Mr. CUTLER. Senator, the point we are trying to make is that the second manufacturer may be able to do as well as the first, but that you cannot prove it is as good as the first without the chemical testing. And the fact is that these brands or products are on the market and that a generic prescription for chloramphenicol might have been filed with one of these other brands. That is the heart of the matter.

Senator NELSON. The heart of the matter is, as you know, that every formulary in America uses drugs which meet USP standards and then tests them out in the hospitals. They buy generic drugs and they buy brand names. They do not clinically test them before they use them and they have had good results with them.

Mr. CUTLER. They often change as a result of their own clinical experience.

Senator NELSON. Well, anybody might do that. You do it with your products or anybody else's product. That is not really the heart of the argument.

Dr. Harry Williams of Emory University, Atlanta, Ga., and Grady Hospital testified here that—

Prior to 1960, as I said, the hospital administration had watched its drug bill rise fairly steadily from $183,901 in 1935 to $470,000 in 1959. This rise could not be accounted for by an increase in prescriptions or patient care. The surveying drug purchase policies and prescribing habits at the hospital, the new formunary committee found that, except for a very few old drugs such as aspirin, drugs were being ordered by trade names rather than generic names; there were confusing duplications of drugs that had the same therapeutic action and that the pharmacy was in chaos attempting to keep multiple trade-name equivalents of the same drug in stock. In addition, the hospital was spending as much as $50,000 yearly for drugs which had no proved useful therapeutic action.

A few examples, many could be cited. The hospital was paying $167 per thousand—these were wholesale costs—for a trade-name cortisone-type drug when a comparable generic product could be bought for $6 per thousand.

I think this is prednisone, but I am not sure.

Anyway, $167 per thousand versus $6 per thousand.

Senator NELSON. Then you did change in your formulary to the comparable $6 per 1,000 generic drug; is that correct?

Dr. WILLIAMS. Yes, we did.

Senator NELSON. And have the physicians in the hospital observed any difference in the therapeutic effect of the $6 per 1,000 versus $167 per 1,000 drug?

Dr. WILLIAMS. None whatsoever.

Mr. CUTLER. Well, Mr. Chairman, even——

Senator NELSON. Let me finish:

Those of us who had veen vaguely aware that trade named items were more expensive than non-trade-named items were nonetheless appalled when trade named items were found, as shown by the examples above, to be in many cases 20 to 30 times as expensive as their generic equivalents. Not 2, 5, or 10 percent more as might be expected in other areas of commerce, but 2,000 to 3,000 percent more.

Now, the whole record is loaded with testimony from distinguished doctors who have worked in hospitals which use a formulary. Grady Hospital did not do clinical tests on this $6 a thousand drug versus the $167 product. They tested it chemically, if anything, to see if it met USP standards, they used it, and it worked. We have heard the same story from other witnesses as well. You would have to eliminate a part of every formulary in America if you were to follow your theory.