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FACULTÉ DE MÉDECINE

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THÈSE D'EXERCICE

Pour le

DOCTORAT DE MÉDECINE

DE SPÉCIALITÉ MÉDECINE GÉNÉRALE

Par

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**What are the Topics of Definition for Multimorbidity Recognized in Polish
General Practice?**

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Résumé

Introduction : L'organisation mondiale de la santé définit la multimorbidité par l'association d'au moins deux conditions médicales chroniques chez la même personne. L'European General Practice Research Network (EGPRN) a établi une nouvelle définition qui a été ensuite traduite en 10 langues européennes. La Pologne était un des pays participants. L'objectif de cette étude était d'évaluer quels étaient les critères de multimorbidité reconnus par les médecins généralistes polonais afin de savoir s'ils différaient de ceux de la définition académique.

Méthode : Onze entretiens individuels semi-dirigés ont intégré des médecins généralistes polonais. Le recueil des données respectait les critères de variation maximale des échantillons et de saturation des données. Un codage ouvert, puis un codage axial et thématique a été réalisé afin de pouvoir identifier les critères de multimorbidité pour les médecins généralistes polonais. La définition académique de la multimorbidité (traduite en Polonais) a été utilisée comme modèle pour l'analyse en théorie fondée.

Résultats : 501 codes sont ressortis de 11 entretiens individuels. La totalité des thèmes proposée par EGPRN a été retrouvée. Deux nouveaux thèmes étaient identifiés : l'expertise du médecin généraliste et la relation médecin-patient.

Discussion : Tous les thèmes intégrés dans la définition de la multimorbidité ont été identifiés par les médecins généralistes polonais. Deux nouveaux thèmes se sont ajoutés. La définition est étroitement liée aux soins primaires et elle peut trouver son utilité dans les soins de longue durée.

Abstract:

Introduction: Multimorbidity is defined according to the World Health Organization as the occurrence of two or more chronic conditions in one individual. The European General Practice Research Network (EGPRN) designed a new definition of multimorbidity, which was translated into 10 European languages. Polish is one of the participant countries. The aim of this study was to ensure that the definition is clear and useful. The research question was: What are the topics for multimorbidity recognized in Polish general practice?

Method: Eleven semi-structured interviews with Polish general practitioners (GPs) were carried out. Data collection proceeded until saturation was reached. An open, axial and thematic coding was done in order to identify the criteria of multimorbidity for GPs. The multimorbidity academic definition (translated into Polish language) was the model to perform the analysis using a grounded theory framework.

Results: 501 codes were extracted after 11 interviews. All the themes proposed by the EGPRN's definition were identified. Two new themes regarding GPs were identified: GP's expertise and Doctor-patient relationship dynamic.

Conclusion: All the definition themes have been recognized by the Polish GPs. Two new themes appeared. The definition is closely related to primary care and could be useful in Long Term Care.

1.Introduction

The concept of multimorbidity was published for the very first time in a German publication. It was an addition to the concept of comorbidity. Feinstein defined comorbidity as “any distinct additional clinical entity that has existed or may occur during the clinical course of a patient who has the index disease under study” [1]. In 1990 the concept became internationally recognized through research [2]. The progress of modern medicine has substantially increased life expectancy and improved the outcome of previously fatal disease. As a consequence, chronic medical conditions and multimorbidity are increasing.

Today, multimorbidity is turning into a major medical issue for both, individuals and health care providers. Multimorbidity has been defined by the World Health Organisation (WHO) as the co-existence of two or more chronic diseases [3] where one is not necessarily more central than the others [4-7]. This definition becomes simplistic and inadequate [8]. Because there is a lack of agreement on definitions of complexity and not all current definitions include non-medical dimensions, this term is considered challenging. A more holistic definition is required.

For that, in 2012, a research team, including 8 national groups (Belgian, French, German, Greek, Italian, Dutch, Polish, and Spanish), all active within the EGPRN, defined multimorbidity in an academic way: *Multimorbidity is defined as any combination of chronic disease with at least another disease (acute or chronic) or a bio psychosocial factor (associated or not) or somatic factor. Bio psychosocial factor, risk factor, social network, burden of diseases, health care consumption and patient’s coping strategies may function as modifier. Multimorbidity may modify the health outcomes and lead to an increased disability or a decreased quality of life or frailty [9], [10].* This new definition helps general practitioners (GPs) to identify multimorbid patients [9]. Understanding how to manage care and design the health system for patients with multimorbidity may lead to improvements in quality of life (QOL), utilization of healthcare, safety, and mortality [11].

The simultaneous occurrence of various health problems in a given individual, which is defined as multimorbidity, has become the norm rather than the exception [12, 13]. A review conducted by Marengoni showed that the prevalence of multimorbidity in the elderly population is as high as 98% [14]. However, this phenomenon is not confined to elderly populations; its prevalence is also higher than expected for younger age groups and for both sexes [12, 15].

Multimorbidity has extraordinary importance not only for the general population but also for healthcare systems. It has been shown to be associated with increased mortality [16], poor functional status [17], lower quality of life [18], overloaded care, especially at the primary care level [19] but also in the emergency room [20], and the greater use of specialized care [21]. Patients with multimorbidity account for most consultations in primary care [22]; they present more intercurrent morbidity in doctor

visits than patients with single diseases [23], and GPs deal with the majority of these 'additional' patient visits [24].

Lately multimorbidity became a central item for research. Poland is one of the eight participating countries at the European research. In Poland, after the Second World War, primary care was delivered by a wide range of specialists. The basis for GP practice in the new reformed system was created in the years 1993–1994 and finally introduced in 1999 and doctors became self-employed. Polish primary care is still under development [25]. The population is registered with a single GP which provides a new opportunity for both systematic and opportunistic health promotion [25].

Once having defined multimorbidity, and translated the definition into each of the languages of the national groups, qualitative research was planned. The aim of this paper was to ensure that the definition is clear and useful for Polish GPs. The research question is: What are the topics for multimorbidity recognized in Polish general practice?

2. Method

Study design and participants

Employing a qualitative research design a study with Polish GPs was performed in order to explore the full range of meaning of the concept of multimorbidity for GPs. New topics about GP's multimorbidity definition and the added value, of the concept for Polish GPs was also researched. The multimorbidity academic definition (translated into polish language) was the model to perform the analysis in a deductive way.

Semi-structured interviews with Polish GPs were carried out. An interview guide is used to cover items addressing the research question (Table 1). Its construction was based on discussions in the research team and a test session with junior researchers and residents in the university department of general practice. Member checking to improve validity was performed informally during focus group sessions [26]. Participants were recruited among GPs through telephone contact. All GPs consented to participate and anonymity and confidentiality were ensured. During the interviews the interviewer puts himself in a listening strategy and he took notes. When the interviewees stopped talking, the interviewer referred to the information he had gained so far and he stimulated the interviewees to go deeply into details. Also, external open-ended questions, formulated prior to the interview, were asked [27]. All interviews were audio taped and transcribed verbatim. The interviewees had the possibility to read the verbatim and confirm it. The aim of clustering together the interviews was triangulation [28, 29] to obtain the GP's different points of view.

Data analysis

The interviews were carried out until data saturation was reached. Data saturation refers to the point at which additional interviews do not provide any new insights into the topic [30]. Stepwise sampling was performed [31], as in qualitative research, sampling, data collection and analysis typically occur in an iterative process.

To analyze data a phenomenological perspective was applied [28], using a grounded theory framework [30]. Firstly, open coding, to conceptualize the data. Codes was performed and then connected in an axial coding phase. At the highest level of abstraction a selective coding was achieved, in which the core data led to additional, related coding.

The first level multimorbidity codebooks was done in native language. Then each code was related to one or several identical concepts in the verbatim. The Polish team translated that level of coding and sent it to the French team as their first coding book. Consensus between the French and the Polish teams and validation of codes were achieved via mail. During the meeting the final coding book was finalized and validated. Thematic coding was confronted with the definition of multimorbidity which

was used as concept maps. The concept maps are tools that allow graphical representation of concepts and their relationships by a connecting line [32].

Table 1: Interview Guide

Interview Guide	
1st Question	We have described what multimorbidity definition is. Could you describe one case of a multimorbid patient that comes from your practice?
2nd Question	Do patients need peculiar management?
3rd Question	How do you identify these patients?
4th Question	How do you feel these patients?
5th Question	These patients are difficult to spot or locate. What additional means could help you to do so?

3. Results

Sample description

Field work took place in July 2012 in Poland. Eleven Polish GPs were interviewed. The researchers presented themselves at the appointment. A purposive sampling strategy was applied to ensure heterogeneity in characteristics such as age, sex, and urbanization among the participants.

Of all 11 interviewed GPs 8 were female and 3 male. The mean age of the interviewed was 44.5 years (range 32-58 years). Characteristics of the participants are presented in Table 2.

Table 2

Characteristics of the 11 participating GPs	
Sex	
Male	3
Female	8
Practice type	
Single	3
Duo or group	8
Urbanisation	
Rural area	1
Urbanised rural area	3
Urban area	7
Mean age, years (range)	44.5 (32-58)
Mean experience as GP, years (range)	8 (1-15)

Presentation of results

After eleven interviews data saturation was reached. Five hundred and one codes were extracted. Three hundred and eighty-one codes were allocated to the 11th existent themes (listed in [Table 3](#)). All the themes integrated in the academic definition were found in the verbatim.

Table 3: Thematic and axial coding of the results corresponding to the academic definition

Academic themes	Axial Codes
1. Chronic disease	Chronic condition/symptoms signs complaints
	Chronic disease
	Complexity characteristics of chronic disease
2. Acute disease	Acute disease
	Reaction to severe stress and acute disorders
3. Biopsychosocial factors and somatic risk factors	Demographic risk factor
	Lifestyle
	Patient's beliefs/expectations/culture
	Psychological risk factor
	Psychosocial risk factor
	Socio-demographic characteristics
4. Coping	Somatic risk factor
	(Behavioral and psychological) coping strategies
5. Burden of diseases	Patient's basic compliance
	Disease comorbidity
6. Health care consumption	Disease complication
	(Multidisciplinary) disease management
	Cost of care
	Health care
	Health care policy
	Health care services
	Health services/setting/treatment
	Malpractice
	Management
	Medical history
	Medical procedure
	Pain
	Polypharmacy (including polymedication)
	Prevention/education/detection
	Symptoms/signs/complaints (not pain)
Treatment	
Use of caregivers	
7. Disability	Functional impairments
8. Quality of life	Health status
	Impairment implications
9. Frailty	Frailty
10. Social network	Dependence on the network
	Family coping strategies
	Social isolation
	Support from the network
11. Health outcomes	Classification of morbidity statistics
	Medical research, epidemiology
	Health outcome

One hundred and twenty codes were allocated to the two new themes and their axial codes – Table 4.

Table 4: New themes and axial codes

Academic Themes	Axial Codes
FP's expertise	Comprehensive approach
	Holistic approach
	Intuition/gut feeling
	Person centered care
	Primary care management
	Specific problem solving skills
Patient-doctor relationship dynamics	Communication challenge
	GP's and patient's experience

All themes and codes proposed by the multimorbidity academic definition and the new themes and codes found in this study are detailed below.

1. Chronic disease

Chronic condition/symptoms signs complaints – those are represented by the “sleep problems”.

Chronic diseases are represented by conditions seen in general practice: “polymetabolic syndrome”, “hypertension”, “diabetic polyneuropathy, emphysema”.

Psychosomatic diseases – “anxiety and depressive disorders”, “The main disorders are depressive disorders and a lot of accompanying symptoms in a mental sense”.

Complexity characteristics of chronic disease tally with alcoholic addiction “an alcohol addict”, and “multiple pathology, many diseases”.

2. Acute disease

Acute disease refers to “urinary tract infection”, “stroke disorders”.

Reaction to severe stress and acute disorders – mainly hypochondria “hypochondria: she treats diseases seriously”.

3. Bio-psycho-social factors and somatic risk factor

Demographic risk factor – the age span was mentioned “a young woman”, “elderly patients” but also “middle age”.

Lifestyle - Inactivity “unoccupied: all her days she spends at the window” or “bad lifestyle”.

Patient’s beliefs/ expectations/ culture - Mainly mentioned: “expectation of additional tests”, “expectation of referrals”, and “(the patients) want someone to confide in them”.

Psychological risk factor – “low mood”, “stress”, “withdrawn patient” were named.

Psychosocial risk factor – the economic situation and family environment were found as risk factors: “interrelation of many diseases against the socio-economic-situational backdrop”, “unemployment can be a factor in causing many conditions”, “the sick in the family”.

Socio-demographic characteristics – old age “age, an elderly woman”.

Somatic risk factors - somatic disorders “more somatic problems”.

4. Coping

(Behavioral and psychological) coping strategies – those aspects were found: “Mothers often project their own anxiety onto their children”, “If they are over stimulated, these people are simply gone and do something”, “visit as a therapy”. Also the risk behaviors were found: “drinking family members”.

Patient’s basic compliance – “undisciplined patient”, “no diet”, “lack of exercise”.

5. Burden of diseases

Disease complication – it was the consequences of multimorbidity: “in multimorbidity there’s some impotence”, “additional depression”.

Disease comorbidity – “several diagnoses”, “additional diseases”.

6. Healthcare consumption

(Multidisciplinary)Disease management – “bad cooperation with specialists”.

Cost of care – mainly expensive cost of care: “cost expansion economically the patient is expensive”, “cost expansion: greater financial outlays”.

Health care – “not for money”.

Health care policy – the lack of solution of the health care policy was mentioned: “there’s lack of screening tests”, “the need of contact with healthcare system”.

Healthcare services – consists of visits: “I meet (these patients) more often than others- every 2 or 3 weeks”, “time-consuming: longer time of the visits”.

Health services/setting/treatment – extra-examinations, the visits of specialists and medicines were included: “a multidisciplinary approach”, “they look for help in different places and are left alone”.

Malpractice – “difficulty of diagnosis”.

Management – management difficulties for GPs were found: “up to date practice for those patients: good documentation”, “I’ve learned how to manage them”.

Medical history – the importance and complexity of medical history of the patient: “the interview is the most important”.

Medical procedure – all complementary investigations, and the need for thinking about their utility for the patient were mentioned: “extra tests”, “need of psychologist”, “no improvement no additional examinations”.

Pain – follow up: “mostly (they feel) pain”.

Polypharmacy – heavy treatments are mentioned: “they are fed up with pharmacotherapy”, “ten medicaments”.

Prevention/education/detection – these notions were discussed: “difficulty of diagnosing patients unwilling to fill in such questionnaires”.

Symptoms/signs/complaints - “complain about old age”.

Treatment – non drug or drug treatment: “is not only pharmacotherapy”, “temporary application of medicines”.

Use of caregivers – the frequency of consultations: “frequent visit at the doctor’s”, “they used every opportunity to visit other doctors”, the implication of other specialists: “collaboration with a psychologist”.

7. Disability

Impairments – mainly functional impairments as a consequence of multimorbidity: “inability to get pregnant”, “degenerative disease”.

8. Quality of life

Health status - as perception: “I’ve got so many diseases”, “they feel there’s no medicine that could cure them”.

Impairments implications - as a personal consequence: “they can’t cope in life”.

9. Frailty

Frailty as a global consequence of multimorbidity: “when they suffer from these diseases they are acute and they get over them badly”.

10. Social network

Dependence on the network – this includes medical staff: “community nurses”.

Family coping - includes coping strategies adapted or not: “looking after her mother, who’s chronically ill”, “if her daughter stays with her she’s in better condition”.

Social isolation – “she lives alone”, “children don’t look after her”.

Support from the network – supporting network: “support group in the elderly surely play a role”, “meetings with patients”. Also a failing network was mentioned: “the need of attention, psychological needs unfulfilled”.

11. Health outcomes

Classification of morbidity statistics – it’s a need for level of multimorbidity: “a classification of diseases which allows coding the symptoms”, “I’ve got one such patient I don’t know if 10 diseases would be enough”.

Medical research epidemiology – the need of instrument for identification and epidemiological purpose was expressed: “The new MM definition is right (necessary).”

Health outcome – “The MM definition is rightly extended”.

12. FP’s expertise

Comprehensive approach - as a core competency of the GP: “comprehensive care”.

Holistic approach – the medical decision based on different arguments was recurrent: “.the concept of an organic disease in family medicine is not enough”, “it’s impossible to treat any of these diseases (conditions) separately”.

Intuition/gut feeling - as a factor of detection of multimorbidity: “we diagnose diseases that haven’t been diagnosed so far”.

Person centered care - as a tool to detect or follow multimorbidity: “adapted care ruled out by the physician careful listening (to the patient)”, “a tailor-made approach to the patient”.

Primary care management – “showing the bright sides”, “the right attitude, without medicines”.

Specific problem solving skills – adopting a specific approach to the patient: “the necessity of (finding) a solution”, “a broad, calm approach”.

13. Doctor- patient relationship dynamics

Communication challenge - in order to detect multimorbidity a fair communication process seems important: “mental gymnastics, more effort is required on the doctor's part”, “direct communication”.

GP's and patient's experience – The holistic approach of multimorbid patients is very complex by its duration of follow up: “I've known them for 16 years”, “children and neighbors are my patients”, positive feelings: “I empathize with the patient” or negative feelings: “I feel furious”, “(these patients) get on nerves”.

4. Discussion

Overview of results

The aim of this qualitative study was to identify the topics for multimorbidity in Polish general practice. Data analysis was based on grounded theory. Thematic coding of 11 interviews led to the identification of all 11th academic themes. Moreover, two more themes were extracted and added: FP's expertise and Doctor-patient relationship dynamics.

Strengths and limitations

Information bias

Verbatim codes were validated by interviewed GPs. Coding was realized independently by two researchers pooling of the results. The researchers took part in group workshops which were directed by an EGPRN member. All these steps limited the information bias.

Confusion bias

Reference themes and codes were in English as so thematic and axial coding. Sub-codes were in native language (Polish). An expert translated the verbatim. Some translations could be debatable.

Sample characteristics

The selection criteria (sex, practice type, urbanization, and experience) were chosen in order to ensure a maximal variation sample.

Study contribution

This study reveals 13 integrated themes in the definition of multimorbidity for Polish GPs. Some academic codes were suppressed (Psychological distress, Aging, Physiology, Family history, Assessment, Indicator). Many academic codes were not identified. Polish GPs didn't mention: Psychosomatic disease/physical implications, acute condition, complexity characteristics of acute disease, physiopathology, functional impairments, mortality, quality of life, community orientation. There are also few changes regarding academic themes. The participant experts at the Polish translation procedure proposed some linguistic alterations of two concepts: "somatic" and "frailty". During the Delphi consensus [33, 34] the greatest challenge for Polish translators was to find the right equivalence for notions like "frailty" or "social network" taking into account their absenteeism from the Polish medical literature [35]. Hereby "frailty" was replaced by "weakness" and the attribute "somatic" was deleted from the risk factor because in Polish language it doesn't have the meaning of real illness [35]. So these modifications were related to the Polish cultural context, and at the end the structure of the definition of multimorbidity was not changed.

When compared to the EGPRN definition, two new themes appeared: GP's expertise and patient-doctor relationship dynamics.

Poland like all Central and Eastern Europe (CEE) have gone through dramatic changes in the end of 20th century after the collapse of the communist regime. The transformation of the health care system is the greatest far-reaching change particularly in primary care. Family medicine experienced a rapid development since its implementation in 1994 in Poland. GPs are primary care physicians and gate-keepers [36] aiming to improve the quality of medical services [37, 38]. Poland became a member of the world organization of family doctors. GPs had to learn the integrative approach and a new medical language which involves the bio-psycho-social model till now nonexistent [35].

One of the academic themes of the study, GP's expertise is a concept recently appeared in specialized literature [39]. In daily practice GPs are confronted with difficult situations and difficult decision making processes. Therefore primary care is very complex and it demands expertise to detect or manage patients with multimorbidity. Due to its prevalence [40] multimorbidity is routine for the primary care professionals. Consequently they developed a different approach to manage these patients. Core competencies of GPs and "gut feeling" come in addition to the diagnostic flow chart. Core competencies as they were defined by WONCA [41] are essentials for the management of multimorbid patients. Primary care management, person-centered care, specific problem solving skills, comprehensive approach, integrative modeling were frequently named by interviewed GPs. It was not surprising to observe that community orientation wasn't named given the fact that the study is about multimorbid patients.

Patient-doctor relationship dynamics were represented by communication challenge and GP's and patient's experience. The patient-doctor relationship directly affects multimorbidity by supporting or restricting the care for the patient. These findings could help to explore the multiple demands of multimorbid patients by utilizing communication techniques [42]. Polish GPs described some challenges in communication, such-as problems of co-ordination or the impact of cognitive capacity. Prioritizing in medical procession or negotiating with the patient depends on the doctor-patient relationship.

Integrating the definition in a concept map

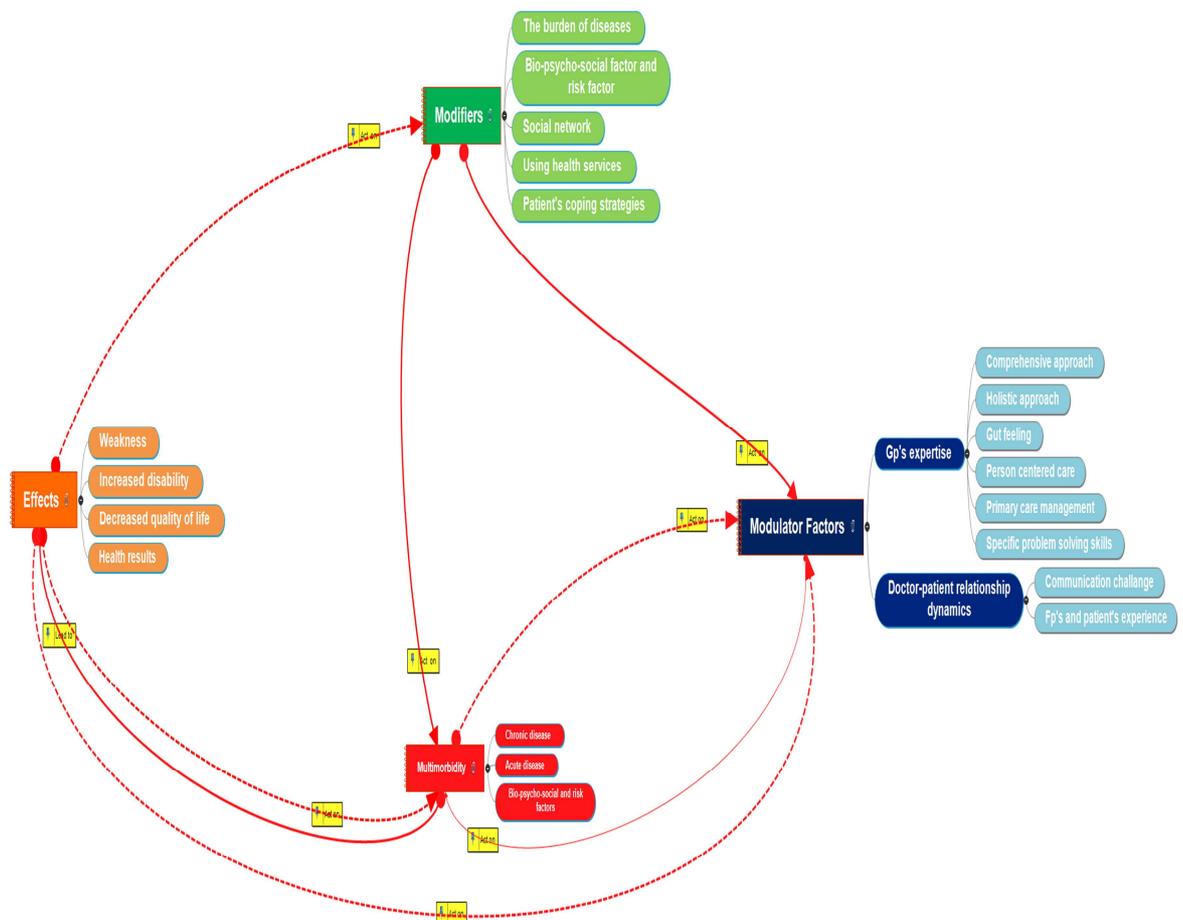
Academic themes and sub-themes integrated in the multimorbidity definition and their connections are represented below in [Figure 1](#) based on a concept maps [32]. This lightens the multimorbidity definition. Chronic disease, acute disease, bio-psycho-social factors and risk factors are assimilated in the intern definition. Others act like modifiers: bio-psycho-social factor, risk factor, the social network, the burden of disease, using health care services, and the patient's coping strategies. The effects of multimorbidity are: an increased disability, decreased quality of life, weakness. These may modify health status. Only the bio-psycho-social factors and risk factors integrate

in the same time the multimorbidity intern definition and modifiers. GP's expertise and doctor-patient relationship dynamics play as modulator factors of multimorbidity.

A conceptual map of multimorbidity was designed as a result of interaction of these four concepts. There is a correlation between the effects, modifiers and modulator factors: the management of a weak patient is different from a healthy patient. Firstly, it leads to a care management modification and then to an echo on the patient health status. Also the combination of a chronic disease with one or many modifiers develops multimorbidity which leads to weakness, increased healthcare consumption and decreased quality of life. In the meantime these modifiers could increase multimorbidity. Having a tool to identify and help multimorbid patients could be useful for GPs. It was highlighted that the needs of multimorbid patients can cause many possible outcomes of multimorbidity. At the present time researchers try to understand how this could be useful for family medicine and long-term care.

Figure 1: Concept Map of Multimorbidity using MidView 5 Business Copyright © 2002/2013

MatchView A/S



5. Conclusion

This study found all 11th multimorbidity themes defined by the literature review. Two more themes were added: GP's expertise and Doctor-patient relationship dynamics.

The forward-backward translation as a result of a Delphi procedure brought some minor linguistic alterations: GPs preferred "weakness" rather than "frailty" and the attribute "somatic" (risk factor) was omitted.

The Polish definition of multimorbidity could be:

“Wielochorobowość jest definiowana jako jakiegokolwiek połączenie choroby przewlekłej z przynajmniej jeszcze jedną chorobą (ostrą lub przewlekłą) lub z czynnikami bio-psycho-społecznymi (związanymi z nią lubnie) lub z czynnikami ryzyka.

Jakiegokolwiek czynnik bio-psycho-społeczny, czynnik ryzyka, sieć społeczna, obciążenie chorobami, korzystanie z opieki zdrowotnej i strategie radzenia sobie przez pacjenta mogą funkcjonować jako modyfikatory.

Wielochorobowość może modyfikować wyniki zdrowotne i prowadzić do zwiększonej niepełnosprawności lub obniżenia jakości życia lub osłabienia [35].”

The Polish final version translated into English:

“Multimorbidity is defined as any combination of chronic disease with at least one or more disease (acute or chronic) or with bio-psycho-social factors (related to it or not), or with risk factors. Any bio-psycho-social factor, any risk factor, the social network, the burden of diseases, using health services, and the patient's coping strategies may function as modifiers as it also does the GP's expertise and doctor-patient relationship dynamic. Multimorbidity may modify health results and lead to an increased disability or a decreased quality of life, or weakness [35].”

This new definition is intended to help Polish GPs to identify multimorbid patients. Qualitative research is needed in order to find the added value by GPs in the concept of multimorbidity.

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Faculté de Médecine & des Sciences de la Santé

AUTORISATION D'IMPRIMER

Présentée par M le Professeur

Titre de la thèse :

What are the topics for multimorbidity recognized in Polish general practice?

ACCORD DU PRESIDENT DU JURY DE THESE SUR L'IMPRESSION DE LA

THESE

En foi de quoi la présente autorisation d'imprimer sa thèse est délivrée à
Madame MODORCEA MITRAN Alexandra, interne en médecine générale.

Fait à BREST, le

VISA du Doyen de la faculté

Le Président du Jury de

Thèse, A BREST, le

Le Doyen, Professeur

C. BERTHOU

MODORCEA MITRAN (Alexandra) - What are the topics for multimorbidity recognized in Polish general practice?

Th. : Méd. : Brest 2014

ABSTRACT:

Introduction: Multimorbidity is defined according to the World Health Organization as the occurrence of two or more chronic conditions in one individual. The European General Practice Research Network (EGPRN) designed a new definition of multimorbidity, which was translated into 10 European languages. Polish is one of the participant countries. The aim of this study was to ensure that the definition is clear and useful. The research question was: What are the topics for multimorbidity recognized in Polish general practice? **Method:** Eleven semi-structured interviews with Polish general practitioners (GPs) were carried out. Data collection proceeded until saturation was reached. An open, axial and thematic coding was done in order to identify the criteria of multimorbidity for GPs. The multimorbidity academic definition (translated into Polish language) was the model to perform the analysis using a grounded theory framework. **Results:** 501 codes were extracted after 11 interviews. All the themes proposed by the EGPRN's definition were identified. Two new themes regarding GPs were identified: GP's expertise and Doctor-patient relationship dynamic. **Conclusion:** All the definition themes have been recognized by the Polish GPs. Two new themes appeared. The definition is closely related to primary care and could be useful in Long Term Care.

RESUME:

Introduction : L'organisation mondiale de la santé définit la multimorbidité par l'association d'au moins deux conditions médicales chroniques chez la même personne. L'European General Practice Research Network (EGPRN) a établi une nouvelle définition qui a été ensuite traduite en 10 langues européennes. La Pologne était un des pays participants. L'objectif de cette étude était d'évaluer quels étaient les critères de multimorbidité reconnus par les médecins généralistes polonais afin de savoir s'ils différaient de ceux de la définition académique. **Méthode :** Onze entretiens individuels semi-dirigés ont intégré des médecins généralistes polonais. Le recueil des données respectait les critères de variation maximale des échantillons et de saturation des données. Un codage ouvert, puis un codage axial et thématique a été réalisé afin de pouvoir identifier les critères de multimorbidité pour les médecins généralistes polonais. La définition académique de la multimorbidité (traduite en Polonais) a été utilisée comme modèle pour l'analyse en théorie fondée. **Résultats :** 501 codes sont ressortis de 11 entretiens individuels. La totalité des thèmes proposée par EGPRN a été retrouvée. Deux nouveaux thèmes étaient identifiés : l'expertise du médecin généraliste et la relation médecin-patient. **Discussion :** Tous les thèmes intégrés dans la définition de la multimorbidité ont été identifiés par les médecins généralistes polonais. Deux nouveaux thèmes se sont ajoutés. La définition est étroitement liée aux soins primaires et elle peut trouver son utilité dans les soins de longue durée.

MOTS CLES :

MULTIMORBIDITY ; GENERAL PRACTICE ; DEFINITION; PRIMARY CARE

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