drugs. On the one hand, amphetamine, methamphetamine, phenmetrazine, and methylphenidate are recognized as having similar abuse potential and as such have been placed in Schedule II. On the other hand, a number of other appetite suppressants have not been extensively abused to date. These drugs have been placed in Schedules III or IV.

Some would argue that all drugs which have pharmacological equivalence to amphetamine should be placed in Schedule II in order to protect the public health. 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 anti-obesity 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 consequence 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