Modern medicine

Too much of a good thing?

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At the beginning of the 20th century, physicians could offer their elderly patients only sympathy and symptomatic treatment. At the beginning of the 21st century, however, a cornucopia of medical treatments is available, and family physicians now must decide what *not* to offer.

Physicians are often criticized for overtreating patients, particularly with medication. The public and the government cite the number of medications per patient as proof of this practice. No doubt we underuse nonpharmacologic measures, such as diet and exercise, but often these interventions are ineffective for most geriatric patients' illnesses. And even after eliminating inappropriate and unnecessary medications, we are still left with a large number of medicines that can prolong and improve seniors' lives.

Easy to prescribe

Using an evidence-based approach for common illnesses afflicting the elderly, it is easy to prescribe many medications. For example, for congestive heart failure, quality of life can be improved with angiotensin-converting enzyme inhibitors, diuretics, digoxin, ß-blockers, spironolactone, and perhaps even anticoagulants. Then add acetylsalicylic acid and lipid-reducing agents to the list for ischemic heart disease. If a patient is diabetic, some of the medication will overlap. Preventing osteoporotic fractures and dementia can add even more medication. Evidence-based medicine has not answered this question: what is the incremental value of adding each of these medications, particularly for the elderly? Family physicians' judgment and knowledge of their patients is invaluable in making these decisions (with their patients) given the limitations of the evidence.

Aside from medication, other interventions, such as cardiopulmonary resuscitation (CPR), are featured in this issue of *Canadian Family Physician* (page 340). Should we be offering or discouraging this intervention for our elderly patients? Family physicians are often the ones to explain to patients what this intervention means and what the benefits could be.

Sorting through our options

How do we sort through the maze of therapeutic options? First, from the science of medicine we need more specific information to help us and our patients weigh the relative value of treatments and make meaningful decisions. For example, if you are 90 years old, active, and have osteoporosis, what is your risk of having a fracture and how much would this risk be reduced if you took medication to treat it? What is your life expectancy? How long would you have to take the medication before you saw a benefit and at what cost? Some of this information is available but not readily accessible to family physicians.

Second, we must discuss the therapeutic options with our patients. Some physicians will complain that we do not have time to do this. We have to make time. If necessary, physicians can book appointments just to discuss treating osteoporosis, dementia, and heart disease, and CPR; I think this practice would be welcomed by most patients. We can tell patients what we know about the benefits of these treatments, but they have to weigh the evidence themselves and decide what their health priorities are and what they are willing to do and take.

The dramatic advances of modern medicine present us with a challenge and an opportunity to help our patients make educated choices to improve the quality of their lives.

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