one of the biggest shotguns of them all. As I said in my statement of 1960: "Too many physicians, pressed for time, would like to believe that medicine can be practiced with a clinical thermometer and a bottle of pills."

There is nothing new or unique in this description of irrational prescribing. As far back as 1953 Dr. Maxwell Finland, an eminent authority on antibiotics, dealt with the problem in a scientific paper. Under the heading "Omnibiotics" Dr. Finland said: "The physician in practice, and many of his patients as well, are constantly on the lookout for some simple substance or formula which they can apply with universal success. The busy practitioner is particularly desirous of having some major weapon on which he can always rely to be successful in all types of infections, and would thus relieve him of the responsibility and trouble involved in the complicated or even simple diagnostic procedures" ("Humphrey Hearings" p. 1507).

In addition to precision in diagnosis (and treatment), medical schools also teach the painful and anxiety provoking process of watchful waiting when the diagnosis is not clear and a laissez faire attitude when the complaint is not serious. Watchful waiting does provoke anxiety and requires much more continuous attention to the patient's changing condition. Laissez faire leads many patients to object because they feel their complaint has not been taken seriously. In either case, only too often, the physician feels compelled to write a prescription, even though the prescription does more good for his anxiety or his convenience than it does for the patient's illness. It also exposes the patient to the additional hazard of drug induced illness which may or may not obscure the underlying cause of the original illness, and may or may not make the cure worse than the disease.

Because it feels that rational prescribing and sound medical practice cannot be legislated, the Task Force leans heavily on education, at both the medical school and the post-doctoral levels, for a partial solution of the problem. While I cannot gainsay the value of education I am dubious about the effectiveness of physician education in this particular area. I am forced to ask the question I asked in 1960. Since it is a long one, I will paraphrase it. Is it reasonable, I asked, to expect legitimate education to compete with modern methods of advertising and promoting drugs? My answer was then, and still is, an unqualified no. Education is not enough and I believe the experience with chloramphenicol, among other drugs, proves it. I agree that rational prescribing and sound medical practice cannot be legislated. We can, however, enforce legislation that exists and consider new legislation, if necessary, to choke off at least part of irrational prescribing and thereby contribute to sound medical practice.

The irrational use of drugs has at least two facets. On one hand we must deal with single drug entities which have specific but limited use and, while they may be irrationally prescribed, are still the drugs of choice in some disorders. Chloramphenicol and penicillin are examples of drugs that have specific uses but are often improperly prescribed for disorders for which they are not indicated. On the other hand, we have irrational combinations of drugs which serve only to encourage irrational prescribing. If the use of these drugs were limited to those occasional cases where they might by stretching reason, be indicated they would wither on the vine and their sale would become unprofitable. Invariably the purpose of these drugs can be served equally or better by prescribing the ingredients separately in those rare cases where more than one drug is indicated. Antibiotic containing cold preparations and the combination of amphotericin B with tetracycline are examples of combinations in this category. We cannot ban products in the first category. We will have to accept the mususe and abuse of these drugs until education or publicity or both reduce such improper use. We should, however, ban the marketing of irrational combinations even if it requires new legislation. We probably will have to interfere with the privilege of the medical profession arrogates to itself but rational prescribing and sound medical practice must take precedence over the AMA's the PMA's or the individual physician's concept of privilege.

Naturally it woul be preferable if the medical profession policed itself. If the AMA could cure itself of its phobia over government control it could serve a useful purpose in contributing to sound medical practice. So long as it adopts astonishing postures it invites regulatory control. Experience has demonstrated that the AMA is phobic and that neither the drug industry nor a considerable segment of the medical profession is prepared to police itself. Actually the AMA and the medical profession should serve as the first line of reserves behind the FDA in the battle to curb the excesses of the drug industry. Instead of supporting the FDA, the AMA and a segment of the medical profession have joined