**Abstract: Prescribing for the oldest old**

Given the global increase in people over the age of 85, there is a growing body of literature looking at treating the oldest old.  However much of this work is confined to the literature specialising in geriatrics and the more generic health care papers refer to ‘older people’ with little definition of what is meant by ‘old’. Age is not a diagnosis, but humans do have a finite lifespan and as they age they become increasing more susceptible to disease and have decreased functional reserve. A major issue in prescribing for people over the age of 85 is that guidelines for diseases are based on trials with younger adults, outline the best practice for one disease in isolation of other diseases and take no account of the interaction of drugs used in managing several diseases. Iatrogenesis (ill health caused by doctors) is a major issue and general practitioners (GPs) need practical help in prescribing for the oldest old. Balancing evidenced based practice with clinical judgement means weighing up what will do good, what will cause harm and what is acceptable to the patient. This has to be carried out mostly in isolation from colleagues, within a time-limited consultation with few relevant guidelines on managing multi morbidities in the oldest old.

The argument that age is a number and not a diagnosis is uncontested, but what appears to be missing from such arguments is that humans have a finite lifespan and as they age they become increasingly more susceptible to disease and have a decreasing amount of functional reserve to counteract physiological threats. An example of such differences can be seen in Scottish statistics, that show of the over 65s, 65% of the population will have more than one chronic disease - but over the age of 85, 82% of the population will have more than one chronic disease [1]. In looking at functional ability, people between 65 and 75 report limitations in activities of daily living similar to the 45-64 year olds, but 25% of people over 85 reported moderate to severe functional limitations [2].

Getting the balance of when to prescribe, de-prescribe and not prescribe takes  
expertise, knowledge of the patient, compassion and courage.

In treating any patient, doctors abide by the Hippocratic Oath. The most widely used version today appears to be that of Lasagna [3] which includes the following affirmations, which seem especially applicable to the care of the oldest-old:

*‘I will apply, for the benefit of the sick, all measures [that] are required, avoiding those*

*twin traps of overtreatment and therapeutic nihilism…I will remember that there is art*

*to medicine as well as science, and that warmth, sympathy, and understanding may*

*outweigh the surgeon's knife or the chemist's drug…I will remember that I do not*

*treat a fever...but a sick human being,whose illness may affect the person's family*

*and economic stability. My responsibility includes these related problems, if I am to*

*care adequately for the sick.’*

It is clear from current literature, that doctors all take these affirmations seriously and question the ‘twin traps’ with regard to the prescribing treatment of the oldest-old and those with multiple comorbidities [4, 5, 6]. Guidelines on prescribing cannot replace clinical judgement, which involve improving quality of life for the individual and with the involvement of family/carers [6]. This involves patient-centred care, where shared decision-making, informed consent and continued monitoring are key. In ethical practice this means working in the patients’ best interests and doing least harm.

References

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[2] McGregor, M. J., & Sloan, J. (2014). Realigning training with need: A case for mandatory family medicine resident experience in community-based care of the frail elderly. *Can Fam Physician, 60*(8), 697-699, 704-697.  Retrieved from<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4131952/pdf/0600697.pdf>

[3] Lasagna, L. 1964 Hippocratic Oath: Modern Version Tufts University

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