

Deprescribing tendencies within primary health care – a literature review

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ABSTRACT

Background

Polypharmacy increases in older persons and in multimorbid patients thus becoming prevalent in primary health care. While deprescribing offers a patient-centered, systematic approach to reducing potentially inappropriate medicines, implementation remains inconsistent based on clinical, systemic, and patient-level factors.

Aim

The purpose of this literature review is to outline the enablers and barriers of deprescribing in primary care and, on the basis of current evidence, identify successful solutions for implementation.

Method

A review of the literature was performed utilising PubMed, Medline, Cochrane Library and Embase, as institutional databases. English publications between 2020 and mid-2025 were screened utilising predefined inclusion and exclusion criteria. The Critical Appraisal Skills Programme (CASP) framework was used to critically appraise the peer-reviewed articles. Data were synthesised thematically with arising patterns grouped into their own main themes and sub-themes.

Results

Dominant themes that occurred were prescriber confidence, patient refusal, time constraints, and lack of overt guidelines as key barriers. Enablers such as multidisciplinary collaboration, use of evidence-based deprescribing tools (e.g. STOPP/START, Beers Criteria), and patient engagement were reported across all settings. Implementation strategies varied between settings but the majority contained important pharmacist interventions, education programmes, and formal implementation protocols.

Conclusion

Deprescribing within primary care can be done and is necessary but requires multi-faceted interventions targeting individual prescribers, systems, and patients. To enhance uptake and sustainment, deprescribing has to be incorporated into routine care in combination with training, decision aids, and policy-level promotion.

Keywords

Barriers, deprescribing, facilitators, polypharmacy, primary care.

INTRODUCTION

The increased prevalence of polypharmacy among the older person poses a huge challenge to primary healthcare systems globally. Polypharmacy, or the concurrent consumption of several drugs, five or more, is quite frequently the outcome of treating multimorbidity, especially in the older person. Although such prescribing is clinically warranted, particularly when evidence-based practice is the impetus, it also heightens the risk of hospitalization, adverse drug events (ADEs), drug interactions, and reduced quality of life (QOL). Thus, deprescribing has become a vital methodology for streamlining drug therapy regimens and enhancing patient outcomes (Hung, Kim and Pavon, 2024).

Deprescribing is defined as the intentional and supervised process of reducing, tapering or discontinuing medications that no longer provide benefit or are likely to harm. Deprescribing is not a failure of treatment but rather a dynamic and active approach to medication management that is concordant with patient-centered principles of care. It enables regular re-assessment of treatment goals, clinical necessity and patient preference (Thompson and McDonald, 2023).

General practitioners (GPs) and other primary care providers are well-positioned to initiate and coordinate deprescribing. Their role as ongoing and integrated carers of patients provides a bird's eye view of long-term medication regimens and evolving clinical needs. GPs often must manage several simultaneous chronic conditions and are charged with reconciling clinical guidelines and patient reality. In spite of this fundamental role, the process of deprescribing is replete with challenges. The factors are time constraints, sporadic access to specialists, fear of withdrawal reactions, lack of training in deprescribing skills and concern about damaging the therapeutic relationship with patients (Alrawiai, 2023). In the United Kingdom, initiatives such as Structured Medication Reviews and clinical guidelines, viz. STOPP/START criteria have been initiated in order to facilitate adequate deprescribing (Alrawiai, 2023).

Above all, deprescribing cannot be envisioned as just a set of interventions or tools but as a clinical tendency; a tendency influenced by culture,

experience, attitude, and support systems. A GP's likelihood of pursuing deprescribing can be equated to their awareness of medication harms, their comfort with clinical uncertainty, and how supportive the healthcare system is seen to be. These incorporate elements like access to multidisciplinary teams, the presence of deprescribing prompts in electronic health records, and the provision of structured clinical education (Liacos, Page and Etherton-Beer, 2020).

Although GPs are at the centre of deprescribing, attention is being given to the role of other health-care professionals (HCPs), notably the pharmacist. Pharmacists, particularly when they are members of primary care teams, can conduct helpful medication reviews, identify potentially inappropriate medication (PIM), and assist in the implementation of deprescribing plans. Rea et al. (2023) demonstrated the effectiveness of pharmacist-driven deprescribing interventions at 16 primary care sites in the United States (U.S.), resulting in the discontinuation of over 350 medications, prescriber acceptance rates over 90%, and substantial cost savings. This highlights the benefits of collaborative care models in supporting rational prescribing.

Despite growing awareness, deprescribing is underappreciated. Barriers confront deprescribing at multiple levels; patient (e.g., reluctance to disturb known treatments), provider (e.g., uncertainty), and system (e.g., absence of standardised procedures). Clinical guidelines also generally prioritize medication addition over deprescribing, thereby leaving clinicians with limited guidance when considering cessation. Accordingly, deprescribing is most often reactive, prompted by adverse events or hospitalisation, and not proactive, which works to limit its more general preventive potential (Thompson and McDonald 2023).

Aim

The purpose of this literature review is to outline both the facilitators and barriers of deprescribing in primary care from the prescriber's point of view, to address patient and system level issues on the basis of current evidence, and

to identify potential successful solutions for implementation.

METHOD

The method is guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines to enable a transparent assessment and process of the literature. Although not expressly systematic, this review integrates similar elements, comprising systematic database searching with predefined inclusion and exclusion criteria, alongside a critical appraisal of included studies.

Databases and search strategy

A search plan was employed in identifying studies that were relevant to the topic. Searches were conducted on various electronic sources, including PubMed, MEDLINE, the Cochrane Library and Embase. Search terms were carefully selected and developed from relevant Medical Subject Headings (MeSH) and keywords. Boolean operators, such as AND and OR, were also utilized to combine terms and enhance the specificity of the search. The search terms used were “deprescribing,” “primary care,” “general practice,” “attitudes,” “polypharmacy,” and “barriers AND facilitators.” Boolean operators have been applied with various combinations of the terms above.

Inclusion and exclusion criteria

To enable a high-quality review, strict inclusion and exclusion criteria were established. The inclusion criteria are outlined as below:

- Original research and peer-reviewed articles.
- Only systematic reviews, literature reviews, randomised controlled trials, observational studies and meta-analysis studies were included in the search.
- Scientific research published between the years 2020-2025.
- The research was conducted primarily in primary care settings.
- Investigation of attitudes, barriers, facilitators and practices towards this role.
- Research that investigates drugs commonly deprescribed, as well as the effects of such a role.

- Existing English research.
- Studies addressing adults.

The exclusion criteria were as follows:

- Only research in tertiary and secondary care.
- Articles unavailable in full text.
- Research not related to human health.
- Studies lacking qualitative methodology.

These research standards ensure that the narrative literature review is not only adequate and pertinent but also up to date and of high quality, hence adding to a proper review of significant worth regarding polypharmacy and deprescribing among the population.

Screening and selection process

All records identified and retrieved were screened. This was initially achieved by optimizing the title and abstract to exclude non-relevant studies. Second, systematic review and overview of the entire text were done to find potentially eligible articles. To have an orderly and unambiguous approach to the selection process, a PRISMA-inspired method was employed, which entailed identification, screening, eligibility, and inclusion/exclusion criteria. Several records were manually located by searching reference lists of relevant, high-quality studies.

Quality evaluation

The methodological quality of studies in the analysis was evaluated by the Critical Appraisal Skills Programme (CASP) tools and respective checklist. The evaluation was conducted for each study depending on its specific design. All studies were analyzed regarding methodological quality, applicability to research questions and clarity of reporting. Quality appraisal was necessary because it enabled the detection and judgment of evidence from literature but did not form the sole exclusion criterion unless there were severe negative findings.

Key areas checked were: research objectives clarity, appropriateness of methodology, the recruitment process, data analysis and collection, and the overall contribution of findings. Research studies not meeting a minimum criterion of methodological quality or not pertinent to the

purpose of the review were excluded. This appraisal process helped with a more targeted high-quality synthesis of evidence to shape the review's conclusions.

Data synthesis

Findings were thematically synthesized to permit recurring themes, shared patterns and variability by setting. These were observed and classified accordingly, as follows:

- System level factors:
 - Healthcare system barriers.
 - Organizational facilitators.
 - Resource considerations.
- Provider level factors:
 - Barriers to clinical decision-making.
 - Professional relationships.
 - Implementation strategies.
- Patient level factors:
 - Attitudes and preferences regarding polypharmacy/deprescribing.
 - Communication issues.
 - Engagement strategies.

Limitations of methodology

Given the nature of a narrative literature review, the following limitations may be faced by the project:

- Selection bias is most frequently occurring in study screening and thematic synthesis contexts.
- Publications can be biased, as results of negative value may be underreported.
- Language bias, because of exclusion of non-English language studies.

Nevertheless, the approach employed during search strategy and data extraction through critical appraisal guarantees transparency and reliability of the results.

RESULTS

The search presented a total of 854 initial records via Pubmed, Embase, Medline and Cochrane Library. The search terms and Boolean operators were employed as specified in the previous section together with the relevant inclusion and exclusion criteria. A total number of 43 scientific articles were included in the production of this literature review. A PRISMA flow diagram was utilised to showcase the search undertaken and the findings are depicted hereunder in Figure 1. A PRISMA flowchart template was retrieved from prisma-statement.org. The original article had a total of 43 studies; however, for the purpose of this article a total number of 25 studies were utilised. These were reduced from the original study as it was modified for the purpose of the article subject.

Themes and sub-themes were extracted according to the aim of the article. The main focus of the theme was the health care professionals' attitudes and beliefs regarding the deprescribing process within their community clinics and how this affects their consultation and management options with their patients. These were based, as described in the data synthesis, via system, provider and patient level factors. Thereafter, articles were reviewed by utilising the CASP assessment tool to filter out the sub-themes chosen for the production of this article. This is shown in tabulated form within Table 1.

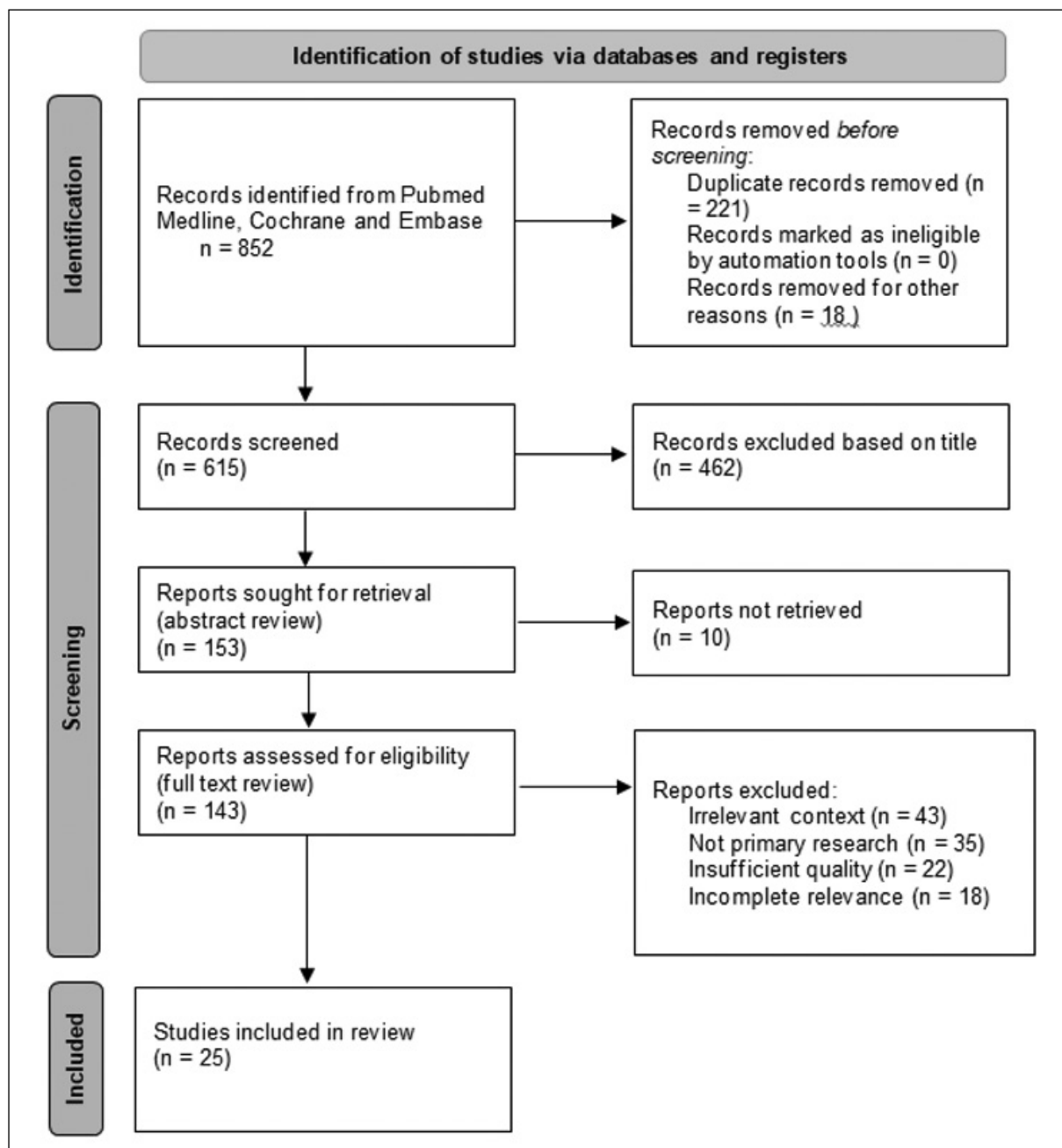


Figure 1: PRISMA flowchart showing the selection of the articles in this literature review

Table 1: Main themes and sub-themes of the individual selected articles

Author and year	Main themes and sub-themes
Alrawiai (2023)	Implementation Barriers; Stakeholder Perspectives
American Geriatrics Society 2023 updated AGS Beers Criteria®	Deprescribing Tools; Enablers; Guidelines
Bloomfield et al. (2020)	Clinical Outcomes; Stakeholder Perspectives
Bužančić and Hadžiabdić (2023)	Stakeholder Perspectives; Patient-Centred Factors
Carollo et al. (2024)	Implementation Barriers; Deprescribing Tools; Patient-Centred Factors
Chang et al. (2024)	Deprescribing Tools; Behavioural Theory
Goh et al. (2023)	Implementation Barriers; Stakeholder Perspectives; Patient-Centred Factors; Enablers; GP Trainees
Hung, Kim and Pavon (2024)	Implementation Barriers; Deprescribing Tools; High-Risk Drug Classes; Stakeholder Perspectives; Patient-Centred Factors
Ibrahim et al. (2021)	Clinical Outcomes
Lee et al. (2021)	High-Risk Drug Classes; Falls
Liacos et al. (2022)	Deprescribing Tools; High-Risk Drug Classes; Stakeholder Perspectives; Patient-Centred Factors; Enablers
Maher et al. (2020)	Deprescribing Tools
Niznik et al. (2022)	Implementation Barriers; Patient-Centred Factors
O'Mahony et al. (2023)	Deprescribing Tools
L'Mahony et al. (2021)	Clinical Outcomes
Rea et al. (2023)	High-Risk Drug Classes; Enablers; Barriers
Reeve (2020)	Deprescribing Tools; Stakeholder Perspectives; Patient-Centred Factors; Enablers; Barriers
Reeve et al. (2024)	High-Risk Drug Classes; Stakeholder Perspectives
Robinson et al. (2024)	Implementation Barriers; Patient-Centred Factors
Scott et al. (2024)	Stakeholder Perspectives; Enablers
Seppälä et al. (2022)	Stakeholder Perspectives
Thompson and McDonald (2023)	Implementation Barriers; High-Risk Drug Classes; Enablers
Trenaman et al. (2022)	Enablers; Implementation Barriers
Veronese et al. (2024)	Clinical Outcomes; Stakeholder Perspectives
Wang et al. (2023)	Implementation Barriers; Deprescribing Tools; Stakeholder Perspectives; Transitions of Care; Enablers

Deprescribing

Deprescribing is conceptualized as the intentional process of discontinuing medications that are no longer beneficial or are potentially harmful to the patient, particularly in the context of polypharmacy (Hung, Kim and Pavon, 2024). In an era of aging population and increasing prevalence of multimorbidity, deprescribing has emerged as a high-priority research field as a component of quality prescribing.

Why deprescribe?

The goals of deprescribing should be patient-centered and proactively done in a manner so as to minimize harm and enhance QOL. A number of strategies may be employed during deprescribing. Withdrawal of non-essential medications has been found to reduce the incidence of potentially inappropriate medication (PIMs) by 30–60%, thereby enhancing compliance with required treatments (Bloomfield et al., 2020). Bužančić and Hadžiabdić (2023) also documented similar findings where up to 40% of older persons are prescribed at least one PIM.

One of the key targets in older patients is the reduction of fall risk. Medications such as benzodiazepines, opioids, antidepressants, antipsychotics, and anticholinergic agents are known contributors (Lee et al., 2021; Niznik et al., 2022). However, studies suggest that deprescribing alone may not have a significant effect on fall risk reduction if not combined with other multifaceted interventions due to the multifactorial complexity of falls (Seppälä et al., 2022).

Other benefits of deprescribing, which are not necessarily linked with the patient's health, include saving costs to policymakers and patients, promotion of safer prescribing, accepting that all medications have potential side effects, and reducing the social burden to patients and carers, particularly regarding compliance with drugs (Veronese et al., 2024).

Which populations are targeted?

Older adults are disproportionately affected by polypharmacy and therefore are more vulnerable to drug-related problems. Older age itself is not an independent risk factor but is

often associated with multimorbidity, complex treatment regimens, transitions of care, and physiological changes that all contribute to a higher risk of drug adverse events (Maher et al., 2020).

Renal impairment patients are particularly vulnerable since lowered kidney function heightens the risk of harm with unadjusted medications (O'Mahony et al., 2021). For instance, inappropriate NSAID prescribing remains common, even among older people. Evidence supports that pharmacist-led intervention can enhance deprescribing; highlighting the importance of collaboration between doctors and pharmacists to optimise prescribing practices and improve patient outcomes (O'Mahony et al., 2021). Similarly, having more than one prescriber and increased transfers between care settings - between community and hospital or between hospital and residential care - can lead to medication miscommunication and errors. Lack of proper clear documentation and lack of regular review often result in the continuation of unjustified treatments (Wang et al., 2023).

Frailty and dementia, two geriatric giants, are further grounds for deprescribing. Dementia has an association with increased likelihoods of PIMs, while frailty has been argued to increase the risk of ADEs, which could further exacerbate already existing vulnerabilities (Reeve et al., 2024). Additionally, care givers often have the complex task of keeping track of medication regimens, something that is time-consuming and results in further issues of safety and adherence (Ibrahim et al., 2021).

Supporting tools and guides

There are numerous tools and guidelines to aid practitioners, with the most current guidance on initiating, continuing or stopping medications. All of these tools whether explicit, implicit, or hybrid ought to support, not replace clinical judgment. Explicit tools are based on robust evidence and consensus, while implicit tools rely more on professional decision-making and nuanced clinical reasoning. Although potentially valuable, to what extent these tools are used in day-to-day general practice is unknown (O'Mahony et al., 2023).

Well-known explicit tools include the Beers Criteria, widely adopted in the United States (American Geriatrics Society, 2023), and the STOPP/START criteria, commonly used in European and UK settings (O'Mahony et al., 2023). There exists no tool that can capture all clinical scenarios. The best deprescribing strategies are those that form part of comprehensive, multimodal programmes that combine prescriber training, evidence-based support and active patient involvement (Reeve, 2020).

Approaches to deprescribing

Effective deprescribing follows a structured, evidence-informed process that is both practical and sustainable within the primary care setting. Given that GPs manage the majority of patients with multimorbidity and polypharmacy, they are central to initiating and sustaining deprescribing interventions. There has been growing interest in establishing models and national guidelines that standardise deprescribing practices, enhance interdisciplinary collaboration, and promote patient-centred decision-making. Among several contributions in this area, two stand out for their application of theory into clinical practice: the Italian national position statement by Carollo et al. (2024) and the internationally validated framework proposed by Scott et al. (2024).

Carollo et al. (2024) propose a five-step framework applicable across various care settings, with a particular emphasis on the role of general practice. The process begins with identifying patients at risk from inappropriate medications; typically older individuals with multiple chronic conditions or those recently discharged from hospital. This is followed by a comprehensive medication review, evaluating each drug's necessity, risk-benefit ratio and relevance to the patient's current health status. Ideally, this step is supported by interprofessional collaboration between GPs, pharmacists, and nurses. A deprescribing plan is then created through shared-decision making focusing on aligning treatment with patient preferences and health goals. The fourth step involves executing the plan via gradual dose reduction or abrupt cessation, depending on the medication and clinical context. Finally, a structured follow-up

is essential to monitor withdrawal symptoms, recurrence of conditions, or new clinical concerns. In general practice, this model encourages continuity of care, clear documentation, inter-provider communication, and integration of deprescribing protocols into routine workflows.

In a complementary approach, Scott et al. (2024) developed a clinician-informed framework grounded in international consensus. Their model simplifies deprescribing into four stages: identify, evaluate, stop, and monitor. It was piloted via a cross-sectional survey involving 263 HCPs including doctors, pharmacists and nurses from 25 countries. The study highlighted 17 discrete activities across the four stages, including risk-benefit assessment, medication reconciliation, patient engagement in decision-making, and planning for follow-up. Although most participants acknowledged the importance of all these steps, those involving active patient participation, such as exploring beliefs and personal goals, were less frequently integrated into routine care. This disconnection between theoretical ideals and clinical reality underscores a persistent barrier in embedding truly patient-centred deprescribing into everyday practice.

Collectively, these two frameworks underscore the fundamental components required for safe and effective deprescribing in primary care: structured clinical processes, multidisciplinary teamwork, patient engagement, and behaviourally informed implementation strategies. Carollo et al., (2024) highlight the value of system-level policies to support change, while Scott et al. (2024) focus on the practical demands faced by frontline clinicians. Together, they emphasise the need for both policy-level (top-down) and practice-level (bottom-up) initiatives to embed deprescribing as a standard aspect of care.

Attitudes, behaviours and beliefs of the HCP

Deprescribing is increasingly recognised as an essential aspect of rational prescribing and medication optimisation in primary care. Yet, the implementation of deprescribing practices is influenced by the attitudes, beliefs, and behaviours of HCPs practicing in these settings. GPs, pharmacists and nurses display variability in their attitudes, ranging from active

engagement to passive resistance, based on clinical, interpersonal, and organisational considerations (Chang et al., 2024).

Attitudinal variability across professions

Primary care HCPs acknowledge the value and the necessity of deprescribing, particularly in older adults with multimorbidity. Chang et al. (2024) used the Theoretical Domains Framework in a cross-sectional study of the behavioural determinants of deprescribing by physicians, pharmacists, and nurses. The findings demonstrated significant interprofessional differences: pharmacists most frequently viewed deprescribing as an essential professional role, while nurses were less likely to view deprescribing as part of their role. Physicians, although generally supportive of deprescribing, were torn due to concerns about patient outcomes, litigation, and perceived specialist expectations.

Robinson et al. (2024) also indicated that while the majority of primary care clinicians accept the clinical and ethical foundations of deprescribing, their willingness to deprescribe depends on contextual circumstances like the complexity of the case, the source of the original prescription and time pressures. Clinicians are more likely to deprescribe if the drug was initially prescribed by them and less likely if it was from secondary care. This concept points to a real psychological barrier; one founded on professional boundaries and clinical hierarchy.

A landmark study by Bužančić and Hadžiabdić (2023) provided more insight into interprofessional differences in deprescribing attitudes among European primary care. This cross-sectional study found that all three groups of HCPs recognized deprescribing as important but had vastly different feelings of ownership and perceived roles in deprescribing. Pharmacists were more likely to report that they felt competent and accountable for conducting deprescribing conversations, as found in the results of Rea et al. (2023). Nurses were less confident and had doubts about their involvement, consistent with similar apprehensions reported by Chang et al. (2024).

Of note, this same study also found that institutional guidelines, professional

culture, and hierarchical level impacted on the perceived autonomy of each profession. GPs, while theoretically supportive of deprescribing, regularly cited external reasons e.g., specialist referral or pressures from the system, to refrain from doing so. These findings reinforce the belief that deprescribing is part of a broad professional culture and cannot be addressed solely by education; organisational and structural change is equally required.

Role of experience and training

Level of clinical experience appears to impact both attitude and willingness to deprescribe. Goh et al. (2023) conducted a study where it found that primary care trainees were particularly reticent to make decisions to deprescribe, with a preference to preserve therapeutic inertia rather than risk destabilising care. Their diffidence was also compounded by the lack of formal training in the principles of deprescribing, highlighting undergraduate and postgraduate medical education as an area for reform.

In fact, training and exposure to deprescribing guidelines were consistent predictors of confident behavior. Robinson et al. (2024) and Chang et al. (2024) both recognized that early-career doctors and trainees were less confident when initiating deprescribing conversations, particularly in the absence of formal training or mentorship. Conversely, more seasoned clinicians who had participated in multidisciplinary reviews or who had used validated tools such as STOPP/START were far more likely to actively deprescribe (Scott et al., 2024). The latter addressed this learning requirement by proposing a ten-step proactive deprescribing protocol, with the objective of rendering deprescribing a standard component of clinical practice and not a last resort. Their proposals welcome clinicians to conduct regular medication reviews, to document therapeutic goals and to utilize validated deprescribing algorithms - principles that would facilitate increased assurance in structured clinical practice.

Patient-centred beliefs and communication styles

Another significant predictor of HCPs' actions is their presumptions about patient expectations.

Bloomfield et al. (2020) found that GPs tend to anticipate patient resistance to deprescribing, and therefore, avoided mentioning the potential for medication withdrawal at all. However, patient-centered studies such as Goh et al. (2023) revealed that older adults are, in fact, open to deprescribing, if it is clearly explained, done together, and with attention to their individual goals and anxieties. This disconnect between assumed versus actual patient attitudes highlights a communications gap that should be bridged to improve deprescribing acceptance.

The Necessity-Concerns Framework, employed in various studies, provides a conceptual framework in which these interactions can be understood. It proposes that the likelihood of medication adherence is determined by the patient's belief in its necessity compared to concerns about potential harms. GPs have a tendency to internalise this framework when describing their deprescribing approach, but variability in its application can lead to heterogeneity in patient outcomes (Goh et al., 2023).

Pharmacist and nurse-led deprescribing initiatives

Pharmacists have been pioneers in active deprescribing efforts. Rea et al. (2023) evaluated pharmacist-led deprescribing interventions within the Veterans Affairs system, demonstrating high rates of successful medication discontinuation, interprofessional collaboration, and significant cost savings. Regular reviews by pharmacists, good patient communication, and coordination with physicians to synchronize deprescribing plans were all highlighted; demonstrating a care model that can be applied to larger primary care practices.

Trenaman et al. (2022) provide insightful perspectives on the ways in which pharmacists reason about and implement deprescribing in inter-professional practice environments. The study revealed that pharmacists were highly invested in the process of deprescribing, based on their understanding of pharmacotherapy and patient-centered care. They made conscious identification of medication hazards and started discussions on deprescribing. Interestingly, the study reported that pharmacists viewed

deprescribing as not just a technical process but part of general medication safety and therapeutic optimization. This is contrary to a more cautious view by some GPs, who occasionally would refrain from decision-making due to perceived complexity or deference to specialists' advice. The findings underscore the necessity for formally recognizing and integrating the role of pharmacists in deprescribing, as their actions were characterized by proactive interaction, team spirit, and priority for patient outcome improvement.

While nurses play a central role in chronic disease management and patient monitoring, their involvement in deprescribing is often hindered by role boundary uncertainty, lack of training, and hierarchical primary care team dynamics (Chang et al., 2024). This calls for greater work to enable nurses' empowerment through targeted education and policy efforts that well define their role in deprescribing conversations.

CONCLUSION

This review of the literature set out to map the ground of deprescribing in primary care through examination of HCPs' attitudes, beliefs, and practices. The review puts deprescribing in a central role as a complex yet essential component of medication optimisation, particularly in the context of an ageing population with polypharmacy and multimorbidity. The evidence consistently demonstrates that healthcare clinicians value the clinical and ethical importance of deprescribing but are limited by a range of individual, interpersonal, and system facilitators to its practical application.

In conclusion, deprescribing is an evidence-based, viable strategy for increasing the quality and safety of care in patients with very complicated medicine regimens. There is a need for future studies to center on developing scalable care models that incorporate deprescribing into regular clinical workflows, multidisciplinary communication, and patient activation. By overcoming existing barriers and leveraging facilitators, primary care systems have the potential to shift toward a more sustainable patient-centered model of pharmacotherapy.

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