

A Day in the Life

William C. Bisbee, PA-C



Photos: Martin Brown Photography

The author treating a patient in the office.

My life as a research technologist changed forever after I attended an informational talk on the physician assistant profession one day in the fall of 1975. After 2 1/2 years of working in laboratory science, I was searching for a career that would bring me closer to human subjects. Two years later I settled in rural Dover-Foxcroft, Maine, to practice medicine. For my first 5 years as a practicing PA, I split my time between a busy single-physician family practice and a developing orthopedic practice. When the family practice physician retired in 1983, I decided to work full time with the orthopedic practice. My duties include all aspects of surgical care, office visits, and on-call coverage. I also work at the student health center at the local high school, cover high school sporting events, and work at the hospital's occupational health clinic.

Bill Bisbee practices orthopedics at Mayo Orthopaedics, Dover-Foxcroft, Maine. He has indicated no relationships to disclose relating to the content of this article.

■ 5:30 AM

I arrive at the office to organize my day and do some paper work that is best done in a quiet environment. I write orders for two patients scheduled for pre-op evaluations later today. I check that all the screening lab work and specialty consults are in order. I complete a couple of disability forms and dictate a referral letter to a neurosurgeon who is consulting on one of my patients. I then check the surgical schedule to see if any special items need to be ordered for upcoming surgeries. After quickly checking my e-mail for late messages, I gather up the charts and films for the patients scheduled for surgery today and head across the street to the hospital.

■ 6:30 AM

After I drop off the charts and radiographs at the operating room (OR) and stop by the emergency department (ED) to see if any patients were admitted during the night, I arrive on the med-surg floor for early rounds. This morning, I have six inpatients plus an AM admit for a total knee replacement. My prize patient is a 100-year-old man who tripped over his cat at home 2 days ago and suffered a hip fracture. The fracture was repaired with a compression screw and side plate that same day. I also have two other patients with hip fractures in various stages of recovery, two post-op patients who had total joint replacements, and an elderly woman with diabetes awaiting medical clearance for amputation of a gangrenous foot. I review all the charts, check vital signs and lab reports, order appropriate anticoagulation doses for the post-op patients, and ask the night nurses for reports on any overnight problems. I then visit the pre-op total knee patient. She is a 69-year-old woman who had a 2-hour drive to the hospital and woke up at 3:30 AM in order to arrive in time for her surgery. During her pre-op evaluation last week, we joked about how she was going to have to get up earlier than I did for this. The patient is waiting with her husband and daughter, and I confirm and mark the surgical site. After asking if they have any final questions, I go back to the nursing station and wait for the rest of my team to arrive.

■ 7:00 AM

My team consists of three surgeons, our head physical therapist, a nurse, and myself. We visit each of our inpatients together to assess their progress and ask about any needs or concerns. I share any test results and nursing concerns, and the physical therapist reports on yesterday's treatments. This morning's rounds include a long discussion about the patient who needs an amputation. She and her family were unwilling to make a decision about her treatment, and the Social Services Department was finally able to have Adult Protective Services appointed as her guardian to make medical decisions for her. Vascular studies confirmed she has poor circulation distal to the knee, and we decide that a knee disarticulation would offer her the best chance of healing and having a pain free limb. This is explained to the patient, who now says she has severe pain in her foot and realizes the need to undergo the amputation.

The remainder of rounds proceeds uneventfully, after which I settle down to write orders and progress notes. The three patients with hip fractures are officially on the medical service, so my orders and notes

A Day in the Life: William C. Bisbee, PA-C



“The patient and I are both relieved that his unusual injury is well on its way to resolution.”

are limited to their orthopedic concerns. I write the pre-op orders for the amputation, which is scheduled for tomorrow. One of our knee replacement patients is ready to be transferred to a rehabilitation facility, so I inform her primary care provider that she will be transferred today and that a 2-week stay is anticipated. I then dictate a transfer summary for the rehabilitation facility and, after a final check with the nurses, I head to the OR.

■ 8:00 AM

The first case of the day is the woman undergoing a total knee replacement. She has been in the OR for 45 minutes. A femoral nerve block and a spinal anesthetic were administered. I go into the OR and set up for the surgery. My job is to make sure the patient is positioned properly for the procedure. With the help of the nursing staff, I position the patient without difficulty. I place the appropriate films on the view box and again confirm the correct surgical site with the patient and the nurses. The orthopedic team prepares for the surgery. This team includes the orthopedic surgeon, me as first assist, an RN as second assist, our scrub nurse, a circulator, and a nurse anesthetist. The surgery proceeds without complications and is completed in about an hour and a half. The surgeon leaves to talk with the patient's family as the RN assist and I close the wound and apply the dressing. The patient is transferred to the recovery room. I write the post-op orders and a brief op note, and then I check that we have enough suture anchors for our next case, a scheduled rotator cuff repair. I swing through the recovery room to see if our patient has any questions, realizing that she will undoubtedly not recall any of my answers because of the amnesic effect of the anesthesia. She reports she is having no pain and wants only to be reassured that her arthritis was bad enough to warrant a total knee replacement. I assure her that she indeed had made the right decision and would be very pleased with her new knee.

■ 10:15 AM

Our second case of the morning is a 62-year-old middle school teacher who injured his shoulder when he fell while supervising recess several months ago. An MRI revealed a supraspinatus tear with mild retraction, and he decided to

undergo an open repair. We are able to reattach the tendon with three suture anchors. The patient is experiencing no post-op pain; he will be observed for a couple of hours in the ambulatory surgery unit (ASU), then discharged home with instructions to perform gentle, passive range-of-motion exercises. A follow-up visit is scheduled for 2 weeks from today.

■ 11:30 AM

Our final case is a 32-year-old housewife and mother who developed carpal tunnel syndrome (CTS) during a pregnancy last year. She was managed with bracing in the hope that her symptoms would abate after she delivered her baby. Unfortunately, this did not happen; in fact, her symptoms intensified. Nerve conduction studies confirmed moderately severe CTS, and she decided on surgical decompression. The surgery proceeds uneventfully. I complete the paper work, make a final check on both patients in the ASU, and head back to the office for afternoon patient hours.

■ 12:30 PM

Office hours begin after a quick bite to eat at my desk. Today my schedule includes two patients for pre-op evaluations; two patients for follow-up of nonsurgical fracture care, including radiographs and cast changes; three post-op checks; two acutes who called this morning with new problems; and four patients requesting repeat cortisone injections for various maladies. My most interesting patient is a 36-year-old man who injured his ankle at work as a garbage collector about 10 weeks ago. His initial presentation suggested a combination contusion/sprain injury with negative films. He presented with significant swelling and pain on ambulation that failed to respond to the usual RICE (rest, ice, compression, elevation) treatment. Physical therapy was initiated 2 weeks post injury but his symptoms persisted, suggesting possible complex regional pain syndrome. A bone scan, followed by an MRI, revealed a nondisplaced transverse fracture of the distal tibia. Both the radiologist and I reviewed the original films and saw no indication of a bone injury. The patient was placed in a fracture walker on somewhat restricted activities, and today he presents with total resolution of his symptoms. His films today show significant callus formation across the distal tibia fracture site with no displacement. He and I are both relieved that his unusual injury is well on its way to resolution.

■ 4:30 PM

Office hours are over, but I still have a pile of charts to dictate. Fortunately, there were no calls from the ED today and only a handful of calls from floor nurses about our post-op patients. By 5:00 PM I am ready to head home to have supper with my wife. Tonight is the homecoming football game at our local high school, so I will be going there later to join the rest of the orthopedic team on the sidelines to cheer on our local heroes. [JAAPA](#)