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**Editorial:**

**Title; 'Across the pond' – a response to the NICE guidelines for management of multi-morbidity in older people.**

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**Keywords:** Older people; Multi-morbidity; Clinical Guidelines

**Keypoints:**

- 1) In sick elderly patients, clusters of disease states are the 'norm', and recognising which morbidities should be prioritised is a key part of good geriatric clinical care.
- 2) Medicine been so slow to adopt a holistic approach to care that recognises the benefits and efficiencies from prioritising possible health care interventions for the multi-morbid patient
- 3) NICE has now formally recognised multi-morbidity as an important clinical issue which merits a clinical guideline.

- 4) The guideline challenges physicians to adopt an approach that takes full and proper account of multi-morbidity.

### **Text**

The Editors of *Age and Aging* of the British Geriatrics Society and the *Journal of the American Geriatrics Society* have agreed to publish periodic partner articles (editorials or commentaries) on clinical or policy issues of interest to our readers. Initially we plan to focus on recently released clinical guidelines or address major policy issues of relevance to the care of older persons. We intend to discuss these topics from our respective viewpoints, with the aim of broadening the dialogue and learning from differences in approach to health care adopted 'across the pond'. These articles will be written by members of our editorial teams or solicited from experts on a given topic.

In this pair of initial companion articles, we discuss our reactions to the recent National Institute for Health and Care Excellence (NICE) guideline 'Multi-morbidity: clinical assessment and management'<sup>1</sup>. The NICE guideline builds on previous work by the American Geriatrics Society Expert Panel on the Care of Older Adults, whose report on multi-morbidity was published in the *Journal of the American Geriatrics Society* in 2012<sup>2</sup>.

Multi-morbidity is a concept that is very familiar to geriatricians. In sick elderly patients, clusters of disease states are the 'norm', and recognising which morbidities should be prioritised is a key part of good geriatric clinical care. However despite the example of geriatrics, modern medicine has been slow to address the implications of multi-morbidity. The result is frail, multi-morbid elderly patients can be subjected to futile or even harmful investigations and treatments and, more commonly, are exposed to considerable treatment burdens. For example, applying NICE guidelines to a person with five common

long-term conditions (previous MI, type 2 diabetes, osteoarthritis, COPD and depression) necessitates at least ten medicines, nine lifestyle modifications, 8-10 primary care appointments per year, 8-30 psychosocial intervention appointments, and possibly smoking cessation and pulmonary rehabilitation<sup>3</sup>.

So why has medicine been so slow to adopt a holistic approach to care that recognises the benefits and efficiencies from prioritising possible health care interventions for the multi-morbid patient? In many countries, including the UK, both primary and secondary care for long term conditions are organised around single disease management systems, supported by a raft of clinical guidelines which become operationalised into clinical treatment protocols that are largely irrelevant for the frail, multi-morbid older patient.

In the US, there are additional problems with the systems of reimbursement (fee per service) which are perceived as resulting in over-use of ineffective (or even harmful) highly specialised costly interventions, while restricting access to more appropriate low technology holistic approaches to care – such as comprehensive geriatric assessment. A more detailed US perspective on this is covered in the accompanying editorial in JAGS<sup>4</sup>.

In this context the recent publication by the National Institute for Health and Care Excellence (NICE) of the guideline ‘Multi-morbidity: clinical assessment and management’<sup>1</sup> is very welcome. Although NICE has authority only in England, their publications are generally seen as providing high-quality evidence based summaries that are highly influential in shaping clinical practice world-wide. In the UK in particular, service provision and clinical practice is strongly influenced by what NICE say.

**Commented [JY1]:** 1.Hughes LD, McMurdo M, Guthrie B. Guidelines for people not for diseases: the challenges of applying UK clinical guidelines to people with multimorbidity. *Age & Ageing* (2012)doi: 10.1093/ageing/afs100

That NICE has now formally recognised multi-morbidity as an important clinical issue which merits a clinical guideline is, in itself, a genuine step forward, if long over-due. It validates and gives licence for health care professionals to 'stray' from stringent applications of single disease guidelines when confronted with a person with multi-morbidity.

Multi-morbidity is conventionally defined as the presence of two or more LTCs. But this definition includes about one quarter of the population<sup>5</sup> and for many of these people the application of single condition guidelines is wholly appropriate. A particular strength of the NICE guideline is the more clinically relevant approach taken to the recognition of intrusive multi-morbidity as identified by symptom complexes (e.g. frailty; chronic pain) and burdens (e.g. polypharmacy; need for multi-agency support). This pragmatic approach will be welcomed by clinicians and sets the scene for a range of recommendations relating to the purposeful identification of people who may benefit from an 'approach to care that takes account of multi-morbidity', both opportunistically during routine health care encounters, and, more excitingly, proactively using systematic searching of primary care electronic health records. In effect, this is the pivot of the whole guideline as it anticipates more timely introduction of multi-morbidity management, before a point of crisis, and has the potential to stimulate new care models more closely aligned to the needs of people with multiple conditions.

The guidelines give twenty recommendations that describe an 'approach to care that takes account of multi-morbidity.' The emphasis is strongly on empowerment of patients in clinical decision making. The aim is to give the recipients of care control over decisions and actions affecting their health. The difficulty is that this is a philosophy of clinical practice that should be integral

**Commented [JY2]:** Barnett K, Mercer S, Norbury M, Watt G, Guthrie B. Epidemiology of multimorbidity and implications for health care, research and medical education: a cross-sectional study. *The Lancet* 2012; 380: 37-43

to the management **all** patients, multi-morbid or not. In a sense this is acknowledged within the guideline as the recommendations draw heavily on the sister guideline on patient experience in adult NHS services<sup>6</sup>. The component of the guideline that is more specific to people with multi-morbidity incorporates the twin pillars of exploring existing disease and treatment burdens, and establishing future goals, values and priorities. These tasks will require a new type of clinical consultation, one that is considerably more discursive. Encouragingly, health economic modelling conducted as part of the guideline indicated that this type of holistic assessment is likely to be highly cost-effective compared to usual care, though this conclusion was tempered by very limited outcome data. The new costs for a holistic care model were estimated at a modest £140 per person but the population cost will be high (many people have multi-morbidity) and the trick will be to chisel funding for this new approach out of existing processes of care that focus on single long term conditions, that will be forgone in favour of the new multi-morbidity approach. With the current, over-stretched state of primary care services in many parts of the world (including the UK), implementation of the guideline will require careful orchestration and incentives, including some transitional funding.

There are numerous potential benefits from the purposeful identification of intrusive multi-morbidity and the individualised, problem based approach described in the NICE guideline. These include better health care outcomes and the potential for more cost-effective use of resources. All too often medical decision-making currently fails to properly involve the patient in prioritising and selecting investigations and treatment. Atul Gawande's book 'Being Mortal: Medicine and What Matters in the End' highlighted how medicine has failed to grasp these issues at the end of life, giving examples

**Commented [JY3]:** The National Clinical Guideline Centre. Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE clinical guideline 138. London. The National Clinical Guideline Centre, 2012. Available from: <http://www.nice.org.uk/CG138>

from the US of inappropriate and wasteful care that were not tailored to patients' wishes and needs<sup>7</sup>

Some teachings are timeless. Sir William Osler (1849-1919) once remarked: "The good physician treats the disease; the great physician treats the patient who has the disease." The NICE guideline on multi-morbidity deserves to have international impact, with influence on both the purchasers and providers of health care. It challenges us to adopt an approach that takes full and proper account of multi-morbidity, and has the potential to re-empower us as holistic physicians and to release us from the constraints of contemporary protocol based medicine.

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