Something New:

This rotation was my first exposure to the inpatient setting, so there were many new techniques and strategies that I had not previously experienced. Compared to my outpt experiences, there was a drastic increase in the breadth of clinical decision-making that I was seeing in real time.

Perhaps the most important thing I learned was the role of an internal medicine ACP as a coordinator between patients and multiple consulting services. The position functions to ensure prompt communication, treatment, and the real-time flow of information between specialists and the patient. One skill I developed is filtering a vast amount of information into what is immediately actionable for the patient. This role as coordinator is more complex and dynamic than I initially understood, especially in cases involving severe disease or unclear diagnoses.

Another adjustment I needed to make was understanding the accessibility to all of the tools of medicine. In the hospital setting, essentially any study can be obtained if justified. Compared to outpatient medicine, where testing is limited by time or access, inpatient care allows for a much more accelerated diagnostic process. The pace of everything could be overwhelming at times. The most important concept to develop for success in the inpatient setting is communication. A single clinician cannot understand everything, and it is vital to reach out for help when you have questions.

Skills, Challenges, and Action Plan:

As a student, one of the ongoing challenges was navigating consultations with multiple specialists whom I did not know. While I was responsible for initiating consults and following up on recommendations, I lacked the understanding of each specialist's workflow that more experienced providers understood. This made interpreting recommendations more difficult. I learned to remain patient, ask clarifying questions, and communicate clearly. Another major challenge was managing conflicting recommendations between services. In several cases, different departments had opposing management plans, placing the IM ACPs in the role of mediator to ensure coordinated care. For example, there was a complicated patient with afib c/w heparin who developed a significant right axillary hematoma. Vascular surgery recommended holding AC due to bleeding risk, while cardiology recommended continuation due to thromboembolic risk. This taught me that conditions change in the hospital, and it's important to remain focused on high-quality patient care.

The most difficult aspect of this rotation was learning how to distill a large volume of clinical information into an actionable, time-sensitive plan. Early on, I approached each patient with a comprehensive structure: problem list, differential diagnosis, diagnostic workup, order sets, monitoring parameters, and goals of care for each issue. While this was a useful exercise, it was inefficient for the fast-paced inpatient environment. I improved by asking the other ACPs their immediate goals for the morning. I specifically ask how they pre-chart, prioritize patients, and what is most actionable within the first hour of rounding. I learned that the primary goal is no completeness but prioritization. Who are the sickest patients? Where are the gaps in care? What orders are not in? Which team still needs to be consulted? This shift helped me move from a detail-heavy framework to a more prioritized and team-based mindset.

Patients with liver disease provided me with the most challenges during this rotation. Hepatic pathology is complex, as it affects almost every other system in the body at a cellular level. In this way, hepatic pathology demands a nuanced, detail-oriented approach to ensure that all goals of care are met. Improving with these patients required reviewing fundamental pathophysiology, asking targeted questions during rounds, and remaining curious. I was also able to learn directly from the patients. For instance, I was unaware that a SE of lactulose was diarrhea. I then learned that lactulose eliminates excess ammonia through fecal excretion, completeing the circle of understanding.

One area I want to continue developing is my procedures. During this rotation, I was able to participate in arterial blood gas draws, IV catheter placement, Foley catheter insertion, removal of PICC lines and Shiley catheters, and CPR. However, I still need exposure to NG tube placement and suturing. I hope to gain these experiences during my surgery rotation. I plan to be proactive with preceptors and express interest in performing these procedures.

Memorable Experiences:

One of the most memorable cases during this rotation involved a 76 yo F w/ pmhx of Afib c/w eliquis, htn, hld, COPD, and a 40-pack-year presenting with SOB and worsening DOE x1 month. She was found to be in acute hypoxic respiratory failure requiring BiPAP -> 5L -> 2L NC w/ 94% O2. CT imaging revealed a large left pleural effusion and multiple pulmonary nodules concerning for an underlying malignancy. Our team of IM ACPs was involved in coordinating her care with pulmonology, heme/onc, and cardiology. Pulm decided to place a PleurX catheter two days later for symptomatic management of the effusion.

However, on the morning of the scheduled procedure, her respiratory status decompensated. She developed persistent hypoxia and required a non-rebreather without improvement. She began using accessory muscles, exhibiting clear signs of respiratory distress, and a code was called. The decision was made to intubate her, and she was transferred to the MICU. The decision was later made to put her on hospice care.

This case highlights how rapidly a patient's trajectory can change. The patient had just become aware of her cancer diagnosis, and within a matter of days, her condition progressed from potentially manageable to end-of-life care. This experience reinforces the importance of timely evaluation; if this pt had been evaluated 1 week earlier, things may have been different for her.

I will carry this experience with me into other rotations. It is crucial to keep the broader clinical picture in mind rather than anchoring on isolated findings. Even stable presentations require careful consideration as they can quickly evolve into something more serious. I will not let any complaint or findings slip through the cracks without considering their place in the larger clinical picture.

Overall Reflection and Perspective:

During these 5 weeks, I became acutely aware of my tendency toward perfectionism. I found my initial approach to be overly exhaustive, which was not always efficient in a fast-paced inpatient setting. I adapted though. Instead of burying my head in the sand and persisting with ineffective strategies, I looked to my team for help and new strategies. Seeking guidance from other ACPs and providers helped me refine my approach and work more efficiently. I gained confidence in my abilities and realized that I can manage complex patients as long as I stay focused, detail-oriented, and attentive to my team's needs.

My perspective of an internal medicine PA role changed significantly during this rotation. I came to understand that medical knowledge is just the foundation of the job. The actual work is built on top of that foundation through care coordination, interprofessional communication, and patient relationships. The role requires constant prioritization, navigation, and collaboration across multiple teams. Not only did this rotation expand my medical knowledge, but it also taught me how to be a better communicator, team member, and person.

I want my preceptors and colleagues to recognize my commitment to the team. I take pride in my work and am intentional in improving my weaknesses rather than ignoring them. More importantly, I want to be a provider who supports both my patients and my team. I want to be a source of confidence, dependability, and reliability for those around me.