My own opinion is that this action would in certain instances be detrimental to the public health. The group most directly affected would be those patients using the drugs in a therapeutic situation since restrictive controls make them less available to the consumer.

This situation is most clearly illustrated with ephedrine. In contrast to amphetamine, ephedrine is not used as an antiobesity drug, but is used mainly in the treatment of asthma to relieve spasms of the bronchioles in the lungs.

An amphetamine-like spectrum of pharmacologic effects, including euphoria, indicates that ephedrine has an abuse potential.

Ephedrine is available in small amounts in a number of over-the-counter preparations and can be purchased without a prescription.

The incidence of abuse of ephedrine is quite low and there is no evidence of danger to the public health.

Under the present circumstances, the control of ephedrine is unwarranted, especially since the major consequences would be to decrease the availability and increase the cost to patients with chronic asthma.

In conclusion, the utility and need for assessment studies to protect the public health is self-evident, especially in those instances where new agents are being introduced into therapeutics.

It is in the interest of public health that we make rational scheduling decisions to forewarn the therapist of the dangers of the drugs he may prescribe and to assist him in their rational use.

At the same time, inappropriate controls must be avoided since this would place unnecessary burdens on the patient.

Our studies with stimulants have demonstrated that drugs which are structurally dissimilar to amphetamine can produce amphetamine-like effects and have abuse potential.

A similar situation exists with substitutes for narcotics where a large number of synthetic and structurally unrelated drugs produce effects similar to morphine and heroin.

Further, drugs which are structurally similar to amphetamine do not necessarily produce amphetamine-like effects.

In this regard, we have only preliminary data on two recently introduced antiobesity agents, cloretermine and mazindol.

We have not studied phendimetrazine. Unfortunately, further data on these agents will not be obtained.

Mr. Chairman, this concludes my formal testimony. I will be pleased to answer any questions you and other members of the subcommittee may have.

Senator NELSON. We have asked all of the questions we have. Thank you very much, Doctor.

Dr. JASINSKI. Thank you very much.

Senator NELSON. Dr. Thomas M. Gellert of Huntington, N.Y. was to appear also this morning, and he has wired the committee that he would be unable to get here, so we hope to have him testify next week.

Our next witness is Dr. Barrett Scoville of Washington, D.C.

I believe he was formerly associated with the Food and Drug Administration.

Would you please identify your work with the Food and Drug Administration?