

EDITORIALS

Priority Setting for Patients with Multiple Comorbidities: Diabetes May Not End Up Number One

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Kerr and colleagues evaluated the relationship between types (related and unrelated to diabetes, microvascular and macrovascular), number, and severity of comorbidities with patients' prioritization of diabetes and perception of their ability to carry out diabetes self-care management tasks.¹ The authors remind us that our continuing desire to focus on treatment of a single disease at a time does not match the vast majority of our patients who have multiple diagnoses. Kerr argues that the importance of this work is delving into the nuances of which comorbidities are more or less influential on patient prioritization (and not just raw counts of comorbidities). However, I would argue the importance is in reminding us that we do a lousy job of integrating information and treatment for a given patient. We need to coach patients with diabetes to make the best decisions for their circumstances, even if that means deciding not to prioritize diabetes.

Let us consider why a new and better version of priority coaching is necessary. Mr. Jones has diabetes, hypertension, coronary artery disease, hyperlipidemia, obesity, severe bilateral knee osteoarthritis, and depression. When his depression worsens, so does everything else. His depression is aggravated by his knee pain and steadily worsening ability to walk. But he is reluctant to consider knee replacements yet because he is only 52 years old and he is worried that they will wear out and need to be redone. His coronary disease is medically managed because it appears on thallium scan to be a 1-vessel distribution, but his angina has been getting worse despite his exercise becoming more limited. He would need to have a more definitive procedure for his heart before he could have orthopedic surgery. In addition to his medical problems, he is the sole breadwinner for his family consisting of a wife and 4 children under the age of 18. Luckily he has sick leave, but has used up most of it by taking sick days for his various doctors' appointments and for frequent viral infections, which his youngest son brings home from kindergarten. His health insurance from his job as a bus driver covers some drug costs, but has significant formulary restrictions, which he does not always know at the time he visits the doctor—he finds out afterwards when he tries to fill the prescription and is confronted with copays of \$100 or more for the newest nongeneric diabetes or lipid-lowering drug. When this happens, he is prone to just not fill that drug rather than call the

doctor back to seek an alternate prescription. How would a diabetes specialist set priorities with Mr. Jones? How would a primary care physician set priorities? What information could be given to Mr. Jones to help him set his own priorities? How could they be woven together to help him choose among priorities if he feels overwhelmed and unable to comply with all of the recommended treatments? How do his physicians "see" his life—his work, his children's needs for his time, his increasing physical limitations—when they make treatment decisions? How well do they engage him in these decisions?

Currently, very few of our care systems in the US are designed to deal with patients like Mr. Jones who are in fact our typical patient. Work like Kerr's serves to remind us of how complex our patients have become as we extend life spans. We now have to create whole new ways of thinking about care for such patients. Even the Chronic Illness Care Model still tends to leave the impression of focusing on a single disease. (<http://www.improvingchroniccare.org>) Clinical practice guidelines, as currently designed in a disease-specific manner, are woefully inadequate for dealing with the intersection of comorbidities and prioritizing among treatments. We need new methods of estimating the added benefit (and risk) of each additional medication in terms patients can understand. We also need new methods of assisting patients with adherence such as the idea of the "polypill"² and removing copayments for drugs for diseases with poor outcomes (Berger J. Health & Welfare Plan Management and Design for Marriott International [speech]. AHRQ Annual Conference: Improving Healthcare. Improving Lives 9/27/2007, Rockville, Maryland). Better behavioral training of physicians will also be necessary to help them motivate patients toward behavior changes. However, the assumption that this will be done within the confines of a 15-minute office visit is a fantasy. Building a system that actually promotes both informational and relational continuity of care will also be imperative—both of which are frequently lacking in our system.

Whereas Kerr's work is helpful to the diabetes health services research field, it is also important to those who are engaged in trying to transform health care. The work reminds us that we need to take care of the whole person, not just their heart, knee, or pancreas, and to truly let that person be the decision maker with the care team providing information and support. The potential of electronic medical records and longitudinal databases helping in these endeavors is real, but more importantly there must be a huge shift in our thinking about what is needed with regard to the human element. Mr. Jones is not a diabetic. Mr. Jones is a father, a bus driver, and a person with multiple medical problems including diabetes, osteoarthritis, coronary artery disease, hyperlipidemia, and hypertension. Our job is to help him prioritize among his

comorbidities in ways that keep him as the most functional person he can be.

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