I am a 58-year-old pianist and composer, and despite a spotty record in the past, have for the past 4 years exercised regularly and eaten a healthy diet. I began noticing pain in my left arm, chest, and jaw during exercise in early April of 2012, and swiftly progressed through testing to a triple bypass a few weeks later. Since then I am generally a highly compliant patient with excellent numbers. My new internist, whom I saw for the first time in November 2013, said I was doing all the right things but was concerned that my systolic blood pressure at the first office visit was 156 mm Hg and suggested after reviewing some of my home monitoring values, which were as usual much lower, that I either start blood pressure medication or take an ambulatory test. Her explanation for this was that I had heart disease involving multiple vessels and readings (my home monitoring values are usually <130/80) that could be characterized as prehypertension and might float up during the day. With some misgivings, because I know that I react strongly to medical situations (I had trouble sleeping the night before this decision was made), I agreed to the test, and the final result was a 143/89 average (awake 144/90; asleep 133/83). On this basis, my cardiologist (my PCP was ill) recommended starting a blood pressure agent and basically refused to discuss the issue further. More precisely, she said she was speechless when I asked about the JNC8 blood pressure guidelines1—I presume because she felt the question was inappropriate. Although she did discuss options with me very briefly, she ended the conversation by suggesting that because I felt the issue was white-coat hypertension, perhaps I should not as frequently as before, but daily and often for several hours. I came in to see my cardiologist, she examined me and conducted an ECG, which I think was normal. My next reaction which I do not usually experience: this was a concern I had mentioned to my cardiologist before taking the test—and she had agreed there was an issue, saying, “there’s no good answer,” which I found a reassuring acknowledgment of the problem. When the result actually came back, however, she dismissed my concern about the test being skewed because the cardiologist who had looked at the data said my numbers at the hospital were only 5 mm Hg higher on average than my overall result—no white-coat hypertension: case closed. Well, to juxtapose my personal experience to this numeric analysis, when I left the hospital during the ambulatory test, I forgot my parking receipt at the pay window—fortunately someone ran after me so that I was able to leave the garage. That has never happened before. I purchased gasoline on the way home ≈40 minutes later—I discovered when I arrived that I had left the gas cap open with the lid hanging down the side of the car. I do not think that I have done that in ≥10 years. That certainly seems like stress to me. I did my best to deal with it, but I felt tense for much of the day: my skin tingled, my breathing was altered, my stomach hurt, etc. When a doctor uses their expertise to tell me that I am not experiencing what I think I am experiencing, I begin to doubt their judgment. What would have been helpful here would have been some effort to help me understand my options and to find out what these numbers—different from readings at home during several years—actually mean, instead of imposing a cut-and-dried answer.

I get the impression that many doctors are busy and highly trained people who find patient input of doubtful value: they are experts—the patient is not. This is entirely understandable: I am an academic with graduate degrees—I have felt this myself. But let me illustrate the downside: like many heart patients, I started on metoprolol a few days before my bypass surgery and continued for about a year afterward. After surgery, my only complication was atrial fibrillation during the next month or 2—tests were initiated; they started me on warfarin; the dosage of metoprolol was significantly increased and gradually the symptom eased; and I was taken off warfarin and put on a lower dose of metoprolol.

But ≈10 months after surgery, the palpitations came back—not as frequently as before, but daily and often for several hours. I came in to see my cardiologist, she examined me and conducted an ECG, which I think was normal. My next option was to see a nice man, as she described him—an electrophysiologist. But I had begun to suspect the metoprolol—I

Patient Viewpoint

Critical Conversations After Coronary Artery Bypass Grafting

Balancing the Evidence and Dealing With Uncertainty

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had experienced some odd and unpleasant sensations while on the drug—something felt off. I also knew that my father had experienced palpitations while on another β-blocker. I looked up the side effects of metoprolol and found out that it can indeed cause arrhythmia. So, before going to see the nice man, I asked to be weaned off the drug—my cardiologist was skeptical, but willing, and in a few weeks the palpitations were almost entirely gone. I have no idea how far into stronger interventions we might have traveled if I had not participated in the process, but at the least, I saved myself some time, money, and anxiety by getting involved. If my body were as well understood as an automobile, the level of communication between the mechanic and the owner would matter less: the physics is well understood and you can always replace a part. But I do not think we are close to that kind of understanding of the human body—and that is why physicians should work with patients, as well as on them.

I spent years studying meditation and other spiritual practices formally and have a life-long interest in Asian thought—especially, Taoism. It is a useful approach for a pianist because it is all about balancing opposites: yin/yang—and a central problem in classical piano playing is that while you cannot get far without serious commitment and discipline, the harder you push, the tenser your body gets and the lower your speed and accuracy. In contrast to what I call the Western rocket to success—bigger, harder, faster, more—Taoism is not about pinning the meter to one side; it is about finding the optimum point in the middle, where you use enough force to reach your goal but not so much that you create unnecessary conflict. This is actually a transformative effort because seeking this balance redefines the question over time so that you come to understand the problem differently, leading to a better result than was possible at the start. Issues of balance are of course basic to medicine, but it seems to me that there is also a lot of bigger, harder, faster, and more in our medical system—professional success, pharmaceutical profits, the belief that suppressing bad numbers is the best path to a good outcome. I suspect this is frightening for physicians because there are many pressures and the price of failure can be high; I guarantee it is frightening to the patients who wander into this maze of medical authorities and powerful interventions, particularly because doctors often seem compelled to express a level of certainty about treatment that does not seem justified by the evidence. I think we are just beginning to move toward a new model—I hope I will live long enough to see it come to fruition.

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