Editorials

'Multimorbidity':

an acceptable term for patients or time for a rebrand?

DEFINITIONS AND MEANINGS

The simultaneous presence of multiple pathological conditions is the norm.[1] The construct of comorbidity was defined by Feinstein as: *'any distinct additional entity that has existed or may occur during the clinical course of a patient who has the index disease under study'*.[2,3] Multimorbidity refers to the co-occurrence of multiple chronic conditions in an individual,[4,5] or the presence of two or more long-term conditions.[6]

Evidence suggests that people with multimorbidity report worse experiences in primary care.[7] Muth *et al* describe the Ariadne principles, which might support clinicians in managing patients with multimorbidity, and include: *'assessing potential interactions'*, *'eliciting patient preferences and priorities'*, and *'individualised patient management'*.[8]

The National Institute for Health and Care Excellence (NICE) guideline for multimorbidity[6] emphasises the need to take a person-centred, holistic approach to patient care, and provides guidance about key principles to consider when managing patients with multimorbidity. The guideline attempts to shift the emphasis from single-disease guidelines, and care delivered in silos, to encouraging clinicians to work with patients with multiple conditions to clarify what is important to them, including their personal goals, values, and priorities. The results of these discussions can help frame a discussion about current treatments and their value to the person.[6] Mair and Gallacher[9] emphasise the need to explore what matters most to people with multiple conditions, and to their caregivers, and to support clinicians to enable them to respond more effectively to the complex care challenges posed by people with multiple conditions.

NEGATIVE PERCEPTIONS

A Taskforce on Multiple Conditions, a cross-sector partnership led by The Richmond Group of Charities, Guy's and St Thomas' Charity, and the Royal College of General Practitioners (RCGP) (https://richmondgroupofcharities.org.uk/taskforce-multiple-conditions), was established in 2018, with the aim that people with multiple long-term health problems live as well as possible, for as long as possible.

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The Taskforce has published results of an ethnographic study: *'Just one thing after another' — living with multiple conditions*,[10] which illustrates the challenges faced by people with multiple conditions, giving an often unheard voice to this important discussion. One of the findings reported was the reflection by participants that 'multimorbidity' was not a useful or acceptable term. Research conducted by Ipsos MORI, on behalf of Guy's and St Thomas' Charity, has explored the framing of 'multimorbidity' and identified that those living with multiple conditions felt that medical language, including the term 'multimorbidity', could feel negative and discouraging. The complexities of living with multiple conditions were not thought to be addressed through the term 'multimorbidity', which was felt to suggest a single disease, reinforcing a biomedical model. The Taskforce has suggested that shared language is needed to describe the complexities across the whole system, ensuring that people are seen 'in the round', with care responding to an individual's wider needs.

At a recent conference focusing on mental–physical multimorbidity,[11] conference participants were asked to contribute to a discussion about the use of the term 'multimorbidity'. One participant asked, 'why do we need a label?', and a further participant commented, 'morbidity sounds serious, like fatality'; reinforcing the negative associations of the term 'multimorbidity'.

THE PATIENT'S EXPERIENCE

How can one word to sum up the experience of individual people, who have varied combinations of medical conditions, set in the context of their real lives, be sufficient? What is clear is that people understand the links between their medical conditions, the medication prescribed (including side effects and interactions), and have clear priorities and preferences.

Many patients bring lists of problems to their appointment; and the clinician working through such a list can ensure that the consultation is patient-centred.[12] Figure 1 is an example of a note brought to a consultation by a patient. The patient has given permission for this summary to be used to help explain how a patient experiences what clinicians might describe as 'multimorbidity' or problems within a 'biopsychosocial' framework. Clearly this patient has made links between their condition and has indicated what their priorities are (the example has been modified to preserve anonymity).

HOW TO BE MORE POSITIVE

Use of language matters, and getting it right (or wrong) can promote (or prevent) an ethos of shared endeavour between clinician and patient. So, what term should be used to reflect the complexity of living with more than one medically diagnosed condition, each possibly needing intervention? Suggestions from people attending the Keele conference focused either on conditions or needs. Experts by experience

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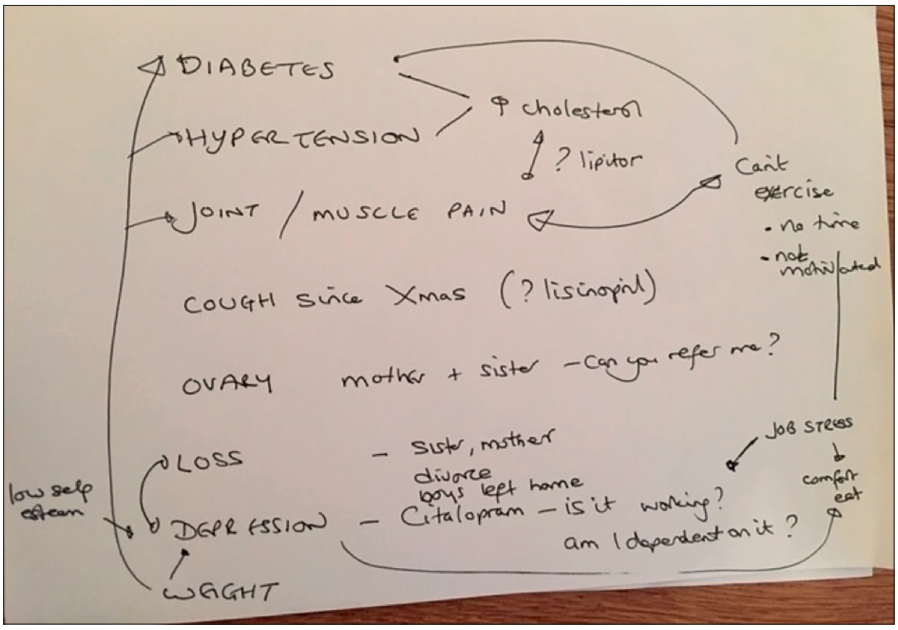

Figure 1. An example of notes that a patient brought to a consultation. The patient gave permission for this summary to be used: it has been redrafted and modified to preserve anonymity.

on the Taskforce suggest that 'multiple health conditions' and 'living with a number of conditions' would be more appropriate terms to use. In addition, 'multiple health needs', 'coordinated care needs', and 'complex needs', are all suggestions to replace the term 'multimorbidity'.

Therefore, we suggest that the term 'multimorbidity' is not an acceptable term to a number of individuals, and we should open up discussion around what could be a more acceptable term for all. We hope that improved and negotiated language will lead to better communication and health outcomes.

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