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EDITORIALS

Prescribing for Older Adults: Finding the Balance

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On the other end of every prescription is a person with a biologic makeup that will react well, poorly, or not at all to the chemical just prescribed.

In older adults, the likelihood of a poor reaction to medication increases with the number of drugs taken together, the exaggerated pharmacologic effect that occurs in this age group, and the general difficulty maintaining homeostasis that sets in as we age.[1]

In this issue of *American Family Physician*, the article by Pham and Dickman[2] will help physicians find the balance between the potentially lifesaving benefits of medication and the life-threatening complications of these drugs. The authors give practical advice on avoiding overuse, misuse, and underuse of medication in older adults.

They advocate "rocking the boat" when it comes to prescribing in older adults, actively looking for potentially dangerous medicines or combinations rather than waiting until a problem occurs. An aid to identifying unnecessary or risky drugs is the Beers criteria,[3] which have become the *de facto* standard for evaluating drug prescribing in older patients. Although based more on expert consensus than firm outcomes data, the criteria are reasonable and have stood the test of time. Some older patients will benefit from receiving medicines listed as potentially inappropriate; however, the typical older patient will be better off if these drugs are avoided.

There is another category of drugs that does not get as much attention: the "medicines of minimal gain." Much drug therapy in older adults is to prevent illnesses by decreasing risks that will never affect them. We treat hypertension, hyperlipidemia, osteoporosis, and other *risk factors*—these are not diseases—just as we would in younger persons. The benefit of these treatments in older patients either has not been evaluated or, if it has, is extremely small at the level of the individual

patient. In this context, the adverse effects (e.g., falls from hypotension, esophagitis from bisphosphonates, or cost of lipid-lowering therapy) are not balanced by the potential for benefit. Geriatric care has been described as the art of taking older adults off drugs they no longer need. This should be the goal of medication management in older patients. A stack of prescriptions should be accompanied by an instruction sheet that includes a list of medicines to be discontinued.

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