As I said, I read this letter, I take this into my consideration, but again I have to make my own decisions based upon the situation as it arises daily in my office.

Senator NELSON. Thank you.

Dr. HAGOOD. May I proceed?

Senator NELSON. Yes, sir.

Dr. HAGOOD. I suspect they are not entirely unique in this regard; I imagine practical politicians feel the same way toward those proud theoreticians of political science who make profound analyses of politics but who have never actually taken the risk of running for office.

What I am saying, gentlemen, is there is a whole ranges of sources of information, impressions, and advice operating side by side with commercial sources. To pretend the doctor has only drug companies' opinions to look at is to ignore reality. The fact is we have a great many communication channels, all of them of value, and none of them unleavened by others. So long as drug therapy is heavily subject to professional judgment rather than solely to hard science, this multichannel approach will be the best one overall. The last thing we need now and in the future is a monolithic concept of therapy, which says this drug, in this patient, in this dosage, is the alpha and the omega of therapy. That approach, I am positive, has no basis in either medicine or science.

Senator NELSON. May I interrupt for a moment?

Dr. HAGOOD. Yes, sir.

Senator NELSON. I don't think anybody before this committee has suggested one monolithic approach. Do you know of any?

Dr. HAGOOD. No; I do not and I certainly hope its does not arise.

Senator NELSON. Thank you.

Dr. HAGOOD. This leads me—may I proceed?

Senator NELSON. Yes, sir.

Dr. HAGOOD. This leads me to comment on the concept of a single drug compendium, that has been discussed before this Subcommittee. We have, of course, the Physicians' Desk Reference, and I must say that book, as good as it is, is becoming a bit large for my desk. It is not perfect, but I find it outrageous it is condemned because it is "just advertising" as some have said. Of course, the material in it is paid for by drug companies. But what of that? Currently, meaning 1969, isn't every syllable in it written in conformance with labeling requirements of the Food and Drug Administration? Where can you show me evidence entries violate FDA-approved descriptions of drugs? Surely, if any do, FDA has ample power to correct the matter. But on what basis is the PDR to be brushed aside?

Gentlemen, I am not here to glorify that book, or any other. But I will tell you this; the current edition of PDR has an estimated circulation of 450,000. That is 318,500 more than the combined estimated circulation of this country's three official compendia of standards; U.S. Pharmacopeia, National Formulary, and Homeopathic Pharmacopeia of the United States. That book, the PDR, is one doctors use more than any other. Take that one away, and you will have removed a working reference. Is it inadequate? Fix it. Is it incomplete? Expand it. But look at it. It now contains entries on nearly 2,600 drugs. It is now 1,415 pages long, 2 inches thick, and weighs 3 pounds, 9½ ounces. Yes, I weighed the 23d edition on my baby scales when it was delivered