Practice formularies

Towards more rational prescribing

Most prescribing is done in general practice, where patient care is usually shared among different doctors. There are wide variations in prescribing patterns both within and among practices[1] and an ever increasing number of drugs available to choose from. The need to encourage rational, cost effective prescribing is well recognised[2 3]; the challenge now is to find ways to achieve this goal.

The idea of practice specific formularies is not new,[4] and several practices have developed them and evaluated their use.[5-9] The objectives of such formularies are to help doctors select cost effective and acceptable drugs for patients presenting with the most common illnesses seen in general practice and to encourage generic prescribing. Specialist drugs, prescribed by hospital colleagues, and new drugs, not shown to be better than cheaper alternatives, would be excluded.

Those who have developed practice formularies emphasise the educational value to all concerned. Doctors have found it useful to discuss the criteria and selection of drugs with others, including community pharmacists and clinical pharmacologists.[10] This ensures that the most useful and cost effective drugs in each category are included. Good practice formularies have now been developed by the Northern Ireland and South East Scotland faculties of the Royal College of General Practitioners (available from Dr P Reilly, Dunluce Health Centre, Belfast BT9 7HR). These were designed for easy adaptation, and clear guidelines are available on how to do this to meet individual practice requirements (Royal College of General Practitioners, in press).

For a practice formulary to work all partners in the practice need to be committed to and active in its development. Initially, formularies are of greatest value in helping doctors choose drugs for treating acute illnesses. Changing long term drugs is more difficult, but this can be done by discussion with and education of individual patients.

Regular feedback is needed if participation and continuous commitment are to be sustained. Detailed information is now regularly available and includes data on costs, type of drugs used, and the proportion of generic prescribing by each doctor. The effects of introducing a practice formulary on prescribing patterns can be readily assessed. There are other advantages, however, which are not so easy to measure. The example of the formulary can show trainees how partners may work together to reach agreed policies. Another advantage is to reduce the influence of pharmaceutical representatives and advertising, which are such powerful determinants of drug selection. Formularies must be regularly updated, a task that should be delegated to a specific doctor who will then discuss the proposed changes with the other partners.

By themselves formularies containing limited lists will not lead to more rational treatment. They should incorporate a practice consensus on indications for starting and stopping certain treatments—for example, antihypertensives, antibiotics, digoxin, oral hypoglycaemics, antidepressants, and benzodiazepines. Guidelines should also be provided on possible interactions and which side effects should be discussed with patients.

Such a formulary would provide an up to date rationale for prescribing in general practice. Although reducing drug costs is the main objective, other benefits include sharing ideas and developing joint prescribing policies. These might even lead to shared policies with local hospitals, many of which have their own internal formularies—a development that might affect the pattern of drug prescribing throughout the United Kingdom.

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Foreign bodies stuck in the rectum

The last word

If a doctor, usually a young surgical trainee, encounters a foreign body impacted in the rectum rarely can he or she resist the temptation to share the story with colleagues. Doctors encountering two such hapless patients in quick succession feel an uncontrollable desire to report on them in the medical journals, the ambitious ones embellishing the report with a review of the literature. I suspect that editors hoping to provide a little light relief are inclined to give such reports higher priority than they deserve. No one can claim that much good is done by these publications other than possibly bolstering the trainee's curriculum vitae and providing a talking point for future interviews.

If these reports do little to help the unfortunate patient or enlighten the medical profession then perhaps there should be a moratorium on such publications. Perhaps some prize should be awarded to those who have encountered many such cases and resisted the temptation to publish. I can claim only four, but I am sure that this is not a record.

Among the latest to succumb to temptation are Busch and Starling from Wisconsin.[1] They report on two men who had inserted a foreign body into the rectum for sexual gratification. One of them admitted to having performed the same act many times and called for medical help only when he could not remove it. What is perhaps indicative of the attitude of the

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