

recommend this drug. It is, however, bacteriostatic or less rapidly active than Kanamycin.

The latter is also toxic, but is easier to control if careful attention is given to urine output and total dose. If one were clearly to enforce and follow the requirements of the package insert, that it be shown to be the only active agent, it would not be possible to use it this way because it requires much more study of the patient than can be given in these shock situations.

Now, this is one area in which I am sure one can find a good counter-argument about whether chloramphenicol should be used or whether Kanamycin should be used.

I happen to belong to the school of thought that Kanamycin is the preferable drug because it is even a little broader than chloramphenicol in its activity, that only about 85 percent of the organisms in this kind of patient will respond to chloramphenicol, and 95 percent will respond to Kanamycin in the laboratory. At the clinical level, because they are critically ill patients, only a handful actually recover, regardless of what you use, but this is still a difference based on laboratory criteria that favors Kanamycin when one has to make an empiric choice.

Unfortunately, the advertising engendered aura about the broad spectrum concept, and this has come about from a wide variety of these not only for chloramphenicol but for the tetracyclines. All these ads essentially say is if a drug kills a wide enough variety of organisms you don't really have to worry about what you have. This is the broad spectrum concept, and it has led to a wholesale use of a wide variety of these drugs, including chloramphenicol, in a variety of minor respiratory infections, in which none of these should be used.

The package insert clearly states that chloramphenicol should not be used this way, yet, because of this miseducation of earlier years, this use is still extensive. In fact, since there are few, if any, indications for this drug outside of the hospital, if the AMA recommendations are followed, it might be wise to restrict it only to hospital use.

I might dilate a little.

I would favor this method of control for several reasons. Granted, there is overuse in the hospital, and I have already documented, I believe, a considerable amount of overuse in the hospital. On the other hand, the overuse in the hospital can be studied. It can be answered progressively as many of our other problems in the hospital because the physician group in the hospital by the nature of hospital accreditation is a self-disciplining organization and it has many of the characteristics, many of the learned professions have for internal self-discipline.

Actually, we control, for instance, the frequency of cesarean sections this way, in which if a hospital upon accreditation examination is found to have twice the usual number, questions are really asked. What are the indications? What is the control in your hospital? If you don't have adequate control, you lose your accreditation.

It is an intraprofessional discipline. Now, I am sure if we restricted the use of chloramphenicol to the hospital, while it will increase paperwork, and as a hospital administrator I have always felt that some day I will be crushed in a paper avalanche, I think the paperwork in this case is worth it. I believe the paperwork would lead the Joint Com-