Implementation of the Beers Criteria: Sticks and Stones—Or Throw Me a Bone

BOGSAT. While not very flattering, BOGSAT (Bunch of Old Guys Sitting Around Talking) accurately describes traditional decision making across many disciplines, including medicine. In an attempt to validate expert opinion panels using the BOGSAT method, the Evidence-Based Medicine (EBM) movement sprang up from the original writings of Dr. David Sackett and colleagues at McMaster University, Hamilton, Ontario. They defined EBM as ". . . the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."[1] At first blush, such a simple definition would seem inoffensive and readily accepted by most rational people; however, breaking the habit of relying on expert panels has been difficult.

In an effort to determine which drugs are truly contraindicated in older adults, Dr. Mark Beers at the University of California at Los Angeles, used a Delphi method survey technique to query 13 nationally recognized experts in 1991. The expert panel compiled a list of explicitly defined criteria to identify inappropriate use of medications in nursing home residents.[2] The list became known as the Beers criteria and is arguably the most widely utilized tool to examine medication use in the elderly. The Beers criteria were updated in 1997 to focus on ambulatory elderly, and again in 2003.[3,4] Both updates used consensus panels of national experts selected by the authors to choose which medications were added or deleted for each update. Previous issues of the *Journal of Managed Care Pharmacy* have presented clinical intervention programs designed to dissuade physicians from prescribing drugs defined by Beers as inappropriate and drugs defined by Zhan as inappropriate.[5] An editorial drew attention to examining more closely the drugs that managed care organizations ask physicians to avoid prescribing.[6]

Given the ripple effect of EBM concepts across the world of clinical medicine, the bar has been set higher for what clinicians are now willing to accept and implement; expert opinion alone is no longer adequate to significantly drive physician behavior. For example, when task force members from the American College of Cardiology wanted to publish an update on exercise treadmill testing, they did not use a Delphi technique and Likert questionnaires to determine the collective opinion à la the Beers criteria. Instead, the task force did a systematic review, rated the available evidence using a standardized taxonomy, and categorized their findings by strength-of-recommendation ratings, according to what the available evidence supported.[7] Although not every specialty uses the same taxonomy, standardization efforts are under way.[8]

If the Beers criteria is truly intended to improve prescribing, then clinicians will need to catch the vision of the originators. As originally published by Ev Rogers, tension must be created between the status quo and the vision of a better future if people are to be inspired to change.[9] The vision of the expert panels is not readily apparent to outside observers, which limits its adoption. While all can see the present situation defined negatively—68 medications or medication classes are currently deemed potentially inappropriate by the Beers criteria—the vision of a better future has never been offered by the expert panels. For example, detailed tables in the 2003 update list what drugs to avoid, but no list is provided of what should be used instead. Specifically, if clinicians are told to avoid something, they would like to see evidence for a recommended alternative therapy, particularly patient-oriented outcomes evidence that demonstrates the superiority of the alternative. Simply put, if you bring up a complaint, don't forget the solution.

The term "potentially inappropriate medications," or PIMs, has also morphed as the concept diffused across medicine. While the authors of the 2003 Beers update note their wide acceptance by the Institute of Medicine (IOM), the Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the American Association of Health Plans (AAHP), PIMs have become DIMs—"definitely inappropriate medications." The CMS Guideline to Surveyors of Long Term Care Facilities has basically codified the Beers criteria into federal regulation.[10] Failure of nursing homes to strictly adhere to these regulations results in federal deficiency tag (F-tag) citations. In Michigan, F-tag 329, which refers to nursing home residents' "right to be free from unnecessary drugs" has been in the top 5 cited deficiencies for 2003 and 2004.[11] Transformation of the Beers criteria into definitely inappropriate medication lists has been condemned by the American Medical Directors Association and the American Society of Consultant Pharmacists.[12]

So where does this leave us? Clinicians still face common chronic conditions such as mood disorders, insomnia, and chronic pain syndromes; these patients demand symptom relief. Instead of codifying suggested prescribing guidelines into regulation, we need to redouble our efforts at collaborative working relationships between pharmacists and prescribers and remember that individual patients may legitimately need one of the "forbidden fruit" drugs. Limited successful efforts to collaboratively use alternative medications have been previously described.[13,14] Refocus on the term "potentially" inappropriate is also needed; potentially does not translate well to definitely. When evidence-based authoritative sources such as the *New England Journal of Medicine* in 2005 are still recommending amitriptyline—a PIM—as first-line medication therapy for persistent low back pain, (which affects up to 33% of the U.S. population), we need to collectively stop throwing sticks and stones at clinicians; throw them a bone and remember that the Beers criteria were intended as suggestions for therapy, not mandates.[15]

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