

A Plea for Patient Centered Treatment-Isn't Individualized Therapy the Highest Precept?

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COMMENTARY

The actual European League Against Rheumatism (EULAR) and American College of Rheumatology (ACR) recommendations for management of rheumatoid arthritis (RA) very much focus on early treatment and the application of the treat-to-target (T2T) principle. In fact, T2T can be regarded a common place as to set and pursue goals since ever is of course essential in any aspect of curative medicine; nobody expects physicians to behave like blind persons in a dark forest. If T2T, although, is understood in the way that the treatment goal to achieve is a certain number on a scale, as it may be required by some originators, you may better forget about, as your patients will only have little understanding for this approach. Apparently the more the physicians lack clinical expertise they think to be in the need of such cloistered proposals. Thus, in clinical routine the compliance with these recommendations appears to be rather poor, it remains an apparently theoretic framework, which meaningful application particularly depends upon the physician's personal expertise.

Of course, the ultimate goal of any therapeutic initiative should be healing, if possible, or remission, which, in case of inflammatory rheumatic diseases, is defined as the absence of signs and symptoms of a significant inflammatory disease activity [1-8]. The T2T recommendations very much focus on reduction of measurable inflammatory activity, prevention of destruction and reduction of mortality. Unquestionably each of these points appears to be outstandingly important. This way of looking at things, though, must be regarded a very much physician created one as patients apparently have particularly different ideas about a situation which comes near health. In fact, patients rate pain reduction, improvement of functionality, health related quality of life, as well as independence similarly vital as inflammatory activity expressed by CRP and/or the joint counts, if not of higher importance [9-11]. By the way, what patients with rheumatic diseases consider necessary to feel in good health has never been interrogated, why?

These different expectations and wishes lead to a significant discordance between and physicians' and patients' perceptions of Rheumatoid Arthritis' disease activity changes [10]. And, this begs the question whether patients' and physicians' treatment goals can be regarded the same? Or, in other words, whether and why physicians should be justified to establish treatment goals for their customers? Where take physicians the arrogance to define boundaries, where diseased individual have to feel well? Moreover, if the physician is affected by the disease himself, experience tells us, that there may be some problems in patient management originating from too less distance to the patient's problems and increased physician's self-efficacy.

The prerequisite for patient centered treatment as expressed by the respective recommendations is based on "Shared Decision-Making" (SDM) and consideration of patient wishes with respect to the treatment of choice [12]. This approach's application means that therapeutic decisions are taken by physicians and patients together on the basis of the best disposable knowledge, including patient preferences. But, what does "shared decision" mean in clinical routine. Which aspects of the disease are to be shared between physician and patient? The physician's position is to provide the patient with all his theoretical knowledge regarding the course of the disease and the respective treatment possibilities, additionally with his expertise derived from a hopefully large number of patients. Patients may give physicians information about their individual experiences with the disease and medications. However pain, anxiety about the future, functional deficiencies, reduced social and professional participation as well as dependence are of course indivisible for the affected individual.

Isn't it, therefore, not a very physician focused euphemism to speak of shared decision? Isn't it the case, that after this shared decision was taken, the patient remains alone with all the disease and therapy consequences? Amongst them one of the most important ones may be the incapability to make plans for the near future despite apparently optimal management according to the recommendations [13].

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Wouldn't it be the normal situation that a patient takes his decision autonomously after optimal advice by his physician in order to guarantee a patient centered individualized treatment? Such a scenario would enable patients to take responsibility for themselves, as in reality, only the patient and his family environment has to master all the problems deriving from the disease. This trend to individualized therapy fortunately is growing throughout the last years. Patients' opinions more and more become the basis of therapeutic decisions and management plans [14,15]. The era of patronizing patient guidance is going to come to an end, although a high degree of resistance can be observed with old fashioned rheumatologists.

Rheumatic diseases affect many aspects of a patient's life. Patient-reported outcomes (PROs) provide valuable information on how patients feel with regards to a health condition and the therapy received [16]. Thus, also for the necessary documentation these instruments are the ones of choice, carrying the advantage to mirror the individual's thoughts and feelings as well as other aspects of the disease, such as fatigue, pain etc. [17] In contrast, all composite indexes weigh the patient's global assessment lower, far inferior to the joint counts, which are in fact physician-dependent, and sometimes inferior to the acute phase reactants [18]. That is why, all the composite indexes utilized do not grant patients' wishes, beliefs, fears, coping mechanisms or morbid-gains a prominent status. [18].

Patients, assessing the T2T approach, judged the pronounced focus on body functions and structure scanty [19]. This result is no big surprise, as T2T is based on study results on the group level. The situation with a patient crowd in front of your office expressing their intention of an improvement of their average disease activity regardless of the individual disease activity sounds curious, however, exactly resembles what T2T means in a stricter sense. Additionally, a physician led systematic literature review revealed unsatisfactory treatment results with respect to pain, physical, social, and mental functioning as well as professional participation and sexual functionality [20]. Obviously, each of these aspects of daily life, and the more the combination of them, may heavily interfere with patients' well-being, and should be worth to be in the centre of therapeutic efforts [20].

On the one hand the satisfying aspects of the rheumatologists' work, namely patient interaction, alleviation of pain, preserving functionality, only become reality in case of engagement in the individual case. On the other hand, we are increasingly confronted with recommendations for almost all aspects of professional and daily life. This does not necessarily mean a contradiction, if the recommendations are applied as aids, and not as absolute allegations. In this way they may help to ease the rheumatologist's life and improve patient care. The prerequisites, however, constitute a responsible dealing with and serious consideration about the respective recommendation and its applicability for the individual situation. In that respect treating patients to target should mean to achieve the best possible individual outcome and not to achieve a simple numerical value.

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