editorial

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Wise therapeutic decisions for older patients

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Treating older patients is challenging. They present age-associated morphological and physiological changes; they have an increasing risk of frailty and multimorbidity and physical and cognitive functional deficits—all resulting in a higher vulnerability including a higher risk for adverse drug events (ADEs). ADEs are a frequent cause of avoidable hospital admissions in older patients. The single greatest predictor of ADEs is polypharmacy, the high number of medications that patients are being prescribed even in accordance with existing clinical guidelines for each of the multiple individual conditions diagnosed. These guidelines are usually for single conditions, they are not appropriate for older patients who often have multiple coexisting, mostly chronic conditions. They help drive polypharmacy by telling doctors when to start medications but not when to stop them. The scale of polypharmacy-related harm in the older patients is underestimated; it adds to the challenge of aging and avoidably drives the cost of the health-care system [1].

It still is an unresolved issue that despite being the most frequent users of most drugs, the growing group of geriatric patients is under-represented in clinical trials, thus making it difficult to evaluate the efficacy and appropriateness of drug treatment interventions proposed in clinical practice guidelines based on evidence from trials disregarding the geriatric dimension. This is particularly true for chronic conditions in the context of frailty and multimorbidity that is still being largely ignored by most of the clinical practice guidelines whose focus is only on individual disorders. Drug treatment options extrapolated from evidence gathered in younger populations cannot be directly applicable to older patients with their physiological status altered by normal aging.

It is important to avoid unnecessary, inappropriate, potentially harmful therapies and medical interventions especially in the frail, vulnerable, chronically multimorbid older patients. The initiatives presented and discussed in this issue of the *Wiener Medizinische Wochenschrift* not only suggest to doctors and patients what not to do in their individual situation, efforts are being made to present an evidence base for the recommendations. They also intend to engage patients, their caregivers, and doctors in discussions about the meaningfulness, the appropriateness, and the safety of medications and procedures, about their potential risks and benefits in the individual situation. It is a common geriatric experience that as one gets older, benefits of many medical interventions go down and their risks go up. The weighing of potential risks and benefits is a process that requires active and informed participation of the patient whose individual goals of care and individual perceptions of quality of life have to be taken into account. Issues such as redundancy of interventions and unnecessary health-care expenditures are also being addressed.

"Overtreatment" should not be the only issue. Of course, there still is legitimate concern of not providing indicated therapies to geriatric patients, a certain level of age discrimination—ageism—might be the reason for such "undertreatment." Examples for this problem: insufficient therapy of osteoporosis, pain, cognitive disorders, or the low rate of vaccination in the geriatric population.

Overtreatment occurs frequently, especially in the very frail patients nearing their end of life when a palliative care approach would be indicated. "Deintensification" of therapy, "deprescribing," can be done based on available evidence systematically and safely without harming the patient [2]. This would be rather new in our

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health-care system, where one is more concerned about failing to do something rather than doing too much.

Physicians should be aware of situations when guidelines are not of much help—like in the complex, multimorbid, frail geriatric patient. There is still little explicit rationing of medical services in the Austrian health-care system. Some degree of implicit rationing may be considered to be the motive behind initiatives modeled after "Choosing Wisely," or "smarter medicine" with their motto "less is more." But, of course, it is not about saving money by not providing useful, indicated, efficient pharmacological treatments that are also in accordance with the individual informed patient's goals. These initiatives are also all about patients' participation and shared decision-making between the patient and the physician. They have another ethical dimension that must not be overlooked: the ethical debate in this context should not be one about rationing finite resources, it should rather focus on avoiding futile or wasteful spending of resources that could be allocated to benefit others, which is also an ethical responsibility of medicine.

Compliance with ethical standards

Conflict of interest
The author declares no conflict of interest.

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