Again, as I understand Dr. Goddard's suggestions, Therapeutic Committees would review the doctor's prescribing habits just as Tissue Committees review his surgical habits. The task will be much more difficult than reviewing pathological reports on organs but just as the uterus and the appendix are prime targets for Tissue Committees certain prescribing habits would similarly become prime targets of Therapeutic Committees.

There is another suggestion made first (I believe) by Dr. Barbara Moulton who was formerly with the FDA. Dr. Moulton suggested a special category for drugs that were hazardous and tended to be over-prescribed. She suggested that a prescription for such a drug would not be permitted without the approval of a consultant. I believe the idea has merit and should be given further consideration.

The FDA should be given authority to form a category of "Dangerous Drugs". Supplies and prescriptions for these drugs would be handled in the manner that now holds for narcotics. These would be target areas for Therapeutic Committees but could also be spot checked by FDA inspectors. Since it is impossible to anticipate every contingency I would not insist on a consultation and allow emergency prescription when approval by a consultant or by a Therapeutic Committee would, because of time involved, not be in the best interests of the patient. The doctor should know, however, that when he prescribes such a drug in an emergency and without approval, he may, if he cannot justify its emergency use, expose himself to censure, loss of hospital privileges, or in cases of repeated offenses, suspension of his license.

Offhand I think of only two drugs I would place in that category, chloramphenicol and tranylcypromine (Parnate). There probably are others and there certainly will be others in the future. I am dubious about the possibility that the medical profession would adopt this method of self regulation voluntarily and it is possible that irrational prescribing will have to become a *cause celebre* and that publicity might force its adoption. If Congress gave the FDA authority to form a category of "Dangerous Drugs" the remaining steps would almost certainly have to follow.

In summary, irrational prescribing can be reduced by legislation requiring that a drug combination be rational as well as safe and effective; by steps that would lead to the formation of Therapeutic Committees, by the creation of a class of "Dangerous Drugs", and by publicity, publicity, and more publicity.

Question. What are your feelings regarding a Compendium?

Answer. I know that the Committee and the FDA are enthusiastic about a compendium. I wish I could share the enthusiasm. The tenor of my prepared statement makes it clear that I would favor anything that leads to more scientific practice of therapeutics and takes the black magic out of medical practice. A compendium would be a step in the right direction. The task of preparing it would be monumental, and it would have to be encyclopedic in scope.

My doubts are raised not by its scientific value but by the reception it would get from the average practitioner who needs it most. Like the Medical Letter it would be used by those who are already skeptical and have less need for it.

I enclose a clipping from *Medical World News* dated January 31, 1969 and which I have marked as Exhibit #7. When the President of the American Academy of General Practice was asked about the compendium his reply (according to MWN) was he "* * * would not want a new drug compendium to be put out by the government because it would be 'garbaged up' by all the material the FDA requires". It is difficult to determine how one should respond to this statement of principle. We can hope that it expresses the views of an individual rather than the official views of the Academy over which he presides. The hope is probably a vain one since a negative response to a compendium is essentially the party line handed down by the PMA and the AMA, and is the response one should expect if he has any knowledge of the thinking of the average practitioner.

Probably the greatest fault of the average practitioner is his inability to understand and to admit the limits of his own competence. The secure physician who is confident about the knowledge he does have is much more ready to admit that he does not know everything, and that there are areas where he needs help. Such physicians would probably welcome a compendium that would help them to find their way through the drug jungle.

As the average practitioner becomes more hurried, more harried, and more confused, the gap between what he does know and what he does not know widens and his inability to admit the existence of such a gap increases. An admission that he does need a drug compendium becomes a tacit admission that up to this time he has been groping in the dark.