

**FAST FACTS AND CONCEPTS #369****COMMUNICATION TECHNIQUES FOR DEPRESCRIBING CONVERSATIONS**

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**Background:** Evidence suggests that patients with a prognosis < 1 year are burdened by polypharmacy and take an average of 11.5 medications per day (1). Deprescribing is the process of tapering or stopping drugs, aimed at improving patient outcomes near the end of life by minimizing polypharmacy (see *Fast Fact #321*) (2). Barriers to deprescribing include a lack of clinician confidence in deprescribing skills and a fear of triggering psychological distress from the patient by discontinuing familiar medications (3,4). Research indicates that, fortunately, patient-clinician trust can endure when deprescribing is done well (5). This *Fast Fact* offers a deprescribing communication framework for leading these conversations.

**Before the Deprescribing Conversation:** Clinicians should identify deprescribing-eligible medications via chart review (see *Fast Fact #321*). Eligible medications include those where: a) the benefits no longer outweigh the adverse-effect risk (e.g. progressive renal failure) b) the time-until-benefit exceeds the anticipated prognosis; or c) the treatment target no longer aligns with the patient's goal of care.

**The 'FRAME' acronym for leading deprescribing conversations:**

**E – Fortify trust:** Patients often have strong perceptions from medication changes. Callous deprescribing advice can lead to mistrust, feelings of abandonment, or a sense of futility of previous compliance. Palliative care providers must first establish a trusting relationship with the patient and/or caregiver in which they understand the medical goals of care prior to initiating deprescribing conversations (6).

**R – Recognize patient willingness or barriers to deprescribing:** While clinicians are often worried patients may be psychologically attached to their medications, evidence suggests patients are also greatly concerned and burdened by polypharmacy. In one cross-sectional study, up to 98% of geriatric patients reported willingness to stop one of more of their medications (7).

- Incorporate open-ended questions like: *“Do you feel that you are taking too many, too little, or just enough medications?”* or *“Do you feel your medications are inconvenient to take? Which ones?”* The Revised Patients' Attitudes Towards Prescribing (rPATD) is a 15-part validated questionnaire which aims to gain a better understanding of patients' or families' beliefs and barriers to deprescribing and the effect various medications have on quality of life (8). rPATD questions can be accessed and then modified into relevant open-ended questions to gauge willingness and barriers to deprescribing (8).
- Motivational Interviewing: this is an evidence-based communication strategy involving a conversational, patient-centered history-taking approach which is utilized over multiple clinic visits (see reference #9 for more information) (9,10). It is meant to gauge a patient's willingness or ambivalence to make a clinically recommended behavioral change and then empowering a commitment toward that change (9-14). Motivational interviewing has been shown to be useful in leading many types of palliative care conversations, including deprescribing (13-14). When used for deprescribing, it should involve four key principles: 1) Empathetic listening to any expressed barriers; 2) Determination of the patient's stage of willingness to pursue deprescribing; 3) Using clinical discrepancy if resistance to deprescribing develops; 4) Empowering self-efficacy by noticing even small incremental changes.

**A – Align deprescribing recommendations to goals of care:** As with any clinical scenario, deprescribing recommendations will be better received if they align with the patient's medical goals and values (10). *“Thank you for telling me that you want to spend more time gardening. I want to discontinue your metoprolol as this medication can cause fatigue as your heart rate has been low lately.”*

**M – Manage cognitive dissonance:** Cognitive dissonance occurs when a person experiences mental discomfort from two or more simultaneous contradictory beliefs, ideas, or values. Often patients or caregivers struggle with cognitive dissonance after a formal deprescribing recommendation is given

because they associate medications with making them better, not putting them at risk for harm. Unless cognitive dissonance is addressed, patients may not be open to deprescribing recommendations. Various techniques have been described for addressing cognitive dissonance during deprescribing conversations:

- **Direct:** *"I know you are taking a lot of medications, but I don't think it's good for you to be on this many. I want to reduce this to a more manageable number of medications for you."*
- **Emotional:** *"I am worried about your falls. Some of your medications may be hurting not helping you by clouding your mind and affecting your concentration and balance."*
- **Reading for Next Time:** A randomized study of 303 long-term users of benzodiazepines (BZDs) showed that an interventional group who received a "Reading for Next Time" deprescribing brochure that described the risks of BZD use was significantly more likely to discontinue BZDs (number needed to treat, 4) than a control group (15). In its simplest form, "Reading for Next Time" is stating, *"Here is some information regarding [medication X]. Read this prior to our next visit and we can discuss"*. Brochures are available for many medication classes via the Canadian Deprescribing Network (16).

**E - Empower patients and caregivers to continue the conversation:** Like advance care planning, deprescribing conversations should not be limited to one point in care. Subsequent conversations are often needed to decrease unnecessary pill burden effectively. Clinicians can set up future conversations via motivational interviewing techniques towards the end of the visit. Sample phrasing include: *"You bring up a good point about your fatigue. I would encourage you to ask your cardiologist what benefit metoprolol is providing you and what your time may look like if you were to discontinue it."*

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