HEART OF THE MATTER

A New Subspecialty for Complex Heart Failure

BY SIDNEY GOLDSTEIN, M.D.

In the beginning, there were very few cardiologists. At another time and in almost another world, a cardiologist could do very little more than could an internist. After all, an internist could give digitalis and quinidine just as well as a cardiologist, and the fee was the same: very little. Cardiologists could do catheterization of the heart, but then again so could some internists. But to what purpose, since we hadn't yet discovered that you could actually get an angiogram of the coronary vessel by placing a catheter in a vessel where you were told to never go?

A lot has changed since then. We have about 30,000 cardiologists in this country, and now we have a new secondary subspecialty proposed that will deal with advanced heart failure and transplantation. The new subspecialty was recently approved by the American Board of Internal Medicine and awaits approval by the American Board of Medical Specialists and the subsequent development of training programs (CARDIOLOGY NEWS, November 2007, p. 1). It joins the other subspecialties in our midst—interventional cardiology and electrophysiology. There are probably others waiting in the wings.

The need to develop expertise in a given field is driven by developing technology and by the increase in the number of patients, both actual and projected. In response to the growing patient population, new drugs and devices have been developed to deal with heart failure. Few of us are familiar with the care and maintenance of left ventricular assist devices and even fewer have the expertise to manage the aftercare of heart transplant recipients. Therefore, to provide competency in these special areas, it is essential that we train a cadre of our colleagues to respond to the exigencies of the technology and support our therapeutic programs as the dimension of our care expands.

Many express their dismay at the further balkanization of internal medicine and, to a lesser extent, cardiology. They point to the fact that about 80% of patients with heart failure are cared for by general internists, family practitioners, and the occasional cardiologist. Indeed, most of these patients can be cared for by using accepted guidelines.

Nevertheless, therapy for heart failure has become more complex as new drugs and devices have become available to optimize treatment of this heterogeneous patient population. The heart failure specialist can help to individualize therapy in more complex patients.

It is clear that the prevalence of heart failure is increasing rapidly as our population ages. It is estimated that the number of heart failure patients will swell from 5.2 million in 2004 to more than 30 million in 2037. Many of these patients will be getting chronic cardiac support and terminal therapy from devices that we now use as a temporary bridge to transplant. Other devices are yet to be fully developed.

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It can be anticipated that just as we have thousands of patients who depend on renal dialysis for survival, we will have patients relying on implantable ventricular assist or replacement devices for permanent heart failure therapy. The availability of donor hearts will never equal the need for heart replacement, given the escalating incidence of heart failure in the future.

The training of heart failure specialists will not occur without some pain. It will require an additional year of cardiology training. Although a number of institutions are equipped to provide the necessary training, many training programs will not be able to provide the dimension of experience necessary to adequately train these new specialists. Their training will require the integration of their experience into a program that has easy access to electrophysiology and surgical specialties. It will unfortunately prolong cardiology training at a time when we are falling short in meeting the needs of our society for general cardiologists.

An additional aspect of the development of this subspecialty will bring recognition of heart failure as an important cost center in the referral network and lead to more institutional infrastructure support for heart failure therapy. The development of the advanced heart failure and transplant specialty will lead to an improvement in the care of our growing and aging patient population. ■

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Free Drug Samples Given to Patients With the Least Need

Poor and uninsured Americans are less likely than wealthy or insured Americans to receive free drug samples, according to a study by physicians from Cambridge Health Alliance and Harvard Medical School.

Using data from more than 32,000 United States residents surveyed in the Medical Expenditure Panel Survey, the researchers found that, in 2003, 12% of Americans received at least one free drug sample.

More people who were continuously insured received a free sample than people who were uninsured for all or part of the year, and the poorest third were less likely to receive free samples than were those with incomes at 400% of the federal poverty level or more (Am. J. Public Health 2008;98:284-9).

"We know that many doctors try to get free samples to needy patients," said study senior author Dr. David Himmelstein in a statement. "We found that such efforts do not counter society-wide factors that determine access to care and selectively direct free samples to the affluent. Our findings strongly suggest that free drug samples serve as a marketing tool, not as a safety net."

But Ken Johnson, senior vice president at the Pharmaceutical Research and Manufacturers of America, said in a statement that free samples help millions of Americans, regardless of income, and "offer an option for those who have difficulty affording their medicines."

—Jane Anderson

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