The Truth about Hospital Formularies, Part 1
We’ve Come a Long Way—or Have We?
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What is the meaning of the term “formulary” in a health care organization?

If you’re a pharmacist, do you think of the formulary as a continuously changing list of preferred drug products that reflects clinically proven pharmacological improvements available in the marketplace? Is it merely an administrative device for identifying drugs that can be ordered through a group-purchasing agreement? Or is it just a subset of the real formulary when you consider the frequency with which physicians prescribe “nonformulary” drugs?

If you’re a physician, do you consider a hospital formulary to be a tacit representation of the full universe of pharmaceuticals in the marketplace, even if it excludes some of the medications you prescribe on paper? Or do you view the formulary as a way for hospital administrators, pharmacists, and P&T committees to dictate your practice and control your choice of medications? Do you cringe at the mere mention of the term because you believe you can render better care with unfettered access to any medication? Do you think that a formulary is merely a hospital’s way of cutting costs?

If you’re a nurse, do you view the formulary as simply a list of all drug inventories available in the pharmacy?

If you’re the Chief Medical Officer or the Chief Executive Officer, does the formulary primarily represent a way to restrain drug costs and utilization to achieve economic goals?

If you’re a pharmaceutical manufacturer, do you consider the hospital formulary an inconvenience that can hamper and potentially nullify your drug-promotion activities?

A formulary can have numerous meanings and can evoke many different feelings, depending on a person’s point of view. Too often, the term is employed indiscriminately to suit the convenience of various individuals, organizations, or companies to describe a particular list of drugs and related medical products. Perhaps these inconsistencies represent an even bigger problem; health care professionals and the health care industry tend to downplay the most important purpose of a hospital formulary: listing the drugs of choice, as determined by their clinical efficacy and their relative safety, including adverse drug reactions, side effects, interactions, the potential for errors, and the risk of patient harm.

Most people, when they hear the word formulary, are not necessarily alluding to a drug’s efficacy and are not referring to the goal of drug safety.

Ideally, a carefully selected formulary guides clinicians in choosing the safest, most effective agents for treating specific medical problems. According to an article from 1990, however, people’s misconceptions have thwarted the full realization of this potential.1 And, as you will see, it seems that times have not changed that much!

During a three-year period from 1987 to 1989, researchers Rucker and Schiff compiled physicians’ statements pertaining to the concept of a formulary during P&T committee deliberations. Sadly, the authors found that these deliberations centered less on critical evaluations of scientific data and more on the purpose, design, and the need for a formulary per se. Rather than debate the relative merits of a drug, the formulary concept itself was often subject to review. In the end, these discussions were actually disagreements about fundamental assumptions about formularies. These conflicts occurred both within the P&T committee and with staff physicians who supported adding or deleting a particular drug. After contrasting these statements and other published misconceptions with the basic objectives and operational requirements of an effective formulary, the authors classified the remarks as common myths about formularies.

It’s been almost two decades since that article was published. Has much changed within the world of hospital formularies since then? The Institute for Safe Medication Practices (ISMP) conducted a survey describing the myths about formularies that had been initially identified by Rucker and Schiff. You might be surprised to find that some of these myths persist (e.g., the idea that the specialist always knows best or that sicker patients need more drugs) and are remarkably similar to many of your experiences today. We’ll report our findings of the survey in the September 2008 issue of P&T.

REFERENCE

The reports described in this column were received through the USP–ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the ISMP (www.ismp.org) or the USP (www.usp.org) Web site or communicated directly to ISMP by calling 1-800-FAILSAFE or via e-mail at ismpinfo@ismp.org. ■