

Something New:

One treatment strategy that was new to me was leaving open referrals. For instance, for some patients with musculoskeletal complaints, my preceptor would say, "Let's try this symptomatic care first with naproxen, rest, and bracing. If you feel that the pain is not getting better after one week, go get an X-ray and come back to see me." This strategy is effective when patients with low acuity, chronic musculoskeletal pain insist on more aggressive management. I appreciate that it promotes patient autonomy, allowing them to make decisions about their care. I also had the opportunity to perform many intramuscular and subcutaneous injections, which is new to me.

Skills, Challenges, and Action Plan:

There were times when I did not understand my preceptor's decisions. Sometimes antibiotics were prescribed in situations I did not think were appropriate. I decided the best approach in this situation was to have a non-judgmental conversation to learn their perspective. Was there something in the patient's history that I didn't see? Did I miss a physical exam finding? What was the provider's experience prescribing that particular antibiotic? Remaining non-judgmental is important to maintaining a relationship. After observing an assessment or plan that I still did not understand or agree with, I would reference the literature to see the most current guidelines and recommendations.

The most difficult situations for me arise when there is no clear diagnosis. As many professors have said, "patients do not read the textbook." I found it important in these moments to take some time to organize my differential diagnosis, list the pertinent positives and negatives, and formulate a proper plan. At times, I would excuse myself from the room, saying, "I want to speak with one of my colleagues about your case. I want to make sure there is nothing here we are missing." Patients were very receptive to this. I plan to improve by continuing to take thorough histories and perform thorough physical examinations.

The most challenging patient situation to deal with is breaking the news of a new diagnosis of type 2 diabetes mellitus. My preceptor had an effective strategy to ease their anxiety. His words stick in my head, "I can't force you to do anything, but based on the current guidelines, this is the next recommended step. Personally, I think this is the best option as well. Do you have any questions?" At this point, the patient typically softens and begins asking questions. This strategy allows the clinician to convey that the recommendation is not just their single opinion, but part of the larger medical consensus. It also promotes patient autonomy by putting the ball in their court as they ask questions about their treatment plan.

I would like to become more familiar with common outpatient medications to treat upper respiratory infections. The variety of medications and formulations can be overwhelming. I do not want to rely on certain medications because those are the only ones I am familiar with. I want to expand my medical vocabulary and tailor treatments specific to my patients' needs. I will accomplish this by reviewing medication flashcards, asking my colleagues about their favorite medications, and staying up to date on the most recent guidelines.

Memorable Experiences:

My most memorable experience was a patient having a hypertensive emergency who refused to go to the emergency department. He presented with bilateral blood pressures greater than 180/120, plus a sudden onset of left arm and leg numbness. The patient insisted on going home, and if he felt worse, he would go to the hospital. It took greater than 20 minutes of counseling and education to convince the patient to go. The conversation shifted when I said, "You can go home today, and nothing may happen. This problem is occurring because there's likely a vessel in your brain that is blocked. They will scan your brain and find out where it is and prevent this from happening again. But if you do not go today and this happens again, it can be much, much worse." Again, I promoted patient autonomy but took a firm stance on my clinical recommendation. Eventually, the patient agreed, and emergency medical services brought him to the nearest emergency department. This experience highlights the importance of communication and persistence. The provider does not complete their mission by simply having knowledge and making a recommendation; part of the mission is convincing patients to put their trust in you and potentially saving their life.

Overall Reflection and Perspective:

Five weeks ago, it was hard to believe that my patients would put so much trust in me. Maybe I was anxious that I would fail them and break their trust. But I have learned to sit in that responsibility with less anxiety. Mistakes are going to be made, but a mistake does not mean I am irredeemable. I will continue to learn from my mistakes through self-reflection and hard work. Becoming complacent, lazy, or cutting corners is irredeemable. I have more faith that I am the type of person who will always try to do right by my patient. When someone puts their trust in me, I will not take that for granted.

I have now seen the stigmas of family medicine firsthand: the repetitive nature, high volume, fast pace, and demanding patients. To be honest, I did not know if I would enjoy family medicine, but I was pleasantly surprised. It did not feel repetitive because I was holistically focused on the patient in front of me. The high volume means building many new connections each day. "Demanding" patients have typically not been properly cared for, or just have high anxiety. I can be a calm voice to put them at ease.

One thing I want my preceptor to notice about my work from this rotation is my desire to make patients feel heard. In fast-paced settings, patients can feel expendable or unheard. I hope they noticed that I was thorough and focused on helping the patient.