

# Role Reversal: The Nurse Practitioner as a Patient

When I was conducting a literature search on the trajectory of a person during the pre-diagnosis phase, I found numerous articles about the journey after diagnosis, but few on the pre-diagnosis phase. It is because of the insight I gained during my own journey and the lack of literature that I decided to share my story from a patient perspective, as well as the recommendations for how a Nurse practitioner (NP) can help patients find a balance between despair and hope during this time. This is my story:

I had been having intermittent pains in my left iliac area for a couple of weeks. As many do, I rationalized that it was just because I had been too active cleaning my basement and the pain would just go away after I had rested. I remember the

## IN MY OPINION

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night that the pain was so severe it awakened me from a deep sleep. I had been sleeping on my left side as I often did, but that night was different. I had never been awakened by pain before. That incident got my attention. So I set my NP mindset into place.

My presenting symptom was "nocturnal pain in the left iliac crest area." The following is my personal symptom analysis.

- **Onset.** The pain had been present for about 2 to 3 weeks, mostly notable during the daytime. It had become increasing worse, now a 3 to 4 (scale of 10). During the last couple of days, the pain became worse at night, 7 to 8, resulting in awakening.

- **Location.** Left iliac crest. When I pressed on the soft tissue near the iliac crest, there was very little tenderness.
- **Duration.** When I turned from my left side, the pain would ease in about 10 minutes to a gnawing, 2 to 3 level, and I was able to go back to sleep. During the day, the pain was continuous, at a level of 3 to 4.
- **Characteristics.** The pain was continuous, gnawing, increased with activity that required bending, sitting, or standing for more than 30 minutes at a time. The pain felt deep, like "bone pain."
- **Associated Factors.** I also began to notice that I had been having more abdominal bloating and sporadic shooting pains across my abdomen. Sometimes these fleeting episodes started from the right lower quadrant, other times from the left upper quadrant. There had been no change in dietary patterns or bowel characteristics, no nausea, vomiting, or abdominal tenderness. Range of motion was not limited, nor did movement increase pain.
- **Relieving Factors.** Changing positions during sleeping, from left lying to back or right, lessened the pain. Avoiding long periods in one position, standing or sitting, also helped.
- **Treatment.** When the pain persisted at levels of 7 to 8, Tylenol extra strength, tabs ii, reduced the pain to a tolerable 2-3 level.

The "patient perception" played a major role in influencing my differential diagnostic list. My experience as a nursing educator whose primary teaching assignment is pathophysiology, with a practice emphasis in hematology-oncology, influenced my perception of what was happening. After careful analysis, my differentials included: "soft tissue injury," osteomyelitis, bone cancer, or ovarian cancer with bone metastasis.

Why cancer? Why osteomyelitis? My significant history included having taken Forteo, a parathyroid hormone injection as treatment for my osteoporosis. Forteo has a black box warning for osteosarcoma. My recent titanium/aluminum implant into my left lower mandible for osteoporotic bone loss was a noteworthy risk factor for osteomyelitis. Because of a strong family history of cancer coupled with having worked with several patients with similar presentations of abdominal bloating and vague abdominal pains who were later diagnosed with ovarian cancer, I felt the need to rule out ovarian cancer.

Although I entered this diagnostic phase with a different armamentarium than many of my patients, I found that the course of my pre-diagnosis phase was consistent with what I found in the literature, as well as the anxiety related to the uncertainty of not knowing that many of my patients have shared with me. Giske and Artinian describe the application of the "theory of preparative waiting" in a group of patients undergoing diagnostic assessment for gastroenterological manifestations. This theory proposes that patients use 4 approaches to balancing hope and despair during the pre-diagnosis phase: seeking and giving information, interpreting clues, handling existential threat, and seeking respite.<sup>1</sup> Different studies found that the most stressful time for patients was during the time when they were waiting for the diagnosis.<sup>1,2</sup>

A patient's cognitive appraisal of the presenting problem has been found to be a key factor in how the patient interprets and copes with the experience.<sup>2</sup> Many of my patients have said, "If only I knew, then I could deal with it," "It is the not knowing that is so hard," "You are just churning inside. You want to talk about it, but you don't want to burden anyone with something that may not be even true."

For me, the "seeking and giving information" approach was consistent with what is described in the literature. I too, sought the expertise of my primary care provider. During the "waiting to be seen" phase, I pondered and worried about all the possibilities. On exam day, after sharing my perception and fears, I listened to my provider's diagnostic recommendations with hopefulness. I remember feeling somewhat comforted by his genuine caring demeanor. In a study of 50 women awaiting the

results of a breast lump biopsy, Poole found that those who cognitively appraised the situation with optimism had less stress and anxiety; those that experienced cognitive avoidance had more distress.<sup>2</sup> Patients who felt informed and involved in the diagnostic phase also expressed a feeling of control.<sup>2</sup> My provider shared this same philosophy of care, so in collaboration, we began the journey of discovery.

In using the "interpreting clues" approach, I, like many of my patients, consulted several resources, including the Internet, and discussed my thoughts with my provider. The Internet often creates unwarranted anxiety and unfounded fears due to informational overload and an inability to analyze the information presented. Patients often talk to and take advice from friends, family, and others before consulting with their provider. So what determines how a person handles all this knowledge and advice?

Many different variables affect a person's perception and response to the pre-diagnosis phase. Studies support that those who are optimistic tend to engage in positive coping strategies such as focusing more on facts than the what ifs. My handling of existential threat was consistent with what Giske and Artinian describe in the theory of preparative waiting.<sup>1</sup> I contemplated the outcome of a diagnosis of ovarian cancer with bony metastasis, bone cancer, and osteomyelitis. Being very aware of the possibilities with each, I chose to think about how I would want to spend my remaining time if a cancer diagnosis were the outcome. I've had soul-searching experiences before, but this time, the threat seemed more imminent. I had thought about my living will before, but I had never talked to my children (my guardians). Even though I tend to cope with optimism, the underlying anxiety was still there, the what ifs? I knew that pursuing factual information would provide comfort in knowing, regardless of the outcome.

I, too, used the "seeking respite" approach. My support resources included prayer and talking with close family members and one colleague. I found strength and support in sharing this burden with a few people I felt very close to. I also knew that the few I had chosen to confide in would not give me false support, that they would listen from the heart, and share the weight of the unknowing. False sup-

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