propoxyphene in my pharmacy receive it at much less than Lilly's wholesale cost, let alone the addition of my fee.

I would like to conclude by stating that I do not really feel that toxicity, that suicides, that misuses are really that important to the entire argument surrounding propoxyphene. I just think it is no darn good.

Senator NELSON. Thank you very much for your very thoughtful testimony. I appreciate it. I do not need to ask you to comment on Dr. Moertel's statement because you just did.

Mr. BOYNOFF. I think I just agreed.

Senator NELSON. I want to thank you all very much for taking the time to come here and present your very useful testimony on the issue on which we are conducting the hearings.

We will continue these hearings on Monday, February 5 at 10 a.m., in this room, 5110 Dirksen Office Building.

Thank you very much.

[Whereupon at 12:30 p.m., the committee recessed, to reconvene at 10 a.m. Monday, February 5, 1979.]

[The prepared statement of Mr. Boynoff follows:]

Mr. Chairman, members of the committee; I am Morris Boynoff, a community pharmacist practicing in Mendocino, California. I shall attempt to convey to you observations on propoxyphene as seen from a pharmacist's frame of reference.

My practice is located in a small, isolated coastal village 175 miles north of San Francisco. The health care community consists of twelve physicians, three dentists and two nurse practitioners. I am the only pharmacist, and because I am unwilling to diffuse my time and energy into activities not related to health matters, my pharmacy is modeled in the pattern of an office, rather than a retail store.

In the nine years I have been in Mendocino, I have been repeatedly impressed by the time spent by all practitioners attending conferences, seminars and other educational meetings in their constant efforts to remain abreast of new developments. My day to day contacts with them, the information they seek from me concerning drug actions and interactions, and their obvious concerns involved inselecting safe, effective medications for their patients allows me to exercise more decision-making judgments than most community pharmacists.

On one point we are all agreed: Propoxyphene is not a significantly useful drug.

Recalling the enthusiasm with which it was greeted when introduced as "a non-narcotic effective analgesic," it received wide use. With more and more experience, however, its limitations were perceived by many prescribers, and I find that I dispense very few propoxyphene-containing products. It seems to to be viewed as a "probably ineffectual" drug, prescribed only when discomfor seems mild and use of opiates unwarranted. Its infrequent use suggests to me that it is chosen to fulfill patient expectations in conditions judged to be self-limiting. The fact that it is almost always ordered as a mixture containing other analgesics also conveys the silent message that little trust is put in the inherent capacity of propoxyphene alone.

Another clue to a commonly held view relative to the usefulness of the drug is the fact that it has never been admitted to our Medi-Cal (Medicaid) formulary. At first it seemed to be barred because of high cost. But even with propoxyphene products now available from multiple sources at greatly reduced prices, the Medi-Cal drug advisory committee has still not added it to the formulary.

As patents on drug molecules expire, my search for reliable sources of supply at competitive costs begins. The continuing allegations made by major manufacturers that less expensive brands are not therapeutically equivalent have encouraged FDA to require bioavailability studies for many products. When results of such studies are presented, the pharmacist can make reasonable choices. Published data, combined with experience in my practice have resulted in my exclusive use of non-branded propoxyphene products.