The peril in the debate now raging is that the generic case will be overstated in the consuming zeal of its advocates, and the public will be convinced that *price* is the primary consideration in the choice of drugs. *This is wrong and it is dangerous!* Quality must remain the paramount consideration if people are to continue to receive the maximum benefits from a system that produces the best, the safest and the most effective drugs in the world. And quality must continue to be recognized in the market place if the system is to remain strong and creative.

If the aim is to grind all drug manufacturing firms down to the lowest common denominator, which I cannot believe, there will be no incentive to excel, no motivation (indeed, no resources) for discovery, and we will begin an unprecedented process of medical retrogression in this country. There can be no other result.

On the question of the price of drugs, about which so much has been said in hearings, let me first point out that this is by far the smallest part of the cost of sickness. Moreover, I believe figures from government sources have been placed before you, showing that this is the one element of health care expenses which has declined in recent years—both as to the prices of drugs themselves and the proportion of the total bill for a sickness which they represent. It is a remarkable record in this inflationary period when the prices of virtually all other commodities have been rising steadily.

It should also be remembered that the efficacy of modern drugs has reduced the average length of stay in hospitals, as has been demonstrated in testimony before you, and thus has helped to *reduce* hospital costs to the patient.

However, I do not want to be misunderstood on this point. Let me state categorically, no physician should overlook the opportunity to prescribe a drug costing less if there is no risk to the patient's health or if it makes no difference in the therapy of the patient.

The AMA, on at least three occasions including the period when I was president of the Association, adopted resolutions urging physicians to supplement their medical judgment with cost considerations when prescribing for their patients. I am heartily in accord with that position and, I might add, it is a rule of professional conduct I have followed throughout my career. I am no stranger to practice among people of limited means.

The memory of some of my earliest experiences as a doctor has been awakened by this controversy, involving, as it does, the attempt to institute government control over the prescribing of drugs for the elderly and financially unfortunate.

I came out of medical school and completed my internship in the depths of the Depression. As a member of the Dubuque County Medical Society, I agreed to do my part in the community to help care for the needy. Accordingly, I received a list of the drugs that could be prescribed for the so-called county patients and for which the county would pay from its slender resources of the time.

That was more than 30 years ago; yet the system was strangely similar to the legislation which was proposed last year on a national scale for millions of beneficiaries of federally-financed health programs, proving. I suppose, that there is really nothing new under the sun!

I had, as I have noted, just finished my internship and supposedly was in command of the pharmacology of the day. But, when I looked at the list of drugs for welfare patients, I found to my dismay that I was not familiar with half of them. My inquiries disclosed that many dated from before I had started medical school and by then were largely obsolete. I was, I realized, unable to use the knowledge I had gained as a medical student if I were to prescribe from this list which was the only way my welfare patients could have free drugs.

There was no choice for me. I had to confide my dilemma to the patients and explain that I could not write a suitable prescription in a great number of cases. How well I remember their answer, which I heard—not once or twice, but time after time, "Okay, Doctor, give us the prescription which you think is the best and we will get the money to pay for it."

The attitude of those people made a lasting impression on me. More than any other experience which I have had, it led to the formulation of beliefs which I hold very strongly to this day: *No man* in his illness and misfortune should be treated as *second class.*

No one insulated in a government bureau from contact with human need and suffering should have the authority in this day and age to tell those who are devoting their lives to the treatment of disease what they can or cannot prescribe for any patient; particularly for the most pathetic group of patients