opinion. It was believed that their proposed additional paragraphs would weaken the labeling's public-spirited appeal to physicians to reserve the use of these drugs to the serious need for which they are so uniquely valuable. For that reason, the Bureau of Medicine did not accept the Bristol addition.

Data from the National Drug Trade Index (1966) indicates that, in spite of the relatively restrictive labeling of the semisynthetic penicillins, these drugs were being widely prescribed for respiratory diseases, etc. Furthermore, the position of the Bureau has been based on the belief that liberalizing, instead of further restricting, the indications, would be followed by even more open promotion and use of these drugs as routine agents in general office practice for the treatment of common upper and lower respiratory tract infections. This would lead to a much more widespread use than has been the case in the past and could, therefore, contribute to the probability of a more rapid development of strains of staphylococci resistant to these agents. More recently, the Bureau of Medicine has become aware of reports from Switzerland, France, and Denmark of the development of increasing numbers of methicillin-resistant strains of staphylococci. (Methicillin is another semisynthetic penicillin.)

Because of these facts and concerns, and because of the permissiveness of the labeling for several of these (semisynthetic penicillin) products, e.g., oxacillin and cloxacillin, it is the intent of the Bureau of Medicine to bring the labeling for all the semisynthetic penicillins, and other antibiotics where appropriate, into consistency with its Medical Advisory Board's recommendations, and the approved dicloxacillin labeling.

Senator NELSON. May I interrupt just a moment? If the FDA considers it important that these semisynthetics not be used in circumstances where another penicillin G or another drug is effective for the purpose of avoiding development of penicillin-resistant strains to this drug, why not make much tougher labeling than you have? Obviously, it would appear from your statement that it isn't working, it isn't persuading doctors to avoid voluntarily using it when penicillin G or other penicillin will do the job, and it is in the public interest. Why shouldn't the labeling be a whole lot tougher, and simply tell the doctor, positively, "You should not use it under these circumstances"?

Dr. MINCHEW. The extent of the restrictions which had been in the semisynthetic penicillins prior to dicloxacillin was principally just a switch statement advising the physician that he should consider switching if the organism is in fact sensitive to the other penicillins. We feel that the dicloxacillin labeling we have implemented is much tighter, and is a basic labeling which would enable us to much more rigidly restrict the promotion or more widespread promotion of the drug. We do feel the dicloxacillin represents a significant tightening.

Senator NELSON. A significant what?

Dr. MINCHEW. Tightening.

Senator NELSON. But I take it you consider it important that they not be widely used to avoid the development of a resistant strain of any kind.

Dr. MINCHEW. Yes, sir.

Senator NELSON. And that this has been, and still is, a serious problem in the hospitals around the country. If that is the case, why not much more strictly limit its use with much stronger language?

Dr. MINCHEW. Our feeling is that the dicloxacillin labeling in essence restricts it to its appropriate place and that with the dicloxacillin labeling we have placed the drug in its proper place for use, and that the labeling is strict enough to enable us to limit promotion and act if promotion is outside of these very restricted indications.

Senator NELSON. What do you do in the event that the doctors