drugs: metoclopramide HCl, tranexamic acid, pheniramine maleate, and salbutamol sulphate. Therefore, these compounds can be combined with cefepime for IV infusion therapy.


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## The Formulary System Reconsidered

I read with interest the Point Counterpoint column in the April issue entitled, "Do Formularies Enhance Patient Safety?"[1,2] First, let me say that I believe this column will provide an opportunity to examine or re-examine many of our practices and perspectives, and the editorial team is to be congratulated on developing it.

The first edition of the column provides just such an opportunity. Formulary systems intended to do what Kevin Hall[1] suggests they can accomplish require major investments of resources, personnel, and systems, and even with those investments, there is no guarantee for success. Furthermore, given the dynamic nature of contemporary medical care, the formulary system needs to be responsive to new information and changes in therapy in a timely fashion—no easy task. Unfortunately, as with many complex tasks, we tend to "cherry pick" the aspects of the formulary system that we will implement, rather than offering the complete package. So one facility will do a good job of documenting allergy status, while another will perform prospective drug-use evaluations while still maintaining outdated automatic stop order policies. But rarely are all aspects of the ideal formulary system put into practice in a single institution.

Even for the aspects selected, there may be very limited supporting evidence of their effectiveness. One of our past residents assessed the effect of prescribing reservations on drug use.[3] Yes, the project was difficult, and its success and subsequent publication of the project report in *CJHP* were attributable to the efforts of the principal investigator. Nonetheless, this is the type of work that is needed to develop an evidence base. Unfortunately, papers such as these are relatively rare, to the point that Hall is left to conclude that use of formulary system for patient safety is built on "belief".

The counterargument is more convincing,[2] in part because it challenges the notion of the age-old structure, originally built with little thought of patient safety, but focusing instead on cost containment. Given that data are available to indicate that pharmacist-provided services do enhance patient safety,[4] we should deploy our staff to provide those services or evaluate our own formulary systems to enhance this evidence base. Continuing to offer and support a system based on "beliefs" reflects poorly on the profession.


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