



What Needs to Change to Make Deprescribing Doable

RANIT MISHORI, MD, MHS, FAAFP

The famed physician Sir William Osler reportedly said, “The first duty of the physician is to educate the masses *not* to take medicine.”¹ That was in the late 1800s. Unfortunately, Osler’s lesson is scarcely observed in our own time, not only by the “masses” but also by the physicians who serve them. To the contrary, today’s patients — plagued by multiple medical conditions, bombarded with direct-to-consumer ads, working with physicians who themselves are targeted by pharmaceutical companies, and sometimes seeking quick fixes — are overmedicated, taking multiple medications simultaneously, and doing so on doctor’s orders.

This is not surprising, given the way that both medical school and residency training put such singular focus on diseases, and the drugs associated with them. We are asked to memorize classes of medications for specific conditions; to select and justify first- and second-line drug treatments; to steep ourselves in data related to side effects and drug-drug interactions; and to master an understanding of drug metabolism. By the time we finish medical school or residency, we are expected to have our own lists of “go to” drugs for whatever it is we are expected to manage clinically.

What is seldom taught or studied formally is how to take people *off* medications — what we have now come to call “deprescribing.”

I first heard the term a few years ago while speaking with an Australian colleague, and the idea really appealed to me. The scenario that Scott Endsley, MD, recounts in his article for this issue, “Deprescribing Unnecessary Medications: A Four-Part Process” (page 28), is all too familiar to family physicians. Polypharmacy constitutes a real patient-safety issue. Recognizing there is a problem is the first step. But what next? Endsley makes some excellent suggestions for what we, as physicians, can do in the exam room.

Yet deprescribing is easier said than done. I learned this for myself when I began experimenting with it in my own practice, and all sorts of challenges popped up. These included but were not limited to managing patient and family expectations, finding time to have the conversation in the first place, and coordinating and communicating with specialists. I learned that a family physician can remove a medication from a

Polypharmacy constitutes a real patient-safety issue. Recognizing that is the first step toward change.

“The first duty of the physician is to educate the masses *not* to take medicine.”

WE WANT TO HEAR FROM YOU

The opinions expressed here do not necessarily represent those of *FPM* or our publisher, the American Academy of Family Physicians. We encourage you to share your views. Send comments to fpmedit@aafp.org, or add your comments to the article online.

ABOUT THE AUTHOR

Dr. Mishori is director for the Health & Media Fellowship and director for the Robert L. Phillips, Jr., Health Policy Fellowship in the Department of Family Medicine, Georgetown University School of Medicine, Washington, D.C. Author disclosures: no relevant financial affiliations disclosed.

patient's prescription list, only to see it added back after a visit to the specialist. Such experiences not only are frustrating for all involved but also can erode patient confidence and harm collaborative care.

My personal implementation challenges were not unique, of course. These challenges were documented in an excellent article by Wallis et al. that noted many physicians feel they are "swimming against the tide" when it comes to deprescribing.²

Some of these challenges are due to the fact that the art and science of deprescribing are still in their infancy. The first entry of the term in the medical literature — in

With so many patient populations set to benefit, the time has come for family physicians to get on the deprescribing train.

the title of a manuscript — appeared in 2007, in French. The first English-language manuscript appeared in 2011 out of Australia by Beer et al.³ To date, 291 articles have been published on deprescribing, according to a PubMed search, with more than half of them published since 2017.

As the issue gains momentum, we must pause and ask ourselves: What needs to happen to make deprescribing not only easier but also sustainable? Here are eight ideas:

1. Recognition of the problem. At the core, deprescribing must be recognized as an important patient-safety issue by multiple stakeholders — clinicians, pharmacists, administrators, policy makers, and payers. Not least, it must be recognized as such by patients, families, and patient advocates.

2. Education. The medical education community must develop curricula around deprescribing and incorporate them into undergraduate and graduate medical education, as well as continuing medical medication.

3. Interprofessional collaboration. We need to create and promote effective partnerships between primary care physicians, pharmacists, and specialists.

4. Payment and reimbursement. Payers

need to create codes and offer reimbursement that value the time and thought that go into deprescribing.

5. Health information technology. Health care organizations need to partner with electronic health record vendors to design prompts and decision support algorithms, enable access to expert prescribing advice in real time, and ensure interoperability for optimal coordination of care among primary care physicians, specialists, and pharmacies.

6. Evidence. We need to build on the existing evidence base⁴ and develop a research agenda that evaluates patient-oriented outcomes, best practices, optimal protocols, and health-system readiness.

7. Patient engagement. We need to create communication tools within our practices and work with patient advocacy groups outside our practices to promote joint decision-making around medication management.

8. System change. Health systems need to establish funding mechanisms for research and implementation, develop quality measures and consensus on desired clinical outcomes, incorporate deprescribing measures into quality initiatives, and enlist health care and physician organizations as allies.

Ultimately, it is about culture change. We are used to drugs being our frontline answer, either because patients demand it or because it's easier to write a prescription than to consider alternatives. A renewed consciousness and paradigm shift must include efforts to create, find, and recommend substitutes for drugs and address health issues via non-pharmacological means.

With so many patient populations set to benefit, the time has come for family physicians to get on the deprescribing train. **FPM**

1. Bean RB. *Sir William Osler: Aphorisms From His Bedside Teachings & Writings*. New York: Henry Schuman Inc; 1950.

2. Wallis KA, Andrews A, Henderson M. Swimming against the tide: primary care physicians' views on deprescribing in everyday practice. *Ann Fam Med*. 2017;15(4):341-346.

3. Beer C, Loh PK, Peng YG, Potter K, Millar A. A pilot randomized controlled trial of deprescribing. *Ther Adv Drug Saf*. 2011;2(2):37-43.

4. Thompson W, Farrell B. Deprescribing: what is it and what does the evidence tell us? *Can J Hosp Pharm*. 2013;66(3): 201-202.