

Kent Academic Repository

Full text document (pdf)

Citation for published version

MacInnes, Julie (2015) Heart failure: What's in a name? *British Journal of Cardiac Nursing*, 10 (9). p. 422. ISSN 1749-6403.

DOI

<https://doi.org/10.12968/bjca.2015.10.9.422>

Link to record in KAR

<http://kar.kent.ac.uk/62950/>

Document Version

Author's Accepted Manuscript

Copyright & reuse

Content in the Kent Academic Repository is made available for research purposes. Unless otherwise stated all content is protected by copyright and in the absence of an open licence (eg Creative Commons), permissions for further reuse of content should be sought from the publisher, author or other copyright holder.

Versions of research

The version in the Kent Academic Repository may differ from the final published version.

Users are advised to check <http://kar.kent.ac.uk> for the status of the paper. **Users should always cite the published version of record.**

Enquiries

For any further enquiries regarding the licence status of this document, please contact:

researchsupport@kent.ac.uk

If you believe this document infringes copyright then please contact the KAR admin team with the take-down information provided at <http://kar.kent.ac.uk/contact.html>

Heart failure: what's in a name?

Julie MacInnes, Principal Lecturer, Cardiac Care, Canterbury Christ Church University, Kent. Email: julie.macinnnes@canterbury.ac.uk

If like me, you shout at the television during hospital dramas when they tell you a 'patient' has had a heart attack when, in fact, they have suffered a cardiopulmonary arrest, you might want to reflect on this—what's in a name? Heart failure/HF, cardiac failure/CF, congestive cardiac failure/CCF, acute heart failure/AHF, chronic heart failure/CHF, left ventricular failure/LVF, left ventricular systolic dysfunction/LVSD, heart failure with reduced ejection fraction/HF-REF, heart failure with preserved ejection fraction/HF-PEF, diastolic failure, cardiomyopathy (of which there are four main types according to the American Heart Association – dilated, hypertrophic, restrictive and arrhythmogenic right ventricular dysplasia)...you get the idea. The International Classification of Diseases, 10th volume (ICD-10), published by the World Health Organization (2010), describes heart failure as congestive, left ventricular or unspecified cardiac, heart or myocardial failure. The term heart failure, therefore, covers a bewildering array of illnesses for many professionals, patients and their families. Some of these terms are not mutually exclusive, so patients with heart failure can be presented with a number of illness diagnoses and acronyms at various points in their illness trajectory or even simultaneously. This can be aptly illustrated by a quote from a patient, newly diagnosed with 'heart failure':

'It was "left ventricular systolic dysfunction', then I got a letter saying "dilated cardiomyopathy, ischaemic heart disease" and I thought, "that's a bit different from what I've heard", so I'm confused really!' (MacInnes, 2014).

In addition, many patients with heart failure have associated cardiac conditions, commonly coronary heart disease/CHD (or should it be ischaemic heart disease/

IHD, or even coronary artery disease/ CAD?) with resulting myocardial infarction (STEMI or NSTEMI or acute coronary syndrome/ACS?). Many will also have atrial fibrillation/AF or other arrhythmias (let's not even get started on those!). As a result, patients' heart problems can be a complicated mixture of cause and effect related to different cardiac pathologies. So, why does this matter? Professionally, we all need to be applying labels accurately and consistently so that we can communicate effectively with each other and be clear about treatment goals and planned patient care. However, at least as importantly, we need to be giving consistent messages to patients. This has a professional and ethical dimension as the Nursing and Midwifery Council (NMC) (2015) Code tells us we should 'communicate effectively' by using 'terms that people in your care....can understand' (7.1) and 'check people's understanding...to keep misunderstandings to a minimum' (7.4). Getting the labels right may also affect clinical outcomes. The 'common sense model' of illness cognitions and behaviour (Leventhal et al, 1980) proposes that beliefs about the identity of the illness, the label or diagnosis influence coping responses (behaviours). In addition, illness coherence or the degree to which the illness 'makes sense' also influences behaviour. A metaanalysis by Hagger and Orbell (2003) has demonstrated good support for this theory across a number of acute and long-term conditions. In the context of heart failure, this means that a clear understanding of what heart failure is, and its associated symptoms and treatment, may positively influence the adoption of health-promoting behaviours such as adherence to medication, regular weighing, reduced salt intake and the selection of other self-care behaviours with potentially improved outcomes for patients (MacInnes, 2013). Interestingly, the choice of the term 'heart failure' may also have a negative, emotional impact on patients. A study by

Taylor and Ogden (2005) found that patients whose GPs used the term 'heart failure' rather than a euphemism such as 'fluid on the lungs as your heart is not pumping hard enough', reported higher levels of anxiety and depression and a belief that the illness had more serious consequences. There needs to be clear, consistent and accurate use of terms across all professional groups—this might be achieved by keeping up to date with changing terminology through continuing professional development (CPD) updates and familiarisation with guidelines from organisations such as the National Institute for Health and Care Excellence (NICE), conference proceedings and professional journals, for example. We need to take care to use terms accurately in our discussions with patients, avoiding any jargon and acronyms. We need to take the time to clearly explain what is being discussed, seeking confirmation of understanding and correcting any misconceptions. However, we also need to be mindful of the effect such terminology may have on our patients.

References:

- Hagger MS, Orbell S (2003) A meta-analytic review of the common-sense model of illness representations. *Psychology & Health* 18(2): 141–84. doi: 10.1080/088704403100081321
- Leventhal H, Meyer D, Nerenz DR (1980) The Common Sense Representation of Illness Danger. In Rachman S, ed. *Medical Psychology*. Pergamon Press, New York
- MacInnes JD (2013) Relationships between illness representations, treatment beliefs and the performance of self-care in heart failure: a cross-sectional survey. *European Journal of Cardiovascular Nursing* 12(6): 536–43. doi: 10.1111/jocn.12307
- MacInnes JD (2014) An exploration of illness representations and treatment beliefs in heart failure. *J Clin Nurs* 23(9–10): 1249–56. doi: 10.1111/jocn.12307. Epub 2013
- Nursing and Midwifery Council (2015) *The Code. Professional standards of practice and behaviour for nurses and midwives*. NMC, London
- Taylor M, Ogden (2005) Doctors' use of euphemisms and their impact on patients' beliefs about health: an experimental study of heart failure. *Patient Educ Couns* 57(3): 321–6.
- World Health Organization (2010) *International Classification of Diseases and Related Health Problems. 10th Revision*. WHO, Geneva