Physician–Patient Agreement in a Rheumatology Consultation

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Background: Several aspects of the consultation have already been studied. These usually comprise the patient satisfaction, patient enablement, physician–patient interaction and physician–patient agreement. After consultations, the physician’s perceptions differed from the patient’s in the level of disease control, cause and nature of the problem and the content of the consultation. Greater physician–patient agreement on consultations was associated with higher patient global satisfaction. Agreement on problems requiring follow-up was associated with a better outcome.

Objectives: Assessment of physician–patient agreement in Rheumatology consultation.

Methods: A 10 item questionnaire - “Consultation Assessment Instrument” (CAI) - was constructed with the aim of assessing physician-patient agreement. It was anonymously applied, after the consultation, to the patient and physician. The higher the score obtained, the more positive the consultation experience. Patients above 18 years of age, with an established diagnosis of inflammatory joint disease under biological therapy were included. Items were evaluated and index of proportional agreement for the dichotomized answers - agree (Ppos) and disagree (Pneg) - was calculated.

Results: 102 observations were obtained, corresponding to 10 physicians and 102 patients. Most patients were female (53.9%) with a mean age of 51.5 ±12.7 years old. Rheumatoid Arthritis was the most prevalent diagnosis (40.2%) and more than half of patients were in disease remission (28-joint Disease Activity Score (DAS28) <2.6 or Ankylosing Spondylitis Disease Activity Score (ASDAS PCR) <2.1). Higher CAI scores correlated with lower Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) scores (r=-0.376; p<0.05). Also, patients with mild disease (scores <3.2) on DAS28 had higher CAI scores (low disease = 3.75 ± 0.3; moderate disease = 35.8±3.4; high disease = 35±2.3; p=0.039). It was also found that the more satisfied the patient, the lower the Bath Ankylosing Spondylitis Functional Index (BASFI) (r=-0.334; p=0.05) and ASDAS PCR scores [low disease = 35.3±4.2; high disease = 30.5±7.8; p=0.001]. There was no statistically significant association between CAI total score and Health Assessment Questionnaire (HAQ) score, ASDAS PCR or BASFI. Patient’s satisfaction did not show an association with DAS28, HAQ or BASDAI scores.

Conclusion: Both patient and physician tend to show a positive experience towards Rheumatology consultation. Patients with a more positive experience had lower disease activity scores. Physician–patient agreement was high in the majority of the consultation aspects. CAI could be useful as a mental checklist in daily practice or as an educational tool for training consultation skills.

Disclosure of Interests: None declared


REFERENCE

Keywords: Patient satisfaction, Patient enablement, Physician–patient agreement, Disease activity, Physician-patient consultation.

Dealing with Comorbidities in Rheumatoid Arthritis with Medical Assistants. The Patients’ Opinion on Assessment and Education by Medical Assistants during Routine Clinical Practice

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Background: In 2006 the curriculum for rheumatology health professionals of the Academy of the German Association of Rheumatologists (DGRh) was developed. Since then more than 1400 health professionals (medical assistants [medizinische Fachangestellte] and nurses) were trained and are currently playing an increasing role in rheumatology practices in Germany.

Objectives: To evaluate the patients’ opinion on the assessment by medical assistants in general and regarding assessment and education on cardiovascular risk and vaccination.

Methods: Patients with rheumatoid arthritis were interviewed by a medical assistant in a rheumatology practice that is part of the public health care system with five rheumatologists in Erlangen, Germany. A semi-standardized structured interview assessed disease activity, pain, medication, general health, and side effects of medication. A part of the patients was also assessed and educated regarding cardiovascular risk or vaccinations. Thereafter they were examined by the rheumatologist and finally asked to complete a questionnaire regarding their visit. The questions were numerical scales ranging from 0 [very good, very satisfied] to 10 [very poor/inadequate].

Results: 293 Patients (mean age 61.3 ± 13.5 years, mean DAS28 2.8 ± 0.9, mean FFH 76.4 ± 20.8) were documented between August and December 2018. 212 completed the general questionnaire, 34 regarding a structured cardiovascular assessment and education, and 18 regarding a structured assessment of vaccinations.

Table 1 shows patient answers between 0 [very good, very satisfied] to 10 [very poor/inadequate]. Overall rating was excellent with a mean score of 1.0 (SD 1.5). The rating was only slightly different, if patients were assessed by medical assistants for the first time (n=111; mean score 1.2, SD 1.5), between the 2nd to 4th time (n=82; mean score 1.0, SD 1.3) or the 5th time or more (n=19; mean score 0.6, SD 0.6).