

Clinician Turned Patient: Lessons from the Heart

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When I entered my 26th year, I did not imagine that I would soon undergo open heart surgery. Yet, in November 2018, my doctor and I discovered a myxoma in my left atrium. The events leading up to, and those subsequent to, this terrifying diagnosis were trying yet ultimately eye opening. Unbeknownst to me at the time, I would meet some remarkable individuals during this journey. These individuals have taught me valuable lessons in patient care that I have tried to incorporate into my own practice.

At the time of diagnosis, I was relatively new to practice, having finished my pharmacy residency in the summer of 2017. In March 2018, I opened a new anticoagulation clinic within the Penn Medicine Lancaster General Health system, caring for about 80 patients from a family medicine outpatient practice. As a new practitioner, I was still developing relationships with my team — providers, staff, fellow pharmacists — and my patients.

ATTENTIVENESS

The solitary symptom that prompted my adventure was a periodic, non-painful “pang,” or tapping, in my chest. The episodes would last only a few seconds. I underwent a myriad of lab testing over the next few weeks. By the time my primary care provider (PCP), Dr. Maria Calderon, and I discussed these results, my symptoms had become less frequent. She nevertheless ordered an echocardiogram, which revealed the tumor and led to surgery.

Later, Family Medicine and Cardiology colleagues reflected on my PCP’s diligence, admitting that if in her position, they might have refrained from ordering the echocardiogram given my improved symptoms. That comment was eye opening to me. Without my PCP knowing me well, sharing the clinical decision with me, and exhausting all options, I may have unknowingly continued with this

benign but nevertheless disconcerting heart abnormality.

During my admission, I battled post-operative nausea, although it improved day by day. One morning, I was taken via wheelchair to have an x-ray. The ride there and back with all its turns left me on the verge of vomiting. When I returned to the floor, my nurses, Tim and Clinton, took one look at my usually cheery face, now a miserable sheet of white, and followed me into my room. All I could muster to say was, “I feel sick,” and Tim was off in a flash for ondansetron, an anti-emetic.

During my admission, many staff members encouraged me to ambulate as much as possible. Several times per day, I walked around the unit. Each time, I would go a little farther, and eventually I was able to complete several laps. I was so pleased with myself at every new distance, feeling victory in recovery. I didn’t share this with Tim and Clinton. Still, they celebrated with me at every milestone — an approving nod, a smile, a brief “great job.” Their validation and support encouraged me even more.

Since this experience, I have found myself paying more attention to and acting on subtleties such as nonverbal communication and changes in tone or demeanor. For example, if I sense hesitation with a proposed medical plan, I share my observation with the patient and get their thoughts on the matter. With a simple question, I have been able to identify and remove more barriers to care and engage in greater shared clinical decision-making than if I had relied on the patient speaking up on their own.

Similarly, I have come to applaud my patients’ achievements more often than I had previously. Really, who am I to say what is a “little” or “big” accomplishment when it comes to their health? Now, I celebrate it all with them, and I have experienced a better connection with my patients for it.

CREATIVITY

During my admission, I had an IV line that needed to be flushed with saline every few hours. When the lines were being flushed, I experienced a smell of rotten sea water, which exacerbated my nausea. I shared this with Tim, and though sympathetic, he didn't know how to prevent this reaction. That evening, however, he shared an idea with me — I was to eat a spoonful of applesauce while he flushed the line to mask what I otherwise perceived to be odorous. It worked! I smelled and tasted lightly salted applesauce and, better still, did not experience nausea. From that point forward, I ate applesauce each time my nursing staff flushed my line.

While in cardiac rehab, there was a prescribed maximum heart rate permitted during exercises. This was calculated based on my resting heart rate, which had been measured during my initial visit. Yet, at that time, I was treated with metoprolol, a medicine that slowed my heart rate and was soon thereafter discontinued. In truth, I have been a very healthy, active individual all my life, and my physical ability quickly surpassed the level of exercise permitted. As a patient, this was a significant hindrance and annoyance.

At one point, I was ordered a Carnation Ambulatory Monitor (CAM) to watch my heart rate for a week. The cardiac rehab nurse, Lisa, had an idea. While I was wearing the CAM, she would remove the heart rate limit to allow a “real world” test of my heart rate and cardiac response while working out. She obtained approval from my cardiologist, and we did just that. I felt wonderful, challenged, and healthy.

While many patient encounters and treatment plans are straightforward, not all situations fit “the norm.” After returning to practice, I have tried to pause in atypical situations and consider creative alternatives.

THE “WHY”

As a clinician, the rationale for medical decisions have become common knowledge through my own repeated use and exposure. It can be easy to fall into the rut of simply advising the patient and not explaining *why* I have given specific advice.

During my journey, I came to realize how important explanations of reasoning can be when trying to motivate a patient. For example, on post-op day one, I was still too weak and in too much pain to move on my own. The nursing staff had to turn me from one side

to the next every few hours to encourage blood circulation and reduce the risk of bed sores. Because I had been taught the reason for this tortuous experience, I did not complain or resist.

I was also instructed to perform spirometry every two hours while admitted and regularly upon my return home after surgery to help regain breathing capacity and reduce the risk of developing pneumonia. Upon being told the latter, I was determined not to miss a single spirometry. Without that explanation, I would have likely been less diligent in my practice, opting to rest or nap.

Further, I was told to cough, whenever I felt the urge, using the “heart pillow” (see Fig. 1). Coughing would help to clear out the lungs and prevent pneumonia, while hugging the pillow applied pressure to the incision site to prevent tearing. Coughing was excruciating with chest tubes, lines, and freshly closed wounds. The pillow's pressure to the surgical sites only added further discomfort. Still, knowing the “why” kept me determined to not suppress that tickle in my throat.



Fig. 1. The author's “heart pillow,” given to her and other heart surgery patients at the time of her procedure to aid in recovery efforts. Photo courtesy of the author.

EMPATHY

Empathy is another essential component to good patient care. It was not until I was on the receiving end of such provider empathy that I fully realized its significance and impact.

As I waited in the exam room for my first meeting with cardiothoracic surgeon Dr. Mark Epler, I was terrified. I had a *tumor inside my heart*! While my cardiologist had said myxomas are typically benign, the remote possibility of the tumor being cancerous plagued me. Enter Dr. Epler. He sat down and looked me directly in the eye. His first words were, “You do not have cancer. I repeat, you do *not* have cancer.” I felt his words pierce the dark shroud that had descended over my mind and life, allowing rays of light and hope to filter back into my thoughts.

While preparing for hospital discharge, the nurse practitioner, Ashley, was given the task of removing my two cardiac pacer wires. The first came out very easily; the second did not. I asked if she could tug harder. She replied that she should not, as she feared she could incise the heart tissue and send me back to the operating room.

Yet, I did not want this metallic keepsake, so I asked if she would gently try again. She agreed to try, although she didn’t seem hopeful it would release. To my delight, the wire gave with her soft tug. Thanks to her empathy and consideration, the only souvenirs I live with are a few faded scars.

SUMMARY

From lectures and literature, we learn the facts and data. We learn that metoprolol can cause fatigue and tramadol can cause central nervous system depres-

sion. The diagnostic process can take time and extensive testing.

When we hear about the experiences from our patients, we add anecdotal information to our body of knowledge. We hear how tired that dose increase of metoprolol made one patient. We listen to another describe a lack of mental clarity while taking tramadol. We see the tears brimming in a third patient’s eyes in fear of what the test results may reveal. However, it brings another level of understanding to each of us when we become patients.

While I was prescribed the lowest dose of metoprolol, this resulted in fatigue and lack of motivation so that I felt as if I had pulled an all-nighter without coffee. Tramadol clouded my mind such that I could not focus to even read a novel; I could engage in nothing more than mindless movie marathons.

I sobbed in my car after learning my symptoms were due to a mass inside my heart, but I had not yet met with the cardiologist to learn the diagnosis. Like many, I feared that “mass” meant “cancer.” All that diagnosis suggests — including chemotherapy, surgery, chronic pain, and more — flashed before my eyes.

This formative personal experience has been one I’ve revisited often, and the lessons I have taken have enabled me to form stronger relationships with my patients, based on close attention to detail, careful communication, and above all, empathy.

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