I anticipate it by saying, "I can see you are a bit unhappy that you have not gotten a prescription." They acknowledge that and seem to leave satisfied. I think that is very simple. I do not think it is necessary to provide the prescription just to satisfy a patient.

Additionally, consider the fact that efficacy is elusive and subtle especially when we attempt to distinguish between biologic and nonbiologic or placebo effects. Often patients conclude, ipso facto, that because they felt better the drug was effective. This operant conditioning is a powerful factor and it is difficult to dissuade a patient of such persuasion or belief.

A physician in the midst of a busy day and unaware of the dangers of propoxyphene may find it easier to prescribe the drug rather than explain that aspirin is more effective and much safer. This is deplorable, but it happens. I think it is happening to a lesser extent because physicians are more cautious in what they prescribe and patients are asking tough questions when they get prescriptions, at least that is my view of practical practice here in Washington.

For many patients, a prescription for a drug like propoxyphene seems tangible proof that their illness was seriously considered and their visit to the physician worthwhile.

A prescription for aspirin has no such connotations and even suggests the opposite. Despite much merit in the recommendation, the jokes and cartoons are about the physician saying, "take two aspirin and call me in the morning." There are no similar jokes about Darvon. Drugs like propoxyphene give pseudolegitimacy to the complaint or illness for the patient, his family, friends and coworkers in a way that aspirin does not.

Also, patients seem happier paying the doctor when a presciption is written rather than paying for a visit after being told to take two aspirin or to follow a regimen of heat, rest, and exercise.

Thus, drugs are prescribed for many reasons not all of them valid. Clearly, the physician has the final responsibility in recommending how to proceed and what drug, if any is to be prescribed based on valid medical medications and knowledge of efficacy and safety. But unfortunately, this is not always what occurs.

What I am saying is it is possible to practice good medicine without prescribing propoxyphene and many other drugs and the indications for propoxyphene are very limited.

I would in no way feel constrained in my practice of medicine by having propoxyphene available only on an investigational basis or by having it scheduled as a class II narcotic. Unfortunately, despite efforts by this committee and others to inform physicians and the public about the lack of superiority, the toxicity and the potential for abuse of propoxyphene, it probably will remain a widely prescribed and used drug unless it is rescheduled as a class I narcotic. I strongly urge that this be done.

I thank you for this opportunity to present my views as a practicing physician before this committee. I would be glad to answer any questions.

I want to take a few moments for some additional comments. First of all, I support Dr. Charles Moertel's testimony 100 percent. I can see no reason why propoxyphene needs to be available.