Quotations

Upon initial submission we have attached the quotations in a separate document to facilitate word count of the manuscript. We suggest that in a later stage, the quotations will be moved into the main text, and that the letters referring to the location in the main document will be removed.

DCGP: Dutch College of General Practitioners. In Dutch: ‘Nederlands Huisartsen Genootschap (NHG)’.

A: If someone like that has COPD, then I think the guideline is very welcome and the same applies for the diabetes guideline. (GP24, male, 56 years)

B: The DCGP guidelines are of course the standard that you can keep to as much as possible. (GP16, female, 44 years)

C: And of course, you go for the things that people really suffer from. Strict diabetes control...these days, that’s not the main aim. (GP7, male, 56 years)

D: Look, there are two things: prescribing something because of complaints, or to prevent something that will happen, or may happen in the future; that makes a big difference. (GP 24, male, 56 years)

E: Sometimes that should be left [...] to the doctor’s judgement. (GP13, male, 45 years)

Yes, but if you don’t emphasise the importance or the statistics, then it’s easy to stay in limbo [...] So it’s actually good that one strives as much as possible towards evidence-based ideas over [...] what’s the smart thing to do, or what is the wisest option to reach a good compromise. (GP15, male, 54 years)
F: It’s also dangerous, doing your own thing, because then it’s just like the way it used to be… and you do wish that some things were sorted out. (GP 7, male, 56 years)

G: The DCGP guidelines are [...] not particularly applicable for the very aged, and also not for lots of things mixed up together.² (GP24, male, 56 years)

H: The flipside of the coin is that these guidelines are not made for the 80 year olds. (GP 12, female, 58 years)

I: As patients get on in years, I tend to adhere less faithfully to the strict norms in the DCGP guidelines for blood pressure and such things. And to say, now, let’s just prescribe extra medicine on top of it all, I won’t do that.² (GP23, male, 51 years)

J: I think that I’d pay more attention to the preventative aspects with a younger patient, to see what’s possible. Someone who’s 55, who’s had a heart attack and COPD and still smokes, I’d push harder for them to quit smoking than with the same person who’s 75. (GP14, male, 63 years)

K: Many of those with multimorbidity take a substantial number of preventative medications [...] of which the benefit isn’t clear, at least not immediately, and it’s also the question whether you will experience that benefit, or whether you’ll mainly get side-effects, or both. (GP 1, female, 36 years)

L: With a 40-something year old, the treatment aim is clear… to reduce risk over a long term period. But for an 80-something year old, it becomes less clear cut [...] What can the patient get out of it, and also, what are the possible side-effects? (GP6, female, 31 years)
M: With the aged, a long-term treatment is...dubious. If it doesn’t go well and smoothly, then there’s totally no motivation for you to go through with it. (GP 24, male, 56 years)

N: In my opinion, blood pressure treatment causes a lot of side-effects. Like dizziness and falls. [...] I think, better to have [systolic] pressure of 160 and not fall - that’s more important. (GP 7, male, 56 years)

O: And that’s the essence of what you’re talking about. Not that this lady has osteoporosis and which pills according to the guidelines are the best - that’s something I can look up myself, that’s not so difficult. But the point is, this lady, who lives all alone, what is best for her, when does she have to relocate? What do we do in this situation? Should we arrange home nursing, or does she need to move anyway? (GP 25, male, 56 years)

P: The question is whether you can ever grasp the complexities of all the interactions between diseases in guidelines. [...] And whether you can find something that applies to this specific patient in the guidelines, well, I fear the worst. (GP 13, male, 45 years)

Q: We have a strong tendency to keep working on the cardiovascular issues. [...] And then you see these people leave the clinic and you think, OK, actually we should have done something about the osteoarthritis. (GP 13, male, 45 years)

R: For example, such a guideline for diabetes or hypertension is based on, I don’t know, research on 40-60 year olds... with mono-morbidity, probably. I don’t know if this is like this in all cases. But in general, that’s what happens. And what’s that worth for an 80 year old patient with multimorbidity? Nothing, in my opinion. (GP 7, male, 56 years)

S: There is of course completely no evidence for these patients, because no one knows if they are going to treat [high] cholesterol in someone who’s 80 with asthma and who’s had
chemotherapy, for example. There’s also nowhere where you can look that up. (GP7, male, 56 years)

T: I think, OK, I can go all-out on treating each and every disease, but whether the sum of the parts actually results in a better level of care from my side, that’s the question. So, that makes me a little more conservative, because I think, well - I'm not too sure about that. (GP13, male, 45 years)

U: All the indicators are for singular problems. That’s how those are often studied, right? But in combination, much less. [...] And what you should focus on - that’s not really covered either. (GP14, male, 63 years)

V: [Multimorbidity] gives you a lot of freedom to use your experience and own ideas as a doctor to help the patient’s problem. Otherwise you’d be much more tied to the evidence [...] you get to a certain point when that’s not as challenging to do. (GP7, male, 56 years)

W: With all of the guidelines available, you can use your common sense to say, well, I’d choose this one for this and that reason, that’s easy to justify, or at least I think so. And then the guidelines are definitely not always followed, because common sense in the case of this patient… (GP11, male, 57 years)

No, but that’s not the reason that the guidelines shouldn’t exist. (GP15, male, 54 years)

No, and the question is also, whether everyone’s common sense is the same? [All laugh] Probably not, so we all probably make different choices. [...] That’s how the guidelines arose. All the doctors, with their own common sense, thought that they were doing it right. (GP 14, male, 63 years)

X: A few extra courses on this subject would be of help to GPs, I think. And to support our common sense. [...] So I think that [more] knowledge, [...] without immediately having to set
up a guideline for it, but just using [that knowledge] I think can also help. (GP14, male, 63 years)

Y: You’d also want to know which interventions are actually the most critical, right? For example, administering an anti-coagulant with atrial fibrillation, that’s what you almost always should do, in any case that’s what I think, but I think you should also still do that with someone who’s 88, because a stroke is a drama of course. And I think cholesterol for example is a different story, as is hypertension. (GP7, male, 56 years)

Z: Do you have the feeling that the guidelines help you to treat people with multimorbidity? (Moderator) No. It would be great if the guidelines would mention for whom it doesn’t apply, and then I think you’d be shocked at the number of your patients that fall into this category. (GP7, male, 56 years)

AA: If you look at the numbers needed to treat, for many of these things, these are around 20, 30, would be considered great, right? But when you discuss with those people, many end up declining the treatment […] many people have their own [well-informed] opinion. (GP13, male, 45 years)

BB: The legislation and the incentives are just completely irrelevant and not to the point if you’re talking about quality. (GP15, male, 54 years)

CC: It would be good if these people with multimorbidity, and especially with complex diseases combined, were to be excluded from the tables. […] So you’d need another set of criteria, separate from the criteria for [relatively] healthy people with only one disease. (GP13, male, 45 years)
DD: What doesn’t help are the performance indicators for diabetes care where you are forced, at the end of the year, to submit all the statistics for diabetes care, and are judged on […] how well the HbA1C has been controlled. Because that doesn’t show that we take the patient [as a whole] and the prognosis into consideration. (GP 16, female, 44 years)