

Chest Pain Units: is it Urgent its Implementation?

To the Editor:

I read with the interest the editorial by E. Alegría and J. Bayón in the REVISTA ESPAÑOLA DE CARDIOLOGÍA¹ in which they drew attention to the urgency of the implementation of chest pain units in Spanish hospitals, and I believe that some thoughts on the subject may be in order, before accepting a proposal that comes, once again, from a country that is socioeconomically very different from ours and with a health care organization that has little in common with ours.

In the Getafe University Hospital the coronary care unit is integrated into the cardiology service and a cardiologist on

call, supported by a cardiology resident, is in the emergency room 24 hours a day. The service established its priorities so that if there is a reasonable diagnostic doubt, the patient can be admitted and a stress test can be performed within a maximum of 24 to 36 hours, following analysis of serum markers and monitoring if necessary. The transfer of a patient from the emergency room to the coronary care unit and from the latter to a general hospital floor does not require consultation or special transport. In this environment it is possible to establish a diagnosis and prognosis and plot a therapeutic program within a period of 24 to 48 hours. Is a chest pain unit necessary? And this hospital is not unique.

We are all thinking about the organization of many of our hospitals. The emergency room physician is disconnected from the cardiology service and is frequently not a cardiologist but an internist or an intensivist who attends the external emergency room. The transfer of a patient from the coronary care unit is difficult at times when the entire hospital is overloaded and this unit is dependent on a service other than the cardiology service. The performance of tests within the cardiology service is frequently isolated and departmentalized, so that the waiting period for a stress test or an echocardiogram depends on another «group» of cardiologists within the service and sometimes on a different service entirely, who may be occupied with their own their duties and work demands and have little to do with the other groups in the same service. Perhaps here indeed improvement could be made in the attention given to the coronary patient in a specific chest pain unit.

But once again we think of our healthcare history which, due to its recent development, contains lessons of interest. We have seen hospitals with organizational charts in which the hemodynamic laboratory, the coronary care unit, and even the testing groups are all separate services. At one time we looked for efficiency by separating large cardiology services into functional units of this or that type. The inefficacy of this line of thinking seems to have been accepted in light of the current tendency to group not only all the cardiologic medical services, including the coronary care unit, but also the surgical units, into the cardiology service. And now we inaugurate a new chest pain unit, with specific ends, which without a doubt will create a group of professionals functioning autonomously. Alegría and Bayón point certainly out that only the enthusiasm of the professionals is behind the development of these units, and we should not forget that we are living out the ideas of other professionals, who are already mature, who initiated other changes, only to find themselves with the passing years frustrated by their isolation and the absence of growth perspectives.

I think that before declaring the creation of chest pain units in our hospitals indispensable, we should reflect on the organization of our cardiology services, analyze them and bravely recognize their defects, where there are defects, and restructure our priorities, centering our attention more on the clinical problems and less on the number of interventions performed or the development of sophisticated technology for its own sake. It would also not be a bad idea to study the

hospital models in our country, where what some call a general problem does not seem to exist, in order to look for alternative solution that do not require new organizational complexities. The proper organization of work is a problem of the coordination of cardiologists and nursing staff in the face of real problems, and this is not solved well by the construction of new structures on bad foundations.

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Response

To the Editor:

The contribution (we take as such his letter of reply that refers to our editorial article on Chest Pain Units [CPU] published in this journal¹) by Jiménez Murillo et al, representing the Sociedad Española de Medicina de Urgencias y Emergencias (SEMES) (Spanish Society of Urgent and Emergency Medicine), is welcome and appreciated. It was a pleasure to accept, at the time, the task from the Ischemic Cardiopathy Section of the Spanish Cardiology Society (SCS) of coordinating the consensus document regarding CPUs,² and to provide our comments in said editorial on the first favorable clinical results obtained in Spain with the use of the recommended methodology, as shown in the excellent article by Pastor et al,³ and with appreciation for the contribution of the SEMES. The principal aim of the previously mentioned directories² (in the elaboration of which, of course, emergency medicine experts participated as well as cardiologists) was precisely what Jiménez et al mention in their letter: to make better use of resources, increase coordination of the personnel and units actually involved in the care of patients who present in an urgent clinical state (not emergency patients, please) and, thus, to increase to the maximum the quality of such care. It is precisely this enthusiasm for the integration of services that governed the SCS group who designed the above-mentioned document to not go provide excessive detail regarding the requirements, procedures, or responsibilities of CPUs, with the purpose of allowing each to be organized locally in response to the their particular version of the wide variety of situations that occur in our country. There is no doubt that the organizations Jiménez et al mention fit perfectly into the proposed structure: an excellent example of this is the Hospital de Valme group.³ The road, then, to rectify the deficiencies and difficulties that Jiménez et al correctly refer to in their letter is, precisely, the functional integration that we defend and cele-

brate. We are working together (virtually or physically), then, toward the same end, without in the same direction, without disparate demands or sterile posturing.

The substantial, courageous, and relevant contribution of García Cosío is no less welcome, and is replete with his known scientific rigor, intellectual depth, and enthusiasm for collaboration with the SCS. Actually, when reviewing his account of how cases of chest pain are treated on the cardiology service of Getafe University Hospital, it appears to be a description, more or less, of a virtual chest pain unit exactly as defended (or as at least we attempted to defend) in the editorial on which he comments.¹

Once again, the purpose of the work document concerning CPUs² was to create a framework for action that embraces the infinite number of particularities of our country, without hiding the defects but also without refusing to improve them where we can, without having to base them on the experiences of countries with very different situations. In the title of our editorial «Total Development is Urgent» (although because of an, in our judgment, inadequate stylistic correction on the part of the journal, the effect that the use of capital letters was intended to achieve was lost—as was its free translation into English—: mimicking the abbreviations CPU/CPU) we justly use the term «development,» which is farther-reaching than «creation,» to attempt to communicate the idea of autonomous function. The rapid appearance of results from 2 different groups^{3,4} is but a demonstration of the possibilities of focusing on the issue in this way.

We understand the comments of García Cosío to show that on his service they have considered various ways to efficiently care for patients with acute chest pain and have chosen those that are most in accordance with the resources available to them. This consideration is, surely, the principal consideration with regard to the success of CPUs, regardless of whether in the end they are organized physically or virtually, whether they are multi or single disciplinary, large or small, located in the emergency service or the cardiology service, or are called CPUs, another name, or no name at all.

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