Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Welcome to Nightintales. This podcast was created during the International Year of the Nurse and Nurse Midwife, and what a year that was. This podcast is dedicated to telling stories of nurses from across our profession. Our goal is to introduce you to the seemingly infinite possibilities in nursing and encourage you to find your true passion within this work. I'm your host, Jessica Spruit and I'm so glad you're here.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Hello there and thank you for listening to another episode of Nightintales. I'm glad that you're back to listen to us. I'm also glad to welcome our guest today. I have Dr. Jim Wiandt here with us. Dr. Wiandt is a cardiovascular nurse practitioner at Knox Community Hospital, where he specializes in cardiology. Has I think a really unique career trajectory in nursing. Has a couple of different advanced practice roles and certifications.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

And so, I'm eager for Dr. Wiandt to share that information with all of you, and for you to hear and learn from his journey. Dr. Wiandt, thank you so much for spending your time with us today and for being willing to share your story in nursing.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Thank you very much. Glad to be here.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Yes. Glad to have you. I think there are some really valuable lessons in what you've done so far. Without giving that away, I would really appreciate if you didn't mind starting by telling us a little bit about nursing school, where you started in your first job, and then we'll work our way all the way to your current role as a cardiovascular nurse practitioner.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Okay. I have a little bit of a, as you were a kindly putting it, a diverse background in nursing. I started out first right out of high school and went to Bowling Green State University and earned a degree in microbiology and chemistry first, because I wasn't quite sure exactly what direction I wanted to go. I knew I wanted something science-based. I wasn't really looking at human interaction. I was looking more at straight science type things.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Somewhere around the second year, my sophomore year, I started thinking about maybe medical school. I don't know. It interested me. I continued on through my baccalaureate program. The summers though, I was in that program, I spent in a local hospital as a nursing tech and was able to pick up some clinical experience. That's what made me start blooming the idea in my head about doing something human-based. I continued thinking about medicine.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

But each summer that I got a little more involved with this hospital, I saw what the physicians did. I saw what the nurses did. Spent a little bit of time, one of the summers, in the intensive care unit, the emergency room areas, and fell longingly in love with that kind of care. I thought, "Wow, these nurses seem to be in control. They seem to really know their stuff. They were right on top of the patients' situations. They impressed me by seeing how they headed things off before anything even happened. I was like, "Wow, that's really cool."

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

And so, I became less and less enamored with what the physicians did because they only saw them a short time. They'd come in, they'd write some orders. They might listen to the heart, and then they're gone. I thought, "I really don't want that. I want to be there at the bedside. I want to be one of these." They were all outstanding female role models, is what they were. There were very few males in the profession, at least in the geographical area I was in at that time. These ladies were just outstanding.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

So I went back. Unfortunately, I was a senior at that time and I went and talked to the school of nursing at Bowling Green. It would have taken me another three years to get my BSN, and I thought, "Oh, there is no way I'm staying here another three years." So I finished up my degree and I thought, "I'll just... My degree was in clinical microbiology. So I thought, "I'll get a hospital job in a lab and that'll be good." Well, in 1983, not belaying how old I am, but in 1983, there were very few jobs out there for most of us college graduates.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

I went around to multiple hospitals in the Columbus area, in the Cleveland area, the Canton area, and found nothing in the way of jobs open for someone with a degree in microbiology. Most labs wanted a medical technologist who was able to float to all the areas of the lab, not just micro. I wrote to my, advisor at Bowling Green and I said, "Okay, I'm lost. I'm really not sure what I'm doing." I started working as a substitute teacher in the school systems here in my hometown.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

That provided money and I enjoyed the teaching aspect and working with the kids, but I still wanted one of the clinical that got in my blood and it never left. I wrote to my advisor who wrote me a 12-page handwritten letter back.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Oh wow.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

She was a chemistry professor, and she said, "I've watched you over the years. I know that you gleaned a huge amount of satisfaction from your summer jobs as a nursing tech. I think you should consider several options. Number one, you could think about medicine, blah, blah, blah. You need to take the MCAT, do these things." I knew that was out right away, because I wanted nothing to do with that.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

"Number two, you could consider being a physical therapist. That gets you in the patients yet you're not greatly exposed to diseases," such and such. Then she got down to, "Consider nursing since you enjoyed your nursing role in the summers. Think about nursing, followed by nurse practitioner or nurse anesthetist education." She said, "Likewise, you could consider physician's assistant education as well." But she said, "You seem to be so involved with the nursing aspect, that I think that's something viable."

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Unfortunately, at that time, there were no accelerated degree programs for nurses. So I went back and earned an associate degree so that I could get in the workforce quicker. I did get an associate degree in nursing and went right into ICU as a new grad. Myself and another new grad were the Guinea pigs for a program at our hospital. That hospital is actually the one I'm working in now.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Oh wow.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

I started there as a new grad in ICU and had outstanding preceptors. Again, these strong female role models that were oftentimes directing the care in ICU, to the point that the cardiologist would pull them aside and say, "Hey, what do you think is going on? You've been watching them all day. What's going on? They actually work together. I worked there, and while I was working there, I went back and earned my bachelor's degree in nursing at Ohio State.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Then, at that time, the director of nursing's husband was a CRNA, a nurse anesthetist. Kathy said to me one day, "You need to talk to my husband because I think you would like that. I always, in ICU, like the patients and I always fought to take them, the ones that were the sickest, they were on drips, they were on a ventilator, they maybe had a balloon pump, just all sorts of things. You had to one-on-one them. She said, "I know that that's what you like, and that's exactly what anesthesia is. So you really need to consider that."

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

I talked to her husband. He didn't have to twist my arm too far, and I applied to anesthesia schools. At that time, anesthesia nurse practitioners and nurse midwives were all professional certificate programs. They were not masters programs at that time. They were postgraduate professional certificates is what they were called. I actually went through Aultman Hospital in Canton's nurse anesthesia program, which was a little over 24 months. I want to say it was 28 months altogether.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

It was a great program. I was actually in the last class before they switched to a master's framework at the University of Akron. So lots of experience. That's what was deemed important to me. We had a lot of didactic upfront, but then a lot of clinical experience. They had no anesthesia physician residents, so we were the anesthesia residents. We were sent to do everything, trauma call, line insertions, everything, Got great experience. I came out and continued to work at Aultman then for four years.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Taught a little bit in the anesthesia program at Akron U. Then got the bug to come back home because we had now had two children and we did not know many people in the Canton area other than our work colleagues. So we wanted to get back closer to family. I moved back to our home, which is about an hour away from Canton. I continued to commute there. At that point in time, decided I enjoyed the teaching aspect that I was doing with the anesthesia students. So I went back to Kent State and earned a master's degree in nursing as a clinical nurse specialist, because I had no real qualms about changing from anesthesia at that time.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Earned my master's degree. Continued to teach at a college level at a couple of different nursing programs for undergraduates while I was working as a CRNA. By this time, I again had moved back home and the opportunity arose for me to work here in my hometown, which is a small hospital. But the anesthesia program, I actually worked for them two years, and then the gentleman that owned our group just called on a Sunday afternoon and said, "Hey, I'm turning the group over. I'm not going to continue at [inaudible 00:09:21] anymore. I'm getting rid of the contract. So if you guys want to continue working here, you'll have to form your own group. Or if not, you'll have to find another job. Hey, good talking to you. Bye." And hung up on me.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

My wife looked at me and said, "What's wrong? You look sick." I said, "I think I just lost my job. I'm not sure what just happened." My three colleagues and I got together. We formed our own anesthesia group. We owned the business for about the next 20 years. It was a very a enjoyable experience, for the most part, a lot of work in owning the business, a lot of administrative things that come along with it. By the end of 20 years of taking call every third night and every second to third weekend, and having to do all of the financial aspect of the corporation, while my partner did all of the insurance and all the scheduling and all that.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

I was reaching a point where I understood what people were talking about with burnout. So I thought, "I can't continue on like this. I'm cranky with my family. I'm tired all the time. I don't feel well. I don't even enjoy what I'm doing anymore. I feel like the anesthesia monkey. I just go in and do the same routine over and over." At that time, I was entertaining the option of getting my doctoral degree. When I was in my master's program, this new beast rose that said [inaudible 00:10:40] DNP.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

I was very, very interested in the fact of a clinical doctorate. So that's the route I chose. I chose Case Western Reserve, which had an outstanding program, a very strong program, for clinical doctor and for research doctorate. So ended up going there to finish my DNP. Again, still struggling with the burnout issue with the anesthesia, but I had two children and a wife and I needed to support and be the bread winner. So that's what I did.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

During the course of that doctoral program, lots of things happened at our hospital. My partner and I ended up resigning our anesthesia contract at the end of our five-year contract. I signed on to work with the new group, just as a plain old staff person, which was nice to get rid of all of the administrative issues. Again, I continued to struggle with that burnout issue. As I was finishing or working through the DNP, some clinical hours had to be completed as far... To complete the actual clinical doctorate.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Not really knowing how I wanted to gear that, and for lack of a better term, whining a lot about that, my advisor talked to me and said, "Hey, you said you had a real interest in cardiology." I said, "Yes." She said, "I have a potential offer for you. We could complete those clinical hours in your DNP in the primary care or acute care, adult gero, and nurse practitioner track, and you could practice cardiology when you came out. Or you could just continue to do your anesthesia, whichever you want to do."

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Well, the rest is history. I completed that program. Never regretted it. Let's see. I finished that program about two years before I actually finished the doctoral degree. So I was able to start working as an NP. Fell into a cardiology position in the same hospital that I started out as a new grad, working with the same cardiologists that I worked with as a new grad. That's where I am to this day. Can't praise Case Western enough for their great program, and of course the wonderful people that I met, which Dr. Spruit is one of those people. But gave me a great option.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Now, to this day, I still do cardiology full time, but I also do anesthesia as a locum on the side. So I'm able to still practice my skills. I do miss those skills at times, but I'm a little torn between the two specialties because I do enjoy both. That's my story, as quick as I can tell it. It's around Robin Hood's barn to get where I'm at today, but I guess there's nothing else. That goes to show that you're never too old to go back as a nurse to diversify yourself.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Sure. Well, when I listen to the story, you really did go full circle. I mean, starting with that cardiologist in that area at that hospital. But what I love when I listen to it is that you earned an associates degree in nursing. You went back and earned a bachelor's degree in nursing. You earned an anesthesia certificate in nursing and then went on to get your master's degree, because at the time that you did it... Right now we all think of anesthesia as a graduate program, and at the time it wasn't.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

But then you still fulfilled that master's. You checked that box of a master's in nursing. Then went on to earn your doctor of nursing practice, which is the clinical degree, like we said. While you were doing that, earned an additional advanced practice nursing certificate with that focus on adult gero primary care. What I love about this story, Dr. Wiandt, is it goes to show that there's really, I mean, unlimited opportunities in nursing.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

As you said, you could have 25 years of experience, really owning your own practice and having all of that, all of the responsibility that comes with management and leadership, in addition to your practice, and still learn something new and take on something new, which I really admire that.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

That's what drew me to nursing in the first place was the... We were chatting before, the nebulous opportunities out there for nurses, whether that's staff nursing, there's so many different clinical areas to work as a staff nurse, as a nurse specialist. You can go on. Even in the graduate degrees, there's so many different realms, from administration to advanced clinical degrees. There's just so many ways to go. I just see it exploding more and more all the time.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Right. Oh, I agree. I would like to talk for a minute about your role currently as a cardiovascular nurse practitioner. Just to clarify, we talked in this podcast before about the graduate nursing specialties. And so, we've said there are certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, and nurse practitioners.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

And so, Dr. Wiandt, you are an adult gero primary care nurse practitioner. But then you went on to identify a specialty that made you a cardiovascular nurse practitioner. Can you describe what that process meant for you, the extra certification?

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

What it meant for me or what I had to do to earn-

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

What you did and how it translates into your work now.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

I'm not aware of any other certification process for cardiovascular NPs. I went through a lot of things. Actually, I was guided by the other NP in our practice. She and I were actually intensive care unit nurses together, back in the '80s. When I came back to work with this cardiologist, she was also working with him. She had already been through the process and she guided me towards it.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

But there aren't, or to this date, as far as I know there aren't other certification options for advanced practice cardiovascular. Mine is to the American Board of Cardiovascular Medicine. What you have to have is a certain number of hours and I want... Hours or years. I've forgotten. Now, I believe you have to have at least two years of practice before you can sit for the exam, or that's what they suggest anyways.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

And then, I actually took a review course to buff up my knowledge base a little bit, because I don't think there's many cardiovascular practices that practice every aspect of cardiology. There is electrophysiology, there's an interventional cardiology, there's medical cardiology, there's cardiothoracic surgical based cardiology. There's all different areas. Ours is basically a medical and electro-phys type practice.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

I wanted to beef up those other areas. So I did a review course offered through the American Board of Cardiovascular Medicine and then sat for their exam, which I have to admit, I think the only exam that was much more difficult was my anesthesia board exam. Again, not belaying my age, but that was a paper and pencil exam back then. It's been a while back.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

But ABCM board for CVNP, which is the credential cardiovasculars practitioner, board certified, was very, very intense. It took every bit of the four hours that was granted to you to take it. The interesting thing was, I thought, "Oh my gosh, I'm behind." And I'd look up and the room was still full. I thought, "Okay, I'm not behind." We all went right to the wire. And we weren't new practitioners. That's the thing. We were experienced practitioners. But wow, it was a rough exam.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Then you had to wait a week or two before you got the results from that back. It was a tough course, but you have to maintain, let's see, 30 hours of continuing education every four years. So it's not a huge burden as far as CE. You have to maintain a practice content, and then the CE, and it has to be all cardiac, obviously, the nature that your CE is. That's been one of the rough things with me, is maintaining my CRNA certification, which is 60 hours of class A, 40 hours of class B, or additional class A, and then four modules, one in airway, one in pathophysiology, one in pharmacology, and one of the anesthetic techniques.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

That has to be done every four years for anesthesia. The AANP certification for NP is every five years, and that's a hundred hours of CE, 25 of [inaudible 00:19:00], and then the CDMP on top of that. So I'm constantly looking for options for CE credit. That's one of the downsides to having multiple specialties.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Right. Oh my goodness. Yeah. If you're listening to this and you're thinking that as soon as you're in school, you're done learning or you're done taking tests, we've definitely proven that wrong this evening.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Oh yeah.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

But I think for good reason. When I think about how fast the environments that we practice in evolve, and how quickly we learn new things, new technologies, our understanding of disease and treatment and intervention evolves so quickly that if we didn't do these things, we'd be way behind and we wouldn't provide the care our patients really deserve, although I can certainly appreciate the burden and especially with maintaining all of those certifications.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Yeah. [inaudible 00:19:50]. But it's worth it because I enjoy learning. I enjoy being in the classroom. I'm a classroom person. I'm not a great online person, although I teach a little bit of online as well. But I enjoy being around the classroom of other people and sharing ideas and knowledge.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Well, I think that collaboration is invaluable, and it also makes me think about how... You talked about your current partner in your job is someone that you worked with as a new nurse. I think about, even though nursing is such a huge profession, that we are represented so largely across the country. But it's also a small community. You also can build networks. When I think about you saying you value being in the classroom, I mean, we were in the classroom together several years ago and had the opportunity to get to know each other.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

But I think that might be one of the take home points for people who are listening, is never underestimate the value of building a good network around yourself, and building that support. I think the classroom certainly provides that opportunity.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Actually, that's what landed me my nurse practitioner job, was knowing my NP colleague in the office 30 years ago, keeping up those... We've known each other through ACLS and various other programs that we've done through the years. And so, we've stayed in contact. But that networking that was set up in 19, gosh, what, 88 maybe, proved to be of great value to me in 2016. So you're right. That networking is a huge opportunity to get out there and find out what there is and what can be done.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Right. If you don't mind, could you just describe... I know there's no such thing as a typical day, but could you just describe maybe a typical day or typical week in your current role as a cardiovascular nurse practitioner, please?

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Sure. What I usually do, I work four nine-hour days is what I do through the week and my NP partner does as well. I am in the office Tuesday through Friday. She is in the office Monday through Thursday. We toggle the days off there so that the doc is not left in the office by himself. Now, my practice was a little different. We actually had two practices where I am practicing now. Another cardiology office "across the street" and then our business.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

In our business, the three of us all had our own caseload of patients. I have patients that I've seen for five years and routinely, I follow them up and follow their cases and all. If I have a problem or a concern, of course, I consult my collaborating doc and say, "I've got this issue. I'm not comfortable with this ejection fraction. I've got him on all these meds and I'm not seeing any improvement. What do you suggest? Where do we need to go from here? Because I think they need your level of care now." We had a wonderful working relationship that way.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

The other group uses their NPs a little bit differently. They actually always make rounds with the cardiologists. They may go in and see a patient, and then the cardiologist will come in the last few minutes and wrap everything up. That was never the case in my practice. We had our own independent practices basically within the practice. Doc did not want to see our patients routinely. If he had a follow-up that he wanted us to see, he would tap it onto our schedule.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

If we had somebody that we felt he needed to see, we would put it on his schedule. We shared the patients, but yet we all followed our own groups. So there's different ways I think that you'll see NPs utilized in that aspect. Now I have some friends who are EP, electrophysiology NPS, and they practice mostly hospital-based. Although they are not acute care NPs, they practice in the hospital mostly for EP issues, pacemakers, arrhythmias, whatever.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

They're intimately involved with one doc at a time. They each are with one doc only, and they follow together the EP patients. They may see the doc one time. The next appointment is with the NP, the next time is with the doc, and they toggle back and forth. So a lot of different ways to do that. But anyways, in our practice, I go in at eight o'clock. I ready all my charts. I usually see anywhere from, on a very slow day, maybe eight patients, on a busy day, about 15 patients.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

I usually see patients about every 15 to 20 minutes around the clock, and I usually have a little bit of time in between the hour break to catch up on some of the charts. But unfortunately, charting, a lot of times, gets left for the end of the day because you have to keep moving on to each... The nurse has the next patient roomed by the time I get out of that room and I just have to keep moving.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

We do have certain days that we do hospital rounding. If we have patients from our practice who are admitted to the hospital, we follow them routinely. So it's a nice mix between hospital practice and office practice. If patients have procedures, we don't assist in any of the procedures. Obviously, the cath lab takes care of all those things and the intervention lab. But we do follow the patients in the hospital after the procedures. And then we follow up in the office as well.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

My day goes from 8:00 AM to about 5:00 PM. I take about an hour break for lunch in the middle, at which time I'm trying to chart the morning patients and get them all done. And then, I have about an hour in the afternoon. I stop seeing patients at 3:30 to 4:00, so I can touch up the last hour, get the charting done. My job involves assessing the cardiac status of the patients, obviously, ordering stress tests, echos, heart caths, whatever I feel is necessary diagnostically.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

That varies. I have adult patients, obviously. Most of the cardiac issues, I would say, the majority of my patients are 60 plus as far as age. That crushes me because I'm at that doorway myself. I see a 60 year old and I think, "Wow, they're young." But the adult gero credential does go down to the level of adolescents, if you want to treat that low. I don't because I don't feel comfortable doing that.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

But, at any rate, that's pretty much how my week goes. And then, again, depending on if Christine and I are both there, we take turns at doing the hospital rounds if anybody is in the hospital.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

I was curious how the hospital rounds figured into your day full of patients. So you do both at the same time, you could be seeing patients in clinic and also responsible for rounding at the hospital?

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Yes. Yes and no. I prefer to not have office patients when I have hospital rounds. But it depends on what's on the... Sometimes the ladies in our office will come to me and say, "Hey, I've got to put somebody on a Friday. I'm sorry. They have a 48-hour urgent follow-up from the ER. We've got to get them in." Okay. I cut Friday off with a maximum of four patients. If I have eight patients in the hospital, I've got to get over there because people want dismissed if they're post intervention. They're sitting there going, "Where's the guy that's going to send me home?" So they get a little bit antsy about doing that. I prefer to do just hospital or just clinic. But yeah, it does happen that it happens on the same day.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Sure. Oh, that makes sense. Well, I think this role sounds really interesting. I remember the time that you told me, I knew you as a CRNA, and I remember the time you told me, "I'm really burned out of being a CRNA and ready to make this transition. I'm going to pursue also a clinical specialty as a nurse practitioner." I remember really admiring that and thinking that you were brave, and also being really grateful that I wasn't in your shoes, of taking on all of that extra work.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

But I think it just goes to show... I imagine these patients and families that you're working with now, and the excellent care that they're getting, and your dedication to this specialty and to this population of patients, when you're in a better space, when you're not feeling so burned out. And I [crosstalk 00:27:47] that.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Right. I do have to say, I miss the anesthesia full-time. Now that I'm out of it, I've had a chance to rest my mind about it. I'm not doing all the administrative things. That made a huge difference. Each patient population brings its own challenges and its own rewards with it. Anesthesia is relatively rapidly moving all the time. You arrive early. I used to get at the hospital at 5:30 in the morning to get my room ready for the anesthetics.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

You have to test the gas machine and make sure that the blue line is carrying the nitrous oxide and the green line is carrying oxygen, and then you analyze all those things, set everything up before you ever start with the patient. So there's at least an hour worth of work before you get the patients in the room. Then you do the anesthetics all day long. You're one-on-one with the patient. You get them to recovery room. You get them stable there. You're back and you start all over again.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

You do that five to 10 times a day, and then you're done. There isn't the charting aspect to take home. We do keep records, obviously, but it's done basically when the anesthetic is done. The rewards to that are you seeing the patient usually preoperatively, and you're that one mainstay through the surgical process. They have one person that they know.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

The nursing staff changes. The surgeon isn't there. They never hardly see the surgeon because they just come in and say hello in the morning and they're gone. And so, Joe's grandmother could have done the surgery, for all they know, because they don't see them. But it's rapidly moving and it's short term. The opportunity in the office that you don't have anesthetically is you get to develop a relationship with the patients.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Sometimes that is a wonderful thing. Sometimes it's a little burdening because you get into things that you don't always want to get into aspect-wise with that too. I won't kid you, there are days that I go home and I think, "Why did I choose to work with awake patients instead of asleep ones?" Because sometimes some of the things you get into, as you well know, it can be rough at times too.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

But again, there's different rewards and different issues with both of them, and I enjoy both of them. There's a huge amount of cardiac involved with the anesthesia as well. So they're not really mutually exclusive at all. They're pretty complementary to one another. In anesthesia, if your heart rate goes up, I bring it down. If your heart rate goes down, I bring it up. I manipulate your blood pressure so you don't bleed so much.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

It's a constant process. It's not giving the drugs, sit there and read the newspaper until the [inaudible 00:30:14] is done and wake them up. I mean, it's a constant titration. And so, they're very closely linked, cardiology and anesthesia.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Sure. Yeah. I can imagine what a nice complement those practices are to each other. I appreciate you explaining the pros and cons of each of those roles, Jim, because I do think it's a lot to think about. If you were to give advice to nurses, maybe a nursing school, or new graduate nurses, of everything that you've learned, and perhaps it's related to recognizing that burnout and making a change, or building your network, whatever it is, what pearl would you share with newer nurses or nursing students?

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

I think the number one pearl... I could share probably a lot, as you can tell. I don't enjoy not talking. But I think the number one thing is, don't ever think you can quit learning or need to quit learning. When I graduated from my anesthesia program, our director took us all out in the hallway and told us two things. He said, "Number one, don't ever think you know everything, because the minute you think you know everything, you've experienced everything, you're dangerous, because you're going to miss something. You're going to let something go by that was important. So don't ever think you can't tell someone, 'Well, I need to look that up and make sure about that, because I'm not sure.'"

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

None of us have every experience that is out there. You get more and more the older you get and the longer you practice. That's merely a situation of getting yourself in trouble and then learning how to get yourself out successfully, and that only comes with experience. But number one, I think, don't ever think you're too far into a profession and you're too old or you're too whatever to continue learning because you shouldn't. That's ongoing, with our profession, like you already mentioned.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Number two, I think, don't ever think you can't change because I'm living proof that... If you talk to some of my CRNA colleagues, the first thing they say is, "What the heck did you do that for? Why would you leave anesthesia to be a nurse practitioner? What advantage did that give you?" I have to admit, anesthesia's probably one of the highest paid specialties that there is. And if you're strictly looking at money, that's what's going to get you probably the most money, is usually anesthesia.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

But that's not all I was looking for. I loved critical care, and that's why I did anesthesia. The money was nice along with it. But when you're hip deep in a massively bleeding patient, and you're the... The surgeon is doing their thing. I worked in practices all except for three years of my 25 years independent CRNA practices. So we did not have anesthesiologists. There is no edict that you have to have an anesthesiologist.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

You must work with a physician as a supervisory situation, and that's usually the surgeon, the obstetrician, the dentist, or a podiatrist. Any of those can do that. But you're on your own, basically, where you're in a CRNA practice. So when you're hip deep trying to save someone, you're using every skill you've got. That compensates for the money aspect there a little bit. But again, don't ever think you're too old or you're too far in to change, because I had just gotten to a point where I was not fulfilled. I wasn't happy at my... Everything was just...

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

I'd go to work and be angry and I would come home and I'd be angry and tired. I'd go to work the next day and be... It really wasn't the job. It was everything else. It was the administrative aspects. It was just all sorts of things. So don't ever think you can't change, because you can, and you can meld the things together quite well. It does work out. There's so many programs now to be able to do that in different lights, accelerated degree programs, and all sorts of things that are very helpful.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

My last tidbit of information, I would say that I... Pearl, whatever you want to say, is I... This is maybe not appropriate for this group, but I guess what I want to say is something that an older nurse told me many, many, many years ago. She said, "The true skill in nursing," and this was as a critical care nurse, so she was trying to drive home to me the point, "The true skill in critical care nursing is not running a code, not the fact that you can follow ACLS protocol, not the fact that you can defibrillate, and you can put in lines, you can do all sorts of things."

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

She said, "That's great, and we need that." But she said, "The true skill in critical care nursing," and I think this speaks to any aspect of nursing, "The true skill is seeing the problem happen two hours before it happens and heading it off before it's an issue." That has served me well for years to follow and watch every single change. "Hey, they're not nearly as awake as they were," or, "They're not nearly in as much pain as they were, and I did not medicate them. Something is going on with them. They're a little more tachycardic than they were. That's different for them."

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Those little subtle things that you think are not important are important. To a patient's life or to a patient's family, those things are extremely important. I had a patient come up to... Actually a wife of a patient, come up to me probably three, four years after I'd taken care of him. She said, "I just wanted to tell you, you saved my husband's life about five years ago." I didn't even know who she was. I said, "Really, I'm sorry, but I'm a little..."

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

She said, "I wouldn't expect you to remember because you've seen so many patients." But she said, "You told us that something was happening before." And she said, "You said something about changes in the EKG and you weren't comfortable with that. You actually stopped the surgery before he went into surgery." Well, I remembered it then. It was a patient with a new onset of left bundle branch block, which is indicative of some significant heart disease.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Finally, her husband came over. It was in a store and she said, "This is the man that saved your life." Still, I couldn't recognize him, but he said, "You stopped my surgery and sent me to have a heart cath before you would do the surgery. I had a 98% lesion in my left main coronary artery. So my widowmaker would have shut down." He said, "You saved my life." That was a rather humbling experience. You don't remember all the details, but you think, "Okay, I guess what you're doing is important."

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

There's little things sometimes, even though you incurred the wrath of the surgeon, "What do you cancel that surgery for? You can't do that, blah, blah, blah." It came in a very positive light for the patient, and that's what we're there for, is the patient.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Absolutely. Well, and I think that highlights, what you just said, really highlights nursing, our eyes, our ears, our pattern recognition. We truly are the ones who pick up on so much of that. Those subtle changes are really difficult to pick up on when, as a provider, you come in once or twice a day. They can be missed so easily. But it's the bedside nurse who recognizes that, and who can speak up and alert providers to those changes and advocate for exactly what you did.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

It may not have been the popular decision to cancel that surgery, but your advocacy was in the best interest of that patient and truly saved his life. That's amazing, Jim.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

And patients do realize that. I mean, we all do those things. It's not that I'm anything special. We all do those things. But down to the point that you stop a wrong medication, a wrong dose or something, and it happens. That's just life. That's what happens. And that's what our job is. Like you say that's what drew me to nursing in the first place, was being there at the bedside with that patient and making those decisions. That's what I wanted to do, and I've never regretted that. I would never have been happy with a career in medicine.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

I had somebody say to me once, "Well, why'd you go on and be an advanced practice nurse? Why didn't you stay at the bedside?" That stumped me for a minute, and I thought, "Well, that's a valid point. I guess, it looks like I really didn't like nursing that well. But that's not the case. Nursing is, again, back to the so nebulous, you can practice in so many settings and make such a difference that I just, I wouldn't have been happy with anything else.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Yeah. Well, I hope everybody who's listening remembers that story when you have that just... Maybe it's a gut feeling or maybe it's a recognition and trends of something that you're charting. I hope that you remember that story and you feel empowered to say something, and speak up, and alert people to even the most subtle of changes, because I think that that can make all the difference for our patients and their families.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Definitely.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Dr. Wiandt, I am so grateful for your time today. I loved hearing about this change of trajectories that you took. We said before, the most overused word of the year, but the pivot that you had and when you recognized that you were burning out and struggling. I'm just so grateful for your time today.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Well, thank you, Dr. Spruit. I appreciated it. It was very enjoyable to talk to everybody. Good luck with everything out there. Just remember, you're there for the patients. You're there for yourself. Take care of yourself and take care of your patients. So good job.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Awesome. Well, thank you so much.

Guest: Jim Wiandt, DNP, APRN, CNP/CRNA:

Thank you very much. Take care.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Thank you for listening to this episode of Nightintales. As you do, we encourage you to consider the unique nature of each person's journey through this profession. The views shared on this podcast are those of an individual, not the academic institution that they graduated from, their employer, or the professional organization that they're active in.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

The stories of their career path and progression are not intended to suggest that there's a uniform approach to achieving similar accomplishments, but to open your mind to all that is available to you. Each journey in nursing is as unique as each individual that we serve. We hope you'll listen again next time.