A Day in the Life

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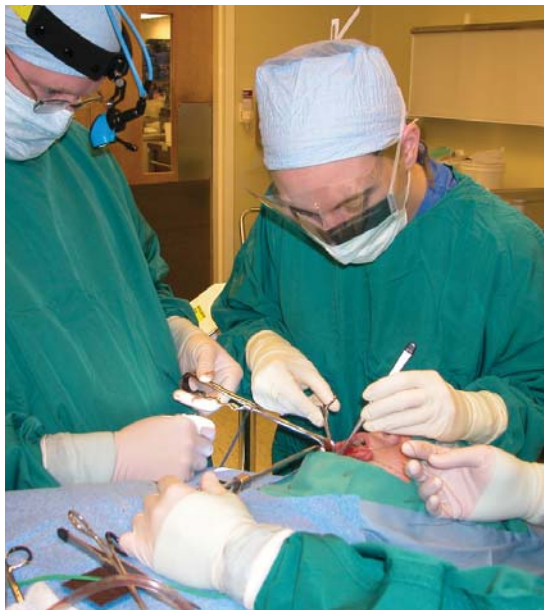

Supervised and taught by Dr. Samuel Fisher, the author sutures during a partial glossectomy.

When I started PA school at the University of North Texas Health Science Center, I knew I would focus on surgery. I had worked in the OR as a clinical assistant for 3 years while attending college, and becoming a surgical PA was definitely at the front of my mind. But not until my clinical rotations during my third year of PA school did I research attending a PA surgical residency program. I wanted to hone my skills as a PA in surgery and get more experience with larger cases, patient management, and multitasking before settling into a surgical position. I also wasn't sure which surgical field I wanted to go into, and attending a surgical residency would let me rotate through many while exploring my options. I was accepted to Duke University Medical Center's surgical residency for PAs.

Michelle Grisonichi is completing the PA surgical residency program at Duke University Medical Center, Durham, North Carolina. She has indicated no relationships to disclose relating to the content of this article.

0500 HOURS

I arrive at the hospital and find the intern who was covering the night shift. We go over my list of patients on service, and the intern tells me what happened overnight. Luckily, this time none of my patients had had any problems and all were stable. I go over their lab, culture, and pathology reports so that I can report any new findings to my chief resident. If any patient has an abnormal lab value, I circle it and try to put together a possible differential diagnosis and care plan before rounds.

0530 HOURS

The interns, residents, and chiefs meet to discuss who will be on what surgeries for the day. I am listed on three surgeries for that morning. The first case starts at 0815. I find my team, which consists of a chief resident and a fourth-year or third-year resident.

0540 HOURS

We begin rounds. Today we have eight patients on our service, but sometimes I am managing 15 to 20 patients on the floor. As we round, I present each patient to my chief resident. We go over labs, vital signs, and the plan for the day. When rounds are finished, I put in the orders for all my patients. I fill out discharge paperwork for a patient who is 3 days post-op after an appendectomy and fill out scripts for his discharge medications. I finish early with all my orders, so I dictate his discharge summary now rather than wait until later. I know it will be a busy day.

0615 HOURS

I go to the M&M (mortality and morbidity) conference, which we have every Wednesday morning. All the general surgery interns, residents, chief residents, and attending physicians are there. The chiefs present surgical cases in which a death or complication occurred. When my chief presents a patient I have taken care of, it is interesting to replay events and hear ideas about how the patient could have been managed differently. The chiefs usually present four or five cases, and the attendings discuss and pose questions about management or treatment.

0700 HOURS

We stay in the same auditorium for a lecture presentation. Today we hear from Dr. Levin from plastic surgery about reconstruction and flaps. He goes through the procedures for creating different types of skin flaps for reconstructive procedures. Pictures of the different flaps help to give a visual understanding. I get paged several times during the lecture about minor things that are occurring with my patients. I answer the nurses' questions, give verbal orders, and return to finish watching the presentation.

0800 HOURS

My first case begins in 15 minutes. I grab a quick bite to eat before heading to the OR. I scrub, put on sterile gloves, and prep the area for surgery. This patient is a 56-year-old male who is status post-isolated limb infusion for malignant melanoma with local recurrence to the left

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medial thigh. He has three lesions clumped together that will be widely excised for clear margins. When my chief resident shows up, we drape the sterile surgical field. My job is to cut through the skin and then use electrocautery to get down to the subcutaneous fat and finally right to the muscle. My chief lifts the lesion up, and I finish removing the complete lesion with the electrocautery, confident I have my wide margins. I close the subcutaneous layer and put in vertical mattress sutures. My chief gives me some hints on technique and tells me that it looks great. Our first case is done. I write the op note, dictate the case, and head to the post-anesthesia care unit (PACU) with the patient.

0930 HOURS

My second case is about to begin. It is another wide local excision of malignant melanoma. This time the lesion is located on the patient's back. I perform basically the same procedure I did for the first case. This time I am working with the attending physician. He lets me excise the lesion while talking to me about the staging and treatment of melanoma.

1030 HOURS

I am paged about a patient who recently had a distal pancreatectomy. The nurse is worried because the patient's oxygen saturation has dropped. When I see her, the patient states that she feels "a little worse today than yesterday" and that all her coughing and wheezing is making her breathing worse. I do a quick exam and step out to order a stat chest x-ray. The film shows patchy infiltrates bilaterally. It looks like pneumonia, so I start the patient on IV Zosyn (piperacillin/tazobactam), call respiratory therapy, and keep her on oxygen for now. I also order chest PT to help her cough up the sputum since she is still recovering from surgery and has only a very weak cough. While I am out of the OR, I check on the rest of my patients.

1200 HOURS

I grab another quick bite to eat in the cafeteria and head off to my third surgery for the day.

1300 HOURS

My last case is an exploratory laparoscopy, sigmoid colectomy with primary anastomosis and retroperitoneal and periaortic lymph node dissection. The patient is a 34-year-old female with a recent diagnosis of colon cancer who has undergone chemotherapy. She responded well to the chemo and now presents for removal of the tumor and lymph nodes. This is a major surgical procedure that includes complete colon resection. The entire aorta and inferior vena cava are stripped of the periaortic paravesical nodes up to the level of the renal veins and arteries. A functional end-to-end, stapled anastomosis is created between the two ends of the transected colon. We pour normal saline into the abdomen, wash it out, and suture the incision closed. I go with the patient to the PACU while my chief resident finishes up the note.

1600 HOURS

The last surgical case was very long, and I have just enough time to make pre-rounds on my patients before doing evening rounds with my chief. I review vital signs and say a quick hello before rounds start. My patient with pneumonia is feeling much better, and her oxygenation has improved. I make sure she is scheduled for a follow up chest x-ray tomorrow. I am paged a couple of times about issues with other patients that I have to attend to.

1700 HOURS

I meet my chief and third-year residents for evening rounds. I do an abbreviated presentation of my patients' events for the day. We also check in on all the patients who had surgery that day and make sure they are doing well postoperatively. I enter orders for any changes or additions in my patient's plans.

1730 HOURS

It has been a long day by the time the night intern comes in to start her shift. Before I sign out, I give her a rundown on all my patients, including the needed follow-up on any pending labs or tests.

1800 HOURS

I make one last stop to see the woman I operated on for my last case. She is still in PACU waiting to go to the floor. I talk with her for a minute. I see the relief in her eyes when I tell her that the surgery went well; the chemotherapy had shrunk the tumor, and we were able to resect the colon and get all the lymph nodes. She thanks me. I tell her I will see her bright and early in the morning, and I head out the door. I call my fiancé in Texas and tell him about my day.

It was a difficult decision to leave my home in Texas, especially since I had just gotten engaged, but the opportunity was a chance to learn from great teachers, surgeons, and residents. In coming to Duke, I moved to the birthplace of the PA profession to start my life as a PA surgical resident. I love what I do. I am so excited to come in the next day to see what amazing things I will get to do next. JAAPA