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Social inequity is a life and death situation for our patients

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Social inequity is a life and death situation for our patients

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On our inpatient Family Medicine service, we cared for a patient presenting with acute heart failure secondary to stress cardiomyopathy. Also known as Takotsubo cardiomyopathy, this is a syndrome characterized by impaired movement of the left ventricle of the heart, that often leads to symptoms similar to those of an acute myocardial infarction.[1] Stress cardiomyopathy is a self-limiting condition from which many patients recover. While hospitalized, our patient's heart failure symptoms were controlled, however she was still at risk. The chance of life-threatening arrhythmias in patients with stress cardiomyopathy is great, with one study population finding 13.5% of patients suffering from a malignant arrhythmia.[2] Patients at risk of sudden cardiac death due to a fatal arrhythmia can benefit from cardiac defibrillators. Due to the short course of stress cardiomyopathy, usually resolving within four weeks[3], and the availability of less invasive options, it is not considered worth the risk to implant a cardioverter defibrillator. As such, during the interim between the onset and resolution of her stress cardiomyopathy, it was decided that the best management for this patient would be to discharge her with a LifeVest™. This is an external wearable cardiac defibrillator for patients at high risk for sudden cardiac arrest from arrhythmia. We conducted a search of the literature and found that our decision was supported: patients with asystolic events who had a wearable cardioverter defibrillator had higher survival rates.[4] This solution is minimally invasive and suitable for our patient who has a temporarily increased risk for fatal arrhythmia. Moreover, it's a more efficient use of health care dollars than the costs associated with an implanted cardioverter defibrillator.

Like millions of people in the United States, our patient has a form of Medicaid insurance. We hoped that the cost of the LifeVest™ would be covered to some extent. Upon speaking with an agent from her health insurance company, we were informed that the LifeVest™ was not a covered benefit. The insurance company offered the option to ask for a preauthorization. However, we were told by a representative of the manufacturer of the LifeVest™ that the company would not accept a preauthorization as there had been cases in which they were never reimbursed for their product. Our final option was for the patient to pay for the device herself — a one-time payment of $3,450. When the patient explained she would not be able to afford this cost, the manufacturing company presented the option of a payment plan. Unfortunately, this was still more than she could afford. These negotiations with multiple entities were time-consuming, frustrating, and disappointing. Even though we attempted to secure proper care for our patient, she was forced to endure the increased risk of cardiac complications and go to a rehabilitation facility without a potentially life-saving intervention.

This patient received inferior care solely due to her financial status — a commonplace scenario we have seen in a variety of settings throughout our medical training. As future and current physicians, it is our professional responsibility to care for our patients to the best of our ability no matter their background or circumstances. We are taught to treat each individual equally, without judgment or discrimination. Yet the health care system in the United States renders it impossible to carry out these ideals. Seeing a patient forced into a situation that puts her at direct risk of preventable death is a reminder that as professionals we must advocate for changes in our society to provide better, safer, and more efficient care for all patients. This is a moral imperative.

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