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Letter to editor

Overtreatment in elderly care: ethical considerations

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To the Editor,

One of the biggest challenges facing Western societies is demographic change and the rapid growth of the population over 65. This increase in average life expectancy, associated with improved health care delivery, has resulted in an increase in the prevalence of various chronic pathologies and the consequent need to use medicines to control these same pathologies (1). This multimorbility situation leads to concomitant use of several medicinal products, i.e. polymedication. Polymedication is considered a global public health problem, assuming a particular dimension in the elderly, where the consumption of medicines is more prevalent (2, 3).

The administration of medication is not at all an innocuous process, especially in the elderly due to the structural and functional physiological changes specific to aging that lead to pharmacokinetic and pharmacodynamic changes that compromise the efficacy and safety of medicines (4). In this context, the *American Geriatrics Society* (2019) recently updated the list of drugs considered inappropriate for the elderly, incorporating new scientific evidence on the drugs most used by the elderly, supported by more information around geriatric care and specific pharmacotherapy (5).

Due to the presence of multimorbilities, polymedication, increased use of inappropriate medications for the elderly, the elderly person is exposed to an increased risk of adverse drug events, with harmful effects on the health and quality of life of the elderly. In these circumstances, where the damage of intensive control of pathologies probably exceeds the benefits, we speak in the notion of "overtreatment" (6). Overtreatment is not a new concept, it is used to mean unnecessary medical or surgical interventions. However, it has recently become a public health problem, whose reasons most commonly pointed out by clinicians as a cause of this over-prescription are fear, neglect and pressure of the patient (7).

In addition to these reasons, we also highlight a certain "dictatorship" of the treatment guidelines for the various chronic pathologies, which do not discriminate the old person with various diseases of the young adult patient (8). In this sense, the individualized approach in the practice of care to the old person, with regard to pharmacological treatment, imposes an ethical reflection and deliberation. To the extent that drugs are substances with proven biological activity, they are therefore at higher risk for the older person. In view of the physiological weaknesses common in the elderly, the use of medicines should be based on the ethical principles of caution and non-maleficence. This means conducting a clinical trial with the responsibility of weighing the risks and benefits of medicines and making a choice.

This choice can have two possible paths. It can go through a decision based on the rigidity of the guidelines directed to the pathology and less to the person. Instead, it can go through a decision based on clinical experience, adjusting doses and dosages against the specific pathological condition of the old person. In this context, applying the principles of prudence and non-maleficence consists of making reasonable and balanced decisions for a specific person.

By embodying good professional practice in a relationship of closeness and respect for the dignity of the person, the prescription of medicines to the elderly citizen must consider the right of the person to participate in this decision-making. Looking at

the needs, interests and values of the person and full respect for the autonomy of the old person, the prescription of medicines constitutes a shared responsibility for a good that both have the duty to care for and protect - health. In this regard, the various studies suggest that the development of a relationship of trust between the physician-elderly is an important and decisive factor to reduce the excess prescription (9). We know that the present time does not favor or promote communication and interpersonal relationships between health professionals and patients to ask questions about the medication that is prescribed. This situation ends up exposing the elderly to an unnecessary risk, related to the side effects and adverse reactions of the medicines, which often cause them harm.

Thus, the increased vulnerability of people of geriatric age justifies that the counseling and use of drugs in this group be carried out in a personalized way, considering the interests and will of the patient, so that the final choice complies with all the precepts of a correct deliberation from the clinical point of view, but also ethical.

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INVITED COMMENTARY

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Multimorbidity and polypharmacy: a risk factor for older patients

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Multimorbidity and prolonged use of addictive medications are prevalent among older patients and is known to increase the risk of adverse drug events. In the last 20 years this tendency has significantly increased. Not only poly-pathology, but also other factors such as prescription accumulation and self-medication concur to make this phenomenon increasingly common and dangerous. While effective medical treatment should be associated with improved health status and survival, use of multiple drugs remains an important risk factor for hospital admission, adverse drug reactions and mortality in the aged population. Multiple substance use may aggravate disease burden of older patients, but there is the tendency to look

selectively for evidence of impact ("confirmation bias") that leads to seek only evidence that supports what is believed to be true. Physicians may be particularly susceptible to that bias when caring for a patient with a complex illness. When a patient has multiple medical problems, it's often possible to find some evidence of improvement by chance after any intervention, particularly if the patient is being intensively monitored.

"Polypharmacy" usually describes the accumulation of 5, and often more, medications and in advancing age frequently results in drug therapy problems related to interactions, drug toxicity, falls with injury, delirium, and nonadherence (1),and is associated with resulting increased hospitalizations and higher costs of care for individuals and health care systems. Unplanned 8.6 million hospital admissions in Europe every year caused by adverse drug events: 59% are preventable and 70% of these are in patients over 65, on 5 or more medicines (2,3).

Many papers reported polypharmacy and hyper polypharmacy among old and very old are strictly associated with the risk of multiple potentially inappropriate prescriptions, in all settings of care. And older people are more likely to have an inappropriate prescription after hospitalization.

To fight these negative effects a strategic reduction (deprescribing) of medications is compulsory ,in agreement by patients and their families, advocates, and care teams. Patients with terminal illnesses or those moving toward a comfort-care emphasis benefit from medication adjustments that are recognized beneficially within each patient's care goals. In caring for older adults complicated regimens and high-risk medications requires a care plan to reduce or prevent medication-related problems and costs, that are associated with polypharmacy (4,5).

Deprescribing is the planned process of reducing or stopping medications that may no longer be of benefit or may be causing harm. The goal is to reduce medication burden or harm while improving quality of life (1-5). And all physician interested into the care of old and oldest people must remember the 4th of the TEN COMMANDMENTS of the IAGG-ER: "Demonstrate sufficient knowledge of pharmacology to understand the principles of prescribing for older people, with special attention to adverse effects. Recognize the risk of prescribing tranquilizers, hypnotics, anti-hypertensive, and the inadequacy of polypharmacy in the oldest. Regard withdrawing a drug is as important as prescribing one. Avoid prescription of a new drug to treat side effects of another one" (6).

Conflict of Interest: Author declares that she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article

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