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MEDICALLIES IN-DEPTH INSIGHT REPORT

Polypharmacy in Chronic Care: What Pharmacists See Behind Medication Burden

Pharmacist perspectives on rising polypharmacy, prescribing cascades, deprescribing, poor coordination, adherence burden, medication review, and safer chronic care. This report moves from the central clinical question to the evidence, the pattern behind it, and the practical implications for care.

Content · Data · Insight · Impact

123	6	10	80.4%
Complete responses	Countries represented	Closed-ended findings	Completion rate

THE CLINICAL QUESTION

What do pharmacists see when polypharmacy becomes a medication-safety problem?

Pharmacists describe the safety problem as a loss of coherence across the full regimen. Medicines accumulate without reassessment, and the prescribers work without a shared plan, side effects can trigger additional prescriptions, and the health system becomes difficult for patients to follow.

The concern is not the number of medicines alone. It is the interaction between burden, unclear ownership, prescribing cascades, fragmented communication, and a regimen whose combined purpose becomes harder to explain.

The report traces that pattern through medication accumulation, coordination failures, adherence burden, guideline layering, and the balance between disease control, quality of life, and treatment simplicity.

Countries covered: United States, United Kingdom, Canada, Italy, France, Germany. The survey included pharmacists from the United States, United Kingdom, Canada, Italy, France, and Germany.

EXECUTIVE SUMMARY

What the data is showing

FINDING 01

51.6% become concerned when medicines accumulate without reassessment

The trigger is often loss of review rather than a fixed medicine count.

FINDING 02

44.4% identify complex schedules as the main adherence barrier

Regimen design can make adherence difficult even when the patient is motivated.

FINDING 03

66.7% see guidelines as a major or moderate contributor to medication burden

Condition-specific recommendations can become difficult when layered together.

FINDING 04

44.4% say quality of life and simplicity are hardest to balance

The therapeutic target extends beyond disease markers to the lived burden of care.

SECTION 01

01 The medication list is expanding, and review priorities are changing

CONTEXT

Polypharmacy is becoming more common as people live longer with multiple chronic conditions and condition-specific therapies accumulate. Pharmacists must actively assess whether the combined regimen remains safe and coherent.

The survey shows that medication burden has become a central review concern rather than a secondary consideration.

WHAT THE DATA SHOWS

Eighty-three point five percent report a significant or moderate increase in polypharmacy. During review, 77.2% prioritize burden and interaction risk over understatement.

THE INSIGHT

Pharmacists are not rejecting disease control. They are identifying the point at which the total regimen begins to create its own clinical risk.

WHY IT MATTERS

Medication review needs time and authority to evaluate not benefit across the whole regimen, not simply confirm that each medicine appears on a guideline.

SECTION 02

02 Accumulation and prescribing cascades reveal missing reassessment

CONTEXT

A medication list can grow gradually through specialist additions, symptom treatment, transitions of care, and attempts to manage adverse effects. Without periodic reconstruction, the list may no longer represent one coordinated strategy.

Prescribing cascades are a visible consequence of this fragmentation.

WHAT THE DATA SHOWS

Accumulation without reassessment is the leading concern at 51.6%. Possible prescribing cascades are seen frequently or occasionally by 96.0%.

THE INSIGHT

The problem is not only the number of medicines. It is the failure to revisit the causal story behind each addition.

WHY IT MATTERS

In the pharmacists' accounts, high-quality review reconstructs what changed after each medicine started and whether a new symptom may reflect an adverse effect rather than a new diagnosis.

SECTION 03

03 Deprescribing is limited more by coordination than by clinical uncertainty

CONTEXT

Deprescribing can involve several conditions, prescribers, and monitoring responsibilities. Even when the rationale is clear, fragmented communication can make change feel unsafe.

The survey identifies coordination as the dominant operational barrier.

WHAT THE DATA SHOWS

Lack of coordination leads the barriers to deprescribing at 60.5%. Poorly coordinated regimens are encountered frequently or occasionally by 92.8%.

THE INSIGHT

The findings suggest that deprescribing is not a single-prescriber action. It is a cross-system transition that needs shared ownership and reliable information.

WHY IT MATTERS

Interoperable records, direct prescriber communication, and explicit follow-up responsibility are likely to matter as much as the deprescribing framework itself.

SECTION 04

04 Adherence burden is often created by regimen design

CONTEXT

Patients may be willing to follow treatment yet struggle with multiple timings, changing instructions, duplication, cost, side effects, and uncertainty about the purpose of each medicine.

Guideline layering can make this worse when condition-specific recommendations are applied without a whole-person review.

WHAT THE DATA SHOWS

Complex schedules and medication fatigue account for 78.2% of the leading adherence barriers. Sixty-six point one percent see guidelines as a major or moderate contributor to burden.

THE INSIGHT

Poor adherence is often a rational response to a regimen that has become difficult to execute or understand.

WHY IT MATTERS

The responses connect simplification with dosing frequency, duplication, indication clarity, affordability, and patient confidence in their medicine count alone.

SECTION 05

05 Complex care requires a shared definition of treatment success

CONTEXT

In medically complex patients, maximizing disease control can conflict with avoiding adverse effects, preserving function, and keeping the treatment plan understandable. Pharmacists place quality of life and simplicity at the centre of that balance.

WHAT THE DATA SHOWS

Quality of life and simplicity lead at 44.4%, followed by aligning multiple treatment plans at 29.8%. Better interdisciplinary coordination is the leading improvement at 42.7%.

THE INSIGHT

The desired endpoint is not the fewest medicines or the most intensive treatment. It is a regimen that delivers meaningful benefit with acceptable burden and clear ownership.

WHY IT MATTERS

Pharmacists need a formal place in treatment decisions, especially where they identify interactions, cascades, duplication, and opportunities to simplify.

PRACTICE PATTERN

What pharmacists' opinions reveal beneath medication burden

The combined findings describe polypharmacy as a coordination problem before it becomes a medicine-count problem. Pharmacists are seeing risk emerge from the way separate prescriptions accumulation into one regimen that no single clinician fully owns.

This helps explain why medication burden and interactions dominate review decisions, why prescribing cascades are common, and why deprescribing stalls even when the clinical rationale for simplification is visible.

The full regimen is the unit of risk

Pattern interpretation

Pharmacists appear to judge medicines as a connected treatment system rather than as isolated prescribing decisions. Interactions, duplication, schedule complexity, and cumulative burden become visible only when the whole regimen is reviewed together.

Ownership is the hidden deprescribing barrier

Pattern interpretation

The dominance of coordination as a limiting factor suggests that deprescribing is often blocked by uncertainty about who can change a medicine, who monitors the result, and how the decision is communicated across prescribers.

Simplicity is linked to adherence and quality of life

Pattern interpretation

The emphasis on complex schedules, medication fatigue, and quality of life suggests that regimen design itself can create non-adherence. The pattern may be responding rationally to a treatment system that has become difficult to understand or sustain.

Taken together, the opinions suggest that medication optimization depends on whether the care system can reconstruct one shared treatment story. The hidden risk is fragmentation: each medicine may have a reason, while the combined regimen no longer has a clear owner, a clear priority, or a workable place in daily life.

OPEN-TEXT THEMES

What respondents added beyond the fixed choices

Respondents were asked to identify the most underestimated consequence of polypharmacy in chronic care. The themes below summarize interpretable comments about what happens when medicine burden is not recognized early.

1 **Prescribing cascades**
Several pharmacists described adverse effects being misread as new illness, leading to additional medicines and a self-reinforcing cycle.

2 **Duplicate and interacting therapies**
Comments highlighted overlapping treatment and clinically significant interactions that prescribers working without shared information.

3 **Loss of trust and disengagement**
Some respondents described patients becoming confused, losing confidence in the healthcare system, and withdrawing from their own care.

4 **Sedation, falls, and functional decline**
Additive drowsiness and other adverse effects were linked to reduced activity, fall risk, and worsening quality of life.

5 **Avoidable harm and hospital use**
Pharmacists connected medication errors, unnecessary medicines, and overlooked interactions with preventable deterioration and hospitalization.

FORWARD PERSPECTIVE

The safest regimen is the one the system can explain, own, and review

The survey shows that pharmacists see polypharmacy as a failure of coordination before it becomes a failure of any one medicine. Medicines accumulate across conditions and care settings, while responsibility for the combined regimen becomes less visible.

This is why the strongest signals are not simply about medicine counts. They are about reassessment, prescribing cascades, poorly coordinated regimens, complex schedules, and the difficulty of deprescribing when no one owns the full treatment story.

A safer model of chronic care would treat medication optimization as a recurring interdisciplinary process. Pharmacists would not only identify risk after the regimen becomes unmanageable; they would be interrogated earlier into decisions about addition, continuation, simplification, and withdrawal.

SELECTED EXTERNAL CONTEXT

1. WHO Medication Without Harm
2. WHO medication safety in polypharmacy

MDForLives

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Real Opinions. In Depth. Validated by Data.

This report combines MDForLives survey findings with carefully selected external clinical context. Survey values are presented exactly as reported.