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Editorial

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The Challenge of Managing the Elderly Patient

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We assist at a profound demographic change, which is the rapid aging of the society. Although some people reach a very old age completely free of physical ailments, most seniors are exposed to increasing frailty, disability and poor quality of life. More often than not, they have multiple concomitant diseases, which are more and more difficult to manage by the general practitioner alone. It is extremely challenging to establish a good medical approach in elderly patients, and in order to get a complete evidence of all medical problems and to prevent or reduce complains from the patients or their families, the doctors prefer to order numerous extra tests, procedures and interdisciplinary consults – best known as defensive medicine - which would result in more and more drugs and dietary restrictions recommended, and which would end up in polypharmacy, therapeutical non-compliance and iatrogeny.

Defensive medical practices can be either positive or negative. When extra procedures are performed primarily to reduce malpractice liability, it is considered a positive defensive medicine. Avoidance of certain patients and procedures, thereby withdrawing medical services and denying patients care is negative defensive medicine. Both practices are becoming professional behavior in medical practice, thus increasing the cost of healthcare and sometimes lowering the quality of the service provided to the elderly population. Each medical consult will increase the risk of exposing the patient to aggressive investigations (contrast investigations, endoscopy, catheterism) and to polymedication, usually prescribed by different specialists that do not know about the existence of each other. In the end, in the absence of an astute GP or a geriatrician, the senior patient is highly exposed to unnecessary medication, potentially inappropriate prescribing and non-adherence.

Senior patients are particularly vulnerable to unnecessary medication and to unwanted side-effects of the drugs, mainly due to the aging process itself, with alterations of the main systems responsible for the pharmacokinetics and pharmacodynamics of the drugs. There is other several factors related to different markers of old age, such as physical handicap (weakness, arthritis, tremors, postural hypotension and tendency to fall) or functional barriers, such as memory loss (they simply forget to take their medication on time), confusion (it occurs especially with multiple drugs and complex regimens), insufficient income, multiple pharmacies, solitude.

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It is extremely challenging to establish a good medical approach in elderly with multiple dietary recommendations and numerous drug regimens as one should try to reconcile the medical benefits of the treatment with the possibilities of each patient to fulfill it. Elaborating a personal, realistic therapy is the main key for providing a good compliance, an excellent evolution of the diseases and quality of life at least as good as the patient's expectations.

Therapeutically non-compliance represents the extent to which the patient's behavior does not follow medical recommendations. Physicians are unable to predict patients' non-compliance at rates better than chance. When a medical professional asks about compliance, patients tend to exaggerate ("white coat" effects). Studies have shown that one out of every four seniors were non-adherent to their medications. Therefore, patients' self-reports usually overestimate compliance by a significant amount.

Causes of medication non-adherence are often multi-factorial but can be broadly separated into two categories: intentional and non-intentional. Intentional non-adherence is an active process whereby the patient chooses to alter the medical treatment, motivated by a rational decision-making process. Unintentional non-adherence is a passive process in which the patient may be careless or forgetful about the treatment, or the patient can be fearful of complications (especially those who had already experienced such problems previously), or has no faith in the physician, all along with general disapproval of medications, and concern over side effects. One very important factor leading to non-adherence is overprescribing, especially in senior patients with difficult medical schemes or with cognitive disorders, sensory and motor deficiencies and lack of a familial or social support for the possible handicap; more than once, drug posology is usually inappropriate.

While there is no foolproof method that will guarantee the detection of adherence or non-adherence, physicians are encouraged to try more than one strategy and to implement an adherence plan early in the treatment process. An authoritarian and dictatorial manner can alienate some patients, particularly those who prefer participatory involvement. Patients are more likely to follow the advice of doctors who are seen as warm, caring, and friendly or to adhere to prescriptions when they are convinced that the medication they are taking is clearly linked to health improvement. It is more likely to increase compliance when the patient is made an active participant in the decision-making process regarding the medications.

Elders and caregivers recognize medication non-adherence as a community-wide issue and are eager to offer solutions they believe would work in their communities. These solutions can lend credibility to strategies currently being developed and offer innovative recommendations for future interventions. Elderly patients need a careful monitorization and a refined therapeutical individualization, which should take care of the patient's and his family's needs and respect the rules of informed consent; these patients should have a multidisciplinary approach without excessive hospitalization due to the complex psycho-social context of the patients himself.

When treating elderly patients, one must determine the proper combination of a beneficial effect and an acceptable level of the often unavoidable adverse side effects of the drugs. The challenge lies in finding the proper balance between efficiently treating the

disease and avoiding harm to the patient. There are medications that should be generally avoided in elderly patients and doses or frequencies of administration that should not be exceeded. Medicines that are considered potentially inappropriate lack evidence based indications, are not cost-effective and may pose a higher risk of adverse events including increases in morbidity, adverse drug events, hospitalization and mortality. In terms of assessing the appropriateness of prescribing in older people, both implicit and explicit measures of process (providers' actions) and outcome (e.g., adverse drug events) are used. Implicit process measures involve a clinician's judgment of appropriateness for the individual patient based on patient characteristics and published work. Explicit process measures are criterion-based and are derived from published evidence based reviews, expert opinion and/or consensus.

An ethical dilemma in determining the treatment of an elderly person occurs when in order to simplify the treatment scheme, we need to choose – from the total of drugs correctly prescribed, according to the guidelines – only the most important ones, with low risk of side effects. How do we choose? Do we have the right to choose? There are several tools created on this purpose, Beers criteria, START/STOP criteria, The GerontoNet ADR Risk Score, Inappropriate Prescribing in the Elderly Tool (IPET), but the final decision rests with the medical team.

Conceiving a long-term therapeutic plan for a senior patient calls for a multi-factorial approach. When prescribing, one must take into account the patient as a whole, including his or her life expectancy and quality of life within a social and economical environment. We should also bear in mind that our therapeutic plan should change the style of life of our patients and their families for a long time. In order to succeed, we need a tailored plan and the full participation and collaboration of our patient, our partner.

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