

ANALYSIS

Better management of patients with multimorbidity

Martin Roland and **Charlotte Paddison** call for greater emphasis on continuity of care and clinical judgment to improve the experience of patients with multiple conditions

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As the population ages more people are living with multiple medical conditions,^{1,2} and a new model of care for these patients is needed. This should take account of the complex health, emotional, and social problems they face which can make their management so challenging, especially in socioeconomically deprived areas.³

Although this is widely acknowledged, there are few practical examples of good models of care for this group of patients and worrying trends that are taking care in the wrong direction. This paper discusses current problems in the care of patients with multimorbidity and suggests steps that should be taken to improve it.

Role of guidelines

It has been argued that evidence based guidelines (mostly developed for people with single diseases) are inappropriate for people with multiple conditions, resulting in overtreatment and overcomplex regimes of assessment and surveillance.^{4,5} This is a particular problem for patients who are elderly, less well educated, or from less affluent communities.^{6,7}

Although the criticisms levelled against guidelines for single conditions may sometimes be valid, we have little with which to replace them. Guidelines could be made for a few specific combinations of conditions and common comorbidities such as depression,⁸ but their role is limited because there are simply too many conditions and combinations to cover.² A less well recognised limitation of guidelines is their lack of recognition of the effect of age and general frailty. The effect and management of multimorbidity in a 50 year old is very different from that in a 100 year old, in whom the burdens of both illness and treatment are likely to be greater.

That said, the notion that multimorbidity inevitably results in overtreatment is too simplistic. When a new condition increases the absolute risk of a complication from an existing condition, then the argument may be for more treatment not less—for example, when a hypertensive patient develops diabetes. It is wrong to assume that the development of comorbidities should automatically lead to a de-intensification of treatment.

Valuing clinical judgment

Evidence based guidelines have contributed to improved care by providing clear standards against which care can be assessed. However, doctors increasingly feel unable to deviate from them, especially if there is an implication that this might be assessed as substandard care or lay the doctor open to criticism or sanction.

Professions are in part defined by their ability to operate in the face of uncertainty,⁹ so we should value the ability of doctors to take a broad view of patient care and use a guideline only when they judge it to be in the patient's best interest. This need is recognised in the pay for performance system that underpins a quarter of UK primary care physicians' pay: a system of "exception reporting" allows doctors to exclude individual patients or indicators from the quality calculations for a range of clinical reasons.^{10,11} Although this system is criticised for allowing doctors to exclude the most needy patients, we believe it is essential to prevent inappropriate use of guidelines that were never intended to apply to every patient.

Doctors must be encouraged to think about the patient as a whole when deciding whether to apply guidelines developed for single diseases and to consider whether comorbidities mean that a more aggressive or more conservative approach to management is indicated. Furthermore, skill at making these judgments needs to be built into medical training.

Listening to patients' priorities

Listening to patients is key to determining which of their needs are most pressing and to identifying goals that matter to them and will lead to the most appropriate care. Rueben and Tinetti argue that the focus on disease outcomes that comes from a single condition approach to medical care is the most important barrier to goal oriented care.¹² It is therefore important to recognise this key step in medical management (fig 1⇓)

Identifying goals is difficult for patients who are less articulate or need more help in guiding them through what are often complex decisions. Longer consultations are needed to deal

with the “cumulative complexity”¹³ of patients with multiple chronic conditions.

Personal responsibility for patients is important

Patients value interpersonal continuity of care, especially those with chronic diseases.¹⁴ Good continuity and coordination of care are associated with improvements in patient outcomes^{15 16} and increased patient satisfaction.^{17 18} Both are important to “order the chaos” for patients with multimorbidity.¹⁹ Although the evidence linking continuity of care to improved outcomes is modest, patients in both primary care and hospitals commonly complain that they “never see the same doctor.” Perhaps even more important is that, from the doctor’s perspective, it is very hard to provide good care to previously unknown patients with multiple complex problems, especially in a time limited primary care consultation.

In a recent UK survey, most patients expressed a preference for seeing a particular doctor, rising from 52% among those aged 18-24 to over 80% among those over 75.²⁰ However, more than a quarter of patients reported being unable to see their preferred general practitioner consistently, and recent evidence suggests that interpersonal continuity has declined in both inpatient and ambulatory care.²¹⁻²³

This decline may be the result of an increasing emphasis on technical or clinical aspects of quality—for example, with routine primary care follow-up in disease specific clinics led by nurses. But there are other reasons too. Doctors are increasingly likely to work part time and to have professional interests outside clinical care such as teaching, research, or healthcare management. So they are simply less available for their patients. Of more concern perhaps, shift systems during hospital training mean that a generation of young doctors is emerging with limited experience of taking personal responsibility for a defined group of patients. The idea that problems can always be passed on to someone else at the end of a shift is difficult to reconcile with the ethos fundamental to relational continuity.

General practitioners claim to value continuity of care,^{24 25} but in England at least, that’s not how they seem to organise their practices. In 2004, GPs were given a financial incentive to provide prompt appointments. They did so by introducing an “advanced access” system that gave prompt access, but often at the expense of patients being able to see the doctor of their choice.

Most practice booking systems continue to prioritise speed of access over continuity of care despite the removal of the financial incentive. However, patients are willing to wait several more days to see a doctor they know, especially older patients and those with long term problems or conditions about which they feel uncertain.^{26 27} Booking systems in primary care therefore need to allow for patients who want to see their own doctor as well as those who want to be seen quickly and don’t mind who they see.

The box suggests some of the things that could be done to improve continuity of care, based on the work of Hill and Freeman.²⁸

New professionalism still needs old values

Much has been written of the “new professionalism,” which sees a less paternalistic relationship between doctor and patient.²⁹

Such descriptions play down the doctor’s autonomy, emphasising the importance of evidence based practice and critical evaluation of the doctor’s performance. Although these are important, there is a danger that overliteral interpretation may disempower doctors. Clinical judgment becomes more important, not less, as evidence based guidelines become limited by the increasing complexity of patients’ illnesses.

Many interventions aimed at patients with multimorbidity use new types of generalist, most often nurses (case managers, community matrons, etc).³⁰ Such interventions are designed to increase coordination of care, but sometimes increase demand and rarely reduce cost. We seem to have forgotten the value of the skilled generalist doctor who already sits at the heart of healthcare delivery in the UK.

Incentives to improve care

Incentives need to be provided to improve care of patients with complex multimorbidities in primary care. However, for the reasons outlined above, these cannot be disease oriented indicators such as those currently used in the UK Quality and Outcomes Framework. Firstly, the time required by complex patients needs to be acknowledged. Payment systems for Australian doctors have for many years recognised that some patients need longer appointments, and other countries could follow suit. Secondly, the structure and organisation of primary care needs to recognise the importance for doctors and patients of building relationships over time.

Conclusion

We have argued that multimorbidity introduces clinical uncertainty in a way that is unlikely to be resolved by ever more sophisticated guidelines. Doctors must therefore embrace clinical judgment based on their assessment of a patient’s needs. This requires time to deal with more than one problem at a time and coordination of care in ways that promote long term or at least medium term relationships between doctors and patients. This approach will inevitably emphasise the importance of generalist skills, whether among primary care doctors or those who specialise in the care of older people.

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How to provide better continuity in primary care

- Help people to understand that it's easier for doctors to provide good care if they're seeing patients they know.
- Change receptionists' behaviour and prompts on booking systems so that the patient's "own doctor" becomes the default choice
- Organise large practices or clinics into small teams of two or three doctors who see each other's patients when one is unavailable. Make sure that patients know about these arrangements and know when junior doctors are going to be changing
- Enable online booking for both hospital and general practice clinics. This will help patients book with a doctor of their choice.
- Allow patients to email their doctors so that continuity can be maintained even when the doctor is off site. Protected time needs to be built into the working day for these email consultations.
- Identify patients with particularly complex problems who should be seen by a restricted number of doctors and adjust the appointment system to ensure this happens. Explain to patients that they may have to wait longer but will get better care
- Monitor whether patients get to see the doctor of their choice
- Include questions on how a doctor's practice or clinic provides continuity in revalidation or recertification procedures

Key messages

Clinicians need to be free to exercise professional judgment in their management of patients with multimorbidity

Patients need to determine treatment priorities and the goals of medical care

Clinicians should provide continuity of care for people with complex long term problems

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Figure

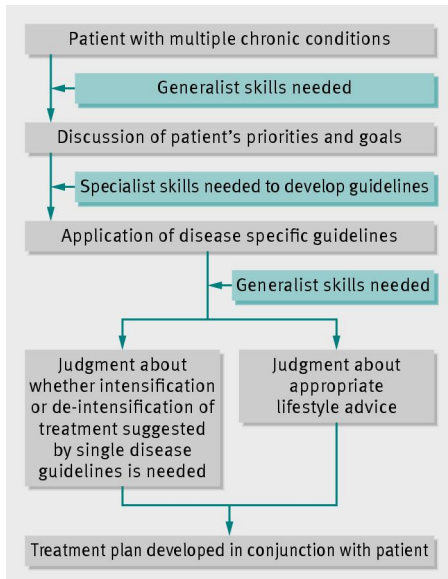


Fig 1 Management of patients with multiple chronic conditions