even to some extent the physician. He—the physician—wants to do something for the patient but it is particularly dangerous to give large quantities of mood-affecting drugs to patients with psychiatric, alcohol, or drug-addiction problems. But it is done commonly.

In my experience this group of hospitals has been one that stood out in my mind.

What is the medical justification for having propoxyphene on the market?

As I see it, the only justification is habit, custom, acceptance by physicians and patients.

As has been discussed, propoxyphene offers no efficacy, no more than over-the-counter preparations, but except that the over-the-counter preparations lack the "psychic" authority of prescription drugs.

Also, there is more magic in having a prescription than something which somebody obtained over-the-counter which seemingly would not be that effective or give that same effect.

It—nonprescription medication such as aspirin—is not that impressive to the patient.

I believe it is generally true the third party payees usually do not pay for aspirin, acetaminophen and the like, but they do for the prettier, more expensive, less effective propoxyphene.

Do the benefits of the drug outweigh its risks?

No. The benefits are minimal if indeed they exist. The risks are the demonstrated frequency of drug abuse, accidental combination with other central nervous system depressants, and availability to the potential suicide victim, among others.

In your experience, what is the relative abuse liability of propoxyphene and codeine?

I do not know what the abuse frequency and addiction severity would be if the two drugs were used by equal numbers and types of people at equivalent dose levels. I believe no one knows.

There is inexplicably an awareness within the medical profession of addiction potential of codeine but the proper awareness has not yet developed for propoxyphene.

The margin of safety for codeine may be greater than that of propoxyphene.

There have been hundreds of proven deaths from propoxyphene for every one documented for codeine. I see no logic in having codiene in schedule II with propoxyphene in schedule IV.

We are aware of some 200 or so of propoxyphene deaths in North Carolina during the same period of time; we have been able to identify three deaths that primarily used codeine.

Your last question, please discuss the nature and extent of DAWN deaths involving propoxyphene, including the manner of classification of these deaths as suicidal, accidental, or undetermined, and the role of toxicologic analyses of blood, liver, and tissue in determining the presence of propoxyphene and its chief metabolite.

If I may, I for one have not been impressed with the DAWN data, primarily because of its vagueness, more specifically to the term "drug related."

The definitive identification, or what to me approaches the definitive identification of a drug is not only the history of the opportunity