

# Polypharmacy and continuity of care: medicines optimisation in the era of multidisciplinary teams

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Polypharmacy, and the negative effects that can arise from it, is increasingly recognised as an issue by healthcare systems globally. Although there is currently no consensus on the number of medicines that defines polypharmacy, it is generally understood as the concurrent use of multiple prescribed medicines. In England, the 2021 National Overprescribing Review estimated that 8.4 million people (around 15% of the population) are regularly prescribed five or more medicines.<sup>1</sup> Rates are similar in other high-income countries, for example, in the USA around 20% of the population in community settings experience polypharmacy.<sup>2</sup> These figures are likely to rise due to an ageing population living with multiple long-term conditions. Although polypharmacy can be beneficial, it is viewed as problematic or inappropriate when the actual or potential harms of taking medication outweigh the intended benefits, or the intended benefits have not been realised for an individual.<sup>1,3</sup> The National Overprescribing Review identifies medicines optimisation as having a pivotal role in addressing the treatment burden and potential for harm associated with problematic or inappropriate polypharmacy. Medicines optimisation focuses on a person-centred approach to the safe and evidence-based use of medicines, with the aim of improving patient outcomes.<sup>4</sup> Importantly, this should include consideration of deprescribing, the reduction or withdrawal of inappropriate medication.<sup>3</sup> Managing polypharmacy is, however, a highly complex challenge, complicated by structural drivers of overmedication, the complexity of individual patient cases and uncertainties around medication decision-making, which often fall outside of clinical guidelines.<sup>5,6</sup> It may require compromise between the healthcare professional's

goals regarding medication and the goals and preferences of the patient.<sup>3</sup>

## MANAGING POLYPHARMACY IN EVERYDAY PRACTICE

The paper by Swinglehurst and colleagues in this issue of *BMJ Quality & Safety* used video-reflexive ethnography (VRE) to explore how primary care clinicians actually manage polypharmacy in practice.<sup>7</sup> VRE involves researchers conducting observations and making video-recordings to gain a deep understanding of context and practice, and then using selected video clips in workshops with clinicians or other practitioners to prompt discussion and reflection. The research was conducted across three primary care practices and focused on medication reviews for patients with polypharmacy, including formal scheduled reviews (both general practitioner (GP) led and pharmacist led) and brief opportunistic reviews within consultations booked for other reasons. Selected video clips of medication reviews, chosen to reflect different challenges and approaches, were discussed by multidisciplinary teams within each practice, including GPs, clinical pharmacists and practice nurses. These discussions generated a different view and new insights on medication reviews in everyday practice.

Initially, clinicians described medication reviews as mundane technical work. Viewing and reflecting on video clips of their practice prompted a profound shift in their perspective on the management of polypharmacy. Although medication reviews were initially framed as discrete events that could straightforwardly be documented as 'done' or 'completed', clinicians came to realise that managing polypharmacy was instead an ongoing, iterative process. Clinicians recognised the difficulty of getting to grips with the



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complexity of patients' conditions and medication regimens within a single consultation. The lack of an evidence base for managing complex multimorbid patients, and the uniqueness of each individual patient in terms of their combination of conditions and medications, meant that managing polypharmacy necessarily involved making tentative, incremental changes over time—'tinkering' with medication, in partnership with the patient, to find the optimal balance. Based on this reframing, the authors argue that responsible decision-making in the context of polypharmacy is dependent on affective aspects of the clinician–patient relationship, and requires relational continuity—knowing the patient's history and understanding their goals and priorities, building a relationship of trust and being able to maintain continuity with the patient in the future.

### CONTINUITY AND POLYPHARMACY

While the approach outlined by Swinglehurst and colleagues may represent an ideal model for managing polypharmacy, the reality is that relational continuity, in the form of an ongoing GP–patient relationship over time, is increasingly difficult to achieve in the context of modern primary care. Concerns about the erosion of relational continuity have been expressed across the UK and other countries where patients traditionally had a named or personal doctor.<sup>8 9</sup> In England, relational continuity has been eroded by the changing landscape of primary care, including growth in demand and shifting GP working patterns and employment contracts. Although the Royal College of General Practitioners has restated the value of 'long-term, therapeutic relationships with patients, particularly with those with complex needs or multiple health conditions', they also suggest new forms of relational continuity—for example, between patients and micro-teams or named key workers.<sup>10</sup> Also important is the increasing tendency for the work of medicines management to be distributed within multidisciplinary teams, with pharmacists playing an expanded role. In order to improve access to primary care, the Additional Roles Reimbursement Scheme was introduced in England in 2019 to support the recruitment of additional staff, including clinical pharmacists.<sup>11</sup> Clinical pharmacists have a central role in medicines management, with responsibility for undertaking structured medication reviews (SMRs)—a holistic review of all medication including the patient's goals and preferences. From 2020, National Health Service (NHS) England has required all Primary Care Networks to identify and conduct pharmacist-led SMRs with patients experiencing complex and problematic polypharmacy.<sup>12</sup> The National Overprescribing Review for England prioritised providing more SMRs for people with long-term conditions and funding more pharmacists to conduct these, as key recommendations.<sup>1</sup> This focus on pharmacist-led medication reviews in England mirrors

developments in other countries, including the introduction of pharmacist-led medication therapy management in the USA, and community pharmacy-led medication reviews across Europe.<sup>13 14</sup>

The emphasis that clinicians in the study by Swinglehurst and colleagues placed on continuity is echoed in a recent review of interventional strategies for effective deprescribing in older people with polypharmacy.<sup>15</sup> The review identified continuity and trust as critical mechanisms underpinning effective interventions, but discussed the roles of multiple types of continuity of care, alongside relational continuity, in supporting the effective management of polypharmacy. The review authors argue that informational continuity (access to and use of information about past events and personal circumstances to support person-centred decision-making) and management continuity (consistency in management approach reflecting changing patient needs) can play a role in the context of a more multidisciplinary and team-based approach. The review identified the importance of collaboration between individual clinicians in multidisciplinary teams to maintain informational and management continuity, and to overcome some of the challenges presented by limited time within consultations. The strategies recommended in the review focus on maintaining consistency, effective communication and a collaborative approach in order to build patient trust in the system and enable ongoing, iterative medication management.

While the review describes continuity-focused strategies for supporting effective medication review, they may be challenging to achieve in practice. As Swinglehurst and colleagues also identify, the involvement of multiple professionals in patient care can mean diffusion of responsibility for decision-making about medications, a reluctance to stop medications started by others and a lack of confidence to intervene in complex medication regimens. In addition, the relatively recent introduction of clinical pharmacist roles, with responsibility for performing SMRs, introduces a risk that formal medicine reviews become detached from the ongoing medicines management work that happens during routine consultations. The involvement of pharmacists in medication reviews in primary care could result in further fragmentation and lack of continuity, particularly if their role as part of the team is not well understood.<sup>11</sup> Staff turnover in the NHS, resulting in lack of continuity even within professional groups, potentially exacerbates this issue.

### COORDINATING MEDICINES MANAGEMENT WITHIN MULTIDISCIPLINARY TEAMS

All this points to the need for further attention to the work required to coordinate medicines management within multidisciplinary teams—to enable sharing of responsibility for iterative, ongoing, medicines management *between clinicians* involved in a patient's

care over time. Also, to understand how to effectively work in partnership with a patient, over time and under conditions of uncertainty, when care and medicines management are shared between multiple professionals. In-depth methods such as ethnography are vital to surfacing such work,<sup>16</sup> and the paper by Swinglehurst and colleagues highlights the value of incorporating clinician reflection as an integral part.

What might doing this well involve? We suggest five key areas that require attention.

First, developing an explicit understanding of medication management as an ongoing, iterative process, where the decision to prescribe medication is seen as the start of a journey rather than a destination. As the Kings Fund review of polypharmacy suggests, consideration of deprescribing should form part of regular prescribing practice.<sup>3</sup> Clear articulation, forward planning and recording of the goals of treatment at the point of prescribing would help support other clinicians, in subsequent consultations, to have conversations with patients about their medications and make informed decisions about medicines management.

Second, developing our understanding of what person-centred care means in the context of medicines optimisation and medication reviews.<sup>15</sup> Prescribers should recognise the patient as an expert in their own experiences of medication, and in what they want to achieve from their medication.<sup>17</sup> Person-centred care, though, extends further than just involving the patient. The paper by Swinglehurst and colleagues argues for a shift towards sharing responsibility with the patient, and taking an ethical position of acting for the patient and their best interests. Ongoing GP–patient relationships are framed as playing a key role. But importantly, we need a better understanding of how clinicians can take a genuinely patient-centred approach when medicines management is *shared between multiple clinicians*. How can clinicians, within primary care and across services, effectively coordinate their efforts around the goals and priorities of the patient, tailor their approach to the individual patient's history and journey, and build and maintain patient trust, in order to work collaboratively with a patient over time to optimise their medications?

Third, developing clearer guidance about what information should be recorded in medication reviews. This should include documenting detail that extends beyond the outcome of the review, for example, patient goals and preferences, and important elements of the decision-making process. Key to effective recording of ongoing medicines management would be the ability to document uncertainty, discussions and agreements with patients about 'tinkering', and plans for next steps. Moreover, enabling management continuity between clinicians, documenting decision-making in this way and using techniques such as reflexive peer support may help clinicians to feel better protected from risk and able to address any future questions

about their (de)prescribing behaviour. Research is needed into how this approach to documentation could be integrated into existing medical records systems and implemented in the time-limited context of primary care consultations.

Fourth, and more broadly, improving information and management continuity across healthcare professionals within primary care, and the transition between primary and secondary care, will support healthcare professionals to have more informed discussions with patients. Evidence suggests that, in the case of pharmacists conducting medication reviews post-discharge from hospital, the extent of information available beyond simple medication information is an important predictor of positive actions from reviews.<sup>18</sup> The National Overprescribing Review in England recognised the need to improve patient records, and chief pharmacists within each Integrated Care System will lead on medicines optimisation and coordination of the safe and effective use of medicines across the system.<sup>1</sup> Understanding how to improve informational continuity for patients with polypharmacy, between different professional groups and across services, will be an important part of this initiative.

Finally, research has shown a lack of understanding of the purpose and potential contribution of clinical pharmacists following their integration into primary care.<sup>11 19</sup> In order for pharmacists to work effectively as part of a multidisciplinary team and contribute to continuity of care, there needs to be clear dialogue between the pharmacist and GP to develop trust, and an understanding of their respective roles and responsibilities in relation to medicines optimisation. Developing trust and understanding of the pharmacist's role by patients is also important if pharmacists are to effectively contribute to medicines management work via the new roles being created for them.<sup>18 20</sup> Although patient trust in clinicians is widely researched, the process of building trust between healthcare workers, particularly when they are not co-located, is less well understood.<sup>21</sup>

In conclusion, polypharmacy can be an unnecessary burden and source of harm for patients, and places significant strain on healthcare systems. The paper by Swinglehurst and colleagues contributes to our understanding of the challenge of tackling problematic polypharmacy by uncovering the nature of the work involved. Medicines optimisation involves much more than simply reviewing each item of medicine: it is a social process involving the management of uncertainty, in partnership with a patient over time, to achieve the optimal balance of medicines based on a patient's priorities and goals. Understanding how this work can be done most effectively by multidisciplinary teams will be vital for addressing polypharmacy in the context of modern primary care.

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