







Article

The Elderly's Thoughts and Attitudes about Polypharmacy and Deprescribing: A Qualitative Pilot Study in Portugal

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Abstract: The high prevalence of polypharmacy and potentially inappropriate medications in the elderly makes them a vulnerable group to adverse drug events. Deprescribing is the medication review plus cessation of potentially inappropriate medications with a health professional's help. Several barriers and enablers influence it, and its knowledge can help health professionals. The objective of the study is to understand the Portuguese elderly's attitudes and ideas about polypharmacy and deprescription. We made a qualitative approach through a focus group with elderly patients from an adult daycare center with transcription and codification into themes and subthemes based on previous frameworks. Eleven elderly patients participated in the focus group. The identified elderly's ideas and attitudes could be clustered into five main barriers: appropriateness, process, influences, fear, and habit, and five main enablers: appropriateness, process, influences, dislike, and cost. Although the elderly's strong beliefs regarding medication benefits and necessity prevail, contrary opinions regarding lack of benefit/necessity, drug interaction/side effects, and medication complexity/number may influence their willingness to deprescribe positively. The health professional's influence and the patient's trust in their doctors were perceived essential for decision-making as either a barrier or an enabler. The medication benefit was a big barrier, and side effects/drug interaction experiences are an important enabler.

Keywords: aged; deprescriptions; polypharmacy; potentially inappropriate medications



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1. Introduction

The elderly are a vulnerable group to adverse-drug reactions due to polypharmacy and age-related changes in pharmacokinetics and pharmacodynamics [1,2]. Although there is no consensus regarding polypharmacy's definition, the most commonly used is the simultaneous use of five or more drugs [3].

Inappropriate polypharmacy can increase the risk of adverse drug events, mortality, and the health care system's use and decrease quality of life [4]. According to recent studies, 77% of the older Portuguese population is under polypharmacy, and 68.6% have one potentially inappropriate medication [5,6]. Potentially inappropriate medications are those whose risks outweigh the benefits [7]. Therefore, being the elderly more vulnerable to potentially inappropriate medication, and they take the most advantages too [8,9]. So, it is essential to carefully review the elderly's medication, to reduce potentially inappropriate

medication as a process of dose reduction, substitution, or withdrawal of an inappropriate medication held by a health professional [8,10,11]. According to previous studies, around 90% of older adults would be willing to stop taking one or more medications if their physician said it was possible [8,12]. However, a recent study reported that out of the 86% who would be willing to stop, only 41% acted accordingly [13].

Numerous barriers and enablers may influence this process, so their knowledge, through the investigation of the elderly's attitudes and ideas about polypharmacy and deprescribing, would help health professionals to approach this subject more effectively and with better outcomes. Several qualitative studies have already identified barriers and enablers to deprescribing. Some of the established barriers to deprescribing are the beneficial effect and the need for the medication, fear of symptoms/condition return, fear of withdrawal symptoms, previous bad experiences with stopping, and distrust. Established enablers are the existence of a process, lack of benefit, fear of or experiencing side effects, number and complexity of medications regimens, good experiences with deprescribing, trust and cost reduction [14–21].

This study aimed to understand the elderly's attitudes and ideas about polypharmacy and deprescription and infer the main barriers and enablers to deprescribing in a Portuguese daycare center. From the literature review, we hypothesized that many factors might influence the management of polypharmacy and deprescription, either related to the elderly's attitudes and ideas, the doctor-patient relationship, and the health professional's own barriers and enablers.

2. Materials and Methods

2.1. Study Design

We used a focus group to explore how older adults integrated information about polypharmacy and deprescribing with their existing knowledge of medications [22]. The qualitative design involving face-to-face contact with participants ensured that we could be confident that the communication of the information was effective since older adults were able to make questions in order to clarify some topics. Therefore, we could assess their understanding and identify possible sources of confusion. The advantages of focus groups over individual interviews are participants having more control of conversation topics, allowing them to bring up and discuss among themselves other relevant points not anticipated by the researchers, and the opportunity for participants to hear each other's views and exchange ideas, in their own language, helping to clarify individual understanding, attitudes and ideas [23].

This study is part of the “Deprescribing in primary care in Portugal (DePil17-20)” project, which was approved by the Ethics Committee of the Beira Interior University and the Health Regional Administration of the Centre. The study's objectives were explained to the participants, and informed consent was obtained for participation in the study and session audiotaping.

2.2. Participant Selection and Recruitment

We recruited elderly patients from a daycare center in Beira Interior, Portugal, that lived independently. The inclusion criteria were: being 65 years or older, and aimed to have 50% women and 50% men and 50% between the ages of 65 and 75, with 50% above 75 years old. Of the five daycare centers contacted, only one was accepted to participate in the study, and due to the COVID-19 pandemic, participants without polypharmacy were accepted. We believe that, as these participants also have experience with taking drugs, the information collected will reflect possible opinions and attitudes toward polypharmacy. Exclusion criteria were any disease that compromised memory or communication (e.g., severe dementia) and refusal to participate.

2.3. Data Capture, Coding, and Analysis of Qualitative Data

The focus group discussion was designed to last one hour and was held by two moderators, who followed a previously made script, with open-ended questions on the subject and information exposition if needed (in Appendix A). The focus group discussion was audiotaped, upon authorization, transcribed verbatim and followed by a thematic analysis, aiming to identify a set of main themes that captured the diverse views and feeling expressed. Two researchers (NF and PS) independently reviewed the transcript and allocated each key piece of text to themes and subthemes [24,25]. Each one of these corresponds to a barrier and an enabler of deprescription. We based our codification on seven core themes (appropriateness, process, influences, fear, dislike, cost, and habit) and correspondent subthemes from two frameworks [11,14].

3. Results

This section may be divided into subheadings. It should provide a concise and precise description of the experimental results, their interpretation, as well as the experimental conclusions that can be drawn.

3.1. Sample Characteristics

Of the 12 older adults present in the daycare center, 11 decided to participate in the focus group. Seven participants were women (63.6%), eight were older than 75 years (72.7%), seven took 5 or more medicines per day (63.6%), and nine had less than 6 years of education (81.8%).

3.2. Focus Group Speeches: Factors to Consider in Deprescription

Table 1 describes the core dimensions of enablers and barriers resulting from the focus group transcription and codification.

Table 1. Focus Group analyses: factors to consider in deprescription.

Core Dimensions	Subcategories	
	Enabler	Barrier
Appropriateness	Lack of benefit or necessity Alternative available Drug interactions Side effects Mistrust	Benefit of medication use Acceptance of medical condition Lack of current harm Long term use Desire to increase medication
Process	Discussion with the doctor Doctor support Trail	Health unawareness
Influences	Health professional (medical advice to stop taking a medicine) Good experiences Medication complexity and patients' knowledge (reason to start the discussion)	Health professional (maintenance of medical prescriptions as routine, no dialogue) Bad experiences Medication complexity and patients' knowledge (difficult the discussion)
Fear	—	Feared to start felling or getting worse
Dislike	Dislike of medication	—
Cost	Save money	—
Habit	—	Dependency of medicine; be used to

3.3. Appropriateness of Deprescribing

In this category, we intend to make explicit the points the participants consider not to be important or appropriate or to have no deprescription. If you consider that you benefit

from the use of medication and that there are no side effects, for example, it seems to will be more difficult to understand or accept the idea of deprescription. On the contrary, the absence of benefit or need for the drugs in use, the existence of other alternatives and the recognition of side effects, among others, tend to appear to be factors favoring the possibility of a deprescription proposal process.

Several participants pointed out the benefits of medication use as a barrier. They reported feeling good about their medication, considering the medication beneficial and needed. Those with good experiences with their medication would be more likely to continue it.

“But I am fine, there are no problems. The medication is regulated. And I always, always, always take it.”

“We have always been well with them. We keep going until we leave.”

On the other hand, the act of benefit or necessity of medication use could be an enabler of the deprescription process. Two participants stated that their medication was not necessary since they believed they had recovered from their disease(s). This reflects how different the perception of the impact of the medications is between doctors and patients.

“I take two that I should not take, and the Doctor doesn’t take them . . . Because I no longer have anything in my heart, and I am no longer sad and crying as I was, and they do not take me these two medicines.”

Quite a few participants recognize that they have a specific condition for which the use of their medication is necessary for its management. The acceptance of having a medical condition is a barrier to deprescribing because patients conceivably assume as a fact that they need to take medicines.

“This thing that I have has been working on since 2004. It is the beginning of a disease of ‘forgetfulness’ or what it is. But I have to take these medicines to calm myself and to the ‘forgetfulness’.”

One participant mentioned using, besides the medication, tea as an alternative treatment. Although he mentioned that it could not be as beneficial as he thinks, he still feels better with it.

“ . . . I take those pills that I have there that are for pain, for the acid uric, and it gets better. Now I have had a tea with rosemary . . . it gives me the impression that it is doing me well It may not be, but it gives me the impression that it is doing me well.”

It could be the case that, for patients, if an alternative to medications is available, they could be more willing to stop the potentially inappropriate medication.

The sense of lack of harm of medicines could be a very important barrier. If no perceived harm is associated with medications, the need to reduce may not be understood. One patient said:

“I feel good with the ones I take. I think it doesn’t harm me.”

Otherwise, knowing that there are possible effects in taking simultaneous medicines could function as an enabler. Two participants questioned the possibility of drug interactions. One participant even described a bad experience with taking two medicines together, attributing it to their interaction.

“Doesn’t one medicine on top of the other harmful? . . . I had to take one of those pills to put into the water, that are good for the throat, but I had taken another, and I got unwell.”

“Every time I go there, I’m always asking the doctor that maybe are some (medicines) who are doing harm to the others . . . he says, ‘it can’t, it can’t’.”

Long-term use of medication could be a barrier to deprescribing. Even though the effect is not present, it seems they keep the medicine, as they have already been taking it for so long.

M(Moderator): *“So do you continue to take them if they no longer work?”*

P(Participant): *“I still take them . . . ”*

Side effects are a strong motive to recognize the importance of deprescribe. One participant recognized that medications could cause side effects. Moreover, a few participants recalled their experiences with side effects that they attributed to a medicine.

P: *“I dream a lot. I’m always dreaming. Always dreaming. Dreaming and waking up, dreaming and waking up.”*

M: *“And do you think this is from the medication?”*

P: *“I even swear it is from the two pills I take at night . . . ”*

The sentence below is an example of side effects as an enabler to deprescription. After noticing a side effect and talking to the doctor, a deprescription was made.

“I noticed that it hurt me . . . And he told me to stop with them.”

One participant expressed the desire to increase the dosage due to the lack of effect of the current dose and the "trouble" of breaking a tablet in half.

“It’s just that if I took a ‘higher pill’ I wouldn’t need to take more half pill. There are packages that have more milligrams than others. No longer reaches ‘sleep pressure’.”

As mentioned, mistrust in the prescriber is a factor that may lead to stopping taking a medicine previously prescribed.

M: *“And if there is no trust in the doctor, what happens?”*

P: *“What happens? It is not to take, exactly . . . ”*

3.4. Process

It may be said that participants find it important to discuss the deprescription process with a health professional before whether or not to cease a medicine. The physician was the person most mentioned. The pharmacists also were mentioned as professional help to reach, especially as the doctor was more difficult to get in touch with.

“ . . . I wouldn’t stop with it without first contacting someone who knew, for example, the pharmacy. Sometimes the doctor is more difficult . . . at least in the pharmacy . . . in fact, I have already done that, I have already gone to the pharmacy to ask how it is . . . ”

M: *“What if it was a member of the family or a friend saying to stop the medication? Would you stop? . . . ”*

P: *“I would go ask the doctor . . . ”*

This participant mentions the doctor as the person who should take the first step in the deprescribing approach.

“But let’s see something . . . This (deprescribing) is the doctor himself who has to do it? Not us, I will not do it without the doctor telling me that I can do it.”

When questioned about polypharmacy and deprescribing, no one had an opinion. Regarding the concept of potentially inappropriate medication, they also had no opinion on it. One possibility is that it is a less-discussed subject in a doctor’s appointment. Health unawareness on this matter could interfere with deprescription.

“Right, it’s these words (polypharmacy) that we don’t know what they mean.”

M: *“And this word (deprescribing), do you know what it is?”*

P: *“No . . . I hear, I just have trouble to understand . . . ”*

Discussion of the process and the reason the doctor has to stop the prescription of medicine were some factors pointed out as enablers.

“The doctor told me, about the prostate . . . I went there and didn’t prescribe anything to me. ‘So, Doctor, won’t you prescribe me anything?’, ‘Oh Mr(s) X tells you that I’m going to prescribe a medication to the prostate if it does well to the prostate, but it will do harm to other sides.’ He had the courage to tell me that.”

Having their doctor's support was another factor pointed out as key in stopping a medicine.

M: *"What do you think about stopping a medication with the help of the doctor when it is no longer needed?"*

P: *"Stop."*

One participant mentioned being willing to try a deprescription on a trial basis. Perhaps one possibility to gain confidence with deprescription is to do it as an experimental situation.

3.5. Influences

Health professionals seem to have a great influence on deprescription processes. However, its influence can be both an enabler and an obstacle.

For example, if the doctor keeps prescribing a medicine (without explaining the reason) even though the patient desires to stop a medication, it may be difficult to reduce the medication.

"I have talked to him (the specialist doctor) many times, but he says he doesn't take them (deprescribe)."

Generally, patients trust their doctors because of their medical knowledge and knowledge about their conditions. As they trust their doctors, they are satisfied with their medication.

"It's like so, and here we are. They know (doctors), they studied for that . . . "

"The Doctor here already knows more a less the ill I have."

Besides doctors, pharmacists were also mentioned as an influence on keeping medicine. Otherwise, if their doctors advised stopping a medicine, they would go along with it because they trust them and their medical knowledge.

P: *" . . . It depends on what it was. If I had to stop it . . . it would be the doctor who told me to stop and naturally he is who knows."*

M: *"And wouldn't you be worried about anything?"*

P: *"I don't know . . . maybe not, if he said to stop, it was because it (the medicine) wasn't doing me well . . . Naturally, I wouldn't be upset."*

Previous experiences can also be seen as variables that sometimes facilitate and sometimes oppose the decision to reduce the consumption of medicines. One participant reported a bad experience with deprescription, with the experience of symptoms after stopping a medicine.

"The sleeping pills, one of these days, I brought the heart pressure too high because I stopped taking them. Then the lady from the pharmacy even told that I always had to take those pills."

Yet, several participants mentioned a good experience with stopping, either because of their condition's improvement or because it was held with the help/indication of their doctor.

"There were some (medication) that I left out, but I haven't taken them for a long time . . . but it was the doctor who said it."

"I used to take one, here for the thyroid, but they had already taken it."

The complexity and number of medicines and not knowing each tablet's function, medication complexity and patients' knowledge about their medication could be either a barrier or an enabler. This is because it could make the discussion more difficult, or it could, in fact, be a reason to start the discussion.

M: *" . . . Do you know why you take each medicine?"*

P: *"So-so . . . There are so many that I end up shuffling everything. I have for the poor circulation, for example. I don't know . . . There are so many things . . . "*

"For cholesterol, for diabetes, for the heart, it's everything . . . "

3.6. Fear

In some ways, the fear of leaving the medication is an important barrier. Patients somewhat fear returning to a previous condition. If they stopped a medicine, they feared starting to feel or get worse in terms of disease progression and pain.

“ . . . I can't stop it. I have to take these pills without fail, every day, if one day fails, I start immediately with prostate problems.”

“I have to take them. If I don't take them, I can't walk anymore.”

3.7. Dislike

Generally, dislike of medication is common when someone is taking too many medicines, and it is an enabler to reduce

M: *“And about the medication you take, do you think it is adequate, do you think you take too much?”*

P: *“I think they're too much . . . I don't know . . . I take 15–16.”*

3.8. Cost

The medication cost could be a good reason for the predisposition to eliminate or reduce medication. The cost is arguably a problem for patients if they have no help with their health expenses (state co-payments).

M: *“From those who take a lot of medicines, who thinks that he/she spends a lot of money in the pharmacy?”*

P: *“What's worth is the discounts.”*

Besides that, if medicine was stopped, it would not be a problem as they could save money.

M: *“And when he said it was to stop what did you feel? Were you happy?”*

P: *“I was happy . . . And I kept the money in my pocket . . . it was expensive . . . ”*

3.9. Habit

In many cases, taking medication is a habit implemented in people's routines. Whether it's a medication with addictive effects or not, breaking the medication habit can be difficult.

The sleeping medication was the medication most mentioned when this theme was approached.

M: *“Do you think that medicines create addiction or dependency?”*

P: *“No. It's just more the stomach one.”*

Two participants reported the need to take more tablets since the original dose no longer had a sufficient effect. One participant admits "to be used to them" with experience of possible withdrawal effects.

M: *“But you said that the sleeping medicine doesn't always work. That you sometimes wake up and have to take another one . . . ”*

P: *“I always take one medicine, when I lie down . . . but when it's 4:00 am I have to break a pill in half . . . ”*

M: *“But before it was enough, now you need one and a half.”*

In some ways, taking medication is a habit for them as it becomes part of their routine, and they are used to it.

“I take two pills in the morning, one at noon and another at 8 pm.”

4. Discussion

Our findings are consistent with and highlight previous frameworks [11,14].

As a barrier and an enabler, the 'appropriateness' theme was mentioned by the participants in our study and previously reported in Reeve et al. [11,14]. In the former, the outstanding subthemes were 'benefit/necessity of medication' and 'acceptance of medical condition' to which the medication is necessary. Patients' well-being and memory of clinical improvement, and older adults' assumption of medication benefit if kept being prescribed, are proven reasons in previous frameworks [11,14–16]. In the second, the predominant

subthemes were lack of benefit and side-effects/drug interactions experiences. ‘Lack of benefit or necessity, because of condition/symptoms improved/resolved [14,15], might be explained by patients’ focus on short-term outcomes rather than long-term outcomes, especially in regard to preventive medicines, as mentioned in previous studies [15,21]. Contrarily, for others, evidence of efficacy in the short-term could be a reason to keep a medication [15], reflected by the subtheme benefit of medication and long-term use. Evidence shows that experiencing side effects might be a strong influence on deprescribing [11,14,15]. Although recalled, for some, it did not seem to be a trigger to cease a medicine, as similarly reported by Hesper et al. [26]. One reason might be the elderly’s strong beliefs about medication benefits prevailing or their belief of no other alternatives are available. Patients’ understanding that side effects might occur and unawareness of the medication risks, and that those might be sometimes greater than the benefits, could contribute to this as well [11,21]. As proved in our results and previous studies [14], a positive alternative treatment available is an enabler. Drug interactions were resembled by participants¹⁴ and raised concern to approach the doctor about it.

A process, with discussion, is required for deprescription [14]. In our study, we could perceive the patients’ need to discuss these matters with a health professional, namely the reason for a medication to be stopped once it was previously prescribed. Although being an enabler, it could also be a barrier if it does not align with their preferences, as suggested by Zechmann et al. [18]. Further to this subtheme (Discussion), we found out that the terms “polypharmacy” and “deprescribing” were unfamiliar terms to them, which is consistent with a quantitative study [27]. A possible explanation for this is health unawareness once it may be a non-discussed or forgotten subject in appointments. Including it in the “common vernacular” will raise the chances of initiating a deprescribing conversation [27].

In this theme, the onus’ approach also standouts. Although it is not clear who should approach deprescribing because it is not symptom-driven [20], we believe that the willingness should come from the patients too, once the elderly’s goals, preferences, and values matter [28] and as they are the ones who may experience a new medication-driven symptom, as two participants did to do. Besides including these terms in appointment language, patients’ capacity for new symptoms surge is also important.

The doctor takes an important role as either support (process theme) or an influence [11,14]. Pharmacists are also mentioned as an influence, as making recommendations about the medication (influence theme) or as someone to approach when considering ceasing a medicine (discussion subtheme). A reason for that is that they are easier to reach and are more frequently visited by the elderly to refill their prescriptions. Other studies also mention participants’ willingness to pharmacists’ involvement in deprescribing [8], as an advisory role but not in initiating it [15], or as making recommendations to the doctor [14]. One reason for that might be a less interdisciplinary approach, but that is essential for it [29,30]. Our study is not clear about the participant’s ideas about this difference, and further discussion would be needed.

Patients’ trust in their doctors was mostly implied by their doctors’ medical knowledge and their doctors’ knowledge about their conditions. As previously reported, patients recognize that doctors hold the knowledge [14,15,20] and the power [16,30]. Thus, the doctor’s influence will be either a barrier or an enabler depending on the situation, for example, if the doctor advises stopping [14–16].

Patients’ trust in their doctors might also explain the following two findings, the patients’ stronger beliefs regarding medication necessity/benefit, although limited knowledge about their functions [16]. Moreover, the onus is on the doctor to approach deprescribing. Regarding the medication function, some participants were unfamiliar with it, which is similar to Palagyi et al. [17], where the elderly were aware of the number of pills, they were required to take but not of its indications. This is common among patients taking multiple medicines and especially in the elderly, as they are, in general, a population with less literacy in health [16]. This could difficult the discussion or be a reason for them to be willing to simplify their medication.

Dislike of medication was mentioned as an enabler. Otherwise, keeping a medicine because of fear of symptoms/condition return was also mentioned. This contradiction was already previously reported by Zechmann et al. [18].

Less treatment burden and cost are established benefits [29] and enablers of de-prescription [9,11]. In our study, the cost was not implied as a major enabler because of the health discounts. The cost was also previously implied by Reeve et al. as not being the sole motivator [14]. Therefore, cost as an influence will depend on the medication subsidy schemes and insurance status of each country [11] and on each person's income.

Regarding the subtheme habit, this was implied as being used to the medication as a routine and being dependent on it to sleep, with increased doses. These ideas have been previously reported [11,21,26]. Contrarily, not finding a medication to cause dependency might be a barrier too. Otherwise, fear of addiction/dependency was implied in some studies as an enabler [11,15,21] but not in ours. One reason for that is the participants' strong beliefs about medication benefits, which outweighs the rest.

The elderly from daycare centers seem to have similar thoughts and attitudes about polypharmacy and deprescribing as the general older adult population. However, the degree they want to be involved in decision-making can vary; most of them seem to only want to be informed of medication changes, leaving the decision of deprescription or not to their doctor. This can be related to their lower independence regarding medication and health-related problems since most of the time, the daycare center that controls the medication and accompanies the older adults to their medical appointments and is responsible for listening to changes made to the medical plan.

Strengths and Limitations

This type of method, focus group, allowed us to gather the data faster and more in-depth opinions about participants' ideas and attitudes than with structured individual interviews. Although not applied to all the participants, some deprescribing episodes were remembered by them during the focus group, giving it an extra value. This is one of the first studies to address the elderly's ideas and attitudes about deprescription in Portugal.

As limitations: due to the COVID-19 pandemic, we had to delay our study. Even though we could restart it, it was not possible to gather a sample with the previous inclusion criteria, as the number of enrollees in the center was small, so age heterogeneity was one limitation. The generalizability application of the results is because of a unique focus group and the participants being from a unique area. Future research should be carried out in larger groups of elderly persons as well as in other healthcare centers in Portugal to obtain more substantive results.

5. Conclusions

The elderly's attitudes and ideas about polypharmacy and deprescribing are wide and uncertain, influencing their willingness to deprescribe.

Although the culture of diagnosing-prescribing prevails, deprescribing, when needed, must be seen as an improvement of the patient's treatment rather than an act of giving up [18,29]. Including the patients in the decision-making process, taking into account their preferences, goals, fears and expectations, and informing them about their medication, benefits and risks, without increasing fear, will enable them about their medication and empower them in the decision.

Knowing these barriers and enablers will help health professionals to approach this theme. Continuous research on the elderly's attitudes and ideas might give a wider range of opinions. As seen in previous literature, further research on health professionals' points of view regarding the barriers and enablers to deprescribe and on the role of each one of them in the deprescribing process will bring additional value in order to reinforce deprescribing as a patient-centered process and become the deprescribing process a multidisciplinary approach, avoiding the system-related barriers.

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Data Availability Statement: Not applicable.

Conflicts of Interest: The authors declare no conflict of interest.

Appendix A

Focus Group's Script

Aims:

- To understand the elderly's attitudes and ideas about polypharmacy and deprescription;
- To infer the main barriers and enablers to deprescribing;

First Part-Polypharmacy

I. Have you heard of polypharmacy? Do you know what it is?

II. Presentation about polypharmacy:

- Definition;
- Difference between number of drugs and number of pills;
- Risks of polypharmacy;
- Difference between appropriate and inappropriate medication-potentially inappropriate medication.

III. Questions:

- How do you feel about the medication you are taking? (Do you like the medication? Do you feel it is good or bad for you? Do you feel it causes some unwanted effect?)
- How do you feel about the number of pills you take?
- Do you think doctors prescribe too many medications?
- Do you know why you take each medication?
- Do you think you take too much medication that you don't need?
- Do you think that drugs create addiction? Do you think people should stop them for a while from time to time?

Second Part-Deprescribing

I. Have you ever heard of deprescribing? Do you know what it is?

II. Presentation about deprescribing:

- Definition;
- Phases of the deprescribing process.

III. Questions:

- Would you like to take less medication?
- Have you ever stopped taking any medication?
- What do you think about deprescribing a medication, that is, stopping a medication with the doctor's supervision? Do you agree or disagree? And why?
- Do you think it is important to stop a medication that is no longer indicated or is causing side effects?
- What worries you about stopping a medication? And why?
- What would help you to accept ceasing a medication? And why?

- If your doctor suggested to stop taking a medication, would you be willing to do so? And why?
- Would the opinion/experience of a family member/friend be important to you?
- What are the doctor's attitudes that could help to cease a medication? How could your doctor help you to make the decision of stopping a medication?

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