between hospital visits. If any side effects occur the patient should promptly be referred back to the rheumatologist.

The specific indications for referral may thus be summarised as the three D's: disease decline; deformity; and disability (with diminishing function).

Actors get despondent when after interview they hear the familiar words, "Don't call us, we'll call you." Many patients with chronic arthritis feel the same. But much can be done for them, even in the absence of specific cures for most arthropathies. Thus the general practitioner should have a low threshold for referring his or her patients to a specialised unit.

M ANNE CHAMBERLAIN

Consultant Physician in Rehabilitation Medicine,
Leeds General Infirmary,
Leeds LS1 3EX

¹ Scott DL, Coulton BL, Chapman JH, Bacon PA, Popert AJ. The long-term effects of treating rheumatoid arthritis. *J R Coll Physicians Lond* 1983;17:79-85.

² Zinn WM. Rehabilitation of patients with chronic polyarthritis. *International Rehabilitation Medicine* 1982;4:118.

Local formularies and good patient care

There can be little argument that good treatment must be based on informed treatment, and in the context of drugs this means rational prescribing. The main problem facing the prescribing doctor is that the wide variety of drugs and medicines makes rational choice for a particular patient very difficult. This is not the only problem, however, for during the past two decades not only has the number of drugs available to doctors increased enormously but so has our understanding of the complexity of their action, interaction, and potential for adverse effect. Unfortunately, despite the recent increase in clinical pharmacology departments in teaching hospitals, undergraduate medical education is not yet uniformly preparing doctors adequately for the best use of this drug armament, and those who qualified in earlier days are all too often totally baffled—and unsure where to turn for advice.

The new *British National Formulary* provides valuable information but has certain limitations. It is not a textbook of therapeutics and so does not give detailed guidance on drug usage in individual patients. Nor does it give sufficiently specific advice on choices of drugs within particular therapeutic classes. It might be argued, however, that such advice on a national basis would be inappropriate, for drug usage varies from one geographical area to another, depending on a variety of factors.

A great deal of information on drugs and their prescribing is now provided at a local level from the 200 or so drugs and therapeutics committees throughout Britain.¹ These are composed of senior medical, pharmacy, and nursing staff, whose primary terms of reference include the development of drug policies through local formularies or recommended lists, the achievement of economy and safety in the use of drugs, the provision of information on their costs and efficacy, and the monitoring of their use and expenditure.

The use of local formularies or limited lists is often said to restrict a doctor's freedom in prescribing and would, it is said, be generally resisted by British doctors. Experience among general practitioners and hospital doctors in many

parts of Britain has shown, however, that many (and probably most) welcome positive guidance on which drugs in different groups should be considered the "best buy" for given conditions. Such guidance may be provided by drug information centres in response to specific inquiries or in the form of circulated notes, but the long experience of the late James Crooks in Tayside led him to the conclusion that the "economic and effective means of communication is through the production and adoption of local formularies."²

The success of a local formulary will depend on the extent to which there is a consensus among the doctors concerned to follow the recommendations; and this in turn usually depends on the extent to which local clinicians have been concerned in producing the recommended lists of drugs. The recommendations must have the confidence of local doctors, not only in hospitals but also in surrounding general practices, for one very important consequence of the circulation of a formulary is that it should lead to a uniformity of drug usage throughout a district—so simplifying the continuation of drug treatment when patients are admitted to, and discharged from, hospital.

Auditing the success of such local formularies is not easy, but in one London teaching hospital a survey showed that 80-90% of prescriptions for beta blocking drugs and diuretics were for the recommended drugs more than one year after circulation of the formulary.³ Other studies have shown a pronounced reduction in the range of preparations stocked in hospital pharmacies,¹ and Crooks described a 15% reduction in drug costs in the medical wards in Dundee in the first year after introduction of a formulary.² Furthermore, analysis of reports from junior medical staff suggests that such formularies have an educative role of their own, particularly where the clinical pharmacological basis of the recommendations made is briefly but clearly set out.¹

Formularies or recommended lists are not, however, usually considered to be binding on prescribing doctors, who in the last resort remain free to prescribe what they consider to be in the best interests of a particular patient. Whatever system is introduced must allow for this freedom but it should also require the doctor exercising that freedom to justify his decision to his colleagues. The formulary must also be subject to regular review and updating, and there must be a mechanism whereby an important new drug can be introduced quickly when advised by the local specialists.

Local formularies are, then, complementary to the *British National Formulary* and will remain so at least until the latter is more positive and detailed in its advice to prescribers. Even then, however, there may well be a need for local lists in particular hospitals or districts in which the presence of special clinical units influences certain therapeutic decisions in particular ways. The sensible use of formularies leads to significant economies in drug expenditure and storage space. Their prime purpose, however, must always be not economic but the improvement of patient care by more rational prescribing of drugs by doctors who have gained experience in their use.

PAUL TURNER

Professor of Clinical Pharmacology,
St Bartholomew's Hospital Medical College,
London EC1A 7BE

¹ George CF, Hands DE. Drugs and therapeutics committees and information pharmacy service: the United Kingdom. *World Development* 1983;11:229-36.

² Crooks J. Drug epidemiology and clinical pharmacology: their contribution to patient care. *Br J Clin Pharmacol* 1983;16:351-7.

³ Turner P. Talking about drugs—the role of the clinical pharmacologist. *J R Soc Med* 1982;75:77-82.