

A Day in the Life

Kristen K. Will, MHPE, PA-C



The author with a patient at the Mayo Clinic Hospital

Like many new PAs, I wasn't sure which specialty I wanted to practice in after graduation. I worked in everything from family medicine to cardiovascular surgery. It wasn't until almost 5 years after graduating, when I accepted a position with a new hospitalist group, that I realized that being a hospitalist PA encompassed everything I enjoyed—high acuity patients, a team approach to medicine, and a fast-paced environment. Over the past 5 years, I've learned that hospitalist PAs must be able to multitask and prioritize patient care based on acuity while working effectively within the hospital institution as a “system.” I admit patients and round on them during hospitalization, write orders, establish care plans, discharge patients, and perform inpatient medical consults for medical and surgical subspecialties.

Kristen Will is a hospitalist PA at the Mayo Clinic Hospital, Phoenix, Arizona. She has indicated no relationships to disclose relating to the content of this article.

■ 7 AM

I arrive at work and page my attending physician, who is carrying the main triage pager for the hospital. During the day, I usually work with four physicians and another PA. This morning, my attending physician assigns me six patients to see. A few I know from the day before, but two were admitted overnight. As usual, their admitting diagnoses are diverse. I look up all their lab results and vital signs on the computer before starting rounds to see if I need to address any immediate problems. I find that one of my patients became confused overnight with decreased urine output and decide to start with her. This patient was admitted yesterday with an altered level of consciousness from a urinary tract infection and has a history of dementia. Clinically she appears dehydrated, so I order a small IV fluid bolus with maintenance fluids along with tomorrow's morning labs. After determining that her antibiotic is still appropriate, I meet with her family. They are concerned that her confusion will not improve, and we discuss acute delirium and the prognosis. We also discuss possible short-term placement in a skilled nursing facility after this admission. After our discussion, I make a note to check her urine output and mental status later. I also call social work to come and speak with the family for discharge planning. Continuing through the rest of my morning patients, I examine each patient, write progress notes, order labs, and consult other services as needed. When I'm finished, I check back with my supervising physician to go over the patients I've seen. My attending will visit those patients later, reviewing my note and cosigning my orders.

■ 11 AM

My attending physician calls me with a consult requested by orthopedic surgery. The patient is an 86-year-old female with good functional status who fell early this morning in her assisted living apartment and sustained a left intertrochanteric hip fracture. The hospitalist service has been asked to perform a preoperative medical risk assessment before the patient undergoes open-reduction internal fixation of the fracture. I quickly review her medical history, laboratory studies, chest film, and ECG on the electronic medical record (EMR), and then I go to see the patient. After taking more history from the patient and family, I perform a physical examination, which is unremarkable except for a grade 3/6 systolic murmur and, of course, the fracture. I recommend to the patient and the surgery team an echocardiogram to rule out significant valvular disease. After completing my dictation and orders, I call my attending physician, who then meets me to review the case and briefly examines the patient. She agrees with my management, and she tells me that after a quick lunch, I should see another new patient—a direct admission from the medical oncology outpatient clinic.

■ 12:30 PM

Before I even grab lunch, I call the nurse on the floor to ensure that the new admission is stable and no immediate orders are needed. After quickly eating, I head upstairs. My patient is a 29-year-old female currently receiving chemotherapy for invasive cervical cancer, and she has acute onset of fever. Because she is neutropenic, she is admitted for a workup and empiric antibiotics. While I am reviewing the history on the EMR, the nurse comes to tell me that the patient is

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becoming more tachycardic with new hypotension. I immediately go in to see her. She is awake and calm, but her BP has dropped from 124/74 mm Hg to 84/58 mm Hg. I give a verbal order for the nurse to give a 500-mL IV fluid bolus and to start another IV site. I am worried that the patient is becoming septic, and I order stat blood and urine cultures as well as empiric IV antibiotics. While I'm with the patient, she becomes lethargic and more hypotensive. I have the nursing staff start IV fluid boluses wide open in both peripheral lines and in her central line (already in place for her chemotherapy) and call my attending physician. She meets me in the room and we call for a step-down ICU bed. Unfortunately, the patient is too tachycardic at this juncture to start vasopressors, and her BP remains low. During transfer downstairs, the patient becomes unresponsive. My attending physician and I stay with her while the boluses continue. Finally, after minutes that seem like an eternity, her BP improves and she becomes more alert, asking, “Oh, hi Kristen—did I go to sleep?” “Yes,” I respond, “and you're going to be just fine.” I finish writing the admission orders, and then I go to speak with the family.

As a hospitalist PA, one of my main functions is to educate and communicate with patients and families. This is by far one of the most important jobs I do, and it helps to free up my supervising physician to see other patients. This particular case is a good example. Just as I am going to meet with the young woman's family, my attending physician is called about another patient becoming increasingly more ill. She quickly excuses herself to go attend to that patient. After spending over 30 minutes with the family explaining what has happened and the prognosis, I go back to check on the patient. She is awake with a stable blood pressure for now.

■ 1:45 PM

I take a short break to follow up on the patients from the morning. My delirious patient is improving, with less confusion and better urine output. I review the echocardiogram on the patient going to surgery and find that her murmur was only aortic sclerosis without stenosis. I call the orthopedic surgery service to say that she may proceed to surgery. After answering some work e-mails, I head back to the step-down ICU to check on my septic patient. Her urine Gram's stain is

positive with gram-negative bacteria. Her BP and mentation continue to be stable.

■ 2:30 PM

I spend the rest of my afternoon admitting three patients from the emergency department. The first patient is admitted for observation of chest pain. He has no history of coronary disease, but he has many risk factors. His initial cardiac enzymes are negative with a normal ECG. The second patient is admitted for a lower GI bleed but is hemodynamically stable. Before writing her admission orders, I call gastroenterology for a consult; then I complete my orders and dictation. The third patient is admitted for a workup of syncope. After each patient, I call my attending physician to review the case and my management plan. My attending then will see each patient later and cosign my orders.

■ 5:30 PM

Today I have a meeting arranged with the chair of the Department of Education for the Mayo Clinic College of Medicine and all the other postgraduate program directors for physician assistants at Mayo Clinic Arizona. I am co-program director of a new postgraduate physician assistant fellowship in hospital internal medicine. We meet to discuss issues that affect all our programs and to go over expectations for the coming academic year. I am excited about our new fellowship! It will be a tremendous experience for the PA fellow and a value to our institution.

■ 6:15 PM

Our service is caught up on admissions for now, so I return to check on my patients. The patient with septic shock is doing better, with improved urine output and a stable BP. I review the earlier lab results and make sure my antibiotic is still the right choice. After speaking with the family and saying good night to the patient, I quickly make my way through the remainder of the patients I have seen today, checking updated vital signs and laboratory findings. I revisit the patient who underwent hip surgery, seeing her in the postanesthesia care unit. She did well through surgery and looks stable. Lastly, I sign out my patients to the night PA, asking him especially to check on the patient in the step-down ICU. I check with my attending physician one last time, learning that there is no more work for me tonight. I turn off my pager and head for home.

On my way home, I reflect on all my patients today, especially the young woman who became critically ill. I realize that I've made a difference in her life—the very reason I became a PA. Truthfully, it is patients like her who have made a difference in *my* life. I am thankful that I have found a specialty within my profession that allows me to utilize my strengths every day to help patients when they need it most. Being a hospitalist PA is challenging and satisfying—and I am excited to go to work each day! [JAAPA](#)