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VITAL aging

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THE FOUNDATION FOR VITAL-AGING

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Thème

Ageing and Medicine Consumption

Editorial

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Studies on pharmaceutical consumption focus largely on two issues: medication overconsumption among seniors, especially with respect to psychotropic drugs, and inappropriate medication use, which seriously threatens seniors' health and quality of life. Looming in the background, are the rising budgets allotted to medication and their impact on public spending in a context characterized by population ageing. Still, the increasing costs of the Québec Public Prescription Drug Insurance, in particular those of the portion regarding seniors, are not due solely to demographic ageing. Many factors also contribute to this upward trend, such as the adoption by prescribers of new and therefore generally more expensive medications and the growing number of prescriptions per senior beneficiary.

According to data from the Régie de l'assurance maladie du Québec, pharmaceutical consumption has risen constantly in the last 10 years in the case non-sheltered people aged 65 and over[1]. The percentage of people with an active prescription went up from 70% in June 1996 to 74% in June 2000. In this group, the percentage of users with at least five active prescriptions climbed from 24 to 31%. This growing phenomenon of senior polymedication is alarming because the risks of side effects and drug interaction increase with the number of medications prescribed and with user age. Several studies reveal the iatrogenic effects (falls, cognitive problems, worsening psychic disorders) associated with psychotropic drugs (anxiolytics-sedatives and hypnotics). These drugs ranked fourth in 2000 for medications taken by people aged 65 and over—with close to one out of five Québec seniors taking benzodiazepines[2]. In fact, these drugs are at the origin of many hospitalizations[3].

While seniors use medication widely, they should not be considered as a homogenous group. Many considerations are related to pharmaceutical use, and research is necessary to better differentiate the types of consumers beyond the usual sociodemographic and health factors. The increasing health problems associated with ageing explain only part of the current level of drug consumption, in particular psychotropic consumption, among seniors. A Québec study shows that greater use of these medications by seniors is not related to a greater prevalence of psychiatric problems in this population[4].

Certain authors, among them Guilhème Pérodeau (see her contribution to this issue), underline the importance of enhancing the analysis of senior consumer behaviour concerning psychotropic drugs by adopting a broader perspective that takes into account the relation society has with suffering and ageing, factors which are increasingly problematic and hard to define. Another important consideration is to better understand the beliefs people elaborate through their interactions with caregivers, their surroundings and, more generally, the media. In this respect, Pérodeau points out that psychotropic drug patterns among seniors reflect the various interaction processes they maintain with close caregivers. She cautions, however, that efforts could be made to better document the role played by the family with regards to medication usage by seniors.

How seniors use medication is also related with prescription practices. Yet, physicians do not always seem to follow prescription standards, especially those involving psychotropic drugs. The greater tendency to prescribe this type of medication to elders depends on certain physician characteristics, with older physicians, men, general practitioners and physicians with higher consultation numbers being more likely to display high prescription rates. Nonetheless, as notes Collin regarding psychotropic drugs, such overprescription, which might seem irrational at first glance, also reflects subjective factors (the pressure stemming from patients' demands and the reluctance to refuse; the desire to maintain a trusting relation; compassion toward the difficulties seniors face).[5] According to Pérodeau, while physicians are aware of the risks related to long-term benzodiazepine prescription, they feel rather powerless before suffering seniors. In his article, community pharmacist Michel Tassé demonstrates that the lack of coordination between the various practitioners that non-institutionalized seniors and particularly frail seniors are in contact with throughout their care, contributes to multiple prescriptions and inappropriate medication use.

In most studies, the question of medication is essentially addressed in terms of compliance, or rather non-compliance, with the medical prescription. This phenomenon takes on several forms: not taking the prescribed doses, disregarding medication taking times, forgetting or interrupting treatment, not updating the prescription, or even taking unprescribed or natural products, etc. This behaviour is generally ascribed to patient misunderstanding of the characteristics of the illness and treatment, the constraints and complexity of the prescription (particularly the fear of difficult adverse effects brought on by some treatments) and, finally, the existing physiological and/or cognitive user limitations. Furthermore, prescription non-compliance may be caused by an economic problem in accessing medication, as Annie Michaud points out in her summary of the memorandum issued by the Conseil des ainés in response to the *Draft Pharmaceutical Policy* of the Ministère de la Santé et des Services sociaux. Indeed, the annual premium hike incurred by senior contributors to the Basic Prescription Drug Insurance Plan (BPDIP) may be leading the most economically disadvantaged to reduce or altogether stop taking their medication.

The question of prescription non-compliance must be qualified, however. If non-compliance rates are high among people aged 65 and over, they are not that different from those among other age groups[6]. Seniors may appear less compliant mainly because they combine concurrent diseases and polymedication. In addition, the notion of compliance defines the relation to medication only in terms of compliance with the medical prescription and assigns seniors an essentially passive role. In any case, the health education program *Les médicaments : Oui…Non…Mais !* carried out in the Montérégie by the team of Dr. Serge Moisan (see his contribution in this issue) demonstrates seniors' ability to play a more active role in their dealings with physicians and pharmacists regarding health- and medication-related questions. Extending such programs is among the demands put forward by the Conseil des aînés.

Finally, inconsistencies regarding prescription compliance do not necessarily constitute irrational behaviour; they may also be likened to a form of medication regulation exerted by patients[7]. Such inconsistencies may also be part of a personal illness-management strategy. Health interventions must thus take into account the meaning that medication takes on for individuals, a meaning largely beyond its pharmaceutical effectiveness. In her article on the relation pharmaceutically institutionalized patients establish with medication, Delphine Dupré-Léveque draws attention to the identity-making function of medication—through its presence in the rituals and high points of the seniors' life history—which provides a connection to individuals' past. As such, medication constitutes a particularly important communication tool between seniors and health care teams, a characteristic not much taken advantage of. The article by Joseph Levy and Christine Thoër-Fabre on the medicalization of sexual dysfunctions and menopause clearly reveals that the relation seniors develop with medication is part of the growing pharmaceutical-industry-sustained pharmacolization process of ageing and, more generally, of life itself. This movement contributes to the emergence of new representations of the ageing body and the relation with time, along with new expectations on the part of ageing people.

Through the various articles by our contributors, this issue of *Vital Aging* tackles the question of senior pharmaceutical consumption from a global perspective, while focusing on the actors taking the medication. Our contributors also emphasize the multiple real and symbolic interactions surrounding medication, an object "saturated with meaning." They also insist on the benefits of better coordination between the professionals involved in the health of seniors and medication. Finally, they urge us to go beyond the myth of the passive and non-compliant senior to focus our efforts instead on the implementation of initiatives aimed at fostering empowerment in these areas.

Translated from French by Marc Pilon

Notes

1 Régie de l'assurance maladie du Québec (2001). *Portrait quotidien de la consommation médicamenteuse des personnes âgées non hébergées : Régime d'assurance médicaments administrés par la Régie de l'assurance maladie du Québec : les 9 juin 1996, 7 juin 1998 et 11 juin 2000*. Québec.
2 Idem.
3 Tamblyn, R. M., McLeod, P.J., Abrhamowicz, M., Monette, J., Gayton, D.C., Berkson, L., Dauphinee, W.D., Grad, R.M., Hunag, A.R, Isaac, L.M., Schnarch, B.S., Snell, L.S. (1994) Questionable prescribing for elderly patients in *Quebec, Canadian Medical Association Journal*, 150(11), 1801-1809.
4 Pérodeau, G., Ostoj, M. (1992). *Adaptation au stress et utilisation de psychotropes par les personnes âgées*, Québec, Conseil québécois de la recherche sociale (CQRS).
5 Collin, J., Damestoy, N., Lalande, R (1999). La construction d'une rationalité : les médecins face à la prescription de psychotropes aux personnes âgées, *Sciences sociales et santé*, 17 (2), 31-52.
6 Mishara B.L, McKim, W.A. (1989). *Drogues et Vieillissement*, Chicoutimi, Gaëtan Morin.
7 Collin, J. (2002). Observance et fonctions symboliques du médicament. *Gérontologie et société*, 103, 141-159 ; Conrad, P. (1985) The meaning of medications: another look at compliance. *Social Science and Medicine*, 20(1), 29-37.

In this Issue:

Interview with Guilhème Pérodeau

Conducted by **Christine Thoër-Fabre**, Ph.D., Postdoctoral Fellow, GEIRSO, Programme des grands travaux du CRSH sur la chaîne des médicaments, UQAM

Guilhème Pérodeau is full professor at the department of psychoeducation and psychology, Université du Québec in the Outaouais, and psychologist in private practice.

You have carried out extensive work on the use of psychotropic drugs among seniors, which is very high in Canada, particularly in Québec. Why is this heavy use a cause of concern and how can it be explained?

The intense use of such drugs is disquieting, especially in the case of benzodiazepines. In fact, medical studies have revealed that the benzodiazepine molecule should not be used for more than four weeks, at the maximum for a few months. Benzodiazepine treatment is really not intended for long-term use. Nevertheless, this medication is used year after year and such chronic use affects the health of seniors. The problem is that society cannot tolerate psychological suffering. In the interviews for my last study, this factor was mentioned at length by consumers, physicians and pharmacists alike. As the professionals pointed out, society requires that people perform. Naturally, as people age, their sleeping patterns change, and they sometimes have less energy. Unfortunately, they sometimes have difficulty accepting this normal ageing process. And so, they tend to see their treating physician and ask for pills. As for the physicians, they mention being trained to resolve immediate problems; they have neither the time, the training nor the parameters needed to follow up on patients on the psychological level or explain to them what the ageing process is about. Some of them therefore end up prescribing benzodiazepines. Yet, the professionals are very much aware that these people should be referred to psychosocial resources. But, scheduling an appointment in CLSCs is a six-month wait at minimum and consulting a private psychologist is not feasible for everyone, given the fees involved.

Obviously, there are various degrees of suffering. A major depression—where a person no longer eats, sleeps and functions—requires intervention. There are many people, however, who feel down because they are experiencing difficult circumstances and life transitions. They feel down because there is a problem they should be addressing. In fact, feeling a bit depressed and anxious may not be a bad thing. This feeling may be warning sign. Nonetheless, in our society, people are expected to find a quick fix, a way of carrying on with daily life without looking into the reasons why things are out of kilter. Accordingly, everyone works on the symptoms, prescribes drugs, and the basic problem remains unresolved. This situation is not restricted to seniors; children are medicalized for hyperactivity, women for menopause, etc. The process extends to all aspects of life.

Are the seniors who take benzodiazepines aware of the risks involved?

There are important differences among consumers. In general, seniors aged 75 years and over do not think much about their benzodiazepine consumption, which often goes back 10, 15, 20 years. They have this image of the "physician-priest" and consider that what has been prescribed is necessarily good for them. On the other hand, in our last study, we questioned younger consumers in their 50s, and the results were quite different. In this age group, benzodiazepine consumption was mostly related to difficult work-related problems. Because they were under a lot of pressure, the drug was used to help them sleep well so that they could work and perform better. These people though of stopping treatment, once retired. They were aware that long-term benzodiazepine use was not the best solution. This rebellious attitude was found especially among men, leading some of them to suddenly stop taking their medication, an unwise and possibly dangerous proposition. For most of them, however, they continued the treatment because they were stuck on the performance treadmill.

Once more, I would say that people are unprepared for ageing, a fact observed by several physicians we interviewed. This is the case for baby boomers as it is for younger people. Society is focused on performance and youth—while ageing is something else. Physically, certain changes take place, but there are also gains. As people age, they become wiser and have more inner resources; still, these qualities are not necessarily valued. Today, people over 50 are caught up in a lifestyle where few provisions are made to accommodate the changes resulting from ageing. Even people in their 60s are expected to perform as they did at 30, or almost. Those who can't succeed need only take pills! I'm oversimplifying, but barely. Work should be done on what ageing means. In the workplace, some accommodation is needed as well. This will no doubt happen eventually because there are fewer and fewer young workers in proportion to their older counterparts. Things are moving a little bit. Perhaps baby boomers will bring about attitudinal changes. In any case, they are more likely to question professionals and demand more from the system than their predecessors.

Many studies on psychotropic drug consumption highlight a gender effect, with women being the greatest users of benzodiazepines. How would you explain this trend?

The gap between men and women exists but it is narrowing. Men are catching up with women, which is explained by the fact that, in the last decades, men have also been through stressful times, for instance experiencing unemployment. I also think—something that has been documented—that the gender effect must be linked to the patient-physician interaction. First of all, men generally will not see a physician unless they are really quite ill, while women who have been pregnant will more readily consult. The problem is that whoever sees a physician more often risks having medication prescribed. Several studies have also demonstrated that prescriptions are influenced by how patients describe their illness, what they say and how they say it. A woman who presents her condition in more ambiguous and less clear terms, saying for example "I don't feel well, I can't sleep, I'm nervous," has a greater chance of leaving with a psychotropic drug prescription, contrary to a man who emphasizes more precise physical problems. Certain studies also report discrimination on the part of physicians as they tend to consider that men really have a physical problem when they consult, whereas women imagine problems and are nervous or emotional. Studies on prescriber characteristics also show that all physicians do not prescribe in the same manner. Heavy prescribers of psychotropic medication tend to be older, less trained practitioners, and more often than not, men.

Do you think the current analysis models of psychotropic drug consumption among seniors are sufficient to clearly distinguish the various user categories?

I think there are few models, and the studies conducted are quite sketchy. It is known that consumers are more often women, that they are older and more stressed. Beyond this men/women difference, however, I believe the difference lies mostly in generational terms. Older consumers are often less educated and more centred on the physician, whom they greatly trust. As a result, they are more submissive regarding medical prescriptions. Younger generations are different: they are better educated and have learnt to question medical authority. Baby boomers will be more demanding and more liable use the Internet on account of their work. Consumption analysis models are available, which focus on the psychological aspects, the individuals and their personality, as well as their sociopsychological profile. It would be interesting to develop models that take into account much more socially-related and systemic aspects that refer to the influence of media and the perception of ageing in society. Sociologists are working in this direction. What is needed, however, is a blending of both perspectives.

How does the first benzodiazepine prescription happen? Does the process vary according to generation?

In both cases, the difference must be made between initial prescription and prescription renewal. At the start of treatment, the same thing happens for many people: there are specific circumstances. The situation, which is well documented, by the way, often begins with an illness or hospitalization for which sleeping medication is prescribed. Another frequently found situation is a crisis, a lost spouse, for which tranquilizers are given. When physicians prescribe medication, they should stress upon the patient that the situation is specific, the prescription is related to a fixed period of time, not the long term, and a psychologist should be consulted. In reality, benzodiazepines are simply prescribed, without a specific time limit. The person then takes the medication, "as needed." Nevertheless, physicians are increasingly aware —at least the ones we interviewed and some more than others, naturally— of the problems related to chronic consumption and mindful of the risks linked to drug interaction. Unfortunately, they don't know what else to do. As for us researchers, we can talk from our lofty heights, but physicians face suffering people. Pharmacists are somewhat more removed, which affords them a broader perspective. In the end though, physicians are on the front lines; they are the ones who people come to see; they are the ones needing resources. They are not necessarily trying to push pills, no, not at all. But, what alternative is there? Especially considering the constraints they face, such as lack of personnel and time. Several of them have said during interviews, and I have seen in the course of other research, that it takes less time to write up a prescription for benzodiazepines than to explain that something else should be done. In my opinion, both the patients and professionals feel powerless. This is why prevention should take place in the initial stages of prescription. When people have been taking benzodiazepines for 15 or 20 years, habits form, the users depend on their pills—because it is a dependency—and intervention is much more difficult.

Do patients question physicians on the risks related to benzodiazepines?

Generally speaking, people taking benzodiazepines tell themselves that their physician is monitoring them and so they ask few questions. Some people do decide to take charge of themselves and try to stop, as shown in our interviews. In such cases, the situation might be biased because the consumers that we met accepted the interview; not everyone does. I have the example of a couple where both spouses were taking benzodiazepines and decided to stop. They had seen a pharmacist for guidance and a withdrawal plan since it is important not to suddenly cease medication. They were quite motivated, which is rare. Physicians regret this as they would very much want to bring their patients to stop taking benzodiazepines. And so, even though excellent withdrawal programs exist where the process is clearly explained, people are not motivated. Incidentally, this motivation problem will be the topic of my next study.

And yet, there is much talk in the media about the risks related to psychotropic drug consumption.

You think so? Well, shortly after the Vioxx affair, the media did bring up certain problems linked to medication and antidepressants. Still, the average person hears nothing about the risks associated with benzodiazepines. On American television networks, even Canadian networks, there are many ads promising better sleep, an end to depression, etc. The medication consumers' image has also changed. For example, previously, the image shown was that of women with dirty hair, seemingly straight out of a psychiatric hospital. Now, the image is that of young people, bristling with energy, the image of average people. The message is, "Are you having a hard time sleeping? Feeling nervous? Then ask your doctor for advice." Apparently, this method works because people are indeed going to see their treating physician, asking for the medication they saw on television.

We conducted a study (with Philippe Voyer) on the sources of information that mobilized frail women taking psychotropic drugs. The results revealed that these people were not overly concerned with the risks associated with such treatment. For example, some women happened to read an article in the press, say on Halcion®. Some of them then decided to discuss the matter with their physician, who reassured them. Or, they would call upon other health professionals in their vicinity. The problem was that the advice

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obtained was often contradictory. As a result, they often gave up.

Different physicians may also provide varying advice. I remember a patient living out in the country, to whom her physician had prescribed benzodiazepines for many years. When she was hospitalized, the hospital physician examined her therapeutic regimen and told her to stop taking all that "garbage." Upon being discharged, the woman decided to defer to her family physician whom she trusted and who had prescribed this medication for so long. This type of clash, which happens more often than not among physicians, is quite trying for patients. As for pharmacists, who are better informed than physicians with respect to medication and drug interaction, they rarely question the medical prescription. It seems that they have another role to play. They would often like to consult with patients but lack the facilities to do so, even if some pharmacies have set up small consultation spaces. In the interviews, pharmacists also emphasized that they are not paid for this type of advice, which may take a lot of time.

What about the family, what is its role regarding psychotropic drug taking?

In a study carried out with senior women and their caregivers, we highlighted a range of attitudes on the part of caregivers. In certain families, the caregivers considered that the decision to use such treatment rested with their mother or at the very least with the physician; consequently, they did not get involved. In other families, medication taking was seen positively because it helped relieve and calm the senior, something that could be interpreted as a form of social control. In saying this, I am not laying blame. These caregivers, often the daughter or daughter-in-law, generally held a job and were involved in other family roles; in light of this, they did a wonderful job helping the senior. Nevertheless, they were overstretched and tired, and the medication provided support for them too. Other caregivers displayed a much more open attitude, considering the psychotropic medication as a solution among many. To summarize, we found from this study that family dynamics strongly reflected the way in which medication was discussed in the family. These senior women taking psychotropic drugs were often quite anxious, and the medication could serve as a communication tool in the family, for instance when asking, "Mom, did you take your medication?" instead of a means of exploring with them the causes of their anxiety.

How do you see things evolving in the current context, considering the constraints mentioned?

That is the million dollar question! Action is necessary on several levels. If physicians are the treatment entry point, then they need to have access to resources, something our interviews with these professionals underscored. There could be nurses because seniors appreciate nurses greatly, whereas they are not fond of psychologists, believing that only crazy people consult them! Paramedical staff with psychosocial training could also be used to provide information, help and guidance to seniors. What is needed are practitioners that seniors really trust. Withdrawal groups exist, but people do not sign up for them; in any case, people do not suddenly decide to move toward withdrawal. Therefore, these resources would have to be available in the medical system. This is where people go to see a physician: because they have been programmed to do so when things are not right and because everything is reimbursed and free. Seeing a psychologist is not. Based on our interviews, I have the feeling that if physicians knew where to refer patients, if there was somewhere the patients could be immediately taken care charge of, a place where there was someone to talk to, then things could be quite different. Instead of prescribing psychotropic drugs, some physicians would know that they could redirect the patients.

I believe intervention is required regarding continuing medical training to ensure that, in the future, benzodiazepines will be prescribed for a limited time. Pharmacists could also take on a more significant role, notably with younger people who would be more likely to ask for advice if a special room was made available for this purpose and confidentiality was ensured, as is the case in certain pharmacies. Right now, the health system is over burdened and very costly. The medication is, however, also very costly.

It should also be said, and this concerns young seniors, that medication, as well as antidepressants, is mainly prescribed to people having experienced burnout. These people see a physician, obtain leave of absence, and then, after a few months, consult a psychiatrist who often prescribes antidepressants. This is where the third-party payer enters the picture, i.e. when insurance companies pay for medical follow up only if the patients take their medication. In the literature on medicalization, much mention is made of the physicians and pharmaceutical companies, whose role it is to make a profit. This is obvious, but there is also the third-party payer. Here is a new player that must be taken into account in the medicalization process.

On the social level, as I mentioned, we are talking about how people relate to ageing and the resulting changes, in other words, how people relate to normal ageing, something not well accepted. Ageing could be promoted, the advantages emphasized, and seniors could be valued by granting them a privileged place in society. I also think the symptoms witnessed by people reflect suffering and transition, which are related to approaching retirement or sometimes to the onset of illnesses. In society, problems are resolved on the surface, chemically, and medication is used for psychosocial adjustment purposes. And yet, this suffering could be the starting point of a true transformation in our way of contemplating ageing.

Guilhème Pérodeau, thank you very much for this interview.

Translated from French by Marc Pilon

Symposium

Presentation

Elder abuse and the quality of homecare support programs is a concern to public institutions as well as the private sector and constitutes an important issue for seniors themselves as well as their families and caregivers. The Centre de recherche et d'expertise en gérontologie sociale of CSSS Cavendish, in partnership with the Escola de Prevenció i Seguretat Integral of the Universitat Autònoma de Barcelona is organizing a symposium to explore these issues.

The symposium, which will take place in Barcelona on November 21st and 22nd, invites researchers, jurists, social practitioners and caregivers from both Catalonia and Quebec to discuss practices concerning abuse prevention, simultaneously promoting quality of homecare service in Quebec and Catalonia to improve the collective well-being of seniors.

Prevention of elder abuse and homecare policies

Comparative analysis Quebec-Catalonia

Objectives

1. Prevention of elder abuse through a better understanding of Quebec and Catalonian realities;
2. Discussion of issues around homecare;
3. Sharing innovative approaches;
4. Determination of new intervention modalities.

This symposium targets social workers, educators, policy-makers, researchers, jurists, homecare workers, caregivers, volunteers and students. A summary of the symposium will be made available in the next edition of the Vital Aging newsletter.

Centre de santé et de services sociaux Cavendish

EPSI Escola de Prevenció i Seguretat Integral

Mental Health Monthly Teaching Rounds 2006-2007

from 1:00 pm to 2:00 pm

Date	Topic	Presenter Language	Location
October 10 2006	**Occupational Stress: Burnout and Stress Management**	Dr. N. Casacalenda Psychiatrist at JGH English (exceptionally from 1 - 2:30pm)	René-Cassin 6th floor 19-20-21
November 14 2006	**Forward House: Social Reintegration and Rehabilitation**	Chris McFadden Director of Forward House English	NDG 1st floor Boardroom
December 5 2006	**Depression and Alcoholism**	Dr. Tremblay Psychiatrist, Douglas Hosp. English	René-Cassin 6th floor 19-20-21
January 9 2007	**Omega-3 Fatty Acids in Psychiatry**	Dr. H. Olders Psychiatrist, St-Anne's Hospital English	René-Cassin 6th floor 19-20-21
February 13 2007	**Les services de Diogène: profil de la clientèle SM vs itinérance et problèmes judiciaires**	Christiane Cadieux Intervenante sociale au Services de Diogène French	René-Cassin 6th floor 19-20-21
March 13 2007	**Suicide Survivorship and Postvention**	Dr. N. Casacalenda Psychiatrist at JGH English	René-Cassin 6th floor 19-20-21
April 10 2007	**L'aide du masculin: la réalité des hommes qui prennent soin de leurs conjoints à domicile**	Francine Ducharme Professeur de soins infirmiers à l'Université de Montréal French	René-Cassin 6th floor 19-20-21
May 8 2007	**Understanding Self-Mutilation Behavior**	Janice Clarini M.A Socio., Lect. at Vanier College English	René-Cassin 6th floor 19-20-21

For more information, please contact Maya Gharzouzi at (514) 488-3673 ext. 1451

"Medication is not to be taken lightly." Observations on medication consumption by seniors living in retirement homes[1]

Delphine Dupré-Lévêque, Ph.D., Anthropologist, Aménagement, Développement, Environnement,Santé et Sociétés, UMR 5185 Université Bordeaux II – CNRS; Responsable Pôle Gérontologique, Caisse Primaire d'Assurance Maladie de Périgueux, France.

"*Medication is not to be taken lightly*" was the catch phrase used in France a few years ago as part of the effort to counter the risks related to self-medication and drug interaction, and to raise the population's awareness of the importance of prescription compliance.

This Catchline probably has had an impact; however, its effect would be difficult to measure today. On the other hand, one thing is certain: seniors, particularly those suffering from chronic illnesses, do not take their treatment lightly. Medication holds an important place in their lives, and the treatment is a part of who they are. As a result, a relation verging on the emotional develops between people and their treatment:

The daughter of a resident—
My mother knew her medications well (…) My husband picked them up at the drug store and then she unwrapped everything. She greatly enjoyed looking at the package inserts and the medications.

A resident—
I used to take a lot of medication. But I later changed doctors after the first one retired, and then the new doctor cut off everything. So I no longer have the same regimen, but I've kept the other boxes as a souvenir. When I came here, I had to change doctors again, but this one maintained the same treatment. When the name of this medication changed, I wrote to the company to find out whether or not it was true. They confirmed that it was the case and sent me 10 boxes for free. Anyhow, I have a list of everything I am taking.

Another resident—
The sleeping medication I have to take at bedtime. It's in the box on the left. With the pills here, however, I have to be careful because they are round and tiny; sometimes I drop them. Those ones are naughty.

We are well aware that seniors moving into an institution experience many disruptions in their habits, but few establishments are concerned about the way these people manage their medication. As soon as the seniors arrive, the process of preparing their treatment is taken away from them. They no longer have access to the medication packaging. This "confiscation" creates an additional rift between the time "before" at home and "now" in the healthcare institution. For some people, this brutal separation from their medication is painful, an experience they do not take lightly. A resident confirms this by saying—"*When I came here and they took away my pills, I felt a bit irritated. You know, when you are not accustomed.*"

In the name of risk limitation and resident welfare, senior homes follow caretaking practices that may, in the end, cause the residents much anxiety and discomfort.[2] For example, removing medication packaging and disrupting behavioural patterns, which may have given the seniors pleasure and a sense of independence, may be quite destabilizing (infantalizing?). Particular attention should be given to the medication taking habits of new residents instead of denying them the responsibility. This would undoubtedly help them adapt. As for the contention that removing the packaging causes the residents to lose interest in their treatment, some practitioners sincerely think this is true. A healthcare aid notes, for example — "*They rarely ask themselves whether the boxes have any use. They remove them and don't try to understand.*"

On the other hand, other caregivers are very much aware of the relation between seniors and their medication; they are attentive to every senior's medication taking habits:

A physician—
They are quite attached to their treatment. If the little drops they took at home daily are not found in the senior home, they will request them. Medication has real value for seniors. The treatment is a part of themselves and I'm not for changing the treatment initially.

A healthcare aid—
For each person, different rituals surround medication. Medication forms an important link with the past, and this is true with the able-bodied as with the others. Some lose their heads; nevertheless, they view their medication as sacred. They always notice when one medication is missing, or a new one is added. Some can't bear to be told they are doing better. The more medication they have, the more they feel like they exist. If the physician removes anything, it is a real catastrophe at first.

How can residents, who can no longer keep the medication packaging, who are refused permission to prepare their medication and who, in many cases, suffer memory losses, still be capable of exercising some control over their medication taking? Close observation on a daily basis reveals certain techniques used by residents. As a nurse notes, some talk to caregivers directly—"*They often ask me what the medication is for. Sometimes they ask every two days. I always give them explanations. Trust is important when medication is involved.*" Others residents, even if they are no longer really capable of preparing their medication, want the empty boxes in their room. One resident relates —"*At noon, I take three pills: one gold, one white and one red. One is for my heart, the other for constipation, and the last one for rheumatism. I always know what they are for because I always ask for the package inserts. It helps me fight what I feel. It's maintenance work.*" Overall, nevertheless, people control their treatment by creating their own medication taking rituals:

A resident—
"I always take them in the same order, that way I can see if there are any mistakes. I place the pink tablets on the Melba toast where they stay put, while on a slice of bread they go through."

Another resident—
"I take a big blue one and a small white one, which tastes really awful. All of them I used to take at home but here, there's no risk of forgetting. I start with the small one that tastes bad and go on to the harder to swallow ones. I always take them when I begin eating because, if I have problems swallowing the small one, it leaves such a disgusting taste that it's better to have something else in my mouth to make it pass."

Even in an institution, and even when not required to ensure or prepare medication, seniors do not take their treatment lightly: they organize as best they can with their own resources to reclaim their drug treatment to some degree.

Medication may be used to help understand the residents and their life history; it may also point to how well they integrate and adapt to the institution. Indeed, each type of medication corresponds to a specific time in their life, in the process validating a particular pathology: this medication was taken following the death of the spouse, this one after being hospitalized due to the son being without work, etc. The illness makes sense.

From the perspective of medication taking, practitioners can gain a more subtle appreciation of people's life history. If evaluation questionnaires or entry questionnaires effectively aim to account for the life history, they do so superficially. However, if practitioners acknowledged the meaning residents give to their own illness, they would better understand these people. In turn, the residents would adapt more easily to the institution. In fact, when residents exert a measure of control over their treatment, it provides a yardstick for measuring how well they are adapting to the institution.

Medication is more than a medical tool designed to fight illness. By observing the rituals at play when medication is prescribed and taken, it is possible to gain an understanding of the many types of social controls involved. Medication taking follows a lengthy path along which medical reasoning is of little importance in comparison to social considerations.

"Medication is not to be taken lightly." Rather, it is an infinitely complex process that should be better scrutinized by caregivers and, more particularly, by social science researchers.

Translated from French by Marc Pilon

Notes

1 Dupré-Lévêque D., Demoures G., et Lévêque F. (1996). *Santé mentale, psychotropes et personnes âgées en institution*, Paris, MIRE –rapport.

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Ageing and sexuality: from hormonotherapy to Viagra®

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Sexual potency, deferment of ageing, and even victory over death through inaccessible immortality, rank among the great concerns of our time. These aspirations seem to have provided a model for modern medicine in its essential project to ward off death and maintain health, energy and vitality, reversing, in the process, the bodily erosion caused by the passing of time. These hopes appear to have materialized thanks to the marketing of innovations in the pharmaceutical field: hormonotherapy in the 1940s and substances like Viagra® to treat erectile dysfunction in the 1990s. This article will dwell on these two very typical examples of the current medicalization process.

Different studies have shown that the social construction of menopause-hormonal deficiency and erectile deficiency as clinical entities has been closely linked to the development and the commercialization of hormonotherapy and Viagra®, and the mediatization of these forms of treatment. Since the 1960s, hormonotherapy has been featured in many works of vulgarization of medical knowledge, in the press and on television programs as the way to counter the consequences of menopause, which appears as source of danger for the physiological and psychological health, and as social passage into old age.[1] Fortunately, starting in the 1970s, feminist criticism has prompted the emergence of other models that view menopause as a normal transition in women's lives. Such criticism has led to question the systematic prescription of hormonal replacement therapy, raising demands for a more important participation of women in managing this stage of their life and advocacy for the use of natural and alternative medicines.[2]

This distancing from medical discourse is found in the discourse of women, who generally show a positive attitude towards menopause, a condition they do not consider to be pathological.[3] Nonetheless, they alternately refer to the biomedical model of menopause and the discourse contesting the medicalization of menopause. Moreover, if some of them view menopause as a non-event, even a period of new opportunities, other women seem to consider that this period marks a turning point in the ageing process. Consequently, a number of women who reach menopause today face a difficult decision: resort to hormone replacement therapy or not. The choice appears especially critical since the publication, in July 2002, of the results of the American study Women's Health Initiative (WHI) that highlighted an increase risk of breast cancer and cardiovascular events among women treated with a combination of estrogens and progestatives. The results have elicited much a controversy around this treatment[4].

A study done in France on the representations and uses of women regarding hormonotherapy has shown that this treatment fulfils different functions for users[5]. For participants, the treatment was first considered as a means to attenuate the problems attributed to menopause, for instance hot flashes, migraines, uterine bleeding, or a way to make them disappear—thus fostering a return to "normal" life. Several women also used hormonotherapy to prevent the onset of diseases linked to ageing, chiefly osteoporosis. Hormonotherapy was also considered as a method of extending youth and fostering identity continuity because it allowed the women to carry on with their activities, within the professional and family spheres. The treatment was indeed presented as a mood regulator and a guarantee of continued performance—preventing the women from being looked upon as "cantankerous and old," and allowing them to better manage the multiple social roles they played. Finally, the treatment was deemed to slow down bodily deterioration and the resulting image thereof. For many users, hormonotherapy erased or staved off menopause. A much more negative view of hormonotherapy was held by some participants who elected to refuse or terminate this treatment due to contraindications, side effects or following the publication of the WHI study. Those women insisted on the artificial and potentially toxic nature of the treatment. Others stated that they were opposed to the medicalization of menopause and the feminine cycle as a whole, judging as unnatural the absorption of exogenous hormones.

Like hormonotherapy, Viagra® has also been widely covered in the media. This public diffusion has been largely driven by the pharmaceutical industry, which, through colloquiums and various communication channels, contributed to creating the event even before product commercialization was to begin. Giami[6] underscores the fact that media diffusion, particularly on the Internet, of this medical discourse has allowed several audiences, mostly men, to appropriate the treatment. In turn, this has fostered the emergence of new representations of Viagra® as an aphrodisiac, an instrument of a hedonistic sexuality, a comfort medication serving to improve the quality of life, and a recreational drug. Thus, Viagra® has joined the long list of synthetic drugs, with the difference that it acts directly on the sexual response process. And, unlike other therapies (dose inhalers, injections of various products), this molecule affects the biochemical processes regulating sexual response and erection.

Studies done on the representations of Viagra® have attempted to define how users view the effects of this medication7. They reveal that the functions of the treatment are essentially to repair, normalize and extend bodily capacities. However users' discourses outline contradictory views. Some see the restoration of the erectile function as a reappropriation of a normal sexuality. In their view, Viagra® temporarily corrects a chemical imbalance and, as such, does not artificially intervene in the excitation process or the unfolding of the sexual act. On the contrary, sexual impotence, as a loss of bodily control, is deemed "unnatural," and with the introduction of this technology, new representations of the sexuality of ageing men have emerged. For other users, Viagra® is certainly considered as a remedial medication, but above all as a crutch, a trick used to produce "phoney erections," leading to a sexuality that goes against the order of things and upsets relationships and representations of ageing. For a third category of users, the effects of Viagra® go beyond restoration, providing them with a newfound sexual potency that could be considered artificial, even robotic, and sometimes disconnected from desire. Nonetheless, this medication does contribute to attaining an idealized and standardized masculine sexuality, and seems to lighten the burden of the passing years. In other words, if, for certain men, Viagra® opens new sexual horizons, it also contributes, as a medical technology, to a prescriptive view of masculine sexuality, especially with regards to heterosexual sexuality centered on the genital organs and coital relations. The "pharmacologization" of impotence also tends to reduce the problem strictly to its biological aspect, at the expense of symbolic and emotional factors, and even of the sexual partner, who is largely ignored both in the medical discourse and the discourse of pharmaceutical firms. In fact, if some women appreciate their spouse's newfound sexual vigour, others seem dissatisfied with the resulting sexual upsurge and deem it unnatural, particularly because it bears witness to the negation of the unavoidable ageing process.

In the case of menopause, as well as of erectile dysfunction, it is difficult from now on to ignore available methods of treatment that are seen as means of restoring, extending or modifying certain bodily capacities, or preventing bodily deterioration. These medications also make it possible to submit the body to the standards of youthfulness and performance that characterize our society and contribute to the emergence of new representations of the ageing body. At the same time, users display feelings of ambivalence toward hormonotherapy and Viagra®, which, like other medications, are considered "questionable and contradictory substances: at once toxic and beneficial, source of fear and attraction, danger and relief, object and spirit, apparent form and hidden power"[8].

Translated from French by Marc Pilon

Notes

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Educate the Elderly with Self-Management of their Health and how to Take their Medication Properly

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Since January 1997, the Direction de santé publique de la Montérégie, in partnership with regional CLSCs and the Montérégie chapters of the Fédération de l'Âge d'Or du Québec (FADOQ), has been running the program *Les Médicaments : Oui… Non… Mais!*[1], which is aimed at educating people aged 55 and over, living outside healthcare institutions, on various health issues. In the Montérégie region, it is also referred to as En santé après 50 ans.
To date, more than 20,000 seniors with an average age of 67 years old have been reached by this regional program for which the Direction de santé publique has only received positive comments from participants, health professionals, group leaders and institutions' managers.

Program's objectives

The program is mostly aimed at developing people's sense of responsibility and knowledge towards their health, notably by teaching them health-conscious behaviours and how to make proper use of medications. The expected outcomes include:

- Improving participants' knowledge in regards to adequate behaviours towards certain health problems frequently associated with the ageing process;
- Improving participants' attitudes with respect to self-managing their health;
- Increasing participants' sense of personal effectiveness as a preliminary step to the adoption of positive health-conscious behaviours;
- Developing participants' ability to better prepare consultations with their doctor or pharmacist;
- Motivating participants to use alternative means to complete or replace their medications;
- Increasing participants' compliance with pharmaceutical treatments.

Les Médicaments : Oui… Non… Mais! was inspired by a program set up in the early 1990's by the Direction de santé publique de l'Outaouais, which drew notice from the Ministère de la Santé et des Services sociaux and was subsequently included in the provincial action strategy entitled *L'utilisation rationnelle des médicaments chez les personnes âgées*[2]. Concerns over the inappropriate usage of medications by seniors are reiterated in the *Programme national de santé publique 2003-2012*[3] and the *Plan stratégique 2005-2010*[4] published by this department.

Program's description

Les Médicaments : Oui… Non… Mais! is aimed at increasing participants' ability to adequately use medication. It suggests, among other things, ways to replace or complete prescribed medications and emphasises the development of a healthy lifestyle.

The program involves a series of six meetings offered to groups of 15-20 individuals. These meetings, jointly led by a nurse and a previously-trained peer, deal consecutively with general information on medications, sleeping drugs, analgesics/anti-inflammatory drugs, laxatives and anxiolitics; the sixth meeting being a summary. Each session, which lasts approximately two and a half hours, includes an overview of the ageing process in terms of the type of medication covered, its effects on the human body and alternatives to replace or complete its action. Preparation for consultation with the doctor or pharmacist as well as a review of available resources within the community are also covered. An exercise-break and a healthy snack are scheduled during each session.

Conceptual framework

The conceptual framework rests on Bandura's theory of personal effectiveness[5], which holds that individuals' confidence in their own abilities affects their future behaviour. This principle is applied in order to bring participants to carry out self-management tasks.

The program is also based on principles that support educational methods geared to adults. The andragogical approach used in the program is deemed effective in improving the knowledge, attitudes and behaviours of participants. It leads to a heightened sense of personal effectiveness. The five principles underlying the approach are as follows:

- Groups are co-led by a nurse and trained peer;
- Learners actively participate during the sessions;
- Learners are autonomous in their learning process;
- Learners' personal and professional experiences are capitalized on;
- Group resources are turned to good account.

Assessment of program's outcomes

Five years after the program was implemented in the Montérégie region, an evaluation of its effects was conducted using a pretest/postest analysis with a control group: 563 individuals participated in the assessment.[6] Observations made during the last meeting of the program demonstrated that the sessions improved participants' sense of effectiveness in regards to self-management of their health and increased their knowledge with respect to certain physiological phenomena and health problems frequently encountered during the ageing process. Moreover, results showed a more positive attitude among participants regarding the role they should play in the maintenance of their health. Finally, the findings revealed behavioural changes of participants towards their health, for instance in the self-management of one's health and in the preparation of one's consultation with the pharmacist.
Furthermore, one year after their participation in the program, improvements in former participants' behaviour towards health remained constant and was at times even consolidated. Improvements were noted in the following areas: preparation towards consultation with the doctor and pharmacist; self-management of health including self-management of psychological factors such as stress, depression and anxiety; level of physical activity; eating habits; and sleeping hygiene.

Subsequent data examination also indicated a sense of personal effectiveness heightened by participation in the program, which led to better preparation before consultation with a doctor or pharmacist and acquisition of health-conscious behaviours.

Impact of the findings

The effects measured by the assessment have considerable implications at the scientific, individual, social and socioeconomic levels.

At the scientific level, the study demonstrates the program's short-term impact on participants' health-conscious behaviours and indicates that they are still maintained one year after their participation in the program. Furthermore, the findings highlight how the sense of personal effectiveness helps attain the program's objectives.

At the individual level, the study shows that it is possible, through an andragogic program, to have people aged 55 years and over develop new knowledge, adopt positive attitudes concerning their role in keeping healthy, and develop health-conscious behaviours. In a wider sense, the study indicates that for people in that age group, it is possible to improve their sense of personal effectiveness with respect to becoming responsible for and self-managing their health.

At the social level, like other health education programs, *Les médicaments : Oui… Non… Mais!* brings to light interesting perspectives for improving the health of the ageing population. These results support recommendations made by the United Nation[7] and the World Health Organization[8] to the effect that, disease prevention and health promotion interventions should be offered to individuals throughout their lifetime, even in old age. At the socioeconomic level, it could be argued that the positive effects of the program on healthy behaviours might lessen the tendency to resort to healthcare services and thus decrease related costs. Fries, Green and Levine[9] are of this opinion. They also argued that health promotion interventions, especially those aimed at chronic and degenerative disorders, are most effective in the senior and pre-senior population.

Conclusion

According to the World Health Organization[10] in its global strategy targeting "health for all," acquiring individual skills in health promotion constitutes a most appropriate field of intervention. Indeed, health education initiatives motivate individuals to want to be healthy, to find the means to improve their health, to adopt means to maintain good health and seek help, if needed. By means of its andragogic approach, *Les médicaments : Oui… Non… Mais!* is consistent with this pedagogical process and with a strategy of personal empowerment.

Les médicaments : Oui… Non… Mais! is the type of program that has been recently proposed by the Ministère de la Santé et des Services sociaux in its draft Pharmaceutical Policy, specifically in the section entitled *Promoting Optimal Drug Use—Empowering citizens to maintain and improve their health by informing them about medication and its use*. Our observations have indicated that, contrary to common beliefs, seniors, particularly those aged between 55 and 75 years old, constitute a target of choice for custom-made activities in the area of health education. Moreover, during parliamentary commission hearings on the draft policy, organizations representing seniors requested programs of this type.

Finally, clinicians would hope that their patients, especially those affected by chronic health problems, become more proactive and better informed partners so that they may participate more effectively in the implementation of their health and treatment plans.

Translated from French by Marc Pilon

Notes

1 Olivier, C. (1991). *Description et évaluation du projet d'intervention sur « Les médicaments chez les personnes de 55 ans et plus »*, Hull, Département de santé communautaire de l'Outaouais, 126 p.
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For a pharmaceutical policy adapted to seniors

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Senior prescription drug consumption has been a major concern of the Conseil since its inception. This is why it filed a memorandum concerning the Draft Pharmaceutical Policy, tabled by Minister of Health and Social Services Philippe Couillard in December 2004. The memorandum was then referred to a parliamentary committee in May 2005. This article summarises the positions held by the Conseil des aînés in this matter.

Accessibility of medication

Since 1997 in Québec, prescription drug insurance coverage has been mandatory. However, because private plans are mainly available to workers, the vast majority of seniors are covered under the Québec Basic Prescription Drug Insurance Plan (BPDIP).

The Conseil des aînés believes that significant increases in plan premium rates result in negative health and welfare effects for many seniors, considering for instance that their average disposable income was $17 850 for 1997 , compared to $22 328 for 2003. In fact, from 1997 to 2004, the annual premium paid by people insured under the BPDIP rose from $175 to $494 (the maximum amount was set at $538 on July 1, 2006). From this, the assumption can be made that, with each rate increase, many seniors reduce or stop taking their medication, running the risk of being hospitalized.

The following observations from the study conducted by Tamblyn and colleagues[2] confirmed the assumption:

- Reduction in essential medication taking for 9.1% of seniors
- Reduction in non-essential medication taking for 15.1% of seniors
- Increase in emergency consultations for 43% of seniors
- Increase in adverse drug effects for all seniors

The Conseil des aînés was thus pleased with the proposal put forth in the draft policy to Provide free access to drugs for elderly people who receive the maximum payment from the Guaranteed Income Supplement (GIS).[3] Nevertheless, it is obvious that other people have a difficult time obtaining their prescription drugs. Consequently, for the Conseil, it is equally paramount that free access to prescription drugs be extended or premiums reduced, as warranted, for low-income clienteles.

Optimal drug use

Optimal drug use is, "Use that maximizes benefits for and minimizes risks to the health of the population, taking into account alternatives, costs, available resources, and values of the patient and of society."[4]

Regarding non-optimal drug use, factors noted include non-compliance, voluntary or otherwise, with the frequency, intensity and duration of drug taking; inappropriate choice of medication or dosage; drug interaction or duplication; the need to update physicians' knowledge and the influence of advertisement from pharmaceutical companies; and lack of pharmacists in hospitals CHSLDs and CLSCs.

In addition, half of seniors accept prescriptions out of hand without asking questions as to potential side effects, recommended dosage and other possible choices. Consequently, seniors must be made aware of the importance of fully discussing these matters with their physician or pharmacist in order to ensure optimal drug use.

Moreover, seniors regularly resort to "natural" products. Yet, given the multitude of these products available, seniors must have the ability to make enlightened choices supported by precise, reliable and accessible information. Unfortunately, these purported "natural" products often cause side effects and may interact with other drugs. It is crucial, therefore, that seniors be informed of the need to consult a doctor or pharmacist before using such a product.

The Conseil also considers appreciation training in gerontology and geriatrics to be essential for health professionals, especially medical practitioners and pharmacists. As such, university medical and pharmaceutical faculties should provide a significant place for such training in their program.

Finally, the Conseil notes that no representative of clienteles sits on the Conseil du médicament or the round table on prescription drugs. The pharmaceutical policy would thus provide an excellent opportunity for adding a seat to these bodies, one reserved for an elder.

Establishing a fair and reasonable price
The continually rising costs of the public prescription drug insurance plan stem from three main factors:

- The higher average cost per prescription (due to the prescriber adopting new and generally more expensive drugs to replace older medication)
- The increase in the number of prescriptions per beneficiary who is actually purchasing prescription drugs (due to new drugs that address previously untreatable disorders, the rising use of medication for preventive reasons and increasingly frequent chronic conditions)
- The number of people insured by the public plan who actually use prescription drugs (factor influenced mainly by demographic ageing).

On the basis of these three factors, the Conseil has concluded that optimal drug use could eventually alleviate the first two factors. Just the same, it appears inevitable that rising drug costs must be closely examined.

Since 1994, a non-increasing price policy concerning drugs listed in the Drug Formulary has been in effect in Québec. In spite of this policy, the costs of managing the BPDIP have risen. And so, given the importance of preventing a new cost increase, notably for senior users, the Conseil has formally expressed its disagreement with the decision to End the non-increasing drug price policy.

A dynamic pharmaceutical industry
Market opportunity ranks at the top of considerations influencing pharmaceutical businesses in their investment decisions. In turn, market opportunity is greatly influenced by coverage conditions. Interestingly, the pharmaceutical industry is one of the key sectors targeted by the strategy devised by the Ministère du Développement économique régional et de la Recherche. This undoubtedly explains the reasoning behind the proposal to Keep the 15-year rule in its current form, instead of setting up a reference-based pricing system, with which the Conseil disagrees.

For example, the 15-year rule ensures that innovative drug manufacturers are fully reimbursed for the cost of their products for a 15-year period from the time the drug is listed on one of the formularies, even if the drug patent has expired and a cheaper generic equivalent exists. In comparison to the rest of Canada, this rule extends the protection given to patented products by five years.

This measure entails expenditures, but, according to assessments done by the Ministère des Finances, the economic benefits for Québec outweigh the costs. Yet, since 2000, the government has paid out $10 million annually into the prescription drug insurance fund to offset additional costs resulting from the 15-year rule, this in keeping with Act respecting the Régie de l'assurance maladie du Québec. Moreover, the amount of this compensation has not been reassessed since and so today it clearly appears insufficient to cover the actual resulting costs. In 2004, le Auditor General of Québec found that the BPDIP was incurring losses of $4.7 and $12.4 million for the two previous financial years respectively.

As was recommended by the Auditor General, the Conseil has underscored the need to review the 15-year rule with regards to generic or therapeutic substitution, whenever possible, while taking into account the impact on the pharmaceutical research support and development policy.

Pending the arrival of the pharmaceutical policy…

Following the consultations on the Draft Pharmaceutical Policy, Bill 130 was quickly passed. Improvements to previous legislation included the addition of a component in response to some of the criticism made by the Auditor General to improve management of the BPDIP.

Nonetheless, the Conseil des aînés does not deem these measures sufficient to prevent rising BPDIP costs. In fact, certain measures will trigger a rise in the average cost per prescription, one of the main causes, if not THE main cause, of the increasing costs of the Plan. What matters most for the Conseil is neutralizing the inflationist nature of BPDIP expenditures. Current costs have already caused a portion of seniors to be deprived of their essential medication. The Conseil therefore stresses the urgency of improving this deplorable situation by way of the future drug policy.

As for the Policy, which was due in early 2006, consultations are currently underway with the pharmaceutical industry and wholesalers. So stay tuned…

Translated from French by Marc Pilon

Notes

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2 Tamblyn, R. et coll. (2001). Adverse events associated with prescription drugs cost-sharing among poor and elderly persons, *Journal of the American Medical Association*, vol. 285, no 4, 421-429
3 La prestation maximale du Supplément de revenu garanti (SRG) équivaut, en 2006 (juillet à septembre), à un revenu annuel de 13 021 $.
4 Conseil du médicament.

Fall 2006 Schedule: Elder Abuse Consultation Team Lectures and Case Discussions

The Elder abuse consultation team of the CLSC René-Cassin of CSSS Cavendish would like to invite you to join us in our monthly meetings for a case discussion and a special presentation by one of our members. Each month, one member will present on a topic related to elder abuse in their professional context.

All meetings take place at CLSC René-Cassin, 5800 Cavendish Blvd., from 3:00pm to 5:00pm in room 19-20-21 on the 6th floor (except for the September meeting that will take place in room 31 on the 6th floor).

October 19, 2006

Sergent Denis Théorêt, Division des stratégies avec la communauté - Sûreté Québec
Programmes de la Sûreté Québec pour contrer l'abus et la fraude chez les aînés

November 16, 2006

Me. François Dupin, Lawyer, Bureau du Curateur Public de Québec
La fin des foyers clandestins pour aînés ? Qu'apporte la nouvelle loi en matière d'imputation de responsabilité?

December 14, 2006

Me. Marie Claude Lauzanne, Procureur, Cour municipale, Montréal
Abus physiques et financiers commis par des enfants-adultes envers leurs parents dans un contexte de cohabitation : plaintes enregistrées par les services policiers et réponses judiciaires

RSVP : Francine Cytrynbaum francine.cytrynbaum.cvd@ssss.gouv.qc.ca or by phone at 514 484-7878 extension 1352

Medication: seniors' unruly ally

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Medication has become an unavoidable therapeutic healthcare option. Today in emergency rooms, it is not rare to see seniors who regularly take more than 10 different medications daily. More than any other group of patients, elders who suffer from several illnesses face the increased risks of adverse drug effects and harmful drug interaction due to polypharmacy.

When properly used, medication can serve to treat or slow down several disorders or avoid resorting to more invasive procedures. More often than not, however, medication causes frequent suffering and visits to the hospital, all of which could be avoided. As such, polypharmacy among seniors constitutes a public heath problem because these harmful effects are reflected by elderly patient hospitalization rates. According to the World Health Organization (WHO), this phenomenon is responsible for 10 to 20% of geriatric hospitalizations. Better medication toxicity monitoring procedures for those most at risk could have a significant effect on traffic flow in certain health service facilities.

First, consider an alternative to medication

Due to the frailness of many seniors, a systematic and rigorous approach is needed when adding or modifying medication. The risks and benefits to the health of individuals must be assessed, and a non-pharmaceutical alternative must be envisaged if it is available. If medication cannot be avoided, several parameters must be taken into account, such as the individuals' physiological vulnerability, their ability to metabolize the substance, along with certain social and personal factors, including getting their enlightened cooperation regarding the pharmaceutical care plan. Going against these principles risks creating obstacles to observance, and provoking adverse effects or the unforeseeable follow up of disorders, all of which could lead to a breakdown in mutual trust and the undue use of other resources.

The elderly represent a very heterogeneous group, which is why individualized treatment is essential. And since there is much variability in each individual's response, it is important to engage in systematic monitoring of the effectiveness and adverse effects of medication. Furthermore, patients should benefit from the proven knowledge derived from fact-based medecine, but frail elderly are not represented in clinical studies conducted toward marketing medication. This is because experimental and clinical data are generally extrapolated from results taken from younger subjects without the same age- or illness-related dysfunctions. Thus, a certain empiricism is at the origin of prescribing medication for these already vulnerable people.

Prevent or react after the fact?

Several seniors are homebound and have limited access to all the services adapted to their situation. Pharmacists rarely see these patients in their dispensaries. Medical home visits are infrequent. If pharmaceutical intervention is necessary at a critical moment, the successful outcome will depend on effective communication channels between the physician, pharmacist and home support service team. Unfortunately, emergency services are often the only alternative for the home visiting nurse who detects a serious problem. The emergency physician must frequently adjust a patient's medication without knowing the details of the person's habits or medication consumption. In addition, certain pharmaceutical profiles are complex enough that no professional can find the time necessary for in-depth analysis. So, health conditions permitting, the patient is returned home. At that point, many practitioners expend much energy and waste precious time recovering information and understanding the changes made to the pharmaceutical care plan in order to adjust their own intervention.

After being discharged from hospital, the patient is at a high risk of… returning to hospital. A recent study shows that problems due to medication can account for close to 72 % of cases of rehospitalization[1]. According to the authors, half of these events could have been prevented. Lack of communication and concertation between various service structures were mainly to blame for this situation.

Coordinating interventions becomes more complex when pharmaceutical care depends on several organizations answering to different administrative authorities. To avoid such a break in continuity, individualized data concerning patients' medication must be accessible, when needed, by practitioners who are involved with the use of medication. This avoids always having to start over collecting the information specific to each service point, which, in turn, helps in establishing the necessary patient follow up. It is a simpler matter to guide the concerted efforts of several care providers toward the prevention of medication-related problems if the potential risks of using a given medication have already been identified in a service point. Concerning frequently-hospitalized patients, hospital and community pharmacists must play an active role in maintaining this type of pharmaceutical information and build on the continuity of the care they provide.

This continuum can contribute to better integration of pharmaceutical services to the health network. Ideally, this regularly updated information should contain the following items: certain patient-related specifics (allergies and intolerances, medical diagnoses, ability to manage medication, and presence or absence of specific medication-taking aid); list of medication used (including natural medicines, over-the-counter products, products from abroad); and analyses and recommendations by pharmacists who evaluated the patient and the patient's medication (pharmaceutical care plan). This last item would complete the home support team's interdisciplinary intervention plan.

The importance of periodically reviewing medication

Seniors should have their medications fully reviewed periodically by a competent practitioner. The frequency can be determined by their condition, but an annual review is desirable.

Such a review makes it possible for patients to be taken off or cut off obsolescent or potentially dangerous medications. Currently, few home support programs feature a systematic procedure for reviewing high-risk patients' medication. Certain countries have considered and implemented measures aimed at having pharmacists review seniors' medication at home[2]. In Québec, pilot projects should be implemented in order to assess the contribution such preventive approaches have on preventing pharmaceutical problems. Home visits focusing on patients and their medication then become privileged opportunities to teach, and find out the patients' needs, habits and their attitudes regarding medication. Such interventions can provide precious information on these patients' ability to adequately manage their medication, reveal observance problems or allow early detection of adverse effects. Certain guides can help practitioners better structure their systematic review of patient medication during home visits[3].

Pharmacovigilance at home

In a context of restricted resources, programs that promote optimal use of resources must be implemented. Using medications safely concerns many practitioners from various professions, who have a role to play in sustaining the autonomy of seniors. For example, members of a CLSC-based home support team were invited to report problems they deemed potentially related to the medication of frail seniors. After undergoing brief training, these practitioners (visiting homemakers and social aids, nurses, social workers, physiotherapist and nutritionist) would keep the pharmacist informed, using a pharmacovigilance card, about the medication-related problems they had spontaneously detected when providing homecare services to patients. In this unpublished study, more than 80% of reported events were considered sufficiently relevant to warrant action regarding the patients' medication[4].

The use of medication by seniors impacts their health to a degree that requires immediate attention. For this reason, implementing procedures directed at preventing medication-related problems must be a priority. Furthermore, these procedures must be developed jointly with home support programs because these front-line services already have the organizational structure that enables close contact with homebound patients. Creating and using common work tools must also contribute to helping service providers clarify their homecare role when medication is involved. The eagerly awaited information from the health network should allow for more coherence in tackling this type of problem and foster better integration of pharmaceutical care and pharmaceutical services.

Translated from French by Marc Pilon

Notes

1 Forster A.J., Clark, H.D., Menard, A. et coll. (2004). Adverse events among medical patients after discharge from hospital. CMAJ, 170(3): 345-9.

2 Australian advisory Council (2001). *Quality use of medicines: A decade of research, development and service activity 1991-2001.*

3 Tassé, M. (2003). A guide for pharmacists involved in home visit services. *Canadian Pharmaceutical Journal*, 136(2):36-40

4 *Programme de pharmacovigilance à domicile. Projet SIPA.* CLSC Bordeaux-Cartierville, 2001.