Interpreting differences over time in patient self-evaluation

The survey of patients with hip and knee osteoarthritis reported by Peters et al showed improvement or no change in a substantial proportion of patients followed up by telephone after 7 years. Consequently, the authors conclude that osteoarthritis does not invariably deteriorate, but such conclusions bear closer investigation. Outcome assessment involved score criteria including assessment of pain and functional activities. How though might an individual's appraisal of pain or disability reflect either 'true' change (physical improvement) or consideration of other factors?

Longitudinal assessment requires stability of the construct being assessed. It is possible though that responder conceptualisation of what is being assessed alters through a natural process of accommodation and coping with chronic illness. Self-evaluation of pain to which a patient has accommodated may indicate stability or even improvement, which a patient has accommodated may reflect either 'true' change (physical improvement) or consideration of other factors?

The point here is one of interpretability: what does an outcome measure tell us about the patient’s experience and how can it inform us about how experience changes over time? Methods to explore such change processes, including individualised approaches, are emerging such change processes, including individualised approaches, are emerging to sit alongside conventional assessment. We heartily endorse the authors’ recommendation for further research on measuring change and especially that patient assessment should be in a broad biopsychosocial model that attempts to understand the individual's unique perspective.

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REFERENCES

Unfair treatment

The recent article¹ on patients dying of chronic cardiorespiratory disease demonstrates an important defect in our provision of services. The associated leading article² stated that symptom patterns for patients with cancer or cardiorespiratory disease are similar, including depression, cachexia, fatigue and generalised pain, in addition to the severe breathlessness that characterises advanced heart and lung disease. In fact, quality of life, psychological morbidity and debility often appear to be worse in patients with non-malignant disease. For instance, in a comparison of patients dying of lung cancer and of COPD, 90% of the patients with COPD and 52% of the patients with cancer had clinically important anxiety or depression.³ Despite this, McKinley found that the inverse care law applied: 45% of patients with cancer and 12% of patients with non-malignant disease received antidepressants.¹ Opioids provide effective relief from dyspnoea, with relatively few adverse effects:⁴ opioids were given to 57% of patients with cancer or 12% of patients with non-malignant disease.¹

To improve the lot of patients dying from cardiorespiratory disease, the first step is for established treatments to be provided by existing services. In addition, there is a need for continuity of care and expertise, best provided by nurse outreach teams, to promote good palliative care. Palliative care should start early in COPD — smoking cessation, education and self-management affect quality of life and outcomes.² Pulmonary and cardiac rehabilitation are not routinely available despite strong evidence of benefit.³ Only