EDITORIAL

Listening to our patients, at last?

It's my impression that a quiet revolution is taking place in the way that patients' subjective sensations or feelings are being used to assess illness severity. Illness is here used in the sense of "the way disease interferes with everyday living"; thus, "doctors may be experts in disease, but only patients can experience the consequences of illness" (1). The distinction highlights the importance of symptom severity and the associated psychological reactions in the handicaps and quality of life experienced by patients. The revolution, in which respiratory researchers have been in the van, may be seen to reverse the commonly held view that subjective or sensory impressions are unmeasurable and unreliable, and, in short, not to be trusted. A number of factors have contributed to this change.

First is the now obvious fact that patients react differently to a given disease severity – asthma is a good example of this truism; there is a wide variability in disability and handicap in patients showing similar clinical and physiological features.

Second is a large body of research showing that sensory intensities can be quantified precisely and reproducibly. Initially there was considerable scepticism regarding measurement of sensory intensities, but Stevens (2), in establishing the field of psychophysics on a firm foundation in the 1940s and '50s, was able dispel these doubts. Stevens' "Power Law" (3), states that sensory intensity ($\Psi$) does not increase linearly but is a power function of the stimulus intensity ($\phi$), the exponent ($\beta$) being uniquely related to a given sensation:

$$\Psi = k\phi^\beta$$

The application of Stevens' theories, particularly with the scaling techniques of his follower Gunnar Borg (4), has been crucial to studies of dyspnea and the sense of muscular effort during exercise in health and disease (5).

Third is the realization that patients want to feel better as well as to know their disease is improving, and that their quality of life may be reliably measured (6). Questionnaires, such as the Medical Research Council's questionnaire on respiratory symptoms, have been widely used during the past 30 years and more recently have been adapted to measure various factors contributing to the quality of life. In an approach developed by Guyatt and colleagues (7), a 20-item Chronic Respiratory Disease Questionnaire (CRQ) assesses not only dyspnea and the sense of muscular effort during exercise in health and disease (5).

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From being considered misleading and unwanted accompaniments to many diseases, symptoms have come to occupy a leading role in the assessment of illness severity. Thus, the measurement of symptoms during incremental exercise has opened up fresh approaches to identifying limiting factors (5), and has allowed the mechanisms contributing to dyspnea in cardiorespiratory disorders to be identified and quantified (10). Symptom assessment has been successfully used in clinical trials (11), and quality of life has become a variable that may be reliably used as an outcome measure (12). Of course, there will be clinical situations in which symptom assessment will continue to be viewed with suspicion, such as in occupational disability, but even here validity may be established with safeguards to identify responses that are clearly anomalous and inconsistent.

It seems clear that the subjective features of many conditions are capable of reliable measurement and can be incorporated into clinical assessment of functional capacity and quality of life, both as part of the clinical examination and in clinical trials.

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