MEDICATION ERRORS

The Truth about Hospital Formularies,
Part 2
Survey Shows Many Myths Still Exist Years Later
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This article is the second part of a two-part series. Part 1 appeared in the August 2008 issue of P&T.

Ideally, a carefully selected drug formulary guides clinicians in choosing the safest, most effective agents for treating medical problems. In 1990, however, an article by Rucker and Schiff documented that the ability to realize this potential had been thwarted by misconceptions and myths.1 Eighteen years later, many of these same myths still exist.

In a survey conducted by the Institute for Safe Medication Practices (ISMP), respondents were asked to report the frequency with which specific comments reflecting these myths had been made during formulary deliberations at their P&T committee meetings. At least 19% of the respondents encountered all 11 myths presented in the survey. In reviewing just a few of the most frequently encountered myths, we can see that formulary deliberations today appear to be centered less on the critical evaluation of scientific data and more on the misconceptions.

1. The specialist knows best. This was the most common myth encountered during P&T committee meetings. Seventy-four percent of respondents reported that they had received comments suggesting that it was presumptuous for non-specialists to play a role in formulary decisions for specialty drugs. Nineteen percent of the respondents reported receiving frequent comments along these lines, and 73% of all respondents who encountered this myth mentioned that these comments influenced their formulary decisions. Although specialists must be represented and consulted about formulary drugs within their specialty, nothing should preclude P&T committees from pursuing a thorough evaluation of each formulary request. Furthermore, safety is best evaluated by an interdiscipli- nal group of health care providers (i.e., physicians, pharmacists, and nurses) who, in collaborating with specialists, may discover otherwise unrecognized safety hazards to address before prescribing certain drugs.

2. Causal empiricism. This was the basis for another frequently encountered myth. Again, 75% reported assertions from physicians that favorable experiences, replete with personal cases or anecdotal observations, justified the addition of a new drug to the formulary, at least for a trial period for the medical staff to “evaluate” the drug. Almost three-quarters of all respondents (70%) who encountered this myth reported that the comments affected their formulary decisions. Physicians are well aware of the importance of practicing evidence-based medicine, which includes the need for randomized, blinded drug studies to prove a medication’s efficacy and safety, but they may be unprepared to treat their own favorable experiences with skepticism, sometimes relying too heavily on their own ability to evaluate a new product. Thus, they may assume that their personal clinical impressions about the product are crucial to determine the quality of drug therapy rather than relying on the P&T committee’s evaluation of available scientific evidence.

3. Sicker patients need more drugs. Most respondents (74%) and two-thirds (67%) of all respondents who encountered this myth reported that the comments had an effect on their formulary decisions. Even though most formularies include second-line alternatives for specified classes of medications, the assumption that sicker patients need more intensive pharmacotherapy or more choices among available products is warranted only if the benefits are evident. Some physicians also claim that a strictly controlled formulary can cause life-threatening delays if an alternative nonformulary drug must be obtained. However, lack of therapeutic restraint and standardized protocols that carefully explain how to handle emergencies well in advance—not the absence of a particular drug—have long been identified as major factors in iatrogenic injuries and catastrophic outcomes.

4. The formulary interferes with clinical freedom. Two-thirds of respondents (67%) cited this myth as problematic, yet the basic underlying tenets of an effective formulary include (a) acknowledging that each clinician prescribes a limited subset of available products; (b) recognizing that a formulary prepared by a group of experts and peers with adequate resources is usually better than a clinician’s personal formulary; and (3) preserving clinical freedom by providing broad therapeutic decision-making guidance, not interference with prescribing.

5. Widespread use equals the drug of choice. Almost three-quarters of respondents (72%) encountered this claim during their deliberations. Nine percent of respondents reported frequent comments that promoted adding products to the formulary because of widespread use, increased patient demand, and variations on this theme, including potential loss of competitiveness because other hospitals are using the drug. However, widespread use may be more a measure of marketing success than comparative benefits of the product, especially in view of the rapid acceptance of new drugs that ultimately proved to be potentially harmful and the inappropriate prescribing of some high-volume medications.

Perpetuation of these myths and others about formularies that were initially covered by Rucker and Schiff can be traced back to many factors, including claims continued on page 510
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from the pharmaceutical industry that formularies inhibit prescribers' knowledge of their products and restrict the freedom to use medications approved by the Food and Drug Administration. The lack of training about using formularies as a powerful patient safety/quality tool—rather than a restrictive cost-containment strategy—during medical and pharmacy training also hinders progress and allows biased, negative feelings about formularies to be reinforced. Sadly, one fact becomes clear from this survey: tapping into the enormous potential of formularies will require a marathon in health care, not a sprint.

Holding frank discussions about the formulary myths might be one giant step toward providing optimal health care for patients. Focusing attention on the basic purpose and theory of formularies by medical and nursing schools, the research community, and funding agencies may also help to identify the most appropriate role of drug formularies in society today.

**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.