EDITOR’S PAGE

As Serious as a Heart Attack

Advances in the treatment of acute coronary syndromes (ACS) have been blazing fast, and it seems like the general public has lost its mind. The unintended consequence of the successes of our field has been a growing public misperception of the gravity of coronary artery disease (CAD). Usually, the immediate outcomes of ACS are reasonably good, and people seem to superficially return to a “normal” state. Patients can therefore have a somewhat laissez-faire attitude. This sets the stage for inappropriately high expectations that can be hard to match, especially if there is a bad outcome. We cannot be blasé. We need to remind our patients that this is high stakes stuff, that the diagnosis of CAD should be a strong life-changing force, and that when things do go well, we should all be grateful.

Several years ago, I cared for a middle-aged man with a large ST-segment elevation myocardial infarction. He had a percutaneous coronary intervention (PCI), and I worked late to ensure that his hospitalization was smooth with a relatively short stay; yet, on the morning of discharge he was mad because he was not sent home before 9:00 AM (a goal he had established without informing me). This was one of the few times that I truly became angry with a patient. I was thinking about life or death, and he was thinking about his tee time. He got the message, remains one of my more compliant patients, and is now extremely nice to me. While I do not think that sternness or anger is always a good way to reorient people, some patients do need to be reminded of the context of their illness.

Even with our fancy science and seemingly infinite wealth of outcomes data, our crystal balls are not as clear as we would like to think. Ultimately, all of our honest discussions with patients and their families will tend to be flavored with bias. Without intending to, physicians will be either overly optimistic or pessimistic along the spectrum of reality. I suspect that it is easier and more common to err on the side of being optimistic. This tendency (gently lying to the patient) may be more comforting to the patient and less unpleasant for the doctor. After all, we are being graded too, and no one wants to deliver bad news or be disliked. Being optimistic can also help avoid all those pesky questions, particularly when we are pressed for time. The public is used to hearing what it wants to hear, and people will sometimes take their business elsewhere if they are not pleased with the perceived results. This folie à deux can be in some ways adaptive or productive, but it can also be destructive. At stake is the insidious erosion of the trust between doctor and patient.

After my fellowship, I remember feeling confident in my training and ability to care for sick people (at least it felt that way), but I had some mild anxiety about being asked the hardest questions. How long will I live? How likely is it that I will have another heart attack? Am I going to be physically restricted? When can I have sex? (At one point, a patient’s wife asked me, “When can we have sex?” I told her anytime really, but that her husband might object.) These are normal questions that any rational person would consider, and the best resource to answer them would be the man or woman with the stethoscope. Yet, I have been impressed by how rarely I am asked these questions. Is this denial, suppression, or repression? Is it “don’t ask, don’t tell”? Is it too uncomfortable to discuss, or would people rather just not know? My parents taught me that when things were uncomfortable or unpleasant, that is more reason for discussion, not less. I must admit, however, that I usually allow patients to get away with not asking these unpleasant questions. After all, that is far easier for me. But I may do a disservice to patients when I allow them to return to their safe fantasy world of thinking that “everything is okay.” This will inhibit some people from rising to action to modify their lifestyle and pay...
attention to future symptoms. The point is this: If we tell patients that all is well (even by omission), they will tend to forgo important lifestyle interventions, such as exercise, and they may miss the opportunity to favorably impact outcomes. Additionally, we can inadvertently propagate the misperception that their illnesses are just not a big deal.

The evolution of system designs in the treatment of ACS has brought about the performance of PCI at nontertiary hospitals. Although this has many obvious benefits, there are also some disadvantages. One subtle harm is that the proliferation of PCI at smaller hospitals will send the message to the public that PCI is routine. If it no longer requires a trip to the “big house,” it cannot be such a big deal. Therefore, the wake-up call for lifestyle change is less potent.

Same-day discharge following PCI is being evaluated in many centers, and there is data to suggest that in select patients it is a good strategy to improve costs (1). If this is widely adopted, however, one of the unintended consequences of in-and-out PCI will be a lost opportunity to communicate the severity of the illness, and in fact, we will communicate the opposite. The expectation will become that all PCI should be same-day discharge, and that all patients should have a rapid return to “normal.” Elective PCI is still not a haircut or a day at the spa. Remember, the intended goal is to cram a foreign body into a diseased artery and then stretch it. We often take a stable plaque and make it unstable. The real risk is not dying, but rather living and not respecting the significance of living with CAD.

We have become enablers of unhealthy behaviors. Why would anyone stop smoking or begin to eat right if they can just get another angioplasty? You can drop by and have a PCI on your way home from work. Maybe if you forgo sedation, you can txt message your friends during your PCI and update your Facebook page with before and after images. You can tweet and write in your blog while sipping cappuccino in the recovery area. What is a night (or not) in the hospital anyway? It is worth it. Have we trivialized the routine so that patients get a false sense of infallibility? Come on in for a little “nip and tuck,” and off you go back to your chips and snack cakes.

In parallel with the evolution of our culture, such that we are raising a generation of seekers of instant gratification, there is the expectation that many problems can be quickly fixed by someone else. It seems probable that there will be increasing numbers of patients who will have a passive role in their health care.

Sometimes people tell me that they are not afraid to die, and very often I truly believe them. (Woody Allen is often quoted as saying, “I am not afraid to die, I just don’t want to be there when it happens.”) Usually, this comes up in the context of the smoking cessation discussion. Some lay people confuse “heart attack” with dying suddenly. I have to remind them that most people who have heart attacks do not die, and that they may just become progressively debilitated with long-term serious chronic health problems, restricted lifestyles, and unpleasant symptoms.

We cardiologists need to continue to aggressively push for better treatments and outcomes in intervention, but we also need to not “promise the moon.” It is sometimes difficult not to become cavalier with our patients. We do these procedures every day, and in general, outcomes tend to be favorable. The public has become desensitized to heart attacks. Heart attacks are losing their impact as teachable moments. “Ho hum, Bill had another heart attack, but have you seen what Lady Gaga was wearing?” Every patient with ACS needs to be reminded that this is a very serious problem. Sometimes this is hard to do, because we can be sucked into the patient’s denial, and we too want to believe what they want to believe: that everything is okay. Appropriate concern and education will help our patients become compliant with therapies and will allow outcomes to exceed public expectations. We can then be seen as successful.

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