

How to best treat the patient with multimorbidities

“It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.”
 —William Osler

Multimorbidity is the new normal in hospital. It seems almost rare to meet a patient with just one disease. Multimorbidity is increasingly prevalent with age and is associated with reduced function, high mortality, and increased use of health care resources.¹ The onset of multimorbidity occurs at a younger age in populations with socioeconomic deprivation, especially when mental illness is one of the morbidities.² We know that people with multimorbidity have reduced quality of life, increased morbidity, and increased rates of depression. It is also inconvenient, inefficient, and unsatisfactory for patients in that they feel that no one doctor is really caring for them as a whole person.³

Recently, I met a frail lady in her late 80s. This lady had visited our hospital multiple times in past months. The cascade of interventions began when her long-standing cerebellar ataxia and dementia caused a fall resulting in a fracture needing open reduction. Her atrial fibrillation and diastolic heart failure prompted a cardiology consult: vaginal bleeding was detected and resulted in a gynecology consult, and pneumonia and bilateral pleural effusions were complications needing a respirology consult. The fracture healed poorly and her most recent admission was for sepsis secondary to the infected wound, which needed an infectious disease consult. Her worst morbidity was a lack of family or friends.

While all my colleagues were working hard to achieve the best possible outcome for the organ, system, or disease they had been asked to see about, by the last admission the person with these morbidities was needing a one-to-one caregiver in the hospital to watch over her, a PICC line to continue antibiotics as she had pulled out lines and run out of IV sites, as well as a special mattress to prevent formation of more pressure ulcers. She could not answer questions about symptoms or preferences for care but with prompting could tell me that she liked to watch TV shows. Her nurses believed she was in considerable pain when they moved her. She was incapable of moving herself and would be restrained if she did. Lying in bed she was able to view a blank white wall.

Why does it seem like a collection of organs with diseases has replaced a person with an illness? Why is it that we are seeing organ-focused care rather than person-centred care?

It is particularly difficult to establish a relationship with patients who have moderate-to-severe dementia. They cannot tell us their symptoms or convey their preferences for care. Therefore, it seems that the disease becomes easier to deal with than the person who is lost among the cognitive impairment. When people with dementia do not have family members to represent them and aid us in knowing their story, they are at a significant disadvantage.

It can also be challenging when the language of the patient does not match ours and we can only get a few basic details. Again, it makes it easy to fall back onto disease indices and

standardized treatment, and to treat the disease without getting a professional interpreter in order to treat the person with the disease.

However, organ-focused care can occur even in patients who speak a common language and do not have any cognitive deficit. It seems to occur mostly in the setting of patients with multimorbidity. Consider the following reasons, which are probably only a few among many.

1. Lack of knowledge of how one disease impacts another. We do know that multiple conditions have effects on function, and function is related to mortality. Unless prognosis is clear and discussed openly with everyone, including the patient and family, there seems to be a hesitancy for specialists to modify their investigations and management in view of a potentially shortened life.
2. A medical culture that focuses on making the diagnosis, having complete knowledge of the disease indices, and never missing anything (even if it is the monitoring of failing organs).
3. A reluctance to speak with the patient about his or her prognosis—partially because of reasons 1 and 2 but also out of a fear of seeing our own mortality when we consider the patient as a person with needs and hopes that might mirror our own.
4. Reluctance to allow a complication (in this patient’s situation, infected screw and plate) to result in death even though infection is the most common sequel of advanced dementia⁴ and a likely cause of death for this woman.

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5. The culture of needing to do something. The very words we use, such as “just talked with the patient,” are reflections of the culture of medicine to be actively doing something. Perhaps physicians feel that implicit in a consult is a request for investigation and additions or changes to be made to the plan of care. But is observing the patient or stopping medications considered less adequate than applying guideline-based therapy even if there is no evidence for the therapy in certain age groups and stages of life? Often, what is needed is reassurance that all that is appropriate has been done. It reminds all of us to be explicit in our expectations when we ask for a consultation.

Assessing and managing a condition of an organ or system within the context of a whole person with hopes, goals, and values can be very difficult and time consuming, especially in those patients who do not have family members or friends and cannot make their preferences for care known. And perhaps you are not expert in the other four or more conditions that the person has and whether that person might live long enough to benefit from the interventions that you may be initiating.

The Palliative Care Program at Providence Health developed a tool to help clinicians identify patients who may be in their last 6 months to 1 year of life and who may benefit from a palliative approach to their illness. The tool is based on the question “Would you be surprised if this patient died in the next 6 months?” along with general and disease-specific indicators of advanced disease.⁵ The combination of the question and the two indicator categories can give the clinician an indication of whether the patient has advanced disease and is more likely to benefit from a palliative approach to care.

A palliative approach to care

focuses on controlling symptoms and improving quality of life. It is an approach that places the patient’s goals of care and quality of life as the guide to care rather than ideal disease indices and potential for a longer life. Studies have shown that patients’ goals of care are prognosis sensitive, so patients need to be aware of their limited time when they have advanced disease.

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Knowing a patient’s goals of care and understanding the probable trajectory of the patient’s diseases will help you decide if you really do need to order that scan, or start the insulin sliding scale or the guideline medications. If the patient will not live long enough to benefit from your intervention then don’t burden him or her with another treatment. Many patients with multimorbidity will be grateful for one less test or drug especially if it will not improve their quality of life. The question to ask yourself is *What should I do?* not *What can I do.*

So what do you do with that urge to do something? Multiple studies have confirmed that the healing part

of medicine is a result of the clinician, not the drug or procedure. Being treated with respect, listened to, given information in a compassionate and straightforward manner—even if the information is not good—can all be healing. People will often forget what you told them but will always remember how you made them feel.

The Providence Health Care prognostic tool is part of the iPal app that gives you essential palliative care information at your fingertips. It is free and works on all smartphones and computers. Access it at <http://ipalapp.com> and save it to your home screen or bookmark it to keep it close at hand.

—Romyne Gallagher, MD
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