At about the same time Axon *et al* were undertaking their study,¹ we too (in August 2013) investigated clinical pharmacists' and FY1 doctors' approaches to, and beliefs about, prescribing practice and patient safety.² At our 650-bed district general hospital where an electronic prescribing and administration system had recently been introduced, we conducted a focus group with 12 Foundation Year One (FY1) doctors. We sought to explore FY1 doctors' beliefs and expectations of developing a safe prescribing practice prior to commencing their first job, and how prepared they are following their undergraduate medical training.

The questions and prompts we used to elicit responses were somewhat different to those used by Axon *et al*. We likewise identified four emerging themes from the focus group. These were: (1) Organisational—FY1 doctors had concerns about how to manage the anticipated quantity of prescriptions required under pressurised circumstances, and their unfamiliarity with the Trust's computer systems for electronic prescribing. (2) Environmental—the doctors were mindful of the hectic pace of work on the wards, anticipating multiple and simultaneous demands from staff and patients. They did not anticipate receiving any dispensation for being new to their post. (3) Information—seeking strategies for prescribing-related information—FY1 doctors would initially rely on the British National Formulary (BNF) and Trust's guidelines. The clinical pharmacist was also considered a source of technical prescribing-related information. However, where participants envisaged seeking information relating to particularly complicated scenarios, they proposed to rely on their doctor colleagues. (4) Learning to take risks—inherent risks to patients associated with prescribing is exacerbated by the FY1 doctors' lack of 'real world' experience. Undergraduate prescribing was considered to be of limited use as it was largely formulaic and unable to impart a sense of their being responsible for prescribing.

The overarching concern was less to do with the properties of medicines, but more to do with ensuring appropriateness of prescribing in the context of the individual patient. In this sense, the pharmacist's expertise as medicines specialist may offer limited support because, while they may have the detailed knowledge of medicines, they may not necessarily have the relevant clinical details of the patient. We note that in the authors' study there were instances when FY1 doctors would defer to senior doctors' recommendations. Our findings of concerns with the work environment, access to drug information, and lack of prescribing experience are consistent with other studies. It is unclear from the report by Axon *et al* if the study hospitals had electronic prescribing systems in place; systems which require appropriate training so junior doctors are familiar with the functionality of the system in order to realise the potential benefits of electronic prescribing.³

At that time we concluded that a lack of understanding of how pharmacists might work collaboratively with FY1s impedes the development of this potentially

effective relationship, while medical training in place then did not seem to include relevant exposure to the pharmacists' role and function, and prescribing responsibilities are part of a packed curriculum. The impact of the Trust's existing induction programme on prescribing practices and understanding the pharmacist's role was considered of limited use and as a result we introduced a ward-based induction by specialist pharmacists.

We agree wholeheartedly with the authors' conclusion that improved communication between FY1 doctors and pharmacists could lead to safer prescribing.

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