

condition.^[1,2] However, the exact causes of errors made by the most inexperienced doctors (first-year foundation trainee (FY1) trainees) has yet to be empirically explored. In particular, the role of the professional culture of medicine (the language, thought processes, styles of communication, customs and beliefs that characterise the profession of medicine^[3]) is unknown. This study (part of a larger programme of work) aimed to explore the interplay between self-reported causes of prescribing errors made by FY1 doctors and factors in their practice environments, such as some aspects of professional culture.

Method

An in-depth qualitative exploration of the causes of prescribing errors using a critical incident approach was conducted. Thirty FY1 trainees, working in 17 hospitals and who had graduated from 18 UK medical schools, were purposively selected for interview. Doctors were requested, prior to interview, to remember any prescribing errors that they had previously made. During the interview, those errors were discussed in detail. This discussion was followed by general questions regarding doctors' attitudes towards teaching and training about prescribing and the perceived safety culture of their hospital. Interviews were tape-recorded and transcribed verbatim. Data were analysed by the constant comparison method. NHS Research Ethics Committee approval was obtained.

Findings

Doctors' accounts of error, of which there were 85 reported incidents, demonstrated several aspects of professional culture which were incongruent with a 'safety culture'. Specifically, prescribing errors were sometimes perceived as 'silly errors', and respondents relied heavily on pharmacists and nurses to identify and correct errors. These 'safety nets' detected the vast majority of errors reported before they reached the patient. This behaviour appeared to arise from working within a professional culture that regarded prescribing as less important than other areas of practice. A culture was observed that facilitates a general acceptance of routine violations of prescribing rules; however, these were sometimes understandable adaptations to busy and stressful working conditions. Perhaps most worryingly, FY1 trainees avoided using reference sources when prescribing because of their perception of a medical culture in which they should be seen as expert rather than learner.

The staunch hierarchical arrangement of medical teams made it difficult for doctors to ask for help when prescribing, particularly when on-call and during surgical placements. This lack of support was discussed by many respondents and was linked directly to several prescribing errors. Participants also described errors that had arisen because they had blindly followed the instructions of a more senior doctor, demonstrating the existence of some cultural trends in which communication was inhibited by authority.

Conclusions

Although errors were often detected prior to reaching the patient, our findings pointed to the deficiencies in the safety

culture of medical practice, which were inextricably linked to the professional culture of medicine. Although there is no evidence that FY1 doctors make more errors, these findings demonstrate the need for a change in medical culture as a means to develop and strengthen the safety culture of medical workplaces.

Acknowledgements

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Session 3C: New Pharmacy Services

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Pharmacist-led management of chronic pain in primary care: patient expectations, attitudes and concerns

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Background

Chronic pain affects approximately half the population.^[1] Recovery is rare and management often unsatisfactory. Most people are managed with prescribed analgesics, but suboptimal prescribing, imperfect monitoring of repeat prescriptions and concomitant use of nonprescription medicines means that treatment is often ineffective or inefficient. The aim of an ongoing small randomised controlled trial (RCT) is to compare pharmacist medication review of patients with chronic pain with recommended changes implemented by a general practitioner and with pharmacist prescribing for patients with chronic pain. The Medical Research Council framework for development and evaluation of complex interventions^[2] emphasises the importance of identifying key components of an intervention and the feasibility of delivery before undertaking the RCT. In line with this, focus groups were conducted to explore patients' beliefs and concerns about the proposed service before finalising the intervention.

Methods

This study was reviewed and approved by North of Scotland Research Ethics Committee. Patients with chronic pain were identified using a previously used computerised search strategy of pain-related prescription records^[3] in two Grampian general practices. A random sample of 60 patients from each practice was screened by a GP, and eligible patients were invited to participate by a letter mailed by the GP. Two focus groups were conducted, one in each practice. The focus group schedule explored (1) patients' previous consultations with pharmacists, (2) methods of managing pain other than medication, (3) importance of medication, (4) views on consulting a pharmacist in the general practice for pain, (5) what should happen in a consultation with a pharmacist, (6) how a pharmacist would be able to help manage pain and (7) what patients hoped to derive from treatment. The focus groups were audiotaped, transcribed verbatim and analysed thematically, independently, by two researchers.

Results

Of 108 patients invited to participate, 13 agreed and 11 attended. Group one ($n = 7$) consisted of two men and five women aged 20–73 years. Group two ($n = 4$) consisted of one man and three women aged 66–80 years. Patients in group two knew each other. Most patients expressed positive views about the proposed intervention; pharmacists' specialist training and knowledge were acknowledged. Patients expressed an expectation that pharmacists would have more time and be better equipped to monitor and educate about medicines and their use. Concerns were expressed about seeing the pharmacist in the practice that this risk being viewed as another 'layer' in their care. A pharmacist-led service might be used as a 'quick track' option instead of seeing a GP, not as an addition to seeing a GP. The current sample in both focus groups also expressed a preference for an acute service located in a community pharmacy.

Conclusion

The opinions of these participants may not be generalisable to a wider population and are about a service they have not yet experienced. Nevertheless, the results show that patients would accept pharmacist-led pain-related medication management and prescribing, as this is the area of their expertise. Implications of the findings will be discussed in relation to development of a pharmacist-led management of chronic pain service.

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Pharmacist-led medication therapy adherence clinic: exploring views of health care professionals

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Background

Recently, hospital pharmacists have begun to offer medication therapy adherence clinics (MTACs) for patients with diabetes, asthma, human immunodeficiency virus (HIV) and few others in some public hospitals in Malaysia. We wanted to examine whether the MTAC service could be expanded to other disease management setting like tuberculosis (TB), where high level of medication adherence is required. MTAC service is a complex intervention. To better understand a complex intervention, the UK medical research council has recommended the use of qualitative methods.^[1] The aim of this study was to find out the experiences of pharmacists running the MTACs, the perceptions of other health care professionals regarding the service and the potential role of pharmacist in managing TB.

Methods

Qualitative methodology using semistructured interviews and focus group discussion were employed. This study received ethical approval from the Ministry of Health, Research and Ethics Committee (MREC), Malaysia and was conducted at a public hospital in the northern region of Malaysia. A focus group discussion was held with four pharmacists where three of them were MTAC pharmacists. Two pharmacists were offering the service to patients with diabetes and one was caring for the HIV patients; the fourth pharmacist was responsible in providing pharmaceutical care services to inpatients at the respiratory wards, which includes TB patients. Semistructured one-to-one interviews were carried out with three physicians and three nurses. Of six, one physician and one nurse had experience working with MTAC pharmacists, while the rest were from the respiratory unit. Those from the respiratory unit were recruited to have their views on the potential role of pharmacist in managing TB. All interviews and discussions were audiotaped, transcribed verbatim and analysed using NVivo (version 8). Transcripts were thematically analysed using the constant comparison approach.

Results

Pharmacists narrated their experiences of running the MTACs with enthusiasm and satisfaction. They believed that they have gained more knowledge, experience and confidence through provision of pharmaceutical care and interactions with other health care providers. The MTAC was felt to be strategically located, convenient and utilised patients' waiting time