To stop or not to stop : deprescribing preventive cardiovascular medication in low-risk general practice patients

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CHAPTER 4

Deprescribing Potentially Inappropriate Preventive Cardiovascular Medication: Barriers and Enablers for Patients and General Practitioners

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ABSTRACT

Background
The use of preventive cardiovascular medication by patients with low cardiovascular disease (CVD) risk is potentially inappropriate.

Objective
The aim of this study was to identify barriers to and enablers of deprescribing potentially inappropriate preventive cardiovascular medication experienced by patients and general practitioners (GPs).

Methods
A total of 10 GPs participating in the ECSTATIC trial (Evaluating Cessation of STatins and Antihypertensive Treatment In primary Care) audiotaped deprescribing consultations with low-CVD-risk patients. After initial conventional content analysis, 2 researchers separately coded all barriers to and enablers of deprescribing medication using framework analysis. We performed a within-case and cross-case analysis to explore barriers and enablers among both patients and GPs.

Results
Patients (n = 49) and GPs (n = 10) expressed barriers and enablers with regard to the appropriateness of the medication and the deprescribing process. A family history for CVD was identified as a barrier to deprescribing medication for both patients and GPs. Patients feared possible consequences of deprescribing and were influenced by the opinion of their GP. Additionally, a presumed disapproving opinion from specialists influenced the GPs' willingness to deprescribe medication.

Conclusions
Patients appreciated discussing their doubts regarding deprescribing potentially inappropriate preventive cardiovascular medication. Furthermore, they acknowledged their GP's expertise and took theiropinion toward deprescribing into consideration. The GPs' decisions to deprescribe were influenced by the low CVD risk of the patients, additional risk factors, and the alleged specialist's opinion toward deprescribing. We recommend deprescribing consultations to be patient centered, with GPs addressing relevant themes and probable consequences of deprescribing preventive cardiovascular medication.

INTRODUCTION

According to many international guidelines on the prevention of cardiovascular disease (CVD), patients with low CVD risk should be given lifestyle advice and do not require treatment with antihypertensive and/or lipid-lowering drugs.[1-6] Nevertheless, it has been shown that drugs are frequently prescribed and used on a long-term basis by low-CVD-risk patients. More or less depending on the reason for prescription, use of these drugs is considered potentially inappropriate because their potential risks (eg, side effects) outweigh their potential benefits.[8-10] Deprescribing medication after long-term use is preferable for (subgroups of) patients with low CVD risk for whom deprescribing is found to be a safe and effective procedure.

Two recent systematic reviews based on studies concerning deprescribing medications identified several categories of barriers and enablers for patients and for prescribers to deprescribe potentially inappropriate medication.[8, 11] Both reviews included studies of hypothetical deprescribing of various kinds of medication (eg, benzodiazepines, antidepressants, psychotropic medications).

We hypothesized that the barriers and enablers of deprescribing in general might differ from the factors playing a role in the decision concerning deprescribing preventive cardiovascular medication. Regarding implementation of a deprescribing policy, knowledge of these factors would be valuable. Therefore, the aim of our study was to identify the barriers and enablers encountered in real-life discussions between patients and their general practitioners (GPs) considering deprescribing preventive cardiovascular medication.

METHODS

The study population was selected from the ECSTATIC trial (started in 2012, end of follow-up December 2015). In the ECSTATIC trial (NTR3493), we evaluate whether it is cost-effective and safe to deprescribe antihypertensive and lipid-lowering drugs in primary care patients to whom medication is not recommended, according to the current Dutch guideline Cardiovascular Risk Management (Box 1).[1]

Box 1. ECSTATIC Trial

ECSTATIC Trial

The ECSTATIC trial evaluates whether it is cost-effective and safe to deprescribe antihypertensive and lipid-lowering drugs inprimary care patients to whom medication is not recommended according to the current Dutch guideline Cardiovascular Risk Management. Patients without cardiovascular disease (CVD) were included in the ECSTATIC-trial when having low CVD risk and using antihypertensive and/or lipidlowering drugs. GPs in the intervention practices received a training providing information about this guideline and its differences with respect to the former guideline. In preparation of the deprescribing consultations they were presented cases of fictional low-CVD-risk patients and they discussed these patients' suitability to have their medication deprescribed. GPs participating in the trial sent a written invitation to their patients without CVD, using potentially inappropriate antihypertensive and/or lipid-lowering drugs. After obtaining informed consent, the researchers determined eligibility on the basis of the patients' pre-treatment 10-year risk of morbidity and mortality of CVD, using the SCORE risk function as well as their (possible) additional risk increasing factors (positive family history for CVD, obesity, decreased kidney function, and sedentary lifestyle).[1] When, based on the combination of the risk score and additional risk increasing factors for CVD, medication was not recommended according to the current guideline Cardiovascular Risk Management, patients were considered eligible for inclusion and were advised to make an appointment for a deprescribing consultation with their GP.

In the intervention practices, patients knew in advance that, if found eligible (from here on referred to as low-risk patients), they would be offered a consultation with their GP discussing deprescribing and deciding whether to deprescribe or continue the medication.

Participants

Through purposeful sampling,[12] we included 9 general practices that were in the process of organizing deprescribing consultations in the course of their participation in the ECSTATIC trial. The GPs of the included practices selected the patients based on opportunity (having an appointment for a deprescribing consultation) and on the patient's informed consent to audiotape their consultation with their GP. The GPs did not receive additional training in communication skills, and the deprescribing consultations did not follow a predefined format. The patients signed a written informed consent before the consultation was audiotaped. The study was approved by the Medical Ethics Committee of the Leiden University Medical Center (P12.095/SH/gk).

General Description of the Deprescribing Consultations

All audiotaped consultations were transcribed verbatim. The transcripts were used to describe the characteristics of the consultation and the sequence of barriers to and enablers of deprescribing.

Analysis of Barriers and Enablers

To identify barriers to and enablers of deprescribing preventive cardiovascular medication for both patients and GPs, transcripts were analyzed using a conventional content analysis.[13] This analysis revealed that emerging themes matched the theoretical framework of Reeve et al.[8] This framework consists of 6 categories of barriers and enablers: (1) appropriateness, (2) fear, (3) process, (4) influences, (5) dislike, and (6) other (Table 1). To ensure that no themes were missed, we performed an additional round of coding using a framework approach based on Reeve et al,[8] which allowed deductive and inductive coding. All coding was performed by 2 researchers (CHL and RMJJvdK), and differences in codes assigned were resolved by discussion. The codes identified inductively were added to Reeve's framework (Table 1).[8] We also described whether themes were intertwined when separate codes were assigned to the same citation. Within-case and cross-case analyses were then conducted, as described by Miles and Huberman.[14] We performed an indepth exploration of both patient and GP barriers and enablers for each consultation using the within-case analysis. This allowed us to properly interpret all mentioned barriers and enablers per consultation as we

investigated each consultation separately. We then used the cross-case analysis to evaluate whether barriers and enablers occurred in patterns across cases, intending to explore commonly mentioned barriers and enablers during the consultations. In addition, we specifically compared barriers and enablers mentioned in consultations in which the outcome was "deprescribing of medication" with consultations where the outcome was "continuation of medication". The outcome of the consultation was deduced from the conclusion of the consultation itself by noting whether medication was continued or deprescribed. The barriers and enablers discussed in consultations were compared depending on the type(s) of medications the patient used (antihypertensive medication, lipid-lowering drugs, or both). If any inconsistencies in themes were found during the crosscase analysis, transcript information was consulted for verification.

RESULTS

Table 2 shows the characteristics of the patients (mean age = 55.4 years) and the outcome of the consultation. We included 49 deprescribing consultations of 10 different GPs from 9 general practices. In 42 of the 49 consultations, the outcome was deprescribing of medication. Median time for all consultations was 6½ minutes.

Table 2. Characteristics of the participating patients (n=49)

	Patients
Male – no. (%)	14 (29)
Age in years – mean (SD)	55.4 (5.5)
Using antihypertensive medication – no. (%)	42 (86)
Using lipid-lowering drugs – no. (%)	12 (25)
Outcome of the consultation deprescribing of medication (%)	42 (86)
Outcome of the consultation continuation of medication (%)	7 (14)

Course of the Deprescribing Consultation

Table 3 shows the characteristics of the GPs and their deprescribing consultations. The GP often started the consultations by explaining the reason for consultation: the patient was included in the ECSTATIC trial and had a low risk.

Four GPs specifically mentioned that the decision whether or not to deprescribe the medication was a joint decision that needed to be made by both the patient and GP. Additionally, regardless of the outcome of the deprescribing consultation (deprescribing/continuation), 6 out of 10 GPs discussed a healthy lifestyle with their patients as an alternative to medication.

Table 3. Characteristics of the participating GPs (n=10) and their deprescribing consultations

	Gender of GP	Age of the GP	Years of working experience as GP	Number of audiotaped consultations	Duration of consultation (range in minutes)	Consultations with the outcome 'deprescribing of medication' (%)
GP-1	Male	35	3	11	4-25	10 (91)
GP-2	Female	60	28	6	5-29	4 (67)
GP-3	Male	52	9	3	1-2	1 (33)
GP-4	Male	58	28	10	3-7	10 (100)
GP-5	Male	60	30	5	1-4	5 (100)
GP-6	Male	56	24	5	5-8	5 (100)
GP-7	Female	53	25	1	10	0 (0)
GP-8	Male	58	19	3	5-10	3 (100)
GP-9	Female	60	32	2	4-12	1 (50)
GP-10	Female	48	14	3	8-14	3 (100)

GP, general practitioner.

Barriers and Enablers

Barriers were more frequently cited by patients than by GPs, and patients also mentioned more diverse barriers than GPs (Table 1). Irrespective of the outcome of the consultation, barriers to deprescribing were cited by both patients and GPs. Although the number of enablers mentioned by patients and GPs differed, in general, both cited the same enablers. The enablers cited by patients and GPs were similar regardless of the outcome of the consultation. However, GPs mentioned fewer and different barriers in consultations in which the outcome was to deprescribe medication. Furthermore, in a majority of consultations, the GP mentioned an enabler after a patient mentioned a barrier.

When the GP expressed doubts about deprescribing, the barriers mentioned were often personalized and directed toward the consulting patient. In contrast, the GPs more frequently brought a general, nonpersonalized barrier forward when they were positive toward deprescribing medication.

'The ophthalmologist can tell that that you have a high blood pressure based on the examination of your eyes . . . and that's why we need to ask ourselves whether it would be wise to stop your medication.' (GP-2 consulting a patient whose outcome was continuation)

'And to some patients we say that their [CVD] risk is really too high, and that they have to continue their medication.' (GP-10 consulting a patient whose outcome was deprescribing)

When comparing consultations of patients using antihypertensive medication, lipid-lowering drugs, or both, we found no differences in the barriers and enablers mentioned by both patients and GPs.

Appropriateness

We found that 9 of 49 patients and 7 out of 10 GPs mentioned that medication was currently necessary or beneficial. This reason to continue intertwined with other themes in patients, such as (1) the GP's advice to take preventive medication, (2) fear-related themes, and (3) mistrust or scepticism of the recommendation to deprescribe.

'We were always told that there would be so much damage done to heart and blood vessels by high blood pressure.' (52-year-old woman whose outcome was deprescribing)

In GPs, this theme was intertwined with the patient having an unhealthy lifestyle and/or having several risk factors for developing CVD:

'As a doctor, I feel your smoking behaviour argues against withdrawal.'
(GP-2 consulting a patient whose outcome was continuation)

When explaining the reason for the consultation or when the patient asked for advice, all GPs expressed that medication was not (medically) ecessary, implying a general positive attitude toward deprescribing — for example, when the patient had a low risk or when the revised recommendations concerning the use of preventive cardiovascular medication indicated that the medication was unnecessary for a certain patient.

'So according to the current guidelines you would not need lipid-lowering drugs.'
(GP-10 consulting a patient whose outcome was deprescribing)

Patients expressed doubts regarding the necessity for medication use; they stated that they were "unsure about their (continuous) need" for it.

'I used these [medications] for two years now, [or rather] one and a half years, maybe even longer. This makes me think, well, is it necessary? And . . . shouldn't we stop it?' (53-year-old man whose outcome was deprescribing)

Patients sometimes assumed that at the time their medication was initiated, stress had induced their hypertension. In that case, their rationale for having a well-controlled blood pressure at this moment in time was the absence of stressful events.
We found that 20 of 49 patients and 4 of 10 GPs expressed
a general positive attitude toward deprescribing, which makes it a dominant theme among patients:

'That [deprescribing] would be fantastic.' (61-year-old woman whose outcome was deprescribing)

Fear
Both patients and GPs cited the fear of the return of the previous condition for which the medication was started/prescribed:

'I don't know if we take one [of the medications] off, whether my blood pressure will rise again.' (61-year-old woman whose outcome was continuation)
'Also, how over the past few years we struggled to get that blood pressure under control, makes me say like, no, we're not going to withdraw that medication now.' (GP-7 consulting a patient whose outcome was continuation)

Patients feared the return of hypertension or hypercholesterolemia and feared the dangers that might accompany these conditions (CVD/death). Two of the 3 GPs who forwarded fear of return of the previous condition advised to continue medication. Only patients expressed fear for the unknown consequences of deprescribing:

'However, maybe I will have side effects [of deprescribing], such as dizziness or something?' (64-year-old woman whose outcome was deprescribing)

Process
Both patients and GPs encountered problems with the timing or with the complexity of

the process of deprescribing. However, these problems were always solved: when timing was the issue, the deprescribing was postponed, and in the case of complexity, the GP wrote a dose-lowering scheme for the medications. Patients and GPs appreciated the availability of a follow-up scheme for the blood pressure and cholesterol levels after deprescribing and noted the possibility of restarting medication:

'However, I can always return to have my blood pressure measured again and restart the pill?' (59-year-old female whose outcome was deprescribing) 'Yes, yes.' (GP-5)
'If your blood pressure rises above 180 [mm Hg], yes, then there is an indication again to restart medication.' (GP-6 consulting a patient whose outcome was deprescribing)

Five of 10 GPs reassured patients that deprescribing would be safe by stressing that the medication would be deprescribed step-by-step.

Influences

In the analysis, several themes emerged as important factors in the decision-making process. The patient's decision was strongly determined by the GP's voiced opinion, which we deduced by noting whether the GP said it was justified to deprescribe the medication. The outcome of these consultations then was very likely to be deprescribing medication, and vice versa:

'That doesn't feel right with me, honestly speaking.' (GP-2)
'Then, we just don't do it [name of GP].' (61-year-old woman whose outcome was continuation)

This quote was derived from 1 of 2 consultations in which the GP's arguments seem to change the patient's initial thoughts about deprescribing. In this particular consultation, the patient expressed her desire to have her medication deprescribed. The GP had reservations because of the patients smoking behavior. The patient acknowledged the hesitations of the GP and decided to persist using the medication. They continued discussing smoking cessation.
In the other consultation where the patient and GP had discordant views, the patient was afraid of getting agitated after stopping. The GP addressed her low risk that would justify deprescribing her medication, after which they decided to lower the dose. He indicated that medication was not necessary to lower her blood pressure. However, the GP did forward that the dose-lowering might prove the medication's supposed necessity to keep her from getting agitated.

When patients had earlier bad experiences with stopping their medication, they tended to decide to continue medication.

'According to me, we stopped them once, but then it rose again . . . according to me . . . and then you prescribed it again, so . . .' (52-year-old woman whose outcome was continuation)

Both patients and GPs cited a family history of CVD explicitly as a barrier to deprescribing.

'I have a father who . . . got 5 bypasses. His youngest sister died of a stroke. So also in my family there are examples . . . of which I think, well . . .' (58-year-old woman whose outcome was continuation)
'So we have just gone through all your risk factors and we came to the conclusion that we won't stop the medication. Predominantly based on your family history [being positive for CVD].' (GP-3 consulting a patient whose outcome was continuation)

GPs considered the patient having an unhealthy lifestyle and the specialist's opinion that the patient needed medication as serious barriers to deprescribing.

'And then you went to see the specialist, isn't it? . . . and he also advised to continue [the medication] isn't it?' (GP-7 consulting a patient whose outcome was continuation)

Dislike
Both patients and GPs expressed a general dislike of taking (or prescribing) medication.

'The less [medication] the better.' (51-year-old woman whose outcome was deprescribing)

'Well, that means that someone who was used to taking medication, suddenly doesn't need medication anymore, which is quite nice of course.' (GP-6 consulting a patient whose outcome was deprescribing)

Other enablers for patients within the dislike theme were the following: (1) removing the stigma of "being a patient," (2) psychological benefits of deprescribing, (3) lowering costs for society, and (4) easier access to a mortgage once off medication.

Other

A lack of fear of the consequences of deprescribing medication was cited by 7 of 10 GPs.

'When your systolic blood pressure is above 180 [mm Hg], or when you get all kinds of complaints [of deprescribing], but, well, you didn't have that much complaints back then [before medication was started], so that's not to be expected.' (GP-6 consulting a patient whose outcome was deprescribing)

GPs stated that they had positive expectations of deprescribing because no serious adverse events occurred in a previous study, or they assumed that patients might only experience light complaints after deprescribing.

DISCUSSION

Summary

Our study showed that patients were generally positive toward deprescribing preventive cardiovascular medication and that they relied on the information and expertise of their GP to determine whether deprescribing was justified. Patients also mentioned that they feared the consequences of deprescribing. However, knowing follow-up care was available and that medication could be restarted facilitated the patients' agreement to deprescribe.

The main reason for GPs to advise deprescribing was the low CVD risk of patients when recalculated following the current guideline. The GPs also considered the impact of additional risk factors such as a positive family history for CVD, unhealthy lifestyle, and earlier advice of the specialist to continue/start medication.

Strengths and Limitations

One of the strengths of this study is its unique nonhypothetical setting. We believe that this led to the emergence of themes reflecting those themes that in day-to-day clinical practice play a role in the patient's and GP's decision to deprescribe/continue. In contrast to other deprescribing studies that focused on older adults with polypharmacy, as a result of the prerequisite of having low CVD risk to be included in the ECSTATIC trial, our study investigated a relatively young population (mean age = 55.4 years). This adds new information to the current knowledge of the deprescribing process. Furthermore, deprescribing of a specific kind of medication (ie, cardiovascular medication) is studied. This knowledge could be useful when designing implementation

plans to facilitate deprescription policies in general practice in patients with low CVD risk.

Two GPs (GP-1 and GP-4) together audiotaped 21 consultations of which the outcome was deprescription in 20 consultations. This suggests a strong positive attitude of these GPs toward deprescription, which possibly affected the statements of their patients. All GPs participating in the ECSTATIC trial were informed about their patient's (low) CVD risk. We asked GPs to select patients themselves for our study, which may have led to an underestimation of patients with a presumed negative attitude toward deprescribing. Furthermore, the patients in our study agreed to and were, therefore, willing to have a deprescribing consultation. This selection bias may in turn have led to an incomplete overview of barriers to deprescribing. Despite these methodological limitations, in our opinion, the large sample of 49 patients from 10 GPs allowed the emergence of a generalizable framework of barriers and enablers.

Comparisons With Individual Studies in Patients

Our study showed many similarities between the mentioned barriers and enablers of patients and GPs. Anderson et al[11] also concluded that there were similarities in the cited barriers and enablers in prescribers and patients when comparing their results (of barriers and enablers of prescribers) with the outcomes of the review by Reeve et al[8] (of barriers and enablers of patients). However, in our study, we found even more similarities when comparing the barriers and enablers mentioned by GPs with the barriers and enablers that Reeve et al[8] identified in patients. This discrepancy is probably caused by the fact that in our study, patients and GPs discussed real deprescribing of medication, and they were able to react to the barriers and enablers mentioned, whereas both reviews included studies regarding (hypothetical) medication deprescribing/continuation. Additionally, we believe that having investigated nonhypothetical consultations, our findings are more close to day-to-day clinical practice.

Our study supports earlier findings that patients value the opinion of their physician when considering deprescribing.[7, 15, 16] Our findings are also consistent with a study on the deprescribing of selective serotonin reuptake inhibitors; this study included patients who had actually tried or discussed deprescribing with their GP and highlighted the importance of being monitored and knowing that there was a possibility to restart their medication.[17]

The health care system in the Netherlands is funded by a combination of taxes and a state-controlled mandatory insurance for all people. Payments to physicians are combined per capita for service and are paid out-of pocket by patients themselves. A health care allowance is provided by the government for patients with lower incomes.

Patients aged 18 years and older have to pay for their own health care costs up to 350 euro a year (2013). In our study, however, reducing individual costs was never mentioned as an enabler for deprescribing, in keeping with a study by Benson and Britten[18] concerning deprescribing antihypertensive drugs. This is possibly caused by the low prices of the most commonly prescribed generic antihypertensive and lipid-lowering drugs.

Comparisons With Individual Studies in Physicians

Most GPs take preventive measures, such as blood pressure monitoring in response to a positive family history of CVD, obesity, smoking, and other risk factors.[19] Thus, it is not remarkable that in our study, GPs mentioned these patient characteristics as barriers to deprescribing.

Several themes emerging from the analysis that we added to the patient perspectives-based framework of Reeve et al[8] were actually described by Anderson et al.[11] For example, themes such as the influence of the specialist and the positive attitude of physicians toward deprescribing were already present in the framework of Anderson et al.[11] However, knowledge or skill deficits seemed to be less of a barrier to deprescribing in our study. This is probably a consequence of the fact that GPs were informed about suitability for deprescribing (ie, low CVD risk) by the researchers.

Anderson et al[11] argued that physicians needed to discuss rather than assume the patients' attitudes toward deprescribing. In this study, the GPs discussed the views of their patients adequately.

Possible Implications for Practice

In the context of implementation of a deprescribing policy of preventive cardiovascular medication in general practice, we believe, on the basis of our results, that a consultation aiming at deprescribing is not necessarily time-consuming and should be a patient-centered discussion. Based on their specific cardiovascular risk management expertise and individual knowledge of the patient involved, GPs should address all probable consequences of deprescribing, ensuring that patients make an informed decision. If necessary, they should stress that regular follow-up and the possibility of restarting medication is available, which will potentially reduce patients' fears.

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Table 1. Framework of Reeve et al[8] including the added barriers and enablers

Category	Theme	Barrier (-) or enabler (+)
Appropriateness	Medication is currently necessary/ beneficial for condition	-
	Medication is necessary/beneficial for condition in the short term[d]	-
	Blood pressure well-controlled in the end[b]	-
	Hope for future benefit[s]	-
	Many risk factors and therefore hope for future benefits when taking medicationd	-
	Psychological benefits of taking the medication (empowerment)[b]	-
	Lack of suitable alternative/unwillingness to try alternatives[c]	-
	Beliefs about lack of ability to continue/sustain alternative treatments	-
	Desire for increased dose of medication[c]	-
	Mistrust/scepticism of recommendation to cease	-
	Acceptance of medical condition and therefore need for medication[b]	-
	Lack of negatives[b]	-
	Experiencing side effects	+
	Fear for side effects	+
	Medication is not necessary	+
	Limited number of risk factors	+
	Nonsmoker[d]	+
	Good activity level[d]	+
	Blood pressure well-controlled	+
	Lack of efficacy	+
	Fear of addiction/dependency[b]	+
	Considering alternative treatment option	+
	Advising alternative treatment option[d]	+
	Preference for lifestyle intervention over medication[d]	+
	Unsure about continued need	+

	Mistrust of prescriber who started the medication[c]	+
	General positive attitude toward ceasing	+
	Benevolent toward goal of research[b]	+
	Mistrust of pharmaceutical industry[d]	+
Fear	Psychological issues related to cessation/ non-specific fears	-
	Fear of return of condition	-
	Fear of withdrawal effects[b]	-
	Fear for CVD/death[b]	-
Process	Lack of primary care physician support/time[b]	-
	Unknown how to cease/conflicting information	-
	Lack of ongoing support needed[c]	-
	Need for appropriate timing for cessation	-
	Knowledge that there are possibilities to handle negative effects[d]	+
	Knowledge that they could restart medication	+
	Follow-up/primary care physician support available	+
	Other support available (family or processes)	+
	External factors relating to ability to cease removed[d]	+
	External factors causing hypertension removed[b]	+
	Action planning[b]	+
	Withdrawing medication step-by-step	+
Influences	Previous bad experiences with stopping	-
	Influence of primary care physician/family/friends[b]	-
	Influence specialist	-
	Family history positive for condition	-
	Family history negative for condition[d]	+
	Primary care physician[b]	+
	Other advice[c]	+

Dislike	Psychological benefits of ceasing[b]	+
	Inconvenience (including cost)[c]	+
	Feeling of unfairness having to take medication[b]	+
	General dislike of taking medication	+
	General dislike of prescribing medication[d]	+
	General dislike of taking tablets	+
	Medications are unnatural[b]	+
	Stigma associated with taking medication[b]	+
	Beliefs about costs for society[b]	+
	Problem getting a mortgage[b]	+
Other	Pragmatic considerations[b]	-
	Habit[b]	-
	Not wanting to have one's mind occupied with tapering[c]	-
	Guilt related to depriving loved ones of something that might work[c]	-
	Inconvenience (including cost)[b]	-
	Lack of fear of consequences of stopping	+
	Concern about compatibility of drugs[c]	+

Barriers and enablers written in italics were added to the existing framework of Reeve et al. [8]; * barriers and enablers not mentioned by patients in this study; ** barriers and enablers not mentioned by GPs in this study; *** barriers and enablers both patients and GPs did not mention in this study.