leave for the headache clinic, located a 10-minute walk from my office across the busiest intersection in Syracuse. The clinic is made up of one physician and me, and we usually see 18 to 24 patients in 4 hours. We are the only tertiary care headache clinic in seven counties. A quick schedule check reveals 16 follow-up patients—not too bad. Most have primary headache syndromes, including migraine with and without aura, chronic daily headache, or analgesic rebound. I try to put patients on preventive medications, empower them to control their headaches through lifestyle changes, and limit their use of OTC drugs.

At the headache clinic, I move from room to room, visiting the familiar faces. I see a 56-year-old gentleman who had chronic daily headaches for 6 years without



The author tests a patient's pulmonary function.

relief. His new preventive medication has given him periods of no headaches for up to 10 days. But not all the cases are that easy. There are a few I am still having trouble controlling, despite trying multiple medications. Some patients have only periodic headaches and just need medication refills. Others seem to come in only to catch up on the gossip. All get a brief neurologic exam. I find myself discussing herbal alternatives, and I tell them which have been shown to be effective and which are ineffective or dangerous. Finally, I review diet journals at each visit, check caffeine use, and assess use of OTC medications with an eye for analgesic rebound.

1630 hours

I've seen my last patient, and now I find myself staring at a pile of charts to dictate. Unfortunately, there is no time between patients to get the dictations done, so I pick up the phone and get started.

1700 hours

I'm back in my office doing one final sort through the e-mails and voice mails. I answer the ones that can't wait until the morning. An hour or two of research data sits on my desk, waiting to be entered online. But for now, I'm tired, and the data isn't going anywhere.

As I head home, I often think about the day. For example, did I forget to do something? What else can I do for a patient's headache when most treatments have failed? Occasionally, I have a brainstorm and call the patient the next day. But most of the time I reflect on the ALS patients and their constant struggle, every day, not only fighting the disease but also fighting with insurance companies and the government to get the most basic kind of help, like wheelchairs. Patients with ALS face difficult times, yet they smile, laugh, and thank me for my time. It sounds corny, but I'm happy just to be a part of their lives. □