Similarly, the propoxyphene mentions for consistently reporting medical examiners peaked in January–March 1977 at 169 and declined to 125 for the most recently analyzed period (October–December 1977).

I believe that the available data in general support the image that the profession has had of propoxyphene—an analgesic which can be useful in treating people with mild to moderate pain with a minimum of side effects and no significant toxicity unless taken in doses much larger than those recommended for medical use.

Some drug abuse will occur with any analgesic drug. It is of interest, e.g., that DAWN reports twice as many mentions in its emergency rooms for aspirin and two-thirds as many for acetaminophen, as for propoxyphene. These two OTC drugs, available to anyone without a prescription, can also, in large doses, produce organ damage and death, even without the ingestion of other drugs. Branding these OTC analgesics as an "imminent hazard", nevertheless, would be as foolish as the recommendation to do so for propoxyphene.

The concept that propoxyphene is an excessively expensive and excessively prescribed analgesic has its supporters but the proposed remedies for these putative problems would represent a dangerous and ill-advised precedent. Our medical care system should not be politicized by unscientific pressures to abolish a drug, or to impose manufacturing quotas on it whenever a group of individuals object to the extent of use and the cost of a given drug. The implications of yielding to such demands are ominous for medical care. If propoxyphene is banned today, which drug will be doomed for extinction tomorrow? Aspirin? Acetaminophen? Narcotic substitutes for propoxyphene? Valium?

It is appropriate to debate these issues, but I do not believe that a thoughtful and dispassionate analysis of propoxyphene will find it necessary to accuse the FDA or the manufacturer of either apathy or irresponsibility.

I would urge, Senator, that you exert your considerable influence to help convene meetings invovling the FDA, the DEA, the relevant scientific advisory groups for these agencies, and representatives of responsible and prestigious professional and patient groups to assess what we know about propoxyphene, to plan studies for obtaining better data on the motivations and circumstances leading to abuse from propoxyphene and other drugs, to consider the implications of encouraging the substitution of other nonnarcotic and narcotic analgesics for propoxyphene, and to study the level of information among physicians and patience as to the benefits and risks of propoxyphene and of competing analygesics, and the treatment of accidental or purposeful overdose. Such meetings could identify what educational efforts might be needed to optimize medical care for patients in pain.

Thank you for the opportunity to express these personal opinions.

Senator NELSON. Our final witness is Dr. Bryan S. Finkle, director of the center for human toxicology at the University of Utah Health Sciences Center, and assistant professor of pharmacology-toxicology and pathology.

Your statement will be presented in full in the record, together with your memo which is attached to your statement.

## STATEMENT OF DR. BRYAN S. FINKLE, DIRECTOR, CENTER FOR HUMAN TOXICOLOGY AT THE UNIVERSITY OF UTAH HEALTH SCIENCES CENTER AND ASSISTANT PROFESSOR OF PHARMACOLOGY-TOXICOLOGY AND PATHOLOGY

Dr. FINKLE. I would like to point out I have brought copies of my statement, not available earlier and I see the clerk has attended to that.

As you have said, I am Dr. Bryan S. Finkle, director of the Center for Human Toxicology at the University of Utah Health Sciences Center and assistant professor of pharmacology-toxicology and pathology.

I have been continually engaged in forensic toxicology, medico-legal investigation and clinical toxicology for some 22 years. I welcome the