

## Short Communication

# Notes for a Theory of Multimorbidity in General Medicine: The Problem of Multimorbidity Care is Not in Practice, but in the Lack of Theoretical Conceptualization

Jose Luis Turabian\*

Health Center Santa Maria de Benquerencia, Regional Health Service of Castilla la Mancha (SESCAM), Toledo, Spain

## Abstract

Multimorbidity is usually defined as the coexistence of two or more long term conditions within an individual. Multimorbidity is not simply a problem of chronological ageing, neither it is randomly distributed, and it come about most in deprived areas than in the affluent ones, and with a greater mix of social, mental and physical problems. In everyday primary care settings, multimorbidity is more the norm than an exception, and there is a broad international consensus that multimorbidity is best addressed in primary care settings. But, a despite of this, current guidelines focus on isolated management of one disease, and it forgets the psycho-social problems. In this dramatic scenario, this article presents some first notes to develop a theory of multimorbidity in general medicine, by the use of similes, metaphors and analogies, based on the art world, for helping to clarify concepts in response to the misleading dilemmas produced by the multimorbidity approach, with the aims of: (a) to discover unspoken forms to give multimorbidity meaning; (b) to name experiences of make decisions in multimorbidity; and (c) to imagine new possibilities of care. It is concluded that the problem of multimorbidity care is not in practice, but in the lack of theoretical conceptualization, and the main theoretical elements on which practical initiatives should be based to address multimorbidity in general medicine, are: 1.-Prioritize problems with “energy” or “hot” (“master problems”) with qualitative methodology (and these “master problems”, generally, are not the most serious diseases, nor the most important from the orthodox biomedical point of view); 2.-Medicine based on prognosis, which is marked mainly by psychosocial rather than biological factors; and 3.-De-prescription for leaving the labyrinth of polypharmacy and multiple drug interactions.

“He who loves practice without theory is like the sailor who boards ship without a rudder and compass and never knows where he may cast.”

Leonardo da Vinci

## Introduction

Multimorbidity (the presence of two or more long-term conditions), with the overlapping of mental, cardiovascular, diabetes, cancer and respiratory diseases, is a generalized phenomenon that affects the health of populations throughout the world, with the highest burden among individuals or disadvantaged subpopulations, having become a serious public health problem due to its negative consequences on the quality of life, the greater tendency to disability and mortality, polypharmacy, and cost of utilization of health services, and that give place to a considerable burden of care which falls heavily on the primary health care provider (1).

There is a broad international consensus that multimorbidity is best addressed in primary care settings by a patient-centred approach, including regular appointments for comprehensive problem review and management options tailored to individual patient preferences. This care should be provided by a multidisciplinary team with a named lead clinician/family doctor/general practitioner and should be based on effective clinical information systems (2-4).

However, conceptual systematization of multimorbidity care in the specialty of family medicine/general medicine has not matched with practice. But, it is not until that the conceptual heritage of family medicine, is ordered, systematised and fully clarified when it can begin

the real practical work. The theory interprets facts. It is created in contact with them and then it can anticipate others that are not yet known or did not occur. A good theory detects causes and predicts effects. The theory must be articulated with practice, but many want to confront them. The ignorance or contempt for natural laws, action without feedback, generates catastrophes. To generate hypotheses, observation can be replaced by ideas, observing from another point of view. For scientist, knowledge is his instrument. Therefore, it is necessary to achieve more meaningful representations of the fundamental concepts of family medicine and facilitate the transfer of these to clinical practice. But, these concepts can be difficult to understand and explain, even for experienced physicians in the specialty (5-9).

## Observation or Findings

Many practical initiatives arise in relation to the assistance of the patient with multimorbidity and / or complex fragility, to help the family doctor to treat the main pathologies in the complex sets of diseases such as heart failure, COPD, etc. : hospital-primary care coordination, creation of interconsultation channels, patient-centered

\***Correspondence to:** Jose Luis Turabian, Health Center Santa Maria de Benquerencia, Regional Health Service of Castilla la Mancha (SESCAM), Toledo, Spain, Email: jturabian@hotmail.com

**Received:** August 10, 2018; **Accepted:** September 7, 2018; **Published:** September 16, 2018

**Key words:** Multimorbidity; General Practice; Decision making; Theoretical Study; Metaphors

interventions, etc. But the essential question remains as to whether these practical interventions really improve outcomes for patients living with multimorbidity and the health systems that care for them. For example, regarding patient-centered interventions, it has been reported that they have little or no difference in clinical outcomes or in the use of the health service, while it is suggested that health outcomes could be improved if interventions are directed to specific risk factors or functional difficulties (2). Therefore, we are facing practical initiatives, undoubtedly well-intentioned, but which suffer from being childish, superficial, medicalizing (although they start from the opposite assumption), and therefore, counterproductive for these patients and health systems. In summary: the practical solutions without having consolidated their theoretical conceptual base are unproductive.

Doctors are working within the legacy systems that have been developed to address the problems of the 19th Century, which provide specialized responses to disease and acute individual infection. At the same time, daily practice is strongly influenced by a growing variety of protocols that are not clearly focused on the reality of clinical practice, and in particular, on the ubiquity of multimorbidity. The result is fragmented and poorly coordinated health services for those most in need of vulnerable patients with multimorbidity. Today's health professionals are faced not only with the increase in the disease, but also with the interactions between drugs and the iatrogenicity of drugs, in populations with multimorbidity, and of socioeconomic disadvantage. Meanwhile, patients, their families and their social networks experience not only the burden of symptoms, but also the burden of treatment (10).

It is implausible to assume that the organisation and delivery of even the highest quality primary care is sufficient in itself to address the complexity of multimorbidity, the underlying causes of which are often rooted in socioeconomic deprivation (2, 11-13). In this dramatic scenario, where it happens that health professionals know how to act in practice, but have nothing to say about their theoretical conceptualizations; that is, there is practice but ideas and concepts where the practices are settled are lacking, this article presents some first notes to develop a theory of multimorbidity, which later allow to give rise to multimodal approaches that link the primary care centered on the patient with multimorbidity with public health policies that address the determinants of behaviour, environmental and occupational diseases and long-term inequity. And for this task of showing theoretical concepts, we are going to use metaphors based on the art world. The new metaphors have always been crucial to any theoretical advance; a metaphor means that in relation to what we use the metaphor for, it becomes a new thing (14).

In this way, the aims of this paper are: a) to discover unspoken forms to give multimorbidity meaning; b) to name experiences of make decisions in multimorbidity; and c) to imagine new possibilities of care. This can give rise to transformative experiences because new ways of thinking and acting are generated (15).

## Discussion

The main theoretical elements on which the practical initiatives to address multimorbidity should be based are:

1.-Prioritize problems with “energy” or “hot” (“master problems”) with qualitative methodology (and these “master problems” are not usually the most serious diseases, or the most important)

2.-Medicine based on prognosis which is marked by psycho-social factors

3.-De-prescription

### Prioritize problems with “energy” or “hot” (“master problems”) (1)

Multimorbidity is presented as non-operative to make useful decisions. Patients with multi-morbidity produce feelings of despair and impotence in the doctor. To these problems it seems that the known patterns of diseases and the existing protocols and guides can not be applied, and their intensity and complexity can overwhelm even experienced professionals. In many cases, the attention is made entirely in somatic terms or using biological protocols, which if applied to each of the patient's problems, produce contradictions and originate new and serious problems such as polypharmacy (16-18).

Furthermore, in patients with multi-morbidity, it must be understood that, independently of their multiple biological problems, they present a secondary psychosocial problem “hidden”: the own multi-morbidity. And of all the health problems of the patient with multimorbidity, which one should we prefer to focus on as a priority? What factors, or characteristics, make one of them superior, or with more value than another? The nature of an important problem is distinguished by two characteristics or aspects: 1) that is more permanent, deeper, elemental and less variable; and 2) that the intervention on the problem is more beneficial or adequate, or that the intervention produces a convergence of its effects that intensifies its beneficial value (Table 1). The health problem will be more important the more dominating these characteristics are. Prioritizing the intervention on the problem with more important character, the value of the intervention is intensified up to the highest limit.

A major problem or energy or “master problem” is one in which, in the clinician's judgment, for that patient, at that time, and that context, concentrates the greatest importance or significance for the patient's health / illness, and that allows “advance” (open doors, change scenarios). A “master” problem is one that allows us to address or “cure” or “solve” facilitating the unlocking of a situation, change or move from one scenario to another with new perspectives or restore interrupted connections. So, finding the problem “with energy” is a subjective experience.

A problem with “energy” or “master-problem” is the one that gives us a blow in the mouth of the stomach, the one that makes us beat faster the heart, the one that moves us on many levels. This type of problem has a great “density of emotions”, human elements, social symbols, it is complex, multiple and dramatic or theatrical (the clinical history is articulated as a scenario, all the things in that clinical history make us look, to leading us, towards a certain point) (1). A general orientation is to find “the system that defines the problem”, which means the set of problems, situations and people affected or related by the problem, both in terms of maintenance (cause) or changes (treatment). In many

Table 1. Characteristics of the more important problems.

Characteristics of the more important problems	Concept
1.-It is more permanent	Problem is deeper, elemental and less variable
2.-That the intervention on the problem is more beneficial or adequate	Intervention produces a convergence of its effects that intensifies its value

occasions, we can find in the clinical interview and the taking of the clinical history, a series of signals that direct us, whether we like it or not, towards the “master-problem”. If we use a simile in the art world, we could say that is what happens when we look, for example, The Seizure of Jesus, by Giotto di Bondone, 1302-05, fresco in the Chapel of the Scrovegni of Padua. The position of the characters, and the spears, canes and torches of the second and third rows, directed us toward to seeing the kiss of Judas to Jesus with all its drama (Figure 1) (19).

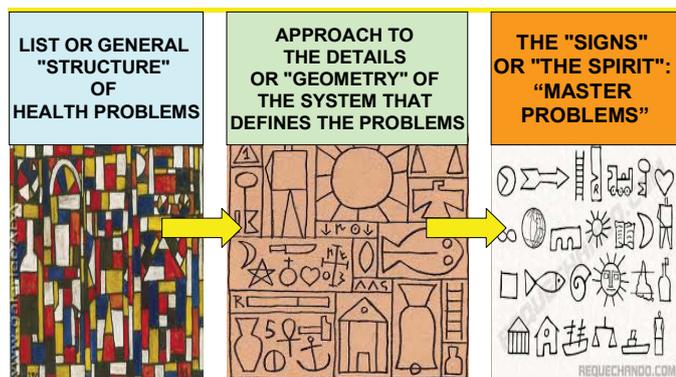


Figure 1. The unveiling of the “Master Problems”.

The mechanism to try to be “objective” in unveiling “master” problems is to always consider the importance of detail against the background of the theoretical framework. The choice of detail, which directs us towards the “master problems”, is mainly a decision of interests of the professional as the scientific truth depends on the theory, and some form of theory is necessary for all forms of attention (20, 21).

“Master problems” should be “iconic” or as abstract as possible (that transcends the external appearances of reality, referring to the most essential). That is to say, they do not have their own reality, but rather they depend on the interpretation that is given to them, and based on the theoretical framework bio-psycho-social and not exclusively on the biological. “Master problems” are a consequence, not of the health problems we see, but of how we see them: coronary heart disease, COPD and inflammatory bowel disease mean nothing, until they acquire a certain meaning from a discharge of energy that is produced within the mind of the professional from the narration and experience of the patient. This dependence on the theoretical framework brings as a consequence its effect of objectivity; the more an effect of plausibility is sought with the theoretical framework, the more must be resorted to the maximum abstraction or contextualization (16).

From their narrations, a more varied picture of living with multimorbidity can emerge. This then represents a more realistic image of how each person shapes their multi-morbidity and gives flexible responses within their own social context, which can help formulate more effective ways of supporting them (22-26). The management of

people with multiple chronic conditions challenges health-care systems designed around single conditions. There is international consensus that cares for multimorbidity should be patient-centred. Although patient-centred interventions have been reported to have little or no difference in clinical outcomes or in the use of the health service, these interventions do not cause harm and have a better assessment by the patient (2). Therefore, despite the fact that the disclosure or decision making about “master problems” is a task and responsibility of the family doctor and not of the patient, it should be carried out taking into account the narration and experience explained by the patient. A modified version of the so-called “triangular reflective equation” has been proposed that could allow the interaction in medicine of the inputs coming from conceptual and existential reflections. It would be a question of directing attention to the possibility of remodelling decision-making in a way that best accommodates socio-psychological reflections, as well as narratives and rational ones. The method and process is based on 1) descriptive narratives, 2) judgments, and 3) rational arguments. It is intended to do everything possible to facilitate the interaction between entries from individual narratives of a situation and critical reflection on it that the professional can deduce from the interaction with other people (27).

The unveiling of “master problems” is like the task of the abstract painter, which begins with charcoal drawings of concrete problems -the list of problems-, and is transformed, through later drawings with a slow and intuitive painting and repainting on the canvas, in a layout of lines and colours (28). Figure 1 presents graphically, based on this artistic metaphor, the process of the unveiling of the “master problems”: 1) list or general “structure” of health problems; 2) approach to the details or “geometry” of the system that defines the problems; and 3) the “signs” or “the spirit”: the true “master-problems”. Following this metaphor, the process is to capture the “small sensations” and arrange them as “master-problems”; it is not to simplify the list of problems but to create a list “parallel to nature”; this it is not for dealing with the “light”, but for capturing the “issues where is the force” that are in front of doctor, and so showing its physical presence, and also its relations and special tensions that exist between them; the emphasis is not on retinal seeing, but on the complex process by which we relate physically and spiritually to the patient’s problems. This requires emotion first and understanding later, but is also based on thought and knowledge (29). Table 2 presents the possible mechanisms to attribute energy or value to the patient’s health problems.

But then, how to try to be “objective” in the “subjective” choice of the master-problem? A judgment based on instinct can be unpopular. Medical journals tend to avoid “poetry” for these same reasons (30). Is there any way of understanding and controlling the subjectivity of the assessment of what is a major problem or master-problem? Is there any way capable of avoiding subjectivism without moving on to “fictitious” objectivity (“mathematical” decisions, for example by giving values to problems and using some kind of statistical calculation to know the

Table 2. Possible mechanisms to attribute energy or value to the patient’s health problems.

1.-By means of reflecting and arguing in an interpretative way about the essence and the peripheral as a means to confer or confirm a value
2.-By means of giving less importance to the “figurative” or visible meaning of the problem and more to its underlying “intention”
3.-By means of seeking the interdependence of knowledge and opinion. It is not about accumulation of information, but about knowledge
4.-By means of applying the findings of science to the humanities. Humanizing and personifying images, ideas, problems, pathologies and concepts by turning them into living subjects
5.-By means of accepting uncertainty: the construction of “master problems” is more passionate than precise, and its knowledge is not exact
6.-By means of abstracting or contextualization
7.-By means the narrative in the clinical interview (often during many visits in the course of a long time -continuity of care in family medicine) that patient and his relatives or other characters protagonists of the story, make about their problems

different importance or the weight of explanation of the variance)? **Table 3** shows how “objectivity” is achieved in “subjective choice” through the certain processes.

The conventional clinical approach implies to establish a diagnosis, a prognosis and a treatment. “Prognosis” is the forecast of the probable outcome or course of a disease; the patient’s chance of ‘recover.

**Table 3.** Processes by which the "objectivity" is achieved in the subjective choice.

Processes by which the "objectivity" is achieved in the subjective choice	Concept
1.-Reflecting and arguing	Reflecting and arguing in an interpretative way about the essence and the peripheral as a means to confer or confirm a value
2.-Triangulating	Triangulation is to get different perspectives of the phenomenon studied using different research methods. It is possible to differentiate four types of triangulation: 1) by the sources of data (data triangulation), 2) by different evaluators (triangulation of researchers), 3) by perspectives on the same set of data (triangulation theory), and 4) by methods (methodological triangulation)
3.-Verifying	Verifying is the process of checking, confirming, making sure, and being certain. Verification refers to the mechanisms used during the process of decision to incrementally contribute to ensuring reliability and validity and, thus, the rigor of a decision

### Medicine based on prognosis which is marked by psycho-social factors (24)

The concept that something is “objective” actually refers to that something is relative to the object itself. Therefore, we are always facing subjectivity. To be “objective” it would be necessary to be the object in itself and that is only possible with us. That is, it is only objective, for us, what we ourselves think, believe, perceive. In this scenario, the mathematical vision is the most objective, but the one that deduces fewer things and, therefore, the one that has less possibility of anticipating a false fact. The vision that we traditionally call “objective” (biomedical) is the one that worst performs the task of “forecasting” (prognosis).

One example is the artistic work- experiment “Registry of Inside” of Antonio Ortega (31), on which he explains that is the base of the determinism of actions: as long as you know and can effectively measure all the variables within a specific space, you can potentially predict the behavior of their elements; The artist plants four equal plants located in a line, being its only source of light a focus located at the extreme right on the same line. Evidently the plant that receives more light grows faster and stronger. It is objective in that it reproduces a universally accepted system, that is, it reduces the minimum of variables to analyze the results without distractions. Their results, in addition, agree with the expectations of anyone who has the minimum notions of biology. The plant with more light is the one that best develops: It is foreseeable. So, you could say that as long as you know and can effectively measure all the variables within a specific space, you can potentially predict (“objectively”) the behaviour of its elements; but, the human being is too complex to predict their actions, unless the study is reduced to elements of less complexity and the variables are controlled, that is, in laboratory conditions and of “reductionism” (loss of information), but not real life, it could be reached to predict with certainty the behavior. The topic of interest is then how to decide what is important and what is not, or what is real and what is not.

Trying to anticipate the future (forecast), as the companies that make predictions on the consumption of their customers know (For example, Amazon, one of the famous online store in the world, tells us what “we” should buy in its section “This also could interest you” based on previous buyers, the social network Facebook” guess “who we know” from the information of our contacts, and pioneers supermarkets (real, not virtual) are already implementing similar techniques on a screen coupled to the shopping cart where they remind you of the products that you usually buy when passing near them), could be made with predictive engines that use statistics and algorithms. But this prognostic is related to network environments, forms, objectives and participation: it is related with psychosocial context (31).

Diagnosis has been considered as the main guideline for treatment and is considered the central component of clinical practice; but prognosis, which refers to the possible outcomes of a disease and the frequency with which they can be expected to occur, is an essential element of health care decision making is related to “what is going to happen next” (32-34).

The prognosis is a fundamental requirement to be able to make correct therapeutic decisions. Of course, the diagnosis of the disease is a basic component of medicine, but it does not provide a sufficiently big framework to make useful decisions, which must incorporate the variability in the patient’s individual risk, that goes far beyond biomedical disease; so, the prognosis can provide the general practitioner with such a framework for future decisions.

Many are the factors depending on the disease, such as its severity and extent, the involvement of vitally important organs, the degree of disorder in the organic functions and the possibility of reversibility of the functional and morphological changes of the organism, the frequency and severity of its complications and the duration of the disease, which greatly influence the prognosis, and should be known and evaluated. Other factors that depend on the patient, such as age, sex, previous health status, the diseases they suffer, the inheritance, the cultural level, the disposition and possibilities of cooperating with the treatment, and the physical and mental state are also very important in the forecast. The temperament and character of the patient are also essential for the prognosis of the course of the disease and the ability to work after convalescence. Some patients become disabled because of insignificant disorders, and others fight valiantly against their illness and have an active lifestyle (35).

The identification and management of the physical signs and symptoms of the diseases has improved, but the psychosocial burden is often not recognized and neglected. In this way, the psychosocial dimensions of the diseases are often overlooked when considering medical care and disease prognosis, despite its relative importance (30). The topics or questions that interest the patient are not easily known, and can be presented by symbols, as does the arrangement of the notes in a musical score; as a “mysterious constellation” (36).

General practitioners are able to understand the prognosis and full impact of the disease (neurological, cardiologic, etc.) and assess the prognosis, course and severity in a specific individual, without having “protocols” for each health problem in each patient. What do family doctors use to target the breadth of the clinic? How do they manage to find the middle of the clinic, without apparent reference points, in such concrete data? The course of the disease is influenced by the concurrent psychosocial factors; the severity and prognosis of the disease can be

predicted more accurately from the loss of social and family roles and activities than from the biologic pathology. The prognosis of diseases depends more on psychosocial factors than of biomedical factors (37).

For the family doctor, the same problem takes different forms according to its context background. There are different prognoses of the same symptom or disease according to contexts (21). Patient prognosis is determined by more than disease diagnosis. Prognosis can be highly variable in persons with a same particular diagnosis. There are different prognoses of the same symptom or disease according to contexts. Given the fundamental importance of the prognosis in medical practice, it is recommended to move from a diagnosis-based medicine to one based on prognosis (24, 38).

## De-prescription

Polypharmacy is the other side of the coin of multimorbidity when its attention is focused, as is usually done, with the “evidence-based” guidelines of each isolated disease. And, in addition, polypharmacy in turn causes more morbidity, basically iatrogenic. It must be borne in mind that the possible pharmacological interactions multiply exponentially as the number of drugs present in a patient increases, and such interactions, in each particular case, are not even described in the literature, being a new phenomenon not yet explored. So, multimorbidity tends to suggest the metaphor of the “Labyrinth” (39, 40): the story says that Ariadne, having consulted the architect Daedalus helped Theseus to find his way out from the Labyrinth, where he was supposed to be destroyed by the Minotaur (41). **Table 4** presents some suggestions to help us out of the maze of polypharmacy in multimorbidity (39, 42).

De-prescription is a symmetrical process and closely linked to the prescription that requires prudence, deliberation and assimilation of the ethical principles that direct the medical duty: 1) justice; 2) It can attract health benefits (beneficent); and 3) It is safe (not maleficent) (43, 44). De-prescription is not prudent without deliberation, without taking into account the patient’s preferences. The autonomy of the patient is the power of veto that must modify the priorities of de-prescription. If this is not the case, there is a risk that the patient interprets the de-prescription process in a distant, passive, distrustful manner, such as a bureaucratic problem, cost reduction or health care inter-level confrontation. The doctor should also monitor the risk of uncritically de-prescription, without considering the patient’s preferences or their vital context, guided by business interests or consensus algorithms that ignore the importance of the doctor-patient relationship. It is essential

to inform and reassure the patient that de-prescription does not mean abandoning the therapeutic objectives; on the contrary, it is designed to eliminate the risks of those non-beneficial medications. One approach is to propose the relaxation of these objectives (blood pressure figures, glycaemia), as well as anticipate possible barriers and discuss them with patients and caregivers.

Family doctor has the responsibility to update and review the prescriptions that he carries out, as well as any other drug that each patient takes, especially elderly, polymedicated or multi-pathological persons, in order to promote the benefits and safety, including the withdrawal of the inappropriate prescriptions. This makes to family doctor the most suitable health professional for de-prescription due to patient closeness, for controlling treatments prescribed in other levels, for longitudinality and accessibility in care. General practice level is the best place to understand and integrate the different orbits of the patient: social, functional and biomedical.

Basically, we should perform de-prescription when: 1) the indication of the drug is unclear; 2) the benefits achieved with the drug are not clear; 3) the risks of serious adverse reaction are high; and 4) the risks of serious drug interaction are high. What tools to de-prescribe can be used? (43). De-prescription is usually guided by intuition, although there are decision instruments that allow us to indicate the drugs susceptible to withdrawal. **Table 5** presents these instruments of help for de-prescription. As with prescription guidelines, these instruments should be used with prudence, since they can bias the process and trigger decision cascades that detract from the context and preferences of the patient (45-47).

## Conclusion

Multimorbidity is not simply a problem of chronological ageing, neither it is randomly distributed, but it comes about most in deprived areas than in the affluent ones, and with a greater mix of mental and physical problems. On the other hand, despite the ageing population experiencing an increased prevalence of many chronic conditions current guidelines focus on isolated management. In everyday primary care settings, multimorbidity is more the norm than an exception (48). There is a broad international consensus that multimorbidity is best addressed in primary care settings. This care should be provided by a multidisciplinary team with a named lead clinician/family doctor/general practitioner, and should be based on effective clinical information systems (49).

**Table 4.** Some suggestions to help us out of the maze of polypharmacy in multimorbidity.

1.-We should avoid using drugs to treat problems that are not “master-problems”, if possible. This would be the first rationalization of drug treatment - avoid “gun shot therapy”
2.-We should Identify “master”-drugs interactions: avoid clinically important drug interactions in that particular case and in that particular context (it is a semi-qualitative tool)
3.-Each patient needs a comprehensive assessment with a view to developing a personalised therapeutic regimen
4.-De-prescription

**Table 5.** Some instruments of help for de-prescription.

Instruments of help for de-prescription	Commentary
- Garfinkel Algorithm	Formal structure guided by questions that assess scientific certainty about the benefits of a medication in a given patient.
- Hamdy questionnaire	Similar to the previous one, it consists of 5 formal questions to identify drugs to be withdrawal
- Medication Appropriateness Index questionnaire	It also has a formal structure of evaluation of each medication through questions aimed at assessing risks and benefits in the specific patient. A global score is obtained for each medication that weighs the adequacy of this drug
- Criteria de Beers	Consensual list of drugs that may be inappropriate and that is intended to be a guide for reflection
- STOPP-START criteria	List of potentially inappropriate drugs that provides the prescriber with brief indications of use, benefits or risks and that has demonstrated validity and reliability

They have been communicated implications for three fundamental areas of action: a) the need to change the orientation of clinical guidelines that focus on a single disease; b) the need to change health policy that is based on a disease rather than on the whole person; c) the need to change current incentive policies that focus the health professional's attention on a disease rather than on multimorbidity, which includes not only diseases but also drug interactions, polypharmacy and the process of patient-health professional interactions (50), and d) the need of effective interprofessional, integrated care programmes, and interagency multimorbidity care (51, 52).

In this dramatic scenario, where it happens that health professionals know how to act in practice, but have nothing to say about their theoretical conceptualizations; that is to say, there is practice but ideas and concepts are missing where the practices are solved, this article presents some first notes to develop a theory of multimorbidity, and for this task of showing theoretical concepts, metaphors based on the world of art have been used.

It is concluded that the problem of multimorbidity care is not in practice, but in the lack of theoretical conceptualization, and the main theoretical elements on which practical initiatives should be based to address multimorbidity in general medicine, are: 1.-Prioritize problems with "energy" or "hot" ("master problems") with qualitative methodology (and these "master problems", generally, are not the most serious diseases, nor the most important from the orthodox biomedical point of view); 2.-Medicine based on prognosis, which is marked mainly by psychosocial rather than biological factors; and 3.-Prescription for leaving the labyrinth of polypharmacy and multiple drug interactions.

## References

1. Turabian JL, Perez Franco B (2016) A way of helping "Mr. Minotaur" and "Ms. Ariadne" to exit from the multiple morbidity labyrinth: The "master problems". *Semergen* 42: 38-48.
2. Dowrick C (2018) Patient-centred care for multimorbidity: an end in itself? *Lancet* 392(10141): 4-5.
3. US Department of Health and Human Services (2010) Multiple chronic conditions—a strategic framework: optimum health and quality of life for individuals with multiple chronic conditions. US Department of Health and Human Services, Washington, DC.
4. NICE (2016) Multimorbidity: clinical assessment and management. National Institute for Health and Care Excellence, London.
5. Davies P (2000) Is it time for a new definition of general practice? General practitioners' main interest is people. *BMJ* 321(7254): 173.
6. Turabian JL (1995) Cuadernos de Medicina de Familia y Comunitaria. Una introducción a los principios de Medicina de Familia [Family and community medicine notebooks: an introduction to the principles of family medicine]. Madrid : Ediciones Díaz De Santos.
7. Epstein RM, Hundert EM (2002) Defining and assessing professional competence. *JAMA* 287: 226-235.
8. Engel CL (1980) The clinical application of the biopsychosocial model. *Am J Psychiatry* 137: 535-544.
9. McWhinney IR (1989) A textbook of family medicine. Oxford University Press, New York.
10. Mair FS, May CR (2014) Thinking about the burden of treatment. *BMJ* 349: g6680.
11. Pathirana TI, Jackson CA (2018) socioeconomic status and multimorbidity: a systematic review and meta-analysis. *Aust N Z J Public Health* 42: 186-94.
12. Jose Luis Turabian (2018) Longitudinal Study of a Series of Cases on Trajectory of the Chain of Accumulating Health Problems in Certain People. *Am J Family Med* 1(1): 1001.
13. Turabian JL (2018) The "power-law" phenomenon in health problems among patients in family medicine: 20% of patients present 50% of health problems. *SF J Pub Health* 1: 3.
14. Huyck PH, Kremenak NW (1980) Design and memory. Computer programming in the 20th Century. New York: McGraw-Hill Book Company.
15. Hoggan C (2014) Simile, Metaphor, and Analogy as Levers for Learning. *Adult Learning* 25(4): 134-41.
16. Sinnott C, Bradley CP (2015) Multimorbidity or polypharmacy: two sides of the same coin? *J Comorb* 5: 29-31.
17. Buitrago Ramirez F (2013) Methods for measuring the suitability of pharmacological treatment in the elderly with multiple conditions and on multiple drugs. *Aten Primaria*; 45(1): 19-20. <http://www.elsevier.es/es-revista-es-revista-atencion-primaria-27-articulo-metodos-medida-adequacion-del-tratamiento-S0212656712004118>
18. Mangin D (2012) Beyond diagnosis: rising to the multimorbidity challenge. *BMJ* 344: e3526.
19. Bucci M (1989) Giotto. The life and work of the artist illustrated with 80 colour plates: A Dolphin Art Book. New York. Thames and Hudson.
20. Turabian JL (2018) A Conceptual Framework about Interstitial Space between the Bio-Psycho-Social Structures in Medicine General. *Res Med Eng Sci*: 5(5) RMES.000623.
21. Turabian JL (2017) For Decision-Making in Family Medicine Context is the Final Arbiter. *J Gen Pract* 5: e117.
22. Turabian JL (2017) A Narrative Review of Natural History of Diseases and Continuity of Care in Family Medicine. *Arch Community. Med Public Health* 3(1): 041-047.
23. Turabian JL (2017) Opportunistic Prevention in Family Medicine: Anticipatory Care, Case-Finding and Continuity of Care. *J Health Care Prev* 1: 101.
24. Turabian JL (2018) Prognosis-based medicine-The importance of psychosocial factors: Conceptualization from a case of acute pericarditis. *Trends Gen Pract* 1(1): 1-2.
25. Ong BN, Richardson JC, Porter T, Grime J (2014) Exploring the relationship between multi-morbidity, resilience and social connectedness across the lifecourse. *Health (London)* 18(3): 302-18.
26. Salisbury C, Man M-S, Bower P, Guthrie B, Mann, C, et al. (2018) Management of multimorbidity using a patient-centred care model: a pragmatic cluster-randomised trial of the 3D approach. *Lancet* 392(10141): 41–50.
27. Chiapperino L, Boniolo G (2014) Rethinking Medical Humanities. *J Med Humanit* 35(4): 377-87.
28. Art Museum of the Americas (2013) Between the lines: Joaquín Torres-García's constructive composition. Washington, DC. [Homepage on the Internet].
29. Lynton N (1988) Historia del arte moderno. Barcelona: Ediciones Destino, S. A.
30. Abbasi K (2014) Ebola and the wisdom of Haygarth. *J R Soc Med* 107(12): 463.
31. Jacoby D. El método científico en arte. [Homepage on Internet].
32. Altman DG, Deeks JJ, Dunn KM, Hay AD, Hemingway H, LeResche L, et al. (2015) The science of clinical practice: disease diagnosis or patient prognosis? Evidence about "what is likely to happen" should shape clinical practice. *BMC Medicine* 13:20.
33. Pimentel-Nieto D, Morales-Carmona F (2010) Medicina basada en la evidencia. Intención clínica: Pronóstico. *Perinatol Reprod Hum* 24 (3): 202-6.
34. Bail, K (2008) Patient and professional dissatisfaction: a literature review of prognosis communication related to hospital settings. *Contemp Nurse* 29(2): 135-46.
35. Díaz Novás J, Gallego Machado BR (2004) El pronóstico. *Rev Cubana Med Gen Integ* 20(2).
36. Turabian JL, Pérez-Franco B (2013) Journey to what is essentially invisible: Pysochosocial aspects of disease. *Semergen* 40:65-72.
37. Turabian JL, Perez Franco B (2008) Do family doctors seem like turtles? *Semergen* 34(8): 373-4.
38. O'Cleirigh, C, Pantalone, D.W, Batchelder, A.W, Hatzembuehler ML, Marquez SM, Grasso C, et al. (2018) Co-occurring psychosocial problems predict HIV status and increased health care costs and utilization among sexual minority men. *J Behav Med* 41: 450.
39. Turabian JL, Perez Franco B (2015) Helping "Dr. Theseus" leave the labyrinth of multiple drug interactions. *BMJ* 350: h1059.
40. Muth C, van den Akker M, Blom JW, Mallen CD, Rochon J, Schellevis FG, et al (2014) The Ariadne principles: how to handle multimorbidity in primary care consultations. *BMC Medicine* 12: 223.
41. Parada C. Genealogical Guide to Greek Mythology. Greek Mythology Link. [Homepage on Internet].

42. Marengoni A, Onder G (2015) Guidelines, polypharmacy, and drug-drug interactions in patients with multimorbidity. *BMJ* 350: h1059.
43. Orueta R, Sánchez-Oropesa A, Gómez-Calcerrada RM, Arriola M, Nieto I (2015) Therapeutic appropriateness in chronic patients. *Rev Clin Med Fam* 8(1).
44. Frank C (2014) Deprescribing: a new word to guide medication review. *CMAJ* 186: 407-8.
45. Fernández-Liz E (2013) How to review the medication in patients with multiple chronic conditions? *Aten Primaria* 45(5): 233-4.
46. Schuling J, Gebben H, Veehof L, Haaijer-Ruskamp F (2012) Deprescribing medication in very elderly patients with multimorbidity: the view of Dutch GPs. A qualitative study. *BMC Family Practice* 13: 56.
47. Woodward MC (2003) Deprescribing: Achieving Better Health Outcomes for Older People Through Reducing Medications. *J Pharm Pract Res* 33: 323-8.
48. Mercer SW, Guthrie B, Furler J, Watt GCM, Hart JT (2017) Multimorbidity and the inverse care law in primary care. *BMJ* 344: e4152.
49. Taylor CJ, Harrison C, Britt H, Miller G, Hobbs FDR (2017) Heart failure and multimorbidity in Australian general practice. *J Comorb* 7(1): 44-49.
50. Violán C, Roso-Llorach A, Foguet-Bore Q, Guisado-Clavero M, Pons-Vigués M, et al. (2018) Multimorbidity patterns with K-means nonhierarchical cluster analysis. *BMC Fam Prac* 19: 108.
51. McKinlay EM, Morgan SJ, Gray BV, Macdonald LM, Pullon SRH (2017) Exploring Interprofessional, Interagency Multimorbidity Care: Case Study Based. *J Comorb*.
52. Mólken M R-V, Leijten F, Hoedemakers M, Tsiachristas A, Verbeek N, Karimi M, et al (2018) Strengthening the evidence-base of integrated care for people with multimorbidity in Europe using Multi-Criteria Decision Analysis (MCDA). *BMC Health Serv Res* 18: 576.