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JUNIOR DOCTORS' PERCEPTIONS OF HOSPITAL PHARMACISTS:
A qualitative study exploring discharge summaries and medication reconciliation

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BACKGROUND

Discharge summaries, universally prepared by junior doctors, are an important communication tool between hospital and community healthcare. The process of medication reconciliation at discharge has been shown to improve accuracy of the medication lists incorporated into these summaries. Limited studies have explored doctors' collaboration with pharmacists, particularly when completing medication reconciliation and discharging patients.

AIM

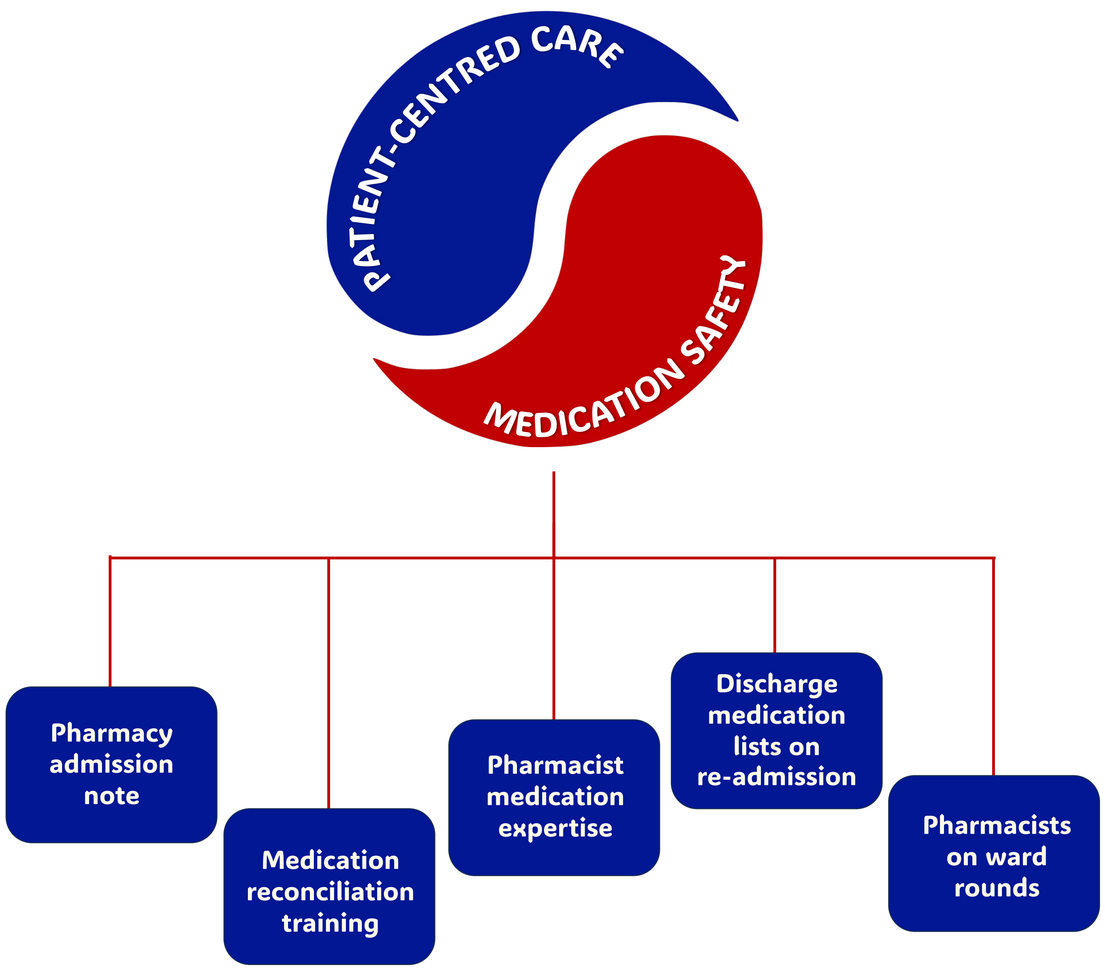
To explore junior doctors' perceptions of the processes involved in preparing discharge medication summaries and impact of hospital pharmacist involvement.

METHODS

Qualitative methodology and purposive recruitment were used to explore the opinions and experiences of 20 junior doctors (interns, residents, and registrars) across two metropolitan hospitals. Semi-structured interviews (mean length of 16.67 minutes) were conducted between 24/11/2022-15/12/2022. Interview transcripts were thematically analysed using inductive reasoning.

RESULTS

Patient-centred care and **medication safety** were identified as primary motivators influencing junior doctors during the discharge process. When discussing collaboration with pharmacists, the main themes raised by junior doctors were:



QUALITATIVE ANALYSIS

Pharmacy Admission History Note:

Early completion of a pharmacy admission and medication history was noted to facilitate accurate medication reconciliation at discharge.

"In order for us to know what the patient should be discharged on… it's important that during the admission they've had a pharmacy admission consult."

Medication reconciliation training:

Participants received **minimal training** on how to accurately complete medication reconciliation, thus pharmacists were seen to provide extensive guidance throughout the early stages of their career. An **interest in more medication education** surrounding the rational of starting and ceasing medications was raised by multiple participants.

"We should get a lot more pharmacy lectures in medical school from pharmacists. Even just on how to work with the pharmacist to safely prescribe… other people told me how helpful pharmacists can be if you reach out… having it formally explained in your training years would be really, really helpful."

Pharmacist medication expertise:

The perception that pharmacists have **extensive medicines knowledge** and experience reconciling medications meant junior doctors often depended heavily on pharmacists to perform safety checks. Many participants cited it was beneficial to have an independent health professional review medication changes to minimise errors in discharge prescriptions.

"As I worked with more and more pharmacists, I realised they knew much more than I ever did about any medication."

"I've found pharmacy to be an amazing resource, probably my best resource I've had in the hospital this year."

Discharge medication lists on re-admission:

The Discharge Medication Record (DMR) completed by pharmacists was noted by numerous participants to be *"…very useful for when patients get readmitted to hospital,"* especially when charting a patient's regular medications.

"A lot of the times the patients hold onto that list when they see their GP, if they've made any changes they add it to the list, they edit it themselves with a pen and paper. So, that's helpful for us."

Pharmacists on ward rounds:

Junior doctors largely thought having pharmacists on ward rounds would allow for more **efficient medication discussions** and immediate **resolutions of prescription errors**, as well as ensuring pharmacists are well-informed of upcoming discharges.

"Having [pharmacists] there is really efficient because any kind of discrepancies or things that needed to be changed got addressed on the round immediately."

However, the feasibility of pharmacists on ward rounds was perceived by some to be a potential problem, as participants noted that doctors tend to operate under a team-based model, with multiple medical teams rounding simultaneously.

DISCUSSION

This study highlighted the **value of pharmacists in medication safety** from junior doctors' perspectives.

1. The high reliance on pharmacists to check for errors demonstrates the importance of pharmacists in the discharge process.
2. Pharmacy admission history notes and discharge medication lists are highly valued, and should be completed as early during admission as possible.
3. Given the enthusiasm demonstrated by doctors, pharmacist presence on ward rounds should aim to be increased.
4. Education for doctors on medication reconciliation should be encouraged.