



Short communication

The impact of psychosomatic co-morbidity on discordance with respect to reasons for encounter in general practice

Antonius Schneider^{a,*}, Eva Wartner^a, Isabelle Schumann^a, Elisabeth Hörlein^a, Peter Henningsen^b, Klaus Linde^a

^a Institute of General Practice, Klinikum rechts der Isar, Technische Universität München, Germany

^b Department of Psychosomatic Medicine, Klinikum rechts der Isar, Technische Universität München, Germany

ARTICLE INFO

Article history:

Received 2 April 2012

Received in revised form 12 September 2012

Accepted 16 September 2012

Keywords:

General practice

Reason for encounter

Discordance

Patient–doctor communication

Psychosomatic co-morbidity

Shared decision making

ABSTRACT

Objective: Concordance between general practitioners (GPs) and patients is an essential requirement for treatment success and patient satisfaction in general practice. The objectives of this were to estimate the total amount of discordance with respect to reason for encounter (RFE) during consultation in German general practices, and to explore the influence of psychosomatic co-morbidity of the patients in case of discordance.

Methods: 1101 consecutive patients completed a questionnaire, including questions about the RFE and the Patient Health Questionnaire (PHQ). RFEs, as stated by the patients and diagnosed by the GPs were matched according to a predefined index. Factors that may influence the level of discordance between patients' RFE and GPs' RFE were analysed.

Results: Amount of concordance was 74.9%, incomplete concordance 11.2%, discordance in different physical RFEs was 9.1%, and discordance when GPs diagnosed psychosomatic illness while patients presented physical complaints was found in 2.5%. The number of RFE (OR 3.03; 95%CI 2.48–3.69; $P < .001$), depression (OR 2.27; 95%CI 1.51–3.41), anxiety (OR 1.78; 95%CI 1.03–3.10) and somatisation syndrome (OR 2.20; 95%CI 1.50–3.22) significantly predicted incomplete concordance and discordance, respectively. The number of RFE was significantly associated with depression (OR 1.32; 95%CI 1.09–1.61) and somatoform syndrome (OR 1.45; 95%CI 1.21–1.74).

Conclusion: The considerable amount of discordance and incomplete concordance can partly be explained by the psychosomatic co-morbidity of the patients. If it is seen as a fundamental right of patients to be adequately understood, more efforts are necessary to improve patient centredness. Further studies have to evaluate if improvement of identification of psychosomatic co-morbidity might reduce discordance.

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Introduction

Patient-centred care, i.e. focussing on the individual needs of the patient is proposed to be a hallmark of quality in family medicine [1]. In this context, it is a challenge for the general practitioner to address all different reasons for encounter during the consultation and to understand, for every encounter, the whole person in a biopsychosocial perspective, finding common ground, being realistic and establishing therapeutic alliance [2,3]. A number of studies have demonstrated that adequate concordance between physicians and patients is an important component of a good physician–patient relationship and an

essential requirement for patient satisfaction [e.g., 4–6]. However, it was pointed out in different studies that concordance might sometimes be difficult to achieve in routine care [7–9]. Remarkably, a lack of concordance is often found for patients with mental or psychosomatic disorders [8–10]. The proportion of discordance with respect to reasons for encounter in general practice under consideration of multiple complaints remains unclear, in particular when the impact of psychosomatic co-morbidity is taken into account. The aim was to estimate the amount of discordance during consultation of a large sample of patients in German general practices, and to explore the influence of psychosomatic co-morbidity on discordance.

Method

Study design and participants

A total of 1101 consecutive patients from thirteen rural and inner-city practices (11 solo-practices, 2 group practices with 2 and

* Corresponding author at: Institute of General Practice, Klinikum rechts der Isar, Technische Universität München, Orleansstrasse 47, 81667 München, Germany. Tel.: +49 89 614658913; fax: +49 89 614658915.

E-mail addresses: antonius.schneider@tum.de (A. Schneider), ewartner@googlemail.com (E. Wartner), isabelle.schumann@lrz.tum.de (I. Schumann), elisabeth.hoerlein@lrz.tum.de (E. Hörlein), p.henningsen@tum.de (P. Henningsen), klaus.linde@lrz.tum.de (K. Linde).

3 GPs, respectively) in the Region of Upper Bavaria/Germany took part in this cross sectional observational study. The study was carried out between April and August 2010. All participants provided written informed consent.

Patient questionnaire

Patients were first asked to write down their reasons for encounters in the questionnaire. The validated German version of the Patient Health Questionnaire (PHQ) was used as a screening tool to assess whether patients experience symptoms of depression, anxiety, panic or somatoform syndrome [11–13].

Data from physician documentation

The physicians were asked to document the diagnoses as exactly as possible in the computerised charts. All diagnoses for each patient were extracted manually from the computerised medical record systems and documented in a structured form (EW, EH). Physicians were asked to complete the diagnoses if these were missing at the end of the working day.

Coding

Both the reasons for encounter reported by the patient and the diagnoses as perceived by the GPs were classified by the research assistants according to the International Classification of Primary Care (ICPC-2) [14]. The research assistants were trained in ICPC coding beforehand. All uncertain diagnoses were discussed between the authors. If there was not enough information available for a proper diagnosis, the reason for encounter was coded as unclear.

The level of concordance between reasons for encounter reported by the patient and the diagnoses made by the GPs was estimated by two researchers (IS, EW) independently. The classifications were 1) full concordance, 2) correct renaming (the GP classified several symptoms of the patients as one condition e.g. cough and sore throat according to infection of the upper respiratory system), 3) incomplete concordance = agreed, but not all reasons are taken into account (doctor and patient agreed on symptoms but not all reasons for encounter described by the patients were taken into account; e.g., diabetes was discussed, but not low back pain), 4) discordance (clear discordance in different physical reasons for encounter), 5) the patient presented a psychosomatic/mental complaint but the GPs documented a physical disorder, 6) the patient presented a physical complaint but the GPs documented a psychosomatic/mental disorder, and 7) unclear. Disagreement was resolved by discussion with a third independent researcher (AS).

Statistical analysis

Kappa statistics was used to measure concordance beyond chance between the two coders before discussion of disagreement. The χ^2 -test was used to investigate differences in the level of agreement depending on diagnoses of mental disorders. In addition, multivariate binary logistic regression analyses adjusting for age, sex, level of school education and practices (to account for centre effects) were performed. The dependent variable was concordance (= summarising classifications 1 and 2) vs. discordance/incomplete concordance (= summarising classifications 3 to 5). It might be a self-fulfilling prophecy and result in circular reasoning that PHQ scales are rated higher in classification group 6. Therefore, classification group 6 was omitted from the discordance group. Independent variables were the number of RFE and the psychosomatic diagnoses as established by the PHQ. Binary logistic regression adjusted for sex, age and education was also calculated with PHQ diagnoses

(dependent variable) and number of RFE (independent variable) to determine their inter-relationship.

Results

57% of participants were female; the mean age was 49.5 years (standard deviation 17.8). Participants were significantly younger than non-participants ($n=248$ [18.4%]; mean 59.1 years; $P<.001$), there were no sex differences. 91.8% were members of the statutory health insurance while 8.2% were privately insured. 61.5% had visited school for 10 years or more. In total, patients reported 1646 reasons for encounter (Table 1).

Psychosomatic morbidity was significantly higher in patients when 'discordance in different physical RFEs' or 'incomplete concordance' was found; and highest when physicians made a psychosomatic diagnosis while the patient presented physical complaints (Table 2). At least one psychosomatic co-morbidity was present in 185 (22.8%) patients of the concordance group ($n=811$) and in 79 (35.9%) patients of the discordance/incomplete concordance group ($n=220$). The kappa value for agreement beyond chance between the two coders (IS, EW) before discussion with the third researcher (AS) was 0.51.

Discordance/incomplete concordance was predicted by the numbers of RFE (OR 3.03; 95%CI 2.48–3.69; $P<.001$), depression (OR 2.27; 95%CI 1.51–3.41; $P<.001$), anxiety (OR 1.78; 95%CI 1.03–3.10; $P=.041$) and somatoform syndrome (OR 2.20; 95%CI 1.50–3.22; $P<.001$), whereas panic disorder showed no significant relation (OR 1.51; 95%CI 0.78–2.92; $P=.218$). There was no significant interaction between RFE and PHQ diagnoses. The number of RFE was significantly associated with depression (OR 1.32; 95%CI 1.09–1.61; $P=.005$) and somatoform syndrome (OR 1.45; 95%CI 1.21–1.74; $P<.001$), but not with anxiety (OR 1.20; 95%CI 0.92–1.56; $P=.183$) and panic disorder (OR 1.15; 95%CI 0.82–1.60; $P=.431$).

Discussion

The proportion of incomplete concordance in our study was 11.2%, and we also identified a group with discordance (= completely no concordance) with respect to physical RFEs which comprised nearly 10% of the patients. Bell et al. found in their elaborate study, that 11.6% of patients had unmet expectations during outpatient visits which contributes to less satisfaction on both sides – doctors and patients [15,16]. We found that discordance/incomplete concordance was predicted by the number of RFE, depression and somatoform syndrome. Several studies pointed out that difficult doctor–patient relationships often prevail in case of mental/psychosomatic disorders [8,17]. Fitting to this, it might be speculated that it was more difficult for patients with enhanced psychosomatic co-morbidity to present all their complaints in detail and to receive full attention of their physician. The significant association between the number of RFE and PHQ diagnoses and their predictive value for discordance/incomplete

Table 1

Reasons of encounter reported by patients ($n=1101$) and physicians coded according to ICPC-2

	Patient	Physician
Total number of reasons of encounter coded	1646	1425
Median number (range) per patient	1 (1–5)	1 (1–3)
Categories coded	N (%)	N (%)
A General and unspecified	133 (8.1)	84 (5.8)
B Blood, blood forming organs, lymphatics, spleen	12 (0.7)	10 (0.7)
C Procedures (e.g. blood sample, administration)	448 (27.2)	193 (13.5)
D Digestive	128 (7.8)	109 (7.6)
F Eye	11 (0.7)	12 (0.8)
H Ear	25 (1.5)	13 (0.9)
K Circulatory	134 (8.1)	171 (12)
L Musculoskeletal	316 (19.2)	265 (18.6)
N Neurological	79 (4.8)	61 (4.2)
P Psychological	54 (3.3)	153 (10.7)
R Respiratory	175 (10.6)	173 (12.1)
S Skin	47 (2.9)	58 (4.1)
T Endocrine, metabolic and nutritional	48 (2.9)	71 (5.0)
U Urology	20 (1.2)	23 (1.6)
W Pregnancy, childbirth, family planning	5 (0.3)	5 (0.4)
X Female genital system and breast	9 (0.5)	18 (1.3)
Y Male genital system	1 (0.06)	3 (0.2)
Z Social problems	1 (0.06)	3 (0.2)

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