On Being a Patient

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ABSTRACT

When doctors become patients, their hearts run the entire gamut of emotions—from acute denial to acceptance and everything in between. Although they enjoy a privileged status, and receive apt attention from their professional colleagues, they realize that making personal decisions about their own health is not easy—particularly during an emergency. What should a patient expect from a doctor? How should a doctor anticipate what kind of patient he is dealing with? How should we blend evidence with patient preferences, choices, and priorities? How should a doctor assuage unvoiced concerns of visitors? In this essay, the author describes his own experience of acute coronary syndrome that led to an angioplasty and wonders how difficult it is to choose wisely, even for doctors.

Keywords: Angioplasty, Autonomy, Evidence-Based Medicine, Informed Consent, Patient Preferences

Worldwide, an estimated three million coronary angiograms and angioplasties are performed each year. These interventions are used to look for blockages in coronary arteries and to open them with balloons and stents. Global Industry Analysts (2011) predict that by the year 2017, the global market of coronary angioplasty products is likely to be close to U.S. $1.84 billion (about 100 billion Indian rupees). Big numbers, these. Two weeks ago, I contributed a tiny drop to the angioplasty ocean. Admittedly, the drop was small but it caught the eyes of those treading along the shore. For, they were unable to fathom what made me land up in a cardiac catheterization lab.

Cardiologists use several risk assessment tools to estimate the person’s 10-year risk of developing cardiovascular disease. Almost all scores placed me in a low risk category. For example, the Framingham Risk Score (2004) suggested that 6 of 100 people like me would develop a cardiac problem over a ten-year period. The Interheart Study (Yusuf et al., 2004) revealed that nine risk factors explain 90% of the global risk for heart attacks. I lacked all nine factors.

And yet strangely, I developed cardiac pain on that Monday noon which eventually led to an angioplasty. I was lucky on several counts, though. I was working in the hospital when my chest pain began; my pain was severe enough to make me rush to the outpatient department of the hospital; my physicians swiftly administered me aspirin, clopidogrel, heparin, and atorvastatin—drugs with proven benefits. My electrocardiogram showed no infarction; the echocardiogram showed no damage to the cardiac muscle. My colleagues in the ICU consulted each other and decided to accompany me to a cardiac hospital—50 miles away.

Six hours following my chest pain, I was wheeled into the cardiac catheterization lab. The

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