Dr. BEAVER. I do not have a private practice of medicine. My practice or work is involved mainly in consulting on pain problems at the University Hospital. I am the analgesic consultant at the Washington Home Hospice where we are taking care of terminal cancer patients. I have done a little private practice.

Senator BOSCHWITZ. Do you consult with the patients or the doctors?

Dr. BEAVER. Both. We do not disagree at all on what is appropriate.

I was trying to describe my insights into why physicians do the things they do, which I think is what you have also said, Dr. Newman. I am not saying one should, therefore, prescribe whatever the patients ask for.

Dr. NEWMAN. As a physician, I would say there are types of pain, such as pain related to a specific acute episode.

The issue of chronic pain is a problem where I am not persuaded that drugs are the only modality. There are a variety of modalities of managing patients with chronic pain, and drugs are not the only modality to be used there.

I am sure Dr. Beaver would agree with that. In many instances people who have taken a large number of drugs for severe pain have been able to stop using those drugs entirely by using other modalities such as biofeedback, electrical stimulation, better control of the underlying process, hypnosis, and so forth.

Very often we think if the problem is pain, a pill is necessary. That simply is not the best approach.

Senator NELSON. Yesterday, Dr. Moertel from Mayo Clinic stated the following in his last paragraph; and I would ask you if you want to comment on it:

> To summarize, I will answer specifically the four questions addressed to me when I was invited to testify before this committee.
>
> The first question, from my knowledge and experience what is the relative efficacy of Darvon as compared to other analgesics?
>
> In my judgment Darvon is inferior to the commonly marketed aspirin, acetaminophen, or APC combinations.
>
> The second question, is it possible to treat patients for pain with analgesics other than Darvon? Absolutely. For patients with mild pain you can do just as good a job, if not better, with aspirin or APAP alone, and you can do it for about one-tenth of the price. With regard to the use of Darvon combinations for the treatment of moderate pain, you can achieve significantly superior pain relief using combinations of aspirin with codeine, aspirin with oxycodone, or aspirin with pentazocine or Talwin. For the treatment of severe pain, the use of Darvon either alone or in combination is grossly inadequate treatment and is really inhumane to the patient.
>
> The third question, is it possible to maintain good medical practice without the use of Darvon? Yes. I would seriously question whether the use of Darvon is good medical practice at all. And the last question, what is the medical justification for using Darvon? I know of none.

Dr. NEWMAN. I agree with Dr. Moertel's last paragraph entirely.

Senator NELSON. Dr. Adriani, would you agree or disagree?

Dr. ADRIANI. I agree with that. That summarizes my statement.

Senator NELSON. Dr. Beaver.

Dr. BEAVER. In terms of the comparative efficacy aspect of the thing, we are in reasonable agreement as I went to considerable pains to document in my prepared testimony which is part of the record.

With regard to the aspect of combinations, I agree that those of codeine and certainly oxycodeine are likely to be more effective. In the