

VIEWPOINT**VOICES IN CARDIOLOGY**

Pragmatic Care in Cardiology

A New Transition Phase Between Curative and Palliative Care



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Cardiologists perform a range of interventional procedures and contribute to the prevention, treatment, and palliation of patients with unpredictable trajectories. Cardiologists are therefore well placed to understand and improve the transition from curative to palliative care. However, there is no agreed-on transitional model inside or outside of cardiology, and—originating in oncology—palliative services require ongoing adjustment for cardiac patients (1). This paper identifies deficiencies in transitional care as pertinent to cardiology and proposes renaming it “pragmatic care,” a new and improved term, not used in the literature, with foreseeable benefits to patients in the curative-palliative transition.

CHALLENGES IN TRANSITIONAL CARE

Curative care and palliative care benefit patients, but challenges in defining, recognizing, and researching their interface continue to affect both (2). The term “transitional care” has unrelated uses, lacks inherent meaning, is inseparable from palliative care, and is not the focus of any guidelines. The curative-palliative transition requires time and careful thought, discussion, and referral, but remains under-researched, variably managed, and unsettling for patients and providers (2). Given the mortal connotations of palliative care, clinicians are slow to initiate conversations, and mixed messages create confusion, anxiety, and fear (1). Negative feelings are

exacerbated by time shortages, changes in provider, and the need for repetition if deficiencies in interdisciplinary communication arise (3).

Early referral benefits cardiac patients, but uptake of palliative care is low (4,5). Although cardiologists increasingly deliver palliative care in the United Kingdom, the Gold Standards Framework palliative care register focuses on primary and pre-terminal care rather than secondary or transitional care (6). Cardiology training curricula exclude transitional care, and trainees feel unsupported delivering it (7). Patients with heart failure and congenital heart disease have transitional needs with clear pathways, but other patients—those with ischemic and valvular heart disease, for example—do not. Patients with late-stage disease are no less deserving of evidence-based care de-escalation than early-stage patients are deserving of evidence-based escalation. However few studies have discussed transitional care, none specifically in cardiology, and de-escalation trials, usually justified by side effects or cost, are greatly outnumbered by care escalation trials (1,2,8).

PRINCIPLES OF PRAGMATIC CARE

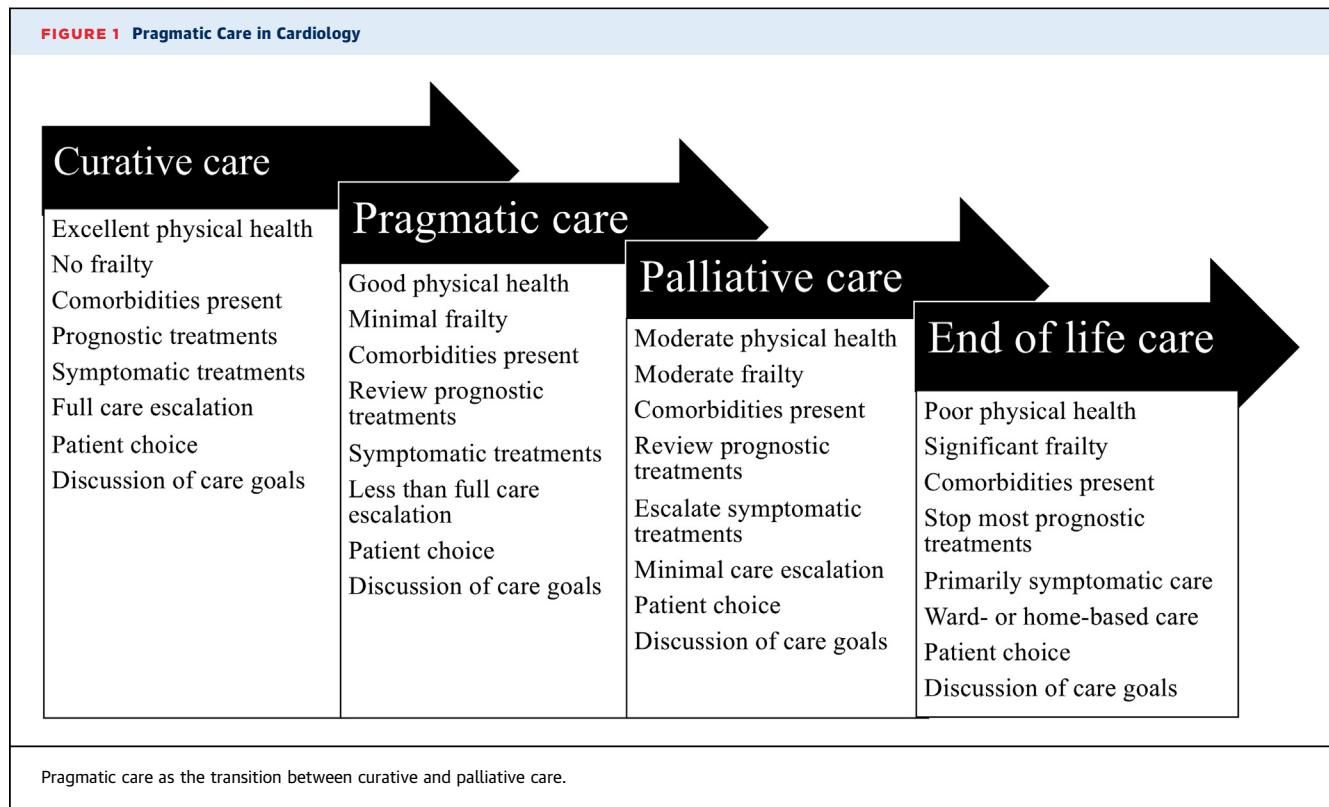
“Pragmatic care” is a more meaningful, optimistic, familiar term than “transitional care,” beginning during curative care when theory diverges from practice, *when escalation plans first exclude the most invasive treatments available should an indication arise*, for example, when a patient with systolic dysfunction first becomes hypothetically ineligible for cardiac transplantation. *Pragmatic care ends during palliative care when symptomatic priorities overtake prognostic priorities* (Figure 1).

Pragmatic care recognizes the following:

1. Pragmatic discussions are important but challenging.

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2. Premature conversations can cause unnecessary worry.
3. Timely conversations can prevent later difficulties.
4. Little changes initially.
5. Care remains holistic, family-oriented, and patient centered.
6. Goals, initially curative, become increasingly focused on symptomatic care.
7. New and existing treatments are regularly reviewed.
8. Prognostic returns from care escalation gradually diminish.
9. Prognostic treatments are indicated but may become inappropriate.
10. Prognostic harms from care de-escalation gradually diminish.
11. Symptomatic treatments become increasingly appropriate.
12. Percutaneous treatments will still be considered carefully.
13. Geriatric, palliative, primary, secondary, or tertiary care teams may be involved.
14. Care plans may progress rapidly, slowly, pause, or reverse.

NEXT STEPS

Beneficial interventions will be patient-centered, multidisciplinary, and evidence based, piloted in selected sites, and included in guidelines for audit purposes. Examples include the following:

1. *Pragmatic care scores:* Patient and staff questionnaires refine the concept and validate a score to compare pragmatism between groups.
2. *Pragmatic care outcomes:* Trials with customized outcome measures determine the effectiveness of pragmatic interventions (e.g., quality of life and perceptions of care).
3. *Pragmatic care trials:* Randomizing patients meeting pragmatic inclusion criteria to nonprescription of exclusively prognostic treatments such as statins, antihypertensive agents, and antiplatelet agents supports pragmatic care decision making and guidance.
4. *Pragmatic care staff:* Nurses, physician associates, and clinicians from primary, secondary, and tertiary care with a special interest in pragmatic care help shape and deliver new services. *Pragmatic care coordinators* act as single points of access for patients, families, and staff.

5. *Pragmatic care training:* Undergraduate and post-graduate curricula, including pragmatic care services, prescribing, communication, and philosophies, educate staff, improve care, and encourage special interest.
6. *Joint clinics and multidisciplinary meetings:* Cardiac, palliative, and primary care teams agree on interdisciplinary treatment plans and ceilings for patients with complex pragmatic needs.
7. *Pragmatic care register:* A register is established for qualifying patients with customized pragmatic care plans to record patient perspectives, care plans, and agreed-on treatment ceilings.
8. *Pragmatic care passports:* A book or app is created for patients to record their values, notes, and appointments, including information about support groups, learning materials, and other services.

BENEFITS OF PRAGMATIC CARE

Although many aspects already represent good medical care, the recognition of this stage as a standalone phase of care and its renaming from transitional care to pragmatic care allow the curative-palliative interface to be more easily defined, measured, standardized, audited, scrutinized, researched, and improved. Patients, families, and staff may be more understanding of, and comfortable with, the term “pragmatic care.” This allows conversations to be expedited and more time to talk, collaborate, agree on goals, align expectations with reality, and plan ahead, thereby reducing the risk of real or perceived

confusion, miscommunication, or care discontinuity. Early conversations may renew enthusiasm for life-style interventions, avoid inappropriate procedures or hospitalizations, encourage shared care, and increase palliative care uptake.

CONCLUSIONS

With aging populations and advancing technologies, the curative-palliative transition continues to challenge patients and clinicians. I propose pragmatic care as a discrete intermediate phase between curative and palliative care to address transitional deficiencies and improve patient care during this difficult stage of life, both inside and outside of cardiology.

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AUTHOR DISCLOSURES

Dr. Collins has reported that he has no relationships relevant to the contents of this paper to disclose.

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