

PERSPECTIVE

LESS IS MORE

A Grateful But Not Passive Patient

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As an environmental scientist and expert on evaluating risk, I've become something of a therapeutic nihilist. I rarely see my physician (Andy Lazris, MD, my co-author, encouraged me to share and helped write my story)—and want no screening tests when I do. But when I had a heart attack at age 75, I was both very grateful for medical intervention and frustrated by hospital physicians' subsequent failure to take my preferences into account.

It began as intermittent, burning abdominal pain and exhaustion. I called Andy, and he sent me to the closest emergency department, where I was found to have a right ventricular myocardial infarction (MI).

I got 2 bare metal stents, 1 in the right coronary artery and 1 in the circumflex. I also had an 80% left anterior descending (LAD) lesion that my physicians did not revascularize. To this day, I credit the staff and physicians for saving my life that evening.

However, what transpired subsequently opened my eyes to some disturbing realities about medical care in the hospital setting. As I lay in the cardiac care unit, my blood pressure low and my status tenuous, a string of residents, interns, and nurses gave me conflicting information and advice. Some told me that I would probably need bypass surgery. Others said I would need a stent for my LAD if that were technically feasible. All these proclamations were tossed at me with little discussion of my prognosis, the uncertainty of the potential benefit, potential harms, why such interventions were needed or treatment alternatives.

Andy did not have admitting privileges at the hospital where I was being treated, but I called him several times a day. He told me he did not think that I needed bypass surgery. After our conversation, I asked my physicians to explain their reasons for suggesting surgery. They offered no discussion of the efficacy of revascularization vs medical treatment of my remaining single vessel disease¹; they simply stopped recommending surgery.

While hospitalized, I had a brief episode of atrial fibrillation (AF). A group of physicians assembled near my bed and told me in no uncertain terms that I needed to be on warfarin. I knew from work I had done with Andy that there are possible harms due to anticoagulation for patients with AF² as well as potential benefits. I was already taking clopidogrel and aspirin, which also pose a risk of a major bleeding event. I decided I did not want to take the additional risk of warfarin.³ My medical team was not pleased. They told me my chance of a stroke in the next year was 4% if I did not take warfarin, which I knew was an exaggerated estimate, even if I had sustained AF.⁴ I told them I was comfortable with a 96% chance of not having a stroke. They didn't answer my

question about the chance of stroke if I did take warfarin—information necessary to characterize absolute risk reduction or discuss the increased bleeding risks of adding warfarin.

I left the hospital with an angiotension-converting enzyme (ACE) inhibitor, β -blocker, high-dose statin, clopidogrel, and aspirin, with instructions that I would likely need to take them for the rest of my life. When I visited Andy in his office a couple of weeks later, I felt dizzy and weak with some shortness of breath. My blood pressure was low. On discharge from the hospital, my ejection fraction was 50%, and I had no significant wall motion abnormalities. Andy had me reduce the statin dose because there is no need for acute statin treatment for MI,⁵ and no proven efficacy of high-dose statins at my age.⁶ While β -blockers have been shown to reduce the risk of a second MI, there are no randomized clinical trials showing efficacy of either β -blockers⁷ or ACE inhibitors post-MI for a patient like me,⁸ so Andy and I decided to eliminate them. My strength rapidly returned and my dyspnea resolved. My blood pressure is now normal.

I subsequently looked up studies relating to the duration of antiplatelet therapy for patients with bare metal stents,⁹ and, with Andy's support, felt comfortable stopping the clopidogrel after 3 months. Today, 5 months after my MI, I am back to feeling fit and well. I'm on 2 medicines: a low-dose statin and aspirin.

Several weeks after the event, I went to a party where a guest suggested that given my experience, I had probably changed my mind about medical interventions. I just smiled. I have not changed my mind at all. Had I been a passive patient, I might have undergone an unnecessary bypass procedure. I could be taking medicines that dramatically escalated my risk of a major bleeding event without significant benefit, and I might have remained tired and short of breath on medicines I likely did not need.

Most medical decisions are rife with tradeoffs and uncertainty. Each patient has a level of risk he or she is willing to accept, and his or her own unique circumstances that affect the potential benefits and harms of interventions. While I would not expect shared decision making in the emergency setting, I found it remarkable that once I was stable in the cardiac care unit, my physicians consistently pushed for aggressive treatment with little or no attention to the tradeoffs, or how I might feel about them. Not once did they elicit my preferences; I was simply told what to do. When a discussion did ensue, typically because I initiated it, the information I received often conveyed neither the uncertainty nor the tradeoffs.

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Shared decision-making has received widespread support in both policy circles and the clinical community, but implementing it has been very slow. There are undoubtedly many reasons for this. Helping patients understand potential benefits and harms is complicated and takes time. There are few decision aids available for the many decisions that are made routinely in physicians' offices and hospitals.

But I wonder if sometimes there's another reason for the slow uptake of shared decision-making. Conveying the potential harms as well as the possible benefits of treatment requires physicians to reevaluate their own assumptions about what constitutes optimal therapy. I know that can be hard to do, but it's necessary if we are going to curb overtreatment, reduce harmful medical care, and ensure that patient preferences are respected.

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