# CRUCIAL CONVERSATIONS II:
## Deprescribing in Hospice Care

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## Introduction

Hospice care often includes the addition of medications that support comfort and symptom relief. However, it's also an opportunity to review medications initiated pre-hospice. This process is called deprescribing. Working with patients and caregivers, hospice clinicians weigh medication benefits (and time to achieve those benefits) with any risks of continued use, consider dose reductions, and identify medications for discontinuation. Deprescribing can improve overall quality of life in several ways, including:

- Lower risk of drug-drug, drug-disease, and drug-food interactions
- Relief from associated medication side effects
- Reduced pill swallowing burden
- Fewer medications and doses to remember and manage

Deprescribing should be a collaborative process with patients and their loved ones.[1] Nurses, prescribers, and pharmacists all play a role in guiding the evaluation of each medication's risks and benefits based on patient prognosis and goals.

Deprescribing conversations can evoke strong emotions among patients and providers alike. Pharmacists can be effective mediators due to their unique expertise and distance from the provider/patient relationship.[2] Nurses can also play an important role by addressing misconceptions and focusing attention on deprescribing benefits. This guide is intended as an approach overview to help hospice teams guide conversations to maximize patient comfort and safety. For more clinical details, suggested resources are noted under *further reading* at the end of this ebook.

**When to Discuss Deprescribing**

Deprescribing is a process rather than a one-time event. There are numerous opportunities to reevaluate medications on the patient's profile:

- On admission or prior to recertification
- During routine visits
- During a family or facility care conference
- When it's time to refill a medication, especially medications that have no short-term benefits or medications that do not palliate symptoms
- When medications need to be changed due to changes in patient condition
- When there is a change in care setting or level of care

**Questions to Consider**

When reviewing the patient medication profile, consider the following:

- What is this medication treating?
- Does the medication support the patient's hospice goals?
- Does the medication have a likelihood of interactions with others on the patient's medication profile or likely to be prescribed in the future?
- Do the medication's possible risks outweigh its benefit?
- Is there another medication that may be superior?
- Is there a non-medication treatment option for symptoms managed by the medication?

## General Deprescribing Talking Points

The following are general talking points about the deprescribing process to guide conversations. It is essential to reinforce that each deprescribing decision is based on the best interests of the patient.

**Understanding Deprescribing**
In hospice, the goal is quality of life rather than active treatment or prevention. That means we add some medications to ease symptoms. It also means we may need to adjust some medications to improve quality of life.

- Deprescribing is the careful process of reevaluating medication use. In contrast to prescribing new therapy or increasing doses to manage symptoms, we are "de-prescribing" using one or more of the below approaches:
    - Continual evaluation of each medication's role, or indication
    - Assessment of a medication's benefit(s) and risk(s) to the patient today (not when it was first prescribed and not in the future)
    - Identifying opportunities to gradually reduce doses to the lowest, most effective dose
    - Continuing medications that are deemed beneficial or are providing pain or symptom relief
    - Stopping medications that are no longer helpful or may be causing harm
- Deprescribing helps keep the focus on what matters most—comfort and well-being
- Every care plan and every patient differs, necessitating a patient-specific approach

**Reassuring Patients and Their Loved Ones**
This is a team effort involving the hospice team, caregivers, and loved ones. Hospice care is about compassion, dignity, and making the most of each moment.

- It's normal to feel worried about stopping medications that were once important.
- Many of these medications were meant to prevent problems over many years. As life nears its end, the focus shifts from long-term prevention to comfort right now.
- Stopping a medication doesn't mean we're giving up! In fact, stopping it at the right time can actually help hospice patients live longer by reducing risk of dangerous side effects.

**Explaining the "Why" of Deprescribing**
Every medication has risks. Those risks can multiply as more medications are added and dosages are increased. In hospice, we look at all the medications a patient takes and find the right combination of medications to maximize comfort and minimize risk. That usually means adding some medications while reducing or eliminating others.

- **Safety Risks and Side Effects:** Some medications can cause side effects or safety issues. While those risks might have been acceptable before, they may not be worth it now.
- **Potential Interactions:** In hospice care, new or worsening symptoms can develop quickly. When someone is on many different medications, we have to worry about interactions when treating new symptoms. If we can cut down on the number of medications earlier, we can respond faster when it really counts.
- **No Current Indication:** As we age, medications are often added over time for different indications but are not always reviewed to see if they're still necessary. In hospice, we regularly perform medication reviews to see if each medication still makes sense.
- **Preventive vs. Palliative:** Many people take preventive medications to lower blood pressure, cholesterol, and blood sugar. These conditions, when left uncontrolled, can damage our bodies over long periods of time, however often do not need strict control as end of life approaches. Past management provides protection for months and even years. We call that the legacy effect.
- **Prescribing Cascade:** Sometimes a medication causes side effects, and another is added to treat that side effect. This is called a prescribing cascade. Sometimes that's okay. For example, when we prescribe an opioid, we will also prescribe a laxative because opioids cause constipation. However, there are also times when it is better to stop both medications and find a better way to treat symptoms.

## Decision Matrix: Continue, Reevaluate, Discontinue

| ACTION | CLASSES/TYPES OF MEDICATIONS |
|---|---|
| **Continue** | Medications that palliate current symptoms:<br>• Pain relievers<br>• Antidepressants<br>• Antipsychotics & other medications for agitation<br>• Anti-anxiety medications<br>• Laxatives<br>• Antidiarrheals<br>• Antiemetics |
| **Reevaluate** | Medications that continue to palliate current symptoms in some patients but should be reviewed frequently to assess for continued benefit:<br>• Blood pressure-lowering cardiovascular medications (including medications used for high blood pressure)<br>• Bone medications used for bone pain palliation<br>• Blood thinners (antiplatelet agents, anticoagulants)<br>• Inhalers (MDI, SMI, DPI)<br>• Proton pump inhibitors<br>• Dementia medications<br>• Oral hypoglycemic medications and insulins (diabetes medications)<br>• Urinary incontinence medications in patients without urinary catheters |
| **Discontinue** | Medications that do not palliate symptoms, significantly increase adverse effect (side effect) risk, and/or benefits are not seen in short-term:<br>• Antihyperlipidemic (cholesterol-lowering) medication<br>• Vitamins and supplements<br>• Bone medications used to treat or prevent osteoporosis<br>• Urinary incontinence medications in patients with urinary catheters |

## Deprescribing Decisions in Hospice Care

It is important to note that while there are several medication classes considered prime candidates for deprescribing, many may still have a palliative benefit for some patients. Approach each medication profile with patient-specific factors in mind. For organization and facilitating discussions with patients and caregivers, it is recommended to group medications into one of three buckets according to action plan: continue, reevaluate, and discontinue.

**Top 10 Medication Classes for Deprescribing or Reevaluation**

While there are many medications suitable for deprescribing, this guide focuses on 10 of the common classes from the Decision Matrix above.

1. Antihypertensive (Blood Pressure Lowering)
2. Antihyperlipidemic (Cholesterol Lowering)
3. Blood-Pressure Lowering Cardiovascular
4. Blood Thinners (Antiplatelet and Anticoagulant)
5. Bone Medications
6. Dementia Medications
7. Oral Hypoglycemic Medications and Insulins
8. Inhalers
9. Urinary Incontinence Medications
10. Proton Pump Inhibitors (Acid Reflux Medications)

## Antihyperlipidemic (Cholesterol-Lowering) Medications

**Recommended Action:** Discontinue

Antihyperlipidemic medications, such as statins (e.g., atorvastatin, simvastatin), are designed to lower cholesterol and thereby reduce arterial plaque buildup. This lowers the risk of cardiovascular events over time. These long-term benefits are less relevant for patients nearing the end of life.[3] Unpleasant side effects can conflict with palliative goals: In a study of nearly 400 patients with a life-limiting diagnosis, discontinuing statins led to improved quality of life and had no statistically significant impact on lifespan at 60 days.[4] These medications can be discontinued with no need for tapering.

### Sample Talking Points

I'd like to talk about the cholesterol medication. These are usually prescribed to prevent heart problems over many years, but at this stage, they may no longer be necessary. If you have any concerns or questions, I'm here to talk through them with you.

- Statins can sometimes cause side effects like muscle pain or fatigue and stopping them can help reduce discomfort. Right now, our focus is on comfort and quality of life, so we're recommending stopping this medication.
- For medications like these, we consider the legacy effect, which means the benefit of years of good control of cholesterol continues to benefit patients after the medication is stopped.
- Stopping this medication won't cause immediate harm, and it can help reduce side effects which can improve overall comfort.

## Blood Pressure-Lowering Cardiovascular Medications

**Recommended Action:** Reevaluate

Despite well-established best practices favoring deprescribing, clinicians are sometimes reluctant to deprescribe cardiovascular (CV) medications due to a perception that they continue to benefit the patient, including medication classes that provide no short-term symptom relief and offer only long-term benefits (e.g., cholesterol-lowering agents, anti-platelet therapy).[5] While several CV medication classes do palliate symptoms and may be appropriate to continue at end-of-life, regular reassessment for deprescribing is still necessary, especially for medications prescribed solely for lowering blood pressure (antihypertensives).

Antihypertensives are often reviewed for deprescribing in hospice care because the risks of moderately high blood pressure are typically cumulative over long periods of time.[6] As patients' physical function and intake of food and hydration decline, blood pressure lowers and hypotension becomes a greater risk factor, leading to dizziness and falls.[7] Some antihypertensive medications carry a risk of rebound hypertension when stopped suddenly, so tapering or monitoring may be required.

### Sample Talking Points

Let's talk about the blood pressure medications. We know that blood pressure can start decreasing naturally due to the body's changes, and some medications can make it drop too much, which might cause dizziness or even falls.

- At the end of life, we find that blood pressure may decrease naturally.
- Moderately higher blood pressure is not known to cause immediate harm and can actually improve mood and energy.[8]
- We are more concerned with low blood pressure at this stage because it can cause dizziness and falls.

## Blood Thinners (Anticoagulant and Antiplatelet Medications)

**Recommended Action:** Reevaluate

Anticoagulants (e.g., warfarin, apixaban) and antiplatelet medications (e.g., clopidogrel) are often prescribed long-term to help prevent strokes and blood clots. In hospice care, the potential benefits of these medications may be outweighed by the risks, especially the increased chance of bleeding.[9] The decision to continue or stop these medications should be based on each patient's individual risk factors, overall health status, and goals of care.

**Sample Talking Points**

I'd like to talk about the blood thinner medication. These medications are often used to prevent strokes and/or blood clots. They can be very helpful in many situations, but they also carry risks, especially as people get older or become frailer.

- Blood thinners can increase the chance of serious bleeding, especially after falls.
- When we look at risk of bleeding compared to risk of having a stroke or blood clot, the risk of bleeding may be higher than the risk of a blood clot or stroke.

## Bone Medications

**Recommended Actions:** Discontinue for osteoporosis; reevaluate for bone pain

Medications such as bisphosphonates (e.g., alendronate) or denosumab are used for osteoporosis treatment and prevention to reduce bone fracture risk over time. When used for osteoporosis, these medications should generally be deprescribed, as they offer no ongoing benefit but do have potential side effects, including gastrointestinal tract issues, especially when not administered correctly[10]. Discontinue the following in persons/patients using for osteoporosis treatment or prevention:

- Bisphosphonates
- Denosumab (Prolia®)
- Calcium + Vitamin D

It is important to recognize that bisphosphonates are also used to manage bone cancer and bone-related conditions and their symptoms, including bone pain.[11] Reevaluate the continued

benefit of bisphosphonates like alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®) and zoledronic acid (Zometa®, Reclast®) if the person/patient has:

- Known metastatic bone disease
- Breast/prostate cancer or multiple myeloma
- Paget's disease of bone (usually high dose)
- A functional status that supports continuing

**Sample Talking Points**

*For medications used for osteoporosis treatment or prevention:*

I'd like to talk about the osteoporosis medication. Research shows that after several years of use, especially in older adults or those with limited mobility, the benefits may taper off.

- These medications can cause side effects like bone or joint pain, and digestive issues. That is why we recommend stopping the medication. Our goal is to reduce unnecessary medication burden as we focus on comfort and safety.
- These medications work slowly over years to improve bone density. Those benefits continue for months or even years after the medication is discontinued. Continuing them now won't provide any additional benefit, and we feel that it is safe to stop them.

*For medications that manage bone cancer and bone-related conditions and symptoms:*

- The medication used to manage bone pain can cause side effects like abdominal pain, gastritis, stomach ulcers, dyspepsia, and reflux.
- There are other medications we can use to manage pain at this stage of life, so stopping this medication may be the best approach.

## Dementia Medications

**Recommended Action:** Reevaluate

Dementia medications, such as cholinesterase inhibitors (e.g., donepezil, rivastigmine, galantamine) and memantine, are used to slow cognitive decline and improve function (e.g., activities of daily living (ADLs)) in patients with Alzheimer's disease. The continued use of these medications in advanced dementia must be guided by patient goals of care.

Patients with advanced dementia often have swallowing problems, and discontinuing unnecessary medications can improve quality of life and reduce adverse effects.[12] Cholinesterase inhibitors can cause diarrhea, nausea, anorexia, insomnia, and bradycardia, while memantine can cause dizziness, headache, constipation, somnolence, and weight gain.

For patients with advanced dementia already taking these medications, it may be reasonable to reduce doses gradually with frequent assessment and, once stopped, only restart them in the event of patient decline (e.g., worsening agitation or function).[12, 13]

**Sample Talking Points**
I'd like to talk about your loved one's dementia medication. These medications are designed to slow the decline that occurs in patients with dementia and improve function in activities like self-care, but they may not provide additional benefit in more advanced stages and can cause undesirable side effects. Since our focus in hospice is comfort, stopping this medication may be the best approach.

- In advanced dementia, stopping these medications may help reduce side effects like nausea, poor appetite, or dizziness, which can improve overall comfort.
- We'll focus on other ways to support your loved one's well-being, by doing things like making sure we are managing pain that might otherwise cause your loved one to be anxious or agitated.
- I suggest that we slowly decrease it over the next few weeks while we carefully observe whether there are any changes. Are you okay with that?

## Oral Hypoglycemic Medications and Insulins

**Recommended Action:** Reevaluate

Oral medications for diabetes, including metformin (Glucophage®) and glipizide (Glucotrol®), and insulin injections (e.g., Humulin®, Humalog®, Lantus®) are often deprescribed in hospice when the focus shifts from tight glycemic control to symptom management. Additionally, as appetite declines, the risk of hypoglycemia increases, and with it, the increased potential for confusion, dizziness, and falls.

Most patients can tolerate a modest increase in blood sugar levels without having any symptoms of hyperglycemia. Oral medications are usually deprescribed first, as they carry a higher risk of hypoglycemia. Insulins are often continued in the short term because their dosages can be tailored to a patient's daily eating habits, offering a more immediate adjustment and impact compared to oral medications.

**Sample Talking Points**
I'd like to talk about the diabetes medications. Tight control of blood sugar prevents long term complications in the future; however we are now more focused on shorter-term comfort and preventing low blood sugar.

- Low blood sugar can make someone feel shaky or weak and may even lead to falls. Stopping or reducing the doses of oral diabetes medications medications and/or insulins can help prevent those risks.
- In hospice care, we don't target strict blood sugar control because the risks of low blood sugar, like shakiness or confusion, can be more harmful. Slightly higher blood sugar levels are usually not dangerous and can help avoid those uncomfortable symptoms.
- Stopping the medications will likely not cause the blood sugar to become dangerously high, but we can monitor for signs and symptoms of this, just in case.

## Inhalers

**Recommended Action:** Reevaluate

Inhalers are medication delivery devices used to deliver medication—including bronchodilators and corticosteroids—directly to the lungs to manage respiratory symptoms such as dyspnea, in patients with chronic lung conditions like COPD or asthma. Many of the medications found in inhalers offer continued palliative benefit by easing breathing and reducing airway inflammation. However, their effectiveness is highly dependent on the patient's ability to use the device correctly, something that often becomes compromised near the end of life.

Many hospice patients experience progressive respiratory muscle weakness, fatigue, or deconditioning, which limits their ability to generate the deep, forceful inhalation required for effective delivery of medication from inhalers. Often, inhalers require hand-breath coordination between actuation and inhalation, which can be difficult for hospice patients. Conditions such as dementia, Parkinson's disease, or advanced frailty can impair coordination, memory, and dexterity, making it difficult to follow the multi-step process of using an inhaler correctly.

Some medications can be delivered more effectively through a nebulizer.[14] Nebulizers convert liquid medication into a mist that can be inhaled passively through a mask or mouthpiece and are ideal for patients who cannot use inhalers effectively. Nebulizers do not require coordination or strong inspiratory effort, making them more suitable for end-of-life care.[14]

Oral medications, including short courses of oral steroids (e.g., prednisone, dexamethasone), can also reduce airway inflammation and improve breathing comfort in patients with COPD exacerbations or bronchospasm[15], providing an alternative to inhaler-delivery for some patients. Additionally, low-dose opioids can be effective in managing breathlessness. They reduce the sensation of air hunger and improve comfort, even in non-hypoxic patients. Morphine is commonly used and has been shown to be effective in both opioid-naive and opioid-tolerant patients.[16]

**Sample Talking Points**

I want to talk about the inhalers you've been using. These medications can help with breathing, but they work best when someone can take a deep breath and use the device correctly. As breathing becomes more difficult, many patients aren't able to get the full benefit from inhalers anymore.

- We often recommend switching to a nebulizer instead. It delivers the same medication as a gentle mist and doesn't require deep breathing or coordination. That helps make sure the right amount of the medication is delivered every time.
- We also have other options to help with shortness of breath, like oral steroids or low-dose opioids, which can be very effective in keeping you comfortable.
- Our goal is to make breathing as easy and comfortable as possible. Would you be open to talking about adjusting your medications to better match your current needs?
- Inhalers can be very helpful when someone is able to use them effectively. But as the body gets weaker, it becomes harder to breathe in deeply enough or coordinate the steps needed to get the full dose. So even though it's familiar, it may not be working as well as it used to.
- By switching to a nebulizer or using other medications that don't rely on inhalation, we can often provide better relief with less effort. Our goal is to make sure every treatment is still helping—not just something we continue out of habit.

## Urinary Incontinence (UI) Medications

**Recommended Actions:** Reevaluate with no urinary catheter; discontinue with urinary catheter

Urinary incontinence (UI) is a common complaint in older adults and encompasses a variety of conditions that can lead to poor bladder control, or urinary leakage. The main types are:

- Stress urinary incontinence (SUI): Involuntary leakage of urine caused by exertion, sneezing, coughing, and/or laughing.
- Urgency, or overactive bladder (OAB): Frequent, small-volume voids that may keep them up at night or a strong urge to void resulting in leakage before reaching the bathroom.
- Overflow incontinence: Continuous leakage or dribbling of urine.

The most commonly prescribed medications for UI include oxybutynin (Ditropan®, Oxytrol®), tolterodine (Detrol®), and solifenacin (Vesicare®). All UI medications have anticholinergic effects which are known to increase the risk of confusion, dry mouth, constipation, and falls in older adults.[17]

The benefits of UI medications tend to be modest and may not be meaningful for patients who are homebound or able to use absorbent products like adult undergarments. There is no reason, nor benefit, to continuing UI medications with patients using urinary catheters.

**Sample Talking Points**
We've been reviewing your bladder medication. These are often used to help with urinary incontinence, but they may not be providing much benefit anymore and can cause side effects like confusion, dry mouth, and constipation. For these reasons, we're recommending stopping or reducing them.

- If you're out in public, the frequent and sudden need to urinate can be a big problem. That's why these medications are usually prescribed. When people are homebound or using absorbent products, the urgency isn't as distressing.
- We are often more worried about dehydration in older adults and those with an advanced disease because their fluid intake tends to drop.

## Proton Pump Inhibitors (Acid Reflux Medications)

**Recommended Action:** Reevaluate

Proton pump inhibitors (PPIs), such as omeprazole and pantoprazole, are commonly prescribed for gastroesophageal reflux disease (GERD), peptic ulcers, and gastric protection during NSAID or steroid use. Many patients stay on PPIs long after the original symptom or condition has been resolved, especially if started during a hospital stay.[18] Long-term PPI use is associated with increased risks of *Clostridioides difficile (C. diff)* infection, pneumonia, fractures, dementia, and vitamin/mineral deficiencies. Ongoing use of PPIs may not be warranted in patients with minimal oral intake.

**Sample Talking Points**
We've been reviewing your acid reflux medication. At this stage, since eating is minimal and the body is changing, the risk of acid-related problems is low. These medications can also cause side effects. For these reasons, we're recommending stopping or reducing them.

- If any discomfort comes up, we can use an antacid as needed.
- Long-term use is associated with increased risks of infection and pneumonia, which are more concerning at this point.
- In hospice care, many patients aren't eating foods that trigger acid reflux, and the body's needs change.

## Vitamins and Supplements

**Recommended Action:** Discontinue

As the population ages and chronic illnesses become more prevalent, many seniors and patients with conditions like cancer, COPD, dementia, and heart failure turn to dietary supplements and herbal remedies. These products promise relief from symptoms, improved energy, and even disease prevention. However, despite their popularity, the scientific evidence behind many of these remedies remains limited. Their use can pose risks (particularly when taken with prescription medications) and increase pill burden and choking hazards for patients.

**Sample Talking Points**
We've been reviewing the supplements and vitamins currently being taken. Many of these were started earlier in life with the hope of long-term health benefits. At this stage the body's needs are changing, and there's limited evidence that these supplements provide meaningful benefit in hospice care. In fact, they can sometimes cause side effects or interact with other medications. Let me know if you'd like to talk more about this.

- As more medications are added for comfort and symptom management, swallowing can become more difficult. Reducing unnecessary pills helps ease that burden.
- In hospice care, we have a lot of effective options for symptom management. We also worry about interactions, so we try to stop any unnecessary products to maximize safety.
- If any symptoms or concerns arise, we'll respond quickly and adjust the care plan to improve comfort.

If you find this ebook valuable, remember to check out part one of the series! *Crucial Conversations: Educating Patients & Caregivers on Common Symptoms in Hospice Care* provides tips to clinicians in effectively conveying key information about hospice care, including helping families anticipate what to expect and clarifying what effective symptom management looks like. **Click here to download it today!**

## Further Reading

This guide focuses on talking points and general considerations, but it is not medical advice nor is it a substitute for peer-reviewed clinical guidelines. The following open-access resources are available for a more in-depth exploration of deprescribing.

**Deprescribing in older people approaching end-of-life: development and validation of STOPPFrail version 2**
Review by Curtin D, Gallagher P, O'Mahony D.
Published in Age and Ageing, Volume 50, Issue 2, Pages 465–471
Read the full article: Link Here

This article presents the development and validation of **STOPPFrail version 2**, a deprescribing tool designed for frail older adults nearing end-of-life. The updated version includes 25 evidence-based criteria to help clinicians identify medications that may no longer be beneficial and could pose risks. It introduces a practical method for identifying patients appropriate for deprescribing and emphasizes **shared decision-making.** New guidance includes recommendations for deprescribing antihypertensives, anti-anginal medications, and vitamin D supplements. The tool aims to reduce medication burden and improve quality of life in end-of-life care.

**NHPCO Hospice Medication Deprescribing Toolkit (2025)**
Developed by the *NHPCO Pharmacist and Physician/AP Provider Communities*
Access the toolkit (PDF): Link Here

This practical toolkit provides hospice clinicians with medication-specific deprescribing guidance for common medication classes such as anticoagulants, dementia medications, inhalers, diabetes treatments, and statins. It includes decision trees and clinical considerations to help determine when medications can be safely discontinued. The resource emphasizes reducing pill burden, avoiding adverse effects (side effects), and focusing on comfort. It's designed to support hospice teams in making individualized, evidence-informed deprescribing decisions.

**Prescribing and deprescribing in older people with life-limiting illnesses receiving hospice care at the end of life**
Published in *Palliative Medicine*, Vol. 38(1), Pages 121–130
Read the full article: Link Here

This longitudinal cohort study examined prescribing and deprescribing patterns in older adults admitted to hospice units in Northern Ireland. Using STOPPFrail and Morin criteria, researchers found that polypharmacy persisted until death in over 96 percent of patients, and more than half received potentially inappropriate medications (PIMs). The study highlights a lack of proactive deprescribing and calls for systematic medication reviews to align treatment with end-of-life goals. It underscores the need for deprescribing guidelines tailored to hospice settings.

**Recommendations for Deprescribing of Medication in the Last Phase of Life: An International Delphi Study**
Published in *Journal of Pain and Symptom Management*, Vol. 68, Issue 5, 443 - 455.e2
Read the full article: Link Here

Experts working in palliative care or other relevant disciplines were asked to participate in this international Delphi study. Existing tools for deprescribing of medication in the last phase of life were integrated in a list of 42 recommendations regarding potential deprescription of various medication types. Recommendations were accepted, if at least 70 percent of the experts (strongly) agreed, the interquartile range (IQR) was one or less, and less than 10 percent strongly disagreed.

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