Communication study

Complex health care decisions with older patients in general practice: Patient-centeredness and prioritization in consultations following a geriatric assessment

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ABSTRACT

Objective: To examine to what extent general practitioners in consultations after a geriatric assessment set shared health priorities with older patients experiencing multimorbidity and to what extent this was facilitated through patient-centered behavior.

Methods: Observation of consultations embedded in a cluster randomized controlled trial,1 in which 317 patients from 41 general practices received the STEP assessment followed by a care planning consultation with their GPs. GPs in the intervention group used a structured procedure for setting health (care) priorities in contrast to control GPs. A sample of 43 consultations (24 intervention; 19 control) were recorded, transcribed and analyzed with regard to priority setting and patient-centeredness.

Results: Patient-centeredness was only moderately apparent in consultations dealing with complex care plans for older patients with multimorbidity. The shared determination of health priorities seemed unusual for both doctors and patients and was rarely practiced, albeit more frequently in intervention consultations.

Conclusion: Setting health care priorities with patients experiencing multimorbidity is ethnically desirable and medically appropriate. Yet a short structured guide for doctors cannot easily achieve this.

Practice implications: More research is needed in regard to handling complex health needs of older patients. It requires a professional approach and training in patient-centered holistic care planning.

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1. Introduction

One of the current challenges in primary care in Germany is the treatment of older patients who consult their general practitioners (GPs) with multiple health and associated everyday problems [1–4]. GPs can generally only respond to one or two patient problems due to short patient contact times in the current structure of consultations [5]. The use of disease-oriented guidelines and disease management programs reinforce this focus on single issues and lead to the fragmentation of what should be a holistic approach to the patient [2,6]. Furthermore, treatment of multiple health problems in accordance with guidelines often leads to a disproportionately large number of recommendations and to an unimplementable number of codes of conduct that are frequently contradictory [2,7,8]. A holistic approach therefore needs to assess all individual health problems and select only a few for treatment. An ethnically desirable process of reducing individual health problems for treatment is by a priority setting process involving the mutual agreement of the doctor and the patient. The question of how this individual prioritization [see 9] can be integrated into the consultation currently remains largely unanswered. However, ascertaining the patient’s view on health priorities in relation to his other problems seems inevitable.

Setting priorities has been defined as part of a patient-centered approach in the European definition of general practice [10]. The basis of this process is the creation of a trusting relationship in which the older patient and the doctor can both participate in the shared decision-making process of priority setting [see 11]. Whereas at a health policy level much thought has already been given to the process of prioritization, only little is known about individual priority setting in patients with multimorbidity.

Achieving agreement in priority setting between the doctor and the patient is essential. Agreement not only strengthens the
doctor–patient relationship, but also promotes adherence and can lead to improved health outcomes [12]. Agreement itself is an inevitable prerequisite of shared decision making (SDM), and it requires a patient-centered approach.

Patient centeredness contributes to better patient knowledge and more realistic patient expectations about the course of the disease, more active patient participation in the treatment process and fewer decisional conflicts [13]. For the doctor, including the patient perspective in the consultation demonstrably leads to less medication being prescribed for certain conditions [14]. However patient-centered care has been studied more often in doctors caring for healthier patients [15] in contrast to our multimorbid target group. Furthermore the specific evidence for improved outcomes of patient-centeredness in consultations is mixed and limited [16,17].

This study has two objectives:

(1) Doctor–patient care application consultations following geriatric assessments are examined as to whether individual prioritization actually takes place and to what extent patient-centered elements are applied.

(2) The GPs in the intervention group, who have received a short training on prioritization and patient-centeredness, are compared with the GPs in the control group, who have received specific training, in order to investigate whether such training has an effect on the extent of patient-centered conversation and shared priorities.

2. Methods

The nonparticipatory observational study was embedded in the cluster-randomized controlled intervention study “PrefCheck: Preferences in treatment planning for older patients”. The aim of the overall study was to develop and test a treatment planning consultation based on individual health and treatment priorities [18]. The results presented here are taken from audio-recorded consultations to assess how GPs actually proceeded in the patient-centeredness and priority setting in these treatment planning consultations. The data was collected between July 2009 and July 2010. The study is registered in the German Register of Clinical Trials (DRKS 00000792) and approved by the ethics committee of the Hannover Medical School (No. 5069).

2.1. Recruitment

All GPs in pre-specified postcode areas of Hannover were invited to participate. Forty-one doctors agreed to take part in the study (18.6%). A block randomization procedure was used to assign the general practices to either the intervention or the control arm.

The patients were enrolled during a practice contact in a predefined recruitment week (participation rate of 57%; 317 patients with available data). The practice nurses consecutively approached patients aged 70 years and over who came to the office for whatever reason after 10 a.m. Recruitment lasted until up to 12 patients agreed to participate in the recruitment week. Exclusion criteria were long-term care dependency level II or III (no independent living possible), dementia, limited legal capacity, insufficient language skills, severe hearing loss, current participation in another clinical trial, or no availability by telephone.

2.2. Practice procedures

Each patient underwent a geriatric assessment (STEP [19]) so that an overview of the patient’s health problems could be obtained. The STEP-assessment inquires into 44 health and everyday problems of older patients over several health domains. Immediately afterwards a computer printout of the health problems was prepared and given to the patient and the patient’s doctor. In a second step patient and doctor independently rated each identified health problem in order of importance (on a scale from 1: not at all important to 4: very important). Finally, each patient participated in a treatment planning consultation that included the health problems from the STEP-assessment.

2.3. Intervention

The doctors in the intervention arm conducted the consultation with a specially developed guide “PrefCheck”. They had previously received a 30-min training covering the background and practical implementation of this guide from the administrators of the study. The guide consisted of the following:

(1) Disclosure of the patients’ rating on the importance concerning each health problem in tabular form,

(2) A three-step guide to the exchange of health and treatment priorities in a patient centered manner,

(3) A sheet on which to document priority health problems.

The untrained control GPs were also asked to set health and treatment priorities. They only obtained the individual STEP problem lists for their consultations without the patients’ importance ratings.

2.4. Recording the consultations

The aim was to record one consultation for each participating general practice in order to carry out a comparative conversation analysis of patient-centeredness and the prioritization of health problems. The GPs were asked to record their third treatment planning consultation or in case of the patient’s non-consent the next one with patient’s consent.

A flow chart of the study design is presented in Fig. 1.

2.5. Mixed method analysis

Audio recordings of the consultations were transcribed verbatim. In a first qualitative step, an analysis scheme based on theoretical considerations was created and further developed inductively using the first three consultations. In a second quantitative step, we determined the occurrences of patient-centeredness, SDM and priority setting.

2.5.1. Theoretical concepts and category construction

In order to balance competing needs and treatments, patients and doctors have to come to an agreement on priority problems [20]. Exchanging views and reaching a shared understanding underpin the decision making process [21].

We used three theoretically derived categories of patient-centeredness and one of prioritization to analyse the transcribed recordings:

(a) patient-centered communication: In view of the increasing evidence that doctors are often just led by assumptions on what patients think, feel and believe, we chose the widely used ICEE mnemonic (ideas, concerns, expectations, experiences) to assess the doctor’s exploration of the patients’ views [14,22,23]. We also distinguished between ICEE determinants initiated by the physician or patient.

(b) shared decision making: SDM stands for a shared and equitable decision-making process between patient and doctor, with
decisions based on available evidence and clarification of patient preferences [10,12,24,25].

(c) categories of empathy and empowerment were added as a result of analysing the first consultations. An empathic approach promotes the doctor–patient relationship and makes it easier for the patient to express his perspective [26]. The concept of empowerment assumes that people possess coping competences. Nevertheless, it is accepted that conducive conditions, help and support, are necessary in order for these competences to be able to unfold [27].

As priorities are determined by attributing the relative importance to the competing conditions [13], we assessed this dimension in two subcategories:

(d) any discussion on the importance of a patient’s problem (1) and any decision on concrete priority problems (2) [28].

All four categories were operationalized in the process as follows (Fig. 2).

2.5.2. Quantitative assessment of the qualitatively obtained data
Two researchers independently entered the occurrences of patient-centeredness and prioritization into an Excel spreadsheet. The rows in this table contained the individual subcategories of patient-centeredness and prioritization, while the columns described the health problems dealt with in the consultation. At the end of this process, a joint discussion ensued and, if necessary, the data was harmonized. Finally, sum scores were generated for each patient (the total occurrence of each subcategory in a consultation).

Three different reference units were used to represent the results: Occurrences of subcategories ….

1. …per consultation (N = 43), 2. …as percentages of all patient problems that were discussed in the consultations (N = 216), 3. …in relation to medical problems (N = 150) versus everyday health related problems (N = 65). Medical problems are defined as: somatic complaints and diseases, problems with sensory

Fig. 1. Study design.

<table>
<thead>
<tr>
<th>a.) ICEE (Doctor &amp; Patient)</th>
<th>b.) SOM</th>
<th>c.) Empathy &amp; Empowerment</th>
<th>d.) Importance rating discussed &amp; Prioritization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideas:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every opinion concerning the diagnosis, therapy or prognosis expressed by the patient or induced by the doctor.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every concern expressed in relation to a health problem.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expectations:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any suggestion made in relation to a health problem.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiences:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any experience in dealing with a health problem.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Example:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P: “And if it does actually go up that much, is it also possible to take one more or what, or doesn’t it matter, or isn’t that a good idea?”</td>
<td></td>
<td>Every statement by the doctor showing empathy and understanding for the patient’s situation.</td>
<td>Every statement with which the patient or the doctor discussed the perspectives on importance.</td>
</tr>
<tr>
<td>(Patient 131, doctor 58, 00:04:16)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Example:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P: “I don’t want that anymore (…)”</td>
<td></td>
<td>Every statement by the doctor, in which the doctor: a.) confirms that the patient himself has an influence over his healthcare. b.) encourages the patient to actively do something for his/her health.</td>
<td>Every statement with which the patient or the doctor make a decision on concrete priorities.</td>
</tr>
<tr>
<td>(Patient 62, doctor 34, 00:02:16)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Example:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D: “I think that is all right. Then I’ll just write that down.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Patient 62, patient 504, 00:00:24)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Example:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D: “The most important thing is in fact that you (…) get involved in life and stay mentally active (…). Play sudoku, do crossword puzzles, do anything to challenge the mind”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Doctor 58, patient 132, 00:22:29)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fig. 2. Overview of the categories and their definitions.
organs, pain, problems with medication, and pending vaccinations. Health-related problems known to affect the everyday lives of older patients are: sleeping problems, reduced activities of daily living, mental health problems, problems with housing and finances, role as carer, lifestyle factors, and cognitive impairment (determined by clock-drawing test [29]).

2.5.3. Statistical analysis
The patient’s sum scores were transferred together with the patients’ and his doctors’ demographic data in an SPSS file (Version 18, SPSS Inc.) and analyzed. Differences between the intervention and control group were determined using the chi-square test at the consultation level and the Mann–Whitney U-test at the health problem level.

3. Results
28 out of 41 general practitioners consented to a recording of the consultation. In order to obtain the planned total number of recordings nevertheless, 15 doctors provided a further recording. Table 1 shows the demographic data of the GPs and their patients who were involved.

The results from the STEP-assessment on the 43 patients show, on average, 9.7 ± 3.3 health problems, of which half on average (5.0 ± 2.2) were discussed in the subsequent care planning consultation. Of these health problems, doctor and patient had mutually rated almost 2/3 (63.9%) as “important” beforehand. The consultation lasted, on average, 9.5 ± 5.1 min. There were no significant differences between the intervention group and the control group with respect to the above results.

Below, the results on “patient-centeredness” as a supporting element of prioritization will be presented first. Then prioritization will be discussed, drawing on the results of the three units of analysis.

3.1. Patient-centeredness and SDM

3.1.1. Patient-centeredness and SDM: results at the “consultation” level
At the “consultation” level, Table 2 presents the occurrences for the subcategories “patient-centeredness”.

At least one ICEE component that was initiated by the doctor was present in a good 1/4 of all consultations. For example, a GP asked: “Are you worried about your cholesterol?” (doctor 24). Patients had the opportunity to discuss their beliefs in about 2/3 of all consultations. Empathy tended to be observed more frequently than empowerment in the consultations. In 2/3 of all consultations the doctor displayed empathic behavior towards the patient at least once. For instance, “My god, you must have felt sick with hunger and worries” (doctor 21). The self-competence of the patients was reinforced by the GP in approximately half of the consultations during the discussion of at least one problem, i.e. “I would also put the emphasis on your own activities” (doctor 35). In 7/43 consultations doctors displayed no patient-centeredness (5 control, 2 intervention).

SDM took place in almost half (20/43) of all consultations at least once, e.g., “(...) In the end it is always up to you to decide (...) do I want it or not” (doctor 58).

If intervention and control consultations are compared, significant differences can be observed in the patient expressed ICEE subcategory as well as a trend in SDM in favor of the intervention group.

3.1.2. Patient-centeredness and SDM: results at the “problem” level
As the patients and their GPs addressed several health problems in a consultation, it makes sense to investigate the share of patient-
centered elements in relation to all health problems discussed (N = 216) – see Table 3.

The GPs asked about ideas, concerns, expectations or experiences (ICEE doctor) in almost every tenth health problem discussed. Patients spoke about these aspects of their own accord in one-third of all health problems. When the patient perspective was addressed, this was mostly in the context of the patients’ experience on how the patients dealt with their health problems. For example – hearing problem: “When watching TV I move closer…” (patient 302).

Aspects of empathy were apparent for a fifth of problems discussed. The self-competence of the patient was reinforced in roughly every seventh problem. A decision-making situation occurred in 38.4% (83/216) of all the discussed health problems. However, only a third of the decisions were shared. Doctor-dominated decisions prevailed.

Differences between intervention and control group were similar to the ones found for the “consultation level”.

3.1.3. Patient-centeredness and SDM: results at the “nature of the health problem” level

A distinction was made between medical problems (70% of all discussed problems; N = 150) and everyday health-related problems (30%; N = 65). The proportions of the patient-centered elements in relation to all the problems of the respective health problem group are presented in Table 4.

Overall, elements of patient-centeredness appeared more often in the discussion of everyday problems than in the discussion of medical problems whereas SDM was prominent for medical problems. Intervention doctors tended to show more patient-centeredness than control doctors especially for everyday problems.

3.2. Prioritization of health problems

3.2.1. Prioritization of health problems – results at the “consultation” level

General statements on setting priorities were made to clarify the purpose of prioritization in 27.9% (12/43) of the consultations. For instance, “It is certainly interesting to see what is important for you and what is important for me and what that actually means for both of us” (doctor 61).

Consultations in which the importance of at least one health problem was addressed amounted to 15/43 (see Table 5). In 80.0% (12/15) of these consultations the doctors, or in 33% (5/15) the patients, said something about their own importance rating of a health problem. For example, a doctor asked: “Have you given some thought to what would now be most important for you?” (doctor 44). Agreement on priorities were reached in only six consultations. For instance, a doctor stated at the end of a discussion: “So I think we can now agree that what is most important for you is the situation with your bladder” (doctor 49).

3.2.2. Prioritization of health problems – results at the “health problems” level

Also based on the health problem reference unit did doctors or patients make statements on their importance or unimportance infrequently – more often in the intervention than control group. An agreement on priority treatment resulted in less than 5% (7/216) of the health problems discussed altogether.

3.2.3. Prioritization of health problems – results at the “nature of the health problem” level

Statements on the importance of medical problems occurred more often than on the importance of everyday problems. Not a single agreement on setting priorities (0/65) was made with respect to everyday health problems.

3.3. Other common themes in the consultations

As it was striking to find in 16% of all consultations no patient-centered element and to discover in 65% no discussion on the importance of problems, we further investigated what else had been a common topic of the consultations. One regular and expected theme involved the further clinical information gathering of health problems uncovered by the STEP-assessment (86% of all consultations). Another theme was giving medical information to the patient (93% of all consultations). Finally the discussion of further actions took part in 91% of all consultations.

Table 4
Patient-centeredness in relation to the health problem groups.

<table>
<thead>
<tr>
<th>Health problem group</th>
<th>Medical problems</th>
<th>Everyday problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All (N=150)</td>
<td>Control (N=66)</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>ICEE (doctor)</td>
<td>8.7</td>
<td>13</td>
</tr>
<tr>
<td>ICEE (patient)</td>
<td>30.7</td>
<td>46</td>
</tr>
<tr>
<td>Empathy</td>
<td>20.0</td>
<td>30</td>
</tr>
<tr>
<td>Empowerment</td>
<td>9.3</td>
<td>14</td>
</tr>
<tr>
<td>SDM</td>
<td>14.0</td>
<td>21</td>
</tr>
</tbody>
</table>

Table 5
Overview of the elements of prioritization at consultation level and health problems levels.

<table>
<thead>
<tr>
<th>Consultation level [observed at least once in a consultation]</th>
<th>All (N=43)</th>
<th>Control group (N=19)</th>
<th>Intervention group (N=24)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Importance rating discussed</td>
<td>34.9</td>
<td>15</td>
<td>31.6</td>
</tr>
<tr>
<td>Prioritization</td>
<td>11.6</td>
<td>5</td>
<td>5.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health problems level</th>
<th>All (N=216)</th>
<th>Control group (N=101)</th>
<th>Intervention group (N=115)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Importance rating discussed</td>
<td>10.0</td>
<td>21</td>
<td>7.9</td>
</tr>
<tr>
<td>Prioritization</td>
<td>3.2</td>
<td>7</td>
<td>1.0</td>
</tr>
</tbody>
</table>
4. Discussion and conclusion

4.1. Discussion

The aim of this study was to gain an insight into the care planning communication between general practitioners and their older patients following a geriatric assessment. The underlying rationale is to reduce the manifold and unconnected treatments of older patients by using a shared priority approach. In order to arrive at shared decisions on priorities, a patient-centered procedure seems inevitable. The results show that doctors seldom initiated a discussion on priorities for treatment – contrary to our original expectations. Especially priority decisions on health related everyday problems were missing altogether. A patient centered approach occurred in the consultations with moderate frequency; more often in the context of health related everyday problems. In fact, medical history taking, clinical information giving and planning were mainly observed.

In the present study, a statistically significant and relevant difference between the intervention and control group is evident in the subcategory “ICEE (patient)”. The intervention group also tended to display a greater occurrence of all the subcategories of patient-centeredness and especially SDM. Consideration of the ICEE components and patient involvement in decisions are important in a consultation because communication that includes these can have a positive effect on patient satisfaction, adherence and health [11,12,30]. Our findings tally with the results of the EUROCOM study [5], according to which patient-centeredness is only moderately common in consultations in German practices compared to those in practices elsewhere in Europe. This suggests that patient-centeredness should find more consideration especially for older patients whose health needs impact on their everyday life, as shown with our patient sample.

An analysis of the category “SDM” in our consultations shows that shared doctor–patient decisions occurred in a third of all health problems requiring a decision. Similar results can also be found in other international studies, e.g. Towle et al. [31]. Barriers on the doctor’s side that inhibit practicing SDM are, for example, lack of skills using this concept, the difficulty to change well-established patterns of behavior on the part of the doctor and the patient, little confidence in the patient’s ability to make an informed decision, and an anticipated stressful experience for the patient [32]. Patients also often do not expect to share decisions, in particular older patients find this difficult [33]. For our older patients it must have been particularly unfamiliar and demanding to decide upon health priorities.

The type of health issue also plays a major role not only in SDM [34] but also in the demonstration of patient-centeredness. The latter aspect was determined more frequently with everyday life problems. This finding supports the result of a German medical survey [24], where doctors were asked to what extent patients are involved in the care process. The majority of doctors stated that the ideas of patients tend not to be considered enough in medical matters. Our results also indicate that although physicians react in a patient-centered way when dealing with everyday problems, they either do not feel entitled to make (shared) decisions on priorities or simply cannot offer any solutions leading to a treatment decision in this area. Even though health related everyday topics have been shown to be very important for older patients [see 35] and even though doctors act empathically, doctors may feel more confident in making decisions on medical problems because of their specialist knowledge.

In the consultations, there was little discussion about the importance of health problems and subsequent priority setting. Everyday health-related problems were hardly considered and not one agreement on a priority approach was made in this context. However it needs to be taken into account that this approach of setting priorities on the basis of a health overview was new and unaccustomed to both, the GP and the patient.

Due to the small number of participants and audio recordings, results should not readily be generalized. However this study serves as a pilot study into an innovative care planning consultation based on shared priorities.

We are also aware that “patient-centeredness” and “prioritization” have no universally accepted definitions, and we deal with a lack of conceptual clarity for these terms [28,36,37].

Further limitations are concerned with the shortness of the planning consultation and the doctors’ training. Our participating GPs did not accept a training session of more than 30-min or longer consultations, as they feared organizational disruption, patient complaints and financial loss. A priority setting consultation may, however, require more time, even though studies on the implementation of SDM have shown that this form of patient involvement does not necessarily lead to an increase in consultation length [11].

4.2. Conclusion

If individual priority setting is to be achieved in consultations, then doctors need to be willing to respond to the patients’ important problems, independent of the type of health problem, and assist them in setting priorities. This is demanding. Schwengl [38] aptly sums up the challenges and frustrations of dealing with multimorbidity and the associated complex treatment planning. Balancing priorities of treatment in a deliberate way has so far been an unfamiliar concept and does not fit in with the usual reactive behavior found in the daily routine of general practitioners.

The effectiveness of communication training with regard to immediate endpoints in doctor-patient communication is well documented [39]. It should be a goal to raise the GPs’ awareness of patient-centeredness and setting priorities early on. Attention should be paid to the different communication patterns of GPs. Roter et al. demonstrated that patient satisfaction is highest in the psychosocial pattern, characterized by psychosocial exchange with the patients [40]. Communication training is increasingly offered to medical students and various techniques and teaching methods are currently applied in Germany (e.g. Calgary-Cambridge guide [41], simulations [42]). However, feedback on interpersonal skills is not sufficiently pursued in German general practice training and not assayed in the specialty exam.

4.3. Practice implications

A short training on patient-centeredness and priority setting made some difference in patient-centered information gathering for our GP sample. Priority setting was, however, hardly practiced. Nevertheless, this investigation instigates a discussion on individual priority setting on the doctor–patient level, in the face of overprovision of medical care for multimorbid patients. So far treatment priorities have been developed on the health policy level in the face of scarce resources. Prioritization is already taking place in GP consultations with older patients today, albeit hidden, unrecognized and not discussed by either side [43]. The German Ethics Council maintains that priority setting is routinely practiced when balancing treatment options for a single disease [44]. The question thus arises, on the basis of which criteria and how transparent can this process be implemented when health problems need to be prioritized first of all? In our opinion, the patients’ individual perspectives are to be included as an essential criterion in the priority-setting process.
Competing interests

None declared.

Acknowledgments

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We confirm all patient/persons identifiers have been removed or disguised so the patient/person(s) described are not identified through the details of the story.

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