

**INTERNATIONAL ACADEMIC PUBLICATION DOSSIER**

# **THE VIEN GUT MODEL**

**Integrated Outpatient Care for Complex Chronic Multimorbidity**

**Part A – FOUNDATIONAL DOCUMENTS**

**DOCUMENT A.4**

## **OPERATIONAL CONCEPT SET**

From the WHAT–HOW–DATA-to-operate framework to the four validation targets  
and the dialogue–validation pathway of the Vien Gut Model

The Vien Gut Model — International Academic Publication Dossier

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## **AUTHORS & ACADEMIC LEADERSHIP**

Nguyễn Đình Quang Independent medical researcher | Founder of Vien Gut | Overall design of the HOW — DATA-to-operate / operational layer

### **CONTRIBUTORS TO THE DESIGN OF HOW AND DATA-TO-OPERATE — VIEN GUT**

Nguyễn Đình Quang Huy Contributed to the design of HOW — DATA-to-operate | Systems operations management and transfer organization — The Vien Gut Model

Huỳnh Phước Đại, Nguyễn Sơn Patient-oriented language editing | Communications data management, implementation, and transfer support — The Vien Gut Model

### **ACADEMIC SUPPORT & WHAT (GUIDELINE) BENCHMARKING — INTERNATIONAL EXPERT GROUP**

Thomas Bardin, Pascal Richette Co-authors of the EULAR recommendations — together with experts in cardiovascular medicine, nephro-urology, hepatology, diabetes, diagnostic imaging, and biostatistics at Université Paris Cité and Sorbonne University, France. Transfer of the WHAT of guideline-based treatment for gout and comorbidities; international benchmarking for WHAT; support for the design of HOW — The Vien Gut Model.

### **DATA GOVERNANCE TEAM — VIEN GUT**

Trương Ánh Dương, Huỳnh Hồng Đức Data governance and transfer support — The Vien Gut Model

### **TREATING PHYSICIANS + MULTIDISCIPLINARY TEAM OF VIEN GUT GENERAL CLINIC**

Implementation of clinical HOW — risk stratification, windows of opportunity, longitudinal follow-up, risk control, multidrug management, and activation of transfer safety valves.

### **RESEARCH SITE**

France–Vietnam Center for Research on Gout and Comorbidities

Vien Gut General Clinic — 13A Hồng Hạ, Tân Sơn Hòa, Ho Chi Minh City, Vietnam

## **POSITION OF THIS DOCUMENT WITHIN THE ACADEMIC DOSSIER OF THE VIEN GUT MODEL**

Document A.4 is the central reference document of the academic dossier of the Vien Gut Model. If A.0 establishes the overall architecture, A.1 establishes the EBM reference framework, A.2 identifies the three layers WHAT – HOW – DATA-to-operate, and A.3 confirms the global HOW gap through international evidence, then A.4 has the task of deploying in detail the full operational terminology of the model in a unified language that can be referenced, compared, and shared across all subsequent documents.

A.4 belongs to Tier 1 — Basic Architecture of the full dossier. It does not describe specific clinical processes like Part B, does not present each disease axis like Part C, and is not the place for dialogue–validation like Part D. The role of A.4 is to place all central terms of the model — from terms that already exist in the international literature to terms developed by Vien Gut out of practical experience — within a clear reference frame that is consistent, transparent in origin, and sufficiently precise in meaning so that international reviewers can read across the entire dossier without conceptual discontinuity.

### **GUIDE FOR READERS OF A.4**

- To understand the overall architectural statement, read A.0.
- To understand the WHAT – HOW – DATA-to-operate EBM framework, read A.1.
- To understand the foundational definitions of the three architectural layers, read A.2.
- To understand the international evidence on the global HOW gap, read A.3.
- To quickly consult the condensed standardized table version, read A.5.
- To see how these terms are transformed into an operational model, read B.1–B.5.
- To see how these terms are applied to each disease axis, read C.1–C.n.

## SUMMARY

Document A.4 is the official operational dictionary of the Vien Gut Model. Every HOW term that appears in the dossier — from terms already established in international guidelines to terms developed by Vien Gut from real clinical operating needs — is compiled here using a single presentation structure: origin, operational definition, and international comparison or conceptual distinction.

A.4 does not seek to create a “private language” detached from the international literature. Its aim is the opposite: to clarify which terms Vien Gut uses exactly in their international sense; which terms are near equivalents or more concretely operationalized interpretations in the context of complex outpatient multimorbidity; and which terms were in fact developed by Vien Gut to name operational components for which the current literature does not yet provide sufficiently specific concepts.

A.4 is therefore a required document for correctly reading Parts B, C, and D.

## BACKGROUND

In most health systems, clinical terminology and operational terminology are often blended together. Guidelines use terms such as integrated care, care coordinator, risk stratification, transition of care, patient activation, monitoring, red flags, outcome, and response time. But once these terms are brought into outpatient treatment for patients with complex chronic multimorbidity, they are often not yet specific enough to function as real operational tools.

Precisely because it had to operate on patients with severely complicated gout accompanied by multiple chronic conditions at the same time, Vien Gut was compelled to differentiate and standardize terminology at a deeper level: what belongs to guideline-standard knowledge, what belongs to the model’s operational layer, what counts as data that triggers decisions, who holds the coordinating axis, where the patient still lies within guideline coverage, when the window of opportunity remains open, when the safety valve must be activated, and how those decisions can be traced and validated. A.4 was written to standardize that entire language.

## PURPOSE AND DRAFTING PRINCIPLES

Document A.4 is the central reference document of the academic dossier of the Vien Gut Model. Any international reviewer who encounters a HOW term anywhere from A.0 through Part D can consult A.4 and find a precise, consistent definition with an international comparison.

The drafting principles of A.4 follow three rules:

Rule 1 — Transparency of origin. Each term is clearly classified as: already established in the international literature (Group A), having an equivalent or near-equivalent meaning under another label (Group B), or developed by Vien Gut out of real clinical operating needs (Group C).

Rule 2 — Operational definition. A.4 does not prioritize abstract theoretical definitions; it prioritizes how the term is actually used in clinical practice at Vien Gut.

Rule 3 — International comparison. Each term is compared with the closest concept in international guidelines or integrated-care models so that both similarities and differences are explicit.

## GROUP A — TERMS ALREADY ESTABLISHED INTERNATIONALLY

The terms in Group A are used exactly according to definitions already established by the international medical community. Vien Gut does not change their meaning; it applies them to the LMIC context of complex outpatient chronic multimorbidity.

Code	Term	Origin and operational definition
A-01	Treat-to-target (T2T)	Source: ACR 2020, EULAR 2016. Operational definition: A treatment strategy in which therapy is titrated until a specific measurable target is achieved. In the Vien Gut Model, T2T is not applied only to the gout axis, but is expanded into goal-oriented thinking across four axes: gout, kidney, heart, and liver. International comparison / distinction: The meaning in the Vien Gut Model is consistent with the original

Code	Term	Origin and operational definition
		rheumatology definition of T2T; the difference is that the model extends the T2T principle to multiple simultaneous axes within one patient.
A-02	Crystal-free state	Source: EULAR 2006, EULAR 2016, ACR 2020. Operational definition: A clinical state in which monosodium urate crystals have been completely dissolved from joints, tendons, and soft tissues, confirmed by OMERACT ultrasound and/or DECT at the time of assessment. This is Verification Target No. 1 of the Vien Gut Model. International comparison / distinction: Vien Gut uses “crystal-free” in line with the international intent, but avoids equating it with “remission,” because remission may imply a clinical-symptom state, whereas crystal-free emphasizes a mechanistic–structural target.
A-03	Multimorbidity / complex chronic multimorbidity	Source: WHO 2016, Barnett et al. 2012. Operational definition: The simultaneous presence of multiple chronic diseases in one patient. In the Vien Gut Model, the phrase “complex chronic multimorbidity” is used for patients with four or more severe diseases, target-organ damage, and structurally conflicting treatments. International comparison / distinction: WHO often uses the threshold of $\geq 2$ chronic diseases. Vien Gut adds the “complex” tier to distinguish patients who are severe, multi-axis, and marked by multiple interacting pathological spirals, making single-disease guidelines difficult to apply.
A-04	Risk stratification	Source: Chronic Care Model, ESC, KDIGO. Operational definition: The process of classifying patients into different risk tiers based on disease burden, degree of stability, and likelihood of adverse events, in order to determine the appropriate monitoring rhythm and level of intervention. In the Vien Gut Model, T1–T4 stratification is a mandatory output of the first visit. International comparison / distinction: Unlike stratification by each disease separately, Vien Gut stratification is multi-axis and integrated.
A-05	Integrated care	Source: WHO 2016, Chronic Care Model, SELFIE. Operational definition: A model of organizing health services that coordinates multiple specialties, levels of care, and providers around the patient’s needs. International comparison / distinction: Vien Gut uses integrated care in its established international sense, but goes one step further by describing the concrete HOW required to make integrated care operational in complex outpatient multimorbidity.
A-06	Chronic Care Model (CCM)	Source: Wagner 2001. Operational definition: A foundational framework with six components: the health system, community, self-management support, decision support, clinical information systems, and delivery-system design. International comparison / distinction: Vien Gut inherits the spirit of the CCM but adds a more explicit HOW for severe outpatient multimorbidity, where decision support cannot stop at single-disease guidelines.
A-07	Real-world evidence (RWE)	Source: FDA, EMA, and the RWD/RWE literature. Operational definition: Clinical evidence generated from data collected in routine treatment practice. For Vien Gut, this is the evidence layer emerging from longitudinal cohort data of patients with severely complicated gout and complex chronic multimorbidity. International comparison / distinction: Vien Gut’s RWE has complementary value because it reflects patient groups that are often excluded from RCTs.

## GROUP B — TERMS WITH EQUIVALENT OR ALTERNATIVE INTERPRETATIONS

The terms in Group B have concepts that are close to, or equivalent with, those in the international literature, but Vien Gut uses a different label or operationalizes them more concretely to fit the context of complex outpatient chronic multimorbidity.

Code	Term	Origin and operational definition
B-01	HOW gap	Source: WHO know-do gap, Implementation Science. Operational definition: The structural gap between the WHAT of guidelines and the ability to organize integrated treatment in complex outpatient chronic multimorbidity. International comparison / distinction: Vien Gut uses “HOW gap” to emphasize that the missing layer is operational architecture, not simply the distance between knowing and doing.
B-02	Verification target	Source: treatment target, measurable endpoint. Operational definition: A treatment target that can be objectively confirmed through imaging, function, or standardized clinical events. International comparison / distinction: Vien Gut uses “verification target” to emphasize the requirement for objective confirmation, not merely a descriptively stated goal.
B-03	Clinical Conductor	Source: care coordinator, lead clinician, case manager. Operational definition: The physician responsible for overall coordination of the treatment plan, adjudication when guidelines conflict, activation of safety valves, preservation of the longitudinal care axis, and final responsibility for the logic of clinical priorities. International comparison / distinction: Unlike a passive care coordinator, the Clinical Conductor has both the authority and the duty to make inter-guideline priority decisions.
B-04	Fragmented care	Source: fragmented care, siloed care, uncoordinated care. Operational definition: A model in which each specialty applies its own guideline without structured coordination, leading to duplication, treatment conflict, missed events, and the burden of self-coordination being shifted onto the patient. International comparison / distinction: Vien Gut uses the term in its standard international sense and emphasizes that this is a structural consequence rather than an individual physician’s fault.
B-05	DATA-to-operate	Source: operational data, actionable clinical data, decision-relevant data. Operational definition: Longitudinal clinical data gathered and organized sufficiently to trigger HOW decisions in real time. International comparison / distinction: Unlike ordinary electronic medical records or retrospective research datasets, this is data meant for immediate action, not merely for storage.
B-06	Operational multidisciplinary team chain	Source: MDT in WHO, CCM, NHS. Operational definition: A multidisciplinary team organized not as periodic disconnected case conferences but as a continuous operational chain in which each component is both a sensor and a response point of the system. International comparison / distinction: Unlike conventional MDT case conferences, the Vien Gut MDT functions as a sensing–response chain.
B-07	WHAT – HOW – DATA-to-operate framework	Source: knowledge translation framework, implementation framework. Operational definition: A three-layer framework describing everything required to operate integrated care: WHAT as guidelines and evidence; HOW as structured clinical operations; and DATA-to-operate as longitudinal data that triggers decisions. International comparison / distinction: Unlike purely research frameworks, this is an operational framework for complex outpatient multimorbidity.
B-08	Dialysis deferral / RRT deferral	Source: KDIGO 2024, conservative kidney management. Operational definition: Verification Target No. 2 of the Vien Gut Model: maintaining a window of renal function and postponing kidney replacement therapy as long as possible in the setting of complex multimorbidity. International comparison / distinction: Vien Gut pursues this target simultaneously with gout T2T and therefore must resolve HOW conflicts between urate-lowering treatment and kidney protection.
B-09	Cardiac decompensation prevention	Source: ESC 2021, ACC/AHA HF guidance. Operational definition: Verification Target No. 3: stabilizing cardiac function, reducing worsening heart failure, and lowering emergency hospitalization for decompensated heart failure. International comparison / distinction: Vien Gut places this target in the simultaneous context of gout treatment and

Code	Term	Origin and operational definition
		kidney protection, making the HOW more complex than in isolated heart failure.
B-10	Hepatic recompensation	Source: Baveno VII, EASL, Caraceni et al. Operational definition: Verification Target No. 4: achieving and maintaining recompensation in patients with decompensated cirrhosis who still retain a window of opportunity for outpatient treatment. International comparison / distinction: Vien Gut places this target at the intersection of cirrhosis, gout, kidney, and heart disease — an area not fully covered by either hepatology or gout guidelines.
B-11	Follow-up SLA	Source: service management, turnaround time, response time. Operational definition: A commitment to response times among MDT components when clinical signals cross thresholds, for example 4 hours, 12 hours, 24 hours, or 48 hours. International comparison / distinction: Vien Gut brings the SLA principle from service management into outpatient clinical operations for complex multimorbidity.
B-12	Necessary conditions vs sufficient conditions	Source: logic, philosophy of science. Operational definition: The distinction between system-level elements that must exist for the model to operate at all (necessary conditions) and patient-side elements that must be present to convert the model into real outcomes (sufficient conditions). International comparison / distinction: Vien Gut operationalizes this pair of logical concepts in relation to windows of opportunity and patient participation capacity.
B-13	Onboarding	Source: patient enrollment, intake process. Operational definition: The structured process of bringing a patient into the model: assessment of multi-axis disease burden, risk stratification, evaluation of participation capacity, creation of a phase-based treatment plan, definition of action thresholds, and establishment of the baseline dataset. International comparison / distinction: Unlike ordinary intake, Vien Gut onboarding does not simply record information; it builds a personalized monitoring architecture from the outset.
B-14	Phase-based treatment plan	Source: phased treatment, stepped care, titration–maintenance. Operational definition: A strategy that divides the treatment journey into phases, each with its own goals, monitoring rhythm, transition thresholds, and HOW. International comparison / distinction: Vien Gut extends phase-based logic across multiple disease axes simultaneously within the same patient.
B-15	Complex chronic multimorbidity	Source: multimorbidity, highly complex multimorbidity. Operational definition: A clinical state in which a patient has four or more severe chronic diseases, multi-organ damage, structural guideline conflicts, and no guideline that describes an integrated HOW for the entire clinical profile. International comparison / distinction: Unlike multimorbidity as simple disease counting, “complex” here emphasizes structural conflict and operational burden.
B-16	Kidney function preservation in end-stage CKD	Source: KDIGO 2024, conservative kidney management. Operational definition: A strategy to maximally protect kidney function and delay or avoid kidney replacement therapy by simultaneously controlling the renal axis together with other axes, particularly gout and heart failure. International comparison / distinction: This is a deeper operationalization of B-08, emphasizing operation rather than only the endpoint.
B-17	Heart failure decompensation prevention	Source: ESC 2021. Operational definition: A strategy of longitudinal cardiac monitoring, medication-conflict management, and heart–kidney–gout coordination to reduce the risk of decompensation and hospitalization. International comparison / distinction: This is the operationalized version of B-09 in the context of multimorbidity.
B-18	Hepatic recompensation in end-stage liver disease	Source: EASL, Baveno VII, Caraceni et al. Operational definition: A strategy to achieve and maintain recompensation in patients with

Code	Term	Origin and operational definition
		decompensated cirrhosis who simultaneously carry other disease axes such as gout, CKD, and heart failure. International comparison / distinction: This is the operationalized version of B-10 in the overlap zone where multiple guidelines fail to cover the intersection.

## GROUP C — TERMS DEVELOPED BY VIEN GUT

The terms in Group C were developed by Vien Gut out of practical clinical operating needs when the international literature did not yet provide concepts specific enough to describe what was actually occurring in complex outpatient chronic multimorbidity.

Code	Term	Origin and operational definition
C-01	Clinical blind zone	Source: Vien Gut. Operational definition: A clinical zone in which the patient requires treatment but is not fully covered by any single-disease guideline because the evidence was generated within a reference frame different from the reality of the complex patient. International comparison / distinction: Close to an “evidence gap” or “clinical uncertainty,” but it emphasizes reference-frame mismatch rather than absolute absence of evidence.
C-02	Safety valve escalation protocol	Source: Vien Gut. Operational definition: A system of predefined clinical thresholds which, once crossed, triggers transfer or urgent intervention according to a defined SLA. International comparison / distinction: Unlike a rapid response system or generic safety netting, this is a multi-axis mechanism for integrated chronic outpatient care.
C-03	Clinical priority map	Source: Vien Gut. Operational definition: A tool for determining the order of intervention priorities when multiple guidelines conflict within the same patient. International comparison / distinction: Close to “competing priorities,” but operationalized as a clinical decision tool.
C-04	Structural fracture point	Source: Vien Gut. Operational definition: The point in the EBM chain at which the single-disease reference frame is no longer sufficient to operate safely on complex chronic multimorbidity. International comparison / distinction: Close to “implementation failure,” but emphasizing that the limit lies in the architecture, not merely in execution.
C-05	Operational conditions / enabling conditions	Source: Vien Gut. Operational definition: Diseases or accompanying conditions managed as prerequisites for the four verification targets to be achieved safely, rather than as independent verification targets. International comparison / distinction: Differs from generic “comorbidity management” because Vien Gut clearly separates these conditions from verification targets.
C-06	Guideline paradox	Source: Vien Gut. Operational definition: A situation in which doing each single-disease guideline correctly can still produce the wrong overall reference frame for the patient with complex multimorbidity. International comparison / distinction: Close to the “pitfalls of disease-specific guidelines,” but identified by Vien Gut as a structural paradox.
C-07	Reference-frame mismatch	Source: Vien Gut. Operational definition: The condition in which a guideline is applied to a patient population that lies outside the population for which the guideline was designed to be valid. International comparison / distinction: A more concrete way of naming the conflict between research populations and real patients.
C-08	Blind-zone map	Source: Vien Gut. Operational definition: A longitudinal data reference frame describing where guideline coverage still exists, where the border zone begins, and where the model must operate outside guideline coverage. International comparison / distinction: No sufficiently specific equivalent concept currently exists in the international literature.

Code	Term	Origin and operational definition
C-09	Sensing-response system	Source: Vien Gut. Operational definition: An architecture in which each component of the team both captures clinical signals and carries responsibility for responding when thresholds are crossed. International comparison / distinction: Unlike a static MDT conference model, this is a dynamic MDT.
C-10	Window of opportunity	Source: Vien Gut, compared with emergency and early-treatment literature. Operational definition: A longitudinal monitoring state in which the patient still has sufficient physiological reserve and sufficient risk-control conditions to pursue integrated outpatient treatment. International comparison / distinction: Unlike a fixed biological window in emergency care, here it is an operational state that can widen or narrow according to HOW and DATA-to-operate.
C-11	0–30 day reintegration loop	Source: Vien Gut. Operational definition: The period of reconstructing the treatment plan and intensifying monitoring after a break such as hospitalization or decompensation, with the aim of bringing the patient back onto the trajectory of integrated outpatient care. International comparison / distinction: Close to transition of care, but emphasizing reintegration of the entire multimorbidity system.
C-12	Clinical audit trail	Source: Vien Gut. Operational definition: A longitudinal record of the full chain of clinical decisions — who decided what, when, on the basis of which data, and according to which HOW threshold — so that the process can be traced and learned from. International comparison / distinction: Unlike audit trails in IT security, this is a tool for clinical accountability and continuous learning.
C-13	Operational MDT / sensing-response MDT	Source: Vien Gut. Operational definition: A deeper operational form of the MDT in which the seven components of the team function as a continuous sensing–response chain. International comparison / distinction: Unlike the traditional MDT conference, it operates continuously between visits.
C-14	Complete blind zone / double blind zone	Source: Vien Gut. Operational definition: The intersection zone of two or more guidelines in which both sides are silent, for example the intersection between severe gout and decompensated cirrhosis. International comparison / distinction: Not the “double blind” of an RCT; rather, it is a metaphor for an intersection completely uncovered by guidelines.
C-15	Multi-axis ULT titration	Source: Vien Gut. Operational definition: A way of titrating urate-lowering therapy while simultaneously considering uric-acid targets, kidney function, liver function, cardiac risk, and enabling conditions. International comparison / distinction: Different from titration in isolated gout; this is titration within a multi-axis intersection.
C-16	Flare control under treatment restriction	Source: Vien Gut. Operational definition: The architecture for managing an acute gout flare when NSAIDs, colchicine, and corticosteroids are all limited by CKD, heart failure, cirrhosis, or other complications. International comparison / distinction: This is a zone in which gout guidelines provide very little specific description for patients with severe multimorbidity.
C-17	Cardio-renal coordination during gout T2T	Source: Vien Gut. Operational definition: The method of simultaneously coordinating three aims — urate lowering, kidney protection, and prevention of cardiac decompensation — within a single treatment plan. International comparison / distinction: Close to cardiorenal thinking, but adds gout as an independent source of treatment conflict.
C-18	Three patient zones (green/yellow/red)	Source: Vien Gut. Operational definition: A tool for classifying patients according to whether they remain within guideline coverage, are at the border, or lie outside coverage but still remain sufficiently safe for outpatient operation. International comparison / distinction: No

Code	Term	Origin and operational definition
		international framework has operationalized degree of guideline coverage into a patient-zoning tool in this way.
C-19	Three-level patient capacity classification (A/B/C)	Source: Vien Gut; related to PAM. Operational definition: Classification of the patient's treatment-participation capacity into three levels: A — proactive; B — needs support; C — the team must take the initiative almost entirely. International comparison / distinction: Unlike PAM, it is directly linked to HOW design, SLA, contact frequency, and resource allocation.
C-20	Eight sufficient conditions for patient participation	Source: Vien Gut. Operational definition: Eight capabilities or conditions on the patient/family side that must be present to convert the model's necessary conditions into real outcomes. International comparison / distinction: Unlike readiness assessment, this is a fully operationalized set of conditions that can be managed longitudinally.
C-21	Structured patient training	Source: Vien Gut; related to ETP/self-management support. Operational definition: A process of training patients and families according to content, rhythm, and level appropriate to the A/B/C classification and the treatment phase. International comparison / distinction: Not only knowledge transmission; actual execution capacity must be verifiable.
C-22	Cooperation as an operational indicator	Source: Vien Gut. Operational definition: The patient's level of cooperation is not treated as a subjective impression but as a variable that must be measured, reviewed periodically, and used to adjust HOW accordingly. International comparison / distinction: Unlike pure adherence, this is an operational indicator of the treatment system as a whole.
C-23	Patient behavior science	Source: Vien Gut; related to COM-B and behavioral medicine. Operational definition: A way of viewing the patient not as a passive object but as a behavioral agent who can be predicted, trained, supported, and managed within a structured longitudinal monitoring system. International comparison / distinction: Vien Gut integrates behavioral logic directly into outpatient operations rather than separating it into a distinct educational track.
C-24	Sensing-response chain	Source: Vien Gut. Operational definition: The smallest operational unit of the model: collect signals, confirm threshold crossing, respond according to SLA, record the decision log, and reassess. International comparison / distinction: Unlike an administrative workflow, this is a real-time clinical response chain.
C-25	Decision pivot	Source: Vien Gut. Operational definition: A branching point at which a clinical decision has major consequences for the entire treatment journey, such as escalating the monitoring tier, changing phase, or initiating transfer. International comparison / distinction: Close to a decision node, but tightly tied to the audit trail, clinical priorities, and window of opportunity.
C-26	Decision log	Source: Vien Gut. Operational definition: A record capturing the context, data, rationale, and responsible person for each important decision throughout treatment. International comparison / distinction: Unlike an ordinary progress note, it focuses on the decision itself and the logic behind it.
C-27	Pathological spiral	Source: Vien Gut. Operational definition: A chain of interactions in which deterioration along one disease axis drags another axis downward, creating an adverse positive-feedback loop over time. International comparison / distinction: Close to a vicious cycle, but Vien Gut uses it as an operational tool to describe and interrupt the chain.
C-28	Conflict-resolution matrix	Source: Vien Gut. Operational definition: A tool to adjudicate between guidelines or treatment targets when they conflict within the same

Code	Term	Origin and operational definition
		patient. International comparison / distinction: Close to clinical trade-offs, but operationalized as a structured matrix.
C-29	Visual Medicine	Source: Vien Gut. Operational definition: The use of clinical images, ultrasound, X-ray, DECT, and before–after video as both operational data and as tools to reinforce adherence. International comparison / distinction: Unlike imaging used solely for diagnosis, here images are also a component of HOW and DATA-to-operate.
C-30	Caliper mm <sup>2</sup>	Source: Vien Gut. Operational definition: A method of quantitatively measuring crystals or tophi on ultrasound using caliper-derived area in mm <sup>2</sup> for longitudinal follow-up rather than relying only on semi-quantitative description. International comparison / distinction: Different from OMERACT 0–3 scoring in that it increases quantitative resolution for longitudinal monitoring.
C-31	Learning feedback loop	Source: Vien Gut. Operational definition: The cycle in which clinical outcomes and the audit trail are analyzed to adjust HOW for the current patient and improve the model for future patients. International comparison / distinction: Close to a learning health system, but focused at the level of an integrated outpatient model.
C-32	Window of opportunity — operational criteria	Source: Vien Gut. Operational definition: A set of criteria distinguishing whether the window of opportunity is open, narrowing, or closed, used as an operational tool in clinical decision-making. International comparison / distinction: Unlike generic biological-window concepts, these are concrete operational criteria.
C-33	Integrated outpatient care model for complex chronic multimorbidity	Source: Vien Gut. Operational definition: The central concept describing the entire integrated outpatient architecture of Vien Gut: four verification targets, structured HOW, longitudinal DATA-to-operate, the Clinical Conductor, the operational MDT, safety valves, and dialogue–validation. International comparison / distinction: Unlike integrated care at the level of principle, this is the name of a concrete operating model.
C-34	Multi-organ chronic damage	Source: Vien Gut. Operational definition: A state in which the patient simultaneously carries damage in multiple target organs, each organ being both a treatment target and a limiting barrier for treatment of the others. International comparison / distinction: Different from multimorbidity understood merely as multiple diagnosis labels; it emphasizes genuine multi-organ structural injury.
C-35	Multiple interacting pathological spirals	Source: Vien Gut. Operational definition: A state in which several pathological spirals operate at the same time, amplifying one another and rapidly narrowing the margin of treatment safety. International comparison / distinction: This is a higher level of complexity than a single pathological spiral and is appropriate for the most severe patients received by the model.

## RELATIONSHIP AMONG THE THREE GROUPS OF TERMS

Group A ensures that the Vien Gut Model does not detach itself from the international literature. These are the terms whose original meaning the model inherits intact.

Group B helps transform concepts that are near equivalents in the international literature into clearer operational tools for the context of complex outpatient multimorbidity.

Group C provides names for components that practice made necessary, but for which the current literature does not yet offer sufficiently specific terminology.

These three groups are not opposed to one another. They form an academic continuum: from inheritance of international standards, through operational reinterpretation, to the creation of new operational concepts when needed. This is the language logic of the entire academic dossier of the Vien Gut Model.

## LIMITS OF THE DOCUMENT'S SCOPE

A.4 includes: its purpose and drafting principles; classification of term origins; operational definitions; international comparison or conceptual distinction; and systematization of the full HOW terminology used across the dossier.

A.4 does not include: biomarker tables, laboratory thresholds, imaging modalities, or abbreviation tables; those belong to A.5. A.4 also does not replace the process documents of Part B or the applied documents of Part C. A.4 is an operational dictionary, not a case-report document or a treatment protocol.

## THE POSITION OF A.4 WITHIN THE VIEN GUT DOCUMENT SYSTEM

A.4 is the central reference document of the dossier. After A.0–A.3, once the reader has understood the overall architecture, the EBM framework, the three layers WHAT – HOW – DATA-to-operate, and the international evidence of the HOW gap, A.4 performs the step of language standardization. From A.4, the reader can proceed to A.5 for the condensed standardized table, or go directly to Parts B and C without conceptual discontinuity. If A.2 defines the three foundational layers, A.4 defines the full operational language of the model.

## CONCLUSION

Every substantial academic model requires a clear operational language. In complex outpatient chronic multimorbidity, this is even more important because small distortions in language can lead to distortions in understanding, operation, and validation. A.4 was built to ensure that this does not happen in the dossier of the Vien Gut Model.

A.4 does not aim to create a terminology system detached from the international literature. On the contrary, it makes transparent the relationship between the model and the international literature: what is inherited intact, what is re-operationalized to fit complex outpatient multimorbidity, and what Vien Gut has been compelled to newly identify from practice. That transparency is precisely what makes A.4 an indispensable foundational document of the entire dossier.

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