Should hospitals have a designated consultant with a specific interest in heart failure?

Chronic heart failure (CHF) is common, costly, disabling and deadly. NICE has recently issued guidelines on its management, and its decompensation is now one of the commonest reasons for acute medical admission to hospital. Yet its current management is far from optimal: even in the US, only 64% of recommended care is being delivered to CHF patients. Not surprisingly, specialists deliver care closer to the guidelines than generalists. Such specialty-related practice differences may even explain the alarmingly variable differences in outcome for CHF patients between different hospitals: for example, in-patient case fatality in Scotland varies from 8.5% to 23.4%.7

Currently, cardiologists look after large numbers of CHF patients, but the average age of a CHF patient in the UK is now 79 years of age, and the current shortage of cardiologists in the UK often means that cardiologists are only able to look after selected (often the younger) CHF patients. In many hospitals therefore, most of the acutely admitted elderly CHF patients are looked after during their stay by the admitting general physician of the day, and in the majority of such cases, the admitting physician will have a different subspecialty interest.

In the UK, both newly admitted stroke patients and newly admitted CHF patients tend to remain under the care of the general physician of the day. With stroke patients, it is now recognized that they would be better looked after by a designated stroke physician, but there is no such recognition yet with regard to the acutely admitted CHF patient. This despite the similarity between CVA and CHF patients that both conditions require a multidisciplinary team. This is obvious for stroke patients, but is also true for CHF, for two main reasons. Firstly, recent data show clearly that a specific heart failure nurse produces huge benefits in CHF patients. Secondly, decompensated, acutely admitted, (elderly) CHF patients often need considerable extra time in hospital for physiotherapy and rehabilitation before they can be discharged and function adequately at home. This extra time is often after the patient’s medical therapy has been optimized.

It is appropriate to first consider what kind of doctor the specific heart failure consultant should be. The main stipulation is that they should be specifically interested in, knowledgeable about and experienced in heart failure, but their background training could include cardiology, general medicine and/or geriatric medicine. In an ideal world, they should all perhaps be cardiologists, but the UK is probably too short of cardiologists for this to be really feasible. A key point, however, is that whatever background the heart failure consultant has, he/she will need to work closely with an (invasive) cardiologist so that appropriate patients can be referred for appropriate procedures and, of course, many appropriate young CHF patients are likely to remain under the care of the cardiologist. This kind of cross-referral is common in medicine but the procedure-related specialist is often too busy to undertake the many more mundane aspects of looking after (elderly) CHF patients (see below).

What then would the heart failure consultant do? He or she would be head of and co-ordinate a multidisciplinary team, who should at least include a specific heart failure nurse practitioner and possibly a pharmacist, ought probably to run a specific out-patient clinic for CHF, and should ideally have all acute medical admissions where CHF is the main problem referred to them on the next working day and undertake their care thereafter. This could be a large burden of work, and perhaps they should be excused some other work in order to do this. The heart failure consultant could also act as a focus of contact for local GPs, as they often are uncertain what to do at home when one of their CHF patients becomes more breathless, as is common. A timely phone call or a quick out-patient appointment or even a home visit from a nurse may well in this situation be able to prevent a long rehospitalization episode or even facilitate admission when appropriate.

Every year, there are enormous advances in the medical management of CHF. Each new therapy...
brings with it the need for more patient monitoring to avoid the inevitable adverse effects, e.g. spironolactone and beta blockers, both requiring extra monitoring to be given safely. The heart failure consultant would keep up-to-date and be able to implement as early as possible each new proven advance as it comes along. We tend in the UK to be rather slow at implementing new advances, but there is good evidence that specialists implement new therapies more quickly and more extensively than generalists.6

Close liaison with cardiologists would be essential, even more so now that implantable defibrillators and cardiac resynchronization are being used more in CHF. Paradoxically, the need for cardiologists to deliver these new technologies may reduce even more the time cardiologists have to devote to the mundane aspects of the management of elderly CHF patients, and hence increase the need for a designated heart failure consultant.

As CHF patients are increasingly elderly, they have more and more associated non-cardiac medical problems requiring attention, e.g. anaemia, renal dysfunction and arthritis.10,11 The skills of a general physician are often appropriate here to deal with these non-cardiac problems and optimize their inevitable polypharmacy.11 Liaison with nephrologists is often helpful for ultrafiltration in cases of resistant oedema and in the management of high creatinine values and the use of erythropoietin for anaemia.

Physiotherapy and rehabilitation are also essential, as these patients are mostly elderly with multiple pathologies.11 This requires close liaison with geriatricians. Close liaison with palliative care specialists is also essential, but the heart failure consultant should also be specifically skilled in palliative care themselves, as this would inevitably be a large part of their work.12,13

Finally, another important role would be for the heart failure consultant to facilitate research, teaching and audit activity into CHF. None of these crucial activities is likely to occur in any hospital unless a specific consultant is responsible for it.

In conclusion, there is a good case for hospitals identifying at least one designated consultant with a specific interest in heart failure to act as a focus for the delivery of better care to patients with CHF. The designated consultant could head a multidisciplinary team and should liaise closely with cardiologists, geriatricians and palliative care specialists. In the analogous area of stroke medicine, the need for specific stroke consultants is now well accepted, and many of the arguments which were relevant to stroke apply also to CHF. In Ninewells Hospital, Dundee, a system similar to that proposed now operates. Clearly it will never be the case that any one system for delivering care will suit all localities, and many modifications are likely. The main purpose of this article is to float this idea and to open a debate on this subject.

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References


