Editor's Note

Heart Hospice

Key words: hospice, palliative care

Introduction

In recent years heart hospitals have sprung up throughout the United States, bringing to patients focused expertise on matters relating to cardiovascular medicine and surgery. Most academic centers and many large community

hospitals provide high quality sophisticated diagnostic and therapeutic techniques in cardiology. As a result of these efforts, patients are living much longer than they did 100 years ago. Life has been extended 20–30 years in our patients, but some may not be living the life they would like to live. After all, cardiac disease is a chronic illness and much of that chronic illness is related to heart failure with or without multi-system involvement.

Care of Chronically Ill Cardiac Patients

All cardiologists have had experiences with chronically ill cardiac patients.

As we continue to take care of cardiac patients, we are witnessing a change in what is available to offer them. Most cardiologists think they can make many cardiac patients feel better and palliate their symptoms, allowing them to maintain a limited but happy lifestyle. However, eventually, there does come a point when this is no longer the case and both the cardiologist and the family must come to an agreement that it is now time to focus on comfort care for the patient. This is not easy to do. In many instances cardiologists won't give up, even though overly aggressive medical or even surgical therapy is really not prolonging useful life but is prolonging death. Consider the elderly patient who has had coronary bypass and/or valve surgery but now needs a redo procedure. This is the patient in whom continued medical therapy and comfort care may be more in the patient's best interests than a complicated high-risk procedure with a high risk for cognitive dysfunction as well as a prolonged complicated recovery. In this patient, aggressive continuing medical or surgical therapy may be futile. It is sometimes hard to convince families of the futility of aggressive treatment in patients dying from cardiac and cardiac-related conditions—that is, renal failure, stroke, and so forth. Continuing aggressive therapy seems to be par-

ticularly futile in the patient who has chronic left ventricular dysfunction and heart failure associated with multiple arrhythmias, who is being treated with drugs such as amiodarone and devices such as an implantable cardiac defibrillator, a biventricular pacemaker, and so forth.

The Hospice Concept

Stedman's Medical Dictionary defines hospice, which derives from the Latin *hospes* (a host, a guest), as an institution that provides a centralized program of palliative and supportive services to dying persons and their families, in the form of physical, psychological, social, and spiritual care; such services are provided by an interdisciplinary team of professionals and volunteers who are available at home and in in-patient settings.

Hospice care is a specialized form of palliative care in which the patient has decided to forego all life-prolonging treatment.

Prognosis, not diagnosis, is the primary indication for hospice care.

Our colleagues in oncology have been facing the problem of end-of-life care for many years, and have developed hospice programs to deal with end-of-life issues. It seems that oncology doctors and oncology patients' relatives accept the hospice concept much more readily than the cardiologist and relatives of the patient who is at the end of life due to a cardiac condition. The reason may be that although the heart failure patient may have symptoms similar to those of the cancer patient, end of life due to cancer may be more predictable than end of life due to cardiovascular disease.

Determining End of Life

The question is, of course, who determines what patient is at the end of life? No doctor can predict the future in any individual patient whether it be the cancer patient or the cardiac patient but it seems to be much easier to predict end of life in the former than in the latter.

Studies have shown that patients dying from heart disease report a wide range of symptoms including pain, breathlessness, and depression, all of which tend to increase hospital readmission rates of patients with heart failure. Often the cardiologist feels uncomfortable talking to patients about end of life, but there are other individuals—heart failure nurses come to mind—who may be able to communicate better with these patients.

Heart Failure Patients, Palliative Care, and Outcome

There is no doubt that the heart failure specialist can improve outcome for patients with heart failure. We have learned from our heart transplant programs that many patients in New York Heart Association functional class IV can be aggressively treated with some improvement in their symptoms and functional classes. Unfortunately, most of these patients return to hospital with heart failure, and many will die of arrhythmia. The majority of studies evaluating the effect of palliative care on outcomes in patients with cancer have shown that palliative care results in patients spending more time at home, thus reducing the number of in-patient hospital days. It is highly likely that the same would be true in heart failure patients. Although death may not be around the corner, both the patient and the patient's family and medical professionals will be happier about the medical situation. Many of these heart failure patients are incapacitated and are unable to visit their doctors; thus, it is important to make some arrangements for home health care.

Conclusion

Finally, to quote Gibbs and colleagues, "The aim of palliative care is to improve the quality of life in the broadest sense

for patients with incurable disease. It also aims to improve the quality of dying (to achieve a 'good' death) and to ameliorate the devastating effects of dying on the family and those responsible for the care of the patient."¹

Perhaps it is time for our professional society, The American College of Cardiology, to develop a consensus conference on this subject of hospice care for heart failure patients. The outcome of such a conference could be the development of guidelines for the practitioner, which might also be an important document for family members.

Selected Readings

1. Gibbs JSR, McCoy ASM, Gibbs LME, Rogers AE, Addington-Hall JM: Living with and dying from heart failure: The role of palliative care. *Heart* 2002;88:ii36–ii39
2. Stewart S, McMurray JJV: Palliative care for heart failure—time to move beyond treating and curing to improving the end of life. *Br Med J* 2002; 325:915–916

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