Managing multimorbidity in primary care:

Eliciting implicit skills general practitioners use while providing evidence based care for patients with multiple chronic conditions.
A qualitative exploration.

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Masterproef
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Voorwoord

Deze masterproef werd geschreven in artikelvorm. Samen met de promotor en de co-promotoren, kozen we ervoor deze studie als een onderzoekspaper in te dienen. In de hieropvolgende appendix, is een synopsis weergegeven van de onderliggende data-collectie, data-analyse en het proces van deze studie.

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ABSTRACT

Setting: Traditionally, external medical evidence is built for single diseases, but patients often suffer from multiple diseases. Especially when diseases co-occur, it is important to integrate the best external medical evidence with the individual expertise of clinicians and the personal preferences and values of the patients. This approach refers to the original definition of evidence based medicine (EBM) as proposed by Sacket in 1996. The clinical expertise providers use to practice EBM, in this case EBM in multimorbidity, is not easy to define. It is imaginable that general practitioners (GPs) have skills in managing their multimorbid patients, but these skills remain mainly implicit.
Objective: To elicit skills of GPs in managing multimorbidity.
Methods: A qualitative analysis of transcribed simulated video consultations in a workshop on multimorbidity developed for practicing GPs.
Results: Throughout the consultations we observed both exploration and action skills. Exploration skills are skills GPs use to explore the patients' perspective: e.g. talking about functionality and exploring patients' preferences and values, by asking for Ideas, Concerns and Expectations (ICE), checking for compliance, and trying to elicit personal goals. Time management was observed, as were action skills through working on functionality. We did not explicitly observe GPs screening for psychiatric co-morbidities, goal-defining and shared-decision-making.
Conclusion: The clinical expertise in multimorbidity in primary care that was elicited from these simulated consultations was seen in explorative skills (interviewing skills exploring the patient's perspective) and action skills (actual care planning). Some skills such as explicit screening for psychiatric co-morbidities, goal-defining and shared-decision-making were not clearly observed. This may imply that this workshop was unable to elicit all skills, or that there is less expertise in topics such as screening for mental comorbidities. Future seminars could focus on exploring the underlying reasons for these observations with GPs. Future studies on how providers integrate the columns of EBM when providing care for patients with multimorbidity, would be of added value to EBM management in multimorbidity.

Key-words: evidence based medicine, primary care, multimorbidity, communication training, goal-oriented care, patient-centered care, qualitative research

Introduction

Together with the ageing of the population, the numbers of people with chronic diseases are rising. This rising prevalence of chronic diseases is accompanied by a rise in multimorbidity as chronic diseases often coincide(1).

Caring for patients with multimorbidity is a challenge. Evidence Based Medicine guidelines are mainly based on single-diseases. Summing these disease-specific guidelines for patients with multimorbidity leads to inappropriate treatment strategies which are at risk to forget about the person who actually lives with these diseases.

Especially when diseases co-occur, it is very important to integrate the best external medical evidence with the individual expertise of clinicians and the personal preferences and values of the patients. This approach refers to the original definition of evidence based medicine as proposed by Sacket in 1996(2). So, while caring for patients with multimorbidity, providers probably integrate medical evidence with their individual clinical expertise and the personal preferences and values of their patients but knowledge on these underlying foundations of EBM is far less apparent. Previous studies clarify the perspectives from GPs on how they manage multimorbidity(3) however, such focus groups only elicit perspectives and skills providers are aware off, but they do not elicit the skills providers implicitly use in daily clinical practice.

Throughout this study we aim to elicit implicit skills of GPs in clinical care for patients with multimorbidity. Hereto we have performed a qualitative analysis of consultations GPs performed with simulated patients with multimorbidity. The observation of simulated consultations allowed to explore the clinical expertise or skills GPs use while taking care of patients with multimorbidity.

Methods

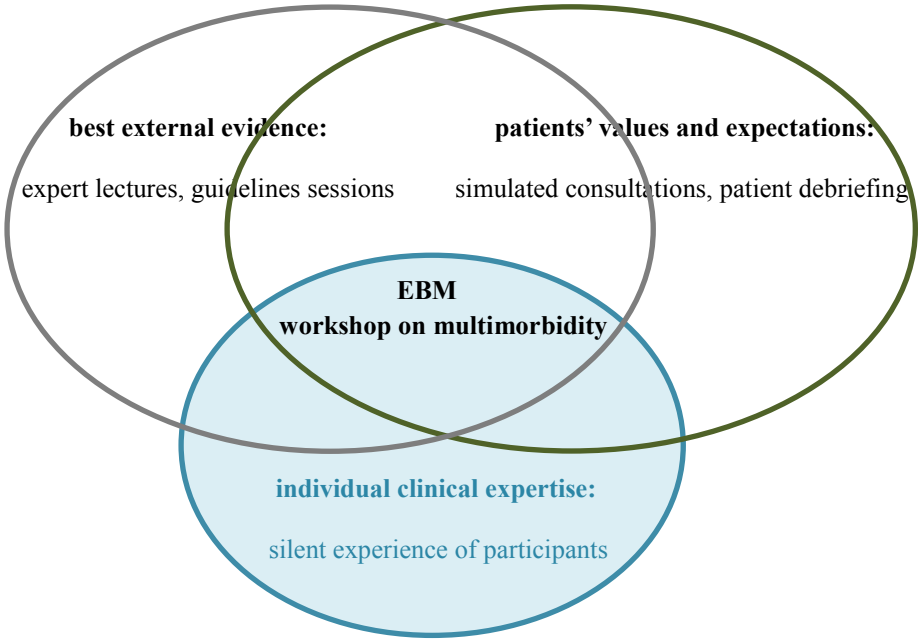
Study design

This study is a qualitative analysis of observed simulated consultations in a workshop on multimorbidity that was designed for GPs.
The Ethics Committee of the Ghent University Hospital approved this study in april 2014.

Workshop lay-out

It was set up as 3 consecutive days of training in October 2013, in Gent, Belgium, organised by Dialogue on Depression and Diabetes (DDD), World Organisation of National Colleges, Academies and Academic Associations of General Practitioners (WONCA), and the department of Family Medicine and Primary Health Care of the University of Ghent. The workshop consisted of lectures, group sessions, and simulated consultations (Table 1). The workshop on multimorbidity explicitly integrated the 3 circles of EBM, as stated in the Cochrane Collaboration definition of 'Evidence-based Health Care'(4), i.e. best external evidence (expert lectures, sessions on guidelines), patient values and expectations (simulated consultations, patients' feedback during and after the sessions) and individual clinical expertise (all sessions were highly interactive to elicit the silent expertise of participants) (Fig.1). The 4 simulated patients were specifically trained in advance and had multimorbid profiles. Informed consents were discussed in group by the author and written copies were offered and signed by 9 out of 15 participants.

Fig. 1. 3 circles of EBM: The Cochrane Collaboration model applied on this workshop.



Blue = focus of this study

Participants

Participants were GPs from 8 European countries. In the faculty of the workshop, however, there were many different backgrounds, psychiatrists, 1 nurse, and communication experts in shared-decision making. This stimulated interaction and learning effects in the group.

Observation

Data-collection took place through non-participating observation. The observational data we used for this study, were the verbatim transcriptions of video-recorded simulated consultations with the trained patients. Observing GPs performing consultations was used to capture the silent skills the participating physicians already have. One video-consultation could not be used due to a technical error.

Coding and analysis

Simulated consultations were videotaped and transcribed verbatim by the first author of this paper. The phase of analysis started with fragmenting the text. In the second phase, the fragments that reflected skills were labeled with a 'code'(e.g. 'talking about compliance'). Then, the codes were grouped together into larger categories, a tree data model(5) (e.g. 'talking about functionality', ' patients' concerns', 'goal-eliciting'). Even though the workshop was supported by a clear theoretical body (the 3 circles of EBM and by concepts such as goal-oriented care), the analysis we performed had an open approach.

Several team discussions served to identify key skills. The role as a non-participant observer, allowed to use field notes and verbatim transcriptions of the taped discussions and this helped us interpret the observed skills we saw in the simulated consultations. PubMed and Cochrane Library were used for literature research.

Table 1. Course program.

Topic	Organisation
Day 1	
An overview of the development from DDD towards multimorbidity.	DDD
A consultation with a real patient with diabetes and multimorbidity.	University of Ghent
Diabetes and depression in the framework of a multimorbidity approach?	University of Ghent
Exploring and arriving at a shared understanding of problems and patient-centered goals with the patient.	WHO partner**
Clinical complexity in multimorbidity. (split group work)	University of Ghent
Day 2	
A morning surgery session. (simulated multimorbidity patient consultations)*	University of Ghent
Contextual complexity in multimorbidity. (On the International Classification of Functioning and Disability in health (ICF))	University of Ghent
Contextual complexity in multimorbidity: workshop on classifying multi-morbidity in ICF.	University of Ghent
Motivational interviewing skills and patient-empowerment.	University of Ghent
Community Health Center visit: integrated inter professional team care, a discussion.	University of Ghent
Day 3	
Addressing the social context of patients with multimorbidity.	University of Ghent
Developing a therapeutic plan with the patient: shared-decision-making, behavioral activation and problem-solving.	WHO partner
Barriers to and potential levers for GOC.	University of Ghent

*Legend: *this session provided us with the data from the video-taped consultations.*
***prof. Dr. Linda Gask, WHO partner, Institute of Population Health, University of Manchester.*

Results

Two large categories of skills were defined throughout the analysis: exploration skills through interviewing, vs. action skills used when both patient and provider turn into action in order to actively start managing multimorbidity (Table 2).

I. EXPLORATION SKILLS: Interviewing skills

Next up are a list of skills, which are defined separately. Illustrating each skill with quotes from the GPs in the simulated consultations, puts a clear view on the skills that were seen.

- **ICE**

It was natural to open a consultation with checking the patient's ICE (ideas, concerns and expectations), or even to do so within the consultation.

> *"When you had gotten used to having diabetes, what did that mean to you? Were you anxious,…?"*

- **patient-provider relationship**

We saw professional skills in building a trustful relationship, checking the barriers and conflicts for the patient, or for the provider, and what possible conflicts there had been in the past. We saw how the communication experience for the patient was made very explicit, by literally asking how they felt about it. This was a strong skill.

> *"If there is a question that you don't want to answer to, then feel free to say."*
>
> *"Did you have any problems in communication with the retired colleague?"*

- **shared-decision-making**

Participants showed good techniques in ensuring patient information and patient empowerment.

> *"and we could try to make a plan… Do you have ideas yourself, what you could do?"*
>
> *"So do you think, these are things we can work on?"*
>
> *"So let's start thinking how can we balance the two?"*

There were attempts of using shared-decision-making (SDM), however missing the concept by focusing on 'doctors' goals' and 'giving patients presents' instead of on joining patients' and doctors' goals.

> *"So if I propose to (…) will you accept that, without any question?"*
>
> *"So I don't know if this is possible for you?"*
>
> *"But maybe, if we say things again and again and again, she will start hearing it?"*

Getting to motivational talk or behavioral activation is a next step we did not see in this short set of consultations.

- **talking about functional status**

Assessing functionality took the larger part of the consultation time, taking time to talk about the patient's functional status and compliance, up to an entire consultation. Participants consistently tried to couple the patient's functionality to his or her life and family events, and eventually to health goals.

> *"So you don't have any discomfort with the medication?"*
>
> *"Does that hinder you to do the things you would like to?"*

'So you've got help. What do they do? What do you do?"

'Did that make you short of breath?"

We saw how including the family was important, as there were several attempts of involving the family into the (shared-) decision-making.

'I ask myself, would it be helpful, to talk with your husband?"

- **disease listing**

Before getting to patients' goals, it is important to have a complete view on the patient's multimorbidity. Disease listing and actively searching for co-morbidities, as well as checking medication lists, was not done systematically.

'Apart from the diabetes, you also suffered from another problem ..."

As a part of one's functional status, GPs proved to have systematic attention for the problem of loneliness. We did not observe that asking about loneliness was coupled to consequently screening for depression.
It was more exploratory than it was listing it as a 'condition'. There were only few attempts to explicitly screen for mental health problems - beyond loneliness -, such as depression.

'Does it bother you that you are lonely?"

'It seems to me, when you tell me that your physical health is good enough, that a major topic for you, is this other problem of feeling lonely."

'And does that sometimes make you depressed, not feeling well?"

- **eliciting individual patient goals**

Some goal-oriented skills were well integrated in the habits of the participants, others were not used consequently. Goal-eliciting, however, was one of the strongest skills, as participants paid much attention to what was "important to you", and "what are the things that you enjoy doing?". Goal-defining was a problem. It was very difficult for participants to distinguish the patient's goals from their own goals. This hindered checking those goals and how goals change over time. These skills explored patient preferences and values, which is the second of three circles of EBM.

'Of the important things that are going on in your life, what are the things that you would like to do?"

'Try to tell me."

- **time management**

Participants proved to be consistently setting the agenda, spreading consultations and not trying to go for the all-in-one consultation.

'Is there anything else you would like to work on today?"

'We'll put that on our list of things to talk about in the future as well."

II. ACTION SKILLS: Working on individual patients' goals and functionality

- **goal prioritizing**

To prioritize goals and make up a priority list of goals to work on, was natural for the GP, but not easy to realize, for both patients and doctors.

> *'So what are your priorities?"*
>
> *"What are your top 3 things to do?"*
>
> *"I am just trying to make a (list) on the whole of the topics, which are important for you. Still, is there something left, which has to be mentioned?"*

- **translating goals into functionality**

After getting to the patients' goals, most GPs did not build the bridge to translating these goals into functionality. E.g., in one case, for whom hearing loss was a priority, a hearing aid would not only have helped, it would also have been a stepping stone towards social participation for that individual. These translations towards the patients, saying e.g. that it would increase their social functioning, were not made.

- **working on functionality**

Asides from medical therapies, in each consultation, participants tried to increase the patient's functioning and quality of life through small interventions (Table 2).

> *'So we need an opportunity to help (you) find a way to get to a community."*
>
> *"It would probably help us, with having you move a little bit."*
>
> *'So how about when somebody came to help you to make to eat and to …?"*

III. Key findings

- **Talking about functionality is a silent skill.**
- **There are clear skills in exploring patients preferences and values - the second component of EBM - by using 'ICE', checking for compliance, and through eliciting goals.**
- **Several short consultations were a means of taking gradual steps in exploring one's patients' multimorbidity.**
- **Screening for psychiatric co-morbidities, goal-defining and shared-decision-making were not consequently observed.**

Table 2. Silent skills in managing multimorbidity.

I.	EXPLORATION SKILLS: interviewing
1.	ICE (ideas, concerns and expectations) (+)
2.	doctor-patient relationship
	- trustful relationship (+)
	- checking barriers and conflicts doctor - patient (+)
	- checking the communication experience for the patient (+)
3.	shared-decision-making (SDM)
	- patient information and patient empowerment (+)
	- getting to shared-decision-making , motivational talk, behavioral activation & reading the barriers (-)
4.	talking about functional status
	- patient medication (+)
	- patient motivation - compliance (+)
	- daily life (+)
	- professional & social status and goals (+)
	- family, screening for conflicts with family, involving family in SDM (+)
	- coupling life events to health events (+)
5.	disease listing
	- screening for multi-morbidity (-)
	- psychiatric comorbidity screening (-)
6.	eliciting individual patient goals
	- goal-eliciting: health & life goals (+)
	- goal defining (-)
	- goal checking (-)
	- goal rechecking, changing goals in time (-)
7.	time management:
	- setting the agenda & spreading consultations (+)
II.	ACTION SKILLS: working on individual patient goals and functionality
1.	goal prioritizing (+)
2.	translating goals into functionality (-)
3.	working on functionality (+)

Legend: (+) means it is a consequent skill, (-) means it is a less consequent skill.

Discussion

1. Summarizing the results

This study aimed to elicit implicit skills general practitioners use while providing evidence based care in multimorbidity. Following Sacket's definition of EBM, it is important to integrate the best external medical evidence with the individual expertise of clinicians and the personal preferences and values of the patients. Compared to studies focusing on perspectives of GPs on how they manage multimorbidity, this workshop's simulated consultations allowed to observe skills of GPs while performing consultations in patients with multimorbidity. These are the key findings.

In summary, two groups of skills were observed: exploration skills vs. action skills.
Some were observed systematically, such as time management, talking about functionality and exploring patients' preferences and values. Other skills were observed to be used less consequently. Examples are screening for psychiatric co-morbidities, goal-defining and shared-decision-making.

2. Discussing and linking the results to literature

Repeated discussion on the found skills and linking them to previous studies, led to an understanding of the clinical expertise GPs have in multimorbidity, and how this can contribute to managing multimorbidity in primary care.

I. Exploration skills: interviewing

Using ICE and building a trustful doctor-patient-relationship are skills GPs use to engage their patients into the management of their chronic conditions. This is confirmed throughout the CanMEDs role of communicator(6). Key-competencies in the role 'communicator' are to 'develop (…) trust, and ethical therapeutic relationships with patients and families'. These skills build on providing continuity of care.

Secondly, we observed how skills in informing and empowering of the patient were used, but we did not observe the explicit use of shared-decision-making techniques However, patient information and patient empowerment have led to the development of shared-decision-making and decision aids(7-10). Interestingly, Luijks' study on providers' perspectives on the management of multimorbidity concluded, that GPs saw SDM and a holistic patient-centered approach in multimorbidity as the most important skill(3); This may imply that this workshop was unable to elicit all skills, or that there is less expertise in how to adopt SDM. Future work could focus on exploring the underlying reasons for these observations with GPs.

Integrating the perspective of the patient by talking about functional status, is incorporated as a skill. Bringing the perspective of the patient in the consultation, is important both for the patient's coping and for his or her compliance. It can be seen as a major stepping stone in achieving quality of life despite multimorbidity. We refer to a study showing how a high sense of coherence was protective against mortality in patients 80 years old or older, and with high levels of quality of life(1). It concludes "the need to focus increasingly on capabilities instead of (..) on impairments", and we saw how GPs are already making this positive approach towards their patient's strengths. Focusing on capabilities, fits a more individual and patient-centered approach that aims to enhance his or her functioning.

Throughout the exploration skills, we also observed attempts to elicit patients' individual goals. However, providers did not always recognize they were actually defining their own doctor's goals, and not those of the patients. This was illustrated in the field notes made throughout the discussions in between consultations. Sometimes it was felt that repeating doctor's goals, was equal to defining the patient's goals. After recognizing this pitfall, the group talked about checking patient's goals and how to differentiate their own goals from patient-goals. A history of problem-oriented care may explain why this is a pitfall(3, 16). In Luijks' study, one of the results of what GPs saw as important in managing multimorbidity, was individualisation of care(3). In this study, goal-eliciting is not mentioned specifically, but it does indicate how GPs 'stressed the importance of tailoring care to the individual and tried to understand the meaning of illness for a person'. The evolution towards eliciting and defining the patient's own goals, asks for training, as well as for a change in attitude.

What about mental health? Studies indicate multimorbidity is often related to mental health comorbidity(11), although there is conflicting evidence on patterns between both(12, 13). We observed how screening for depression, as a part of the patient's daily functioning or social participation was indeed a weaker skill. We did see how this was briefly touched, e.g. by asking if patients were lonely. We did not see the skills to go deeper into this, and to detect mental

comorbidities through aspects of daily functioning. A careful conclusion is that detecting mental health comorbidity is a challenge in primary care. The question is why?
This observation may also be the focus of future work with GPs on why they do not systematically screen for mental comorbidity, even despite its prevalence. Possibly, providers are hesitant for systematic screening for mental comorbidity, as this bares a risk of 'medicalizing' normal reactions to suffering in patients with multimorbidity.

Time pressure is one of the main issues providers introduce as a challenge while providing patient-centered chronic care. Luijks' paper illustrates how GPs 'felt there was insufficient time and compensation for consistently putting into practice their main objectives'(3). This demonstrates how these GPs saw lack of consultation time as a limiting factor for fulfilling their role as health providers. Lemon et al. indicate in a review of 9 selected papers on consultation length, that both patient and GP characteristics are important in both consultation length and patient satisfaction(15). Indirectly, the studies they refer to, illustrate how GPs see time as scarce, as e.g. they shorten consultation lengths when there are more patients waiting. In the group of GPs in this workshop, time management was not an issue. We observed how the time issue of setting an agenda was managed. Participants held several short, e.g.10-minutes consultations, fragmenting their consultations. Lemon et al. did not mention the effect of fragmenting consultation time in several shorter consultations. There were no studies found on the use of several brief consultations in primary care. We observed how fragmenting patient contacts into several short consultations can be realistic and offer a constructive insight in patient's functioning and goals as well as a goal-oriented management that allows for checking how goals change over time. Summarizing, this may imply, that it is not about time.

Managing multimorbidity in an EBM way, requires a broad perspective, inclusion of both somatic and mental health comorbidities, and integration of the patient preferences and values.
In 1991, Mold and Blake proposed goal-oriented care (GOC), as problem-oriented care overlooked modern health problems, chronic care and prevention amongst others, and individual patient's health needs(14). In GOC, the physician-patient collaboration forms the basis of defining individual patient's needs as a guide towards aiming for the highest possible level of health for that individual.
The name GOC is semantics, as other terms such as patient-centered care have also been used.
Skills that explore the second circle of EBM (clinical expertise - patient preferences and values - best external evidence), suit a goal-oriented approach that is fitted to patient's individual needs. These skills were clearly present in the simulated consultations.

An example from a simulated consultation in this workshop, was a 54-year-old unemployed and divorced woman, a smoker with a history of cervix cancer and chronic back pain, and depressive symptoms. A reasonable strategy would have been to tackle smoking first, to act on prevention such as lipid levels, and to explore the depressive mood. In this case, this strategy would have failed. She felt threatened by GPs trying to force her to stop smoking, which would reduce the chances of getting further in other areas, such as in behavioral activation. What did suit her individual goals, was to increase her activity, leading to a better social life, reducing the pain and enhancing coping (with her multimorbidity).

II. Action skills: Working on individual patients' goals and functionality

There is clinical expertise in primary care in exploring functionality and in enhancing the patients functioning by working on achievable goals. Goal-eliciting is an exploratory basis skill that was present during these consultations. A next step in meeting multimorbid patients' health needs, is to act on their individual patient goals and enhance their functionality. For example, acting on poor eye-sight, can lead to a better vision, allowing to re-join the sports club, which increases the patients' social participation.
As Neuner-Jehle put it, in theory, adopting a patient-centered management seems easy enough, but it requires training(16). It is easy to fall back into problem-oriented habits, and tick boxes of the disease list. Following the disease list risks missing the link between the patient's morbidity and his or her functionality. Taking time to follow up on the effects of medical therapy on functioning, increases consciousness on the patient's functional status.
To achieve a conscious management that is patient-centered and that enhances functional status, there will be a need for change in both physicians' and patients' attitudes(1, 16).

III. Understanding the pattern

Communication, time management, talking about functionality, and exploring patient preferences through goal-eliciting are strong skills. As there are good patient empowerment skills, it is unclear why SDM and other goal-oriented skills, and screening for psychiatric co-morbidity are not as developed.

From an educational perspective, the question is why, carrying a history of a problem-oriented care model, we observed such differences in the consequent use of the implicit skills in these GPs. Debriefing these observations towards the participating GPs could be an interesting way of exploring why these skills were not observed explicitly; What are their expert opinions? Do GPs feel a need to adopt shared-decision-making or not as such? How does the learning curve after several skills seminars look like? These are all interesting approaches - outside of the scope of this study - towards the question of why we observed differences between certain skills.
We searched for an answer by means of a PubMed literature review on teaching skills in GPs.

Summarising, the first step is to identify the skills that are required to develop EBM management of multimorbidity in primary care. More skill seminars can be a means to elicit skills that GPs use. Next, the phase of debriefing and collecting the opinions from the GPs themselves, contributes to understanding the clinical expertise. Afterwards, developing teaching in these skills is a next step. There are few described skills seminars for GPs(17), and teaching specific GOC skills in medical students is insufficient in current curricula(18-22), as it is in continuous medical education for GPs(23). On the other hand, GPs do express the need for a 'holistic' goal-oriented approach in multimorbidity(3), which fits the observation that skills such as talking about functional status and goal-eliciting, are already being used consequently and efficiently.
Therefore, when skills in multimorbidity are well known, integration of teaching goal-oriented skills in curricula and in CME for primary care providers, could contribute to the management of the multimorbid patient in primary care.

3. Strengths and weaknesses of the methodology

Strengths of this study:
To our knowledge, this is the first paper to elicit skills of experienced GPs through observation of consultations with simulated patients with multimorbidity. The role as a non-participant observer of this workshop (with additional transcripts and field notes made throughout the workshop) allowed for a more in depth understanding of the observed processes of care and the underlying meaning of what GPs were doing in these consultations. As such, this paper adds to the knowledge of how to provide EBM care for multimorbidity. This is important for developing further training for primary care providers on this important challenge for primary care.

Weaknesses:
There was a limited number of observations and no time for debriefing the observations and their interpretation towards the participants. More consultations and more time to practice, and repeating the observations after a period of e.g. several months could lead to a different pattern in the resulting skills.
Secondly, the study was done by one researcher. However, because of the thorough documentation of the workshop (as a non-participant observer) and the repeated discussions with a second researcher who also participated in the workshop, this implies that this study had a broad basis on more than one researcher, which allowed for a wide interpretation of the results.
Next, this training did not take place in the actual consultation room, which could give more accurate results, as participants would then also have the possibility to use medical records, contact colleagues or patient's family, consult guidelines etc.
Also, there was only a limited number of simulated patients. However, the set-up of these consultations, within a workshop specifically aimed at patient-centered skills in multimorbidity, allowed to elicit and interpret the observed skills.

4. Practice implications and implications for further research

On the theoretical level of the definition of EBM, we saw how clinical expertise in managing multimorbidity was present. This fits one part of the definition of EBM. Clearly, these skills reached to exploring another component of EBM, namely patients preferences and values, through exploring their concerns, compliance and goals. This means we saw how two factors of EBM were being used directly and implicitly. This suggest that the management of multimorbidity in primary care in this small scale workshop, was EBM-oriented.

On the level of the consultation itself, time management in multimorbidity can be split over several shorter consultations, taking time to explore the patient, his goals and health needs. This offers an alternative to time pressure, and has the benefit of gradually following up on the mutual health goals.

On the meso-level, integrating goal-oriented skills in primary care, from medical school to GP trainees to experienced GPs, is a challenge. To reach an entire generation of primary care providers, and other disciplines within primary care, requires specific skills seminars bottom-up, in academic curricula up to in continuous medical education.

On a macro-level, adopting a goal-oriented care model will ask for a change in attitude in both providers and in patients. The shift towards this care-model, will require some changes in for example consciously using shared-decision making, involving the patient and helping the patient to define their own goals. Previous studies have found this is not so easily done(3, 17). There are many pitfalls

risking to fall back into problem-oriented habits. Adopting a goal-oriented care model, requires regular teaching for providers, as well as patient education. These changes can contribute to the management of multimorbidity in primary care.
For future research, it will be interesting to see more skills seminars, and studies integrating the three columns of EBM.

Conclusion

This study focused on one column of EBM, namely on clinical expertise in multimorbidity in primary care. The simulated consultations in this workshop elicited exploration skills (exploring the patient's perspective by talking about functional status and trying to elicit patients' goals) and action skills (committing to actual care planning by working on goals). Other skills were not observed explicitly, such as shared-decision-making or screening for mental health problems. This may imply that this workshop was unable to elicit these skills, or that there is less expertise in these topics. Future seminars could provide insight in the reasons for these observations with GPs. Integrating future studies on the two other columns of EBM, best external evidence and patient values and expectations, would be an interesting contribute to EBM management in multimorbidity.

Abbreviations

EBM	- evidence based medicine
GP	- general practitioner
ICE	- ideas, expectations, concerns
DDD	- Dialogue on Depression and Diabetes
WONCA	- World Organisation of National Colleges, Academies and Academic Associations of General Practitioners
SDM	- shared-decision-making
GOC	- goal-oriented care

Appendix

1. Data-collection
2. Data-analysis
3. Describing the process of this study
4. Informed Consent
5. Approval by the Ethics Committee

References

1. Boeckxstaens P. Multimorbidity: A quantitative and qualitative exploration in primary care. 2014.
2. Sackett et al. Evidence based medicine: what it is and what it isn't. BMJ. 1996 Jan 13; 312(7023): 71–72.
3. Luijks HD et al. GPs' considerations in multimorbidity management: a qualitative study. Br J Gen Pract. 2012 Jul;62(600):e503-10.
4. Evidence-based health care and systematic reviews, Cochrane, 2014 May, http://www.cochrane.org/about-us/evidence-based-health-care.
5. Ullman J. Foundations of Computer Science. Freeman 1992, http://i.stanford.edu/~ullman/focs/ch05.pdf.
6. Royal College of physicians and surgeons of Canada. CanMEDS 2015 Framework. March 2015, http://www.royalcollege.ca/portal/page/portal/rc/canmeds
7. Ubel Peter A. Critical decisions. How you and your doctor can make the right medical choices together. Harper One. 2012.
8. O'Connor AM, Wennberg JE, Legare F, Llewellyn Thomas HA, Moulton BW, Sepucha KR, Sodano AG, King JS.Health Aff (Millwood). Toward the 'tipping point': decision aids and informed patient choice. 2007 May-Jun;26(3):716-25.
9. Wennberg J. www.informedmedicaldecisions.org.
10. O'Connor A. www.decisionaid.ohri/ca.
11. Jones SM, Amtmann D, Gell NM. A psychometric examination of multimorbidity and mental health in older adults. Aging Ment Health. 2015 Feb 12:1-9.
12. Woodhead C et al. Patterns of physical co-/multi-morbidity among patients with serious mental illness: a London borough-based cross-sectional study. BMC Fam Pract. 2014 Jun 11;15:117.
13. Prados-Torres A et al. Multimorbidity patterns: a systematic review. J Clin Epidemiol. 2014 Mar;67(3):254-66.
14. Mold JW, Blake GH, Becker LA. Goal-oriented medical care. Fam Med. 1991 Jan;23(1) 46-51.
15. Lemon TI, Smith RH. Consultation Content not Consultation Length Improves Patient Satisfaction. J Family Med Prim Care. 2014 Oct-Dec;3(4):333-9.
16. Neuner-Jehle S, Straumann M. Die Betreuung multimorbider Patienten in der Hausarztpraxis – neue Ansätze. Primary Care, 2013;13: Nr 21:382-383.
17. Neuner-Jehle S, Schmid M, Grüninger U. The "Health Coaching" programme: a new patient-centred and visually supported approach for health behaviour change in primary care. BMC Fam Pract. 2013 Jul 17;14:100.
18. Branch WT. Teaching professional and humanistic values: Suggestion for a practical and theoretical model. Patient Educ Couns. 2015 Feb;98(2):162-7.
19. M van Es J, Wieringa-de Waard M, Visser MR. Differential growth in doctor-patient communications skills. Med Educ. 2013 Jul;47(7):691-700.
20. Van Nuland M, Thijs G, Van Royen P, Van den Noortgate W, Goedhuys J. Vocational trainees' views and experiences regarding the learning and teaching of communication skills in general practice. Patient Educ Couns. 2010 Jan;78(1):65-71.
21. Reinders ME, Blankenstein AH, Knol DL, de Vet HC, van Marwijk HW. Validity aspects of the patient feedback questionnaire on consultation skills (PFC), a promising learning instrument in medical education. Patient Educ Couns. 2009 Aug;76(2):202-6.
22. Bombeke K, Symons L, Debaene L, De Winter B, Schol S, Van Royen P. Help, I'm losing patient-centredness! Experiences of medical students and their teachers. Med Educ. 2010 Jul;44(7):662-73.
23. Rotthoff T, Baehring T, David DM, Bartnick C, Linde F, Willers R, Schäfer RD, Scherbaum WA. The value of training in communication skills for continuing medical education. Patient Educ Couns. 2011 Aug;84(2):170-5.

Managing multimorbidity in primary care:
Eliciting implicit skills general practitioners use while providing evidence based care for patients with multiple chronic conditions.
A qualitative exploration.

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APPENDIX 1: Data-collection

Methodology of the data-collection:

Data-collection took place through non-participating observation.
There were two sets of data:

a) Observational data that was used, from the video-taped simulated consultations:
- only the transcriptions from the consultations were used,
- transcriptions from the moderation or the feedback in between consultations, was not used.

b) Observational data that was not used:
- written observations of each session of the 3-days workshop,
- evaluation forms.

The observational data we used for this study, were the verbatim transcriptions of video-recorded simulated consultations with the trained patients, as real-life consultations were the only way to capture the silent skills the participating physicians already have. One video-consultation could not be used due to a technical error.

Following notes are the verbatim transcriptions of one introductional consultation and of 3 out of 4 video tapes with simulated consultations.

A next step, towards data-analysis, is underlining the found skills in the transcriptions in light gray. This step of analysis is followed-up in Appendix 2.

a) Observational data we used:
Legend: PT = patient, DR = doctor

1. video transcription: introductional consultation (session 1):

DR: Okay. Okay. (To group) Thanks for giving us the opportunity. This is X. She was born in Africa, in Ghana. Yeah?
PT: Yes.
DR: And she lived there, and was willing to talk to us now. She is with us today, although she only arrived yesterday,
PT: Yes.
DR: Coming back from Accra, because you had to go there for…
PT: A funeral.
DR: A funeral, yes. I think it was your cousin who died.
PT: Yes.
DR: He died from…
PT: Diabetes.
DR: From diabetes. Diabetes is quite a problem. And we are so happy, although you were just returning, that you committed yourself to being with us, thanks for that very much. And we will have some talk, if there is a question that you don't want to answer to, then feel free to say.
PT: Okay.
DR: Good. We have known each other for a long period of time.
PT: Yes.
DR: Okay, good. Diana, first, tell us a little bit, you came to Belgium I think twenty years ago. Tell us a little bit of your background, your country.
PT: I came from Ghana, in the year 1992.
DR: Okay.
PT: Then, I visited my sister, and said, I will not go back anymore.
DR: Okay. In Belgium?
PT: Yes, with my sister.
DR: And your family joined you? You have, I think, 3 children?
PT: I have 3 children. 2 boys and a girl, but they are not living with me anymore. I had the last one, with me, on and off.
DR: Uhu, okay, and your children have already also children, so you are a grandmother.
PT: I have grandchildren.
DR: And you see them regularly, your family members?
PT: Yes. They are with me most of the days. Even yesterday, they were with me.
DR: Okay. And, um, your husband?
PT: Yeah, I had a husband. But I don't want to talk about it.
DR: Okay. And so, you came here in Belgium in 1992, then you joined the health center (GP practice), I think, once you lived in Ledeberg.
PT: Yes.
DR: Yes, okay. And I think it was some years ago, that it was discovered, a problem in relation to diabetes. Can you tell us a little bit about that?
PT: Yeah, I went, because I used to visit the health center regularly. One time, they said they were going to take a blood sample of me, and so when it came, the doctor told me, the sugar in my blood, was not good. And so, through that, in the meantime, I was not feeling good. Then they saw I had diabetes. So they started to treat me.
DR: Okay. When you had gotten used to having diabetes, what does that mean to you? Were you anxious, were you …?
PT: Well, I, from the beginning, I didn't know anything about diabetes, so I ...
DR: Okay.
PT: … (missing) so when I was going through the process, I saw that it was not something to talk about it.
DR: Uhu.

PT: I was serious for the treatment.
DR: Uhu. And, um, there were some things that you were concerned about.
PT: Yes. Because um, through the process, I got to know that you can be blind! That it "calculates" or something like that, so I began to be worried!
DR: Uhu. And that was the motivation to comply with the treatment?
PT: Yes.
DR: Okay. Now, regularly, you are followed-up. I think, every three months?
PT: Every three months. They check the blood, and sometimes my foot check. And every three months I have to go.
DR: Yes. You go to the diabetic clinic, to the health center, and you are regularly invited to come and have a health check.
PT: Yes.
DR: Do you also have to take medication?
PT: Yeah, I take medication for it.
DR: Uhu.
PT: I take it once a day.
DR: Uhu, yes. You take it once a day. And of course, there were other things you had to cope with. Was it difficult, to cope with the nutrition, diet?
PT: Yeah, from the beginning, it was very difficult. But the doctor talked to me that it is also very important, because before I was very fat, so I had to loose weight.
DR: Uhu.
PT: And I thought it was very difficult, because when I was with some others, at the table, at some time, I should rest (eating).
DR: Uhu, yeah. But that was quite a change in your habits?
PT: Yes.
DR: There was another thing that the doctors didn't like. You were a smoker.
PT: Yes. I smoked, and they told me to stop but it's not easy. I stopped sometimes for a year, and then I would go back. Even now, I stopped for a few months, but I'm not sure, even now, I might go back, I don't know.
DR: Or forever? Maybe, there is an opportunity now, to stop forever (laughter).
PT: Yeah, because when I spoke about this now, I could still go back for it, you see, that is the problem.
DR: Uhu. Apart from the diabetes, you also suffered from another problem, your back pain.
PT: Yes, and I had an operation,
DR: Uhu, yeah.
PT: And it is not, it is not all that good. I have pains from that also.
DR: Uhu, yeah. Does that hinder you to do the things you would like to?
PT: Yes, yes, because the pain is still there! I want to work, but it doesn't help me, because I cannot sit for a long time and I cannot stand for a long time.
DR: Yeah.
PT: I cannot do what I want to do.
DR: Uhu. Yes. And does that sometimes make you depressed, not feeling well?
PT: Sure, it does, because I want to achieve more, you see. Because when you come from Africa, in Europe, everybody is doing what is waiting for you. I was there (in Africa) and for the diabetes, there is not medication like here for you. Like, here you get the medication, and there you have to buy, you see. You have to send money, to do all those things, and you have to work also. So if you are not working, how do you do that?
DR: Uhu, yeah. You mean, about your family, financial unequals, in Ghana.
PT: Yes, yes.
DR: And then there was a third problem, you have also hypertension.
PT: Yes. I have that too, but that is not all that serious, because I take my medication and anytime I go to the control, it is always good. (missing) Because when I start to think, then I start to think because I want to do something and I cannot do it, then my pressure goes up. Normally speaking.
DR: Uhu, yeah. That brings us to, can you tell us Diana, what is important to you? You are actually 52 years old, so you have children, grandchildren, but what are the things that really matter for you?

What in your life is worthwhile, what are your goals?
PT: I want to… my last born is, how do you call it, she is going to school, and from her I get a lot of help. I do not want to… you see, because there you have to pay for that. I cannot afford not working. It is what I have to support her with, you see. It is something that is making me very sad sometimes, you know, because I want to do something (for her) you see, so…
DR: Uhu, yeah. So, if I listen well, for you, being able to work, is important?
PT: Yes.
DR: Because you see…
PT: I'm not old. I'm not old.
DR: Not at all. Yeah, okay. And so, that is because of this income, that enables you to do these things. Is it also to do with the fact that… Tell us a little bit of the work that you are doing.
PT: It is a secondary use shop.
DR: Yeah, it is a recycling shop where used things are sold. And it is a social project.
PT: Yeah, and I work for three days a week. Because I cannot work more days. So that is what I am doing.
DR: Yes.
PT: Just to support my income.
DR: Yes, apart from that, is that helpful? At your working place, do you have contacts with people?
PT: Yes I have contact with people, a lot of people, they count on me. And I have to carry things. And because of my back, sometimes I can't, so sometimes they have to help. So I like it there, because sometimes when you meet people, then sometimes you can forget about your problems, and I like to do that. And I like to work full days, but I can't, so…
DR: Yeah, okay, but the fact that you can meet people there, that you can share, helps also, to cope with your disease?
PT: Yes.
DR: Are there things that, you say, this for me, is really important? Apart from your work, apart from your family, things that you say, that makes me enjoy life?
PT: Yeah, it is for me, my sickness also, because here I can go to the hospital, when I don't feel good, I just call my doctor and they tell me do this do that…
DR: You get help.
PT: Yeah, and that is also important, because in Africa, you don't have those chances, also. That, yes that is what helps me a lot.
DR: Yes.
PT: For every problem, I can go to the doctor, I can go to her, doctor Hilde, I go to her, then she tells me what to do and how to, so yeah.
DR: It is very supportive for you?
PT: Yes, it is very supportive for me.
DR: And you can talk with her about all the issues that you…?
PT: Sure, yes.
DR: Yes, okay. You told me that, in Africa, it is not always so easy, to find a doctor that you can go to…?
PT: No, no, no. Because they are there, they are good, but they are not social. When you are sick, they treat you not like as if you are sick. They treat you like you are just to come there… I don't know how to explain that, they don't support… That is not good. Because I told you, I wanted to go back, also for my sickness, I want to go back, because Africa is also good! When I went there, when I went there 3 weeks ago, I can tell you that even my medication, I don't take it.
DR: Uhu.
PT: I don't take it, but I feel good (there)! Here, I forgot to take it yesterday, and I don't feel good! So it is. I don't know why, but so it is.
DR: Yeah. Africa…
PT: Yeah…
DR: helps you to, feel good?
PT: Because when you are there, how do you do it? Because the medicine I am taking here is free, but there you have to buy. So that is also not good for us.
DR: Uhu, yeah. That is the reason why you stay in Belgium?

PT: Uhu, yes.
DR: Okay. Um, just for finishing, before we are going to the people (participants) for their questions, what do you see as important, for doctors and nurses, who are to take care of you, what are important things to look after?
PT: Here, or in Africa or something?
DR: Here, and in any place. …That they should look after, to be good doctors?
PT: Social contacts! Social contact is important, because nobody wants to be sick, but when it is there, you need somebody to help, you need somebody to … You see. But when you don't get that lucky also, sometimes you can get into depression or so… Even doctors and the nurses can talk, and also, ask questions! And for me, what the doctor and the other doctors are doing for me in the health center is very good. It is what I see. You should let the patient feel free. That I feel free.
DR: That you can tell everything that you want to tell?
PT: Yes. When you are social to be a patient, the patient is (then) also ready to talk too. When you have a problem, you don't have to talk to everybody, but it is secretive, and that you can talk to them.
DR: Uhu. Okay good. I think I would like to thank you very much for your coming and I think we will ask the audience to share questions they have and you can answer them.
PT: Okay, okay.
question round from the audience:
DR: Thank you very much Diane for coming here today to teach us. Have you had much people to learn you more about diabetes, or do you teach them?
PT: Yes, I have had the opportunity to talk to some of the patients, even if, there was one patient who also, who has had diabetes. And I said okay, because it was from the beginning, so I tried to talk to her that she should go, because she can be blind, and … Because she is very young! And if you don't take care of you, then you don't know when you are going to die! It is very sad.
DR: Okay, so you share your concern with her?
PT: Yes.
DR: Yes, good.
PT: No problem.
DR: Are there things that you enjoy doing?
DR: What? Yes. Are there things that you enjoy doing? That makes life enjoyable?
PT: Well, I like, I like, we Africans, we like coming together. I like going to church every sunday. I like meeting friends when I'm free. That is the most important thing to me, yeah. Sometimes you have to be in the room alone. And we Africans, we are not like that. We always like to come together. So if I'ld be in a room for like an hour, I have to go, so I have to go out, talk, and do these things.
DR: Uhu.
DR: But you have your grandchildren with you?
PT: (laughter) They come to me for some hours. I don't like to take care…(laughter). Because I had enough, three children already. It is better they come, then they go.
DR: Yes, okay, good. Other questions?
If not, we thank you very much, because, that brings us to the reality, to see patients as people, and I think that is something we should really be focussing on. So thank you for this message.
PT: Yes, thank you also for giving me the opportunity to express myself also.
DR: You did a wonderful job.
PT: Thank you.

2. video transcriptions: simulated consultations: group 2

moderator:
(missing) look at what her goals are for her life, and then try to go through them, I don't care, but really no longer then ten minutes, because this is in a grosser picture, you have to do it within a short amount of time. Then you give a little bit of feedback to one and other, saying this went well, this went less, and I am ready so you can start.

consultation:
DR So you are lonely. Does it bother you that you are lonely?
PT: Does it bother me? Of course it does! Before I had my petanque, I was happy, I had company, I had my (missing), even though we had some problems, ..
DR: But before you said you were…unhappy.
PT: Well I'm not depressed. (agitated) Before I was depressed, when my husband left, it it hit me in the check, but that is in the past, it is not that I am depressed, it is just .. sometimes I am just fed up with waking up, with not sleeping well, with having sores, with not being able to go to petanque anymore, .. You know, small things, just to have less pain, (missing), but she ..
DR: So what are your priorities. You said you are not feeling well. Are they financial, … Is it difficult, do you want more money…?
PT: Well, what?
DR: Yeah I know, but..
PT: Well of course it is difficult, that is why I cannot afford not to work. If I loose this job, then it is worse hey. So you are asking what I need. Well it is this, I need this job, to work.
DR: Yeah, so you are not interested in for example being retired, or half (employed)?
PT: No, I have to work.
DR: You have to.
PT: I have to. I have to.
DR: Okay.
DR: (missing) So there was one thing I was wondering. Did you also visit specialists?
PT: Yes I did, I did see a specialist for my arm, for my frozen shoulder, and then I did see a kine, but this is all (missing)
DR: (missing)
PT: Yeah, I try to live with it, but what do you expect?
DR: What about your pension?
PT: Yeah, well, I put something aside, but that is also… Other times I take some medication, and then you still are not feeling fine. So It is true, I used to be able to do, to go to petanque, it was nice, and now I cannot do it anymore. (missing)
DR: Do you perhaps have some problems with the different medications, and with knowing when it is useful or not?
PT: Well, probably they would not prescribe it if it doesn't do anything. It is not that I feel, that "O I have these meds, I will do what I want to do (with them)". My work is already difficult for me, and that is bothering me. I take painkillers, and my neighbourhs sometimes, they give me brufen sometimes, so I, pff!
DR: Did you have any problems in communication with the retired colleague(GP)? With the painkillers, sleeping medication…?
PT: I could talk of it with him, yeah.
DR: You could discuss this openly with him…?
PT: Yeah.
DR: So you could make an agreement (with him)?
PT: Agreement? He owes me, yeah. And the cigarettes I told him I will not stop, so we didn't talk of it any more.
DR: So your cigarets are important to you?
PT: Yeah! I know it sounds silly, I know it is unhealthy… I know. I know!
DR: I'ld like to hear a little more, you said, this petanque was very important to you,
PT: Yeah!

DR: Do you see your friends from there? Or how is it with your family and your friends?
PT: I, I don't have family. The two of my parents died, my husband left ten years ago, and umm, I have no children. And the people from the petanque, yeah, in the beginning it is nice when you can play along, but then I couldn't because of my shoulders, so then I stand there, and that is not for me. I am not somebody to just stand there and watch. So that is ..
DR: Well I can see, by the look of it, that you are not a person to just stand there and look at it, ..
PT: Yeah you can see hey, "Why are you not playing along"?
DR: I understand. And before that, were you often out with friends, …?
PT: Yeah I was, or I invited someone to my home. But this (petanque), someone suggested me some years ago, and it was nice, yeah.
DR: So what I hear, is that you needed this time to, …
PT: Yeah, at least it was something to look forward to. It is different then, to go home…
DR: And then another thing, you stated once that all these problems were worse after your cancer…
PT: Yeah,
DR: So what happened? I think, you had had time (missing) So after that?
PT: Yeah, all of these things were after the cancer.
DR: So the time you recovered from your cancer, how was that?
PT: Yeah, it was ok, but you grow older hey, and I think for the family and for the prognosis, also my mother had it, … Yeah so the older I become, the more of a problem I have. I don't know if it has to do with the cancer, I never linked it with the cancer. But it is true that these last years, I started having all these problems…
DR: So your mother, she had…
PT: A hip fracture, yes.
DR: So are you worried about fracture, or…, because, …
PT: Pff no, it is just that the hip, it worries with what I have to do(work), because yeah cleaning is hard hey, it is a hard job. I can't do certain things, like with my shoulder, with the dusting, I can't …
DR: How many tablets are you taking? How may tablets per day?
PT: I don't know! I ..
DR: But how often do you need to take those tablets?
PT: Yeah sometimes I take one right at dawn, but I am sorry, I have no idea. I am not… pff. I just, I just right down, this one so much, this one so much (per day).
DR: It is because the doctor had said it (PT and GP talk through one and other simultaneously)
PT: Yeah, but I don't know the names and so on. I just take it.
DR: And it is completely right…? (suspicious)
PT: I don't know anything about that. But when it helps, then I am happy. When it doesn't help, then I'm not happy.
DR: When you go to the pharmacist, do you buy any additional, over the counter medications?
PT: Well sometimes…
DR: Like painkillers, …
PT: Well yeah, like Dafalgan I sometimes, the paracetamol, that I sometimes buy myself because you don't need a prescription for that, and then also yeah, they are able to give me sleeping tablets to try, and sometimes when I don't have a prescription, she just gives me some Brufen. I don't always take them…
DR: Why do you have to go to your neighbor to ask for it, and not to your doctor? Do you think that is necessary?
Because maybe the habits from your neighbor, are not good for you.
PT: Yeah but it helps. And it is written on it, that it is used for that. So…
DR: Yes, I know, but for this inflammation of the knees, or the hips of the shoulder, it helps, but sometimes, in combination with other drugs…
PT: I don't know…
DR: So sometimes it is better to ask your GP…
PT: But she (neighbor) knows a lot about me…
DR: … just to try and protect your health.
DR: Maybe we should summarize it. From the information you recall from your health, we can see that you have some health problems, but we should try and gain some more information, to hear

about, what is important (to you). Because we want to know what is the best to you and also for the future, to find out, what is the most important to you.
PT: To have less pain!
DR: To have less pain.
PT: And that I will be able to do something again, and I can petanque again, and just yeah, so I can at least finish those last years (of work). So that the pain is less, so that I can sleep, not be tired, …
DR: So what we understand is that you hope to get a little better for your work, but also, as your doctors, what we hope to do is that (missing) also with you to find out what is the most important. Really hear what you say, the pain, to get a little more of a life, but also to treat your diabetes, and…
PT: But for my diabetes, it is not, I don't, …
DR: Okay, so let's work together with you, to help this impaired functioning. It is very important for us too.

moderator:
Can I interrupt? Did all three of you get some chance to exercise? Do you have the idea that you have enough information about her goals, and her …? If you think that you are that far, please give some feedback to one and other, and ..
DR: No we haven't, we are still gathering information.
Moderator : Okay. Then you give some feedback to the colleagues on this went well, this not, when you said this went "rurururumm" or when you said "well she was with you". And then, think about the exercise yesterday. Yesterday you discussed a lot of medical stuff, in a comorbidity patient. And today you can think of how can we balance, and I saw you were already starting to see, how can we balance. And that is the next exercise. From your (refers to PT) perspective, you know what your goals are. We (GPs) of course have ours, and we need to come to shared decision-making. So that is up next.
DR: So we talk a little amongst us?
Moderator : First give feedback, try to figure out, "well I would like to have some information on that", and then ask the PT. If you think, no, we are done, and that is enough information, then you think, how can we bring both books together, the medical aspects - important for us, and her goals, important to the PT. And do the second part of the exercise.
DR: Okay, the first part is done. Can the PT give feedback as a person or as a PT?
Moderator : She will stay in her role. She can say, "Well if you say, you have to stop smoking(makes choking sign)" She will not say, as a human person, do this or do that.
DR: So we don't ask as a person, …?
Moderator : Not yet. You do that this afternoon. Okay I'll be back. So you can ask her "I thought I did a very good job, and then she can say no, I didn't experience it like that".

feedback:
DR: I think it was interesting to see what she said about the medication…
DR: So we would really need to see this paper and review what… You know you can write one right then. (laughter)
PT: That might come over me, like, they don't trust me.
DR: My feeling is that, maybe we should not have asked you so much, but just left you to say, what you actually wanted to. So we were asking all this (showing list), because we were really forced to. (because of day 1) But I am not sure that I would…
DR: Well the assignment that I had, was to observe, then you said, we should indeed also be silent and not ask questions and listen for a while. Well you did offer to, by asking how she experienced her illness and by asking what is important to her. But before we put her on the spot, maybe we could have made her a little more comfortable too, you know, we could have …
PT: I felt, in this situation and if it was me, I am invited, and I am already a bit suspicious of these 3 GPs…
DR: You looked a bit irritated.
PT: Yeah, I think, especially for somebody like her (PT), this is a bit threatening, …
DR: With 3 as a doctor…
PT: Yeah, even when I tried with only one (of you 3), but still.
DR: You mean with 3 different doctors?

PT: Yes, even when I tried with only one, but still it is… yes.
DR: So I think you are totally right, we should have given her more space and invite her to (missing) and work together with her.
DR: Maybe that would not be feasible within the context of just one consultation. (missing) It is a bit, that is the situation we are forced into.
I would probably, the first consultation, not be ready with the list, but I would just want to see, okay why and how do you…
DR: Yesterday, when we saw the list of the symptoms, we thought, whether or not there would be some behavioral component, and she now stated very clearly that she didn't want to give up her cigarets, so we said we'ld might have to learn, in the course of her day, whether or not she gets enough exercise, or whether she could use more exercise. Is the housekeeping work aerobic, or is it just, you know, polishing? That would be, that would perhaps need to be supplemented. We found out, obviously, that the most important things were reducing the pain, being able to do something, to petanque, that does not seem to work. I don't know whether or not that is possible?
PT: Yeah, she needs her shoulder to (mimics petanqueing).
DR: So oh, her shoulder?
DR: Well, that's what I was thinking, is it possible to maybe get her back into petanque, or maybe to just (laughter) roll a ball? As opposed to throwing it?
DR: I think it needs to be better.
PT: I think, it doesn't work.
DR: Would you have been embarrassed, if already I, within this first consultation, asked "what is your expectation from your doctor". Already within this consultation.
PT: No (it wouldn't have). Maybe I would just say "that you help me, with the pain, and…".
DR: You would have said that, …
PT: Yeah. For me, my doctor, he is okay, he is not a threat.
DR: When we asked you if you had a good relationship with your former doctor, maybe it would have been better if we had asked you what you expect from us?
DR: Or "what did you like about the relationship with the (former GP)".
PT: That is why I said, this is not important, he (former GP) knows me.
DR: (missing)
PT: Yeah. He knows that he doesn't have to push.
DR: So that is important to you.
PT: Yes, he knows. He knows my situation. And my old situation, with my past, with my husband…
DR: Well, you've obviously, you felt that you knew what depression was, and that you were depressed when your husband left. A bad feeling. But you still have some sort of scepsis that a lot of these things, your cancer surgery, and you have had a lot of other stresses in your life, and obviously, you have a lot of pain. And so the picture in this, could be to explore this depression. You seem to be resistant about it. You know, it was a statement to admit having had that. But it is symptomatic, so we would might want to explore that.
DR: I would ask, is it the same feeling? Would you answer that?
PT: I would say, no it is not a depression, it is not that I don't want to do this or go there, no it is not that I don't want to do things, it is just my situation that keeps me from doing anything. And it is just because of that …
DR: But it is interesting, why everything has gotten worse after the cancer?
PT: But I don't know, for me, I don't relate it to the cancer. Also, I don't know why my shoulder is bad, I think it is in the family… (missing)
DR: So can I ask about your financial problems? Why were you so...
PT: (missing) I feel shame, I don't know if there is a reason, but I feel shame about my situation.
DR: I think it would be good to know…
PT: Yes, there is a reason why I don't (talk about that)… Well I know of course, but I can't tell you as a person. You would have to ask the PT.
DR: Why is there this feeling?
PT: Because I am so ashamed, my husband left me, and we were okay financially, we had much much better… But when he left, you are okay, alone, and I got so so depressed, that I really didn't fight for my financial rights, so he (makes grabbing sign) took everything. And he left me with no income, that

and almost nothing. And you need to pay all that is necessary. So I blame myself. That is why.
DR: I think it is good to know, that because of your situation, you had to work.
DR: Well she was beating herself up.
PT: Frustrated.
DR: Right. You were blaming yourself.
PT: You are always with the bitterness, for what happened, and the anger.
DR: One more question. Sometimes, do you fail to get out of bed? Or do you…
PT: When my husband left, then it was really hard to. But okay, we move on, and now, I was not as depressed as when my husband left, because I was alone and got cancer.
DR: Was that after your husband left, the cancer?
PT: Yes.
DR: I think this is important to know, because it allows us to go into that. If she said, I don't want to answer these questions, then I suppose it would be different. The anger wouldn't come out.
DR: Exactly.
DR: So and then she gives us in fact the room to build on that.
DR: And to integrate, because she is not with people, she is not playing the sport that she likes, and that compounds her problems. So we need an opportunity to help her find a way to get to a community.
DR: (missing)
DR: (missing)
PT: It is a (missing), because that is when you work and come home, the people are not there. At one hand, it is easy. There is no boss around, everybody just goes ahead.
DR: Is it daytime or nighttime that you are working?
PT: Daytime.
DR: I would just do a physical check. When we listen to this, we hear about pain, substance use, little on diabetes. I don't hear there is fear for the future, it is not something she worries on. The pain is what worries her for the future, and not so much diabetes. We think, if you have diabetes, it is important that the blood sugar is low, … You think, with the pain, it is important that that goes down.
DR: I would suggest, I would ask "what are your top 3 things to do?". I would ask this like that, and then I would know straight away what you want from us to do. And then the sleeping pills, I don't know if I would ask you. In the next phase…
PT: The pain, I know, I am not surprised (because of it), because I know I have osteoporosis in the family. It doesn't come as a shock, but it hinders me and I have to come through these last years and I cannot permit to lose my job and I don't want to have to think about that and I hope that it will help me to have a bit of a social life again, and also in the future, a bit of a pension, time for myself, quality time again, and maybe some work. To be able to do that. Now, I feel i might not be able to come through these years.
DR: When she talks about the pain, all students write down painkillers. What I was thinking is, to ask, what exactly is this pain? Because pain can be just hindering when doing some things. So maybe we should be careful not to fall into this trap. Because it is a directory to a prescription, but that is not what you (PT) want.
PT: No (it is not).
DR: So in the future, when we try to rephrase this, when we are talking about pain, …
DR: Well I think the ability to function is more important here, but she perceives the pain as the barrier to do her job and to get out and do the things that she wants to do.
DR: Yes. So this is not a semantic discussion, it is about what is behind this pain. Pain is the most used way to express a complaint (refers to brain) because it is centrally …
DR: Maybe for the shoulder pain it would actually be better to sometimes (makes petanque movement).
Remmen: And maybe she thinks that because of her pain, it is wrong to do so (petanque).
DR: (missing)
DR: And did you get some physiotherapy after your shoulder surgery?
PT: Yes.
DR: You were gaining the mobility?
PT: Yes, I was.

DR: But was there some incident that caused your shoulder to become, to loose mobility, or did it just started to happen?
PT: It started not being able to raise my hand anymore, and then it got difficult for my work.
DR: Yeah. So you have had the opportunity to have some physiotherapy on the left shoulder now so that you would have some less chance of needing surgery on that (one).
PT: Yeah, I do need surgery on that one.
DR: Okay, yeah.
PT: My neck, you know my neck pains, and my hips also feel like…
DR: So we really need to get into this.
DR: Yes, that is in fact the next step, we need that to be able to get to the shared decision-making. But we need to agree on this. Because if we start talking about either diabetes or smoking, or one of those things, then we would have no common ground, but a fight. (laughter)
DR: You appear to be adherent to your medication, I mean, you seem to be taking your medication as prescribed. But still it doesn't seem to be controlled, so we need to find a way..
DR: (missing)
DR: I mean, this is going to be our patient, you know, so we need to (missing), just to be certain.
PT: I take my medication. I take my medication because I have to, I have to go out hey.
DR: Do you like taking medication?
PT: No I do not like it. I used to go to my neighbor to take the medication, because I really need to take them, because I need them to keep going.
DR: (missing)
PT: You know, I hate this. I hate it. Because I don't understand a thing about "what kind of medication". You prescribe the medication, I don't know. Personally, I feel embarrassed. Because of this and this explanation. Personally, I feel embarrassed, please, am I with the police or something? That is the feeling that it gives me, when you talk about it. Do you understand that it is? The moment it starts like… I feel attacked in a way. And yeah, you make me feel uncomfortable.
DR: So if I propose to vaccinate you against flu or pneumococci, will you accept that, without any question?
PT: Yes, I will.
DR: So I am in the position that you trust me.
DR: You always pay a certain amount of (missing - money? to see the doctor).
PT: But I expect that.
DR: It is not with the vaccination of course,
DR: But still, she'll need to go to the pharmacist and so on. So, what do you earn per hour? Something like 12 euros?
PT: Yes, 12 euros.
DR: So 1 hour is about 8 dollars. So, …
PT: Yes, now I really have found that a lot of my money goes to my medication. So I have to… I need my medication, yes.
DR: Would you like to balance the cost of the medication with the need of what the doctor prescribes?
PT: Yes.
DR: (missing)
PT: (missing)
DR: But also we could write (down) what you would like to reduce from the medication?
PT: Well yeah, if it is possible, then I am always happy hey, but that is what the doctor prescribed me. But yeah, he took my income also into consideration.
DR: So your relationship with your doctor could change when your doctor decides that you should make shared decisions?
PT: For me? Yes, because what do I know? I am not a doctor.
DR: But in which part would you like to be involved in the decision making process?
PT: Well some things I already know…
DR: (missing)
PT: Like some things, like my eating habits, I know, … But yeah.
DR: Would you like to talk to him about it?
PT: But he doesn't.

DR: So that is what happens to you. He does his blablabla and in the end he'll start to prescribe you things.
PT: Yes,that is how it is.
DR: Are there any areas (missing)
DR: But in the negotiation, you might have to give up some things to get to certain things that are more important to you. You want to be able to be active again. Whether it is by playing that game or another, is a way to get back in to that. Which means you might need to allow yourself to get more stamina, more flexibility or more ability to move without pain. And to do that we are going to have to get you to exercise in a way which will allow you to have those better, and try to reduce your smoking, so that you can… So I might ask you to change certain behavioral aspects for the benefit of making you able to move freely, without pain, to get you to interact with your friends. Those things will help with the others, if you get more exercise, and have more social health. The negotiation could involve changing some of those intrinsic behaviors for the benefit of the things that are most important to X (PT).
PT: (missing)
DR: (missing)
DR: I am sure. Do we go into the next phase of the shared decision making now?
DR: Yes, trying to find… Now that we have heard a little of her, what we know about her, trying to get there, trying to find some areas to negotiate.
DR: So I think we will start that part of the exercise.

consultation part 2 (shared decision making):
DR: So for the next part, we really should summarize?
DR: Summarize, yes.
DR: And continue from there?
DR: Okay. (summarizing) Our patient Marleen, mentioned, pain is her main problem. It is a mix of discomfort and of preventing her to work as she would like. Her job is another problem, also socially, so also there is a dominance of equal social security, and the job causes pain, so both are interacting. So we need to help her with this pain, also medically, because maybe the previous GP did not work sufficiently around that, because she was going to the neighbors for the medication and all that. So this area was not very well covered. And it is essential for her life, I think. So there is no depression, but okay, in terms of the pain, some of her pain aspects could be mental. So her pain is her biggest problem. She takes combined medication, she doesn't want to talk to her doctor about the lack of communication, because she doesn't want to … But we as a doctor need to cover this area. So diabetes is for her not her biggest problem, she needs to be treated by just drugs, but diet is on a secondary plan. She doesn't care for these non-pharmacological matters for treating cardiovascular disease. Her pain is important to her, she doesn't care about her heart or cerebrovascular disease. So when we came to nicotine abuse, cigarets, she said okay, cigarets are my friends, so let's not talk about that. But from our area (as GP's), we talked about this yesterday, that quitting smoking should be the first measure.

moderator:
Sorry, can I interrupt. How do you bring those two together? It is part of the exercise of course. You need to say, as a medical doctor, this is the most important. What are her goals compared to yours? Because they will clash. How did you think about that? Did you already get that far? Are you sure that you have enough information (on the PT)? I imagine.
DR: Yes.
Moderator : Yes. And now you are thinking that we have a contradiction here.
DR: Yes.
DR: To negotiate.
Moderator: And was it easy? But you still have to do it?
DR: Yes, we just started to do it.
Moderator : (To PT) Do you, do you want to quit smoking?
PT: No.
DR : Ah, okay.
DR: Maybe next we can discuss with her (PT) what her ways are to get to her goals, and maybe

discuss the area of … I would just discuss it with her.
DR: Maybe we could say, okay, I might not be able to do everything from this (list), but let me…
DR: I would not give her to much time, but just …
DR: Yeah, let her ventilate on that. But maybe, if we say things again and again and again, she will start hearing it?
(missing - all talking together)

consultation:
DR: Marleen, we have heard what your problem is, and we try to understand, but where would you like to start? We talked about the priorities, but if we talk to you, to work together with you on this, then which area is the most important for you, to start?
PT: The pain.
DR: The pain. (To DR:) Maybe you should ask her on that.
DR: Okay so you have this, and you have told us about this. But I don't know if there is anything social you would like us to talk about, other things?
You are in this pain, that prevents you from working, moving, sporting. Is that right?
PT: Yes. It is the pain.
DR: Yes. Now tell me some more about what you call pain, what exactly is it?
PT: I don't know.
DR: Try to tell me.
PT: Yeah, I feel my knee, my hip, and when I am working, when I have to bend to my knees, I hardly can. It is like I feel my body the whole time. And sometimes I just sit down because I cannot continue. Especially with this shoulder, when I move things, and yeah, it is really annoying.
DR: Are there times when you don't feel your body? When you are happy with it.
PT: Yes, I'm not busy all the time, but sometimes, it is in doing things, that I feel my limitations.
DR: So when you are at home…
PT: Yes, then it is okay, except when I get out of my seat or out of my bed, then… Really, really, it is not funny. I wake up and then I have it. And at night I cannot sleep, and then in the morning I have to wake up…
DR: But still, with all these things you need to do…
PT: Yeah, and that makes it very frustrating, because I cannot stay in. You have to do it hey. You have to go, they are waiting for me. I try to.
DR: Do you think to yourself, I have to go on, with these complaints? Is that when you take your tablets?
PT: I try not to take them too much.
DR: And it helps, or…?
PT: I don't know, a bit… That is why I need to be honest with what my neighbor gives me sometimes, because that helps. It's stronger than Dafalgan.
DR: (missing)
PT: (missing)
DR: So that's it. It is not anything more than that? Have you any ideas that can make you lessen this feeling (of pain)?
PT: No. Maybe I should rest but I cannot rest. That is the thing. I know where I have to be, and I still have to continue to work.
DR: And you are still able to do it, you are still on a good time schedule, ..?
PT: Pff, it is a lot.
DR: Did it help to go to the physiotherapist?
PT: Yeah, it is good for that, but it is also not a miracle.
DR: Okay, let us talk on the medication. When earlier(medical session), we talked about the Simvastatine business, I would certainly now go into this, to see if she is not having any side effects. We already know that she is on these other meds, so I would go into this, and talk about medication for this cholesterol. That is what I would do.
DR: Fine, yes.
DR: It would probably help us, with having her move a little bit. Because we don't want to see her handcuffed (like this in a chair) and then reduce her pain.

DR: Yes, I think that is very important.
DR: So let's see if she'll buy that.
DR: Yes, let's see if she'll buy that!
So about this petanque that you like. You also say, okay I have diabetes, so I don't know what my blood values are but okay. Would you might allow us to reduce some medications that might also try and help us, with these complaints.
PT: Reduce the meds?
DR: Yes, because we've found out that some of the medication that you take might be related to some of your complaints.
PT: Yes, yeah.
DR: You would like this?
PT: Yeah, absolutely, yeah.
DR: Okay, so that is something we could work on.
You would like to take a tablet less?
PT: Yes!
DR: But then instead, because diabetes is a vascular disease, if you were to take less medication, you should probably move more, you should try to pick up again your petanque, …
PT: Yes.
DR: So we will try this.
DR: It is important that we know about the pain, but it is also important, that we know, as doctors, that sometimes to reduce the pain (makes petanquing sign). We know that, it would be good for your shoulder, to use it. We know it is important that you use it.
DR: We should reduce the misconception that she has. Because of the pain…
DR: … that it works.
DR: So some of the misconception that you have, is that you feel, that pain is bad for your shoulder. On the contrary, it is better to move and have some pain, to allow it to oil more.
PT: It will not block??
DR: No. So is that a good idea, to try and do this? So I can give you some exercises also, I can do this now, some exercises to make your joint move more smoothly and then we reduce the stiffness. Then we'll see in a few weeks what happened, how things are going.
PT: Well yeah, if you think I will have less pain… And you really think I will have less pain?? Because my doctor said…
DR: Well I would expect that a few moves, simple things, would help the little things, but of course you would have to…
DR: So you notice, for us it is very important…
PT: Yeah.
DR: And does your neck pain occur after you were active, or when you were inactive, … ? We found that, before you go to sleep, if you could relax, perhaps that could reduce the neck pain. A hot bath or something, is that a rely to relax or reduce the pain?
PT: I don't know, I just go to bed. I don't know what to do to… not feel my shoulder. (missing)
DR: (to group) So within this consultation, I would not go to the next level, I would not go into more, because …
DR: It is important to know…
DR: It is a smart approach. What I would probably do, is set the agenda for the next time.
DR: (missing)
DR: Maybe you could say, in opposite, that if she were to take the medicine, that the pain would be more (severe), even with the medication. Now I don't know the shoulder, so I don't know what to expect from a shoulder, but I would… (laughter) say to her to do very good exercise. But I don't have such a patient.
DR: (missing)
DR: Also, wouldn't such pain also affect the neck? Of course it is a good approach, to say, with this (missing), do you feel bad? Of course you never use your muscles. So everything is bad. Then you have to work through it, and then you will be better. So give some medications, they can use, (only) just in case.
DR: Well she can get it anyway from her neighbor, so it is important that you give her some and

balance between efficacy and tolerability for the drugs that she is taking, to … that could complicate the use of other drugs.
DR: So as a present? It is dangerous to give a present, and then get (something) back (for it). But that's umm, how did you describe that?
DR: Well, she, that is also a characteristic thing.
DR: Well, yeah, to also give her the feeling she has something to take home.
DR: Well so if we get the medicine down, that's that, but then what we need to do is work on that shoulder.
DR: That's (tape full and stops).

3. video transcriptions: simulated consultations group 3

consultation:
PT: (missing) he is retired. I have only had him for about a year. You could say, read a book. But uh, you know. I don't have any complaints as such.
DR: So, you are feeling generally well…? or…? is there anything that bothers you?
PT: (refers to her right ear) Say that again?
DR: Is there anything that bothers you?
PT: (as a little joke) I have a little trouble hearing
DR: hearing (understandingly) Shall I speak a little bit louder? (not going into the hearing)
Is there anything that makes you not feel so well, or..?
PT: yes, I am a bit lonely; I am in this big house. My husband has died. I know a few people in town, but
DR: yes
PT: but umm, otherwise, physically, I am fine. I take these pills, for diabetes, my doctor prescribed them.
DR: yes, for diabetes
PT: but otherwise, I think, I am all right uhm.
DR: there isn't anything from the diabetes, that does, make you sick?
PT: no, well, sometimes I forget to take the pills, of course, that is a problem
I try taking them but when I take them, I wonder, should I take them, should I take them twice? I just lose touch sometimes.
DR: did your doctor talk to you about how to take them? Did he give you a prescription plan?
PT: no, I lay the pills out, and I try to remember visually, if I have taken them or not, but sometimes, it doesn't work (minimalizing laughter)
DR: okay, and umm, do you have any problems with sleeping, sleeping disorders…? or do you sleep well?
PT: well, sometimes I get up, I watch a little television, drink a little wine
DR: do you have any pain?
PT: no (cannot understand) ones in a while, but then you think (cannot understand)
DR: So, what are your expectations to me? What do you expect for your health, on coming here?
PT: I I, well of course you can't turn the clock back or anything, but I can't hear as well as I used to. My vision is a bit blurred. I try to get out, but I can't hear them nicely. I fear they think I am not being friendly. Sometimes I find myself just avoiding contact, because, because I can't hear them so well, because there are so many people… And uhm, yeah, it is funny how life changes.
DR: yes. You say many things have changed. So in the past, were you another type of person? Were you looking for contact, … ?
PT: I always remember being out and about … (cannot understand) but then my husband died and I tried to go out and about, but then everybody is talking at the same time, and I can't hear what they say, and I mean, people, and then I have to ask them what they are saying,
DR: uhu uhu
PT: I mean, yeah, I would like to turn the clock back a bit
DR: would like to change..
PT: ..yeah, that would be nice
DR: Do you have children, a family?
PT: yes, I have a daughter… she visits me often, yes, yes, that is nice
DR: okay… she lives nearby or far away?
PT: not to far away, we see each other every other week
DR: okay
PT: but then I am back alone in the large house, and, and
DR: and how do you feel about that? Do you feel a bit alone, lonely, …?
PT: Oh it would be nice to see a bit more people. Because my old friends, they do not live nearby. The house where we lived, belonged to my husband's parents. And it is a very nice house, but it is not my house. (missing part)
DR: And what about the little glass of wine. Is it just, one glass, or is it, often… ?

PT: (missing part)
DR: Have you tried to organize, such a contact…?
PT: (missing part) it is not so easy to see people in the village…. I used to be in the clubs. But now… Otherwise, I have not so many complaints… Mostly my hearing problem.
DR: Yes, I think we should take that up, and take care of your hearing, and just to see..
PT: Yes, it is just really bothering me.
DR: And what about your eyes, what do you think about any test of your eye function, …
PT: You think so?
DR: It might be useful, if you tell me that you are not recognizing people early enough when you are… Also for you, to have a bit more confidence as well, to have more contacts, to be more "friendly" as you say it.
PT: Uhu.
DR: Sometimes this impaires it… So yes, I think it could help also, for the other problem. It seems to me, that umm, when you tell me, that your physical health is good enough, that it is a major topic for you, this other problem of feeling lonely and we could try to make a plan… Do you have ideas yourself, what you could do?
PT: O I don't know, maybe, O well, you can't do anything with your hands, cause I can't see that well, even just… I would go back to the country club, if I could hear better. Maybe that would be a first step.
DR: Let's try, yes. And umm, it is not necessarily a topic right now, in the first meeting we have, but uhm, maybe, we could now work on the sight and hearing problems, and then, maybe, we can develop the next step, a plan to try to handle the other problem. And, I want to also suggest to have a closer look into your physical health, not that you have any complaints or symptoms, but from your past history, we know there is a problem with the sugar metabolism, and maybe with the joints, so I would suggest to have a closer look on that, also by a physical exam, tests, just to come to know your physical health a bit better, and if there is a change there could develop a problem in the future, also to look into the future, to keep you in good health. Although, as good as it is right now. Okay?
PT: Okay
DR: So (rounding up with the hands) next step would be to organize the physical exam

moderator:
Congratulations, you perfectly managed to get it into 10 minutes.
DR: so that is good.
DR: yes, that is the reality in practice, so that is good.
DR: it was good. I think that when the second one (participant) tries the exercise, we should see if the patient herselfs, in defining these goals, wether these are also the goals that she would set for herself. For me, if I were the GP in this consultation, I would also "presume" that these were the goals, because
Moderator: Can I interrupt for a moment? You are now done with the first exercise, with the first goals? You can now give some feedback, from the other colleagues as well.
Then the second exercise will be, if you are quite sure, that you have enough information, if not - because were just saying that you wanted to do this and that, then you do the exercise over, until you have ENOUGH information so that your quite sure to say "all right this is what I need as a GP, this is the story, I don't need to talk to her about her mother, I have her OWN goals, and then take what you did yesterday on this lady('s case (medical plan)) and look if there are any conflicts between what you want and what she wants, and try balancing and come to a shared decision making. It could be, if she says I don't want to talk any, I don't want to take any pills, well then you're not going to be satisfied as medical doctors, or…? And that is the information from yesterday and the information from today, and you bring it together.
So only if you are sure that you have enough information.

DR (to moderator): so you said in these last few minutes, that we did not yet come to defining the goals?
Moderator: well you did define your own goals, but you did not define the pt's goals. You talked to the pt and discussed them with the pt, which is good. You explored and found out, f.e., the hearing and the

visual impairment. You thought this was indeed the highest burden for her, but you didn't really check. You explored the pt and you let the conversation in her hands, and then the last two minutes, you rounded up, ending the consultation, of course. And I think, as GPs, what we often will do is, from our perspective, that we presume to know the pt's goals, but we have to check for them.
DR: would it be right to say " as far as I understand this, your main focus is on…"
Moderator: Yes.
DR: " and I had thought of that and that." And maybe you could confront the pt with that information?
Moderator: Yes.
DR: As you said, it is very early still, but still the first two minutes you (pt) told what was wrong. So I think that the things that are lying on the surface, are indeed on the pt's list.
DR: I mean, there are still 5 other things I wanted to know about.
DR: But, I was trying to stick a bit to the medical program, to the medical list of yesterday, with a physical exam, etc… I was thinking about the diagnostic process.
Moderator: Yes, this is in fact the next exercise. In the first part of the exercise, we tried to come to the her (pt) agenda, afterwards we compared in this group discussion what we talked about yesterday. And then in the second part of the consultation, with our pt, we have to come to the shared decision making, taking the pt's agenda and the doctor's agenda and meet in the middle. That is the goal of this exercise.
So it is really good that we saw you explore for 8 minutes, I think we, or one of you guys, can have another try. You can know what you know (from the first part of the consultation). It is the second time that you see the pt, and you can also refer to her loneliness and you try to come a bit further in the goal-setting. Who wants to try?
Maybe compare it with your own medical plans. Is that clear?
DR: Maybe this can take place after the physical examination.
Moderator: (Yes,) so you know a little bit more about the ..
DR: Because normally, after you physically examine a pt, you start talking again.
Moderator: Yes
DR: Yesterday, we discussed we would try and see her on a regular basis, because we don't have to try and solve everything in one..
DR: Correct, yes.
DR: So let's do the second part of the consultation directly after the physical exam.
Moderator: I agree, I agree completely.
So who wants to try?
DR: I can, I can try.

DR: Hello, uh, Jeanine.
PT: Hello doctor, how are you.
DR: O, fine. You ask about me, that is quite unusual.
PT: Yes, it is nice to see you again.
DR: Yes, so.. Since the first time we met. we spoke about quite a lot of things. Did you feel comfortable about that? Are there any subjects you would like to talk about.
PT: I was wondering about, if in any case, … hearing (missing)
DR: Well, that could be. It was one of the things that you pointed out that could be a problem to go to the club. I think that was quite important to you.
PT: It would be nice to see more people.
DR: Yes. Especially in this city where you don't know a lot of people yet.
PT: Well I did, a few years ago, but I cannot go back … (missing)
DR: I understand.
PT: It is just not easy to go out again. I could try !
DR: So for the hearing problem, so maybe we could have a diagnosis or something like that, to try to get you some small hearing aid, so you could hear a lot more.
And another problem you had to get into contact with people, were your eyes, so can you tell me, how bad you can or can't see?
PT: (missing)
DR: Of course. And do you remember when your last eye exam was?

PT: I don't know, I always just … (missing)
DR: Yes, but with your previous GP, you didn't talk about regular exams for your eyes?
PT: … (missing) diabetes…
DR: And did you, did he talk to you about what was diabetes?
PT: He said that I had a problem simply with my sugar levels. He said that I should try to eat regularly and that …
DR: You are not always hungry?
PT: No. I am not always hungry.
DR: Is it easy for you to eat? I mean, it is probably not always fun to cook, you are quite alone, I suppose umm…
PT: I eat readymade food, sometimes I do that.
DR: So you eat readymade food, you don't cook for yourself? It is hard, yeah, I understand that.
PT: My daughter brings me to eat.
DR: Oh. How many times? Is it a couple of times in a month, or is it several times a week?
PT: Well, just, once a week.
DR: Once a week. And is it so that you have a nice meal with her? And is it comfortable for you to have someone to eat with?
PT: Yes,
DR: That is umm, that is great, because for example, the precooked food you can find in the supermarkets, aren't always the best things you can eat. You have sugar problems, as you have described.
PT: (missing)
DR: So maybe what you could do, so I can look a little bit forward, is for a week or two, just note, note down everything you eat. So I don't know if this is possible for you?
PT: Yes, I can do that.
DR: Yes? You don't have too much problems with your eye vision?
PT: Oh, you'll might have some problems really, with my handwriting, but I can write it down.
DR: Yes, then we can talk about the things you eat and maybe start from there, to see the things that are bad or not. Because it is one of the things that we can do for diabetes, it is that.
PT: Well as I said, I am not always that hungry, so I sometimes just sit and, have a glass of wine.
DR: And this glass of wine; In the last consultation, you spoke a bit of it as a companion?
PT: Yes, it is, it's, when you are on your own, it is not the same as when you have a glass of water.
DR: And what does it give to you, when you drink a..
PT: It just gives me a nice feeling, ..
DR: And so for the hearing yes, there is a center, I could send you there, I could put in a little word for you, and I think it is the most important thing for you to do right now.
PT: O it certainly would help.
It would make a difference. Especially when I am with a lot of people. When I am talking to you, I am fine, but when I am in a group, I wouldn't try to join in, because I would have to ask, "what did you say?". So I don't go..
DR: Yes. And if you go to that center, would you like to have an appointment as well for your eyes? In the same day, so you don't have to go ones, twice, frequently. It would be a good idea to do both. It could be good for you.
PT: Can you arrange for it?
DR: Well I will try. (mimics ringing the phone, calling). Well, we can have an appointment for you, in two weeks now, because there is a free space, the eye doctor in the morning and a little bit before noon, you can see, you can take an audiometry test. I asked them to send me back the results, so afterwards you can maybe come here, and we can talk about the things we do with the ..
PT: Yes.. Okay.
DR: So you can go there, and from now to there, do you think it would be possible for you to write down what you eat?
PT: Yes, I think, I think I can.
DR: Or…maybe not right now? I don't know.
PT: I'll keep track of it, shall I?
DR: Yeah, of course. So we are not really in a hurry anyway, but it would be good.

DR says "stop".

feedback:
Moderator: Okay.
(group discussion on 2nd part of exercise - first try - is not filmed.)

consultation:
DR: (missing) What if I asked you, well you got tested for the hearing, because you couldn't hear so well when you were in a crowd, well did they tell you what the results of those tests were?
PT: Yes, they told me I could try using a hearing aid, maybe that would help, of course I wouldn't hear fully again, but maybe… (missing). Yes, I'll give it a try.
DR: I think you will find it very helpful, because (takes out his own hearing aid showing it to the PT) I were them and there not so.. it takes a little to get used to, but
PT: O yes
DR: (puts the aid back in the ear) so it sort of disappears in the ear. I had trouble hearing when I was in a group, so when I got these, I sort of started hearing well again, but I didn't tell you that before because I wanted to understand how you felt about it, or if you just wanted to stay home. So I understand that. And you got your eyes tested as well,
PT: Yes I do have a blurred vision, but I don't know exactly… they want to do an alteration? (missing) but I can trust them, I hope I … (missing).
DR: I think I would also need to see the blood tests, about the sugar, we talked about that you said the doctor had told you at one time that the diabetes could affect your eye sight, and we can check in different ways, so I have to get some of these medical tests back so I can understand that. And cataract amongst other things was one of the things that we wanted to know about (missing) so you need to understand.
PT: (missing)
DR: Well it might help for eating(?) but you need to know that in general, you need to think about that more, and I'll look into the survey and I'll advise you on the surgery. So no matter which way you look at it, you should be able to withhold your vision and your health.
PT: (missing)
DR: (missing) well we would be able to do that, if you could try to get out, to walk, to (missing)
PT: Yes, I'd like to.
DR: So when was the last time, that you liked to (missing)?
PT: (missing) if it helped, hearing and seeing, maybe I could give it a go.
DR: In the club? Do you know anyone there, anyone to go with you?
PT: Maybe, yes.
DR: Okay so there are more people there. People just maybe waiting for someone like you just to join them.
DR: (missing) might have some breathing problems. Are you aware of that?
PT: Well uhm.. (missing)
DR: (missing) Do you ever get short of breath when you walk up a staircase?
PT: Well I do take the staircase?
DR: And you never stop?
PT: Well I don't (missing)
DR: I don't eather (joke).
PT: It never stopped me before, no.
DR: (missing) So you don't have any sores, that is good. Do you take any medicines for pain? (missing)
PT: I've got so many pills… (missing)
DR: Well when I really have a complete list about what we know about you, I need to know about , then (missing) we will start with the eye sight and with the hearing.
Do you think your shortness of breath is bad enough that we should get some tests on that as well? (missing) Do you think we could make it better?
PT: I don't know…
DR: Well I don't know, but we can test on both things, to see how they are (missing).

There is another thing you have mentioned a couple of times, you said you had problem remembering things. Does that bother you?
PT: (missing) You know then I think, why did I come here? (missing)
DR: I see. That is not that unusual. It is hard to take care of everything (missing).
PT: My daughter checks on my check book, payments (missing).
DR: Did she ever find any problems?
PT: I don't know.
DR: You said it's been (missing)
PT: (missing) Well I do sometimes feel alone. (missing)
DR: (missing). Well I don't know if it is (missing). Do you have to clean yourself?
PT: Well I've got some help.
DR: So you've got help. What do they do? What do you do?
PT: Well they (missing) I do dusting, and sometimes vacuuming, but otherwise, they are very helpful.
DR: (missing) When was the last time you actually vacuumed the carpets?
PT: It was a day or two ago.
DR: Did that make you short of breath?
PT: (missing) I put on some music, to make it better. (missing) But it hasn't really stopped me from doing things.
DR: Yeah, I gather that. You can still do a lot of things. Your breathing is okay. Did you ever smoke?
PT: Yes I used do.
DR: How often did you smoke?
PT: Maybe 20 years ago?
DR: Why did you decide to quit?
PT: (missing)
DR: Well I know, it is very hard to quit. So congratulations on that.
PT: (missing)
DR: Yeah. Did your husband smoke?
PT: Yes, he did.
DR: The first time you were here, you mentioned, you thought he (husband) had some problems.
PT: Yes. He did drink. (missing)
DR: Well does seeing somebody live with that sort of problem, sometimes makes you worry about your own health, does that make you say, oh it is okay, or do you ever feel guilty about it?
PT: (missing)
DR: No no, I understand, that is why I was wondering, if you ever feel guilty about your drinking, even though it is not much?
PT: No, whenever I have a glass to drink, it always makes me feel good.
DR: How much do you drink?
PT: (missing)
DR: And you said, you would just have a glass of wine watching television, … How long does it take you to even go through a single bottle of wine?
PT: Well I don't know… Perhaps, maybe, a day or two?
DR: A day or two?
PT: (missing)
DR: Is there anything else you would like to work on today? We've now got the seeing and the hearing aids, the complete health examination to see where we can help you, and how about what you eat(missing)
PT: (missing)
DR: Is there? How often do you actually sit and enjoy to eat?
PT: (missing)
DR: So how about when somebody came to help you to make to eat and to …?
PT: Yes, yes, (missing)
DR: Yeah? Okay. So what do you think about your general health on nutrition and your diet?
PT: I think actually, I could eat some more fruit, (missing)
DR: When I talked to you about what you knew about your blood sugar and if your doctor had spoken to you about that… Well, would you like to know more about that, about diabetes?

PT: Well sure, yes.
DR: I think that would help you, very well. We'll put that on our list of things to talk about in the future as well.
PT: Okay, thank you doctor.

discussion:
DR: (missing) thanks to all the visuals. I think you did a great job, especially in the beginning, as you illustrated simple things, putting yourself at the same level as her, with the hearing aid.
PT: Yes, that was, that was magic.
DR: I couldn't do the same. (joke)
DR: (joke) When I asked you about the osteoarthritis, I have a total knee (prosthesis) too.
DR: The second thing you said was, well I have a hearing aid too, so you tried to sympathize, at the same level.
Moderator: Yes.
DR: Well I appreciate the sympathy, but like I said, I do have hearing aids, I have a total knee replacement, so yeah.
DR: Then there is this moment, when you discuss with the PT, well how about when you left your house, then she said..
DR: "Well I don't want to go at all". And I was thinking, well maybe she could have a small apartment, or maybe.. Then she said I don't want to go to a nursing home.
DR: Well I thought you left (?) this topic quite early, because (missing).
DR: Well I agree with you, as soon as she said well I wouldn't want to go to a home, I thought (pulls an aching face of "auwch").
Moderator: Yes, it was a misunderstanding.
PT: Well it is typical of older people to say oh no I don't want to go (makes blocking sign)
DR: Well it often happens in a consultation, that you feel you hadn't said that last phrase.
DR: Yes but I think you could afford to say that, because before, you had created the sympathy. (missing)
DR: And in fact, it could be, that you would say (PT), okay, because you had told before, that it was difficult with the stairs.
PT: Yeah.
DR: Well I did say by then, O I didn't mean it like that (missing) but by that time, she might not even hear me, if she really thinks that I think she needs to go into a home. That's like (missing)
DR: Can I ask you (missing). Was your being sympathetic coincidental, or was it a strategy to be able to tackle the more difficult topics?
DR: Oh. I am very careful about how much personal disclosure to make, I wouldn't have said that much about myself to this pt, but I would have shown the hearing aid, because she said "maybe I won't be able to wear them, I am afraid to lose them". So that was a strategy just to reassure her that it was possible, because I've seen that at several times she said "Do you really think that will help?". So she will need that motivation, and that motivation will help her, but it still is easy just to show her. So that was more a strategy to help her with that particular issue, not so much to get into the other things. It was definitely strategy to speak about her husband, because you know, there are a few critical key questions about alcohol and one is "have you ever felt guilty about it", another one is "have you ever felt the need to stop", another one is "(missing)" and the fourth one is "has anyone else ever told you you should stop". And if she would answer yes to any one of those questions, then I would want to talk to her daughter.
DR: Well I thought it was very elegant to talk about very specific items, and then you talked about the theater, to see if she could have some interests, and then you talked about the husband, and the house situation. And it was sort of very elegant, it flowed.
Moderator: Yes, f.e., within your anamnesis for COPD, you gained so much information about her daily functional status. It was really well mixed up.
DR: I really wanted to do that. Before, you guys really set the stage for me to sort of wander around, ask a few questions here and there and asking more kind of her position in this, and at the end, (missing) Normally, I'd have an hour, because I am a psychiatrist. And even if it was just a med

check, and you'd have just half an hour, I would still have trouble. So I am really amazed by what you guys did, so much in just ten minutes.
DR: I have the luxury to work in a patient health center, so I am not obliged to see as many patients as possible, like most people, of course I have to be at lead as productive, it has to be well shared, because if I was seeing four a day, they are not going to be happy, but I have time and my salary doesn't depend on them.
DR: Because some pts do need help in four minutes, they just have a sore throat and you write them…
DR: Yes, I don't have to take much time all the time,
DR: (missing)
DR: Yes I think the social issue is key. It is not that she wants to hear better so she can hear the tv better, but it is gratifying to see, and she really lit up, that to get out and shoeing people is what she really wants, even if/ indicating ?
she doesn't have a serious depression.
Moderator: A remark on the work you have done this morning, is that I would always try to translate, I really think the hearing problem is a priority, because it will enable her, to actively participate in the society, so that is important, BUT I believe that we should even try to help our pts to translate it even to that level. That is the priority of the hearing aid, to translate it within the consultation to the priority of social participation. If we translate our goals at the level of functional status, then it is the language of the functional pt, and this empowers the pt. Then it belongs to her. The hearing still belongs to the doctor. She needs to go to the eye doctor, to the ear doctor, … So I agree it was a priority, but try to translate it to functional status.
DR: Well the reason I didn't ask more about her breathing, .., is because I didn't want to set up an expectation of (missing). I just thought, she is at the theater, I am gonna have to work with her from there.
(missing) If she walks up the light of the stairs, she might not be able to get behind the lobby.
Moderator: Yes, yes, and also because she might just be able to participate. But I think we have to try to bring it up to that level, in discussion with the pt also, the things that are in our heads, for us it is clear, that the hearing might enable her, but if you bring it up to the discussion, then she is more participant in the discussion, because she is the owner of herself.
DR: "Lets discuss what you and I need to do to help you reach to the things you want to do."
Moderator: Yes. It might get more clear the next session(meaning ICF session).

moderator:
What we have to do now, is think of your medical plan of yesterday, see and think about if there are any things you are missing now, exactly what we wanted to do today. We find that the breathing is in fact a non-problem, you called it a non-problem, we explored that she is able to do things, she is not impaired, she is not smoking, so you don't have to tackle smoking. We might even cut medication theoretically and see what happens.
Dr: I think still I would like to do some tests like spirometry to be able to try to correlate it, to have a bit more information, to be a bit more sure about it.
Dr: Yes.
Maybe somebody called this COPD and what she has actually got is asthma. We just saw her in the middle of her text, so I would want to know.
Moderator: Yes. I agree. We have to decide from our medical point of view, where we put it on our (medical doctors) priority list. I would not, if she is not on any drugs now, I would personally not put it on top (of the list) now. But I agree she might have underlying asthma, but if she is not on any current meds, and she has for a few list, then we might put it down (lower) on the list.
DR: (missing) But yesterday we said that she would might need Spiriva, and today…
Moderator: Yes, but we have got it on the list, but you might put it down (lower). And then review it later and maybe put her on the drugs, I would suppose you can wait.
DR: So now I have to sort of round up, as you said, and sort of find a level for the future, to ensure the pt's continuation.
Moderator: Within multi-morbidity, you make your priorities and you share them with the pt. So this (session) is the shared-decision making. This is your part of the exercise, so you can try.
consultation:

4th try:
DR: Hello Jeanine, how are you today?
PT: (missing)
DR: Glad to see you again.
PT: I ordered a hearing aid.
DR: You did? Yes.
PT: I should have it next week.
DR: Oh, that is wonderful.
(missing) And uhm, yeah, do you have..I have a long list of things I would like to talk to you about, is there anything you, do you have anything more to discuss today?
PT: I'll hear a bit better, and I.. I'll be able to be a bit more social. (missing)
DR: Have you today about how to proceed about your eyes?
PT: Well he said that it is actually (missing) That I would need a new lens.
DR: What do you think about that?
PT: Well I don't know, it is a bit… I don't understand.
DR: Are you afraid of complications.. Are you afraid?
PT: I am afraid of the operation.
DR: Yes. It is a small operation. They take one eye at a time, it takes not such a long time, you remain awake, and during the operation, you are not feeling pain. You are comfortable. And the doctors will take you through it, it is not such a risk that it is… I don't have the exact results back yet. As I told you, it is a small operation, and you will be able to (missing). I can tell you there is a small risk, but there is always a risk within an operation.
PT: What is the risk?
DR: The risk of losing your eye sight is very, very small, so I wouldn't… I understand that you, are, concerned. So it is just, that you should talk to your oftalmologist, he will be able to tell you about it. So, as we talked about last time, I had to control your blood levels, to, for your eyes, And I now have the results and your blood sugar is in a good level. Also the blood pressure and the other things were good, and so, the medication from my point of view is good. (missing)
PT: (missing)
DR: Yeah so you don't have any discomfort with the medication? We talked about that before…
PT: Yes I do take quite a lot of pills.
DR: Yes. What do you think about that?
PT: (missing).
DR: Yes. It is of course a balance. It is a balance between how you feel, and how ..
PT: No, it is not that, I have always needed to take the pills. It is just when I am at home, and doing things, …
DR: Yeah, it is just that you know that you need to take them, because if not, then you can get some complications, ..
PT: What are the chances of, getting worse?
DR: It is a long-term disease, and it is a progressive disease, and we know that if you take methformine, and if the blood levels are on an appropriate level, it will delay the complications. But I understand that you think it is a lot of meds.
How about what we have talked about before, we talked about going up the stairs and so on. Do you then take any (meds) to …
PT: Well I do have some.
DR: Do you take them? Do you have any pain?
PT: Well everybody gets pain. In my thumb and in some places, I (missing). I don't feel I need something just for my joints.
DR: You don't. And it is manageable?
PT: I think so.
DR: And do you get any pain in your legs when you walk? Or go to the shop?
PT: My knees hurt sometimes, that is what I get when I walk up the stairs, but not so much in my calfs. I try to walk around on one level, so I just go up to the bedroom at night, staying downstairs is more comfortable, so I try to do things downstairs. (missing)
DR: You like to go around? You can go around?

PT: Yes.
DR: And does it bother you, that you have to slow down?
PT: I thought, I am not a young woman anymore, so I've learned to cope with it, and (missing) I am all right.
DR: So, since last time, you filled in, on what you were eating and drinking, and as far as I can see, you are not eating much.
PT: (missing).
DR: No, but it is important that you eat enough, because you also have a lot of problems with your diabetes. Would you be interested, as we talked about, in getting advice on how to eat (missing). And can you join in, join in there?
PT: Yes. (missing)
DR: Yes, I do. Because we have to now make up a plan for (TAPE STOPS)

4. video transcriptions: simulated consultations group 4

consultation:
DR: … is acting all over. So I'll take over.
DR: (takes over GP position) (missing) So there are several things that I am interested in to know. And um, I was wondering how you (missing)
PT: Yeah, well, could be better.
DR: What do you mean by that?
PT: Well yeah, I have to live with the myalgia and that is a lot to be manageable, and, it is getting worse. Sometimes. Like, now, I am stressed, and I feel it is always there. And sometimes I can't hide it always. And when I had to go, to give a lecture, and yeah, it went rather well, I could say everything I had to, to the audience, (missing) and I was invited afterwards for dinner. But I was very annoyed I had to cancel it, because after the lecture, I had to vomit.
DR: You had to vomit.
PT. Yes, I think because I had to withhold (it) all the time, or something. It had happened before. And that is not nice, because I cannot fulfill my employments.
DR: (missing) So if I understand correctly, you had to vomit, and you (missing) and you were so tense that you (missing).
Pt: Yeah, yeah. It does not happen frequently, but it has happened more than once.
DR: Do you avoid your work?
PT: Sorry?
DR: Do you avoid any lectures, say "no, I can't", …
PT: No, no I do my work, yeah, I keep to that, I stick to that. I am taking up my responsibilities.
DR: (missing)
PT: Rarely, but sometimes, yeah. Especially when my family wants me to do things I cannot.
DR: Like what?
PT: When, when for example my children tell me to go, more easily. And to take less work, to go on a holiday or so. But I'm not ready for that. I'm not ready to retire. People count on me, yeah.
DR: And the people around you, they think you work too much.
PT: My husband is retired, he's 68, and we have um, we have this nice house in Spain, and we go there on holiday, and he's asked me to go over there for longer periods. But you know, that is good (only) for a holiday, I don't have time to go there! I …
DR: It is very important to you to be able to work?
PT: Yeah.

moderator:
Can you pick in?
DR: Yeah. (takes over GP role)

consultation:
DR: Can you spell me your name? Because I am not flemish.
PT: Yes, it is Van der cruyssen.
DR: Van der cruyssen, okay.
PT: Yes.
DR: I just listened to my colleague, speaking of your work. And I just wondered, what are you working as?
PT: Well I am head of the (missing), which is now a chain of the women's clothes shops, and I took it over from my father, and within the year, I have new shops.
DR: (missing)
PT: Well I do have employees. But I am the decision maker at the end.
DR: And are you okay with that, with these choices?
PT: Yeah.
DR: You like it?
PT: Yeah, it is my life.
DR: What do you like most?

PT: Yeah, the variety of the job, the constant … renovation? You know it is being… Yeah, how do you say that in english?
DR: Try to say it.
PT: Well um, to follow… "mode"? Fashion.
DR: Yeah yeah fashion, I understand.
PT: And to follow what trends are going to be. And for me, we are busy with this new formula. We are working on this new shop that we want to elaborate (on). And I think it would be a good new way to check people and clients, yeah.
DR: You appear to be really open to new things.
PT: Yeah, that keeps me young. And competitive.
DR: You are a fighter.
PT: Yes, a fighter, yes.
DR: (missing) always been worried?
PT: off… I try to ignore it as much as possible!
DR: Can you do that? How do you do that?
PT: (silent)
DR: Just to…
PT: I try to do other things, try to forget it!
Dr: Do you try to live your life as it was before?
PT: Yeah. I am what I do!!
DR: (missing)
PT: Yes, and I feel worthfull with this.
DR: It is important for you what your work is, your personality.
PT: Yes.
DR: And now we have that problem of parkinson, trying to retain you… Is there a way…, what do you wish? What do you wish?
PT: I wish it would stop.
DR: That it would stop.
PT: So I can continue.
DR: Yeah. (missing) And what do you think you need, what would help for you, to continue? To be satisfied, both, yeah, … I guess, just to be satisfied?
PT: … it is hard to say.
DR: Yes, I can imagine. Are there circumstances ,where it is less? Are there things, situations, which are better for you?
PT: I feel better when I'm in Spain.
DR: Uhu, because of the warmth?
PT: Because of the warmth, I feel better, I feel less pain, when I am there, yeah.
DR: You feel less pain? Do you have pain?
PT: Sometimes, yes. From the myalgia, that aches, in my joints. Once here, once there. I can live with it, but with the warmth, I almost do not feel it anymore.
DR: So for you, for your myalgia, it is better to be in Spain.
PT: Well, maybe I am less tense there.
DR: Because your job is over here and you are in holiday?
PT: Yeah, there I can leave my worries also a bit aside.
DR: Yeah. Here in Belgium, are there also situations in which you are in less pain? Do you think… It must not be something big, but are there situations when you feel more relaxed?
PT: (missing) I sit next to my husband and I try to relax.
DR: That is very good. So how many (missing), how many days?

moderator:
Okay if you think as a group that you have all the information that you need on her goals and her life, then give feedback to one another on what you did and how you did it, and yesterday you got all the medical information. She has parkinson, and if she says I don't want to take all the pills… So start thinking how can we balance the two? As a medical doctor what you think is necessary and what she wants for her life. So this is the second try you will have, or maybe you have already started, because

in this group I can imagine that it goes a little bit quicker.
Moderator: It is amazing how it went. But do we have a discussion on how it went first?
Moderator: Yeah, give feedback. And this afternoon we start with the debriefing from the whole group, so that we can discuss this in the whole group. But try to come to the second exercise. And go to shared decision making.

feedback:
Moderator: What did you think about this consultation? Did it go easily you think?
DR: It was very short.
Moderator: It is a short consultation indeed, but as a GP, you get to, like, talk 10 minutes, so…
DR: Yes, as a GP I wouldn't have more than 10 to 15 minutes per consultation. It is my experience, you cannot really do (makes fingersnap movement) in 10 minutes.
Moderator: Okay.
DR: That is my experience. But what I liked is that you started, then you went on, then … (round of the GPs)
Moderator: There are so many facets.
DR: Yes, but that makes it so easy to go on.
DR: (to PT) But how was it for you?
PT: Good. I get the impression that step by step you are getting the information you need to … but not quite yet.
Moderator: Okay so that was my question. Did you feel that you reached all information on the goals to … that you tackled every goal or that you received every goal she has…?
DR: No I don't. There is still a lot more that is left. I think for me, it is difficult because she is very anxious and I am not sure how to engage in this part of … what she is saying, and I think that will take time.
Moderator: No but still, I as an observer, I feel there was like one moment that could turn everything. She knew very well what (missing) to her.
You (DR) said "are there any wishes for me to help you"? And then she said "that it stops, that I can continue". And you (DR) went on with that, but you didn't, well, you could have asked "are there any other wishes? because I cannot stop this". "I cannot stop Parkinson, I can help you with the medication, but cannot stop it. Are there any other wishes?" I would explore that a little bit further so you can get the different goals, other than just to stop the parkinson.
DT: Yes, but I would need to know more about this stop, and stress. She is talking about stress and things and I was asking myself if it was to do with the Parkinson, or if it was because of the pension? Because it is a lot better to … But it looked a bit too close for me to say "this is all (due to your) Parkinson".
DR: What really struck me, is when you said that you felt really worth full at work. I thought that you would feel worthless without work and that you were so resistant to the idea of not working, even in a far future, even though you can expect that…
DR: (missing) It was beautiful. (missing) I mean, I wanted to tell you, I found it quite difficult.
DR: Yes.
DR: (missing)
DR: But I don't know what you (DR) expect of her? We talked about her initial fears, set her at ease? Say there is nothing wrong? "I just want to talk about…"
DR: That would have been useful. (laughter)
DR: No, you would have succeeded. (laughter)
Moderator: I agree with you (DR) and make her at ease, instead of exploring. You (DR) went on with exploring, and if I recollect correctly, you made a really good summary of what she had already said. So you (DR) said "but how do you do that?" And then she (PT) really lit up and said "finally, somebody understands me!" And at that point also, she stopped trembling!!
DR: And her face also went calm.
DR: I thought that she was really coherent with what was going on in her life, but another thing to strike me was the threatening aspect of the tablets. So find out about the tablets…
Moderator: But then she (PT) also said "Why did you call her? (the former GP)"
PT: Yes, another thing, and it is already above my head! And I don't want any other disease!

Moderator: Okay, so, do you think it is possible now for you to go on? And go into the shared-decision making or do you need to explore a little further?
DR: Is it possible? (silent) I feel it is a short time, and we have to focus on defining the goals first. Without thinking of the next consultation. And we don't have so much time.
PT: I agree.
Moderator: First, personally, I think it is easier when you have like an oversight of everything she wants to achieve. And then go and see what we can do with it.
DR: Yes.
DR: But we need some more out of this consultation.
Moderator: Yes we do need so more goals, otherwise the shared…
DR: I don't agree with how short it is. I think we have to carry on and focus and try to.
DR: Okay, you can start, (DR).

consultation:
2nd exercise: shared-decision-making:
DR: (To PT) Is this okay for you?
PT: I don't have all that information, so I'll have to invent. (laughter)
DR: I'm not sure I have everything I need either. So let's just work together and try and get there. So, you said that you have worked really hard and that it is very important for you as an individual, really important, going to work. But also, getting tense more times, and about letting go of that pressure, when you go to Spain, it is when you are feeling relaxed.
PT: There I feel more relaxed, yes.
DR: And how is the (missing) there, is that better too?
PT: Better, yes.
DR: You also said you are having less trouble at night.
PT: Yes ,it is the best part of the day.
DR: Of all the things that are important to you, of the important things that are going on in your life, what are the things that you would like to do, to ease the pain, to better that? Try to tell me.
PT: Well there is this, there is this duality. My work always has been the most important part of my life. And… (silent)
DR: It is hard.
PT: … And I feel now, that my family suffers… And I don't want my family to be, to fall apart.
DR: So this disease, that makes you upset.
PT: …I don't like it, I don't want it! I don't want, I, no, I am mad at it!
DR: You get angry.
PT: I do.
DR: You get angry with yourself.
PT: Yeah. This stupid disease!
DR: What happens at home?
PT: My husband always speaks of going to Spain. To the sun, and that it is better for me, and that it is better for us. My children, they also interfere with my life. They are inconsiderate.
DR: What do you mean by inconsiderate?
PT: Well they want me to do things that I do not want to do!
DR: I see, like what?
PT: Like stopping my work!
DR: You argue on that?
PT: Sometimes yes. It is against my will. I feel that I'll loose.
DR: They are forcing you to do things you don't want to do?
PT: Yes.
DR: It is very hard.
PT: This is what I have done all of my life.
DR: It is important to you.
PT: Yes. And also to stand up and not to give up.
DR: Are you worried about what they are going to say? Is that how it is?
PT: Yes. … I mean, I can't stay home all the time.

DR: I can see that.

moderator:
Thank you, you are amazing (DR) with what you did, and you (PT) are amazing.
So now we have like more information to do the shared decision making.
DR: Now we know what the tricks and the dilemmas are.
Moderator: Yes, I think so. So who wants to take it to the next step and do the shared decision making? As a doctor, to take her goals and…
DR: Are we ready to do that? Maybe we are not ready to do that yet, but we need to try.
DR: I am not clear on this, is this to go on or to go to the second step…?
Moderator: To the second step of the shared decision making. We can go on and on and on but I mean, we have to…
DR: We need to move forward to reach some kind of plan about what we are going to do.
Group: Yes.
DR: Okay?
DR: Okay.
DR: You don't necessarily have to come to a decision, but you have to come to some kind of way forward.

consultation:
DR: (to PT) So I think we should try (missing) we should try. But I also think, that this anger, you have, (missing). I feel that you are afraid. That you are afraid that you (missing). And that this fear and anger (missing). How do you feel about that?
PT: Yes, it is true, I think.
DR: So do you think, these are things we can work on?
PT: It's workable.
DR: (missing)
PT: Sometimes, yes.
DR: (missing)
PT: It is manageable.
DR: (missing)
PT: Sometimes I am feeling stiff, too. It aches… To move better.
DR: Yes (missing) with the medication we can (missing) results (missing). So if that…
PT: You think you can give me better medication?
DR: I believe we can see. I have your previous information (mimics file) here, and … yes, sure, we can, we can try and (missing) You should feel better. (missing)
PT: Yeah, sure.
DR: Yes, you should (missing) an hour (missing) and or there other things (missing)?
PT: Well, um, my former physician, told me to go and see a psychologist. And um, okay, I spoke about my problems and I told him, like here, that sometimes I feel depressed and then it goes better, and okay, I continue with it. But it comes back.
DR: Do you try and involve your family in it?
PT: Well, I, I feel I am kind of in the … (missing)
DR: In an empty lane?
PT: In the street, yes. Yeah, so, something has to change, because, I can see, that it won't get better. But it will become worse.
DR: Your fear is (missing) your emotions will get worse?
PT: Well I fear I will not be able to do my work well enough. And then, it is just me. I will have to realize, I will have to, and then I'll be (missing) than I wanted it to be.
DR: It is my impression that you have really (missing), and by way of different patients, and you are young, so (missing), …

moderator:
Can I just interrupt you? Um, (to DR) you did feel the duality between work and her family?
DR: Yes.

Moderator: That decision now, is that something we can…?
DR: I was trying now, to see also on the depression… Yes.
Moderator: I don't know if you got the same impression, but you said that "we can put it off by giving you more medication and …" (PT mimics "no no no" sign) But there was still this duality between the family, between what they want, …
DR: I do not disagree, (missing)
PT: (to DR) I felt that you were postponing the problem.
Moderator: You are feeling depressed, but this duality remains…
DR: She (PT) was making a progress.
Moderator: (to DR) Can you, yes?
DR (takes over GP role): (to PT) Do say where you want to start.
PT: Okay.
DR: Is it okay?
PT: Yeah, okay.
DR: Okay.
PT: It must be hard to be this patient.

consultation:
DR: Yes. So, you told us about how you feel (missing). And I can imagine, in the future, there will be days when you will just want to give up, and this could give irritation. What would you like, would it be helpful, to invite the family and speak about this once? Would that be a good idea? … I don't know how, how it is for them.
PT: He does not like me to see how difficult it is now, he, he doesn't, he is not happy with the situation.
DR: How would you.. how do you express it, how does that happen?
PT: He's already retired, and he, he loves to go with me to Spain. And we had also, still have, those plans, it was always my dream to make some traveling into the far east. (missing) We wanted to go to Vietnam, to … and yeah, that is something, we would have, we would like to do together. We always talked about that, "when we are retired, we are going to do these journeys".
DR: And now he's retired and he wants to realize it?
PT: Yeah. Sometimes we (missing) it, but it would be good to, just go a bit more to Spain.
DR: So it is not something, more than, we talked of this (missing) situation, how to find a solution?
PT: Yeah.
DR: Because how I understand it, this way, you are still active and quietly locking off that you're not ready for retirement, and he is retired and he wants to enjoy life now. And for him it is an argument, you are having Parkinson's, so you (missing) earlier, and this threatens you.
PT: Yeah. It's right, yes.
DR: I ask myself, would it be helpful, to talk with your husband, to really see, for example by the psychologist you are going to, to really clear up this, um, anger and this (missing). It could be helpful. (missing) What do you feel about that?
PT: Could be.
DR: (missing)
PT: I can't deny that, it seems to be necessary to talk about this.
DR: And do you feel ready for it? Or is it still something which has to evolve? (missing)
PT: First, I would have to… see clear about things on how to… arrange things at my work! That I can't let go off, one day to another.
DR: Yes.
PT: And I don't want to let it go!
DR: Yeah. (missing) Do you think you would have to work that through first, before you speak to um, … so I am doubting, because um, … this situation has been going on so long… so that um, this conversation could give… other solutions? It would be the first time you would have this conversation.
PT: (silent) The actual organization, I would do myself, but maybe, it can serve as a mirror.
Straumann: So it would (missing).

moderator:
Well, okay. Do you want us to continue.
Moderator: Yeah, yeah, continue, I just want to listen.
Moderator: (To DR & PT) Okay, I'm sorry, you can… You were about to say something?

consultation:
PT: Yes, I was looking for the word, I meant, I was talking to my husband, how he would function as a sounding board for me to take another approach on my work.
DR: You would do that?
PT: Yes, and I think it would be necessary to involve him in the process.
DR: So you've already made that decision, or you have thought about it at some time?
PT: It will need lots of time, yeah, because I'm not ready yet to let go.
DR: So I'm thinking about that talk with your husband, how you are thinking about involving him in that project. (missing)
PT: Do you think you could help us with it?
DR: Yes.
PT: Yes, I would.
DR: (missing) enough information, and so we can speak of all these things which really matter to you now. We have to talk about that. I am just trying to make a (list) on the whole of the topics, which are important for you. Still, is there something left, which has to be mentioned?
PT: No, I think the core of the problem has been set.
DR: So is it okay then, for us from the medical side of the problem, to involve the neurologist again and to have a look at the medication?
PT: Yes, of course.
DR: And at the same time, we will assist you and your husband.
PT: Yes, of course.
DR: So you agree in having this discussion. Okay. (missing) Goodbye.

moderator - feedback:
It's amazing. No, you are an amazing group.
DR: I liked it.
Moderator: (To PT) So (name missing), how was it for you?
DR: You can come out of your role. Yes.
Moderator: Yes.
Dr: I had a feeling you needed to…
PT: to detense, yes! It was beautiful how, little by little, I went through this process. And that made me make a switch in how to view my problems. And a very important switch. The one, in fact very, was that it needs to be taken in another direction, that is better for me.
DR: I was amazed just how quickly you evolved.
PT: Yeah, that's because I was a bit tired of the (laughter)… It is a long conversation, isn't it?
Moderator: We have more than an hour.
DR: It needs that.
Dr: It does, this type of conversations.
DR: Yes, I'm not pretending, it needs that.
PT: I was more anxious, and mad, becoming mad, and not prepared to discuss any more.
DR: You could have said stop?
PT: Yes, I could have done that, but I had something in my mind, saying, let these (GP's) get on with it (missing) but normally, I would have been, "it is enough, stop it!", and then I would go out. At a certain point, I felt this way, and I read in my case (case preparation),
DR: So (missing)
PT: Yeah I read that at some point they cannot help me, and that I have to go on. But I had done that in the past, it was written in my case, and I went to the psychologist, and it was because I was depressed. And it went, um how did they say?, in "aggressive outbursts". And so…
Moderator: But, you also felt, and I could see it on her face, that your open attitudes, empathetic attitudes and empathetic interferences really touched you.

PT: Yes.
Moderator: You could see her thinking "well, maybe that is a possibility. I should bring my husband. You know, maybe he can be my mirror."
PT: I understood.
Moderator: Yes, and I saw it in her … It is really a lot with the medical stuff, and we can see how we can come together and help her…
DR: (missing)
Moderator: Yes, that's very important.
DR: I think, if you don't do that, you actually are not doing her a favor, and that you're actually not doing the best for her problem. (missing)
DR: Even if it wasn't in that moment, I would be waiting to talk about it.
DR: Yes.
DR: (missing) Parkinson's (missing)
Moderator: (to DR) Yes but it was good, because you said, "this doesn't feel like the priority nów".
DR: The priority nów is that this woman is very distressed.
Moderator: (missing)
DR: It is our (PT's) main problem, in front (of the rest). And I think if the big stone (big problem) is gone, she will be…
Moderator: Yeah, she will say, "something is not working, can you help me with this?". If the first time, …
DR: Or in the next consultation, when she is not so tight (tense), I can say, "you have to think about this and this and this…".
Moderator: (to DR) I was glad you mentioned the parkinson's, we could start from here, and then she could come to her "stone" (main problem).
DR: I thought, it became something like an offer. You know, you cán talk about something, and it does not have to be the main thing, you know, in the decision or the process, and then to go on it might be easier this way…
PT: (shakes head no-no) I know why I wouldn't be able to continue to work.
Moderator: Yes, she is not stupid. She has some "stone" to carry, but …
DR: She is strong!
PT: Yes, but I felt that this stone I was carrying was becoming very heavy.
DR: It is heavy.
Moderator: The inspiration, when you picked that, that problem, to really go to the core of the problem, was thé moment. "This is now the problem, and the rest is not".
DR: Are you GP's?
DR: I am a diabetologist, but also I am, a, yeah, psychosomatician.
Moderator: But that is great, because, this is the most difficult case of the four. I wrote the exercises… (group laughter) I mean, (group talks all together)
DR: I think, this idea, the difficult thing is, because she is so anxious, and irritable, and that makes it quite hard, because you have to work hard to engage her. But I think, once… It is all the time about "we are trying to help you to make you feel understood". I think you (to DR) were…
DR: We were approaching her togéther so well. To have such a …. (group laughter)
DR: Group consultation! Yes.
Moderator: It was a really great consultation. All of the discussions. Also when DR picked up again, and then DR when she said that "Well, I hear several things, I feel that…". And it is so amazing that you do that as a GP, that she says "I feel that you are afraid". And then she (PT) dropped and was like, okay, I feel understood.
Moderator: It is what we… We will have the group discussion, at half past two, because I have other obligations too, so I have to do my part of teaching and then I will come back, and I say, we will come back on this exercise, but what I really want to do with this difficult exercise, is illustrate that GP's áre able to deal with that, although it might be so that you need to say "You might need therapy. - Oh." But I don't care, that is how they learn to go to a specialist. You, GP's cán, and that is what the very goal of this exercise was. And I know very well that psychiatrists do so also… But she is in general practice!
DR: But she would never go to a psychiatrist.

Moderator: Of course not.
DR: This kind of person wouldn't see someone, unless they were really, really unwell. This is the thing that I supervise with psychologists. This is the kind of problem that …
PT: I trust you (DR) enough, to come to you, the GP, with my husband, instead of going to the psychologist. I did not have that with the psychologist…
Moderator: It was a shame that…
PT: I was never understood so well as I was with you! That is quite a compliment.
DR: (missing)
PT: I felt that I trust you enough to open op to you, I think you can help me.
DR: I think that...

b) Observational data we did not use:

We chose not to add these data (written field notes from the 3-days workshop, evaluation forms), as it is far too extensive and outside of the purpose of the data-analysis for this study.

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A qualitative exploration.
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Luc Van Imschoot, MD, co-promotor.
An de Sutter, MD, PhD, promotor.

APPENDIX 2: Data-analysis

Methodology of the data-analysis:

Simulated consultations were videotaped and transcribed verbatim by the first author of this paper. The phase of analysis started with fragmenting the text. In the second phase, the fragments that reflected skills were labeled with a 'code'(e.g. 'talking about compliance'). In Appendix 1, these fragments reflecting skills are underlined in light gray. Then, the codes were grouped together into larger categories, a tree data model(5) (e.g. 'talking about functionality', ' patients' concerns', 'goal-eliciting'). Even though the workshop itself was structured by the 3 circles of EBM and by concepts such as goal-oriented care, the analysis made in this study had an open approach.
Several team discussions served to identify key skills. The role as a non-participant observer, allowed to use field notes and verbatim transcriptions of the taped discussions and this helped us interpret the observed skills we saw in the simulated consultations.

Phase I: fragmenting and collecting fragments reflecting skills (gray underlining, cfr. Appendix 1)

Phase II: coding and categorizing:

INTERVIEWING SKILLS

1. ICE: ideas, concerns and expectations

I: - "what the PT thinks of this."
- "You mean,"

C: - " And I think it was some years ago, that it was discovered, a problem in relation to diabetes. Can you tell us a little bit about that?"
- "When you had gotten used to having diabetes, what does that mean to you? Were you anxious, were you …?"
- "there were other things you had to cope with."
- "Do you think to yourself, I have to go on, with these complaints?"
- "Are you afraid of complications.. Are you afraid?"
- "I understand that you, are, concerned."
- "So I think we should try (missing) we should try. But I also think, that this anger, you have, (missing). I feel that you are afraid. That you are afraid that you (missing). And that this fear and anger (missing). How do you feel about that?"
- "What do you feel about that?"

E: - "what do you see as important, for doctors and nurses, who are to take care of you, what are important things to look after?
- "Social contacts! Social contact is important."
- "to see patients as people"
- "We should reduce the misconception that she has. Because of the pain…"

- "So, what are your expectations to me? What do you expect for your health, on coming here?"
- "Is there anything else you would like to work on today?"
- "Not only PHYSICIAN attitude but also PATIENT EXPECTATIONs are the changing elements in this new approach; both of these are important to know in a getting to know one FIRST visit."

2. trustful relationship
- "if there is a question that you don't want to answer to, then feel free to say."
- "I know,"
- "But was there some incident that caused "
- "I can see that."
- "PT: I trust you enough, to come to you, the GP, with my husband, instead of going to the psychologist."
- "PT: I was never understood so well as I was with you! That is quite a compliment."
- "PT: I felt that I trust you enough to open up to you, I think you can help me."

3. checking the communication experience for the patient
- "Did you have any problems in communication with the retired colleague?"
- "So you could make an agreement (with him)?"
- "what did you like about the relationship with the (former GP)?"
- "we spoke about quite a lot of things. Did you feel comfortable about that? Are there any subjects you would like to talk about."
- "I don't eather (joke)."

4. checking barriers and conflicts doctor - patient
- "There was another thing that the doctors didn't like. You were a smoker."
- "PT: Well I don't want to go at all". And I was thinking, well maybe she could have a small apartment, or maybe.. - Then she said I don't want to go to a nursing home."
- "Well I agree with you, as soon as she said well I wouldn't want to go to a home, I thought (pulls an aching face of "auwch")."
- patient debriefing: patient had problem with focus on medications and resistant to talk about nicotine stop, did not want to share this goal
- patient debriefing: empathy++, breaking point ++ when asked which work she does

5. patient information and patient empowerment

PI:
- "From diabetes. Diabetes is quite a problem."
- " did he talk to you about what was diabetes?"
- "like to know more about that, about diabetes?"
- "giving advice is wasted time. Information giving is nót wasted. GP role is to provide information."

PE:
- "meet people there, that you can share, helps also, to cope with your disease?"
- "Have you had much people to learn you more about diabetes, or do you teach them?"
- "so you share your concern with her?"
- "Do you perhaps have some problems with the different medications, and with knowing when it is useful or not?"

6. SDM, motivational talk, behavioral activation & reading the barriers (- doctors goals) (- misconceptions "giving presents")
- "So we really need to get into this. But we need to agree on this."
- "we would have no common ground, but a fight."
- "so we need to find a way.."
- "So if I propose to (…) will you accept that, without any question?"
- "But in which part would you like to be involved in the decision making process?"
- "And now you are thinking that we have a contradiction here."

- "To negotiate.
  But maybe, if we say things again and again and again, she will start hearing it?"
- "so that is something we could work on."

- "we will try this."
- "So as a present? It is dangerous to give a present."
- "and we could try to make a plan… Do you have ideas yourself, what you could do?"
- "So I don't know if this is possible for you?"
- "do you think it would be possible for you to"
- "Or…maybe not right now?"
- "Would you be interested, as we talked about, in getting advice on how to eat (missing).
  And can you join in, join in there?"
- "we have to now make up a plan for"
- "So do you think, these are things we can work on?"
- "So you agree in having this discussion."
- "BA is a crucial first tool in depression."

7. time management, spreading consultations, setting the agenda, not all-in-one consultation (+)
   - "I would probably, the first consultation, not be ready with the list, but I would just want to see, okay why and how do you…"
   - "So within this consultation, I would not go to the next level, I would not go into more, because…"
   - "It is a smart approach. What I would probably do, is set the agenda for the next time."
   - "It is not necessarily a topic right now, we can develop the next step, a plan to try to handle the other problem, okay?"
   - "We'll put that on our list of things to talk about in the future as well."
   - "So start thinking how can we balance the two?"
   - "It was very short."
   - "Yes, but that makes it so easy to go on."
   - "Is it possible? (silent) I feel it is a short time, and we have to focus on defining the goals first. Without thinking of the next consultation. And we don't have so much time."
   - "PT: Yes, but I felt that this stone I was carrying was becoming very heavy."
   - "what I really want to do with this difficult exercise, is illustrate that GP's áre able to deal with that, although it might be so that you need to say "You might need therapy. - Oh." But I don't care, that is how they learn to go to a specialist. You, GP's cán, and that is what the very goal of this exercise was."
   - "It ís possible, even without a 40-minute consultation. We all "know" this, that ideally, we "should" do it this way, but still, we don't do it?!"
   - "When I give this kind of slide to GPs, they say "this takes too much time.". - It is not about time, I think, it is about HOW you use your time."
   - "These 10-min sessions did not include real life administration work, we did not make file notes etc."
   - "managing multimorbidity is really difficult, but what we do have is CONTINUITY OF CARE, each of the group members kept in the 10 seconds, and they all picked up on each other --> 6x10min instead of the ONE goal-eliciting-consult on which"
   - "this took 20 min,"
   - "10 minute slots"

8. general interviewing skills
   - "My feeling is that, maybe we should not have asked you so much, but just left you to say,"
   - "we should have given her more space and invite her to (missing) and work together with her."
   - "Would you have been embarrassed, if already I, within this first consultation, asked "what is your expectation from your doctor"."
   - "When we asked you if you had a good relationship with your former doctor, maybe it would

have been better if we had asked you what you expect from us?"
- "I think that was quite important to you."
- " I understand."

SCREENING FOR PATIENT'S FUNCTIONALITY (coupling to functioning, to life events, to family events, coupling life events to health events)

1. patient medication
   - " How many tablets are you taking?"
   - "how often do you need to take"
   - "Do you like taking medication?"
   - "what you would like to reduce from the medication?"
   - "did your doctor talk to you about how to take them?"
   - "Yeah so you don't have any discomfort with the medication?"
   - "Yes. It is of course a balance. It is a balance between how you feel, and how … - PT: No, it is not that"

2. patient motivation - compliance
   - "Do you perhaps have some problems with the different medications, and with knowing when it is useful or not?"
   - "that was the motivation to comply with the treatment?"

3. patient concerns
   - "some things that you were concerned about."
   - "So your mother, she had…"
   - "So are you worried about fracture, or…, because, …"
   - "Your fear is (missing) your emotions will get worse?"
   - "Because how I understand it, this threatens you."

4. daily life
   - "what you call pain, what exactly is it?"
   - "But that was quite a change in your habits?"
   - "Does that hinder you to do the things you would like to?"
   - "helps you to, feel good?"
   - "you stated once that all these problems were worse after your cancer…"
   - "Are there times when you don't feel your body? When you are happy with it."
   - "You say many things have changed. So in the past, were you another type of person? Were you looking for contact, … ?"
   - "Sometimes this impaires it…"
   - "you don't cook for yourself? It is hard, yeah, I understand that."
   - "And is it comfortable for you to have someone to eat with?"
   - "My daughter checks on my check book, payments (missing). - Did she ever find any problems?"
   - "Do you have to clean yourself?"
   - "So you've got help. What do they do? What do you do?"
   - "When was the last time you actually vacuumed the carpets?"
   - "Did that make you short of breath?"
   - "Did you ever smoke?"
   - "you gained so much information about her daily functional status. It was really well mixed up."
   - "We find that the breathing is in fact a non-problem, you called it a non-problem, we explored that she is able to do things, she is not impaired"
   - "And it is manageable?"
   - "do you get any pain in your legs when you walk? Or go to the shop?"
   - "You like to go around? You can go around?"

- "Are there things, situations, which are better for you?"
- "Here in Belgium, are there also situations in which you are in less pain?"

5. professional status, social status and goals, screening for loneliness (+)> depression (-)
- "If there is anything social you would like us to talk about?"
- "because of this income, Tell us a little bit of the work that you are doing."
- "is that helpful? At your working place, do you have contacts with people?"
- "Also for you, to have a bit more confidence as well, to have more contacts,"
- "meet people there, that you can share, helps also, to cope with your disease?"
- "Does it bother you that you are lonely?"
- "and how do you feel about that? Do you feel a bit alone, lonely, …?"
- "so you are not interested in for example being retired, or half (employed)?"
  - PT: No, I have to work. - You have to."
- "So can I ask about your financial problems?"
- "I think it is good to know, that because of your situation, you had to work."
- "What about your pension?"
- "And before that, were you often out with friends, …?"
- "So yes, I think it could help also, for the other problem"
- "It seems to me, that umm, when you tell me, that your physical health is good enough, that it is a major topic for you, this other problem of feeling lonely"
- "Do you know anyone there, anyone to go with you?"
- "So there are several things that I am interested in to know. And um, I was wondering how your ability to work is?"
- "Do you avoid your work?"
- "And the people around you, they think you work too much."
- "It is very important to you to be able to work?"
- "And I just wondered, what are you working as?"
- "And are you okay with that, with these choices?"

6. family , screening for conflicts with family (-), involve family in sdm (+)
- "He died from…"
- "your family joined you?"
- "so you are a grandmother."
- "how is it with your family and your friends?"
- "Do you have children, a family?"
- "Did your husband smoke?"
- "you thought he (husband) had some problems."
- "It was definitely strategy to speak about her husband, because you know, there are a few critical key questions about alcohol."
- "then I would want to talk to her daughter."
- "What happens at home?"
- "Are you worried about what they are going to say? Is that how it is?"
- "Do you try and involve your family in it?"
- "you did feel the duality between work and her family?"
- "But there was still this duality between the family, between what they want, …"
- "And I can imagine, in the future, there will be days when you will just want to give up, would it be helpful, to invite the family and speak about this once?"
- "I ask myself, would it be helpful, to talk with your husband?"
- "Yes, and I think it would be necessary to involve him in the process."

7. coupling life events to health events
- "after your husband left, (…) the cancer?"

GOAL ORIENTED CARE

1. disease listing (- not psy), screening for multimorbidity
    - "Apart from the diabetes, you also suffered from another problem,"
    - "And what about your eyes, what do you think about "

2. psychiatric comorbidity screening (-)
    - "And does that sometimes make you depressed, not feeling well?"
    - "comorbidities of "medical" illnesses are ok treated, however "mental" illnesses are still neglected: comorbidities with mental illness is most neglected, in teaching ánd in practice"
    - "There is a stigma in certain unique diseases, not in all ones."
    - ""Equity of diseases" is needed in doctors ánd in patients. "

3. goal-eliciting: life goals ("important") (+)
    - "That brings us to, can you tell us Diana, what is important to you?"
    - "but what are the things that really matter for you? What in your life is worthwhile, what are your goals?"
    - "So, if I listen well, for you, being able to work, is important?"
    - "Are there things that you enjoy doing?"
    - "So your cigarets are important to you?"
    - "I'ld like to hear a little more, you said, this petanque was very important to you,"
    - "Well I can see, by the look of it, that you are not a person to just stand there and look at it, .."
    - "what is the most important to you."
    - "find out what is the most important."
    - "No we haven't, we are still gathering information."
    - "then which area is the most important for you,"
    - "So about this petanque that you like."
    - "You would like this?"
    - "is there anything that bothers you?"
    - "there isn't anything from the diabetes, that does, make you sick?"
    - "would like to change.."
    - "And what does it give to you, when you drink a.."
    - "but I didn't tell you that before because I wanted to understand how you felt about it, or if you just wanted to stay home. So I understand that."
    - "Do you think your shortness of breath is bad enough that we should get some tests on that as well? (missing) Do you think we could make it better?"
    - "Does that bother you?"
    - "Well does seeing somebody live with that sort of problem, sometimes makes you worry about your own health?"
    - "What do you like most?"
    - "Try to say it."
    - "You appear to be really open to new things."
    - "You are a fighter."
    - "Do you try to live your life as it was before?"
    - "It is important for you what your work is, your personality."
    - " what do you wish? What do you wish?"
    - "And what do you think you need, what would help for you, to continue? To be satisfied,"
    - "are there any wishes for me to help you"? And then she said "that it stops, that I can continue". And you went on with that, but you didn't, well, you could have asked "are there any other wishes? because I cannot stop this". "I cannot stop Parkinson, I can help you with the medication, but cannot stop it. Are there any other wishes?" I would explore that a little bit further so you can get the different goals, other than just to stop the parkinson."
    - "of the important things that are going on in your life, what are the things that you would like to do"
    - "Try to tell me."
    - "It is difficult to actually provide goal-oriented-care (GOC), because trying to elicit patient

goals, the patients were themselves stuck in a disease-oriented model."
- " would ask her, if you were in reasonable health, then what would you do?"

4. goal defining (- doctors goals), translating goal to functional status
- "it is about what is behind this pain. Pain is the most used way to express a complaint."
- "some of her pain aspects could be mental."
- "she doesn't want to talk to her doctor about the lack of communication, because she doesn't want to … But we as a doctor need to cover this area."
- "Her pain is important to her, she doesn't care about her heart or cerebrovascular disease."

5. goal checking (-)
- "So what I hear,"
- "summarize?"
- "(! -) (silence) (change of topic)"
- "To have less pain." (repeat goal)
- "So what we understand is"

6. goal rechecking, changing goals in time(-)
- "so you said in these last few minutes, that we did not yet come to defining the goals?
  - Well you did define your own goals, but you did not define the pt's goals.
  You thought this was indeed the highest burden for her, but you didn't really check."
- "Does goal-setting depend on the concept of time?"
- "goals also change over time" (because motivational situations change e.g. family).
- "Recheck those goals."

7. goal prioritizing
- "So what are your priorities?" "What are your top 3 things to do?"
- "But yesterday we said that she would might need spiriva, and today…"
- Yes, but we have got it on the list, but you might put it down (lower)."
- "I am just trying to make a (list) on the whole of the topics, which are important for you. Still, Is there something left, which has to be mentioned?"
- "Yes but it was good, because you said, "this doesn't feel like the priority nów". The priority nów is that this woman is very distressed."
- "This is now the problem, and the rest is not".

TRANSLATING GOALS INTO PATIENT'S FUNCTIONALITY

1. translating goals into functionality
- " A remark on the work you have done this morning, is that I would always try to translate, I really think the hearing problem is a priority, because it will enable her, to actively participate in the society, so that is important, BUT I believe that we should even try to help our pts to translate it even to that level. That is the priority of the hearing aid, to translate it within the consultation to the priority of social participation. If we translate our goals at the level of functional status, then it is the language of the functional pt, and this empowers the pt."
- "So I agree it was a priority, but try to translate it to functional status. "

2. working on functionality (all aspects)
- "so let's work together with you, to help this impaired functioning. It is very important for us to"
- "Well, that's what I was thinking, is it possible to maybe get her back into petanque, or maybe To just (laughter) roll a ball? As opposed to throwing it?"
- "So we need an opportunity to help her find a way to get to a community."
- "Have you any ideas that can make you lessen this feeling (of pain)?"
- "It would probably help us, with having her move a little bit"
- "we can talk about the things you eat and maybe start from there, to see the things that are bad Or not. Because it is one of the things that we can do for diabetes, it is that."

- "I would just do a physical check."
- "So how about when somebody came to help you to make to eat and to …?"
- "Lets discuss what you and I need to do to help you reach to the things you want to do."" (-)

3. coding functionality, using the ICF (-)
- "I cannot imagine applying it."
- "It is also contradictory, that one tries to categorize functions (similar to single-disease model)."
- "can you summarize how a GP can easily use the ICF?
- It is not easy to use, however it's merit is it's conceptual change (the way the GP thinks) of how you think about your patient."

4. CHANGE IN PHYSICIANS ATTITUDE (-)
- "GOC requires from the GP our OWN willingness to change as well"
- "ICF shift in thinking for a GP is in my opinion not that difficult to do"
- "so, concluding: need to change attitudes in physicians"

Phase III: Resulting in a tree nodes model:

Table 2. Silent skills in managing multimorbidity.

	I. EXPLORATION SKILLS: interviewing
1.	ICE (ideas, concerns and expectations) (+)
2.	doctor-patient relationship
	- trustful relationship (+)
	- checking barriers and conflicts doctor - patient (+)
	- checking the communication experience for the patient (+)
3.	shared-decision-making
	- patient information and patient empowerment (+)
	- getting to shared-decision-making, motivational talk, behavioral activation & reading the barriers (-)
4.	talking about functional status
	- patient medication (+)
	- patient motivation - compliance (+)
	- daily life (+)
	- professional & social status and goals (+)
	- family, screening for conflicts with family, involving family in SDM (+)
	- coupling life events to health events (+)
5.	disease listing
	- screening for multi-morbidity (-)
	- psychiatric comorbidity screening (-)
6.	eliciting individual patient goals
	- goal-eliciting: health & life goals (+)
	- goal defining (-)
	- goal checking (-)
	- goal rechecking, changing goals in time (-)
7.	time management:
	- setting the agenda & spreading consultations (+)
	II. ACTION SKILLS: working on individual patient goals and functionality
1.	goal prioritizing (+)
2.	translating goals into functionality (-)
3.	working on functionality (+)

Legend: (+) means well executed, (-) means poorly executed skill.

Managing multimorbidity in primary care:
Eliciting implicit skills general practitioners use while providing evidence based care for patients with multiple chronic conditions.
A qualitative exploration.
Pauline Op de Beeck, MD, author.
Pauline Boeckxstaens, MD, PhD, co-promotor.
Luc Van Imschoot, MD, co-promotor.
An de Sutter, MD, PhD, promotor.

APPENDIX 3: Describing the process of this study

August 2013:
Reading "Critical decisions. How you and your doctor can make the right medical choices together." Ubel Peter A. Harper One. 2012.
First thaughts of exploring shared decision making (SDM) as a topic for this study.

September 2013:
Contacting prof. Jan de Maeseneer, U Gent – application for a study proposal concerning SDM.
Referral to Dr. Pauline Boeckxstaens, PhD-student, U Gent.

October 2013:
Workshop on multi-morbidity:
present as a non-participant observer, making field notes, videotaping simulated consultations and discussions, processing evaluation forms.

October 2013:
Study proposal – P. Boeckxstaens and P. Op de Beeck:
- Title: "Skill-training on addressing multi-morbidity in primary care"
- Objective: A qualitative analysis of the entire 3-day workshop:
  a) silent skills in GPs in multimorbidity
  b) organisation of the workshop
- Format: agreement on choosing an article format for this study, cfr. Icho policy and for future publication.

March 2014:
Study approval by the Ethics Committee.

November 2014:
Narrowing the study topic – P. Boeckxstaens and P. Op de Beeck:
Current approach learns us more about this workshops' organisation itself, but contributes less to the meso- and macro-level of primary care management in multi-morbidity.
New proposal: Shifting the topic of this study from a qualitative analysis of the workshop itself, to a more specific study topic within the field of our data and our approval of the ethics committee U Gent.
Proposal for a qualitative analysis of the clinical expertise general practitioners have while providing EBM for multimorbid patients, through data-analysis of the verbatim transcriptions of the videotaped simulated consultations within this workshop.
Its' very clear research question is more valuable in contributing to the understanding of primary care EBM management in multimorbidity.
Title: "Managing multimorbidity in primary care:
Eliciting implicit skills general practitioners use while providing evidence based care. A qualitative exploration."
- Format: agreement on keeping the article format for this study.

November 2014 – January 2015:
Discussing the change of the study topic with both Dr. Kristof Hillemans (seminariebegeleider) and with Dr. Morad Choukry (praktijkopleider).
Conclusion: the proces of choosing a specific study question is very interesting and is an opportunity to maximally explore correct methodologic options within these data, and to find an interesting approach and study question. Understanding of methodology within qualitative research is as important as are the results of the study itself.

November 2014 to April 2015:
Regular discussions with the co-promotor on the progression of this study.

Medio April 2015:
Doubts about article format by the co-promotor. Challenging to narrow a large group of data to a very precise study focus, permitted by Icho.

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APPENDIX 4: Informed Consent

Skill-training on addressing multi-morbidity in primary care

Jan de Maeseneer, MD, PhD, An de Sutter, MD, PhD, Pauline Boeckxstaens, MD,
doctoral researcher, U Gent - Principle Investigators
Department of Family Medicine and Primary Health Care of Ghent, University of Ghent
- Principle Organization
Dialogue on Diabetes & Depression, WONCA - Supporting Organizations

Informed Consent Form for participating general physicians an d field experts who we are inviting to participate in a 3-days training program, titled "Skill-training on addressing multi-morbidity in primary care", taking place in Ghent, Belgium, from October 14th-16th.

This Informed Consent Form has two parts:
• Information Sheet (to share information about the study with you)
• Certificate of Consent (for signatures if you choose to participate)
You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction
We are Pauline Boeckxstaens, MD, doctoral researcher, and Pauline Op de Beeck, MD, general physician in training, working together with the University of Ghent. Promoted by An De Sutter, MD, PhD, we want to perform a rigourous observation of the training session on multi-morbidity in primary care. The aim is to cover all aspects of physician-patient care in chronic illness, including how to assess the chronic patient's needs and functional goals, and to set up and optimize a medical training program for physicians in this field.

We are going to give you information and invite you to be part of this research. Before you decide, you can talk to anyone you feel comfortable with about the research.
This consent form may contain choices of words that you are unclear. Please alert me and we will take time to explain. If you have questions later, you can ask us to address them.

Purpose of the research
The cure-to-care paradigm has been firmly rooted, in other disciplines as well as in primary care. In the current health care, trends of growing numbers of multi-morbid patients are confirmed in most developed countries primary practices. Over the last 4 decades, patients have undergone the patient's rights movement, have been educated, and empowered. Since Mold and Blake clearly shaped the concept of goal-oriented therapy(1), there have been research focuses on shared decision making and on how to let multi morbid patients define their individual goals and needs. Thus far, the primary physician has not been trained in the field in his or her medical curriculum, as goal-oriented therapy in primary care has not yet been incorporated in medical training programs. This skill-training session focuses on the physician-patient interaction in multi morbidity, learning GP's how to address the chronic patient's individual functional goals.
1. Goal-oriented medical care. Mold JW, Blake GH, Becker LA, Fam Med 1991 Jan;23(1):46-51.

Type of Research Intervention
This research will involve your participation in clinical group discussions, in simulated physician-patient encounters and in interactive expert lectures. All sessions will be videorecorded,
and contextual field notes will be made by Pauline Op de Beeck, participating to the sessions as an observer. All participant attributions who will have consented, will be verbatim transcribed, and content analysed.

Participant Selection
You are being invited to take part in this research because we feel that your experience as a primary health care physician in a developed European country, and your learning experiences in this training program, can contribute much to our understanding of how to train physicians in the complexity of multi-morbidity.

Is it clear to you why we are asking you to take part in this study? Do you know what the study is about?

Voluntary Participation - Right to Refuse or Withdraw
Your participation in this research is entirely voluntary. If you choose not to participate all the services you receive at this Centre will continue and nothing will change. You may stop participating in the lectures, discussions and work-shops at any time that you wish without the rest of the program course being affected. If the interview or group discussion has already taken place, you can request that the information provided by you is not to be used in the data analysis. We will give you an opportunity at the end of the sessions to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with the observant's notes.

If you decide not to take part in this research study, do you know what your options are?

Procedures
We are asking you to help us learn more about primary health care in multi-morbidity. If you accept to take part in this research project, you will be asked to:
- take part in interactive expert lectures
- take part in clinical group discussions
- take part in simulated physician-patient interactions, all together with the other participating GP's, and guided by the principle researchers, as well as by the expert speakers.

The sessions will take place in Ghent, and no one else but the people who take part in the discussion and guide or myself will be present during this discussion. The entire discussion will be video-recorded, but no-one will be identified by name on the video. The video will be kept stored at the organizing Department of Family Medicine and Primary Health Care of Ghent, University of Ghent. The information recorded is confidential, and no one else except the principle researchers will have access to the videos. The videos will be destroyed after completing the data analysis and after reviewing the research.

Duration
The research takes place over 3 days in total. During that time, 7 expert lectures, 2 group discussions and 3 clinical work-shops will be held.

Risks
We will not ask you to share personal beliefs, practices or stories and you do not have to share any knowledge that you are not comfortable sharing. If there is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics, then you do not have to answer any

question or take part in the discussion or work-shop. However, we do not wish for this to happen.

Benefits
The main benefit for you is that you are able to participate in this first skill training on managing multi-morbidity in primary care which achieved to gather different practicing GP's with academic liaisons from all over Europe under the extensive support of the dialogue on diabetes and depression. We believe that taking part in and discussing the training will be a highly valuable learning experience for all participants. Your participation is likely to help us find out more about how to optimally train physicians in the complexity of multi-morbidity and goal-oriented care.

Confidentiality - Sharing the Results
The research being done in this closed training program will be video-recorded. We will not be sharing information about you to anyone outside of the research team, and nothing will be attributed to you by name. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information.

Each participant will receive a summary of the results. Afterwards, we will publish the results so that other interested people may learn from the research.

Did you understand the procedures that we will be using to make sure that any information that we as researchers collect about you will remain confidential? Do you understand that the we cannot guarantee complete confidentiality of information that you share with us in a group discussion? Do you have any more questions?

Who to Contact
If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact any of the following: Pauline.Boeckxstaens@UGent.be, pauline.opdebeeck@student.uantwerpen.be.

This proposal has been reviewed and approved by Pauline Boeckxstaens.

You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

Part II: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant _____

Signature of Participant _____

Date _____

Statement by the researcher/person taking consent

I have accurately given out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:
1. taking part in expert lectures,
2. taking part in group discussions,
3. taking part in work-shops, all of which will be video-recorded.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent: Pauline Op de Beeck

Signature of Researcher /person taking the consent:

Date :

Managing multimorbidity in primary care:
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Pauline Boeckxstaens, MD, PhD, co-promotor.
Luc Van Imschoot, MD, co-promotor.
An de Sutter, MD, PhD, promotor.

APPENDIX 5: Approval by the Ethics Committee

Goedkeuring Ethisch Comité

Universitair Ziekenhuis Gent

Afz: Commissie voor Medische Ethiek

UNIVERSITEIT GENT

COMMISSIE VOOR MEDISCHE ETHIEK

Voorzitter:
Prof. Dr. D. Matthys
Secretaris:
Prof. Dr. K. Vandewoude

Huisartsgeneeskunde en Eerstelijnsgezondheidszorg
Kliniekgebouw 3 - 1ste Verdieping
Prof. dr. An DE SUTTER
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UW KENMERK	**ONS KENMERK**	**DATUM**	**KOPIE**
	2014/0312	31-mrt-14	Zie "CC"

BETREFT

Advies voor monocentrische studie met als titel:
Vaardighedentraining in de doelgerichte aanpak van de multi-morbide patiënt in de eerste lijn: Een kwalitatieve analyse.
(Skill-Training on addressing multi-morbidity in primary care: A qualitative analysis.) - MAnaMA Pauline Op de Beeck

Belgisch Registratienummer: B670201420661

* Adviesaanvraagformulier dd. 20/03/2014 (volledig ontvangen dd. 21/03/2014)
* Diverse
  - Evaluatieformulier deelnemers
  - Begeleidende nota
  - Literature review
  - Programmaclean DDD workshop
* Protocol
* Antwoord onderzoeker via mail dr. P. Op de Beeck dd. 29/03/2014 (ontv. 31/03/2014) op opmerkingen EC dd. 27/03/2014

Advies werd gevraagd door:
Prof. dr. A. DE SUTTER ; Hoofdonderzoeker

BOVENVERMELDE DOCUMENTEN WERDEN DOOR HET ETHISCH COMITÉ BEOORDEELD.
ER WERD EEN POSITIEF ADVIES GEGEVEN OVER DIT PROTOCOL OP 31/03/2014. INDIEN DE STUDIE NIET WORDT OPGESTART VOOR 31/03/2015, VERVALT HET ADVIES EN MOET HET PROJECT TERUG INGEDIEND WORDEN.
Vooraleer het onderzoek te starten dient contact te worden genomen met Bimetra Clinics (09/332 05 00).

THE ABOVE MENTIONED DOCUMENTS HAVE BEEN REVIEWED BY THE ETHICS COMMITTEE.
A POSITIVE ADVICE WAS GIVEN FOR THIS PROTOCOL ON 31/03/2014. IN CASE THIS STUDY IS NOT STARTED BY 31/03/2015, THIS ADVICE WILL BE NO LONGER VALID AND THE PROJECT MUST BE RESUBMITTED.
Before initiating the study, please contact Bimetra Clinics (09/332 05 00).

DIT ADVIES WORDT OPGENOMEN IN HET VERSLAG VAN DE VERGADERING VAN HET ETHISCH COMITE VAN 15/04/2014
THIS ADVICE WILL APPEAR IN THE PROCEEDINGS OF THE MEETING OF THE ETHICS COMMITTEE OF 15/04/2014

- *Het Ethisch Comité werkt volgens 'ICH Good Clinical Practice' - regels*
- *Het Ethisch Comité beklemtoont dat een gunstig advies niet betekent dat het Comité de verantwoordelijkheid voor het onderzoek op zich neemt. Bovendien dient U er over te waken dat Uw mening als betrokken onderzoeker wordt weergegeven in publicaties, rapporten voor de overheid enz., die het resultaat zijn van dit onderzoek.*
- *In het kader van 'Good Clinical Practice' moet de mogelijkheid bestaan dat het farmaceutisch bedrijf en de autoriteiten inzage krijgen van de originele data. In dit verband dienen de onderzoekers erover te waken dat dit gebeurt zonder schending van de privacy van de proefpersonen.*
- *Het Ethisch Comité benadrukt dat het de promotor is die garant dient te staan voor de conformiteit van de anderstalige informatie- en toestemmingsformulieren met de nederlandstalige documenten.*
- *Geen enkele onderzoeker betrokken bij deze studie is lid van het Ethisch Comité.*
- *Alle leden van het Ethisch Comité hebben dit project beoordeeld. (De ledenlijst is bijgevoegd)*

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UW KENMERK	**ONS KENMERK**	**DATUM**	**KOPIE**
	2014/0312	31-mrt-14	Zie "CC"

Vervolg blz. 2 van het adviesformulier betreffende project EC UZG 2014/0312

- *The Ethics Committee is organized and operates according to the 'ICH Good Clinical Practice' rules.*
- *The Ethics Committee stresses that approval of a study does not mean that the Committee accepts responsibility for it. Moreover, please keep in mind that your opinion as investigator is presented in the publications, reports to the government, etc., that are a result of this research.*
- *In the framework of 'Good Clinical Practice', the pharmaceutical company and the authorities have the right to inspect the original data. The investigators have to assure that the privacy of the subjects is respected.*
- *The Ethics Committee stresses that it is the responsibility of the promotor to guarantee the conformity of the non-dutch informed consent forms with the dutch documents.*
- *None of the investigators involved in this study is a member of the Ethics Committee.*
- *All members of the Ethics Committee have reviewed this project. (The list of the members is enclosed)*

Namens het Ethisch Comité / On behalf of the Ethics Committee
Prof. dr. D. MATTHYS
Voorzitter / Chairman

CC: De heer T. VERSCHOORE - UZ Gent - Bimetra Clinics
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