

use of long-acting β_2 -agonists was highlighted by Bisgaard¹¹ in the *Lancet*, who argues strongly that the treatment for children with asthma needs to be based on trial data in children (rather than extrapolation from results in adults), and suggests that the licensing authorities should demand more studies in children. He also points out that the *BNF for Children* stresses the importance of discontinuing long-acting β_2 -agonists in children if there is no response.

Dangers could arise if patients with asthma find that their usual symptoms of deterioration are masked by inhaled β_2 -agonists, and they consequently delay obtaining a rescue course of oral steroids for an exacerbation. Doubling inhaled corticosteroids has produced disappointing results in trials,¹² so it is important to ensure that patients on long-acting β_2 -agonists understand that serious asthma attacks should not be ignored, and early use of a short course of oral steroids remains the most likely way to avoid deterioration leading to a hospital admission.¹³

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REFERENCES

- Anderson HR. Prevalence of asthma. *BMJ* 2005; **330**(7499): 1037–1038.
- De Vries MP, van den Bemt L, Aretz K, et al. House dust mite allergen avoidance and self-management in allergic asthma patients: randomised controlled trial. *Br J Gen Pract* 2007; **57**(536): 184–190.
- Gotzsche PC, Johansen HK, Schmidt LM, Burr ML. House dust mite control measures for asthma. *Cochrane Database Syst Rev* 2004; **4**: CD001187.
- McCowan C, Hoskins G, Neville R. Clinical symptoms and off-label prescribing in children with asthma. *Br J Gen Pract* 2007; **57**(536): 220–222.
- Committee on Safety of Medicines, Medicines Control Agency. Inhaled corticosteroids and adrenal suppression in children. *Current Problems in Pharmacovigilance* 2002; **28**: 7.
- Gibson PG, Powell H, Ducharme F. Long-acting beta2-agonists as an inhaled corticosteroid-sparing agent for chronic asthma in adults and children. *Cochrane Database Syst Rev* 2005; **4**: CD005076.
- Ni Chroinin M, Greenstone IR, Danish A, et al. Long-acting beta2-agonists versus placebo in addition to inhaled corticosteroids in children and adults with chronic asthma. *Cochrane Database Syst Rev* 2005; **4**: CD005535.
- Nelson HS, Weiss ST, Bleeker ER, et al, the SMART Study Group. The Salmeterol Multicenter Asthma Research Trial: a comparison of usual pharmacotherapy for asthma or usual pharmacotherapy plus salmeterol.
- Chest* 2006; **129**(1): 15–26.
- Walters EH, Gibson PG, Lasserson TJ, Walters JAE. Long-acting beta2-agonists for chronic asthma in adults and children where background therapy contains varied or no inhaled corticosteroid. *Cochrane Database Syst Rev* 2007; **1**: CD001385.
- Castle W, Fuller R, Hall J, Palmer J. Serevent Nationwide Surveillance study: comparison of salmeterol with salbutamol in asthmatic patients who require regular bronchodilator treatment. *BMJ* 1993; **306**(6884): 1034–1037.
- Bisgaard H, Szefler S. Long-acting beta-2 agonists and paediatric asthma. *Lancet* 2006; **367**(9507): 286–288.
- Harrison T, Oborne J, Newton S, Tattersfield A. Doubling the dose of inhaled corticosteroid to prevent asthma exacerbations: randomised controlled trial. *Lancet* 2004; **363**(9405): 271–275.
- Rowe BH, Spooner C, Ducharme FM, et al. Early emergency department treatment of acute asthma with systemic corticosteroids. *Cochrane Database Syst Rev* 2001; **1**: CD002178.

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Healthcare providers need to improve communication with patients who have heart failure

A diagnosis of heart failure carries a poor prognosis. Approximately one-third of patients diagnosed with the condition will be dead after 12 months^{1,2} and 5-year survival rates following a first hospital admission for heart failure have been estimated at 25%.³ However, a number of recent qualitative studies have found that a substantial proportion of patients with a diagnosis of heart failure do not understand the nature and seriousness of their condition, in part due to a lack of information supplied by healthcare providers and use of the poorly understood term 'heart failure'.^{4–6}

In a community-based study in Scotland, Murray *et al*⁵ compared the

experiences of 20 patients with inoperable lung cancer and 20 patients with advanced heart failure, along with those of their main informal and professional carers. In contrast with cancer patients, it was reported that patients with heart failure rarely recalled being given any written information and had a poor understanding of their condition and its symptoms. Prognosis was hardly ever discussed and there was little acknowledgment that end-stage cardiac failure is a terminal illness. In addition, patients and carers reported that they did not feel involved in decision making or encouraged to work in partnership with professionals.

It has been reported that patients with heart failure believed that doctors would not want to talk about the patient's likely death or give them too much information about their illness and treatment,⁶ and that patients believed some healthcare providers were unwilling or unable to give them the information and guidance they required.⁴ In addition, a study based in a Barcelona hospital suggested that doctors caring for patients with heart failure rarely discussed end-of-life issues.⁷

There is evidence that many patients with heart failure do want more information. In a UK-based qualitative study of 27 patients with heart failure in secondary care, Rogers *et al*⁸ found that

patients with heart failure would welcome timely and frank discussions about their prognosis and have questions about their condition that they feel unable to ask their doctors. These findings are consistent with a study of 62 primary care patients with heart failure in New Zealand, which found that 20% of patients wanted improved information and that 60% lacked a basic understanding of their condition.⁴

In the first of these studies, confusion about the nature of heart failure and prognosis was encapsulated by one patient as follows:

*'I mean if your heart is damaged, its not working as well as it should be working. But if your heart's damaged, does it deteriorate more over the years or does it remain at that level? Do you know what I mean? Is it terminal?'*⁶

Another patient described a feeling of being kept in the dark by their doctors:

*'I think they like to keep things away from the patient. Like if I were to say to them, "will I see the millennium in?" they won't answer that sort of question.'*⁶

Current guidance produced by the European Society of Cardiology on the management of heart failure indicates that patients and their close relatives should be given general advice about the condition, including an explanation of what heart failure is, why the symptoms occur, what causes it and the prognosis, as well as counselling about the effects of medication and advice on health behaviour.⁸

A number of reasons have been put forward to explain why this guidance may not always be implemented in practice. Informing patients about their diagnosis and the likely progression of their illness, as well as providing general information about heart failure, is complicated by the complex and loosely defined nature of the disease, which can encompass conditions ranging from asymptomatic cardiac dysfunction to end-stage heart failure.⁹ There are also difficulties associated with reliably diagnosing heart failure in primary care,^{10,11}

a lack of good prognostic indicators⁸ and problems in accurately identifying the terminal phase of the condition.¹²

With regards to diagnostic uncertainty, echocardiography is required to make a definitive diagnosis of heart failure⁸ and a lack of access to echocardiographic services has been identified as a barrier to the effective management of heart failure in general practice.¹¹ However, rapid access echocardiography services are now becoming more widely available.

Healthcare professionals have expressed reservations about using the term 'heart failure', which is considered too emotive.^{4,6,9} A study based in a UK general practice suggests that this belief is well founded. Tayler and Ogden¹³ reported that patients whose doctors used the term 'heart failure' in discussing their diagnosis, rather than a euphemism, believed that the illness would have more serious consequences, a longer duration and be more variable. These patients were also more likely to report feeling anxious and depressed. Doctors in the study were therefore presented with a dilemma as to whether they should seek to protect their patients by using euphemisms or ensure openness by employing the more direct term 'heart failure'.

Patient factors are also important. A lack of understanding may be partially explained by evidence that patients with chronic heart failure have difficulty retaining and appreciating the relevance of information provided to them and report confusion and short-term memory loss as 'symptoms or side-effects' of their illness.¹⁴ It has also been reported that patients with heart failure are sometimes unwilling to openly acknowledge their diagnosis and its implications.⁶

Ensuring effective communication with patients who have heart failure is a major challenge and the lack of openness that some patients perceive may be related to the difficulties faced by doctors in sharing information about prognosis and the nature and course of the condition that may be vague or misleading. Nevertheless, the literature suggests that there could be room for improvement in discussing prognosis, educating patients with heart failure about their condition and addressing end-of-life issues.⁴⁻⁷

Good communication is implicit in the model of chronic disease management increasingly being applied to the management of cardiorespiratory conditions in primary care, which aims to educate patients about their condition, including how and when to seek help.¹⁵ In general, there is evidence that open communication increases patient compliance, reduces morbidity and improves patient outcome, while a lack of openness can impair trust between patient and doctor and hence reduce quality of care.¹⁶

Openness and patient education are essential in ensuring that patients can make informed decisions. This is only possible when patients possess some knowledge about their condition and its likely progression, enabling them to weigh the benefits of available treatment options with the potential risks. Discussion of prognosis is important in allowing patients and their families to plan for the future, which, in advanced heart failure, may include end-of-life care planning.

Patient demand, management guidelines, ethical considerations, and current models of chronic disease management all suggest that healthcare professionals need to improve communication with patients who have a diagnosis of heart failure. The availability of new tools to diagnose and predict accurately the progression of heart failure will assist clinicians to this end, as could replacing the emotive and misleading expression 'heart failure' with a more appropriate term. Meeting the challenge of discussing heart failure with patients is vital to improving management of this distressing and increasingly prevalent condition.

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REFERENCES

- Giuli F, Khaw K, Cowie MR, et al. Incidence and outcome of persons with a clinical diagnosis of heart failure in a general practice population of 696,884 in the United Kingdom. *Eur J Heart Fail* 2005; 7(3): 295-302.
- Cowie MR, Wood DA, Coats AJS, et al. Survival of patients with a new diagnosis of heart failure: a population based study. *Heart* 2000; 83(5): 505-510.
- Stewart S, MacIntyre K, Hole DJ, et al. More 'malignant' than cancer? Five year survival following a first admission for heart failure. *Eur J Heart Fail* 2001; 3(3): 315-322.
- Buetow SA, Coster GD. Do general practice patients with heart failure understand its nature and seriousness,

- and want improved information? *Patient Educ Couns* 2001; **45**(3): 181–185.
5. Murray SA, Boyd K, Kendall M, et al. Dying of lung cancer or cardiac failure: prospective qualitative interview study of patients and their carers in the community. *BMJ* 2002; **325**(7370): 929.
 6. Rogers AE, Addington-Hall JM, Abery AJ, et al. Knowledge and communication difficulties for patients with chronic heart failure: qualitative study. *BMJ* 2000; **321**(7261): 605–607.
 7. Formiga F, Chivite D, Ortega C, et al. End of life preferences in elderly patients admitted with heart failure. *QJM* 2004; **97**(12): 803–808.
 8. Taskforce for the Diagnosis and Treatment of Chronic Heart Failure, European Society of Cardiology. Guidelines for the diagnosis and treatment of chronic heart failure. *Eur Heart J* 2001; **22**: 1527–1560.
 9. Lehman R, Doust J. Cardiac impairment or heart failure? ‘Heart failure’ confuses doctors and patients and needs renaming. *BMJ* 2005; **331**(7514): 415–416.
 10. Skaner Y, Backlund L, Montgomery H, et al. General practitioners’ reasoning when considering the diagnosis of heart failure: a think-aloud study. *BMC Fam Pract* 2005; **6**(1): 4.
 11. Hickling JA, Nazareth I, Rogers S. The barriers to effective management of heart failure in general practice. *Br J Gen Pract* 2001; **51**(469): 615–618.
 12. McKinley RK, Stokes T, Exley C, Field D. Care of people dying with malignant and cardiorespiratory disease in general practice. *Br J Gen Pract* 2004; **54**(509): 909–913.
 13. Taylor M, Ogden J. Doctors’ use of euphemisms and their impact on patient’s beliefs about health: an experimental study of heart failure. *Patient Educ Couns* 2005; **57**(3): 321–326.
 14. Wehby D, Brenner PS. Perceived learning needs of patients with heart failure. *Heart Lung* 1999; **28**(1): 31–40.
 15. Lehman R. How long can I go on like this? Dying from cardiorespiratory disease. *Br J Gen Pract* 2004; **54**(509): 892–893.
 16. Hebert PC, Hoffmaster B, Glass KC, Singer PA. Bioethics for clinicians: 7. Truth telling. *CMAJ* 1997; **156**(2): 225–228.

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Moving on from Balint: embracing clinical supervision

Apart from general practice, most of the helping professions now have an established culture of clinical supervision.¹ Some professions, like counselling, consider supervision to be essential for sustaining reflective practice, and they have made it a requirement for continuing accreditation. Other professions, such as nursing, seem to be moving in that direction.² Although it is sometimes seen as part of management, clinical supervision is properly regarded as something non-hierarchical, non-judgmental, and focused on the practitioner rather than the organisation.³ It addresses the need for support and development, and it is also anchored in an awareness of performance standards, patient safety, and public accountability.⁴

Supervision can be used to address the emotional impact of patient encounters, and to examine the technical aspects of case management, and issues within the team and workplace.⁵ There are many approaches to supervision, including one-to-one sessions or group meetings. These activities all share the same purposes. Morton-Cooper and Palmer⁶ define these as:

- clarifying human values;
- acquiring emotional literacy;
- recovering meaning in social relationships;
- providing skill rehearsal and role models;

- evaluating and disseminating best practice in health care; and
- protecting against disorientation, disillusionment, and burnout.

Supervision, like any activity, can be done inexpertly or lead to collusion.^{7,8} However, there is evidence that good supervision contributes to general wellbeing, knowledge, confidence, morale, understanding, self-awareness, job satisfaction, and endurance.^{9–12}

Many people are surprised to find that most GPs do not receive clinical supervision. GPs do discuss cases, although most commonly in the corridor, over coffee, or in phone calls to local specialists. Other activities such as primary care team meetings, and even appraisals, can provide occasions for in-depth discussion of specific cases. A small minority of GPs make arrangements for mentoring, coaching, or even personal counselling or therapy. These approaches may provide effective forms of supervision. However, it is still possible to go through a whole career in general practice without any sustained, regular, and meaningful exchanges with colleagues about the day-to-day challenges of seeing patients. This seems an anomaly, given the technical and psychological complexity of our work.

There are many reasons for the divergence between GPs and other professions in terms of supervision. The culture of self-sufficiency in medicine may deter doctors from acknowledging a routine need for help. GPs in particular have traditionally worked as autonomous practitioners rather than as team members. Heavy workload can limit opportunities for supervision which may appear as yet another demand. Most doctors probably still understand supervision to mean surveillance or management, rather than peer support, and this may contribute to their avoidance of it.

As we move towards multidisciplinary work, more public accountability, and systems of re-accreditation, it seems reasonable to expect GPs to develop their opportunities for case-based discussions. Sooner or later, we will need to give a formal account of how often we check our day-to-day case management, how we do it, and with whom. Whether we decide to call this activity ‘clinical supervision’ probably matters less than whether we take ownership of it. This process should be led by professional needs rather than managerial ones.

One possible form of supervision for GPs can be found in the context of Balint groups. Pioneered at the Tavistock Clinic 50 years ago, these groups have been the