PODCAST SERIES: Managing the Post-MI Patient: Perspectives in Primary Care

Podcast 2: Clinician Self-Reflection and Cardiac Risk Reduction

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Edited slightly for readability.

Milan Gupta
Welcome to this podcast series by MDListen entitled ***Managing the Post-MI Patient: Perspectives in Primary Care.*** I'm Dr Milan Gupta. This podcast series was developed by the Canadian Collaborative Research Network. We actually have four podcasts in this series and today you will be listening to the second in the series entitled ***Clinician Self-reflection and Cardiac Risk Reduction.*** Each of these podcasts is worth 0.25 Mainpro+ credits. And if you complete all four podcasts in the series, you will be able to claim one full credit. Our learning objectives for this program are: to discuss the role of clinician self-reflection in improving practice patterns; to describe the role of early intervention for cardiovascular risk management; and to identify the impact of lifetime exposure to LDL cholesterol. There is a handout that accompanies this podcast available online that includes key information, learning points, and all of our learning objectives and faculty disclosures. I'm pleased to welcome as our discussant today Dr. Neil Naik. Dr. Naik is a family physician in Waterloo, Ontario, and is very well-versed in CME and improving practice patterns to optimize clinical outcomes. Welcome, Neil.

Neil Naik
Thank you so much for having me.

Milan Gupta
As I mentioned, my disclosures and Dr. Naik's are available for you in the handout. This program did receive financial support from Amgen Canada, the program has been developed and peer-reviewed by a scientific planning committee and by CCRN. All recommendations for clinical practice are based on evidence or guidelines, and no off-label use will be discussed. So, with that, let's dive into it, Neil. We all, as physicians, strive to do the best we can for our patients to allow them to have healthy and long lives. But you know, we have a lifelong challenge of learning and becoming better. Talk to me a little bit about the role of clinician self-reflection in becoming a better physician.

Neil Naik
Thanks so much for the question, Milan. This is such a fantastic question because it involves thinking about one's thinking process, and self-criticizing yourself along the way to try and figure out, hey, how

do I become a better person. It's important to note that as individuals we're sensitive when others critique us, audits from our colleges. But the most critical person in actual fact is ourselves. We're self-conscious about what we think about ourselves, what we say to ourselves. And the best person to do this, though, at the same time, is ourselves. Because we know ourselves the most, we can let ourselves down nicely. And we can actually change who we are, and control that change. One of the first parts about that self-reflection is also understanding self-critique, and whether or not we're actually resisting ourselves and our self-critique. And it's important to explore why you don't like to self-critique yourself based on your previous experiences. And it's not important to get around that resistance and understand and fix it. But it's there. Because a lot of that acceptance is the diffusion of an entire situation. And similar to when a patient begins to berate you, as a clinician. We always saw back in med school, back in residency, that by arguing back, you're just fueling that interaction, and in fact, simply acknowledging the patient's feelings diffuses that entire situation. So how can we do that to ourselves by saying, you know what, I'm not happy with what I'm doing. Or maybe, I'm really happy with what I'm doing. And that in itself, that acknowledgement, make ourselves feel better. And I think a lot of this stems from that fact that self-critiquing has come with that negative conjecture. We associate it to our body image. We associate it to our healthy habits or even our lack thereof. And so how do we change that to one where we're caring about ourselves, we're evaluating our clinic, and we want to do that in our happy space, right? If you're having a really bad day at work, that's a horrible day to self-reflect and say, what did I do wrong? That's a time when you should take that time, spend a day, go home, take care of yourself. And on day when you're actually having a good day, reflect on why that day was a good day. Reflect on why the previous day was a bad day. And I know we're talking about self-reflection and guiding, but this is very much part of it. And bringing a third party into that conversation, whether that's your physician assistant, your nurse practitioner, your medical office assistant, so that you have a team player who's telling you whether or not there is place for you to improve, or whether or not you're doing a great job, or you're just being really self-critical of yourself. I know it sounds weird. But the reason why here is so that we get away from that jadedness, and we get back to the why we're doing medicine in the first place until you understand that this is cliche. But how many times have we said to ourselves, I'm not going to bother ordering that lipid test, because my patient doesn't get it done. Why should I waste my time? And that negative attitude? We need to stop that. Because anyone who tells you why will likely convince you in a begrudging way. And what we want to do is actually make that positive encouragement of why we are doing what we're doing. And it goes back to what you were saying initially that we're here to make our patients better, we're here to make sure that our patients get the best care possible with the latest research that we have. That's in the guidelines and finding out what drives you fundamentally will make you want to do more. It's me with my life partner making that conscious decision that we're here in this together. It's not obligatory, it's not mandatory.

Milan Gupta
That's very interesting. I'm trying to imagine how I would it incorporate this into my clinical life. Is this self-reflection meant to be a continuous process, day in and day out? Or should we be actually booking some time off to do this more consciously?

Neil Naik
I think you should be booking time off to do it consciously. I spend about five to 10 minutes at the end of the day with some really good music. And that can be either late at night, I call it my witching hour, it's between seven and 11 at nighttime, where I'm simply sitting there with a good book, listening to music, and sometimes I'll drift off in that book and reflect on the day. And part of me is again, self-critical thinking, okay, I just lost track of my book. But on the other hand, it's that reflection of that book reminded me of something that happened to my daytime. And did I make a mistake, did I not, acknowledging, you know what, I did a great thing, or acknowledging, no, I made a mistake, I need to go fix that first thing in the morning. It goes back to startups, right, just fail fast and reiterate over and over again.

Milan Gupta
I think this is an incredibly important point you're making, and we all need to do this more in our practices. I think we probably do this to some extent, but not in a formal way. Let's switch gears a little bit. We have a case that is running through this podcast series. And I'll just give you the salient details. It's a 62-year-old woman. She's a financial analyst. She actually has a history of prior coronary disease, long-standing diabetes, and hypertension. She's an ex-smoker. And she's had a recent non-STEMI, requiring multivessel stenting. When she had the MI, her LDL was 3.1. And she was discharged on a usual cocktail of post-MI medications, including a high intensity statin, in this case, atorvastatin 80 mg. She has a long-standing history of past coronary disease, she has come in now with a new MI, diabetes. We can't turn back time, Neil. But if we could, and if we could go back 10 years to when this woman was 52. Should we have done things differently?

Neil Naik
I like this is a classic case of what if? And first things first, nobody made a mistake here. What we knew back then and what we know now are completely two separate things. But it's important for us to reflect back on, what if that patient showed up today? How can we change that? And so, was the patient optimized I think is a better question. Did that patient come back over and over again? Were those drugs even available at the time that we could have done something? Most likely they could have been, or they could not have been? To be honest, I can't remember from 10 years ago when the different drugs were approved. But what was the frequency of their LDL testing? Was it even needed? I think I remember from back in the day there was at one point a paper that came out that said, get them once on maximum dose statins and stopped testing. But now we have more drugs that we need to resume testing. Do they tolerate their medication? I think the first step here is don't be too self-critical. But go back to your notes. Was there something that could have been done? And why did you choose not to, because I think that self-reinforcement that you're doing a good job is the first step to making sure that you can make changes. Next thing is to look at, 10 years earlier what were those treatment thresholds? Why did you choose to do something? And again, would you do anything different from 10 years ago? Maybe not? If this was a patient you had now, would you treat them differently? Maybe so. And do you have a process in place to flag these patients, so as they pop up, you can actually proactively go and catch them. And the goal here is to reduce residual risk, the risk that remains after you've optimized the patient. And as science progresses, and new treatments are developed, and regulation on approval medication to the market improves, that residual risk should theoretically drop. And so now the question

is, who else in your practice has an N-STEMI that you can learn from this and then further employ these new guidelines?

Milan Gupta
You know, that makes me think about our approach to managing say, hypertension, or even diabetes and glycemic control. Generally, as soon as we identify a patient that has hypertension, diagnosed for their risk category, or the second a patient's A1C is seven or higher, we start initiating therapy, pharmacologic therapy, along with lifestyle modification. We intervene as early as we can. And in the past, there's been some pushback to intervening early on LDL cholesterol. What's your take on early intervention for CV risk reduction when it comes to lipids?

Neil Naik
There's only benefit. This shouldn't be a multiyear project that you do with your patient but should be similar to hypertension, where the sooner you bring down the LDL, the better the outcomes. We know atherosclerotic plaques grow. We know they become calcified. If your patient has already had an N-STEMI, they've shown that they are at risk. So how this saves time in the long run for your clinical workflow, the work life balance, getting beyond even just the patient, I'm going to be a little bit selfish here, is preventing less paperwork for yourself. Every stroke, every peripheral arterial disease, every N-STEMI means more visits your office, more paperwork, more things to read, more forms to sign. Earlier intervention on the selfish side helps you reduce that in the long run. For your patients, earlier intervention means less heart attacks and less strokes. And that's really key on both ends, because really, this is a partnership between us and the patients.

Milan Gupta
Neil, you've obviously given this a lot of thought. Your role, the primary care physician's role, not just in following guidelines and measuring LDL and treating cholesterol in the high-risk patients and getting LDLs to where they need to be but looking at your own behavior and your own areas for self-improvement. If we close out this podcast with your key messages to our listeners, what would you want them to walk away with?

Neil Naik
Find your barriers, your personal barriers to providing care. Have you become jaded, or are you still passionate about medicine? I think one of the biggest studies that really highlighted things for me was that family physicians were more likely to give antibiotics at the end of the day than the beginning of the day. Because they got tired over the day. Figure out where is that passion, change it into action, scale it so you're not overworking yourself, so that you can let your patients succeed. And remember, patients want to know what you know to be healthy to live a long life. You have those tools and that knowledge to make that happen. So how are you going to do that as a clinician?

Milan Gupta
Wonderful, Neil, thanks so much. This was very interesting. We could have talked for another hour, I think, and we'll have to continue this conversation.

Neil Naik
Awesome. Thank you so much for having me here, Milan.

Milan Gupta
For our listeners, just a reminder that following this podcast you can complete the reflective exercise and program evaluation. You'll receive your certificate of participation by email. And I would invite you to watch out for our third podcast in this series entitled ***Lipid Targets and Thresholds***. I'll be having a discussion about this with Dr. Robert Hegele from Western University. Thanks very much for joining.

References

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