FAILED STEP 2 - I failed Step 2 and I own it. o I misjudged pacing o spread myself thin o I rushed to take to submit my application. - changed approach and PASSED o I Rented a dedicated office with protected daily study blocks. o Focused on UWorld misses with spaced repetition o Used Error log to find weak points o Practiced pacing - What I learned: o base my readiness on data and routine o structure beats volume o Feedback loops are key. Cramming is useless. - Using this preparation for Step 3 now o If my data is good → o 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 • **What I Learned:** Structured followup is critical with congenital heart dz. We were able to adjust diuretics before the infant decompensated	**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..	**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
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.
Tough Feedback → Improved	- Was told my presentations were confusing. - Took 30 seconds before presenting to outline: Chief Complaint, HPI, PMH/Meds/Allergies, ROS, Physical, Assessment, Plan, Disposition. - Huge improvement in clarity and feedback. - Learned that structure is key for teaching and safe sign-out.
Passed Over	- Applied to med school three times. - Did a master's in physiology. - Still only got two interviews, ended up in the Caribbean. - Taught me persistence, grit, and to focus on growth despite setbacks—valuable in medicine.
Difficult News—Pregnancy	- 22F, 20 wks, 2 prior miscarriages, came in spotting. - Explained need for ultrasound, pointed out positives (fetal movement, mild symptoms), but was honest about risks. - Balanced hope and realism—key for supporting anxious families.

Explain Complex Simply	- Elderly patient asked why seeing urology. - I said, "We're the doctors for the tubes that carry urine—if they get blocked, the kidneys get hurt." - Clear analogies make it easier for patients and families to understand complicated care plans. - Used similar approach to explain hydronephrosis: started with normal, then described the blockage.
Explain Policy—Clothes	- ER patient upset about having to change into a gown. - I said, "We do this for safety—so we don't miss any injuries. You'll have blankets; think of it like a spa day." - Humor and empathy usually diffuse tension, help keep patients on your side.
Suicidal Patient	- Young man in the ER with suicidal thoughts, asking for his dad. - Got him a blanket, sat quietly, let him talk. - Asked about outside support; mentioned girlfriend, which helped. - Learned presence and patience matter more than rushing the interview.
Sensitive Topics (ED/GI)	- For patients embarrassed by ED or GI issues, I say, "We see this every day, and you did the right thing coming in." - Normalizing helps patients—especially adolescents—feel comfortable sharing sensitive info.
Difficult Patient	- With anxious, homeless, or withdrawal patients, I start with, "You've probably been asked these already." - Keep my questions short and yes/no. - Break up the interview if needed. - Shows respect, reduces agitation, improves cooperation.

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- **Feeding-Induced Desaturation**
- 5-year-old boy presented with oxygen drops during tube feeds, raising concern for lung pathology.
    - Assessed feeding technique and coordination.
    - Found swallow-breathe discoordination was the culprit, not primary lung disease.
    - Slowed feeds and adjusted positioning.
    - Desaturation episodes stopped.
    - Discussed feeding modifications with family and why aspiration risk mattered.
    - Learned: Fixing technique at the root preserves lung health and avoids escalation to invasive support.
- **Apnea Due to Inadequate Medication Dose**
    - 5-year-old boy with history of apnea had new episodes after recent weight gain.
        - Reviewed stimulant medication dosing.
        - Discovered dose had not kept pace with child's weight.
        - Increased dose appropriately.
        - Apnea resolved.
        - Spoke with family about importance of dose adjustments as child grows to prevent hypoxia.
        - Learned: Vigilance in dosing prevents both harm from under-treatment and risk from excess.
- **Therapy Timing and Vital Stability**
    - 5-year-old boy showed rapid heart rates after therapy sessions that followed full feeds.
        - Noticed timing coincided with digestion and fatigue.
        - Shifted therapy to periods of alertness and rest.
        - Cardiac stability restored, therapy tolerance improved.
        - Explained timing changes to family and its impact on stability.
        - Learned: Aligning interventions with natural physiologic cycles prevents harm and supports recovery.
- **Fluids Versus Calories in Growth**
    - 5-year-old boy with weight gain developed rising chloride levels after fluid increase.
        - Compared volume versus caloric density strategies.
        - Concentrated feeds without increasing fluids.
        - Electrolytes normalized, continued growth.
        - Discussed with family why volume alone can harm and how calorie concentration aids growth safely.
        - Learned: Smart feed concentration avoids volume overload and metabolic imbalance.
- **Weight Dip—No Overreaction**
    - 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.