Editorials

Prescribing for patients with multimorbidity:

aiming to tailor to patient-set goals

MULTIMORBIDITY

Multimorbidity, having more than one condition at a time, if not acquired in youth, is a state of health most of us can expect to attain in old age.[1] The 'morbidities' may be physical or mental, and patients with multiple morbidities have an increased likelihood of experiencing socioeconomic deprivation as well.[1]

Recent years have seen a blossoming of literature on the topic of 'multimorbidity'. There have always been patients with multiple problems, but their numbers are increasing and the concern is that patients in this group should be treated optimally for their sake and for the sake of health service efficiency. The subgroup of patients whose combination of conditions cause them particular burden are a priority, where management is a challenge for themselves, their clinicians, and their carers. One aspect of this challenge is the taking and prescribing of medication.

PRESCRIBING

Prescribing demands an appropriate and safe amalgamation of patient, drug, and condition factors.[2] Prescribers can check formularies for guidance on a specific drug's actions, interactions, and indications. In patients with multimorbidities, the synthesis of factors to consider when prescribing can potentially spiral in complexity.[3] The more conditions a patient has, the more complicated their overall condition and the more medication they require, and polypharmacy ensues.[3,4] However, this is not invariably the case. Single diseases may need multiple medications, but it is possible to have several morbidities and not need drugs at all. Patients with multimorbidity are a heterogeneous group. Those with conditions that 'go' together, with synergistic management strategies, are easier to make prescribing decisions with, than those who have discordant conditions, where the medication regimens may be countering one another.[5]

Any morbidity can potentially alter what can be expected of a drug's action, when it is being used to treat something else.[6] Drugs are more prone to causing toxicity when a disease, such as chronic renal failure, means they are not properly processed or eliminated.[6] Our desktop and electronic formularies may not be sufficiently sophisticated to dictate how to prescribe in complex situations, so utilisation of clinical experience or seeking specialist advice may be required.[3] An increasing number of conditions, with the associated increase in prescribed drugs, leads to a potentially increased chance of adverse drug effects.[4] These can, as well as being uncomfortable inconveniences for the patient, mean that more medication is issued to ameliorate side effects of current drugs.[3] Additionally, iatrogenically precipitated problems such as falls and confusion, may lead to yet further morbidity to add to the patient's load.[6]

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GUIDELINES

National guidelines are available to provide evidenced-based recommendations on how drugs should be used in the majority of single diseases and their use when prescribing is generally expected by professional regulatory bodies.[2]

The literature on multimorbidity is critical of these single-disease guidelines when it comes to treating a patient with multiple conditions.[7] The research on which much guidance is based cannot necessarily be generalised to patients not represented in the original trials; that is, patients with multimorbidity. However, GPs in the UK are asked to achieve clinical targets, including for patients in this group whether applicable or not, in line with these guidelines, and are financially incentivised to do so.

While doctors can be assumed to want the best for their patients, their own performance is regulated and monitored, and may mean some feel they have to follow the chronic disease management 'rules'. Multiple conditions can warrant multiple yet conflicting 'guides,' which are not possible to follow concurrently. There is little evidence on how best to treat these patients with multimorbidity.[8] Therefore, the prescriber has to make relatively uninformed decisions, adjustments, and compromises on treatment paths.

ACTUALLY TAKING THE MEDICATION

Patient information leaflets, as with guidelines, are generally disease specific. Patients may have to wade though piles of information to try and understand their combination of conditions, in addition to talking it through with their clinicians. It may be that they are prescribed medications and yet not clear about what they are for.[3]

It is not an uncommon sight, in the homes of patients with a number of complicated conditions, to see loaded dosset boxes, blister packs, or to have rows of pill bottles laid out accompanied by 'when to take' timetables, in an attempt to facilitate adherence to complex regimens. Carers may need to be employed for the purpose of helping with drug administration. Managing numerous medications in addition to the illnesses can be very problematic for the patients; the physical and financial burdens can be great. Integral to diligent prescribing is review. Frequent 'brown paper bag' reviews, where the patient brings all the medications they are taking and discusses them with the prescriber, are recommended.[3] A review includes assessing whether the patient wants or needs the prescriptions; as many patients choose not to take multiple medications as prescribed.[3]

APPROPRIATE PRESCRIBING

The common occurrence of polypharmacy in multimorbidity should not be expected to be necessarily hazardous.[3,9] Patients with multimorbidities are likely to benefit from medication appropriately prescribed. Payne *et al* conducted an analysis of Scottish primary care data and were able to demonstrate that hospitalisation is reduced in patients with multiple conditions when they are also on multiple medications.[9] Under-prescribing in patients with multiple morbidities for treatable parameters because of prescriber caution may be as detrimental to them as taking too much medication. The difficulty for the prescriber is to know how to best prescribe

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appropriately in these complex patients, while for the patients there is the difficulty in accessing useful advice (because of lack of clear information) to decide what medication to take.

WHY PRESCRIBE IN MULTIMORBIDITY?

Symptoms, risk, and patient's goals

Reasons to prescribe drugs include relieving symptoms of disease, or preventing further disease. Generally these are clinician-set prescribing targets. Emerging preliminary guidance on how to prescribe for patients with multimorbidity involves, importantly, negotiating with the patient, and if appropriate their carer, regarding the goals they want to achieve from their treatment.[10] When setting patient-driven prescribing targets the aim could be, for example, to improve quality of life rather than reducing conventional markers of chronic disease.[10] With this as the primary objective the prescriber can then make prescribing decisions in conjunction with the patient, some of which may be outside current usual practice. Additional suggested recommendations to improved prescribing include longer consultations, continuity of care, working in teams, and streamlining the patient's interface with the medical profession.[4,10]

How prescribing decisions are reached; outside the guidelines

Traditionally we see clinicians using their clinical skill to guide their thinking in complex prescribing decisions either alone in their clinics or with the help of colleagues. At its best, this can be an example of virtuosity in efficient and effective prescribing, providing a patient with their 'gold standard' of care. However, the success of this process can be somewhat haphazard depending on the acumen of the clinicians involved. All patients deserve transparent, auditable and recordable advice, based on good reasoning, even if a tangible evidence base is not available. Soubhi *et al* explain the concept of the use of 'practical know-how' used by clinicians and teams in treating patients with multimorbidity.[11] This 'know-how' can be termed tacit knowledge, which is not usually explicit and hence difficult to communicate to colleagues, trainees, patients, and even to the prescriber, who may be acting on an informed intuition. Making such tacit ideas explicit is important in developing skills to care for patients with multimorbidity, for the education of professionals caring for them, and to be able to maintain accountability by more accurately documenting the rationale behind decisions made.[11]

Sinnott *et al*'s rigorously conducted qualitative study, which appears in this issue,[12] seeks to understand how GPs make prescribing decisions in patients with multimorbidities. They describe this decision-making process as 'satisficing', where doctors accept care that is satisfactory and sufficient for particular patients.[12] The study opens the 'black box' on what is going on in the mechanism of prescribing decisions in complex situations, revealing the tacit processes. It is a substantial contribution to the body of evidence that promises to emerge to guide professionals and patients on how best to prescribe in multimorbidity.

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