

RCPE Symposium – Medicine of the Older Person: Now the drugs don't work: challenging polypharmacy

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The Medicine for the Older Person symposium was held Thursday 21 March 2019 at the Royal College of Physicians of Edinburgh

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With an ageing and increasingly multimorbid population come the challenges and uncertainties of polypharmacy. The number of people prescribed 10 or more medications has quadrupled in the last decade. This symposium provided balance and advice on prescribing for common conditions of older age.

Session 1: Turning prescriptions into recipes for health

Professor Frances Mair (University of Glasgow) encouraged us to consider the burden of multimorbidity and treatment for our patients through 'minimally disruptive medicine'.¹ We were challenged by the realisation that without treatment adherence, effective treatments cannot achieve an optimum outcome. To improve adherence we must focus on increasing patient knowledge and reducing treatment burden. From a quality and safety perspective, we must remember that we do not know the 'never events' of prescribing more than four medicines together and that the burden of treatment should be considered a barometer of *quality* care. We were urged to make our systems easier to navigate and to rethink our diagnostic pathways.

Professor Nina Barnett (London North West Healthcare NHS Trust & NHS Specialist Pharmacy Service) advised 'trials of stopping medications', in place of traditional 'deprescribing', and taught us that there must be ongoing review thereafter. Patients and their advocates need to be engaged in this process and why we hope it will benefit them. Successful deprescribing should result in <10% of patients needing to restart medicines owing to symptoms. This can be achieved with attention

to three essential components: best available research evidence, clinical judgement, and an attention to the patient's circumstances and goals. Professor Barnett highlighted some excellent resources: The Good Palliative Geriatric Programme Algorithm² and the Canadian Deprescribing Network website.

Dr Martin Wilson (Raigmore Hospital, Inverness) introduced the third edition of Polypharmacy Guidelines.³ Dr Wilson reminded us of the challenges of translating evidence and guidelines to an older population with frailty. The evidence that anticholinergic medications accelerate functional decline was addressed. Dr Wilson advised us to take a confident yet person-centred approach to deprescribing and to do so with 'hard heads and soft hearts'.

Session 2: Non-pharmacological therapies – just say 'no' to drugs?

Workshops explored a variety of specialist approaches: sit less, move more, end pyjama paralysis, reverse the cascade to dependency, non-pharmacological management of delirium, nutrition in old age and rehabilitation after stroke.

The Sir Robert Sibbald Lecture was delivered by Professor Antonio Cherubini (Istituto Nazionale di Ricovero e Cura per Anziani, Italy). This gave a comprehensive overview of the evidence base for non-pharmacological therapies in geriatric syndromes, which has been extensively investigated through the SENATOR project and ONTOP (Optimal Evidence-Based Non-drug Therapies in Older People) studies.⁴ Individualised

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multicomponent interventions (including exercise, medication review, fluid/nutritional therapy and staff education) can reduce rates of geriatric syndromes in the community, nursing homes and hospitals. We were encouraged to remain vigilant as 'delirium prevention needs obsessive staff'. We must address *all* factors in *all* patients, *all* the time.

Session 3: Prescribing in practice

Ms Jacqueline Kelland and Ms Ruth Campbell (both NHS Lanarkshire) highlighted the role of practice pharmacists and the impact of prescribing on social care requirement. Aligning medication timings to care visits resulted in over 1,000 hours of social care being released. We were encouraged to adopt a holistic approach to medicines management whilst remaining patient centred. There is a need to appreciate that reduction in care visits can lead to potential client harm including increased social isolation.

Professor Derek Stewart (Robert Gordon University, Aberdeen) gave a balanced account of use of multicompartiment compliance aids (MCAs): they can be useful but there are definite caveats. Evidence-based medicine in this area is challenging owing to difficulty in measuring adherence. Studies have shown that barriers to MCA use include: lack of dexterity and necessity for medications to be outwith MCA owing to the use of sustained release and as-required medications. There is a challenge with flexibility using MCAs with medication changes and following *sick day rules*: we must address such issues when discussing MCAs with patients and carers.

An update on the pharmacological treatment of delirium was delivered by Dr Ajay V Macharouthu (NHS Ayrshire and Arran) with reference to the SIGN guidelines.⁵ Studies have shown no benefit, and potential harm, with use of antipsychotics, anticholinesterases or benzodiazepines in management of delirium. Expert opinion may support use of medication in *crisis*. If medication for delirium is commenced, this should be reviewed *daily* and stopped as soon as possible.

Session 4: Ethical dilemmas in optimising treatment

Best interest feeding decisions are common: Dr Andrew Stanners (Mid Yorkshire Hospitals NHS Trust) challenged

us with an interactive case. The patient's wishes must be established by any means possible. Gaining a second opinion and seeking ethical support can be beneficial. Where proxy decision-makers are assisting in decision-making, the absence of pressure in meetings is paramount and Dr Stanners suggests promoting single-step decision-making.

Dr Premila Fade (Northwick Park Hospital, London) delivered an engaging session on end-of-life decisions. We are often challenged with discussions surrounding do not attempt cardiopulmonary resuscitation (DNACPR) forms and the legal implications. Dr Fade highlighted that professionally we may feel that something is *inappropriate* but this can be subjective. We were reminded that DNACPR forms are legally *advisory*. We were challenged to consider whether completing a DNACPR form serves to avoid our discomfort or that of the patient. Dr Fade stated that when documenting a reason for *not* discussing resuscitation, it must be felt that discussion would cause *significant harm* rather than distress.

The conference concluded with a lively debate between Dr Graeme Hoyle (NHS Grampian) and Professor Carmel Hughes (Queen's University, Belfast). Dr Hoyle argued that older people are *routinely* overmedicated whilst Professor Hughes debated against this motion. Dr Hoyle argued that the crux to this discussion is the word *routinely*: sometimes polypharmacy is justifiable. The concept of over investigation was raised, as this drives polypharmacy and we should be discouraged from viewing patients as 'a collection of diseases'. Dr Hoyle's passionate offering stems from his view that our goal as geriatricians is to help older people to live and die well. Professor Hughes expanded on the idea of *appropriate* polypharmacy⁵ and encouraged us to think beyond reducing the numbers of medications. She noted that multimorbid patients taking no medications were more likely to be admitted to hospital, suggesting it is multimorbidity as opposed to polypharmacy driving admission. Professor Hughes certainly persuaded some delegates to embrace the appropriate polypharmacy model but the majority remained for the motion.

Following an inspiring day, delegates left with the encouragement to remain vigilantly patient centred and reduce the burden to our patients and our system that comes from polypharmacy, whilst bearing in mind the idea that there is a cohort of patients for whom 'appropriate polypharmacy' exists.

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