for upper respiratory infection. Fortunately only 204 of the 3,409 physicians participating in that program prescribed chloramphenicol. The problem was primarily with the 20 physicians who wrote 55 percent of the chloramphenicol prescriptions. For most of the patients who received a chloramphenicol prescription it was prescribed unwisely.(1)

It is unfortuante that the prescribing patterns of some physicians, such as those found in the Tennessee study, still persist. The trend with respect to chloramphenicol in the United States has improved significantly in the past decade. In the late 1960's, prior to important hearings by this Committee which brought the hazards of chloramphenicol use to the public's attention, the FDA certified more than 40 million grams of chloramphenicol annually. After the hearings, in the early 1970's, the figures were between 6-8 million grams annually. This is still far more than is needed for the patients for when chloramphenicol is indicated, but it does show that change is possible. Part of the improvement was due, in my opinion, to improved public understanding stemming from your Committee's hearings.

The situation that Dr. Silverman found in his study of drug promotion in Latin America is far different and far more serious and one that poses a greater hazard for the public. In his testimony today he noted:

> In Mexico and Colombia, the Parke-Davis brand marketed as Chloromycetin is promoted for use not only for life-threatening conditions but also for tonsillitis, pharynsitis, bronchitis, urinary tract infections, ulcerative colitis, pneumonia, staphylococcus infections, streptococcus infections, eye infections, yaws, and gonorrhea.