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The Senior Resident – Beginning the Journey – Richard Donlick, DO

Written by Justin Guthier, OMS-III

My path to medical school was much different from many of my classmates. You could say that I followed in my father's footsteps. I did not even think about becoming a physician til much later in life – just like my father. When my Dad graduated in 1979, he was 36 years old with 4 kids. C. Everett Coop was the commencement speaker that year; he was a pretty important guy at the time. He would later become the Surgeon General of the United States. I was pretty inspired by my Dad's accomplishment but it would be many years later until I would follow in his footsteps.

Before medical school I was in the Air Force and worked in the Counterterrorism unit. It was pretty exciting work, but in the back of my mind, I always wanted to become a physician. With children of my own, I too decided to go for my dreams of becoming a physician. As a medical student, I experienced many life-changing events. Delivering a child, besides my own children, was one of the greatest moments of my education. I have never seen that much joy and complete contentment when the mother took her baby in her arms for the first time. I can see the scene in my mind clear as day. As a medical student the experience of delivering a baby was a lot different than becoming a father for the first time. When you are learning, you are more observant of your surroundings. It probably helped that as a medical student I was a lot more nervous. Looking back at my residency training it is difficult to grab one moment that sticks out in mind. Undoubtedly though, I have surprised myself with the abilities and knowledge I have gained over the past three years. I never thought I would have the skills necessary to identify and diagnose a disease process and in turn save a life on my own. Beyond any particular experience, that by far is the most influential feeling in my graduate and undergraduate education. To that end, I give all the credit and respect to the physicians who trained me.

I knew I wanted to practice internal medicine and PCOM's program made sense for me and my family. In PCOM's program, I get the responsibility to handle the most serious of cases in the critical care setting. There are not many other internal medicine programs that delegate and expect more of their residents than PCOM's. One patient in particular sticks in my mind. A 50-year-old priest was admitted to the hospital. He had recently returned from a trip to Panama where he had been doing missionary work in the jungles. To travel from village to village, he had been using a donkey as his primary mode of transportation. I am not a Catholic, but it does not matter – I was determined to treat and bring back to health another human being who had dedicated his life in service of others. As his

condition in the hospital worsened, I convinced him to be intubated. He agreed and unfortunately he never woke back up. He died from complications of a severe pneumonia. We tried everything that we could to save him and in turn learned more from his case than I have from any other. I did a swan, did zypress, inverse ratio ventilation, bi-level ventilation and 5 pressors. Many priests who had gone on the same trip suffered from severe pneumonias as well. The CDC came in and did autopsies. His death stuck with me for a long time. Yet, in his death, I learned more from his case than from any other patient. I will use those lessons for the many thousands of patients yet to come.

In residency, you have a responsibility to teach those under you. I love to teach. Teaching makes my day worth it – teaching is what sometimes gets me through the day. For students who come to Roxborough for their second year H&P, I try to make their experience as realistic as possible. There are certain things that medical students should know as they progress through their third and fourth years. I do get frustrated sometimes with students and their base knowledge. If I ask a group of students what is the organism you find in otitis externa, I should not hear crickets. I should see hands up in the air. I am not an in-your-face type of guy and I am not expecting you to be an infectious disease genius. But I do expect that a simple fact like that, where it is gone over multiple times in multiple classes and emphasized on boards studying, that this fact should stick. When students are in their first and second years, I feel like they study for the test. Even the students who go to class, usually do it to study for the boards. They do not have that sense of urgency that the information they are given is not simply for test taking and grade achievement. This information will ultimately allow them to do their job as a physician and if given the chance, save a life.

When a medical student is on rotation, I would like to see them display maturity and a strong work ethic. For the most part they do. I have been incredibly impressed with the effort my students have put forth this month. You should know basic antibiotics. You should be able to answer with ease the frighteningly easy questions – swimmer's ear, patient sits in a hot tub, what's the bug? Easy stuff like that. I do not care if you can recite the citric acid cycle. It doesn't help you much in everyday medicine. It is important to know for the boards but in the big picture, you should not emphasize information like that. Memorizing the citric acid cycle is part of the game you play to get to where you want to be. When you are taking the boards, they are not simply measuring your knowledge base; they are testing your endurance. That part of the

boards is a test of your scholastic and personal fortitude.

The information in an organic or biochemistry class is not as important as the lessons you learn from persevering through the material and the challenge. When you get to topics like microbiology and physiology, those directly impact your ability to perform as a medical student on rotation and ultimately your ability to treat patients. In terms of biochemistry, focus on the practical. It may not be as helpful to memorize the Kelvin Benson cycle as it would be the metabolism of alcohol, since there will be a large portion of your patient population that will have alcohol problems. You should pay extra attention to your attendings on rotation. Watch how they perform, how they solve problems. Have your stethoscope handy at all times and be ready to listen. When you hear something funny, always ask your attending, 'Did you hear that too?'. That's how you learn. In summary, I would like my students to have a strong grasp of the practical knowledge. The bigger your knowledge base when you start, the more you can add through your clinical years.

For students reading this, the best advice I can give for when you begin to enter graduate medical training is to know your program and know yourself. Make sure the people you are signing up to work with are ones you can relate to and can respect. You are going to be with these people for a minimum of three years.

As a senior resident in PCOM's program, the attendings have high expectations for me. Though you spend a lot of time making schedules and arranging lecturers, you do become the right hand man for your attending. On Dr. Jeff Bado's service, he called me his "Number One", like on Star Trek. It was a great feeling to have that support from your attending. There were not many experiences that caught me off guard, since I am a person who does think consistently two steps ahead of the problem in front of me. However, there are some experiences which do catch me off guard – for instance, I can not pass up the opportunity to go to Haiti and help the victims of that mass tragedy. I feel like I absolutely have to go – that there is no choice but for me to go. As I approach the end of my residency training, I cannot emphasize how excited I am to become the 'guy'. Dr. Bado has an interesting theory about resident progression. He thinks there is a 10,000 hour mark in a resident's education – specifically 10,000 hours of patient care experience, when the resident becomes completely comfortable in seeing patients, managing patients, writing orders and wants to run the patient's care in the hospital. As an attending who teaches residents, you will notice this. The resident will begin to seek the attending's counsel less and less and will manage the patient singularly with little input from the attending. Dr. Bado is a pretty wise guy. It is a great feeling to know that you can manage a patient, no matter how sick they can be. I am really excited at

the prospect of starting my career.

Now that I have considerable patient care experience under my belt, there are patients whom I know as I am getting their story that they are going to be a handful in the hospital. People who have given up on life and have turned to drugs, alcohol or both are the most difficult to manage. Throw in a couple psychological problems and that is a whole world of trouble. The patient that has given up on his or herself, who simply do not care, can be incredibly difficult to manage. I once had a 31-year-old woman who was admitted to the ICU with pneumonia from drinking and drugs. I remember thinking, "Good God woman, you are 31 years old with a family and children and you are doing this with your life?" You fix up the patient, let them back out into the world, they drink themselves to oblivion and they are back 2 weeks later – this can be a deleterious cycle for both you and the patient. At the other side of the spectrum, you have the 100-year-old woman who has been made a full code by her family. God bless the patient for making it to 100 years of age, but does the family really expect the patient to survive for many years longer? Families can at times be just as much if not more work than the actual patient.

Critical care patients get me going. I know that if I do not do the right things in the right order, in the next few minutes that patient will die. Critical care patients also require you to be Sherlock Holmes at times. When you have an incredibly long differential diagnosis and you have to work through the list, it can be a rewarding experience coming to an answer. We had a case of Babesiosis at Chestnut Hill. The patient had been digging for clams in Nantucket. He presented to the hospital with a cyclic crazy fever – 105, 102, 105, 100.4 – that was a difficult case! For patients that I had little idea of where to start, I would go home and read and read and read. That is the single best thing you can do for yourself as a medical student and resident during your training.

In residency and in medicine in general, you are exposed and placed into some pretty terrible experiences and tenuous positions in dealing with patients and their families. Ultimately, you make jokes to get yourself through the day. The best line that relates to this is from 'Scrubs'. JD, the main character goes, "We do not joke because we are heartless – I mean look at this – I have to go tell that family their father died. That family gets to sit there and grieve for the rest of the day; I have to go back to work. I don't make jokes because its fun, I do it so I can make it through the day." That is the best quote I have heard about being a doctor. You can get messed up in the head if you do not have the proper support structures. There are some terrible things I have to explain to families. We have to bite our tongues and do what is right or what the family requests. That is the definition of professionalism.