But if he is convinced it is useful and TAB feels it is probably useful, it may very well be put in the formulary. Now, many of these drugs that were put in the formulary by therapeutics agent board action, at the time they were put in there probably the consensus of medical people in the country would have been that they were useful. It is a considerable amount of time later now that the——

Senator NELSON. Which drugs are you talking about.

Colonel MCCABE. Many drugs that are now being claimed ineffective, when they were originally put on the drug list were probably considered effective.

Senator NELSON. Well, let's take a look at the biggest, most dramatic case of all, and that is the fixed combination antibiotics. The best authorities in the country were saying for the past 15 years, "It is bad medical practice to use fixed combination drugs," and that was the standard of the top medical experts in the country, in the teaching hospitals and the clinicians and the pharmacologists, and yet physicians continued right on using it.

Colonel MCCABE. That is correct.

Senator NELSON. So those were not considered by the best experts to have been the most effective drugs.

Colonel MCCABE. Another reason for the use of drugs is widespread use. In other words, if there is a large number of physicians who feel the drug is effective, that in and of itself is indication for use, perhaps. In addition to which, if these drugs are ineffective in fixed combination for the indication given, that doesn't mean the drug per se is an ineffective drug. It is just acknowledgement of the fact that when you use two drugs, you should use them, if you use them together, as individual drugs with their own dosage rather than just put them together in a fixed dosage.

Senator NELSON. Correct. But the problem of the fixed combinations was that they were not more effective than one of their ingredients, making other ingredients unnecessary and in the case of Panalba, some tests showed that the effect was antagonistic. Why expose a patient to two drugs when one will do the job.

By that test, the NAS–NRC was saying it was ineffective. They didn't mean to say that if you give somebody tetracycline and novobiocin in a fixed combination it might not affect the target organism. It probably would. But you were at the same time exposing the same patient to sensitizing with a drug he didn't need. It was not more effective than tetracycline alone.

But what I am saying is that all through the years the standard in the profession was you shouldn't use fixed combinations. But aren't we talking about something here that is kind of a mythology? We say the doctors are the ones who have to make that judgment about the drugs and that they are qualified to do so.

I have kept you past 12 o'clock, but I just want to read into the record from the HEW Task Force on Prescription Drugs and what they say on this issue we are now discussing is quite dramatic—page 26.

The Task Force said:

> Finally, it is assumed that he [the doctor] has the training, experience, and time to weigh the claims and available evidence, and thus to make the proper selections.