Dr Ashley Rawson:

- Fellowship at Indiana while i was there

Dr Rawson, with your training in both pediatric nephrology and clinical pharmacology.

I noticed you did both nephro and pharm at indiana IUSM. I think i was actually doing a physiology major at iusm when you were a fellow.

Which parts of all of your specialized training do you find most useful and think is important to teach pediatric residents?

Dr Pollard: went to AUC

I saw you trained in pediatrics here at Our Lady of the Lake

What made you decide to stay at our lady of the lake? What do you enjoy most about the program?

Dr. Courney Cox:

- fellowship in critical care speicialist

what do you think makes the PICU experience for residents at OLOL unique?"

FAILED STEP 2

- I failed Step 2 and I own it.
  - I misjudged pacing
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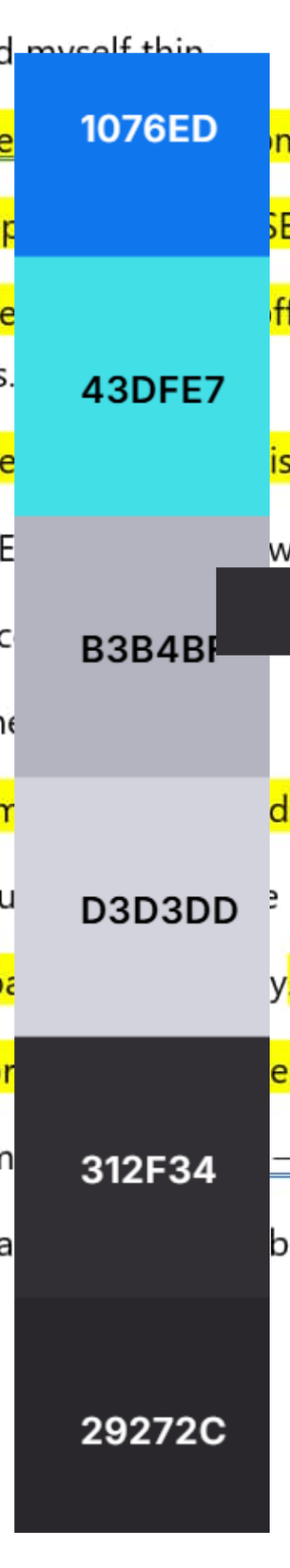

WHY OUR LADY:

- Mission driven Catholic system caring for safety net and underserved kids

- New children's hospital with broad exposure to different pathologies from across the Gulf South

- 3+1 block schedule with substantial elective time in PGY2 and PGY3 for customization

- Small, family style culture that stresses mentorship, and a formal faculty advisor system

- Lots of different types of exposure through continuity clinics at OLOL children's clinics, FQHC sites, school clinics, and advocacy projects and exposure like following a wic officier

- on Reddit people praise the children's hospital pediatric care and staff compared with the adult side

Why pediatrics?

- excelled at ti and enjoyed during rotations.
- I was good at things other people complained about like
  - connecting with kids
  - connecting and communicating with oncerned parents

While workng with kids at:

- camp counselor - guitar teacher - mercy home

Reference your Mercy Home work

Dealing with Difficult People:

• Toddler with severe eczema.

• angry mother, challenged + doubted plan

• I listened to concerns, involved dermatology

• reviewed w/ mother ot build confidence:

• 1st moisturizers to repair skin barrier

• add steroids for flairs to ↓ inflammation

• If frequent flares or large areas after 4 weeks of steroids, talkl about escalating

• Oral immunosuppressants or biologics

• explaining how each step protects against infection by healing and ↓ inflammation.

• What I Learned: Patient listening and clear, stepwise explanations—paired with checking for understanding— builds partnership

???

What haracterists do you look for in a good resident vs residents that don't do well.

2. From a culture perspective, what does the faculty mentorship look like day-to-day

3. I noticed you're part of the CORNET network for research—what kinds of scholarly projects or QI work have recent residents led,

Conflict in a team

- Noticed passive aggressive communication
- And frustration in group text about order people in gorup were taking patients
- Brought it up at a lunch in person and asked frustrated person for their input

We implmented it and agreed let's talk at lunch about changes when necessary

Learned from Mistake:

• 3-week-old term infant with poor feeding, mild cough, low fever, lethargy.

• I suspected viral illness.

• Child decompensated, became hypothermic, respiratory distress, quickly septic.

• We broadened differential, started empiric antibiotics, consulted intensive care.

WHAT I LEARNED: Subtle signs—poor feeding, low tone, hypothermia—may signal early sepsis in infants; time is critical.

-

Disagreement with Team:

• 8-year-old with chronic abdominal pain labeled as functional by team.

• I noticed weight loss, pallor, pushed for celiac and thyroid evaluation.

• Testing showed hypothyroidism.

• Family was relieved

WHAT I LEARNED: Respectful advocacy can be tricky when you don't want to rock boat, but doesn't hurt to mention.

Handling High-Pressure Situations:

• 5-year-old with asthma, severe distress, worsening after treatment.

• Recognized fatigue, silent chest, respiratory failure risk

• **Started duonebs** , eventually had to transfer to ICU

What I Learned: Parents missed signs like fatigue and "silent chest" with little air movement on breathing.

• I now teach families to recognize these red flags for signs to take child to ER

LEARNED SOMETHING:

• Infant with complex heart disease, discharged after long hospitalization.

• Arranged detailed home instructions and early follow-up.

• At follow-up, noticed increased work of breathing

- We suspected early heart failure

- Cardiology later confirmed

• **What I Learned:** Structured followup is critical with congenital heart dz. We were able to adjust diuretics before the infant decompensated.

Addressing **Social Determinants:**

• 8-year-old with poorly controlled asthma, frequent ER visits.

• Found family had no car, unstable housing, couldn't get to pharmacy.

• Connected to social work, arranged transportation, nurse home visits, and med delivery.

• Hospital visits ↓

I Learned:

barriers like transport and housing can be key to real asthma control.

Medication Dosing Oversight:

• Preterm infant (28 weeks), recently home from NICU,

- new episodes of stopping breathing and bradycardia.

• We found caffeine dose hadn't been increased as baby gained weight;

- **We** adjusted dose → episodes stopped.

• **What I Learned:** Discharge instructions are IMPORTANT. must be explicit, specific, and reviewed for understanding with families.

Made a mistake:

• Early in rotations, patient with RUQ pain and obesity, suspected gallbladder disease.

• Forgot to check Murphy's sign; attending asked me to see pt again

• Returned, found Murphy's sign positive: pain and halted inspiration on deep RUQ palpation.

• What I Learned: Skipping exam steps can miss cholecystitis; always perform key maneuvers when indicated..

Root Cause Problem Solving:

• Late preterm infant (35 weeks), recently off breathing tube

• admitted for poor feeding and O2 drops.

• I noticed drops only during feeds, so I considered (milke aspiration) instead of lung disease.

• We ordered swallow study, confirmed aspiration; changed feeding, avoided reintubation.

• **What I Learned:** After extubation, always consider aspiration . Options like thicker formula or slower flow.

Advocacy for Patient Safety:

• 36-week preterm infant in nursery, had several unexplained apneic episodes

• I was concerned about plan to discharge and asked if we could monitor her closely for expisodes.

• another apnea episode required stimulation to restart breathing

• What I Learned: cautious w/ infants w/ unexplained apnea and must monitor carefully.

Greatest Weaknesses

• Used to get lost in details—risked slow pace, missed big picture.

• Now balance precision with efficiency—prioritize "done right, done on time."

• Seek and apply feedback to keep growing.

Realize were hear to take care of peoples childrn

Good teammates

Need help and ask

fly fish in steelhead

Working as a Team:

• 2-month-old with bronchiolitis, suddenly worsening retractions, rising carbon dioxide, dropping oxygen.

• We called respiratory therapy, activated rapid response, prepared noninvasive ventilation, transferred to intensive care.

• Family was kept informed.

• **WHAT I LEARNED**: to quickly recognize early signs of respiratory decompensation, and the importance of calling rapid response early

STRENGTHS:

Greatest Strengths

• Build trust with kids/parents fast—use calm, even tone, treat kids with respect, playful only when needed.

• Business background: used to long hours, staying steady under stress, managing tough interactions.

• Reliable teammate, adapt well on call, never complain—support team through challenges.

• Use feedback to improve, turn mistakes into learning cycles, stay methodical under pressure.

• Techy – love technology, fast with writing tight notes. Love to write

HEART Score—How to Use	- When I forget, I recall: H—History, E—ECG, A—Age, R—Risk factors, T—Troponin. - Each 0-2, total 0–10. - 0–3: discharge; 4–6: observe/stress; 7–10: admit/ACS. - Quick, structured way to risk stratify chest pain at bedside. - Examples: >65yo, classic story, abnormal ECG, 3+ risk factors, elevated troponin = high risk.
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    - Discovered dose had not kept pace with child's weight.
    - Increased dose appropriately.
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  - 5-year-old boy showed a brief dip in daily weight.
    - Checked for dehydration or fluid loss, found none.
    - Held off on increasing feeds.
    - Weight rebounded on next check.
    - Reassured family about normal variability and why overfeeding can cause harm.
    - Learned: Focus on trend prevents over-intervention and protects gut health.
- **Oral Feeds Transition**
  - 5-year-old boy close to discharge but lagging on oral feeds.
    - Prioritized cue-based oral feeds over tube supplementation.
    - Withheld tube feeds when oral cues present.
    - Oral endurance improved, tube weaned off.
    - Explained to family the importance of protecting oral skills for early discharge.
    - Learned: Guarding oral experience hastens feeding independence and discharge.
- **Protein and Micronutrient Check**
  - 5-year-old boy with poor linear growth but adequate weight.
    - Reviewed intake of protein, iron, and vitamin D.
    - Found intake was suboptimal despite high calories.
    - Optimized nutritional plan.
    - Growth parameters improved.
    - Educated family about the need for more than just calories to support growth and brain development.
    - Learned: Composition of nutrition is crucial—calories alone do not build brains or bones.
- **Phototherapy: Timing and Risks**
  - 5-year-old boy with moderate jaundice, labs at threshold.
    - Used guidelines for gestational age cutoffs.
    - Discontinued therapy promptly once safe.
    - Jaundice did not rebound, no dehydration occurred.
    - Reassured family about risks of over-treatment and parent-infant bonding.
    - Learned: Adhering to precise guidelines protects infants from unnecessary interventions and supports bonding.
- **Sepsis Workup and Antibiotic Stewardship**
  - 5-year-old boy with fever started on antibiotics pending cultures.
    - Set a strict 48-hour stop for antibiotics unless cultures positive.
    - Monitored closely, cultures remained negative.
    - Stopped antibiotics as planned.
    - Explained to family why limiting antibiotics prevents gut flora disruption and toxicity.
    - Learned: Strict stop rules are essential to protect infants from harm and antibiotic resistance.
- **Explaining Benign Imaging Findings**
  - 5-year-old boy with incidentally found enlarged brain space on ultrasound.
    - Assessed for neurologic symptoms, found none.
    - Classified as benign variant, avoided further imaging.
    - Shared findings with family, alleviating anxiety.
    - Learned: Clear explanation of benign findings reduces unnecessary tests and calms families.
- **Streamlined Handoff Communication**
  - 5-year-old boy with changing oxygen requirements noted on rounds.
    - Noted confusion over documentation of support levels.
    - Standardized reporting to "current, last 12 hours, and highest" support.
    - Improved team decision speed and accuracy.
    - Demonstrated the change to family during update.
    - Learned: Precise, structured handoff improves safety and clarity in complex cases.
- **Timely Eye Screening**
  - 5-year-old boy nearing window for eye screening for retinal disease.
    - Automated order and assigned responsibility to team member.
    - Screening performed on schedule.
    - Early disease detected and treated.
    - Communicated screening plan and its importance to parents.
    - Learned: Timely, assigned screenings prevent blindness and are easily missed without systems.
- **Hydronephrosis Counseling**
  - 5-year-old boy with prenatal urinary tract dilation.
    - Used visual aids and stepwise follow-up plan.
    - Family anxiety decreased, follow-up rates improved.
    - Avoided unnecessary intervention.
    - Learned: Visual communication builds trust and ensures follow-through.
- **Daily Parental Update Structure**
  - 5-year-old boy with frequent monitor alarms and parental confusion.
    - Adopted daily "breathing, feeding, weight" update script.
    - Focused discussions increased understanding and trust.
    - Family engagement improved, fewer misunderstandings.
    - Learned: Consistent structure bridges knowledge gaps and builds trust.
- **Discharge Expectation Setting**
  - 5-year-old boy medically ready for discharge but parental uncertainty.
    - Used explicit checklist for discharge readiness: feeding, weight, stability, parent confidence.
    - Alignment achieved, discharge smooth.
    - Taught family how each criterion impacts safe transition home.
    - Learned: Clear, shared goals prevent premature or delayed discharge.
- **Antibiotic Stop Scripts**
  - 5-year-old boy with negative cultures, team hesitant to stop antibiotics.
    - Introduced routine scripted timeouts at 24 and 36 hours.
    - Increased on-time discontinuation.
    - Minimized antibiotic exposure.
    - Explained risks of prolonged antibiotics to team and family.
    - Learned: Micro-interventions change culture faster than policy alone.
- **Protecting Sleep and Feeding Windows**
  - 5-year-old boy with feeding intolerance and poor growth from frequent interruptions.
    - Clustered care tasks, prioritized uninterrupted feeds and sleep.
    - Fewer desaturations, improved weight gain.
    - Family educated on the critical role of sleep and feeding windows.
    - Learned: Defending rest and feeding time is as vital as any medication.
- **Advocating Against Unnecessary Volume Increase**
  - 5-year-old boy with small weight dip, team pushed for increased feeds.
    - Argued for trend-based decision over knee-jerk reaction.
    - Held volume steady, weight rebounded.
    - Avoided fluid overload and complications.
    - Demonstrated rationale to family and team.
    - Learned: Clinical restraint prevents avoidable harm.
- **Advocating for Appropriate Antibiotic Stewardship**
  - 5-year-old boy with negative cultures, team requested to extend antibiotics "just in case."
    - Presented evidence and set clear stop.
    - Stopped antibiotics at 48 hours, no infection developed.
    - Protected child's microbiome and reduced resistance risk.
    - Explained importance of stewardship to family.
    - Learned: Standing firm on evidence protects individual and public health.

FAILED STEP 2

- I failed Step 2 and I own it.
  - I misjudged pacing
  - spread myself thin
  - I rushed to take to submit my application.
- changed approach and PASSED
  - I Rented a dedicated office with protected daily study blocks.
  - Focused on UWorld misses with spaced repetition
  - Used Error log to find weak points
  - Practiced pacing
- What I learned:
  - base my readiness on data and routine
  - structure beats volume
  - Feedback loops are key. Cramming is useless.
- Using this preparation for Step 3 now
  - If my data is good →
  - goal to take step 3 before residency around April

WHY Arrowhead

WHY ARROWHEAD

• **High-Volume, Full-Spectrum Training**

→ Perfect to **build confidence across inpatient, outpatient, and procedures**.

• **Mission-Drive**n, Underserved Focus

→ Matches my experience and passion for working with diverse, vulnerable populations

→ like I did for the last 2 years in chicago's safety net hospital

• Hands-On Autonomy

→ I learn best by doing, and Arrowhead's "**see a lot, do a lot**" environment fits perfectly.

• Supportive, Close-Knit Culture

→ Faculty invest in mentorship; residents genuinely support each other.

• **Lots of IMGs aligns** with my background, **year round sunshine is my wife's number one goal for o**ur next move

I'm inteested in the integrative medicine track, the UltraSoundTraining, and the Sim labs.

Questions:

1. What do you look for in potential residents? What tells you that a candidate will likely be a strong fit vs not?

2. I'm interested in the integrative medicine track. I'm curious how the IMR coursework fits into the residency over the three years. Could you walk me through that?

3. I noticed that ARMC hosts an Annual Research Day where residents present research and quality improvement projects.

- Can you tell me about the types of QI projects recent residents have led?

- And for someone interested in research, how much dedicated time is built into the curriculum for scholarly work,

- or is it something residents need to carve out from their electives?

4. With 16 residents per year, how does the program structure mentorship relationships?

- Are residents assigned an attending mentor, or is mentorship something that develops more organically?

WHY FAMILY MEDICINE

• Continuity & Relationships

→ Love guiding patients at every stage—kids, parents, grandparents—and seeing their progress over time.

• My strengths are in Teaching & Mentoring patients and family medicine is where I was able to use that skill the most.

→ My experiences as a camp counselor and guitar teacher honed my ability to break down complex ideas and motivate diverse learners—from children to adults.

• Preventive Focus
→ Drawn to the primary care setting, where proactive counseling on sleep, diet, stress, and social determinants has real impact on families' long-term health.

• Broad Scope & Flexibility
→ Enjoying the variety, keeps me learning and engaged.

• Value of Trust & Communication
→ Family medicine highlights rapport-building; my background coordinating teams and mentoring youth translates well

• Team-Oriented Culture
it's a respectful, mentorship-rich environment

Disagreement with Team:
• 42-year-old woman with chronic abdominal pain labeled as irritable bowel syndrome.
• I noticed unintentional weight loss and pallor, pushed for celiac and thyroid testing.
• Labs confirmed hypothyroidism.
• She felt validated and relieved.

WHAT I LEARNED: Respectful advocacy can be tricky when you don't want to rock the boat, but it's worth speaking up.

Handling High-Pressure Situations:

• 54-year-old man with COPD in severe respiratory distress, not improving with standard treatments.

• Recognized early signs of fatigue and minimal breath sounds, indicating impending respiratory failure.

• Administered repeated nebulizers, escalated to ICU transfer.

WHAT I LEARNED: Adults may not always perceive the gravity of silent or minimal airflow; teaching them to recognize these red flags is critical.

Conflict in a team

• Noticed passive-aggressive comments in a group chat about patient assignment order.

• Brought it up face-to-face at lunch, encouraged the most frustrated team member to share their perspective.

• Proposed a fair, rotating assignment system; agreed to recheck at lunch if adjustments were needed.

• Team embraced the plan, and overall communication and morale significantly improved.

WHAT I LEARNED:
Direct, respectful discussions and inclusive problem-solving can defuse tension and create a more collaborative environment.

Learned from Mistake:
• 72-year-old with mild cough, low-grade fever, and increasing confusion, initially seemed like a mild infection.

• Condition quickly worsened—hypotension, increased respiratory distress, sepsis ensued.

• Broadened the differential, started empiric antibiotics, consulted ICU.

WHAT I LEARNED: Subtle signs—especially altered mental status or low-grade fever—can signal early sepsis in older adults; timely intervention is crucial.

Addressing Social Determinants:

• 60-year-old man with unstable COPD, frequent hospital visits.

• Discovered he had no car, fragile housing situation, and difficulty getting prescriptions.

• Connected him to social services, set up transportation, home nursing, and med delivery.

• Admissions decreased.

I LEARNED:

Barriers like transport and housing can be key factors in controlling chronic conditions.

LEARNED SOMETHING:

• Infant with complex heart disease, discharged after long hospitalization.

• Arranged detailed home instructions and early follow-up.

• At follow-up, noticed increased work of breathing

- We suspected early heart failure

- Cardiology later confirmed

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    - Reassured family about normal variability and why overfeeding can cause harm.
    - Learned: Focus on trend prevents over-intervention and protects gut health.
- **Oral Feeds Transition**
  - 5-year-old boy close to discharge but lagging on oral feeds.
    - Prioritized cue-based oral feeds over tube supplementation.
    - Withheld tube feeds when oral cues present.
    - Oral endurance improved, tube weaned off.
    - Explained to family the importance of protecting oral skills for early discharge.
    - Learned: Guarding oral experience hastens feeding independence and discharge.
- **Protein and Micronutrient Check**
  - 5-year-old boy with poor linear growth but adequate weight.
    - Reviewed intake of protein, iron, and vitamin D.
    - Found intake was suboptimal despite high calories.
    - Optimized nutritional plan.
    - Growth parameters improved.
    - Educated family about the need for more than just calories to support growth and brain development.
    - Learned: Composition of nutrition is crucial—calories alone do not build brains or bones.
- **Phototherapy: Timing and Risks**
  - 5-year-old boy with moderate jaundice, labs at threshold.
    - Used guidelines for gestational age cutoffs.
    - Discontinued therapy promptly once safe.
    - Jaundice did not rebound, no dehydration occurred.
    - Reassured family about risks of over-treatment and parent-infant bonding.
    - Learned: Adhering to precise guidelines protects infants from unnecessary interventions and supports bonding.
- **Sepsis Workup and Antibiotic Stewardship**
  - 5-year-old boy with fever started on antibiotics pending cultures.
    - Set a strict 48-hour stop for antibiotics unless cultures positive.
    - Monitored closely, cultures remained negative.
    - Stopped antibiotics as planned.
    - Explained to family why limiting antibiotics prevents gut flora disruption and toxicity.
    - Learned: Strict stop rules are essential to protect infants from harm and antibiotic resistance.
- **Explaining Benign Imaging Findings**
  - 5-year-old boy with incidentally found enlarged brain space on ultrasound.
    - Assessed for neurologic symptoms, found none.
    - Classified as benign variant, avoided further imaging.
    - Shared findings with family, alleviating anxiety.
    - Learned: Clear explanation of benign findings reduces unnecessary tests and calms families.
- **Streamlined Handoff Communication**
  - 5-year-old boy with changing oxygen requirements noted on rounds.
    - Noted confusion over documentation of support levels.
    - Standardized reporting to "current, last 12 hours, and highest" support.
    - Improved team decision speed and accuracy.
    - Demonstrated the change to family during update.
    - Learned: Precise, structured handoff improves safety and clarity in complex cases.
- **Timely Eye Screening**
  - 5-year-old boy nearing window for eye screening for retinal disease.
    - Automated order and assigned responsibility to team member.
    - Screening performed on schedule.
    - Early disease detected and treated.
    - Communicated screening plan and its importance to parents.
    - Learned: Timely, assigned screenings prevent blindness and are easily missed without systems.
- **Hydronephrosis Counseling**
  - 5-year-old boy with prenatal urinary tract dilation.
    - Used visual aids and stepwise follow-up plan.
    - Family anxiety decreased, follow-up rates improved.
    - Avoided unnecessary intervention.
    - Learned: Visual communication builds trust and ensures follow-through.
- **Daily Parental Update Structure**
  - 5-year-old boy with frequent monitor alarms and parental confusion.
    - Adopted daily "breathing, feeding, weight" update script.
    - Focused discussions increased understanding and trust.
    - Family engagement improved, fewer misunderstandings.
    - Learned: Consistent structure bridges knowledge gaps and builds trust.
- **Discharge Expectation Setting**
  - 5-year-old boy medically ready for discharge but parental uncertainty.
    - Used explicit checklist for discharge readiness: feeding, weight, stability, parent confidence.
    - Alignment achieved, discharge smooth.
    - Taught family how each criterion impacts safe transition home.
    - Learned: Clear, shared goals prevent premature or delayed discharge.
- **Antibiotic Stop Scripts**
  - 5-year-old boy with negative cultures, team hesitant to stop antibiotics.
    - Introduced routine scripted timeouts at 24 and 36 hours.
    - Increased on-time discontinuation.
    - Minimized antibiotic exposure.
    - Explained risks of prolonged antibiotics to team and family.
    - Learned: Micro-interventions change culture faster than policy alone.
- **Protecting Sleep and Feeding Windows**
  - 5-year-old boy with feeding intolerance and poor growth from frequent interruptions.
    - Clustered care tasks, prioritized uninterrupted feeds and sleep.
    - Fewer desaturations, improved weight gain.
    - Family educated on the critical role of sleep and feeding windows.
    - Learned: Defending rest and feeding time is as vital as any medication.
- **Advocating Against Unnecessary Volume Increase**
  - 5-year-old boy with small weight dip, team pushed for increased feeds.
    - Argued for trend-based decision over knee-jerk reaction.
    - Held volume steady, weight rebounded.
    - Avoided fluid overload and complications.
    - Demonstrated rationale to family and team.
    - Learned: Clinical restraint prevents avoidable harm.
- **Advocating for Appropriate Antibiotic Stewardship**
  - 5-year-old boy with negative cultures, team requested to extend antibiotics "just in case."
    - Presented evidence and set clear stop.
    - Stopped antibiotics at 48 hours, no infection developed.
    - Protected child's microbiome and reduced resistance risk.
    - Explained importance of stewardship to family.
    - Learned: Standing firm on evidence protects individual and public health.