Atrial fibrillation (AF) is the most common arrhythmia worldwide, and it accounts for substantial health care resources. Care of patients with AF is geared toward several primary objectives: stroke risk assessment and prevention, addressing modifiable risk factors, and symptom management.\(^1\) Each of these is vital to effectively reduce morbidity and mortality related to AF. Importantly, they each require an engaged and productive therapeutic alliance between patient and clinician.

The foundation for such an alliance is clear and consistent communication, particularly with respect to patient preferences, priorities, and health status. Specifically, symptom status and health-related quality of life (HRQOL) are often the primary drivers in escalation of treatment. While symptoms are routinely assessed in AF clinical encounters, there is increasing interest in more formalized measures of HRQOL through patient-reported outcomes (PROs), which are structured instruments designed to convey general or disease-specific HRQOL measures directly from the patient, without clinician interpretation or translation. The most valuable PROs are rigorously derived, anchored, and validated to ensure they meet the intended objective and are valid, reliable, responsive, minimally biased, and, ideally, interpretable. Yet while a major driver of PRO implementation is to improve on the subjective nature of the clinician’s impression of symptoms, these tools, particularly for AF, are not often tested against that standard.

It is in this setting that the study by Ikemura et al\(^2\) is apropos. In brief, Ikemura et al\(^2\) administered a well-known, well-validated AF-specific PRO, the Atrial Fibrillation Effect on Quality-of-Life (AFEQT),\(^3\) to 330 patients initiating care for AF. Ikemura et al\(^2\) also administered a simplified, analogous tool to the clinicians following the same visit. This is a novel design geared toward understanding discrepancy between patient experience and clinician interpretation, and Ikemura et al\(^2\) also looked at 1-year PROs and interval treatments. There were several important findings. First, clinicians tended to underestimate symptoms among these patients; however, correlation between patient experience and clinician interpretation was highest for the specific symptoms and daily activity impact domains and lowest for treatment-related concerns.\(^2\) Second, clinicians tended to underestimate HRQOL among patients who are classically more symptomatic, eg, younger patients and those with lower CHA2DS2-VASc (cardiac failure or dysfunction, hypertension, age 75 years [doubled], diabetes, stroke [doubled]–vascular disease, age 65-74 years, and sex category [female]) scores.\(^2,4\) It appears, perhaps, that better physical health may have influenced clinician perception of HRQOL (and vice-versa). Additionally, women were least likely to have an HRQOL assessment concordant with that of their clinician. Lastly, patient outcome and treatment varied with correlation of symptom assessment (even after multivariable modeling).\(^2\) Patients with PRO scores that aligned with their clinician’s impression had the greatest improvement in overall summary score 1 year later.\(^2\) Conversely, those with underestimated symptoms had the smallest improvement at 1 year.\(^2\)

The strengths and rigor of the Keio Interhospital Studies-Atrial Fibrillation (KICS-AF) registry used in the study by Ikemura et al\(^2\) have been previously described\(^6\) and include trained abstractors, onsite data monitoring, event adjudication, extensive follow-up, and a priori inclusion criteria. The strengths of this specific analysis by Ikemura et al\(^2\) include the use of a rigorous PRO and subsequent simplification of the tool for clinician scoring (with some validation). Ikemura et al\(^2\) included a relatively broad, representative AF population and 1-year follow-up data. Additionally, clinicians were blinded to patients’ scores.
Of course, there are limitations that may influence interpretation. While the study by Ikemura et al.\(^2\) included 330 patients, only 7 clinicians at 2 sites were involved. This is a relatively narrow sample of clinicians, particularly without understanding the clinician characteristics. Prior work has demonstrated physician specialty can influence care,\(^4\) and future studies should explore whether there are differences among clinician types and specialties that may bias these assessments (e.g., whether proceduralists are prone to overestimate symptoms).

The results of this study by Ikemura et al.\(^2\) have obvious implications for clinical care of patients with AF. If improving HRQOL is a pivotal objective best measured by AF-specific PROs, it is vital to collect these from the patient. Where HRQOL drives treatment decisions, particularly regarding invasive procedures or higher-risk medications, relying on clinician impression of symptoms is suboptimal. However, there may be more subtle implications. KICS-AF previously published a study on correlation between AF HRQOL at baseline and clinical outcomes.\(^7\) Coupled with the findings from this study by Ikemura et al.\(^2\) these findings suggest clinicians underestimating the effect of AF on HRQOL may be missing an opportunity to improve clinical outcomes as well.

The recently updated AF guidelines allow for more nuance and shared decision-making throughout AF care, combined with classic risk score–based decisions.\(^1\) This requires strong patient-clinician communication. The KICS-AF analysis by Ikemura et al.\(^2\) suggest that clinicians can be inaccurate in assessing patients' treatment-related concerns. Thus, PROs and shared-decision making tools provide an opportunity to level the playing field for communication of patients' HRQOL and treatment priorities. These tools, when designed and implemented appropriately, may also offer an opportunity to improve disparities in care among these patients. However, to improve care of all patients with AF, it is time to consistently incorporate PROs in the clinic. Because when it comes to HRQOL assessment for patients with AF, it is us, the clinicians, we are part of the problem.
