Editorials

Palliative care for heart failure

Time to move beyond treating and curing to improving the end of life

The epidemic of heart failure and its costs to health services continue to grow. Despite important advances in evidence-based treatments, age-adjusted survival rates for chronic heart failure remain worse than for many forms of cancer. The only cure for chronic heart failure—heart transplantation—is equivalent to providing a single lifeboat to the sinking Titanic.

Most of the usually elderly patients with heart failure therefore have short lives remaining of extremely poor quality, punctuated by frequent admissions to hospital. They often suffer dyspnoea, pain, confusion, anxiety, and depression during their last days of life. Most of them would prefer "comfort care" and do not wish for active resuscitation. Some would even prefer death. The growing clamour for a better experience of the end of life and the extension of palliative care services to patients with heart failure is therefore not surprising.

Two recent studies in the BMJ add to this debate. Hanratty et al set up a series of focus groups with general practitioners and specialists in cardiology, geriatric medicine, general medicine, and palliative medicine in the north west of England, to determine their views about palliative care for heart failure. The overall picture was grim, describing poor quality of care for patients and frustration among doctors. Among several important findings, this study identified that predicting the illness trajectory is much harder in severe heart failure than in cancer. This creates uncertainty that can virtually paralyse doctors, potentially preventing them from telling patients when they have reached the terminal phase of their illness and from planning appropriate care. This confirms the findings of the study to understand preferences for outcomes and risks of treatments (SUPPORT), in which predicted six month survival was greater than 50% among patients who then died from heart failure in the next three days.

In this issue (p 929) Murray et al describe how they elicited and analysed the experiences and views of patients dying from heart failure or lung cancer, and of their carers. A large series of interviews (219 with patients, 53 with carers, and 73 with health professionals) yielded qualitative data on illness trajectories, healthcare needs, and use of services. As in the study by Hanratty et al, the illness trajectory of lung cancer was much more predictable than for heart failure. Similarly, participants reported poor coordination and inadequate continuity of care, inhibiting the formation of a close and enduring relationship with a single healthcare professional. To some extent, these deficiencies have been overcome in other parts of the United Kingdom (greatly assisted recently by the British Heart Foundation) and elsewhere, with the introduction of specialist heart failure nurses who coordinate disjointed services and often become patients' main professional carers.

The provision of palliative care on the basis of need rather than diagnosis must be debated urgently. If palliative care is to be extended in the United Kingdom, it will need additional funding beyond charitable sources. Who should provide this additional care? Specialist heart failure nurses already possess most of the requisite skills, offering open and sensitive communication, a holistic approach to patient and carer, and attention to controlling symptoms. In some areas (in London and Glasgow, for example) these nurses already have formal links with palliative care services.
As doctors we are facing a marked shift in our thinking about this non-cancerous, terminal disease. It is always hard to acknowledge that therapeutic options are exhausted, particularly when patients have not recognised this themselves. But it is disturbing and lamentable that patients with heart failure, in stark contrast to those with cancer, are still not told their diagnosis or prognosis. Doctors caring for their patients with severe heart failure have much to learn from their colleagues in cancer services and from specialist nurses.

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