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Recommendations to help clinicians safely reduce or stop patients' medicines are outlined in new research. The study included people with multiple long-term conditions who were taking treatments that were no longer right for them.

People living with multiple long-term conditions often take many different medications (polypharmacy). While this can be necessary, polypharmacy can be associated with harm and waste. Many people taking 5 or more medicines per day feel overburdened by their treatment. Polypharmacy is a challenge for patients, professionals and health services alike.

Most treatment guidelines are written for people with single conditions; a recommended treatment might therefore not be right for people with multiple conditions. But clinicians have little guidance to help them decide how and when to stop or reduce medications (a process called deprescribing).

In the TAILOR study, a review of previous research found that deprescribing is generally safe and acceptable if done in a structured way. The researchers then carried out a realist review of papers that explored how deprescribing happens in practice. From this, they identified factors that help clinicians deprescribe.

More information about polypharmacy and deprescribing is available on the Specialist Pharmacy Service website.

Factors that help clinicians deprescribe

- **Clarity on how and when to prescribe outside of guidelines**, and on their professional responsibilities when doing so
- **Access to high-quality data** about patients' medication history, but also life stage and key events such as recent bereavement
- **Discussing plans to stop a medicine when it is first prescribed** to develop a shared understanding of the purpose of treatment

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- **A trusting relationship** with patients.

The issue: why does deprescribing matter?

About 1 in 5 people take 5 or more medicines every day (polypharmacy); this includes elderly people in particular. Medicines can have harmful side-effects, and complicated treatment regimens can make them difficult to take. These negative effects can sometimes outweigh the benefits of treatment. Among people taking multiple medicines, 4 in 10 feel burdened by their treatment.

The Kings Fund has recommended safely stopping or reducing treatments that no longer provide benefit or are causing harm for people with multiple conditions. Existing tools (for instance the Beers Criteria and the Department of Health's STOPP/START tool) can help clinicians stop prescribing long-term medicines that are no longer appropriate. But there is little advice to help doctors stop or reduce treatments that are recommended for a specific condition, but not right for a particular patient. Both doctors and patients can feel anxious about when and how to safely stop medicines.

There is a lack of information and support on how to make individualised decisions to stop or reduce treatments. Researchers therefore reviewed previous research on deprescribing, and carried out a realist review. They drafted recommendations for how it can be improved. The team worked with patients and members of the public throughout the study to ensure their findings are relevant to those affected.

What's new?

The TAILOR literature review included 20 studies on deprescribing. Study participants were aged over 50, had 2 or more conditions and were taking 5 or more medicines per day. The researchers found that existing tools (such as the Beers Criteria and STOPP/START) could be safe and were acceptable to doctors. However, some patients benefitted from stopping treatment while others' health declined. Patients' views on deprescribing were not often reported.

The researchers then carried out a realist review of 119 papers describing how tailored deprescribing decisions happen in practice. They identified factors that help clinicians deprescribe.

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1. **Clarity about caring outside of guidelines.** Guidelines are perceived as best practice, but are usually developed to treat a single condition, rather than multiple conditions. Many clinicians did not feel they had permission to care outside of guidelines, or to deprescribe medications prescribed by specialists.

2. **Access to relevant patient data**. Patients' notes need to include up-to-date information on their goals and background (if they are recently retired or bereaved, for instance), as well as their health. Other team members need this information to continue care.

3. **Discussing plans to stop a medicine when it is first prescribed**. This helps clinicians and patients develop a shared understanding of the purpose and impact of treatments. Currently, reducing or stopping medication is often not discussed until problems arise.

4. **Trust.** Good relationships and trust between clinicians and patients are nurtured through understanding of people's symptoms and situation, and through regular review to discuss how they are getting on with their medication and if their goals have changed.

The research found that longer appointments would be helpful, especially when medications are first prescribed, and when deprescribing. Clinicians need to explain deprescribing and to explore patients' concerns, especially if the medications have given them a sense of safety or support. These discussions help build and retain trust. GPs may also need extra time when prescribing outside of guidelines, to research appropriate approaches for their patient.

Why is this important?

The study showed that existing tools (for instance the Beers Criteria and the STOPP/START) are safe and acceptable. But knowing when and how to stop a medicine is rarely straightforward and clinical judgement will always be necessary.

The researchers stressed that deprescribing is complex. Clinicians have to give tailored explanations to individual patients about their medicines, potentially work beyond guidelines and manage uncertainty. They need a supportive framework, which includes clear guidance about prescribing outside of guidelines, good access to patient information (including previous discussions) and the time to discuss expectations about a medicine (and when it might be stopped) when first prescribing.

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The report stressed the importance of trust between clinicians and patients. It described how trust, and joint working to achieve the patient's goals, can impact prescribing decisions and patient outcomes. Trust is generated and maintained through a clinician's awareness and understanding of the person they are caring for. This includes knowing what is important to them, discussing treatment goals, and putting deprescribing into context. A clear commitment to follow-up, and consistent advice given by the extended clinical team, helps to build trust.

What's next?

The researchers have produced online training on NIHR Learn to help improve doctors' confidence to deprescribe.

The study noted difficulties in finding information about deprescribing. Previous studies had collected data in different ways. Standard definitions of deprescribing would help future research, they say.

You may be interested to read

This Alert is based on: Reeve J, and colleagues. Deprescribing medicines in older people living with multimorbidity and polypharmacy: the TAILOR evidence synthesis. *Health Technology Assessment* 2022;26(32).

An NIHR Evidence Collection about people living with multiple long-term conditions: Multiple long-term conditions (multimorbidity): making sense of the evidence.

A research paper exploring some of the challenges and aids to deprescribing: Okeowo DA, and others. Barriers and facilitators of implementing proactive deprescribing within primary care: a systematic review. *International Journal of Pharmacy Practice* 2023;31:126-152.

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Conflicts of Interest: One author has delivered educational workshops supported by pharmaceutical companies; several authors are members of Health Technology Assessment committees. Full details can be found in the original research paper.

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