EDITORIAL

The right medicine

A now emeritus professor of geriatric medicine once said that the only thing that protects elderly people from their medicines is their inability to take them as directed. The world has moved on, but perhaps not as much as we would like to think. It has long been known that there is a link between age and increasing frequency of adverse drug reactions (ADRs) [1–3], and more recently there has been much publicity attached to published work on deaths and hospitalisation associated with ADRs [4–7]. There is often a need for multiple medicines, most of which are remarkably safe, but risks and benefits can be hard to balance in individual cases. We now know that many modern medicines are hugely beneficial to elderly people, but getting it right is a complex business. There used to be much concern about non-compliance, but that has (rightly) given way to concepts of concordance and appropriateness of prescribing [8, 9].

The paper by Batty and colleagues in this issue describes a large audit project using prescribing indicators, tools used to monitor appropriateness of prescribing. Their previously published detailed methodology paper is important and deserves the attention of the interested reader [10]. Indicators were developed over a long period, then piloted and refined before use in this large centrally funded multi-centre project. A cross sectional approach was used and information gathered on a range of issues in sites across England, Wales and Northern Ireland. With respect to descriptive indicators may well become available to conduct. Some of the information gleaned with respect to descriptive indicators may well become available from electronic systems of medicines management advocated in the report ‘A Spoonful of Sugar’ by the National Audit Office [11]. That report highlighted a number of associated areas of concern, including linking medicines management with clinical governance, and risk management. Not yet widely available, comprehensive electronic prescribing systems will eventually be able to check drug names, doses, frequencies and much more, furthermore they will (should?) do it reliably and completely. Despite much preparatory work and meticulous methodology, the study reported here still missed a significant amount of data due to incomplete collection.

Can a large-scale audit of this type change prescribers’ thinking and stimulate change? Batty’s paper describes the first round of cross sectional observation of appropriateness in 102 hospitals with some interesting results in three clinical areas, but we do not have the detailed results of the second round after feedback and local action. In the background paper they refer to only 62 hospitals taking part in the second round and give the various reasons for non-participation at that stage. It does make one wonder if the huge effort involved with a study of this type could be sustained in the future with a bigger scale exercise directed at a wider range of indicators as the authors speculate.

Audit that remains reliant on case-sheet review still holds potential problems, for if we are not careful we may end up auditing case-sheet completeness rather than the issue of interest. Thus, in this case, clinical information used to justify a decision to treat or not might not have been adequately recorded, and while that in itself is unacceptable, it does suggest caution with interpretation. In addition, data capture by cross sectional review may miss some of the subjective complexity of making treatment decisions, and that in turn may be more important with the very elderly, one of the problem areas highlighted from the data. A reasonable goal in work of this type would be to see if clinical care is improved by feedback, but some link to clinical outcomes data would be needed to study that properly. On the plus side, and accepting the indicators as valid, then by promoting greater awareness, it seems very likely that the culture of audit and commitment to change, and hence clinical care, will be improved over time.

Fully record-linked systems that allow patient-specific medicines information to be linked with laboratory and clinical outcomes is likely to be the way forward, but that does seem to be taking a long time to arrive [12, 13]. However, at last we seem to have broad acceptance that
information and information systems are essential if the NHS is to manage its affairs properly. There is much to be done in improving prescribing in general, not just for the elderly, and the audit reported in this edition is a valuable starting point.

For now, perhaps an updated version of my professorial quote should read something like: ‘The main thing that puts elderly people at risk from their medicines is their doctors’ inability to prescribe properly’.

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References