

Effective collaboration between doctors and pharmacists

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Although greater collaboration between healthcare professions has been widely advocated, little has yet been done to improve doctor-pharmacist relationships in UK hospitals. This article suggests actions that organisations and individuals might take to promote collaboration



Close collaboration between doctors and pharmacists has been shown to improve the cost-effectiveness of prescribing

The latest buzzword in healthcare is “collaboration”. Despite its overuse and associated political spin, the premise of bringing together distinct professionals is admirable, and it presents ideals of improving service quality for patients and increasing efficiency and skills for professionals.

The Oxford English Dictionary defines the word “collaborate” as “to work jointly on an activity or project” and as “to co-operate traitorously with an enemy”. Many healthcare professionals may think of this latter definition when having to work closely with others traditionally considered a separate breed. Political and professional thinking has changed and collaboration exists at some level between groups, for example, between nursing staff and physiotherapists. Medical schools are also sending student doctors on nursing shifts to help them understand the nursing role.

It is notable, then, that the doctor-pharmacist relationship has not been

brought more to the fore. We argue that, although it may bring new terminology and new ways of working that may initially be an affront to traditional healthcare roles, collaboration will bring greater satisfaction in working on busy hospital wards and bring in a new era in patient safety.

Complementary roles

The roles of the doctor and pharmacist are complementary and it has been established that the expertise of pharmacists when channelled through a co-operative relationship with doctors has a positive impact on patient outcomes.^{1,2}

The benefits of such collaboration within the hospital environment include the taking of complete and accurate drug histories, the provision of drug information by medicines information pharmacists, the use of evidence-based prescribing, improved detection of prescribing errors and improved drug safety through careful drug level monitoring.^{2,3} Furthermore, close collaboration has been shown to improve the cost-effectiveness of prescribing.⁴

Closer interprofessional collaboration may lead to greater knowledge, skills and satisfaction for staff and a better service for patients. When teams are running efficiently patients will benefit from simple outcomes such as getting the correct medicines at the correct dosing intervals and

getting their discharge medicines in a timely fashion.

Poor doctor-pharmacist collaboration and communication may have a negative impact on the healthcare provided and the outcome for a patient,³ for example, failure to detect or communicate a prescribing issue.

Communication

It has been suggested that interprofessional communication regarding patient care could be improved, particularly in view of certain high profile cases of patient harm related directly to poor communication.⁵ Aström and colleagues found that opportunities for collaboration occur outside formal multidisciplinary team meetings in everyday informal interactions on the wards.⁵ These interactions are considered opportunistic, involving a doctor or pharmacist trying to obtain information from someone who is also responsible for the care of a patient.

However, an exchange of information does not equate to a true collaborative working relationship. Observational studies reveal that certain key components of communication can be absent from these unplanned interactions. For a successful outcome, the interaction should include self-introduction with a statement of the professional's role in relation to the patient, sharing of details of any planned interventions for the patient and then discussing the point of view of the fellow professional.⁵

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Too often, brief discussions may take place in a corridor or on the telephone after “bleeping” the doctor during his or her rest period. The wrong doctor may have been called inadvertently or the doctor may not recall the patient, or the pharmacist may be covering for a colleague, unaware of the practices of that ward or medical team.

When important conversations take place on an ad hoc basis, relying on implied or implicit information, then errors can be introduced, resulting in poor outcomes and mistrust between professionals. Healthcare is complex, with many variables potentially leading to error. Controlling communication and formally exchanging precise information controls some of these variables and thus reduces error.

— Barriers to communication

Within a busy hospital environment, there are many barriers to good communication between professionals. These include lack of access to required information or persons, time constraints (perceived or otherwise) and a lack of understanding, failure to recognise or a misconception of the role and responsibilities of other members of the team.^{5,6} Other potential barriers to effective doctor-pharmacist collaboration can relate to the professions themselves, in particular their professional isolation (“us and them”) and perceived status and power differentials from the hierarchical structure within the professions.³

The medical profession has a strong ingrained understanding of hierarchy, and recent changes in postgraduate medical training (introduced by the Government’s “Modernising medical careers” programme) have added more acronyms and job titles. The more junior medical staff may not feel they have the autonomy to make decisions with regard to drug-related questions from pharmacists and may be embarrassed by questioning on areas of which they have little or no knowledge. The fears of adverse consequences for the patient are dominant, but there is also fear of underperforming and of the response of more senior members of the medical team.

Understanding the hierarchy of medical staff is a key component to successful collaboration. However, this does not mean only discussing patients with senior doctors. Engaging junior staff early in their postgraduate training will pay dividends for future collaborative working.

— Improving communication

So how can communication and collaboration be improved? Zillich and colleagues identified certain attributes such as proximity, time, clinical knowledge, mutual

Panel 1: Communicating through patients’ notes

Medical teams communicate with each other using patients’ notes, recording findings, thoughts and actions in a standardised way. Many pharmacists do not routinely document their comments in a patient’s notes. Instead, comments are made verbally or on the drug chart, using coloured pens or repositionable notes in the hope that they will be spotted on the next ward round. There is no guarantee that these comments will be seen, read or even actioned by the doctor. This practice may increase delays in communication between doctors and pharmacists, resulting in delays in patient management or errors.

Most other healthcare professionals formally document their patient interactions and their comments. For example, nurses produce formal nursing notes and physiotherapists produce therapy notes. Furthermore, there is a trend to create “patient pathways” or proformas to streamline communication between different teams and ensure that protocols are followed for routine admissions.

Encouraging pharmacists to document their input in patients’ notes may help to ensure that information is transferred, acknowledged and acted on. Indeed, with the current change in doctors’ working shift patterns, a doctor who is given a verbal message today may not be the doctor who manages the patient tomorrow. Documentation should be legible, objective and useful to the care of the patient.

Many hospitals already encourage pharmacists to write in patients’ notes. In our experience, doctors are much more likely to record their responses to a comment made by a pharmacist formally if it is left in the notes. Therefore, a medico-legally clear chain of thought and decision-making has been made.

professional practice interests and professional equality as essential components for practitioner collaboration.¹ Ward-based pharmacy services provide a solid foundation for meeting these attributes and may help to achieve this collaborative working relationship.

This group also identified three types of variables that influence the development of a collaborative relationship — participant (personal variables), exchange characteristics (the nature of the social exchanges between the practitioners) and context (the practice environment).¹

Personal variables Although personal variables differ, training can improve them at a professional level to ensure successful collaboration.

Student doctors receive significant levels of communication training at undergraduate and postgraduate levels to improve patient-doctor communication. This also improves their professional communication skills. It would be appropriate if schools of pharmacy and medicine had formal interprofessional communication training. Structured and supported ongoing work-based assessments may also help develop such skills.

Exchange characteristics Broadly, exchange characteristics look at whether people can get on. It is therefore not surprising that exchange characteristics are identified as the dominating forces affecting doctor-pharmacist collaboration. Trust and accountability between individuals are keystones that allow good social exchanges and rapport to develop between practitioners.^{2,6-8} An individual’s ability to be persuasive can

alter how an exchange proceeds but, importantly, both parties must consider the interaction to be fair without one side being forced into an action for that exchange to be truly collaborative.

Developing trust takes time and effort on all parts. Rotations, where medical or pharmacy staff change wards on a regular basis, can make it difficult to establish trust. However, if trust exists at an organisational cultural level between departments and professional groups, then this problem can be overcome.

Practice environment The “context” or practice environment must also change to optimise collaboration; opportunistic interaction between healthcare professionals is not sufficient. Effective working and collaboration is hindered by incomplete documentation, difficulties in contacting other professionals and the lack of a standardised way of communicating in writing to ensure that any recommended action has been taken.

There is a need for a “central place” for the healthcare professionals to communicate, make requests and gather necessary feedback.⁵ This central place does not have to be a physical location, but perhaps a document, described by Aström and colleagues as an easily accessible joint communication note.⁵ This would allow for effective information transfer, patient monitoring, clarification of any interventions taking place, who is responsible for doing so and acknowledgement that key messages have been acted upon. Patients’ notes go some way towards meeting this requirement (see Panel 1).

— Ward rounds

Cheung and co-workers found that some doctors believe it would be helpful for a pharmacist to join the ward round.⁹ This represents a further change in the “context” variable. With increasing shift work among junior medical staff, the ward pharmacist is often a key factor in the continuity of patient care. The input of ward pharmacists should be maximised and their attendance on ward rounds would be a highly effective way of using their skills and knowledge, resolving issues at the time they arise.

The challenges presented by this include the ad hoc nature of some ward rounds and that others can seemingly last all day. This can be difficult to reconcile with other pharmacy-based commitments. Consultant-led ward rounds provide an educationally rewarding experience for pharmacists, particularly those studying for a postgraduate diploma, while also allowing the pharmacist to provide input to the whole medical team for the overall benefit of the patient. This also overcomes issues of discussing complex issues with junior medical staff. However, this relies on pharmacists having the confidence that their input to a ward round will be beneficial.

— Cautious implementation

Despite increasing levels of collaboration and team-working, some doctors still believe that pharmacists challenge their authority, a belief that may result in disharmony in the working relationship.⁹ Roberts and Stokes encouraged cautious implementation of interdisciplinary collaboration because rapidly imposed change can create conflict and resistance.¹⁰

The first interaction between a doctor and a pharmacist may well be one of conflict, for example, a disagreement over the doctor's prescribing or because the discharge medicines have not been prepared by the pharmacy at the point of discharge. Subsequent relationships may be affected by this and it may lead to later resistance to collaborative work.

Collaboration between pharmacists and nursing staff

Collaboration between pharmacists and nursing staff is essential to ensure drugs are administered appropriately, that ward stocks are replete and that nurses are aware of common and dangerous side effects of medicines. This is important on specialist wards such as oncology or cardiology, where errors can be costly. However, it is perhaps even more important on general wards, where collaboration between professionals can overcome deficiencies in knowledge and experience.

A phased introduction seems appropriate and will ensure that collaboration is an ethos rather than a buzzword. Interacting with and welcoming foundation doctors and other junior doctors during their induction period — or even earlier via interprofessional learning and group work between final-year medical and pharmacy students — seems an ideal way of encouraging a positive attitude towards doctor-pharmacist collaboration. Skilled communication can ensure that even the most resistant become involved with a collaborative team, especially when the benefits become evident.

— Training opportunities

Recent changes in the training and assessment of junior doctors have presented opportunities for hospital pharmacists to develop their relationship with doctors.¹¹ Education and training of junior doctors has recently become part of the formal agenda for some hospital pharmacists. In addition to interaction within the clinical setting, many trusts are now actively encouraging interaction between doctors and pharmacists off the wards via formal teaching and education. Junior doctors in some trusts have participated in a pilot scheme of pharmacist-led teaching with the end point being a written prescribing examination. Junior doctors have welcomed pharmacists to play a greater role in their continuing education.⁹ Courses in teaching techniques and how to structure lectures and group sessions are available, and in the future senior pharmacists may specialise in educational roles within the hospital setting.

Education and training of pharmacists and doctors should be a collaborative two-way approach. Doctors should offer teaching to pharmacists, which may in turn enhance pharmacists' understanding of the doctor's role, responsibility, personal accountability and actively encourage effective communication between the professions.

— Conclusion

Overall, doctors and pharmacists seek to work collaboratively with one another and wish to be respected for their skills and knowledge. Understanding of individual roles, accessibility, effective communication, trust and mutual respect are of utmost importance.

Organisations and individuals should reassess their working practices and ensure obstacles to collaboration are overcome. Professional bodies representing doctors and pharmacists should provide guidance on effective collaboration and include it as part of their good practice guidelines. Each professional should bring and express his or her own distinct expertise, thereby allowing shared care of the patient.

Effective collaboration between doctors and pharmacists is necessary to ensure optimal and safe management of the patient. The relationship between doctors and pharmacists should be further enhanced with active encouragement to interact away from the clinical setting. Reciprocal education and training is likely to enhance the understanding of each profession.

Healthcare delivery is a complex multi-step process and errors are easily introduced with potentially catastrophic consequences. Good collaboration between doctors and pharmacists should at least reduce some of these errors and improve service delivery, as well as being an educational two-way process that will continue to add value to both sets of professionals.

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