busy physician to learn more about the drugs he is using. And this is the heart of the problem. As I said, I feel that most physicians practice rational medicine. As a group they are intelligent, empathetic individuals, dedicated to the welfare of their patients. And I think we are speaking of a noisy but certainly an important minority.

In this same breath, I feel obliged to emphasize that effective drug therapy represents only one facet of the problem of postgraduate medical education in the United States. Admittedly, a proper knowledge of drugs is terribly important, but what about information about new diagnostic techniques, new physiologic principles, even new diseases and syndromes. The proliferation of medical information is not confined to therapeutics alone. If one were to solve this far broader problem of total continuing medical education, the enlightened use of therapeutic agents would fall into place.

Now, several months ago, in my column "Tomes and Tangents," which I write each month for the journal, Medical Opinion and Review, I outlined such a plan for continuing postgraduate medical education which I consider practical and feasible.

Mr. CUTLER. I was just wondering, would the availability of the price information be helpful to the physician on drugs?

Dr. MOSER. I don't quite understand—in what context?

Mr. CUTLER. In the context of prescribing medicines in the hospital, if he knew the cost of the individual drugs, price of one drug as opposed to another.

Dr. MOSER. Are we talking about physicians in the hospital or outside of the hospitals?

Mr. CUTLER. In either instance.

Dr. MOSER. I think it would be a factor, but I don't think it would be the sole factor. I think the most important thing that makes a doctor select a drug is will that drug work for him.

Now, if you show me two drugs; one is cheaper than the one I use now, better, and you can prove to me that the cheaper drug is just as good as the other, I will certainly switch. But if you come and say that these drugs are the same, but you cannot document this to me, I will not go for the cheaper drug. And I think this is common sense.

Senator NELSON. Your hospital has a formulary, doesn't it?

Dr. MOSER. Yes.

Senator NELSON. And you have a formulary committee and your hospital buys drugs on bids, I take it.

Dr. MOSER. Yes.

Senator NELSON. So that answers the question raised by minority counsel in the sense of cost to the patient, because all, I think all of the leading hospitals that use a formulary, have their own pharmacist and pharmacologist and their own clinical experience to draw upon and decide whether or not they are therapeutically equivalent and then accept the bids. And they may very well select the lowest bid or will select it, I assume, if they decide it is equivalent to all the rest of them.

I think the question raised by minority counsel refers to the fact that a practicing physician who isn't practicing with the use of a formulary in a hospital doesn't have that advantage. He does not know what the price is probably, or doesn't have the backup of a formularly committee that has evaluated the use of the drug.