ure, we have to have some controls for the former as we still do for the latter, even though we have abandoned the prohibition laws. We shall need rules as to prescription, as to distribution, as to conditions of use, and the like, for psychotropic drugs. But such rules should be formulated within the context of a social-medical policy, not a police-punitive one. And such rules should be accompanied by the kind of rational education in the uses and dangers of psychotropic drugs—education, incidentally, for both doctors and users—that is so often replaced by the "scare-'em-to-hell" education of the police-punitive approach.

My last point, do doctors overprescribe psychotropic drugs?

In pursuit of good health to function well in their activistic society, Americans go to get help from their doctors. Recently, as we have seen, a larger part of this help has taken the form of prescriptions for tranquilizers. There has been some criticism, often from doctors themselves, that much of this prescribing of tranquilizers is unnecessary; there is the charge that doctors are overprescribing the psychotropic drugs.

Unfortunately, there probably is something to this charge. But we need to understand why some doctors do overprescribe before we can suggest remedies for the problem. Overprescription, it seems to me, does not result from casual carelessness or incompetence but from something that lies deeper in the situation of medical practice.

An observant doctor is once said to have remarked that, until about 50 years ago, the average patient with the average disease consulting the average physician had only a 50–50 chance of getting some help from him. In the period since then, the amount of help that the average doctor can give his average patient has increased enormously. New drugs and other new therapeutic techniques have greatly increased the control that the physician has over ill health, both physiological and psychological. Nonetheless, there remains a great deal of uncertainty and lack of control in the situation with regard to both diagnosis and treatment that the average doctor faces every day.

This uncertainty and lack of control, which we easily tend to forget, were interestingly revealed in a little study which one practitioner made of his own prescribing patterns. We do not know how representative these data are, but my guess is that they are fairly representative. This practitioner kept a record of his prescriptions for a period of 4 months. For each prescription he made an estimation of therapeutic intent, or what he felt was the degree of his certainty and control. His five categories of prescribing intent, with examples, are as follows: Specific (insulin in diabetes), probable (antibiotics in infections), possible (corticosteroids in bronchial asthma), hopeful (mixed corticosteroids and tranquilizers), I take it for the same disease, and placebo (any preparation given with the intention of relieving mental stress and which the prescriber believes possesses minimal pharmacological activity). The results are shown in the accompanying table:

Intention, specific, (number) 44, (percentage) 7.55; intention, probable, (number) 87, (percentage) 15.03; intention, possible, (number) 149, (percentage) 25.69; intention, hopeful, (number) 124, (percentage) 21.38; intention, placebo, (number) 176, (percentage) 30.35; total (number) 580, (percentage) 100.