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No Easy Fixes

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Ms. D., a middle-aged Jamaican-American woman from the Hyde Park neighborhood of Boston, sits amidst many other patients in the waiting room. It's not evident from her outward appearance, but her coronary arteries house 10 drug-eluting stents. Six of them had been placed over the course of a year, now 6 years ago, when she underwent seven cardiac catheterizations at the age of 49. Yes, Ms. D. has terrible coronary artery disease. Yes, with a body-mass index of 41, she is morbidly obese, with type 2 diabetes, high blood pressure, and high cholesterol. Nonetheless, given that she was a nonsmoking and relatively young woman, her initial 10-year risk for developing coronary heart disease, as predicted by the original Framingham risk score,¹ would have been considered low. We now know that these estimates are imperfect at best, particularly for certain subgroups of patients with heterogeneous risk, and studies are under way to permit more accurate and meaningful risk stratification of patients. Yet though it is tempting to assume that Ms. D. must harbor an uncommon cluster of genetic defects contributing to an aggressive and refractory atherosclerotic phenotype, her detailed story is simultaneously simpler and more complex than this would suggest.

I have met with Ms. D. only twice over the course of 6 months, during scheduled 30-minute visits when she came to my general cardiology fellows clinic for routine follow-up. At the time, she was beginning the lengthy evaluation process to determine whether she was a candidate for bariatric surgery. She seemed hopeful. But from the moment I opened her file, I began to feel uneasy. Painstaking review of catheterization after catheterization suggested that her interventions had been performed primarily for symptoms of atypical chest discomfort, not myocardial infarction, with one stenting begetting another. She had had recurrent in-stent restenosis despite the use of various types of drug-eluting stents, and the more interventions she underwent, the worse the angiographic appearance of her diffusely diseased coronary tree seemed to become.

Anyone listening to Ms. D. for more than a few minutes could discern readily that her life has been hard. Divorced and estranged from her three adult children in Georgia, she's no stranger to domestic abuse, violence, and the devastating effects of drugs and crime on family and community. She has long-standing depression and chronic back, chest, and knee pain — symptoms intricately linked to her obesity and all its complications. She frequently has difficulty filling her prescriptions and taking her medicines. As the primary caregiver for her 8-year-old granddaughter, she struggles daily to commute from Hyde Park to a job in Boston's China-town, and she is routinely broke. It was still not entirely clear to me why she trekked farther yet to see me instead of seeing a practitioner in her neighborhood. She told me it was because she wanted the best care for her heart condition.

Silently, I worry that we have not helped her. A few months after our first visit, she showed up with three more coronary stents, having arrived in an emergency department with her usual chronic chest pain. Later review of her records suggested that the blood-test results signaling what she had understood to be a mild heart attack were actually clinically significant only after she'd undergone the lengthy, complicated percutaneous coronary intervention.

When I pointedly asked Ms. D. whether she felt better after these procedures, she said, "No, I still get the pains all the time." She had been discharged from the hospital with a prescription for a new, expensive, second-line anti-platelet agent, which she was unable to obtain at her local pharmacy. This setback led to a flurry of chaotic activity on the part of various well-meaning and disconnected practitioners in an effort to avoid allowing her to miss a dose — a potentially lethal gamble. Perhaps more unfortunately, she was not yet taking atorvastatin, she said, because of ongoing problems with a prior-authorization form, even though the drug was already available in a generic version. Unsurprisingly, Ms. D. remained overwhelmed and confused about her medications.

Less than 4 weeks after her last stent placement, she returned to the emergency department with chest pains and received another stent. Again, there was no objective evidence of an acute coronary syndrome. Ms. D. seemed upset and afraid; different doctors appeared to be telling her different things. She continued to feel unwell — at times boosted slightly by the hospitalization and the days off from work, but always ultimately returning to the same problems. Ironically, with every additional drug-eluting stent (and its concomitant full year of dual-antiplatelet therapy), her primary goal of gastric bypass surgery became more elusive. It was difficult, if not impossible, to convey this information to her in a way that made sense. Worse, I fear I alienated her in my attempts at explanation and formulation of a new plan. Without notice, she moved away, and I didn't hear from her again.

Sixteen months later, I remain amazed by the notion that in our health care system — which Ms. D. and I, from the vastly different perspectives of patient and trainee, have sought to trust and navigate — it was somehow easier to provide her with 10 state-of-the-art stents than with access to a generic, life-prolonging pill. And it was even more difficult to provide her with the appropriate social, financial, and psychiatric support.

There has been much discussion about the importance of bringing value to U.S. health care through reform. It's clear that system complexity, misaligned incentives, and lack of coordination have led to chaos and unintended consequences — a system in which a patient's needs can be overshadowed by what the system can readily provide. Although simple, sometimes nonclinical interventions may have great impact on long-term patient outcomes, their implementation requires strong teams of advocates and the integration of evidence-based processes into deliberately patient-centric models of care.

There are no easy fixes. I have been sobered since my early days as a medical student. But I want us to do better for patients like Ms. D., and I believe that we can.

References

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