interrupt with questions. The committee appreciates very much your taking the time to come here today, and your patience in waiting so long to appear before the committee.

STATEMENT OF DR. CALVIN M. KUNIN, ASSOCIATE PROFESSOR OF PREVENTIVE MEDICINE AND MEDICINE, UNIVERSITY OF VIRGINIA SCHOOL OF MEDICINE, CHARLOTTESVILLE, VA.

Dr. KUNIN. Thank you, Senator Nelson. I will begin my testimony literally from the text, and then summarize parts of it. I would appreciate it if you would interrupt from time to time, for illustrations.

Before I begin my testimony, I would like to state clearly that the views which I shall present are my own and in no way represent those of the University of Virginia School of Medicine, where I am employed.

My qualifications include the following educational background and experience: A.B., Columbia College, 1949, M.D., Cornell Medical College, 1953. Intern in medicine, the New York Hospital, 1953–54. Senior assistant surgeon, U.S. PHS assigned to the Communicable Disease Center, 1954–56. Assistant resident in medicine, Peter Bent Brigham Hospital, Boston, Mass., 1956–57. Research associate, Thorndike Memorial Laboratory, Harvard Service, Boston City Hospital working under Dr. Maxwell Finland. Assistant professor of preventive medicine and medicine, University of Virginia School of Medicine, 1959. Promoted to associate professor, 1964, and to become chairman and professor of preventive medicine, effective September 15, 1967.

I am certified by the American Board of Internal Medicine and the American Board of Microbiology.

My fields of special interest include internal medicine, infectious disease, epidemiology, and, specifically, pharmacologic aspects of antimocrobial chemotherapy. I make no pretense of being an economist or a sociologist, but will try to present my views as a clinical investigator and teacher.

You have presented me with an outline of general questions to be discussed with some latitude to present opinions on other topics and personal experiences. I will follow your outline: (1) Views concerning drugs under generic names as against brand names:

I would take very much the position of the preceding witness, in which we feel that generic names are much to be preferred in teaching brand names. This is the only way to present a systematic approach to pharmacology to the medical students.

I give some examples here of how one would use penicillins and teach these drugs with generic names, such as benzyl penicillin, aminobenzyl penicillin, phenoxymethyl penicillin, dimethoxyphenyl penicillin, oxacillin, and so forth, and then a series of different brand names which have no real relevance to the student's interest in the chemical structure, for example, what would Wycillin, Polycillin, Pen-V-K, Staphcillin, Prostaphlin and Tegopen, and many more, depending upon the names of firms selling them mean? The same could be said for tetracyline derivatives on the market now with more than 20 brand names.