



Geriatrics · Educational evidence summary

What geriatric medication review can and cannot infer from a burden score

This geriatric evidence summary examines what geriatric medication review can and cannot infer from a burden score.

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What does the score establish directly?

When the medication identity and source are correct, it establishes what the named instrument reported for that entry. The [UnifiedACB observation record](#) retains the original label, source version, value and locator so that statement can be checked. This is the strongest immediate inference from the table.

It does not establish how much medicine the person took, which tissue concentration was reached or whether a symptom occurred. Those are separate exposure and clinical facts that need their own evidence.

Can it identify a medication worth reviewing?

Yes. A source classification can direct attention to a plausible exposure concern and help explain why a medicine belongs in the discussion. The usefulness comes from connecting it to a specific question: a new symptom, a relevant condition, a combination of exposures or uncertainty about a product.

The next step is to verify actual use and the clinical context. A high category for a medicine no longer taken is not the same finding as current exposure. An occasional product missing from the chart may be more relevant than its absence suggests.

Can it prove that the medication caused a symptom?

No. Causation requires more than classification. The timing, alternative explanations, known product effects and observed course all matter. A symptom that preceded treatment has a different interpretation from one that followed an exposure change, and several factors can contribute simultaneously.

The [inpatient diphenhydramine study](#) is an example of medication-specific clinical evidence in a defined setting. Even such a study does not adjudicate every individual case. The directory should describe a possible contribution when that is all the evidence supports.



Can it estimate a person's probability of harm?

Only an appropriately developed and validated prediction method could support that type of claim. An ordinal medication category is not automatically a calibrated probability. The same category can occur in people with very different exposure histories and clinical circumstances.

UnifiedACB does not create a synthetic patient-risk score by averaging source categories. Its purpose is to retain the evidence needed to understand the classifications. A percentage of risk should not be inferred from the color or size of a badge.

Does a published association validate every use of a scale?

No. Validation evidence must be matched to the construct, population and endpoint studied. The [ADS assay-association study](#), [functional-outcome study](#) and [cumulative-exposure dementia cohort](#) ask different questions. Their results cannot be pooled conceptually into a guarantee that every burden measure predicts every outcome.

A method can have useful evidence for one task while remaining uncertain for another. Reporting that boundary is more informative than calling it simply “validated” without specifying what was tested.

Does lowering the score prove that care improved?

It proves only that the reported measure changed, assuming the same method and comparable inputs were used. Improvement in cognition, comfort, mobility or another clinical outcome needs to be assessed directly. The original condition being treated also needs follow-up.

The [randomized burden-reduction trial](#) illustrates why intervention and outcome evidence are distinct. An exposure reduction is not a substitute for demonstrating the benefit that motivated the clinical review. A useful plan names that outcome before a change is interpreted as successful.

Can Beers criteria settle the treatment decision?

They add an important clinical framework, but their context and qualifications matter. The [AGS criteria](#) do not replace the person's indication, response, preferences and clinical assessment. A criterion involving a specific condition should not be applied as an unqualified whole-drug verdict.

The selected overlay is also narrower than the full criteria. Absence from it is not a safety finding. The source-scale evidence and supplemental geriatric context should remain separately labeled so the reader can see what each supports.

What can a low result reasonably reassure us about?

It can describe a lower classification under the named method for the covered medication set. It cannot certify overall medication safety or rule out symptoms through other mechanisms. Missing entries should be reported separately, because incomplete coverage can make a result appear lower without providing additional reassuring evidence.



The appropriate reassurance is bounded and specific. Preserve the low finding as published, explain what it measures and keep unrelated clinical questions open.

What should the review produce instead of a verdict?

A good review produces an accurate medication history, a traceable evidence summary and a focused clinical question. It identifies the benefit of treatment, the concern being assessed and the information needed for a decision. If care changes, it includes an appropriate monitoring plan.

This is a more useful outcome than labeling the whole regimen “safe” or “unsafe” from a score. The evidence supports structured judgment by making its limits visible, not by pretending that the numerical output contains the entire clinical answer.



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Explore the evidence

[Ask UnifiedACB](#) about a medication or source, browse the [Medication Library](#), or read the [methodology](#).

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