Health care professionals' attitudes towards deprescribing in older patients with limited life expectancy

a systematic review

Lundby, Carina; Graabæk, Trine; Ryg, Jesper; Søndergaard, Jens; Pottegård, A; Nielsen, Dorthe Susanne

Published in:
British Journal of Clinical Pharmacology

DOI:
10.1111/bcp.13861

Publication date:
2019

Document version
Accepted manuscript

Citation for published version (APA):

Terms of use
This work is brought to you by the University of Southern Denmark through the SDU Research Portal. Unless otherwise specified it has been shared according to the terms for self-archiving. If no other license is stated, these terms apply:

• You may download this work for personal use only.
• You may not further distribute the material or use it for any profit-making activity or commercial gain
• You may freely distribute the URL identifying this open access version

If you believe that this document breaches copyright please contact us providing details and we will investigate your claim. Please direct all enquiries to puresupport@bib.sdu.dk
Health care professionals’ attitudes towards deprescribing in older patients with limited life expectancy: a systematic review

Short running title:
Deprescribing and limited life expectancy

Carina Lundby 1,2
Trine Graabæk 1,2
Jesper Ryg 3,4
Jens Søndergaard 5
Anton Pottegård 1,2
Dorthe Nielsen 6-8

1 Hospital Pharmacy Funen, Odense University Hospital, Odense C, Denmark
2 Clinical Pharmacology and Pharmacy, Department of Public Health, University of Southern Denmark, Odense C, Denmark
3 Department of Geriatric Medicine, Odense University Hospital, Odense C, Denmark
4 Geriatric Research Unit, Department of Clinical Research, University of Southern Denmark, Odense C, Denmark
5 Research Unit of General Practice, Department of Public Health, University of Southern Denmark, Odense C, Denmark
6 Migrant Health Clinic, Odense University Hospital, Odense C, Denmark
7 Centre for Global Health, University of Southern Denmark, Odense C, Denmark
8 Health Sciences Research Center, University College Lillebælt, Odense M, Denmark

Correspondence
Carina Lundby
PhD student, MScPharm
Hospital Pharmacy Funen
Odense University Hospital
Solfaldsvej 38, Entrance 208
DK-5000 Odense C, Denmark
E-mail: carina.lundby.olesen@rsyd.dk
Telephone: 0045 23241245

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/bcp.13861

This article is protected by copyright. All rights reserved.
Abstract

Aims
The aim of this systematic review was to explore health care professionals’ attitudes towards deprescribing in older people with limited life expectancy.

Methods
A systematic literature search was conducted from inception to December 2017 using MEDLINE, EMBASE, and CINAHL. Studies were included if they specifically concerned older people (≥65 years) with limited life expectancy, including those residing in any kind of aged care facility, or were based on representative patient profiles. Results were analyzed inspired by Joanna Briggs Institute’s method for synthesis of qualitative data. Studies were characterized using a checklist for reporting of qualitative research.

Results
Eight studies were included. Six studies explored health care professionals’ views on deprescribing in general while two studies focused specifically on psychotropics. All eight studies explored the views of physicians, mostly general practitioners, while three studies also considered other health care professionals. Four themes related to health care professionals’ attitudes towards deprescribing were identified: 1) Patient and relative involvement, 2) The importance of teamwork, 3) Health care professionals’ self-assurance and skills, and 4) The impact of organizational factors. Within each of these themes, 3-4 subthemes were identified and analyzed.

Conclusions
Our results imply that health care professionals’ decisions to engage in deprescribing activities with older people with limited life expectancy depend on multiple factors which are highly interdependent. Consequently, there is an urgent need for more research on how to approach deprescribing in clinical practice within this population.

Keywords
Prescribing, elderly, drug safety
What is already known about this subject:
- Deprescribing of medications may be particularly relevant in older people with limited life expectancy in which many medications no longer can be expected to provide clinical benefit.
- In order to develop interventions aimed at reducing inappropriate prescribing, more insight into what may hinder health care professionals from engaging in deprescribing activities specifically within this population is needed.

What this study adds:
- Health care professionals’ decisions to engage in deprescribing activities with older people with limited life expectancy seem to depend on multiple interdependent factors.
- These factors are related to patients and relatives, health care professionals’ joined teamwork, health care professionals’ self-assurance, and organizational factors.
- Research on how to approach deprescribing in clinical practice within this population is needed.
Introduction

Polypharmacy is highly prevalent among older people [1,2]. While many older people may benefit from use of multiple medications, they are also more susceptible to the potential adverse effects of medications and drug-drug interactions compared to younger people [3,4]. Thus, certain medications are best discontinued or avoided in this population [5].

There is a substantial lack of evidence for benefits of many common medications among older people [6] as these are often excluded from pivotal clinical trials [7]. Further, treatment guidelines rarely consider multimorbidity which is highly prevalent among older people [4,8,9], leading to uncertainty regarding benefits of treatment. Frail older people may also have a limited life expectancy which might be shorter than the known ‘time to benefit’ for some drugs [10,11]. Finally, goals of drug treatment in older people may change compared to those of other drug users, that is, shift from reducing risk of disease and prolonging life to reducing burden of treatment and maintaining quality of life [6]. As such, the proven benefits of some medications may no longer be consistent with goals of care for this particular population.

Deprescribing is the planned, supervised dose reduction or stopping of a medication [12,13]. For the reasons outlined above, deprescribing may be particularly relevant in older people with limited life expectancy. Although deprescribing has gained increased attention in recent years [13], barriers to deprescribing have been described among health care professionals (HCPs) [14–16]. In order to develop interventions aimed at reducing inappropriate prescribing, gaining insight into such barriers is vital. Recent reviews have summarized HCPs’ attitudes towards deprescribing in adults [17] and older people [18], however, these have not specifically addressed deprescribing in older people with limited life expectancy.

With this systematic review, we aimed to explore HCPs’ attitudes towards deprescribing in older people with limited life expectancy.

Methods

This systematic review was conducted guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement [19] as well as the ENhancing Transparency in REporting the synthesis of Qualitative research (ENTREQ) statement [20]. The review was registered in PROSPERO (CRD42018083819).
Search strategy
Assisted by a research librarian, the following electronic databases were searched from inception to December 2017: MEDLINE (via Ovid SP), EMBASE (via Ovid SP), and CINAHL. The searches were conducted combining keywords for ‘Population’ (older people with limited life expectancy) and ‘Intervention’ (deprescribing) according to the Population, Intervention, Comparison, and Outcome (PICO) model. Only the blocks ‘Population’ and ‘Intervention’ were searched as the blocks ‘Comparison’ and ‘Outcome’ cannot be directly applied to qualitative research [21]. Further, a broad search strategy was used as the searches were also used to identify papers for two other systematic reviews on this topic. The searches were restricted by filters for conference abstracts. In addition to identification of original literature, reference lists of relevant reviews were also scrutinized to identify potentially eligible studies. The full search strategy is outlined in Appendix 1.

Inclusion and exclusion criteria
Studies were included if they i) described original research, ii) were published in English, and iii) qualitatively explored HCPs’ attitudes towards deprescribing in older people, aged 65 years or more, with limited life expectancy. Studies could describe attitudes towards deprescribing through any type of deprescribing intervention as well as of all types of medications. Further, in the absence of a clear definition of when older people can be expected to be in the last years of their life, it was initially decided to include studies concerning older people residing in any kind of aged care facility, e.g. residential care or nursing home. Alternatively, studies had to be based on representative patient profiles, with information on e.g. age, health status, medical history, diagnoses, and medications, from which the patients could be expected to have a limited life expectancy. Studies based on patient profiles were discussed in the full author group, i.e., eligibility of these studies were decided with input from a geriatrician, a general practitioner and clinical pharmacologist, a nurse, and three clinical pharmacists, all with considerable clinical experience.

Studies were excluded if they i) explored HCPs’ attitudes towards deprescribing through surveys/questionnaires or quantitative interviews, ii) did not concern older people with limited life expectancy (according to the criteria outlined above), iii) concerned people <65 years (median), or iv) concerned terminally ill people (last weeks of life).

Selection, extraction, and analysis
Two authors (CL, TG) independently screened all titles and abstracts for potentially eligible studies, using Covidence as screening tool [22]. Disagreements were resolved through consensus. Full-text articles were obtained for all studies that appeared to be eligible or where eligibility could not be adequately judged based on title or abstract. Afterwards, the two authors independently screened all full-text articles for eligibility. Disagreements were resolved through consensus. Finally, all authors went through every study
deemed potentially eligible by the initial assessors to decide on ultimate inclusion or exclusion. A team-based approach was used to reach agreement throughout the screening process as well as on ultimate inclusion or exclusion of each study.

Two authors (CL, TG) independently extracted the following information from the included studies: study details, aim, medication, participants, patients, methods, analysis, and main findings (i.e., HCPs’ attitudes towards deprescribing). Disagreements on content were resolved through consensus. Results were analyzed inspired by Joanna Briggs Institute’s method for synthesis of qualitative data in systematic reviews [23]. The synthesis was carried out in a three-step process. First, the two authors independently extracted all findings from the results sections in the included studies. Findings from each study were organized in tables and accompanied by supporting quotations. Disagreements on findings were resolved through consensus. Next, the two authors collaboratively developed categories based on at least two findings with sufficient similarity. Findings could describe similar concepts and/or different aspects of a concept. Finally, one author (CL) synthesized all findings within each category. The synthesized findings were discussed among three authors (CL, TG, DN) to decide on final content. Again, a team-based approach was used to reach agreement throughout the extraction and analysis.

Assessment of reporting

Two authors (CL, TG) independently assessed the reporting of all included studies using the COnsolidated criteria for REporting Qualitative research (COREQ), a 32-item checklist developed to promote explicit and comprehensive reporting of qualitative studies [24]. Disagreements on reporting were resolved through consensus among three authors (CL, TG, DN). Again, a team-based approach was used to reach agreement. Studies were not excluded on the basis of the assessment; rather, it was used to transparently highlight how the authors reported their findings.

Results

Study selection

The flow of the study selection is presented in Figure 1. The literature search yielded a total of 2,739 references, leaving 2,174 references after removal of duplicates. During the screening process, 2,125 references were excluded on the basis of title and abstract. Of the remaining 49 references, 41 references were excluded following full text assessment. To ensure transparency, a brief summary of these 41 studies, including the reason for their exclusion, is provided in Appendix 2. Ultimately, eight studies were included in this review [25–32].
Study characteristics and main findings

The characteristics and main findings of the included studies are presented in Table 1. HCPs’ attitudes towards deprescribing in older patients with limited life expectancy were explored through either individual interviews [25–28] or focus group interviews [29–32], with one study conducting telephone interviews as well [31]. All but one study concerned older people residing in some kind of aged care facility, i.e., rest home (via patient profile) [25], residential care [26], advanced care facility [27], nursing home [28,29], residential aged care facility [30], and long-term care facility [31]. Patient profiles were used to facilitate deprescribing discussions in three studies [25,30,32]. While six studies concerned the use of multiple medications, two studies focused specifically on the use of hypnotics [28] and antidepressants [29]. All studies explored the views of physicians, mostly general practitioners (GPs) [25–27,31,32], while three studies also explored the views of pharmacists [30,31], nurses [29], and long-term care facility staff [31]. Further, all but one study concerned HCPs working within primary care, either in general practice and/or some kind of aged care facility. For the last study, it was not specified whether the included HCPs were affiliated to primary and/or secondary care [30]. Although two of the studies were not purely qualitative [27,30], only data concerning the qualitative parts of these studies are presented in this review.

The results presented in two of the papers originate from the same study, i.e., they represent the views of the same participants [25,26]. Further, the results presented in one of the papers [27] originate from two separate studies [31,33] and compares factors influencing deprescribing in advanced care facilities in two different countries. Since one of these studies is already included in this review based on the literature search [31], only data originating from the other study is presented in this review [33]. Finally, the investigators of one of the studies also serve as the participants in the study [30].

Assessment of reporting

The completeness of reporting in the included studies is presented in Table 2. The reporting varied across the studies, with a median of 21 (range 13-31) out of the 32 items in COREQ being reported. The lowest and highest rates of reporting were observed within the first domain [median of 3 (range 1-6) out of 8 items] and third domain [median of 8 (range 3-8) out of 9 items], respectively. The first domain concerns reporting of the research team and the authors’ possible relations with the study participants while the third domain concerns reporting of the data analysis and how the authors have presented their findings [24].

The reporting in two of the studies is carried out according to COREQ, with the checklist being included in both papers [25,26]. Although seven of the eight studies state which methodological orientation that have been used, three of these studies do not support this with any references [25,28,30].
HCPs’ attitudes towards deprescribing in older people with limited life expectancy

The analysis elicited four themes related to HCPs’ attitudes towards deprescribing in older people with limited life expectancy: 1) Patient and relative involvement, 2) The importance of teamwork, 3) HCPs’ self-assurance and skills, and 4) The impact of organizational factors. These themes are presented in Table 3.

Theme 1: Patient and relative involvement

GP s consider deprescribing as being an important component in providing good ‘end of life’ care [27]. However, deprescribing in patients with limited life expectancy may be hindered by the patients themselves as well as their relatives [25–28,30–32]. Three subthemes emerged within this theme: 1) Involvement, 2) Characteristics, and 3) Pressure and requests (Table 3).

When considering deprescribing, physicians want to involve patients and relatives in treatment decisions [26,28,32] and provide necessary information on possible treatment choices and outcomes [26,32]. However, physicians and pharmacists experience that patient involvement within this particular population may be compromised by patient characteristics such as cognitive impairment [28,30,32] as well as patients being insistent on continuing their regular medical treatment [26,32]. Further, it may be hindered by some physicians finding it difficult to address ‘end of life’ discussions [32]. Finally, physicians sometimes experience pressure from both patients [25,28] and relatives [27,28,31] to continue prescribing certain medications. Some physicians report to give in on these types of requests, simply to avoid conflict [28].

Theme 2: The importance of teamwork

Many HCPs are frequently involved in the treatment of older people with limited life expectancy [31,32]. However, the teamwork between different HCPs may be compromised by several factors and ultimately hinder deprescribing [25–29,31,32]. Three subthemes emerged within this theme: 1) Interprofessional relations, 2) Specialists, and 3) Pressure and requests (Table 3).

Although GPs believe that treatment of older multimorbid patients requires involvement of different groups of HCPs [26] and value multidisciplinary teamwork [26,27,32], their engagement in collaboration with other HCPs is affected by earlier interprofessional experiences. While some place a great deal of responsibility within other HCPs [29], others are more reluctant to engage in collaboration [31]. Physicians’ apparent lack of interest in collaboration is also recognized by some nurses [29]. Further, when considering deprescribing, GPs may hesitate to address specialist-prescribed medications [25–27] and also find collaboration with specialists on deprescribing decisions particularly challenging, referring to specialists as representing ‘their guideline’ [32]. Finally, both physicians [25–29] and nurses [29] sometimes
experience a feeling of pressure from nursing staff to prescribe certain medications. Again, some physicians report to meet these kinds of requests to avoid conflict [28].

**Theme 3: HCPs’ self-assurance and skills**

HCPs’ decisions on whether or not to initiate or suggest deprescribing in older people with limited life expectancy are highly affected by the individual HCP’s self-assurance and capacity [25–32]. Four subthemes emerged within this theme: 1) Responsibility and concerns, 2) Confidence and self-image, 3) Information and education, and 4) Evidence (Table 3).

Although pharmacists and nursing staff identify GPs as the ones being responsible for deprescribing among older people with limited life expectancy [26,28], GPs and other physicians may hesitate to initiate deprescribing due to concerns related to potential consequences for the patient [26,29] as well as themselves [26,28,32]. Although some GPs express being confident with deprescribing [27,30], others question their own ability to deprescribe [31] and report a feeling of not holding the right competencies for deprescribing within this population [26,28,32]. Following this, GPs experience a lack of information and education on evidence-based deprescribing [26,27] while both physicians and pharmacists express a need for more evidence on deprescribing within this particular population [26,30,32]. GPs, nurses, and pharmacists also express a need for more education of nursing staff in order to facilitate deprescribing [27,29,31].

**Theme 4: The impact of organizational factors**

HCPs identify several organizational factors that influence medication management and deprescribing in older people with limited life expectancy [25–32]. Four subthemes emerged within this theme: 1) Transitions, 2) Workload, 3) Time, and 4) Guidelines (Table 3).

Although GPs perceive clear communication and continuity of care as facilitators for deprescribing [26,27], they often experience the communication between primary and secondary care as being insufficient [26] and consequently find it difficult to appropriately manage patients’ medications following discharge [25,26,30]. Pharmacists and nursing staff also recognize this problem [31]. Further, physicians and nursing staff report insufficient staff availability, heavy workflows, and lack of time to further complicate deprescribing and medication management [26–29,31]. Finally, although some physicians and pharmacists consider deprescribing guidelines as being helpful in identifying medications for deprescribing [30], others believe that current guidelines are too complex to implement in daily practice [26]. GPs also report feeling pressured to continue prescribing due to disease-specific guidelines [32]. GPs believe that deprescribing can be facilitated by protocols for medication management [31].
Discussion

In this systematic review, we identified four themes related to HCPs’ attitudes towards deprescribing in older people with limited life expectancy: 1) Patient and relative involvement, 2) The importance of teamwork, 3) HCPs’ self-assurance and skills, and 4) The impact of organizational factors. Our results imply that HCPs’ decisions to initiate or suggest deprescribing in this population depend on multiple factors which are highly interdependent. As such, deprescribing in older patients with limited life expectancy should be seen as a multifactorial process, meaning that initiatives to implement and/or facilitate deprescribing practices should target several of the possible issues identified in this review.

Comparison to existing literature

Recent reviews have summarized HCPs’ attitudes towards deprescribing in adults [17] and older people [18]. However, in order to examine if the presence of multiple competing factors such as multimorbidity, frailty, and limited life expectancy somehow complicates deprescribing initiatives, we decided to explore HCPs’ attitudes towards deprescribing specifically in the context of treatment of older people with limited life expectancy.

Anderson et al. explored prescribers’ perceived barriers and enablers to minimizing potentially inappropriate medications continuously prescribed in adults [17] while Bokhof et al. explored GPs’ perspectives of and experiences with reducing polypharmacy in older people [18]. Although none of these reviews specifically address HCPs’ attitudes towards deprescribing in older people with limited life expectancy, both reviews provide findings similar to ours within each of the identified four themes, i.e., on how deprescribing initiatives may be affected by patients, HCPs’ joined teamwork, HCPs’ self-assurance, and organizational factors. Similar findings have also been demonstrated in a prior systematic review by Sinnott et al. exploring GPs’ perspectives on management of patients suffering from multimorbidity [34].

However, compared to these reviews, our findings suggest that deprescribing in older people with limited life expectancy may be further complicated by at least two factors. First, HCPs report being considerably challenged when considering deprescribing in patients suffering from cognitive impairment [30,31]. Since studies have shown that a large proportion of older people with limited life expectancy suffer from cognitive impairment such as e.g. dementia [35–37], our findings suggest a specific need for more evidence on how to approach deprescribing within this particular population. Second, following the large proportion of this population suffering from cognitive impairment, HCPs sometimes find it necessary to involve relatives in treatment decisions [26,28]. However, despite the patients’ limited life expectancy, HCPs often find themselves and relatives having opposite treatment goals, with the relatives being more prone to want continuing treatment [27,28,31], which may ultimately hinder deprescribing initiatives. Similar findings have been demonstrated in a recent study exploring nursing home doctors’ experiences
with treatment of dying patients which found that doctors sometimes experience this pressure from relatives, even if the patients do not want treatment [38]. Further, studies have shown that relatives to older patients at the end of life generally are critical towards physicians’ treatment decisions [39], believe that the patients do not receive sufficient medical treatment [40], and consider the information from physicians as well as the information between different HCPs as inadequate [41,42].

In this review, we specifically focused on deprescribing in older people with limited life expectancy, meaning that we excluded studies focusing on deprescribing in people with a life limiting illness such as e.g. advanced cancer. Deprescribing in people with a specific life limiting illness constitutes a different clinical scenario. First, while it is always challenging for clinicians to predict mortality, an estimated life expectancy based on a progressive cancer diagnosis may be more reliable compared to one based on multiple competing diseases. In this way both patient and physician might realistically be more confident in deprescribing of e.g. preventive medications, as they are more certain that the end of life is approaching. Further, when a patient is diagnosed with a life limiting illness and ultimately accepts its prognosis, this may change the patient’s attitude towards medication use, making it easier to carry out deprescribing initiatives. A recent qualitative study, exploring patients’, caregivers’, and HCPs’ attitudes towards medication use in life limiting illness, found that patients diagnosed with a life limiting illness such as cancer, at this particular point, places less importance on taking certain medications. HCPs also describes this point as the ‘transition’, i.e., as the point where patients accept their disease [43]. Another qualitative study, exploring experiences of medication use among patients with advanced cancer, found that patients generally want to reduce their number of medications as it reminds them of their illness [44]. As such, the willingness to deprescribe among these patients may differ significantly from older patients with limited life expectancy as they, although suffering from multiple competing diseases, are not diagnosed with a terminal illness.

Like previous literature [17,18], this review found that HCPs may deviate from engaging in deprescribing activities due to low self-assurance [25–32]. A recent study exploring the effect of implementing evidence-based deprescribing guidelines found that such initiatives appear to increase long-term care clinicians’ self-efficacy in developing and implementing deprescribing plans targeting specific drug classes [45]. A recent systematic review has summarized available tools for deprescribing in frail older people and those with limited life expectancy [46] which clinicians may find helpful to address for future deprescribing strategies.

**Assessment of reporting**

The completeness of reporting in the included studies was assessed according to COREQ [24]. The studies primarily lacked reporting within the first domain, meaning that personal bias cannot be ruled out [24,47]. Higher rates of reporting, and thereby higher transparency, were observed within the second and
third domain. Although not being a tool to assess the quality of qualitative studies, the assessment according to COREQ ensured a critical review of the included studies, giving an overall impression of the quality of each study.

With that said, it should be noted that high reporting rates according to COREQ not necessarily equal high-quality studies. Even if a study reports all the items included in COREQ, the reporting of these may not be adequately described. For example, in this review, three out of the seven studies, which state their methodological orientation (content analysis [25,30] and thematic coding and comparative categorization [28]), do not support this with any references. As any qualitative study explores the content and meaning of the empirical data, these terms barely say anything about how the authors analyzed their data [48]. Consequently, researchers should be cautious with making definitive conclusions on the quality of qualitative studies based on assessments carried out according to COREQ.

**Strengths and limitations**

The strengths of this review include the fact that screening, data extraction, data analysis, and assessment of reporting were performed by at least two authors, with final study selection discussed in the full author group. Further, the analysis was performed using an established method for synthesis of qualitative data in systematic reviews [23] and, in order to enhance transparency, the reporting was carried out according to ENTREQ [20]. Finally, to further enhance transparency as well as for the use of other researchers working with deprescribing, a summary of the 41 studies excluded during the full text screening was completed (Appendix 2).

Some limitations to our review must be acknowledged. First, the restriction to only search three databases as well as only include studies in English might have excluded relevant literature. Next, since the included studies only concern HCPs from primary care, the findings presented in this review may not apply to HCPs working in other settings. Further, although six of the included studies concern the use of multiple medications, the last two studies specifically concern the use of hypnotics [28] and antidepressants [29]. The views of the HCPs presented within these two studies might have been different if the studies had not been restricted to the use of specific drug classes. Finally, the definition of older people with limited life expectancy applied in this review may be attached with uncertainty. Although methods to predict mortality [49] and identify people at the end of life [50] have been reported, it is challenging for clinicians to predict the timing and course of the final year of a patient’s life [51]. As an estimate for limited life expectancy, we therefore decided to include studies concerning older people residing in any kind of aged care facility or studies based on representative patient profiles including relevant information from which the patients’ life expectancy roughly could be estimated.

**Implications for practice**
This review highlights a need for development of initiatives targeting the identified possible issues which may hinder HCPs’ from engaging in deprescribing activities with older people with limited life expectancy. As these factors seem to be highly interdependent, initiatives should preferably be multidimensional. However, first and foremost, there seems to be an urgent need for more evidence on the effects of commonly used medications among this particular population. Further, more studies providing evidence on the safety of deprescribing of commonly used medications within this population should be conducted. A good example is a recent study showing that deprescribing of statins among older patients with an estimated life expectancy of ≤1 year is safe and may be associated with an improved quality of life [52]. This should be followed by more information and education on how to approach deprescribing in older patients with limited life expectancy, including those suffering from cognitive impairment, as well as development of evidence-based deprescribing guidelines which are possible to implement in daily practice. It is reasonable to expect that providing HCPs with such support may enhance their self-assurance and capacity to carry out more deprescribing [45] and also help them approaching ‘end of life’ discussions with patients as well as relatives. Finally, it seems essential to educate and encourage all HCPs, not only physicians, to engage in deprescribing activities in order to effectively enhance the collaboration between different HCPs. As many different HCPs from both sectors are frequently involved in the management of this particular population’s medications, such initiatives should preferably target HCPs from within primary as well as secondary care.

**Conclusion**

This systematic review implies that HCPs’ decisions to engage in deprescribing activities with older people with limited life expectancy depend on multiple factors which are highly interdependent. As such, initiatives to implement and/or facilitate deprescribing practices within this population should target several of the possible issues identified in this review. Most importantly, there seems to be an urgent need for more evidence on the beneficial effects of deprescribing specifically for older people with limited life expectancy, including more evidence on how to approach deprescribing in clinical practice within this population.

**Acknowledgements**

The authors would like to acknowledge VELUX FONDEN for funding this study (grant no. 00018248).
Conflict of interest statement

There are no competing interests to declare.

Author contributions

AP proposed the initial study idea. All authors designed the study. CL and TG performed the screening. All authors decided the final study selection. CL and TG performed the data extraction. CL, TG, and DN performed the data analysis. CL wrote the initial draft. All authors participated in writing and revising the manuscript as well as read and approved the final version of the manuscript.

References


33. Bolmsjö BB, Strandberg EL, Midlöv P, Brorsson A. “It is meaningful; I feel that I can make a difference” - A qualitative study about GPs’ experiences of work at nursing homes in Sweden. BMC Fam Pract. 2015;16:111.


Table 1. Characteristics of the eight included studies as presented in the individual papers.

<table>
<thead>
<tr>
<th>Study details (first author, publication year, country)</th>
<th>Aim</th>
<th>Medication</th>
<th>Participants</th>
<th>Patients</th>
<th>Methods</th>
<th>Analysis</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ailabouni, 2016, New Zealand</td>
<td>To use a hypothetical patient profile to reveal GPs’ insights on deprescribing in an individual with multimorbidity</td>
<td>Multiple medications</td>
<td>10 GPs; 2-32 years of experience with prescribing in residential care</td>
<td>Older multimorbid patient (one hypothetical patient profile)</td>
<td>Face-to-face semi-structured interviews; discussions based on one hypothetical patient profile; GPs requested to comment on which medicines they would review, reduce, discontinue, or change</td>
<td>Content analysis</td>
<td>Responses to each medicine in the hypothetical patient profile varied. Opinions on deprescribing preventive and symptomatic medicines varied a great deal. Conflicting opinions existed particularly around the prescription of statins, dipyridamole, and bisphosphonates. Dilemmas around the appropriate clinical management of reflux disease and insomnia in older people also came to light.</td>
</tr>
<tr>
<td>Ailabouni, 2016, New Zealand</td>
<td>To ascertain challenges and enablers for deprescribing by examining the views of GPs about deprescribing for older people in a residential care setting</td>
<td>Multiple medications</td>
<td>10 GPs (7 male); 2-32 years of experience with prescribing for older people in residential care</td>
<td>Older people in residential care</td>
<td>Face-to-face semi-structured interviews; discussions based on interview guide</td>
<td>Content analysis; analysis assisted by a TDF developed by Michie et al. (2005) [53]</td>
<td>Four themes were identified to define the issues around prescribing for older people, from the GPs’ perspectives. Theme 1, the ‘recognition of the problem’, discusses the difficulties involved with prescribing for older people. Theme 2 outlines the identified behavior change factors relevant to the problem. Deprescribing challenges were drawn from these factors and summarized in Theme 3 under three major headings: ‘prescribing factors’, ‘social influences’, and ‘policy and processes’. Deprescribing enablers, based on the opinions and professional experience of GPs, were retrieved and summarized in Theme 4.</td>
</tr>
<tr>
<td>Bolmsjö, 2016, Sweden</td>
<td>To 1) compare and contrast behavioral factors influencing the deprescribing practices of GPs providing care for ACF residents in two separate countries, 2) review health policy</td>
<td>Multiple medications</td>
<td>12 GPs (3 male); working in primary health care for 2-38 years; having weekly visits in ACFs</td>
<td>Residents in ACFs</td>
<td>Individual semi-structured interviews; discussions based on interview guide</td>
<td>Content emersion; findings coded and systematically collapsed under each of the key</td>
<td>It was identified that deprescribing by GPs in ACFs is a complex process and that there are numerous barriers to medication reduction for aged care residents in both countries, both with similarities and differences. The factors affecting deprescribing behavior were identified and divided into: intentions, skills and abilities, and environmental factors.</td>
</tr>
</tbody>
</table>
and ACF systems in each setting for their potential impact on the prescribing of medications for an older person in residential care of older people, and 3) based on these findings, provide recommendations for future ACF deprescribing initiatives.

Flick, 2012, Germany [28]

To explore 1) what makes doctors prescribe hypnotics for older people, 2) what physicians expect and how they evaluate the relevance of hypnotics in the context of everyday treatment of old people in long-term care settings, and 3) how physicians evaluate the risk associated with hypnotic medication

Hypnotics

20 NH physicians (9 male); aged 36-68 years; specialized in internal medicine (n=9), general practitioner (n=7), family medicine (n=3), and psychiatry (n=1)

Older multimorbid NH residents with sleep disorders

Episodic interviews; discussions based on interview schedule

Thematic coding and comparative categorization

Three interpretative patterns concerning the use of drugs for treating sleep disorders were identified – “by request”, “ambivalence”, and “reflected prescription”. Differences between them were determined by the significance of residents' wishes, neglect of risks, particularly that of addiction, and the attempt to balance benefits and disadvantages.

Iden, 2011, Norway [29]

To examine decision-making among doctors and nurses in NHs on the treatment of patients with depression using antidepressants

Antidepressants

16 doctors (5 male) working either part time or full time in NHs and 8 registered nurses (1 male); aged 30-70 years; 1-40 years of clinical experience

NH patients with depression using antidepressants

Focus group interviews; discussions based on interview guide

Systematic text condensation in accordance with Malterud (1993) [55]

The interviews elicited three main themes. The first theme was the diagnostic process. The informants expressed difficulty in differentiating between depression and sorrow resulting from loss in old age. Further, the doctors reported that they relied on nurses’ observations and rarely carried out systematic diagnostic work and follow-up of patients with depression. The second theme was treatment. Antidepressants were usually the only type of treatment provided, and patients were kept on medication even though staff felt uncertain whether this was effective.
Page, 2016, Australia [30]

To 1) determine agreement between physicians and pharmacists with respect to medicines to deprescribe when using the simplified GPGP tool and 2) define reasons for any observed differences between physicians and pharmacists on medicines selected for deprescribing using qualitative analysis.

| Multiple medications | 2 physicians and 2 pharmacists | Frail older people in RACFs (multiple patient cases a randomized controlled deprescribing trial) | Content analysis |

Palagyi, 2016, Australia [31]

To report perceptions of medication use and the concept of deprescribing for LTCF residents, as identified by the RELEASE study.

| Multiple medications | 8 GPs; aged 43-73 years; experience as GP for 20-42 years | Frail older people in LTCFs | Single coding framework; the IMBP (Fishbein et al., 2006) [54] used as theoretical framework |

| 19 LTCF staff members; aged 21-69 years; working in aged care for 1-20 years | Focus group interviews with GPs and LTCF staff members; discussions based on discussion guides unique to each participant group |

| 2 dispensing pharmacists and 2 accredited medication review pharmacists | Semi-structured telephone interviews with pharmacists; discussions based on interview guide |

The themes that emerged from the data were grouped in three domains: patient centered care, clinical reasoning, and challenges to deprescribing. Physicians and pharmacists had common rationale and shared many concerns, and had similar clinical reasoning. However, pharmacists favored certainty and confidence, whereas physicians were more comfortable with ambiguity.
To explore how experienced GPs feel about deprescribing medication in older patients with multimorbidity and to what extent they involve patients in these decisions


| Multiple medications | 29 GPs (27 male); aged 39-65 years; experience as GP for at least 5 years | Very old patients with multimorbidity | Focus group interviews; discussions guided by a hypothetical patient profile | Not stated |

GPs discern symptomatic medication and preventive medication; deprescribing the latter category is seen as more difficult by the GPs due to lack of benefit/risk information for these patients. Factors influencing GPs’ deprescribing were beliefs concerning patients (patients have no problem with polypharmacy; patients may interpret a proposal to stop preventive medication as a sign of having been given up on; and confronting the patient with a discussion of life expectancy vs. quality of life is ‘not done’), guidelines for treatment (GPs feel compelled to prescribe by the present guidelines), and organization of healthcare (collaboration with prescribing medical specialists and dispensing pharmacists).

---

1. The results presented in these two papers originate from the same study, i.e., they represent the same 10 GPs. The first paper [25] presents the results from the discussions based on the comment on the hypothetical patient profile while the second paper [26] presents the results from the discussions based on the interview guide. Both papers mention the other one as a follow-up study.

2. The results presented in this paper originate from two separate studies [31,33] and compares factors influencing deprescribing in advanced care facilities in two different countries. Since one of these studies is already included in this review based on the literature search [31], only data originating from the other study is presented [33]. Only data concerning the qualitative part of the present study is presented in this review. Parts of the descriptive data (‘Participants’ and ‘Methods’) are retrieved from the original study [33].

3. Aim of original study: To illustrate GPs’ experiences of the work with older people living in NHs in Sweden, to get input on how older people care can be improved, and to identify obstacles for good quality of care [33].

4. Only data concerning the qualitative part of the study is presented in this review.

5. The four participants in the focus group interview are also the investigators of the study.

6. This study encompasses interviews with residents, relatives, and HCPs. Only data concerning the interviews with the HCPs is presented in this review.

Abbreviations: ACF, advanced care facility; GP, general practitioner; GPGP, Good Palliative-Geriatric Practice; HCP, healthcare professional; IMBP, Integrative Model of Behavior Prediction; LTCF, long-term care facility; NH, nursing home; RACF, residential aged care facility; RELEASE, depRescribing: A nEW affordable health care mode for the prescription and Administration of medicineS for vulnerable older people in agEd care homes; TDF, Theoretical Domains Framework.
Table 2. Completeness of reporting of the eight included studies according to COREQ [24].

<table>
<thead>
<tr>
<th>Reporting criteria</th>
<th>Number of studies reporting criterion</th>
<th>References of studies reporting criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 1: Research team and reflexivity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interviewer/facilitator</td>
<td>6</td>
<td>25, 26, 27, 29, 31, 32</td>
</tr>
<tr>
<td>Credentials</td>
<td>5</td>
<td>25, 26, 27, 29, 30</td>
</tr>
<tr>
<td>Occupation</td>
<td>5</td>
<td>25, 26, 27, 29, 30</td>
</tr>
<tr>
<td>Gender</td>
<td>2</td>
<td>25, 26</td>
</tr>
<tr>
<td>Experience and training</td>
<td>4</td>
<td>25, 26, 29, 31</td>
</tr>
<tr>
<td>Relationship with participants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship established</td>
<td>2</td>
<td>25, 26</td>
</tr>
<tr>
<td>Participant knowledge of interviewer</td>
<td>2</td>
<td>25, 26</td>
</tr>
<tr>
<td>Interviewer characteristics</td>
<td>1</td>
<td>29</td>
</tr>
<tr>
<td><strong>Domain 2: Study design</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theoretical framework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methodological orientation and theory</td>
<td>7</td>
<td>25, 26, 27, 28, 29, 30, 31</td>
</tr>
<tr>
<td>Participant selection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sampling</td>
<td>7</td>
<td>25, 26, 27, 28, 29, 31, 32</td>
</tr>
<tr>
<td>Method of approach</td>
<td>6</td>
<td>25, 26, 27, 28, 29, 31</td>
</tr>
<tr>
<td>Sample size</td>
<td>8</td>
<td>25, 26, 27, 28, 29, 30, 31, 32</td>
</tr>
<tr>
<td>Non-participation</td>
<td>2</td>
<td>25, 26</td>
</tr>
<tr>
<td>Setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting of data collection</td>
<td>5</td>
<td>25, 26, 27, 31, 32</td>
</tr>
<tr>
<td>Presence of non-participants</td>
<td>2</td>
<td>25, 26</td>
</tr>
<tr>
<td>Description of sample</td>
<td>8</td>
<td>25, 26, 27, 28, 29, 30, 31, 32</td>
</tr>
<tr>
<td>Data collection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview guide</td>
<td>7</td>
<td>25, 26, 27, 28, 29, 31, 32</td>
</tr>
<tr>
<td>Repeat interviews</td>
<td>3</td>
<td>25, 26, 27</td>
</tr>
<tr>
<td>Audio/visual recording</td>
<td>8</td>
<td>25, 26, 27, 28, 29, 30, 31, 32</td>
</tr>
<tr>
<td>Field notes</td>
<td>5</td>
<td>25, 26, 27, 29, 31</td>
</tr>
<tr>
<td>Duration</td>
<td>8</td>
<td>25, 26, 27, 28, 29, 30, 31, 32</td>
</tr>
<tr>
<td>Data saturation</td>
<td>5</td>
<td>25, 26, 27, 31, 32</td>
</tr>
<tr>
<td>Transcripts returned</td>
<td>3</td>
<td>25, 26, 31</td>
</tr>
<tr>
<td><strong>Domain 3: Analysis and findings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of data coders</td>
<td>7</td>
<td>25, 26, 27, 29, 30, 31, 32</td>
</tr>
<tr>
<td>Description of coding tree</td>
<td>8</td>
<td>25, 26, 27, 28, 29, 30, 31, 32</td>
</tr>
<tr>
<td>Derivation of themes</td>
<td>8</td>
<td>25, 26, 27, 28, 29, 30, 31, 32</td>
</tr>
<tr>
<td>Description</td>
<td>Score</td>
<td>References</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Software</td>
<td>4</td>
<td>25, 26, 30, 31</td>
</tr>
<tr>
<td>Participant checking</td>
<td>3</td>
<td>25, 26, 31</td>
</tr>
<tr>
<td>Reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quotations presented</td>
<td>8</td>
<td>25, 26, 27, 28, 29, 30, 31, 32</td>
</tr>
<tr>
<td>Data and findings consistent</td>
<td>8</td>
<td>25, 26, 27, 28, 29, 30, 31, 32</td>
</tr>
<tr>
<td>Clarity of major themes</td>
<td>8</td>
<td>25, 26, 27, 28, 29, 30, 31, 32</td>
</tr>
<tr>
<td>Clarity of minor themes</td>
<td>5</td>
<td>25, 26, 27, 31, 32</td>
</tr>
</tbody>
</table>

*a* The reporting in these two studies is carried out according to COREQ. Both papers include this checklist.

*b* The results presented in this paper originate from two separate studies [31,33] and compares factors influencing deprescribing in advanced care facilities in two different countries. Since one of these studies is already included in this review based on the literature search [31], only data originating from the other study is presented [33]. Parts of the reporting are retrieved from the original study [33].

*c* The methodological orientation used in these three studies is not supported by any references.

Abbreviations: COREQ, COnsolidated criteria for REporting Qualitative research.
Table 3. Identified themes related to HCPs’ attitudes towards deprescribing in older people with limited life expectancy.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Involvement</strong></td>
<td>Physicians and pharmacists find it important to consider quality of life, life expectancy, and patients’ general well-being when considering deprescribing in patients with limited life expectancy [25–28,30] and consequently want to include patients and/or relatives in decisions on medical treatment and treatment options [26,28,32]. While some GPs report these kinds of talks to have a positive effect on the relationship with their patients, others, however, find it difficult to talk about life expectancy and quality of life and also consider it unethical [32]. Physicians may include relatives in medical decisions if the decisions are considered to be of important character [26], if they concern treatment of multimorbidity patients [26], or if the patients are not able to understand medical suggestions due to cognitive impairment [28].</td>
</tr>
<tr>
<td><strong>Characteristics</strong></td>
<td>GPs find that certain patient characteristics, such as low education, old age, and cognitive impairment, contribute to make patients understand medical issues difficult [28,30,32]. Further, GPs find it challenging to convince some patients to change or stop their medications, either because the patients simply resist as they have been taking their medications for a long time [26] or seemingly have no problem with polypharmacy and medication burden [32]. GPs believe that they may not always be fully aware of patients’ medication-related problems as the patients underreport adverse drug events or report them to other HCPs [32].</td>
</tr>
<tr>
<td><strong>Pressure and requests</strong></td>
<td>Physicians sometimes feel pressure from patients [25,28] and relatives [27,28,31] to prescribe and/or continue prescribing certain medications, e.g. sleeping medication [28]. Mentioned reasons for this are relatives wanting to improve patients’ health state [27] or having strong expectations to the ability of specific medications to keep family members alive [31]. Further, GPs believe that some patients and relatives have unrealistic views on the role and importance of medications for older persons [27] as well as, for the relatives’ part, the stage of life of residents in LTCF care [31]. While some physicians try to explain the risks of a certain medical treatment when feeling pressure from patients or relatives, others keep prescribing the requested medication to avoid conflict [28].</td>
</tr>
<tr>
<td><strong>The importance of teamwork</strong></td>
<td>Interprofessional relations</td>
</tr>
<tr>
<td></td>
<td>Specialists</td>
</tr>
<tr>
<td></td>
<td>Pressure and requests</td>
</tr>
<tr>
<td><strong>HCPs’ self-assurance and skills</strong></td>
<td>Responsibility and concerns</td>
</tr>
<tr>
<td></td>
<td>Confidence and self-image</td>
</tr>
<tr>
<td></td>
<td>Information and education</td>
</tr>
<tr>
<td></td>
<td>Evidence</td>
</tr>
</tbody>
</table>
Further, GPs lack information on benefits and risks of preventive medications in older people [32] and are uncertain on how to apply research evidence to patients with multimorbidity, especially evidence on use of preventive medication [26]. While pharmacists mention this as not having sufficient evidence to change patients’ medical treatment, some physicians view this as insufficient evidence to continue treatment [30].

The impact of organizational factors

Transitions
GPs perceive clear communication and continuity of care as facilitators for deprescribing [26,27]. However, GPs consider the communication between hospitals and primary care as insufficient changes in patients’ medical treatment are not always sufficiently communicated to primary care and discharge summaries often lack information on duration of treatment with new medications [26]. Consequently, physicians and pharmacists may have to assess the appropriateness of patients’ medications on very scarce information [25,26,30], e.g. without any biochemical results available or with no information on why and when a certain medication was prescribed [25,30]. Nursing staff and pharmacists also describe these medical changes as being troublesome as they usually lead to an accumulation in the residents’ medication regimen [31].

Work load
GPs and nursing staff find it difficult to deprescribe and sufficiently manage patients’ medication, respectively, due to insufficient staff availability [26,27,29,31]. Further, GPs describe the workflows in aged care facilities as heavy, with an onerous administrative load [27], messy medication charts lacking standardization within and across LTCFs [26,27,31], and poorly integrated IT systems [27]. While some GPs consider their reimbursement as insufficient compared to the amount of work and time required of them [26,31], others report that their deprescribing practice is not influenced by any financial factors [27].

Time
HCPs consider time constraints as a considerable hindrance for deprescribing [26–29,31]. Some GPs feel isolated in making decisions on patients’ medical treatment as they find it time consuming and difficult to consult a specialist [27]. Further, physicians do not always have time to see their patients themselves [26,28,29] and consequently have to rely on nursing staff’s observations on patients’ well-being and medical treatment [26,29]. Also, some GPs are not always able to timely review new medications which consequently lead to an accumulation in the patients’ medications [31]. Nursing staff also describe not having sufficient time to observe and talk to patients as they have to spend most of their time on basic nursing care and medication rounds [28,29,31].

Guidelines
GPs feel forced to prescribe many different medications due to disease-specific guidelines [32]. Some GPs believe that current deprescribing guidelines are complex to use, making it difficult to implement deprescribing in daily practice [26]. This ultimately forces the GPs to make decisions without guidance [26]. However, GPs mention that the presence of deprescribing guidelines per se do not change their prescribing behavior [26]. On the other hand, using a deprescribing tool can help physicians and pharmacists to identify medication for deprescribing [30]. Some GPs believe that protocols for medication management can facilitate deprescribing by all HCPs providing care to residents in LTCFs [31].

Abbreviations: HCP, health care professional; LTCF, long-term care facility; NH, nursing home; GP, general practitioner.

This article is protected by copyright. All rights reserved.
Appendix 1: Search strategy

The following electronic databases were searched from inception to December 2017: MEDLINE (via Ovid SP), EMBASE (via Ovid SP), and CINAHL. The searches were conducted combining keywords for ‘Population’ (older people with limited life expectancy) and ‘Intervention’ (deprescribing) according to the Population, Intervention, Comparison, and Outcome (PICO) model [21]. The following search strategy was used:

(frail OR elderly OR old OR older OR “end of life” OR “eol” OR “life-limiting illness”)

AND

(depresse OR deprescribing OR deprescription OR "medication cessation" OR "medication withdrawal" OR "medication discontinuation" OR “inappropriate prescribing” OR “inappropriate medications” OR “inappropriate medication” OR “unnecessary prescription” OR “unnecessary prescriptions”)

The searches were restricted by filters for conference abstracts. In addition to identification of original literature, reference lists of relevant reviews were also reviewed to identify potentially eligible studies.
### Table A. Characteristics of the 41 excluded studies as presented in the individual papers.

<table>
<thead>
<tr>
<th>Study details (first author, publication year, country)</th>
<th>Aim</th>
<th>Medication</th>
<th>Participants</th>
<th>Patients</th>
<th>Methods</th>
<th>Exclusion reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ailabouni, 2017, New Zealand [1]</td>
<td>To investigate registered nurses’ views and perceptions on medication use and deprescribing in residential care settings</td>
<td>Multiple medications</td>
<td>91 registered nurses</td>
<td>Residents in RACFs</td>
<td>Cross-sectional survey</td>
<td>Wrong method</td>
</tr>
<tr>
<td>Anderson, 2017, Australia [2]</td>
<td>To explore the views of GPs and CPs about inappropriate polypharmacy and the reasoning they apply to deprescribing in primary care, and to identify factors that support or inhibit this cognitive process</td>
<td>Multiple medications</td>
<td>32 GPs and 15 CPs</td>
<td>Frail community-dwelling older adult with multimorbidity and polypharmacy, but without a terminal prognosis (one case study)</td>
<td>Focus group interviews</td>
<td>Patients without limited life expectancy</td>
</tr>
<tr>
<td>Anthierens, 2010, Belgium [3]</td>
<td>To describe GPs’ views and beliefs on polypharmacy in order to identify the role of the GP in relation to improving prescribing behavior</td>
<td>Multiple medications</td>
<td>65 GPs</td>
<td>Older patients</td>
<td>Semi-structured interviews</td>
<td>Patients without limited life expectancy</td>
</tr>
<tr>
<td>Bell, 2015, Norway [4]</td>
<td>To explore whether GPs associate drug use with falls among their elderly patients, and the factors influencing prescribing and cessation of FRIDs</td>
<td>FRIDs (defined as psychotropic, antihypertensive, and cardiovascular drugs in this study)</td>
<td>13 GPs</td>
<td>Older patients</td>
<td>Semi-structured focus group interviews</td>
<td>Patients without limited life expectancy</td>
</tr>
<tr>
<td>Bourgeois, 2014, Belgium [5]</td>
<td>To investigate initiation, indications, previous stop attempts, and perceived benefit and harm of benzodiazepines as well as the willingness to stop chronic benzodiazepine use in individual NH residents</td>
<td>Benzodiazepines</td>
<td>25 GPs and 16 nurses</td>
<td>NH residents with at least 3 months of benzodiazepine use</td>
<td>Resident-specific questionnaire</td>
<td>Wrong method</td>
</tr>
</tbody>
</table>
To use these indicators [nine previously validated indicators of the appropriateness of long-term prescribing] to explore factors which might contribute to inappropriate long-term prescribing by GPs in the UK

To explore how the intervention [in the OPTI-SCRIPT trial] was implemented, the experiences of those participating in the study, and lessons for future implementation

To explore GP perspectives regarding prescribing and PIP in older primary care patients

To understand factors influencing chronic use of benzodiazepines in older adults

Using the TDF to (i) explore hospital doctors' perceptions as to why PIP occurs, (ii) to identify the barriers to addressing the issues identified, thus identifying potential targets for intervention, and (iii) to use the behavior change wheel to determine which intervention types would be best suited

To explore the views of GPs on the use of the STOPP&START tool in daily practice

To explore physicians’ perceptions and attitudes and the decision-making process associated with prescribing psychotropic medications for

To explore the beliefs and behaviors of patients and GPs who have experience of long-term (≥ 2 years) antidepressant prescription

Antidepressants 10 GPs Older patients In-depth semi-structured Interviews Patients without limited life expectancy

Djatech, 2017, USA [14]

To determine physicians’ perceptions of deprescribing in older patients and assess the potential barriers among physicians in the Local Health Authority of Parma, Emilia-Romagna, Italy

Multiple medications 160 primary care physicians Older patients 9-item questionnaire Wrong method

Dybwad, 1997, Norway [15]

To understand and determine factors that result in variations between GPs in order to form a hypotheses and build theories about prescribing

Benzodiazepines and minor opiates 38 GPs Not specified Semi-structured interviews Patients <65 years (median)

Farrell, 2015, Canada [16]

Using a Delphi consensus process to engage physicians, pharmacists, and nurses in identifying and prioritizing medication classes where evidence-based deprescribing guidelines would be of benefit to clinicians

Multiple medications 8 geriatricians, 11 family physicians, 36 pharmacists, and 10 nurse practitioners Older patients Modified Delphi approach (including a literature review, an expert panel to develop survey content, and three survey rounds to seek consensus on priorities) Wrong method

Frich, 2010, Norway [17]

To explore GPs and tutors’ experiences with peer group academic detailing, and to explore GPs’ reasons for deviating from recommended prescribing practice

Multiple medications 39 GPs and 20 tutors Older patients Focus group interviews Patients without limited life expectancy

Fried, 2011, USA [18]

To explore clinicians’ perspectives of and experiences with therapeutic decision making for older persons with multiple medical conditions

Multiple medications 36 physicians, 2 nurse practitioners, 1 pharmacist, and 1 physician assistant Older persons with multiple medical conditions Focus group interviews Patients without limited life expectancy

Ie, 2017, USA [19]

To investigate variability in

Multiple medications 61 physicians Multimorbid older Survey Wrong method
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Year</th>
<th>Objective</th>
<th>Participants</th>
<th>Data Collection Method</th>
<th>Methodological Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iliffe, 2004, UK [20]</td>
<td>UK</td>
<td>2004</td>
<td>To explore beliefs and attitudes about continuing or stopping benzodiazepine hypnotics amongst older patients using such medicines, and amongst their GPs</td>
<td>Benzodiazepine hypnotics: 72 GPs, 5 practice managers, 4 practice nurses, and 2 counsellors</td>
<td>Non-standardized (conversational) interview approach (discussion)</td>
<td>Wrong method</td>
</tr>
<tr>
<td>Jubraj, 2015, UK [21]</td>
<td>UK</td>
<td>2015</td>
<td>To 1) elicit junior doctors’ attitudes to and awareness of the need to review medicines in older patients, 2) to explore factors that may hinder medication review and deprescribing, and 3) to use this information to formulate a ‘bottom-up’ approach to educate foundation and undergraduate doctors and pharmacists in preparation for their roles in medication review</td>
<td>Multiple medications: 20 foundation year one doctors</td>
<td>Online questionnaire survey</td>
<td>Wrong method</td>
</tr>
<tr>
<td>Kouladjian, 2016, Australia [22]</td>
<td>Australia</td>
<td>2016</td>
<td>To explore the perspectives of HCPs on (1) deprescribing anticholinergic and sedative medications in older adults and (2) the design and implementation of a report on the DBI for older adults into the medication management review setting</td>
<td>Anticholinergic and sedative medications: 12 accredited pharmacists, 12 GPs, and 13 specialist physicians</td>
<td>Focus group interviews and one-on-one interviews</td>
<td>Patients without limited life expectancy</td>
</tr>
<tr>
<td>Lesende, 2013, Spain [23]</td>
<td>Spain</td>
<td>2013</td>
<td>To analyze the potentiality of the STOPP/START criteria to change inappropriate prescribing, considering the acceptance by</td>
<td>Multiple medications: 20 GPs</td>
<td>Data collection from electronic medical records and interviews with GPs</td>
<td>Wrong method</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Objectives</td>
<td>Participants</td>
<td>Methods</td>
<td>Study Design</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td>------------</td>
<td>--------------</td>
<td>---------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>Lindström, 2007, Sweden [24]</td>
<td>To investigate whether SSRI treatment could be withdrawn for older residents in NHs who had been on treatment for at least one year without indications for long-term treatment, and to evaluate a method for systematic drug review in NHs</td>
<td>SSRIs</td>
<td>15 physicians and 19 nurses</td>
<td>Older NH residents with ongoing treatment with SSRIs for more than one year</td>
<td>Semi-structured telephone interviews</td>
<td></td>
</tr>
<tr>
<td>Luymes, 2016, The Netherlands [25]</td>
<td>To identify the barriers and enablers encountered in real-life discussions between patients and their GPs considering deprescribing preventive cardiovascular medications</td>
<td>Preventive cardiovascular medications</td>
<td>10 GPs</td>
<td>Low-CVD-risk patients</td>
<td>Audiotaping of deprescribing consultations</td>
<td></td>
</tr>
<tr>
<td>Magin, 2015, Australia [26]</td>
<td>To explore potentially inappropriate prescribing by Australian GPs by examining the context of PIMs use in community-dwelling older patients</td>
<td>Multiple medications</td>
<td>22 GPs</td>
<td>Community-dwelling older patients</td>
<td>Semi-structured telephone interviews</td>
<td></td>
</tr>
<tr>
<td>Maio, 2011, USA [27]</td>
<td>To assess primary care physicians’ knowledge of appropriate prescribing in older patients</td>
<td>Multiple medications</td>
<td>155 primary care physicians</td>
<td>Older patients</td>
<td>19-item questionnaire</td>
<td></td>
</tr>
<tr>
<td>Mavrodaris, 2013, UK [28]</td>
<td>To investigate current antipsychotic prescribing practices and patient review in primary care</td>
<td>Antipsychotics</td>
<td>60 GPs and 28 care home participants</td>
<td>People with dementia</td>
<td>Questionnaire</td>
<td></td>
</tr>
<tr>
<td>Moen, 2010, Sweden [29]</td>
<td>To describe multiple-medicine use from the GPs’ perspective</td>
<td>Multiple medications</td>
<td>4 private GPs and 27 county-employed GPs</td>
<td>Older patients</td>
<td>Focus group discussions</td>
<td></td>
</tr>
<tr>
<td>Ní Chróinín, 2015</td>
<td>To explore factors influencing</td>
<td>Multiple medications</td>
<td>134 physicians</td>
<td>Older patients with</td>
<td>2-component electronic</td>
<td></td>
</tr>
</tbody>
</table>

This article is protected by copyright. All rights reserved.
Deprescribing practices among specialist physicians caring for older patients, with progressive frailty, dependency, and cognitive decline

Parr, 2006, Australia [31]

To gain more detailed understanding of GPs and benzodiazepine users' perceptions relating to starting, continuing, and stopping benzodiazepine use

Benzodiazepines 28 GPs 23 benzodiazepine users Semi-structured face-to-face interviews Patients <65 years (median)

Ramaswamy, 2011, USA [32]

To (i) examine doctor knowledge of inappropriate prescribing in older people, (ii) to evaluate doctors' confidence in their prescribing for older people, and (iii) to identify perceived barriers to appropriate prescribing in older people

Multiple medications 89 doctors Older people Questionnaire Wrong method

Sinnott, 2015, Ireland [33]

To explore how and why GPs make decisions when prescribing for multimorbid patients, with a view to informing the design interventions to assist prescribing and multimorbidity care

Multiple medications 20 GPs Multimorbid patients In-depth qualitative interviews Patients <65 years (median)

Smith, 2010, Ireland [34]

To document the views and beliefs of professionals working with patients to manage multimorbidity in primary care, specifically those of GPs and pharmacists who are particularly involved in such care

Multiple medications 13 GPs and 7 pharmacists Patients with multimorbidity Focus group interviews Patients without limited life expectancy

Spinewine, 2005, Belgium [35]

To explore the appropriateness of use of medicines for patients admitted to wards for care of the older people from the perspectives of HCPs and patients

Multiple medications 5 doctors, 4 nurses, and 3 pharmacists Older inpatients Individual semi-structured interviews and ward observations Patients without limited life expectancy
<table>
<thead>
<tr>
<th>Author, Year, Country</th>
<th>Purpose</th>
<th>Sample</th>
<th>Intervention</th>
<th>Control</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Šubelj, 2010, Slovenia [36]</td>
<td>To understand and determine factors that influence prescription variations between family physicians from their own point of view, allowing substantial explanation of the circumstances and prescription habits</td>
<td>Benzodiazepines</td>
<td>10 family physicians</td>
<td>Patients on benzodiazepines</td>
<td>Interviews</td>
</tr>
<tr>
<td>Todd, 2016, UK [37]</td>
<td>To explore the lived experience of patients, carers, and HCPs in the context of medication use in life-limiting illness</td>
<td>Multiple medications</td>
<td>3 palliative medicine consultants, 3 advanced nurse practitioners, and 6 GPs</td>
<td>Palliative care patients</td>
<td>In-depth interviews</td>
</tr>
<tr>
<td>Turner, 2016, Australia [38]</td>
<td>To rank factors that GPs, nurses, pharmacists, and residents perceive as most important when deciding whether or not to deprescribe medications</td>
<td>Multiple medications</td>
<td>19 GPs, 12 nurses, and 14 pharmacists</td>
<td>LTCF residents</td>
<td>Nominal group technique</td>
</tr>
<tr>
<td>Voigt, 2016, Germany [39]</td>
<td>To examine reasons for PIM prescription a) in general and b) using real individual case vignettes of family practitioners that were detected beforehand through record analysis</td>
<td>Multiple medications</td>
<td>7 family practitioners</td>
<td>Older patients with ≥2 chronic conditions and ≥2 related long-term medications</td>
<td>Semi-standardized content analysis of patients’ records and qualitative interviews</td>
</tr>
<tr>
<td>Wallis, 2017, New Zealand [40]</td>
<td>To explore the views of primary care physicians on the barriers to and facilitators of deprescribing in everyday practice to inform the development of an intervention to support safer prescribing</td>
<td>Multiple medications</td>
<td>24 primary care physicians</td>
<td>Older people</td>
<td>Semi-structured interviews (either face-to-face or by telephone)</td>
</tr>
<tr>
<td>Wu, 2017, Australia [41]</td>
<td>To assess hospital pharmacists’ perspectives and attitudes on their roles in optimizing statin therapy for older inpatients</td>
<td>Statins</td>
<td>108 hospital pharmacists</td>
<td>Older inpatients</td>
<td>13-item questionnaire</td>
</tr>
</tbody>
</table>

Abbreviations: CP, consultant pharmacist; CVD, cardiovascular disease; DBI, Drug Burden Index; FRID, fall-risk-increasing drug; GP, general practitioner; HCP, health care practitioner/professional; LTCF, long-term care facility; NH, nursing home; OPTI-SCRIPT, OPTImizing PreSCRIbing for Older People in Primary Care, a clusTer randomised controlled trial; PIM, potentially inappropriate medication; PIP, potentially inappropriate prescribing; RACF, residential aged care facility; SSRI, selective serotonin reuptake inhibitors; START, Screening Tool to Alert to Right Treatment; STOPP, Screening Tool of Older People’s Prescriptions; TDF, Theoretical Domains Framework.
References


Figure 1. PRISMA flow diagram [19].