dear residents

Down The Rabbit Hole **August 25, 2024**

Dear Residents,

I've just completed a two-week rotation on the Seldin service, and I aimed to honor the legacy of Dr. Seldin by being meticulous with electrolytes, anion gaps, and renal function, while maintaining a thorough and inquisitive approach. Our team ventured into some diagnostic rabbit holes—two negative screenings for adrenal insufficiency, two unproductive searches for antiphospholipid antibody syndrome, and a deep dive into an osmolal gap, which turned out to be a likely lab error. We also considered diagnoses like vasculitis and IgG4-related disease. We made a concerted effort to de-escalate unnecessary antibiotics and managed the routine, yet critical, aspects of care: addressing constipation, managing pain, assessing nutritional status, and providing ample listening and counseling.

A small moment of personal pride came when one of our students performed a knee aspiration, and I was the only one who suspected acute pseudogout—it turned out I was right! The students and residents were exceptional—organized, efficient, and trustworthy. Most of our patients were dealing with cancer diagnoses (breast, colon, lung, thyroid, bladder), many with severe complications like intestinal obstruction, brain metastases, pleural effusion, and treatment-related issues. Some patients were hypervigilant, while others seemed resigned to their circumstances, yet many remarked positively on their experience at Clements, often praising the excellence of the students and residents. Witnessing this was incredibly rewarding.

Down the Rabbit Hole of Diagnostic Inquiry

Inpatient medicine is intense, fast-paced, and demands meticulous attention to detail. Changes occur rapidly—hemoglobin levels drop, oxygen needs fluctuate, fevers spike, blood pressure rises or plummets, and the physical toll of IV lines and drains can swiftly diminish functional status, particularly in elderly patients. My instinct is to react less, a lingering impulse from an earlier era of residency training when patients often presented with single acute episodes affecting one organ or system. Today, however, we face simultaneous threats to multiple organ systems that can cascade into serious complications.

The sheer volume of information that accumulates in a patient's chart can feel overwhelming. That's why I deeply appreciate the hospital course section, which succinctly summarizes the most critical aspects of the current admission and provides a centralized view of the daily plan.

I'm continually astonished by how adept you are—you adapt seamlessly to new rotations, even when switching hospitals. Although it's only August, you already exhibit the clinical reasoning and judgment of a seasoned physician. On a few occasions, I was gently overruled, and each time, your decisions proved to be correct.

Years ago, when Dr. David Hillis was the residency program director, he emphasized that in our residency, learning flows in all directions. At the time, I didn't fully grasp his meaning, but I've now witnessed this truth repeatedly. Dr. Hillis also spoke of the ABCDEs of residency training—Autonomy, Backup, Collegiality, Didactics, and the Emergency Room. Concerning the ER, he referred to a time before emergency medicine was a separate residency when residents from internal medicine, surgery, OB, and pediatrics ran the ER. While things are different now, we still encounter urgent and emergent cases that test our skills and decision-making.

The academic year is still young, and you will continue to grow in knowledge and expertise. I'll be attending on the wards at least twice after interview season, and I'm eager to witness your ongoing development.

Wishing you a wonderful week,

Dino Kazi