Practical approaches to deprescribing in general practice

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Background
Polypharmacy is common in older people and is associated with a higher risk of adverse drug events, hospitalisation and diminished quality of life. Deprescribing, defined as the planned and supervised reduction or discontinuation of medicines, is an important strategy to address inappropriate polypharmacy. Despite its benefits, integrating deprescribing into routine general practice remains a challenge.

Objective
This article outlines strategies for embedding deprescribing into routine general practitioner (GP) workflows, drawing on deprescribing guidelines, conversation frameworks, patient typologies and multidisciplinary collaborations.

Discussion
GPs, with their holistic understanding of patients, are well-positioned to lead deprescribing. Key opportunities to initiate deprescribing include recent clinical events, structured health assessments and prescribing alerts. Tailored strategies are useful to frame deprescribing discussions according to patient typologies. Integrating deprescribing guidelines into practice, routinely considering deprescribing at the time of prescription renewal and auditing prescribing can help achieve sustainable improvements in clinical care.

DEPRESCRIBING is increasingly recognised as an essential element of good prescribing. Although the term is relatively new, the practice of discontinuing ineffective or harmful medicines has long been part of general practice. The principle of rational prescribing and deprescribing sit within the overarching notion of therapeutics with the aim to maximise benefits that matter to the person and minimise potential harms and burden, achieving an overall net benefit.[1] What remains challenging, however, is the practical implementation of deprescribing in routine clinical care.

General practitioner roles in deprescribing

Deprescribing is a collaborative approach that involves all healthcare professionals involved in a person's care. Having clearly defined roles and responsibilities for each health discipline in deprescribing is seen as a major enabler to wider implementation.[2] General practitioners (GPs) are generally viewed as central medication managers with overarching responsibility for coordinating and overseeing care, including decisions about the continuation of medicines.[3,4] Patients often have a continuing relationship with their GPs, with high levels of trust.[5] In 2022–23, GPs prescribed 88% of all Pharmaceutical Benefits Scheme (PBS) and Repatriation PBS medicines dispensed,[6] putting them in a strong position to also lead deprescribing efforts. Their deep knowledge of patients' medical histories, preferences, comorbidities and social contexts further helps GPs identify deprescribing opportunities.

When to consider deprescribing?

New deprescribing guidelines, endorsed by The Royal Australian College of General Practitioners (RACGP), are now available to support safe deprescribing.[7] Recognising the potential clinical and economic benefits of reducing inappropriate polypharmacy, these guidelines suggest regular medication review for older people (defined as those aged 65 years

and over) who are receiving multiple long-term medicines or experiencing polypharmacy (ie concurrent use of five or more medicines).[7] However, it is important to note that the number of medicines alone does not necessarily indicate medication appropriateness. In practice, a range of prompts to review medicines and consider deprescribing are outlined in Box 1.

Different 'deprescribing' typologies

Deprescribing is generally well received by patients,[8] particularly when the conversation is framed to clearly convey its purpose.[9] It is not about 'giving up' or taking something of value away, but rather about optimising care and aligning treatment with what matters most to the individual.[10] For deprescribing interventions to be effective, they should consider patients' diverse attitudes and preferences. Shared decision-making provides a framework for tailoring deprescribing discussions to these differences. In this approach, clinicians and patients jointly consider the available options, discuss potential benefits and harms of each, and reach a decision that aligns with the patient's unique values, preferences and circumstances.[11] Doing so can improve patient knowledge and risk perception, while reducing decisional conflict.[11]

The extent to which older patients want to be involved in medicine-related decisions can vary greatly depending on factors such as their health status, knowledge, clinician relationship and personal beliefs. Qualitative studies involving older people in Australia have aimed to understand these differences.[12] Through interviews with older people aged 75 years and older, three categories of patient typologies were identified (Box 2).[12] The Patient Deprescribing Typology has since been quantitatively validated in online, vignette-based studies conducted in Australia, the Netherlands, the UK, and the US,[13,14] and in a 14-country primary care survey of older adults taking five or more medications.[15]

A case vignette study involving 1706 GPs across 31 countries, including Australia, found that 80% reported they would deprescribe one or more medicines in the 'oldest-old' (aged >80 years) multimorbid patients with polypharmacy.[16] From the prescribers' perspective, they indicated they would be more inclined to deprescribe a medicine in patients with higher levels of dependency in activities of daily living and in those without a history of cardiovascular disease.[16] GPs have also been found to vary in how they incorporate patient goals and preferences into medicine management.[17] Research has identified three practice patterns among GPs: (1) 'Directive' considered goals and preferences as a lower priority; (2) 'Goal-oriented' saw goals as central to decision-making; and (3) 'Tacit' considered goals and preferences but would not explicitly elicit information about them.[17]

Recognising the differences among both patients and GPs, and tailoring communication guides to the preferences of both groups, can help enact shared decision-making in practice and support safer and more effective deprescribing.[13]

Barriers and enablers of deprescribing

Barriers and enablers to deprescribing have been identified in previous research and

Box 1. Deprescribing opportunities and when to consider

Opportunities to review medicines for deprescribing

- New patient
- Recent medical event (eg hospital admission, acute illness, change in condition/prognosis)
- Recent transition of care (eg movement from hospital to residential aged care or between healthcare providers)
- Frailty
- High HOSPITAL Risk Score (HRS), which predicts risk of 30-day hospital readmissions[34]
- Change in goals of care
- Over 75 health assessments for all patients over the age of 75 years
- 715 health checks for Aboriginal and Torres Strait Islander people of all ages
- GP chronic condition management plans for care planning and medication management reviews
- Reported adverse effects or suspected medicine-related harm
- Practice prescribing software safety alerts (eg Primary Sense [Gold Coast Primary Health Network, Qld, Australia][35,36] medication safety alerts for low HbA1c, low eGFR)

When to consider deprescribing

Deprescribing should be considered for medicines that meet one or more of the following criteria:

- No clear indication, or potentially part of an inappropriate prescribing cascade
- Adverse effects, the development of a contraindication or where interactions outweigh the potential benefits
- Used for symptomatic relief, where the symptoms have resolved and are unlikely to recur
- Used for prevention, when the potential benefits are uncertain or unlikely to be realised

eGFR, estimated glomerular filtration rate; GP, general practitioner.

Box 2. Patient Deprescribing Typology[12]

- 'Attached to medicines': Had positive attitudes toward medicines, high trust in their doctor and were resistant to deprescribing
- 'Would consider deprescribing': Held ambivalent attitudes towards their medicines, preferred a proactive role in decision making and were open to deprescribing if their medicines were causing problems or were not beneficial
- 'Deferred decision making to others': Gave medicines little thought and deferred decisions to their doctor or companion (eg carer or family member) and were generally unaware that deprescribing was an option

are summarised in Table 1.[18,19] Many older people, particularly those living in residential aged care homes, use dose administration aids. In these settings, pharmacies often submit automated repeat requests, which are often approved by GPs with minimal consultation. While routine repeat prescribing is time-efficient, it can inadvertently limit opportunities for deprescribing.[20,21] Additionally, transportation difficulties mean that older patients often attend appointments only when necessary and typically for specific concerns. This leaves limited scope to address broader medication management issues amidst the competing priorities. Additionally, the prescribing landscape in Australia is becoming increasingly complex, particularly with the expansion of prescribing rights to other professional groups such as registered nurses and pharmacists.[22,23] Some enablers and barriers to deprescribing might be specific to professions. However, this emerging area remains underexplored. Multilevel strategies targeting both health system reform and practice-level change might help overcome these barriers.[24]

Table 1. Barriers and enablers of deprescribing[17,18]

Categories	Barriers	Enablers
Prescriber-related	Lack of time or resources	Interprofessional collaboration between GPs, pharmacists and nurses
	Incomplete or fragmented clinical picture	Easy to use, accessible deprescribing tools and resources
Patient-related	Fear of symptom recurrence or condition worsening	Fear of adverse effects from continued medicine use
	Strong belief in medicine necessity	Trusting relationships with prescribers
System-related	Limited public health campaigns on deprescribing	Organisational and financial support for multidisciplinary care
	Limited access to effective non-pharmacological alternatives	Clinical decision support systems to prompt deprescribing

GP, general practitioner.

Medicines Conversation Guide

Many barriers to deprescribing can be overcome when patients and their families are involved in decisions about care and medication management,[25] as this engagement helps patients understand the appropriateness of, and the process for, discontinuing medicines.[26] The Medicines Conversation Guide, for example, is a one-page structured tool developed for pharmacists to use in the context of a comprehensive medication management review.[27] Developed through a systematic and iterative process and tested with pharmacists, patients and their companions, the Medicines Conversation Guide has been found to promote discussions with patients about their health goals and preferences.[27] By combining an understanding of patient typologies, GP approaches, and structured communication tools within a shared decision-making framework, clinicians can better align deprescribing decisions with what matters most to the patient. This approach supports safer, more patient-centred care and might help optimise medicine use in older adults.

Integrating deprescribing guidelines into the workflow

The new deprescribing guidelines provide recommendations for many commonly dispensed PBS medicines in older people.[7] They support decision making by outlining when deprescribing could be considered, ongoing treatment needs, monitoring requirements, and providing specific guidance on how to taper or cease medicines. However, for the guidelines to be effective, GPs need to be made aware of them, as well as be supported to integrate them into routine practice. Although wider collaboration among policymakers, clinicians, researchers, guideline developers and the medical software industry is essential to optimise usability in practice, GPs could focus on small, practice-level innovations to support guideline uptake. These might include:

- leveraging multidisciplinary collaboration (eg collaboration between GPs, pharmacists and nurses)
- setting up workflows for referrals
- encouraging team-based decision-making for complex cases
- using consultation prompts to flag potentially inappropriate medicines.

Limited time and competing priorities during patient consultation is a considerable barrier to deprescribing.[18,19] A previous study has found that consultations lasted an average of 19 minutes, during which eight items were mentioned or discussed per consult with each patient.[28] To address the time barrier to perform a detailed medication review, GPs might consider referring eligible patients to Home Medicines Reviews (HMRs) or Residential Medication Management Reviews (RMMRs) conducted by credentialed pharmacists.[29] Pharmacists can prepare detailed reports on medicine optimisation, identify medication-related problems and provide deprescribing recommendations where relevant. They also support GPs in planning and safely implementing medication changes according to an agreed plan.[30] In addition, carers and other healthcare professionals can also identify the need for medication review and initiate requests. Practice staff and management teams play a key part in identifying suitable patients,[31] and GPs can clarify staff roles to enhance support for deprescribing activities.

Monitoring and audit

Ongoing monitoring is essential for safe deprescribing, with intervals guided by both the medicines involved and the patient's preferences. Deprescribing can be implemented not only at the individual patient level but also at the practice level, for example through quality improvement initiatives. By regularly reviewing practice data, practices can gain insights into polypharmacy and high-risk prescribing, which might point to opportunities for deprescribing.

Automated processes are being designed to assist GP teams to make use of their practice data. Periodic case note audits might also be useful to ensure documentation accuracy, review deprescribing plans and identify opportunities for further improvement. The information gathered from these activities can feed into quality improvement initiatives, and maintaining a continuous improvement register can support both GP accreditation and the ongoing enhancement of clinical care.[32]

However, as previously noted, limited time at the practice level might present a barrier. We suggest appointing a designated team member to lead and coordinate quality improvement activities, gather feedback from the wider practice team and ensure processes are reviewed and updated as needed. Allied health professionals, including pharmacists, can support such process. Funding mechanisms, such as employing pharmacists within general practice or aged care homes, might further facilitate ongoing medication review and optimisation and reduce some of the barriers identified for deprescribing. Collaboration between GPs and pharmacists is an evidence-based approach that has been shown to reduce the use of inappropriate medicines.[33]

Navigating the grey

Deprescribing often involves balancing uncertain harms and benefits. Shared decision-making conversations with safety-net advice help manage this uncertainty in line with patient preferences.

Conclusion

Deprescribing is a person-centred care approach that aligns with general practice's emphasis on whole-person care. GPs are encouraged to utilise existing resources to embed deprescribing into routine workflows.

Key points

- GPs, with their holistic understanding of patients, are well-placed to coordinate and oversee care, including medication reconciliation.
- Key opportunities to initiate deprescribing include recent clinical events, structured health assessments and prescribing alerts.
- Recognising differences among both patients and clinicians, and tailoring communication guides to the preferences of both groups, enables shared decision making in practice.
- New clinical practice guidelines for deprescribing provide recommendations for many medicines commonly used by older people.
- Ongoing processes for monitoring and audit can inform quality improvement initiatives and support continuous enhancement of clinical care.

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