The Views of Indian Practitioners on Deprescribing

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INTRODUCTION

Deprescribing, "a structured approach to drug discontinuation"[1] is rapidly becoming a trend worldwide. Though the Western world has accepted and adopted this approach towards prudent and rational therapy, the concept continues to be controversial in developing countries. The decision to deprescribe any medicine is complicated by the dearth of risk-benefit data and risk of therapeutic failure or withdrawal symptoms. But deprescribing has proven to be a legitimate solution to the age-old challenges of non-adherence, polypharmacy, risk of adverse drug reactions (ADRs), and use of potentially inappropriate medications (PIMs). As the responsibility of prescribing and monitoring of drug therapy falls primarily on physicians, understanding their views on deprescribing is of utmost importance. Hopefully the decision is made after weighing both the risks and benefits of deprescribing.

METHOD

This study is an observational, questionnaire-based survey of 422 registered medical practitioners within a radius of 10 km from Mathikere (Bangalore), with a minimum qualification of MBBS. Over 8 months, face-to-face interviews were conducted using a validated instrument 'Perceptions, Attitudes and Challenges of Physicians towards Deprescribing' (PACPD-12) (Table 1).[2]

RESULTS

The majority of Indian doctors (71.8%) agreed that deprescribing is beneficial. While 56.9% doctors chose to deprescribe in all groups of patients, benzodiazipines (34.6%), anti-depressants (33.2%), anti-psychotics (32.5%), and anti-convulsants (32.5%) were the most common candidate drugs for deprescribing. The prime reason for deprescribing (58.8%) was to reduce harm to patient, followed by latest guidelines where medication is not indicated (49.1%), reducing the cost of treatment (43.1%), and pill burden (32.2%). About 88.2% of doctors had a specific approach to deprescribing medications. The STOPP-START criterion was used by 44.8% of doctors, while 6.6% preferred Beers criteria for deprescribing. A majority of doctors (66.5%) believed deprescribing provides more benefit than harm to patients. With regard to methods that would help with depescribing, 57% felt that flags by pharmacists would be helpful; 49% believed that training on deprescribing of specific medications would also help. Among challenges, 55.2% of doctors felt that prescriptions provided by another doctor was a barrier. Concern about ADR (49.5%) and damaged relation with the original physician (41.7%) were other barriers noted. About 65.4% of doctors were confident in deprescribing. The existence of PIMs listed in Beers criteria (53.8%), acute symptoms possibly related to medication (51.7%), the large number of prescription medications (46%), and advanced age (39.8%) were the most opted factors that would make a doctor more likely to deprescribe.

DISCUSSION

Our finding that most doctors supported deprescribing was also found by Nadarajan et al. (2016).[3] Our study indicated that deprescribing was preferred in all age groups, though most deprescribing studies focus on the elderly. The well-established risk of chronic benzodiazepine use, coupled with good data that they can be discontinued safely with strict monitoring, may be the reason for their being the most preferred drugs for deprescribing.[4]

Similar to Nadarajan et al., we also found that the top three reasons for deprescribing were to reduce harm, followed by reducing pill burden for patients and medications with minimal benefits to patients.[3] About half of the physicians appreciated Beers and STOPP/START criteria as useful tools for deprescribing.

Recognizing barriers to deprescribing is helpful in finding ways to implement and overcome these obstacles. Uncertainty of the rationale behind prescription by another physician, possibly due to the rapid growth in the number of specialist and subspecialist departments that has resulted in fragmentation of patient care, was a major challenge. Minimal communication between doctors, inadequate transfer of information at care interfaces, lack of pharmacists on the clinical team, and difficulty accessing medical records also pose challenges to deprescribing among Indian physicians.

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Table 1 Responses of Physicians to the Items of the Perceptions, Attitudes and Challenges of Physicians towards Deprescribing (PACPD-12) Questionnaire.

Sl. no.	Question	Response *n* (%)
1	Deprescribing is beneficial in the current clinical scenario	
	Strongly agree	188 (44.5)
	Agree	115 (27.3)
	Neutral	76 (18)
	Disagree	39 (9.2)
	Strongly disagree	4 (0.9)
2	Preferred age for deprescribing	
	All	240 (56.9)
	Pediatrics	66 (15.6)
	Adults	121 (28.7)
	Geriatrics	76 (18)
	None	4 (0.9)
3	Preferred drugs for deprescribing	
	Benzodiazepines	146 (34.6)
	Antidepressant drugs	140 (33.2)
	Antipsychotic drugs	137 (32.5)
	Anticonvulsant drugs	137 (32.5)
	Antiplatelet drugs	129 (30.6)
	Antihypertensive drugs	127 (30.1)
	Antibiotics	118 (28)
	Opioids	112 (26.5)
	Proton pump inhibitors	84 (19.9)
	Choline esterase inhibitors	72 (17.1)
	Vitamins/supplements	70 (16.6)
	Bisphosphonates	69 (16.4)
	Statins	62 (14.7)
	Anti-arrhythmic drugs	28 (6.6)
	Antibiotics	3 (0.7)
	Steroids	2 (0.5)
	Analgesics	1 (0.2)
	Glucocorticoids, diuretics	1 (0.2)
	Based on patient profile count	1 (0.2)
	Bronchodilators and steroids	1 (0.2)
4	Reason for deprescribing	
	To reduce harm to patient in view of adverse drug reaction	248 (58.8)
	Based on latest guidelines, the medication is not indicated	207 (49.1)
	To reduce cost of treatment	182 (43.1)
	To reduce pill burden	136 (32.2)
	Because medication has minimal benefit for patient in view of age and comorbidities	107 (25.4)
5	Not making deprescribing a point in daily practice	
	Strongly agree	18 (4.3)
	Agree	23 (5.5)
	Neutral	66 (15.7)
	Disagree	222 (52.7)
	Strongly disagree	92 (21.9)
6	Have an approach to deprescribe a medication	
	Strongly agree	88 (20.9)
	Agree	284 (67.3)
	Neutral	44 (10.4)
	Disagree	6 (1.4)
	Strongly disagree	0 (0)
7	Specific criteria used for deprescribing	
	STOPP-START criteria	189 (44.8)
	AGS-Beers criteria	28 (6.6)
	No criteria used	199 (47.2)
	Others	7 (1.7)
8	Statement that best expresses view on deprescribing	
	Does more good than harm	281 (66.5)
	Does neither good nor harm	58 (13.7)
	Does more harm than good	54 (12.8)
	Not sure	29 (6.9)
9	Enabling factors	
	Flags by pharmacist to deprescribe medications in a patient-centered approach	239 (56.8)
	Training on de prescribing specific medications	204 (48.5)
	Strong department focus on de prescribing medication	183 (43.5)
	Having a pharmacist in your team	116 (27.6)
	Others	1 (0.2)
10	Barriers to deprescribing	
	Medications usually prescribed by another doctor and the current doctor is unsure of the rationale	233 (55.2)
	Concerned about adverse events after de prescribing medication	209 (49.5)
	Damaging relationship with original doctor who prescribed medication	176 (41.7)
	Resistance from patient/family	142 (33.6)

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Table 1. (continued)

Sl. no.	Question	Response *n* (%)
	Lack of benefit/risk information about de prescribing	124 (29.4)
	Lack of time to consider deprescribing	110 (26.1)
	Pressurized to prescribe according to guidelines	102 (24.2)
	Patients belief that you are giving up on them	71 (16.8)
	Lack of experience	9(2.1)
11	Positivity towards deprescribing on a scale of 1–5	
	1	2 (0.473)
	2	51 (12.1)
	3	93 (22)
	4	214 (50.7)
	5	62 (14.7)
12	Factors that make physicians more likely to deprescribe	
	Existence of potentially inappropriate medication listed in Beers criteria	227 (53.8)
	Acute symptom possibly related to medication	218 (51.7)
	Larger number of prescription medication	194 (46)
	Advanced age	168 (39.8)
	Lower economic status of patient	166 (39.3)
	Concomitant comorbidities like hepatic/renal dysfunction that affect drug metabolism	160 (37.9)
	Existence of chronic conditions	80 (19)
	Concomitant ethanol abuse	56 (13.3)

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Compliance with Ethical Standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

Ethical Approval: *All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was taken from all involved participants. This article does not contain any studies with animals performed by any of the authors.*

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