

Ambulatory Care Rotation Reflection

Something New:

I was exposed to ear irrigation for the first time in this rotation. We used something called the elephant ear irrigation system, which looked like a squeeze bottle with a tube attachment. You place the tube into the patient's ear, and you squeeze the handle to propel water and irrigate. Different preceptors had different techniques with this system. I preferred having the patient seated upright, tilted their head to the affected side, and placed a basin under their ear. This way, all of the water dripped straight into the basin, and there was minimal spillage onto the patient. I was exposed to a new technique for suture removal; pulling the knot to one side provides an uninterrupted length of suture from which to clip. This was more comfortable for the patient.

I was exposed to a new treatment strategy for managing hypertension. For a pt on 3 anti-HTN medications, including hydrochlorothiazide, my provider would switch them from htcz to chlorthalidone for improved BP control. It's important to note that chlorthalidone has an increased risk of electrolyte imbalances, so electrolytes should be checked soon after starting this new medication.

Skills, challenges, and action plan:

Interprofessional/interpersonal challenges:

I faced a major interpersonal challenge this rotation when a drug-seeking patient presented to our practice as a new primary care patient. This patient asked for opioids during his initial visit, claiming he had 3 hernias and an untreated testicular torsion. He states his torsion untorsed while he was in the emergency room, and the doctors decided not to perform surgery. This story was highly questionable and prompted my provider to search this patient's ISTOP, which revealed multiple opioid prescriptions from different providers over the past month. These were major red flags, and my preceptor decided not to send an opioid prescription, emphasizing the need to treat the underlying conditions, not just pain. The patient went home that day without complaints, stating he would follow up on the urology referral we gave him. The patient returned 4 days later and was immediately combative with the staff, demanding to see the provider. He was aggressive, threatening, and attempted to instigate fights. He invaded the staff's personal space, filming them with his phone, saying, "make me leave" or "touch me, I'll call my lawyer right now." We attempted to diffuse the situation by saying, "We are not equipped to give you the care you need at this location. We are very sorry for the inconvenience, and we can refer you to a specialist. If there's nothing else we can help you with, today's visit should end as there are other patients we have to see." The pt continued to be combative, refused to leave, so we called the police, and the patient left.

Difficult situations and how I improved:

One difficult situation experienced was high expectations from my preceptor. My preceptor is great at collecting history and performing physical exams, as she was trained as an MD in rural India. She said their training emphasized physical exam and history taking as the foundation of their practice. The challenging (and beneficial) experience for me was that I often fell short of her expectations. She was always willing to collaborate with me, so this was a great opportunity to improve my presentation skills. One example was when I was presenting a patient who I believed was having an allergic reaction. The pt was experiencing hives, a throat-closing sensation, and difficulty breathing for three days. During my presentation, my preceptor commented that I did not clearly state the onset of the symptoms, the distribution of the hives, and the characteristic of the difficulty of breathing. I understood these findings in my head and believed I clearly presented them. This experience highlighted the importance of remaining systematic in presentation (I like to use the OLDCARTS framework).

Dealing w/ difficult pts:

One type of patient I found to be challenging in this rotation was patients with chronic conditions who are resistant to starting treatment. One patient in particular expressed a distrust of the medical system/pharmaceuticals. We calculated the patient's 10-year ASCVD risk to be 35%, warranting immediate statin therapy. Despite educating the pt on her current risks, we were unable to convince the pt to start the medication. She stated many excuses, including "I heard bad things about that medication," "you guys are just trying to scare me," "im healthy," "once you start me on that medication you're going to try and sell me a bunch of other medications," and "I dont care what your math is saying, i'm going to be fine." I learned many things from this interaction. Firstly, no matter how much we try to help, we must respect an autonomous patient's decision-making, even if it is against medical advice. Next, it is important to continue educating the patient, professionally, despite their objections. While this interaction can feel combative, I operated from the frame of "I'm trying to provide good for my patient" and "the patient does not have bad intentions." In my previous rotation, most patients quickly agreed with the provider's recommendations. I think this distrust towards the provider may have to do with socioeconomic factors, belief systems, and personal experiences. Regardless, the ethical thing to do is respect the patients autonomy.

Areas/skills needing improvement and action plans to accomplish them:

One area that I can improve is my presentation. I plan to keep a small notebook and write down the key facts. Sometimes, patients provide extensive or non-relevant information. The provider needs to keep track of the most important facts and not get overloaded. I think a notebook with the key facts will help maintain focus for the presentation.

Memorable experiences

One memorable case was a pt named J.B. who was dealing with resistant hypertension. This pt, a 62 yo F, lost her husband 5 years ago. She has been struggling with not only her mental health but also her physical health. She states she has been hypertensive for the past 10 years, and her pressures remain elevated despite medication compliance. She was taking lisinopril, hctz, and amlodipine, but her BP in the office that day was 186/108. She was seeking medical clearance to have cataract removal surgery, which required an EKG. The EKG revealed signs of LVH and early ischemic changes. The pt was completely asymptomatic and the EKG findings were new to her. We denied her surgery clearance and instead focused on managing her resistant htn. The pt, thankfully, shifted her perspective and agreed to focus on her htn management. I told the patient that if she has truly been compliant with her medications, there are secondary reasons that could cause her hypertension. I explained to her that there are some simple blood tests that we can perform to work up things like primary aldosteronism and pheochromocytoma. The pt began visibly emotional at this time, saying, "Every time she sees a provider, they just tell her to keep taking her medications, there's nothing else to be done at this time." She was very grateful that someone wanted to explore what could be causing her resistant hypertension, as she felt something was wrong with her. She was experiencing chronic headaches, anxiety attacks, and hot flashes for the past 2 years. This experience was memorable for me because I recognized the effect I can have on someone's life by taking the initiative to dig a little deeper for a patient. I also learned that we did not have the proper equipment to draw aldosterone/renin and serum metanephrines labs in our outpt office. We referred the patient to a lab to have these labs drawn. At the time I left the practice, the results of these labs had not yet returned.

Overall Reflection and Perspective

Self-learning during the rotation:

During this rotation, I learned I need to balance my desire to help patients with the reality of clinical practice. My experience with the pt with resistant htn taught me that some things take time to work up, and I have to have patience. My experience with the patient who did not want to start a statin taught me that even if something will have an immediate benefit to the patient, it is ultimately their decision what they want to do with their health. I will feel validated and hopeful, knowing that I show up every day with good intentions.

Changes in Perspective:

During this rotation, I had a change in perspective. I realized there's no single correct way to practice. I felt my first rotation was a well-oiled machine, while the second rotation was experiencing issues with patient flow. The second rotation had different documentation practices despite using the same EMR as the first rotation. In my first week at the second rotation, I felt that this practice was falling short because of self-induced roadblocks. While parts of my analysis may be correct, I realized I will not change the established system here, especially not as a student. I then changed my perspective and embraced the system in front of me.

What do I want colleagues to notice about me?:

I want my colleagues to recognize my thoroughness and desire to help patients. A provider must listen to the patient, collect a thorough history, and remaining engaged in their care at every level. Taking a holistic approach to patient care is my solution to burnout because care then revolves around treating a human being, not treating a group of symptoms. I hope my humility and desire for lifelong learning were noticed.