

A heart twice as big as normal

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Mr. D was admitted with cardiogenic shock to the intensive care unit (ICU) of my hospital, a tertiary referral centre for heart failure located in Milan, the capital of one of the richest regions in Europe. The night D was transferred to my ward, I had already gone home. The on-call resident took care of the paperwork and then notified me with a text message on my cell phone. “We were transferred a patient with really terrible, advanced heart failure. He’s forty-nine years old but lives on the street and therefore cannot be transplanted. Ah, I forgot: he is also *no vax!*”

D was already known to have a severe form of heart failure but, despite cardiac function values that were largely below what we usually considered worrisome, he had not been admitted to hospital in the last 12 months. “The winter months are the toughest,” he repeated several times during his current admission. “Sometimes it’s very cold and there are days, like last week, when I get to eat only one piece of fruit.”

After a few days between life and death, supportive therapy with high-dose inotropes had its effect, and D’s hemodynamic parameters started to improve slowly but steadily. He stabilized after one week in the ICU, and a few days later, he was transferred to the heart failure unit for continued care.

Over the last 3 years, Italy, like much of the world, has been devastated by the COVID-19 pandemic, paying a heavy price in terms of victims and infections. The country is still broken-hearted by the experience, and the memory of the hard lockdown period in the first half of 2020 is still fresh in everyone’s mind. Segments of the population in poor, already precarious socioeconomic conditions were among those most heavily affected. Today, thanks to a mass vaccination campaign,

the health situation in Italy is clearly improving. However, as can be seen by watching the news or reading the comments on social networks, society seems split into 2 unequal parts. The small minority of people who are against the SARS-CoV-2 vaccine for ideological reasons (commonly referred to as “*no vax*” in Italy) is very noisy and often generates debates that result in real arguments.

The arrival of a patient like D represented a real challenge for me on many levels, human, clinical and social. On a dark February night after a whole day spent in the ward, my first impression was that of being faced with an obvious nuisance. Although I felt compassion for the tragic nature of the clinical situation, I couldn’t help but imagine him as hostile, ideological and, perhaps, even a bit mentally unwell. That evening before falling asleep, I remember thinking, with a certain cynicism, about all the difficulties I would have to face in working with such a problematic patient.

The next day, I met D as he was taking his first steps in the hallway of our ward, wearing a pair of flip-flops and one of those horrible hospital gowns, open in the back. I had never seen him before, but I knew immediately that it was him. Thin, lanky and with a somewhat vacant look, he moved with the resigned gestures of a spectre, an ethereal being used to going unnoticed. He smiled at me. In response, with an excess of zeal that I may not have displayed with a vaccinated patient, I invited him to respect the ward rules that, since the first days of the pandemic, have forbidden patients to wander around without reason.

On examination, D’s parameters were satisfactory, his limbs were well perfused and his heartbeat was regular, thanks to the medications; results of his blood

tests, overall, were also much better. “I still have what it takes, doctor,” he laughed, seeing how amazed I was.

Over the next few days, I talked to D a lot. He told me that he had not had a fixed income for a long time, and had only a modest government pension for the disability caused by his disease. He was living by his wits, mostly on the streets. He had been sleeping in a municipal dormitory, but had been expelled a few weeks earlier because the rules for accessing it included the need to be vaccinated against SARS-CoV-2. He had spent his last days in an apartment, paid off-the-books to a landlord who had left him without heating in the middle of winter. Despite these difficulties, which would have been able to bend anyone, D maintained a light in his eyes and a commendable enthusiasm. His long speeches covered the most varied topics, from the world order, to solar energy, to the benefits of riding a bicycle; he always appeared to have an unshakable confidence in the future. This attitude clashed with his resignation toward his wretched existence, which he struggled to deal with, albeit without any aggression.

I do not know how aware D was of the implications of his choice not to be vaccinated, but he stood by it without ranting or controversy. He lived on the margins of society and risked dying at any moment, yet he considered the mandate to receive this “experimental vaccine” a gross limitation of his free will.

We were coming from opposite points of view — I considered this reasoning a substantial madness — but this was not the thing that disturbed me most. Under “normal” conditions, a patient of his age with advanced heart failure would qualify for a heart transplant or, alternatively, for the implantation of a left ventricular

assist device, otherwise known as “artificial heart.” Both options represent a long path, full of pitfalls and possible complications, that is difficult to face even with a strong social, familial and economic network. D was completely alone except for a friend — also *no vax*.

The absence of a caregiver, a stable home, an income and a real perspective of future life made these care options near-impossible for D. In Italy, health care is free and considered to be of a good standard, but this does not mean that barriers to treatment do not exist, especially in the case of patients like D, who, in addition to having a heart twice as big as normal, carried a heavy social burden on his shoulders. His *no-vax* status, although not determinative of clinical choices, represented yet another element of difficulty in access to care for such a fragile patient. Ultimately, this situation forces individual physicians (starting with myself), the health care system and the whole society to face the heavy question of how to truly

care for these patients instead of increasing their risk of marginalization. I do not have any effective approach to offer except to try, as doctors and as citizens, to make sure that our hearts grow a little larger to make room for all the battles, even those that seem already lost. This looks like the only way to a meaningful restart that — beyond drugs, rules and artificial intelligence — can lead us to (re)empathize with whoever happens to be in front of us, whether a patient or a person experiencing homelessness, sitting at a subway stop.

Taking care of D meant taking note of all the limits that society — even an evolved one — places on the lost ones. It meant coming to terms with the boundaries of what we can and cannot do as doctors and as citizens. It meant saying goodbye to a patient who was not even 50 years old as he was being transferred to a palliative care facility and coping with a heavy sense of impotence, almost guilt. The main lesson I took home was

that finding a firm point between absolute empathy and cold detachment is an impossible exercise.

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This article has been peer reviewed.

This is a true story. The patient gave his consent for this story to be told; however, he has been deidentified to preserve his anonymity.

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