Editorial

Should physicians’ consider patient perception for modulating treatment?

An optimal way to target treatment

In the first instance, who is treated seems an absurd question, and most physicians would reply, the patient of course! However, in the second instance, taking into account the numerous publications that cover patient management in RA, the reader may perceive a different impression, as a treat-to-target approach, based on mean values of cohort studies, is widely promoted and in the position to become a theorem [1]. This strategy was originally adopted from the treatment of hypertension and diabetes; however, these diseases do not provide patients with an immediate alert response, such as pain, and the targets—for example, in diabetes—had to be adapted dramatically over time. Treat to target in rheumatic diseases utilises composite disease activity indexes, for example, the 28-joint DAS (DAS28) [2], awarding the resulting number with a status next to the golden cow. However, the DAS28 psychometric foundation is deliberately disregarded [3, 4].

In the paper published by Hendrikx et al. [5] in this issue, patients’ perspective of disease state and burden are increasingly being accepted as important aspects of treatment considerations. Most of the indexes used do not give a prominent status to patients’ wishes, beliefs, fears, coping mechanisms or morbid gains. Moreover, replacing the patient’s assessment with the physician’s assessment was proposed in order to achieve better numbers, which means higher remission rates [6]. However, what is remission good for if the patient does not feel confident, for example, incapable of leaving the physician’s office on her/his own feet? Those patients whose complaints and impairments are neglected by joint counting models, invented for the sake of practicality, in all likelihood would welcome a change in their therapeutic regimen that is not suggested by the number calculated. Having all those arguments in mind, would an approach utilising goal attainment scales not better meet the needs of daily patient management [8]?

Hendrikx et al. [5] address some of these issues from the patient’s perspective. The better physicians understand and subsequently accept a patient’s position about benchmarks and thresholds for decisions about the disease, the more likely the basis for an optimal treatment outcome. In fact, the patient should not just accept the physician’s interpretation of what they, namely the aggrieved party, hope to achieve by the end of the treatment.

Recently a group of Austrian rheumatologists showed that the duration of RA relevant to the patient is not just a simple time frame between two observation points, but fluctuates significantly in 80% of the surveyed patients over 2 months, resulting in the uncertainty of patients’ daily capabilities and understandably compromising their quality of life [7].

But do physicians know or care enough about patients’ attitudes to modulate their treatment? Hendrikx et al. [5] focused on the issues of whether patient perceptions of disease affect treatment intensification in daily routine and whether patients’ perception of disease severity are mediated through individual willingness to alter therapy. Anyone who has been a patient or been on the other side of the desk will not be surprised to learn that a patient’s satisfaction with their RA status is significantly linked to self-reported willingness to alter therapy [5]. This is true for everyday practice too: willingness to alter therapy and therapeutic changes are highly linked. Clinicians are well aware that therapeutic modifications are rarely crowned with success if the patient does not feel confident about them. And such a conviction is not necessarily dependent on changes of measures of disease activity, but highly likely on pain or anxiety.

The only way to capture this type of information is to enable a consensus about the adaptation of therapeutic strategies, which consists of asking and listening to the patient. Therefore, patient-centred disease activity instruments, such as the Routine Assessment of Patient Index Data 3 and the Rheumatoid Arthritis Disease Activity Index–Five, have been shown to provide reliable information about disease activity, functionality and other important aspects of daily life [9, 10]. The individual perception of disease is highly likely to be influenced by socio-economic circumstances, experiences and ageing, among others, and may change over time as the patient’s attitude towards therapeutic changes may vary. To repetitively question the individual’s wishes, beliefs, fears and other factors influencing their personal attitude towards chronic disease will make a contribution towards approaching the true target, which is the best possible individual outcome; this could then be documented by a goal attainment scale [8], because documentation of disease activity as well as of the therapeutic response is a must.

Some recommendations give the impression that others know more about an individual’s situation with a disease than the patient. The patient may feel patronized by these recommendations, and one wonders whether those same
authors would accept this situation themselves were they to become patients. In the author’s opinion, it is certainly less important that the physician is satisfied with the disease outcome than the patient who has to live with the consequences of the disease every day and in many cases for decades. Thus patients and physicians should assess the disease course together.

A true consensus between patient and physician requires acceptance of the patient’s reported measures and incorporating them into therapeutic decisions [5]. For most disorders, including rheumatic diseases, discrete and unbiased parameters to monitor disease activity are not available. The combination of patient-reported and physician-dependent measures as well as laboratory parameters may make it possible to make the best of a bad situation [5], and goal attainment scales may add other options [8]. The therapeutic options for patients with RA or other arthritides have improved a great deal, and disease monitoring and treatment should be performed in an optimally targeted way in an individualized approach.

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References


8 Pincus T, Bergman MJ, Yazici Y et al. An index of only patient-reported outcome measures, routine assessment of patient index data 3 (RAPID3), in two abatacept clinical trials: similar results to disease activity score (DAS28) and other RAPID indices that include physician-reported measures. Rheumatology 2008;47:345–9.