

# Failing better: a new paradigm of care

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A professional colleague and advanced heart failure expert once noted to me that, “heart failure is the cancer disease of cardiology.” He went on to point out that, compared to patients with most solid cancers, patients with heart failure have significantly worse morbidity and mortality, are at risk for more frequent hospitalizations, and create a greater economic strain on the health system.

Even as mechanical circulatory support (MCS) technology extends median survival by years, recipients still experience the distress of medical complications, chronic symptoms, and lifestyle changes. “And at some point,” he continued, “we have to provide end-of-life care to all these patients...even the ones who get transplanted.”

As the heart failure epidemic grows, a growing awareness of the burdens of living with heart failure invites fresh perspectives on how we might best support these patients and their caregivers. If we can agree that the disease experience is far greater and more complex than simply pathophysiology, then efforts to serve these patients must extend beyond disease-modifying therapies.

## Origins

Palliative care—defined in part by the World Health Organization as, “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness”—is a relatively

young field, now perhaps moving from childhood to adolescence [1]. The discipline’s clinical roots have been most well established in and around oncology care. Over recent decades, the timing of palliative care involvement has gradually marched upstream in disease trajectory from exclusive focus on end-of-life care toward much earlier implemented concurrent care, such as the time of metastatic disease staging [2]. Additionally, clinical models of palliative care continue to evolve across care settings. While most prominent clinical presence remains in the inpatient setting, palliative services continue to expand to outpatient clinics (often embedded within other specialty clinic settings), home visit programs, and even telemedicine approaches [3].

Early studies demonstrated clear benefit from palliative care expertise in management of pain and other symptoms associated with advanced illness, supporting caregivers, coordinating communication, and medical decision-making between clinical teams and patient/family unit, and providing comfort at end-of-life [4–6].

Without a doubt, relatively rapid growth of palliative care has also derived from demonstrated cost savings in a world in which medical costs continue to skyrocket. In one landmark study, palliative care patients discharged alive had an adjusted net direct cost savings of nearly \$1700, while the cost savings approached \$5000 for patients who died in the hospital [7]. When palliative care consultation leads to lower hospitalization costs, length-of-stay, and readmission rates, hospital administrators take note and hospital investments in palliative consult services continue to steadily rise [8].

Nevertheless, most revolutionary has been palliative care’s intentional focus on holistic approaches to the relief of suffering. The remainder of the WHO’s definition of palliative care identifies the field’s expertise in “prevention and relief of suffering by means of early identification and impeccable

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assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.” [1] These final qualifiers—“physical, psychosocial, and spiritual”—help emphasize an important shift from multidisciplinary approaches to care (different clinical disciplines represented on site) to interdisciplinary (working synchronously across disciplinary boundaries) or even transdisciplinary (working to integrate beyond distinct disciplinary boundaries) [9]. The effectiveness of such shift reflects the underlying nature of suffering with a serious progressive illness. For example, the debilitating physical pain one might experience also impacts one’s emotional health, social interactions, and even spiritual life. Addressing one but not all aspects of pain experience will not attend to the whole person.

### Heart of the matter

How then do such palliative care approaches interweave in care of the patient with advanced cardiac disease? Following in the footsteps of oncology, the field of cardiology generally and the newer advanced heart failure discipline specifically, continue to develop awareness of positive impact on palliative expertise in care of the patient with heart failure. A quick PubMed search linking the terms “heart failure” and “palliative care” finds 21 publications from the year 2000 and 133 from 2016, indicating, at least in rough terms, remarkable growth in scholarly interest in recent years. In 2013, the American College of Cardiology/American Heart Association heart failure management guidelines now include specific recommendations for implementing palliative care consultation [10]. In 2014, the Centers for Medicare and Medicaid issued a requirement that a palliative care specialist be a part of interdisciplinary teams evaluating candidates for left ventricular assist device as destination therapy, effectively mandating upstream concurrent heart failure/palliative care [11].

This attention to palliative care in the arenas of advanced cardiac disease makes sense. Even with the best of pharmacotherapies and devices, heart failure is progressive and life limiting, affecting multiple domains of patient suffering as well as caregivers. Patients with heart failure experience notable symptom burden, depression, and spiritual distress, perhaps more than matched cancer patients [12, 13]. Caregivers report psychosocial support needs and assistance navigating the health system [14]. Clinical complexities of medical decision-making and uncertain prognosis necessitate expert communication skills, advance care planning, and for patients being considered for MCS, preparedness planning [15, 16]. Even as advanced heart failure therapies such as continuous inotrope infusions and left ventricular assist devices grow in both

sophistication and frequency of implementation, heart failure specialists increasingly recognize the limitations of current technologies to fully engage and support their patients through the trajectory of disease.

By no means comprehensive, this symposium issue of *Heart Failure Reviews* simply aims to call attention to this rapidly developing interface between heart failure and palliative care. By design, contributing authors from a variety of disciplines—medicine, nursing, pharmacy, chaplaincy, and social work—represent the transdisciplinary approaches of palliative care. The collection speaks to opportunities for palliative interventions to enhance heart failure care throughout the disease trajectory, including medical management, MCS, and end-of-life care. Finally, this issue invites the reader to contemplate the not-so-distant future, where palliative care models of care evolve beyond inpatient consultation for cardiac patients, palliative skills continue to infuse into routine clinical practice of cardiology clinicians, and holistic support merges into cutting edge transplantation care.

Toward that end, this symposium issue is dedicated to the patients with heart failure and their caregivers who have taught and continue to teach us how to honor their personhood and serve their wholeness.

### References

1. <http://www.who.int/cancer/palliative/definition/en>. Last accessed July 2, 2017
2. Temel JS, Greer JA, Muzikansky A et al (2010) Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med* 363(8):733–742
3. Cassel JB, Kerr KM, McClish DK et al (2016) Effect of a home-based palliative care program on healthcare use and costs. *J Am Geriatr Soc* 64(11):2288–2295
4. Casarett D, Pickard A, Bailey FA et al (2008) Do palliative consultations improve patient outcomes? *J Am Geriatr Soc* 56(4):593–599
5. Ringdal GI, Jordhoy MS, Kaasa S (2002) Family satisfaction with end-of-life care for cancer patients in a cluster randomized trial. *J Pain Symptom Manag* 24(1):53–63
6. Higginson IJ, Finlay IG, Goodwin DM et al (2003) Is there evidence that palliative care teams alter end-of-life experiences of patients and their caregivers? *J Pain Symptom Manag* 25(2):150–168
7. Morrison RS, Penrod JD, Cassel JB et al (2008) Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med* 168(16):1783–1790
8. <https://reportcard.ccapc.org>. Last accessed July 2, 2017
9. Van Bower V (2017) Transdisciplinarity in health care: a concept analysis. *Nurs Forum* 26
10. Yancy CW, Jessup M, Bozkurt B et al (2013) 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on practice guidelines. *Circulation* 128(16):e240–e327
11. Centers for Medicare and Medicaid. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R172NCD.pdf>. Last accessed July 7, 2017

12. Khan RF, Feder S, Goldstein NE et al (2015) Symptom burden among patients who were hospitalized for heart failure. *JAMA Intern Med* 175(10):1713–1715
13. Bekelman DB, Rumsfeld JS, Havranek EP et al (2009) Symptom burden, depression, and spiritual well-being: a comparison of heart failure and advanced cancer patients. *J Gen Intern Med* 24(5):592–598
14. Doherty LC, Fitzsimons D, McIlfatrick SJ (2016) Carers' needs in advanced heart failure: a systematic narrative review. *Eur J Cardiovasc Nurs* 15(4):203–212
15. Gordon NA, O'Riordan DL, Dracup KA et al (2017) Let us talk about it: heart failure patients' preferences toward discussions about prognosis, advance care planning, and spiritual support. *J Palliat Med* 20(1):79–83
16. Swetz KM, Freeman MR, Abou Ezzeddine OF et al (2011) Palliative medicine consultation for preparedness planning in patients receiving left ventricular assist devices as destination therapy. *Mayo Clin Proc* 86(6):493–500