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The Hospice Patient on 10+ Medications: A Signal, Not a Standard

Explore polypharmacy in hospice care and how to reassess medications to improve comfort and align with goals of care.

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THE SHORT ANSWER

A hospice patient on 10 or more scheduled medications is not, in itself, a red flag. In most cases it reflects appropriately initiated therapies that accumulated across multiple stages of illness, care settings, and prescribers. The key question is not whether a medication should be stopped, but why it is still being continued.

As clinical goals shift toward comfort and symptom burden becomes the primary driver of decision-making, medication regimens often persist without a corresponding shift in therapeutic intent. Medication count is a prompt to review that intent, not a performance metric.

Why does polypharmacy persist in hospice—even when it is no longer beneficial?

Three overlapping factors usually drive persistent polypharmacy in hospice:

1. Indication Inertia

Medications are continued because the original indication is not actively revisited when clinical context changes—for example, at hospice transition or with major functional decline.

2. Time-to-Benefit Mismatch

Many commonly continued therapies require months to years to demonstrate benefit, while hospice prognosis is often measured in weeks to months.

3. Physiologic Vulnerability in Advanced Illness

Changes in protein binding, renal and hepatic clearance, and CNS sensitivity increase the likelihood that previously tolerated medications now contribute disproportionately to adverse effects. As a result, a regimen may remain "technically appropriate" at the disease level while becoming misaligned at the patient–time-horizon level.

When should a medication list trigger a structured reassessment?

A list of 10 or more scheduled medications should not, on its own, be treated as a threshold of concern. It is a practical signal to perform a structured review when clinical context changes, particularly in these situations:

- Admission to hospice or transition from hospital or rehab
- Significant decline in functional status, such as a drop in PPS or increased dependency
- Re-certification periods or a documented change in trajectory
- New swallowing difficulty, reduced oral intake, or escalating caregiver burden
- Emergence of delirium, hypotension, falls, sedation, or unexplained decline
- Ongoing use of medications intended for long-term prevention rather than symptom control

These triggers are most clinically meaningful when they prompt reassessment of therapeutic intent—not just automatic continuation.

What four questions guide hospice deprescribing?

For each scheduled medication, a structured clinical reassessment can be guided by four questions:

Q1 · RELEVANCE
Is this medication treating a current symptom that is still present and relevant?

Q2 · TIMING
Is the expected benefit likely to occur within the patient's remaining life expectancy?

Q3 · BURDEN
Could it be contributing to symptom burden, such as sedation, delirium, hypotension, anticholinergic effects, or pill burden?

Q4 · INTENT
Would this medication be initiated today, given current goals of care and prognosis?

This framework shifts decision-making away from disease-based continuation and toward time-sensitive therapeutic relevance.

Which medication classes commonly persist beyond their usefulness?

Certain categories frequently persist beyond their clinical utility in hospice because their original benefit is delayed, preventive, or no longer aligned with goals of care:

- Long-horizon preventive cardiovascular therapies — lipid-lowering agents, primary-prevention antiplatelet strategies, and select antihypertensives.
- Diabetes agents for long-term prevention — therapies targeting microvascular or macrovascular outcomes, especially when glycemic targets are no longer symptom-relevant, and hypoglycemia risk outweighs benefit.
- Late-stage neurocognitive agents — where modest stabilization effects are unlikely to translate into meaningful functional benefit in advanced disease.
- CNS-active medications that add cumulative burden — sedating, anticholinergic, or dopamine-modulating therapies that may amplify delirium risk or functional decline in frailty.
- Therapies with high administration or monitoring burden — complex regimens or monitoring requirements that are disproportionate to expected benefit, particularly with declining oral intake or caregiver-dependent administration.

Across these categories, the clinical issue is rarely appropriateness at initiation—it is the absence of structured discontinuation once the therapeutic context changes.

Is deprescribing the same as removing medications?

Deprescribing in hospice is often misunderstood as simply “removing” medications. In practice, it is better understood as a reassessment of therapeutic intent in the setting of limited prognosis. This process weighs:

- The patient's current symptom burden and trajectory
- Likelihood and timing of benefit relative to prognosis
- Immediate and cumulative adverse-effect risk
- Administration complexity and caregiver capacity
- Alignment with comfort-focused goals of care

Within this framework, medication count is not a performance metric. It is a signal that the original therapeutic intent of multiple agents may not have been formally re-evaluated in light of changing clinical context.

REFRAMING THE CLINICAL DECISION

What matters is whether each medication still has a justifiable role within the patient's current time horizon, physiologic state, and goals of care—or whether it reflects a prior phase of treatment that has already passed.

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