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Perspectives on the Patient & Physician Experience – Alexander Nicholas, DO

An Interview and Narrative written by Justin Guthier, MS-III

At first I thought it was just jet-lag. I had returned from a teaching trip to southern Germany on the 1st of October, 2008. On October 2nd, 2008, I did not feel like myself and did not even look like myself. That day, I was speaking Dr. Charlotte Greene, who visited me in my office to say welcome back. Dr. Greene commented on how worn out I appeared. I honestly thought it was all just jet-lag.

I went home and was not feeling very hungry. I had a sandwich and soup for dinner and had a handful of trailmix as a late night snack. Over the years, I had known that nuts and seeds and trailmix all could upset my stomach. So when I began to have some pain, I tried not to pay it much attention. Soon though, the pain began to evolve into an epigastric knifelike pain. I tried to sleep it off, but at three in the morning, I awoke with horrible, just horrible epigastric pain. I stayed awake and tried to tough it out. That morning, as I was shaving, I doubled over –the pain had not gotten better – it was worse, much worse. I told my wife to call my office manager and cancel my patients because I could not go to work. A half hour later, I told my wife to call my doctor and inform him I was headed to the Emergency Room.

I have been to the Emergency room more than my fair share of times and know that there is the potential for a long stay. My experience that day was no different. All this time waiting and being medically managed in the ER, allowed me to ponder what exactly was going on inside my abdomen. When I was in medical school, I had had two abdominal surgeries, first was an exploratory laparotomy for an appendicitis and the other was for an intra-abdominal hernia. My bowel most likely had kinked over the years. My family physician ordered a Cat scan for a kidney stone which had shown a “weird link” of bowel a month before, so my suspicions were headed in that direction.

The attending surgeon that day requested that I get another CT scan to give the most current condition of my intestines. I was hesitant to receive the CT scan considering I had just had one a month before. The test required I drink Barium to image my abdomen properly. Ingesting the barium was no small task – especially for someone that is nauseous and in pain. Slowly and carefully I would take small sips of the barium to ensure that I did not vomit any back up. After 2-3 hours of small sips every 5 minutes, I had completed the barium and was ready for my scan. The CT scan technician rolled my gurney against the CT scan table, allowing me to slide into place. Making her routine preparations, she stated, “Alright, now I’m going to hook you up the IV contrast.”

Startled I retorted, “I thought I was only getting the oral barium – I don’t feel comfortable with the IV.”

With a firm tone she stated to me forcefully, “Look, the doctor ordered the test. They want to do the surgery, the surgeon is busy and trying to get you in at the end of the day. Do you want to have the surgery or not?”

“Hold on one second – if you could contact the surgeon, explain that I have had a CT scan and that I could get by without it,” I replied. She replied that she did not have time to wait for the surgeon to contact her and that she needed to do the surgery done now. Having been in the Emergency room all day, woozy on painkillers and exhausted from my pain, I apprehensively consented. I did not feel like fighting with the CT technician – I just wanted to get finished and get out of there.

A physician assistant entered my room in the evening to inform me that the results of my latest CT scan in the ER showed I had a link of bowel that had attached itself to the posterior surface of my right rectus muscle. Confident in my ability to self diagnose, I concurred with the PA and continued waiting for transfer to my hospital room.

After this particular experience in the ER, I have a new perspective on what it means to be admitted to the hospital. When I was getting worked up at Bryn Mawr Hospital, I saw the ER doctor for no more than 5 minutes. I had seen a surgical PA for just as long. I had arrived at Bryn Mawr at 9:00 am and was admitted at 8:45 pm – a long day by any standard. Being a patient in the Emergency room is a difficult and trying experience. You lay in an uncomfortable gurney all day, usually it is loud and difficult to rest. I was getting pain killers like Dilaudid so you feel discombobulated and woozy in unfamiliar surroundings. Vulnerability, anxiousness and frustration are all common feelings for any ER patient.

When I eventually met the surgeon, she was 7 months pregnant. She seemed confident and thought she would have an easy surgery. Unfortunately, she ended up getting a case that was a lot more than for which she bargained. I had a three and a half hour surgery. I lost 6 plus inches of bowel. Immediately post-operatively, I was on bowel rest and had a nasogastric tube inserted in my nose. I was feeling alright. I was not able to eat with the NG tube in, but I felt okay. Two to three days later, the surgeon came into my room and notified me, “Your creatinine is going up. I’m not sure why – we hydrated you a lot.”

My creatinine was going up and my general health was going down. I ended up putting on 50 pounds of third space fluid and my creatinine went from .9 - 3.6. Soon, I was moved to the ICU as my white count was rising precipitously. I got blood cultures upon blood cultures to try to figure out the cause of my infection. Dr. Michelle Hobson, a member of the OMM faculty, was of great assistance and support during this time. Dr. Hobson’s husband was the president of the Bryn Mawr Medical staff that year. He got other physicians on my case, clearly recognizing I had a problem beyond surgical management.

My initial hospital stay was quite long – I stayed in the hospital for over 2 months. I ended up having many additional x-rays and barium swallows for CT scans. My belly would repeatedly become distended with fluid, necessitating

paracentesis four times. Surgery was not an option for me since operating on my bowel would be like operating on wet tissue paper. I received IV antibiotics through a three valve pick line and was allowed to be discharged soon after. Around Thanksgiving of 2008, I was only able to eat small amounts of food. After eating I would, like clockwork, feel nauseous and vomit. This vomiting was nothing like the vomiting you have when you get a GI bug. My sickness felt like a mechanical dysfunction – I began to have projectile vomiting. I started to feel as if I was becoming obstructed. I would eat small amounts of food, then at 8 o’clock in the evening, I would have projectile vomiting. After I would vomit, I would feel like I could eat a whole cheesesteak – but I knew better. The surgeons knew I needed to come back into the hospital, but I pleaded that I would come back immediately after Thanksgiving. I felt as long as I went with just liquids, I could make it through. I tried to enjoy the holiday as best I could, but I went back into the hospital the next day.

Once again, I made my way to the ER at 9:00 am. Tests confirmed that I indeed was obstructed and surgery could be indicated. Medical management by NPO, NG tube and IV fluids could not decompress me. My urine protein and albumin were up. I had not healed well and had developed abscesses in my abdomen which need to be washed and lavaged out. I was operated on for the second time by Dr. Anthony Colletta. I felt confident with Dr. Coletta. I asked him to perform my surgery with the help of the first surgeon. Since she had been in my abdomen before, I felt she could assist Dr. Coletta in navigating through my adhesions and point out her work from two months ago. I have recovered slowly over the past year and am back at work, seeing patients and enjoying my life as a physician and professor of osteopathic medicine.

Having been in and out of the hospital multiple times over the past year, I have gained a unique perspective on the patient experience. When you are out of the hospital, all you can think about are ways to stay out of it. You want

to prevent medically what is happening, procrastinate like hell and not give in to your condition. Each time going back in is more stressful than the rest because you are not sure what the next step in the process will be. Being in the hospital can be awful. You cannot sleep. I still have not slept well for months, most likely because of many, many difficult nights. In the ICU, all you hear is beep, boop, beep, boop. You cannot get comfortable in any position except on your back. You have wires going in and out of you in many different spots. You give up your modesty after the fourth or fifth night.

You start worrying about your family, not so much yourself, but what if something really bad happens to you. I would worry about how my family was going to deal with serious complications. That consumed a lot of my thoughts. A couple times I was so sick, death did not feel like a bad option. I felt so terrible, but I could not forget my wife and children. One day when I was really filled up with fluid, I could not help to think of how my father looked when he died. When my father died, he was really filled up with fluid, he looked like two Michelin men put together. When I put on my 50 pounds I too began to look like a Michelin man. I looked at myself and I said, "Oh my god, I am dead," because that is how my father looked when he died. I remember telling someone, "Do not let my brother see me because that is how my father looked when he died."

Even after I was discharged from the hospital, the image of my poor health still stuck with many people. One night I was out with the Hobson's for dinner, and Dr. Hobson was talking about how seriously ill I was and how they all thought it was "close." I said to my wife, "Did they think I was going to die?" and she said, "- yeah." I can laugh at it now laughed because I only remember being really sick one time for like 6 hours – but I never thought I was going to like "die, die." But I guess I was pretty sick.

I got to the point where I hated being in the hospital. God bless the nurses – I had the most fantastic nurses. I had the best nurses's aides too.

Everyone acted like they loved me, I tried not to give them too much trouble, they would say, "Bother us – that is what we are here for" and I would reply that there were other people who were sick and needed help. I looked forward to them coming in to visit me. The hardest part was 9:00 - 10:00 at night till 8:00 the next morning. The number of staff is down and the nurses that do come in try to work in the dark. Night after night for two months, that was probably the most stressful thing because you do not want to think that the nurses could make a mistake because they are working the dark, trying not to awaken you.

When you are in the hospital, it seems like every third day you were getting another CT scan. I would have to take the barium drinks and it was so hard to keep them down, I would take a big sip with the straw and then wait 5 minutes and then take another sip. When you are sick or nauseous it takes 2-3 hours to get it down. Then you are carted down to cold areas and wait in a hallway, hoping that you do not vomit or have diarrhea. Then you wait to be picked up to go back to your room and hope that you are not forgotten about waiting in the hallway. You have a little blanket and gown. You really do lose all modesty. I tried to keep it light when I was in the hospital. Instead of the standard little pail they give you, I kept a huge bucket in my room, so that I could go down to the radiology department with this huge bucket. I could always get a smile out of people.

I did see one of my former students when I was in the hospital. He was an interventional radiologist. At this point, I had been in the hospital for many weeks. When I saw Stephan, he said, "Dr. Nick – what are you doing here? I saw this humongous, horrible chart and thought, 'nah – it's not him, and look, it's you!'" We exchanged pleasantries and he began to explain to me what he would be doing. I nodded approvingly after he explained the entire procedure. As he was about to begin, I looked at him, after having enjoyed his company and said with complete sincerity – "Stephan, I will do whatever you want me to do, but you have to promise me one thing – I do not want to feel any pain. Six weeks ago, you could

have poked me with a pitchfork, but now, I just can not take it. You have to promise me.” Assuringly, he nodded and continued with the procedure. He counted ‘one, two - ’ and on three the procedure was finished. I felt really lucky to have had a physicians like Stephan to help me. It reminds me that when you are working with patients, they are tired and cranky and can sometimes not be themselves. You need to have patience for your patients if you want to be a successful physician.

I tried not to broadcast the fact that I was a physician when I was in the hospital. My personality trait is not to be pompous – I wanted to be considerate with the nurses and respectful to the hospital staff. After a while people would pick up on the fact I was a physician, based upon the way I would say something with a little more knowledge. Nurses would playfully interject – “Hey-why didn’t you tell me that?” I simply did not want the staff to have the impression that I would say things like – “I AM DOCTOR ‘so and so’ and I expect this.” It really did not effect the way I was treated, but there is an increased level of respect when staff know you are a physician.

OMT was a big part of my hospital experience. One of our former students, a family practice resident who had worked with me in my office, would come into my room to do rib raising. After she ate dinner and would come back and do some more therapy on me. She was really nice and went above and beyond her responsibilities.

My daughter and her boyfriend who are both PCOM students also would come in and treat me. The department had a visiting clinician from Europe, Dr Jean-Marie Buckles, who came in to treat me one night. I had never met him – he came in with my brother and did a visceral oriented treatment that took my abdominal pain down significantly. He said, “I do a lot of this back home in the hospital.” He did a visceral release technique that I initially felt would do nothing, but later that night I did not have any belly pain. Earlier in the day I had had 7-8 out of 10 abdominal pain. My daughter treated my chronic cough by work-

ing on my thoracic inlet and in addition, working some chapman’s reflexes. My chronic cough would be relieved for extended periods of time with those treatments. My OMT in the hospital consisted of visceral techniques, rib raising, ENT treatments and chapman’s reflexes, all of which I found to be incredibly helpful.

It is important that you visualize what life is like for a patient in the hospital bed. When you are sitting in the three quarter position you get so tight. If someone puts their hands under your back, extending you and moving you around, working your traps and thoracic inlet, its feels great at that moment, regardless of the long term effects. Patients get a great deal of relief from rib raising and soft tissue techniques. Simple placement of the hands on the patient goes a long way. I have what I like to call the “Nicholas rules.” When someone under you does something and you see it work with your own eyes, you are conditioned to keep doing it forever. I had a lot of success with rib raising in treatment of post-op ileus and also with the singultus technique, which really does work.

As a physician I have a unique position of empowerment in terms of understanding what is happening to me as a patient. Information empowers patients and makes the hospital stay for them easier. Being in manipulative medicine for so many years I was rusty on a lot of the pathophysiology. I had to think , “Alright if I lose my ileocecal valve, this will be the outcome.” The inconvenience of being rusty on my pathophysiology bothered me the most. I would try to remember nephrotoxic drugs, what happens if I lose my bowel or what is my ileostomy going to be like. The more I started to think about these topics, the more upset I became. My daughter assuaged a lot of my anxieties. She would come in with her laptop would do medical searches and find out all the info I wanted to know. After she would leave, I would sit around thinking about our discussions, using the searches and my own medical knowledge I would go through differentials and when physicians would come in, I could help them rule out certain possibilities. I would

almost always be a day ahead of the physicians. I think most rational, educated people want to know their expected prognosis because there are a lot of issues you have to deal with if you have a bad outcome. It is important to make sure your patient knows all the possible outcomes within reason. The line between fanatical hysteria and withholding information is a fine line. You do not want to paint a picture of doom or get the patient needlessly worked up.

You always have to leave your patient with hope. With all of my patients who suffer from chronic pain, that is one lesson I learned from patient after patient. Hope is pretty powerful. In terms of malpractice, the better you communicate to your patient, the less likely you will have legal problems in the future. Empathy is a strong emotion, but it needs to be sincere. Your body language, your attitude, the empathetic foot you put forward, patients can realize when you do not care. You want your patients to believe you went into medicine to help others, then you will never get sued. If your patients feel that they matter to you, it is very hard to sue. A good example of strong qualities in a good physician is Dr. Anthony Coletta. Dr. Coletta had a strong attitude, which is necessary in surgery. However, Dr. Coletta did an excellent job. Every morning he saw me and gave me a complete physical himself. He did everything like you are taught in medical school. He did not rely on PA's or residents to provide him with information. After my physical, he would spend 5-10 minutes socializing with my family and me. Dr. Coletta is one of the few doctors who have such strong interpersonal skills – that is why I had such confidence in him. Dr. Coletta did the entire gamut. He was attentive to my physical, emotional and social needs. You had total confidence in the guy.

For all of the students out there, you should never be afraid of the patient. Treat your patient with respect and speak with confidence. Remind yourself that your patients are not really your friends. They want to have a connection with you but there needs to be limits. This is a fellow human being that you are dealing with. They are

scared and suffering. The patient, more often times than not, is mentally frazzled and emotionally and physically stressed. You unfortunately do not get the best of the patient when they are sick. Work with what they give you. When you say things – think about what you are saying. Communicate properly and effectively. If you are a student on rotation, only communicate things that students should be saying. Do not talk about diagnoses or tests that you are unfamiliar with and give your “opinion.” Always remember not to ask questions out loud to physicians that would make a patient feel uncomfortable.

Always remember why you became a physician. There are going to be times where you feel burnt out. You will need to bite your tongue. If you feel yourself being callous, step back take a deep breath and go back to the feelings that brought you to a career in medicine. Even the most frustrating patients deserve respect and proper care.

At PCOM, we have naturally gifted and talented students becoming physicians. Obviously when you look at exceptional students, you look at numbers – MCAT's, COMLEX. What is really the difference between a 3.6 and 3.8? When I look at med school applicants, I look to be sure they are well rounded. In college, I was a liberal arts major. Even though it made my first year of medical school more difficult in comparison to some of my classmates, I became so incredibly personally enriched from majoring in history. To become a doctor, you have to have the intelligence. You need to be a little Sherlock Holmes and be a people person at the same time. If you are in this for the right reason – to help patients – then you are more than likely going to be a good physician.

My liberal arts education made interacting with different types of people easier for me than some of my science colleagues. From being a liberal arts major, I felt comfortable with knowing when I did not know something – I knew when to ask for help. Working on my weaknesses, became the mature and intelligent decision for a growing physician. During my intern year, I was

scheduled for an ICU rotation. I felt weak in Cardiology so I spent a month before hand on the cardiology service in preparation for my ICU experience. As a liberal arts major, if you know simple little things like ethnic backgrounds and little bits of information about certain ethnicities, you can make your patient feel more at ease. They are more likely to trust you and you will be more likely to gather a better history. Being well rounded, you will feel confident with different types of people and patients will become confident with you. Whenever I see that a medical school applicant has been a waiter in a busy restaurant for a number of years, I know that they are able to handle the stresses of working with people who have expectations and who require varying amounts of attention.

The last thing I would want students to consider is – think about what is positive or pleasant when you go to the doctor's office. What are you looking forward to that is pleasant? You probably will get your blood drawn, give a urine sample or even worse a stool sample. None of these are the most pleasant of experiences. As a DO, you can make patients want to come to your office. Be conversational, be pleasant, be someone who the patients want to come and see. You never want your patients to be afraid to go see their doctor. Always remember, there is no one who has an occupation like you. Maybe a teacher or a person who is heavily involved in community service, but there is no one as involved in the human experience as intimately as you.

