



CARDIAC CARE

FOR NURSES, NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS and PHYSICIAN ASSISTANTS

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Confronting Ethics on the Frontline

In a perfect world, there would be enough time to teach patients the best care practices and enough money to make that possible. But perfect does not describe real-life health care delivery for cardiovascular nurses, nurse practitioners and physician assistants.



"I'm an advocate for preventive care, and my biggest ethical issue is when patients don't receive adequate time for education on preventative care. But in our current health care environment, there's no reimbursable code for preventive care, even though we as providers are obligated to provide it," said Brenda Garrett, R.N., manager, Advanced Cardiovascular Disease Prevention Program Fuqua Heart Center, Piedmont Hospital, Atlanta.

One way patient education is addressed is through directed clinical pathways provided to patients, which ensures that patients are discharged with clinical directions for their care.

Under current care models, a nurse practitioner or physician assistant tends to spend more time with a patient than an average physician. Having longer time to spend with patients often makes them willing to share sensitive information they may not provide to a physician, said Eileen Handberg, A.R.N.P., Ph.D., assistant professor of medicine at the University of Florida, Gainesville.

"Sometimes patients are more intimidated by the physician than they are by other practitioners," said Handberg.

HIPAA

One common source of frustration is the slowdown of information transfer between providers and patients due to HIPAA. Although HIPAA's intent to protect a person's privacy is admirable, on a day-to-day basis, the law creates some angst.

"Patients can't just call up and get their records, they have to sign releases and send them to the office," said Handberg.

"But most patients don't have fax machines, so this requires mailing a release out, then waiting for it to be mailed back. I find, in practice, that most patients find HIPAA sort of aggravating on a practical level in terms of caring for health care issues, not in terms of protecting privacy," she said. It has also slowed down the transfer of information between physician practices, which can impact patient care.

Family Caregivers

Ethical issues arise when elderly patients are transferred from a nursing home or facility, and the patients don't have an immediate family member for the provider to contact.

"If the patient clinically needs an angiogram, but is unable to give consent, that can



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The Unhealthy Trinity: Diabetes, Obesity and CV Disease

Over the past year, several new studies exploring the links between cardiovascular disease and diabetes, have been published. When combined with obesity, this triple treat represents a risky combination for an aging population.

- New data suggest that patients with new-onset diabetes being treated for hypertension and those with a previous diagnosis of diabetes were three times more likely to have subsequent cardiovascular disease than treated hypertensive subjects who remained free of diabetes. (Verdecchia P, et al. *Hypertension* 2004 May; 43(5):963-9).

- The Irbesartan Diabetic Nephropathy Trial (IDNT) shows a relatively high incidence of clinically unrecognized Q-wave MI among patients with diabetes, hypertension, and nephropathy. (Aguilar, D, et al. *American Journal of Cardiology* 2004 Aug 1).

- Sirolimus-eluting stents can effectively reduce restenosis and late lumen loss in diabetic patients, including patients on insulin, according to results from the DIABETES trial. Aguilar D, et al. *Circulation* 2004 Sep 21; 110(12):1572-
- Two new studies suggest that glycosylated hemoglobin level, hemoglobin A1c (HbA1c), is an independent risk factor for cardiovascular disease, regardless of diabetes status. (*Annals of Internal Medicine* 2004 Sep 21).
- Results of the Collaborative Atorvastatin Diabetes Study (CARDS) shows that in patients with type 2 diabetes and relatively low LDL levels, treatment with atorvastatin (Lipitor[®], Pfizer) reduced the occurrence of first major cardiovascular events. (*Lancet* 2004 Aug 21)

November is National Diabetes Month. For more information, go to www.acc.org and click on Outreach Education. Then click on Make the Link!, ACC's joint education program with the American Diabetes Association. ■



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Cardiac Care

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Confronting Ethics on the Frontline (continued from cover)

cause a problem," said Russell Brandwein, a P.A. at New York Presbyterian, N.Y.

To resolve the problem, a hospital ethics committee guides providers to document on the patient's chart that, although the patient can't sign a consent, it's in the patient's best interest to undergo, say, a catheterization or other medically necessary procedure.

Situations Brandwein faces in his work with patients range from sad — having to explain to two teenage sons that their father in his late 50s has suddenly had a stroke — to stressful, having to call

security because a patient was fighting with her daughter and didn't want to see her.

"Thankfully, that's not the norm for my days," said Brandwein.

What is the norm for clinical care associates?

"As health care professionals, we're asked tough questions, and the goal for all of us is to maintain integrity through all that we do, and to put the patient's interest as the primary goal," summed up Garrett.

"Ultimately, the ethical issues that face us are no different than the ethical issues physicians face," said Garrett. ■

Question of the Month

“What ethical choices do you face most often in your practice?”



Cindy Adams

Producing Billable Encounters

The media focuses a great deal of its attention on the conflict of interest brought about by financial relationships between health care professionals and industry. But as a heart failure practitioner in private practice striving to deliver effective care to patients, I believe a more pressing and prevalent issue exists. Within the current health care reimbursement system, there is a major disincentive to provide desperately needed care and support to patients with chronic disease. Instead, the daily dilemma of trying to produce enough “billable” encounters to break even in the face of shrinking reimbursements and increased overhead costs takes precedence. Heart failure is a complex and severe condition requiring significant lifestyle change, as well as challenging self-monitoring and medication schedules. A systematic, multidisciplinary approach has long proved superior in comparison to the traditional model of care, yet no reimbursement exists outside the traditional office visit structure, which demands high volume and brief encounters for fiscal survival. This issue poses a major threat to our ability to deliver quality.

Cindy Adams, R.N., M.S.N., C.S., is a nurse practitioner in Indianapolis.



Ann Hiniker

Costs vs. Continued Care

As a clinical nurse specialist who deals with terminally ill individuals with heart failure, one of the biggest challenges I face is assisting patients in determining when it is no longer best for them to seek additional treatment for their terminal disease. There are many ethical considerations: Is it ethical to let patients and their families assume this disease is not terminal? Or not to review the

potential trajectory of their illness? Or to withhold palliative care and/or hospice care? In an era of increased cost-containment, we are challenged to provide optimal care and maintain cost-effectiveness, while balancing the desires of the patient or family to provide and/or facilitate interventions which often do not improve outcomes and quality of life. There comes a point when we must assist patients in a full understanding of their treatment options, particularly if they are not only interested in quantity but also quality of life.

Ann Hiniker, R.N., M.S., C.N.S., is a CV clinical nurse specialist in Minneapolis.



Melanie T. Gura

Suicide or Euthanasia or Neither?

More than one million Americans today are experiencing an enhanced quality of life as a result of implantation of an ICD or pacemaker therapy. However, there comes a time when quality of life begins to diminish, despite our best and most advanced medical efforts, and patients no longer feel the benefits of medical interventions. It is then that a clinician may receive a request for withdrawal of ICD or pacemaker support from a patient at the end of life. They must determine whether it is legal and ethical for patients to request treatment withdrawal and to refuse treatment. I am in agreement with ethical analyses that conclude that death after refusal of withdrawal of unwanted interventions is a result of the patient's underlying disease and not considered euthanasia or physician-assisted suicide. Of course, it is recommended that specific steps be implemented in response to requests for withdrawal of life-sustaining interventions, and these steps must always be carefully followed.

Melanie T. Gura, R.N., M.S.N., C.N.S., is director of Pacemaker & Arrhythmia Services, The Heart Group, Inc., Akron, Ohio. ■

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Important Dates

CCA Reception at the Annual Scientific Session

Plans are in the making for a reception for cardiac care associates during the upcoming Annual Scientific Session, March 6 – 9, 2005, in Orlando. Stay tuned for more information.



March 6–9 • Orlando

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To the Cardiac Care Team



Brenda Garrett

Dear Cardiac Care Colleagues:

“Home is where the heart is,” so goes the old adage. Home has traditionally been the place where the occupants speak the same language, continually build on their kinship and enjoy a general connectedness, even when far away. For cardiac care associates, who are finding a home as the newest membership category at the ACC, this heart-

home analogy becomes even more poignant.

As key members of an integrated approach to care, we are adept at understanding the language of “cardiospeak” and translating to patients what they need to know in order to promote prevention and optimize their care.

As those who serve on the frontlines daily, we know what it means to function as family, offering our expertise and skilled support to further the shared goal of quality patient care.

As committed partners within the cardiac care team, we have learned to feel connected even though we’ve not always been invited to the table.

Thankfully, the latter has changed. The ACC has thrown out the welcome mat and added a place setting for CCAs.

They formed a Network Liaison Committee to plan for immediate and future needs and to ensure that the educational needs and wants of the new membership category are met.

To further prioritize the team model and facilitate shared knowledge between team members, the ACC has made *Cardiac Care* (formerly *CCA Update*) the center spread of *Cardiology*. The theme for both publications will derive from an important article in the *Journal of the American College of Cardiology*. I hope you’ll enjoy this month’s ethics theme, which is based on the release of the *ACC/AHA Consensus Document on Ethics*.

So, let me be the first to welcome you to the first print edition of *Cardiac Care*. We hope you’ll enjoy it and take part in the dialogue in these pages, including the question of the month and letters to the editor (cardiologyeditor@acc.org). Of course, if you have suggestions, stories or ideas, feel free to let us know.

Happy reading,

Brenda Garrett, R.N.
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