

Mr. GORDON. All right.

Dr. McCARRON. It takes approximately 3 months between the letting of the bid and the arrival of merchandise—except in emergency situations. I would like to emphasize here that at no point is the patient's welfare jeopardized. The hospital has a system of emergency drug ordering. Any physician may obtain any drug for a specific patient if he has an adequate reason why the standard medication is not suitable. A pharmacist is on call 24 hours a day to provide this service.

By controlling the number of items stocked in the pharmacy, an adequate flow of drugs can be maintained. All orders are placed when the inventory reaches a certain level, and the pharmacist has reasonable assurance that the drug will continue to be used. Before the formulary system was instituted, we had a significant problem in drug wastage. An item would be ordered for an individual physician; by the time the drug arrived, the physician may have decided to use something else, or he may have even left the hospital. Because the drugs were not thoroughly evaluated before the order was placed, some drugs were later found to be unsatisfactory or no longer popular and were not used.

The hospital has recently implemented a program for computer control of drugs. At the present time, the pharmacist, using a typewriter computer terminal and a code system, generates a computer record of the patient's therapy and a label by generic name for all prescriptions. This information is also used for inventory control.

I would like to insert here that we have had problems when our prescriptions were not labeled by generic name. A very good example of this is hydrochlorothiazide, which is a diuretic agent that is in wide use. This drug is made by three drug companies, Hydrodiuril for Merck, Oretic from Abbott, and Esidrix from Ciba.

Because of our system of bidding, and the size of our hospital, we may have three brands of this drug in the hospital at the same time. Patients go to various clinics, and there are several conditions in which the patient would have edema, for which this type of drug would be used. The doctor in the medical clinic would order Esidrix. I am not sure of these colors. I think Esidrix is yellow.

Then the patient would go to another clinic and the doctor there would see a little edema and would give her Oretic or hydrochlorothiazide. The patient might end up with three bottles labeled with different names of drugs that were of different colors. The patient obviously thinks they are three different drugs and takes all of them. We have had patients admitted to the hospital with low potassium levels and with digitalis intoxication and all kinds of things that result from the fact that they have taken an overdose of this medicine—hydrochlorothiazide.

Now, we are trying to obviate this: one, by using generic names and having our pharmacist print the generic name on the label, so that the patient can at least see that, although the tablet colors are different, and the sizes are different, the drug is the same drug.

We have also instituted a computer method, which isn't fully operational at this date. What we would like to do is have a computer record of all the medicine that has been dispensed, and present that to the doctor when the patient comes in to the clinic. The computer record would also include any adverse drug reactions that the patient has had