

De-prescribing in primary care: the clinical, ethical and psychological considerations

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In today's health care environment, a contrasting scenario emerges: the advancements of modern medicine provide patients with numerous treatment options, yet at times, simplicity proves more effective. This idea lies at the heart of de-prescribing in contemporary medicine. Whilst various definitions of de-prescribing have been proposed, it is agreed to involve the planned and supervised discontinuing or tapering of medications that are judged to be inappropriate.^{1,2} This initiative finds its roots in primary care where the established therapeutic relationship between patient and physician provides an essential backdrop for holistic, generalist health assessments, and proactive, preventative care.³

The importance of de-prescribing becomes even more pronounced in the elderly population.¹ As people age, they often accumulate numerous medications, each prescribed for a specific ailment or risk. Polypharmacy, defined as concurrent use of five or more medications, has been associated with adverse drug reactions, poorer adherence, increased health care costs, falls, and reduced quality of life. Elderly patients, due to physiological changes, are especially vulnerable to the harms of inappropriate medications.⁴ There is also the challenge of drug–drug interactions, which can lead to diminished therapeutic benefits or even new issues. In such contexts, the line between benefit and harm blurs, prompting a need for re-evaluation.⁵

Yet, the process of de-prescribing is fraught with uncertainty. Some physicians may encounter de-prescribing as an ethical dilemma, being ingrained with the duty to alleviate suffering and provide care, and finding it counterintuitive to stop a medication. Does stopping a medication signify a withdrawal of care? Or does it represent an evolved understanding of care, one that prioritises the patient's holistic well-being?

From a clinical standpoint, the complexities surrounding the decision to de-prescribe often wade into uncharted waters.⁶ Consider a scenario where a patient, having been on a specific medication for many years, presents no overt side effects. However, the tangible benefits of this medication are ambiguous at best. Such cases provoke the question: is discontinuing this medication warranted? Furthermore, the decision making process becomes complicated by the inherent variability of patient responses to medications.⁷ Whilst one patient might thrive without a certain medication, another might deteriorate, complicating predications about clinical outcomes. Beyond this, a clinician must also seek to understand and negotiate the patient's beliefs and values about their health, and must seek to collaborate with the patient on a decision. Each decision becomes a balance, and clinicians are often left navigating this challenging equilibrium, drawing on both their clinical expertise and their understanding of individual patient priorities.

Uncertainty is greatly compounded for clinicians by the lack of evidence-based guidelines for de-prescribing, or even data on the outcomes of de-prescribing in general, or stopping specific medications. Lack of clear processes or guidelines has been found to be a significant barrier for primary care physician (PCP) de-prescribing.⁸ STOPP/START and Beers criteria have been developed as frameworks to aid de-prescribing decision making, specifically for elderly patients with polypharmacy.⁹ There is an evidence-base for their success in identifying and undoing inappropriate prescription. However, whilst an excellent example of tools that could support clinicians in de-prescribing, when surveyed, many are unaware such tools exist.¹⁰ In certain instances, consulting secondary care specialists may also help inform decision making, although PCPs may feel their holistic perspective may misalign with a specialist's concern for a specific condition or treatment.

PCPs stand as central figures in the complex web of modern health care, particularly when it comes to the initiation and management of long-term medications.¹¹ The PCPs' unique position in observing the holistic picture of a patient's health, and their continuity of care and trust-building over time, have been cited by patients as important factors when navigating polypharmacy (in contrast to specialists).¹² The therapeutic alliance formed between PCPs and their patients can be seen as a double-edged sword. On the positive side, it facilitates an atmosphere of trust and openness, where patients feel comfortable sharing their concerns, experiences, and preferences about their medications. This transparent dialogue and shared decision making is essential as it forms the foundation for patient-centred health care, ensuring that treatments align with the patient's values and circumstances.

However, the relationship also brings significant responsibility. PCPs, equipped with their medication knowledge, are faced with the daunting task of deciding whether to continue, alter, or halt a treatment in the absence of a clear supporting guideline.^{5,6} Such decisions can have profound implications on a patient's life and well-being. The responsibility also requires navigating the balance between addressing immediate health concerns and foreseeing long-term outcomes.¹³ While the bond between patient and physician can be a source of strength and collaboration, it also places an immense weight on the physician's shoulders, requiring a delicate blend of knowledge, empathy, and discernment.¹⁴

Further complexity comes when PCPs must make de-prescribing decisions in conjunction with the families or carers of patients that lack capacity to partake in decision making, or who otherwise wish to involve family members. This can present multiple, sometimes conflicting, beliefs or understandings of medications. At worst, physicians may fear de-prescribing being misconstrued by family members as care withdrawal.¹⁵ A complex ethical position must be maintained between the clinician's responsibility to uphold what they believe to be in the best interests of their patient, in balance with the need to seek and accommodate the views of family members or carers, particularly their knowledge of the patient's beliefs and cultural context.

The influence of external pressures on the medical landscape cannot be understated.¹⁶ The robust health care industry, fuelled by constant pharmaceutical innovations and often aggressive marketing tactics, frequently puts the newest medications at the forefront. Such prioritisation can overshadow the question of whether these medications are the best choice for the patient. Moreover, patients themselves, are often exposed to direct-to-consumer advertising with compelling narratives and promises.^{15,17} In certain cases, surrounding social media discourse can mix with this to promote emotive beliefs about the absolute necessity of specific medications. These are not just minor influences; they can significantly shape a patient's perception of their

health needs. Faced with these external pressures, PCPs are placed in the challenging role of gatekeepers. They must consider the latest evidence-based practices against each patient's unique circumstances and priorities.

Beyond the clinical and ethical complexities, the psychological dimension of de-prescribing cannot be overlooked. Several studies have tried to understand the psychological aspects and belief systems effecting a patients' contribution to decision making.¹⁸ For some, medications can serve as more than just treatment; they act as a symbol of stability in the face of age-related vulnerabilities.¹⁹ Similarly, they can be perceived as an unavoidable accompaniment of aging, and something vital for preserving or even lengthening life (a view reinforced by medical professionals). Conversations around de-prescribing can therefore stir profound emotional responses.²⁰ Such conversations may touch on a patient's more ultimate ideas around their life expectancy, as well as their individual priorities and beliefs about extending life at any cost, or instead prioritising quality of life. This latter aspect can be influenced by innumerable factors, particularly their prior experiences of health and the health of loved ones, as well as their cultural and/or religious background. Discontinuation can additionally alter psychological well-being, and might inadvertently send a message that their health is deteriorating or that they are being deprioritised.²¹ Such patient factors are hugely diverse, and in being unique to each patient, the act of de-prescribing demands a sensitive approach, entailing a deep understanding of the patient's emotional state, beliefs, and psyche.

There is diversity as well in how involved patients wish to be in shared decision making. Certain patients will want to make fully informed decisions, seeing themselves as an equal partner, with the clinician bringing medical expertise, and the patient bringing expertise on themselves.²⁰ Conversely, some patients report a preference to defer all de-prescribing decisions to their doctor and/or family member. Most patients report a positive view of de-prescribing in principle, and a willingness to discuss it, however, in contradiction, many still hold belief in the necessity of each individual medication. Some patients can perceive de-prescribing as an opportunity to be rid of medications they don't believe are offering perceivable benefit, or may be actively causing side effects. Clinicians therefore must help guide patients through this contradiction and uncertainty. Both the patient's and the clinician's individual tolerance of risk and uncertainty additionally influences decisions, although clinicians are well-served by framing any unsuccessful de-prescribing as a worthy and informative trial rather than a failure of recovery.²²

For PCPs, de-prescribing highlights the need for a dual skill set.²³ Alongside their clinical expertise, they must also be proficient in communication around de-prescribing, providing empathetic care, and supporting patients to articulate and realise their health goals over time. PCPs unique placement makes them highly suited to this task. Patient-shared decision making in tandem with existing clinical

frameworks can support PCPs to achieve positive outcomes for their patients' holistic well-being. However, further research is vital to better support PCPs in navigating the complexity of de-prescribing, both quantitatively in evidencing the clinical benefits of de-prescribing, and qualitatively in better understanding patient perspectives.

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