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TAKING STOCK

Rammya Mathew: Learning to manage multimorbidity

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Looking after people with multiple health conditions is challenging, especially in the context of ageing, frailty, and deteriorating health. Although the National Institute for Health and Care Excellence (NICE) guidelines on multimorbidity provide some valuable principles,[1] it's still far from clear how we care for such patients.

As clinicians, we're grappling with many unknowns in terms of the evidence base, and we have to use our clinical judgment and experience to help patients make decisions that make sense for them. Often this means weighing up the risks and benefits of starting or stopping medicines or deciding whether to initiate a whole catalogue of investigations when patients present with new symptoms.

It seems that neither the way we teach medicine, nor the way we practise it, has evolved to tackle the complexity and uncertainty involved in managing multimorbidity. For example, many of the key skills required to manage multimorbidity are sidelined in the medical school curriculum in favour of the more knowledge based aspects of medicine, which revolve around managing single conditions. How many medical students graduate with a sense of what shared decision making is or how to apply it in the context of multimorbidity? Sparingly few, I imagine.

This is mirrored in our assessment process, which often uses a "single best answer" format—reinforcing the notion that there's always a single best way of doing things. In reality, the best route often isn't clear, and our task should be to engage our patients in discussion, communicate uncertainty with honesty and candour, and allow ourselves to be guided by them as to the best option. Shouldn't we be doing open book assessments, allowing students and trainee doctors to look up whatever information they believe that they need to support this type of conversation, and base our assessment of competence on how they collaborate with patients to manage these grey areas in medicine? This seems closer to the reality of practising 21st century medicine.

A strong grounding in the principles of clinical reasoning and shared decision making will create the doctors we need, who are skilled in managing multimorbidity, who know when to step away from using single disease guidelines, and who are brave and confident enough to do so. But educational reform alone is not enough. Looking at this from the perspective of the COM-B (capability, opportunity, motivation) model of behaviour change,[2] having the right skills gives us the "capability" to practise better medicine—but we still need the "opportunity" and the "motivation" to implement these skills.

If we don't acknowledge the time investment and wider systemic changes needed to manage multimorbidity, we'll continue to do this group of patients a disservice. Having skilled doctors and allied health professionals who are motivated to do the right thing but are unable to do so is, unfortunately, just as bad as having a workforce who lack the skill or confidence to manage multimorbidity appropriately.

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1 National Institute for Health and Care Excellence. Multimorbidity: clinical assessment and management—NICE guideline NG56. Sep 2016. https://www.nice.org.uk/guidance/ng56.
2 Michie S, van Stralen MM, West R. The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implement Sci* 2011;6:42. 10.1186/1748-5908-6-42. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096582/ . 21513547

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