COMPETITIVE PROBLEMS IN THE DRUG INDUSTRY

HEARINGS

BEFORE THE

SUBCOMMITTEE ON MONOPOLY

OF THE

SELECT COMMITTEE ON SMALL BUSINESS

UNITED STATES SENATE

NINETY-FIRST CONGRESS

FIRST SESSION

ON

PRESENT STATUS OF COMPETITION IN THE PHARMACEUTICAL INDUSTRY

PART 13

JULY 16, 29, 30, AND OCTOBER 27, 1969

PSYCHOTROPIC DRUGS

Printed for the use of the Select Committee on Small Business

COMPETITIVE PROBLEMS IN THE DRUG INDUSTRY

HEARINGS

BEFORE THE

SUBCOMMITTEE ON MONOPOLY

OF THE

SELECT COMMITTEE ON SMALL BUSINESS

UNITED STATES SENATE

NINETY-FIRST CONGRESS

FIRST SESSION

ON

PRESENT STATUS OF COMPETITION IN THE PHARMACEUTICAL INDUSTRY

PART 13

JULY 16, 29, 30, AND OCTOBER 27, 1969

PSYCHOTROPIC DRUGS

Printed for the use of the Select Committee on Small Business

COMPETITIVE PROBLEMS IN THE DRUG INDUSTRY

HEARINGS

BEFORE THE

SUBCOMMITTEE ON MONOPOLY

OF THE

SELECT COMMITTEE ON SMALL BUSINESS

UNITED STATES SENATE

NINETY-FIRST CONGRESS

FIRST SESSION

ON

PRESENT STATUS OF COMPETITION IN THE PHARMACEUTICAL INDUSTRY

JULY 16, 29, 30, AND OCTOBER 27, 1969

PART 13

PSYCHOTROPIC DRUGS

Printed for the use of the Select Committee on Small Business

U.S. GOVERNMENT PRINTING OFFICE

81-280 WASHINGTON : 1969

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $1

SELECT COMMITTEE ON SMALL BUSINESS

[Created pursuant to S. Res. 58, 81st Cong.]

ALAN BIBLE, Nevada, *Chairman*

JOHN SPARKMAN, Alabama	JACOB K. JAVITS, New York
RUSSELL B. LONG, Louisiana	PETER H. DOMINICK, Colorado
JENNINGS RANDOLPH, West Virginia	HOWARD H. BAKER, JR., Tennessee
HARRISON A. WILLIAMS, JR., New Jersey	MARK O. HATFIELD, Oregon
GAYLORD NELSON, Wisconsin	ROBERT DOLE, Kansas
JOSEPH M. MONTOYA, New Mexico	MARLOW W. COOK, Kentucky
FRED R. HARRIS, Oklahoma	TED STEVENS, Alaska
THOMAS J. McINTYRE, New Hampshire	
MIKE GRAVEL, Alaska	

CHESTER H. SMITH, *Staff Director and General Counsel*
JAMES P. DUFFY III, *Minority Counsel*

SUBCOMMITTEE ON MONOPOLY

GAYLORD NELSON, Wisconsin, *Chairman*

JOHN SPARKMAN, Alabama	MARK O. HATFIELD, Oregon
RUSSELL B. LONG, Louisiana	ROBERT DOLE, Kansas
THOMAS J. McINTYRE, New Hampshire	MARLOW W. COOK, Kentucky
ALAN BIBLE,* Nevada	JACOB K. JAVITS,* New York

BENJAMIN GORDON, *Staff Economist*
ELAINE C. DYE, *Clerical Assistant*

---

*Ex officio member.

CONTENTS

EXHIBITS

COMPETITIVE PROBLEMS IN THE DRUG INDUSTRY

MONDAY, OCTOBER 27, 1969

UNITED STATES SENATE,
MONOPOLY SUBCOMMITTEE OF THE
SELECT COMMITTEE ON SMALL BUSINESS,
Washington, D.C.

The subcommittee met, pursuant to recess, at 10:05 a.m., in room 318, Old Senate Office Building, Senator Gaylord Nelson (chairman of the subcommittee), presiding.

Present: Senators Nelson, Javits, and Dole.

Also present: Chester H. Smith, staff director and general counsel; Benjamin Gordon, staff economist; Elaine C. Dye, clerical assistant; and James P. Duffy III, minority counsel.

Senator NELSON. The subcommittee will open its hearings. We are pleased today to welcome Dr. Margaret Mead. Senator Javits, Dr. Mead is a very distinguished constituent of yours, and I know that you wish to welcome her here today.

Senator JAVITS. Thank you, Mr. Chairman.

I just wish to note that we all know Dr. Mead as one of the most distinguished anthropologists in our country. New York has a very special interest in Dr. Mead as she is, I just wish to spread this on the record, the curator emeritus of ethnology, the Museum of Natural History which is in New York City. She is adjunct professor of anthropology at Columbia also of New York City, and chairman of the Department of Social Sciences at Fordham also New York City, and we naturally take great pride in her eminence and the tremendous contribution she makes to the Nation and the world through her scientific work in these very distinguished institutions. Thank you, Mr. Chairman.

Senator NELSON. Thank you, Senator Javits.

The committee welcomes you here today, Dr. Mead.

The question has been raised before this subcommittee by medical authorities that psychotropic drugs and especially tranquilizers are being overprescribed.

Dr. Fritz Freyhan of St. Vincent's Hospital of New York stated before this subcommittee that:

> It is, of course, no secret that overuse of drugs, not just psychoactive drugs, represents a perplexing problem in contemporary medicine. Depending on orientation, bias and vested-interests, the blame tends to be ascribed to our culture, to professional attitudes and to the promotional influence of the commercial interests of the pharmaceutical industry.

The highly authorative Medical Letter of October 3, 1969, in discussing two well-known tranquilizers stated that:

> . . . there are no reliable figures on the number that do take them, but it is known that few drugs of any class are prescribed more often. Many drugs are vastly over-prescribed and that a great number of persons are being led into unhealthy and costly drug dependence by physicians' too ready acceptance of the therapeutic advice given by a not-disinterested manufacturer.

Dr. Richard Pillard of Boston University stated that he sees advertising of these drugs as:

> . . . part of a trend to suggest the use, both of antidepressants and tranquilizers not only for specific mental illness, but to soothe life's ordinary woes.

He also asks the question whether it is healthy "for people to be reacting to or chemically protected from those emotions which are an inevitable part of a full and normal life."

Dr. Daniel Freedman of the University of Chicago told the subcommittee:

> One thing, I think, we do know in psychiatry is that grief is very important to normal experience, and that stunted emotional working through of these problems, can lead to a serious psychiatric problem. In general we think in psychiatry that trying to meet the challenges, the ups and downs of life, are important to development.

These are opinions of the possible effect of widespread use of psychotropic drugs on individuals. But how about the effect on our society and on our culture? Is there anything we can learn from the past or is this a new phenomenon?

I am sure that Dr. Mead, the world renowned anthropologist and student of comparative cultures, will make an important contribution to our thinking in this field.

Dr. Mead, we are very pleased that you have been willing to take the time from your very busy schedule to come down here and discuss your ideas about the area of interest in which this committee is now conducting hearings. Your statement, which is entitled "Excerpts From Testimony," will be printed in the record. You may proceed to make your observations by reading it or speaking extemporaneously, however you desire.

STATEMENT OF MARGARET MEAD, CURATOR EMERITUS OF ETHNOLOGY, THE AMERICAN MUSEUM OF NATURAL HISTORY AND ADJUNCT PROFESSOR OF ANTHROPOLOGY, COLUMBIA UNIVERSITY

Dr. MEAD. Well, Mr. Senator, I will state very briefly some of my specific competencies to talk about this problem. I have been for several years visiting professor of anthropology in the school of psychiatry at the Menninger Foundation, and I have been for the last 10 years, visiting professor of anthropology in the department of psychiatry of the University of Cincinnati College of Medicine, so I have been working quite closely with medical departments that were concerned with drugs, and specifically with the use of psychotropic drugs. I was president of the World Federation for Mental Health in 1956, and I was a member for 7 years of the group who evaluated research for the

National Institute of Mental Health. During World War II, as secretary of the Committee on Food Habits of the National Research Council, I developed the relationship between the human sciences and the field of nutrition. I have also had some experience with the field of the specific traning given to detail men, by pharmaceutical companies, and with the relationship between Government and industrial practice as chairman, 1967–69, of the Committee on Science in the Promotion of Human Welfare of the American Association for the Advance of Science, and as a member of the board of directors of the Scientists' Institute for Public Information.

Specifically, I have combined intensive anthropological research in eight different primitive cultures, with the study of our own culture, and I am assuming you have asked me here not to give detailed opinions about particular drugs, for instance, but to try to place the use of psychotropic drugs within the wider context of our society.

Senator NELSON. Yes.

Dr. MEAD. I think that our concern about psychotropic drugs, although it is part of our concern about any overuse—whether it is overuse that affects health or overuse that affects the budget of the consumer who has a limited amount of money to spend—crosses a great many other elements in our culture.

You will notice that in those excerpts that you read from previous testimony, what people were talking about were primarily moral problems, and moral problems related to health rather than specific side affects that affected, say, some organ of the body in a disadvantageous way. The overuse in addition to all the points that you have stressed here, disproportionate use of particular prescription drugs, is being questioned in terms of our moral and religious tradition and it has to be understood within this context.

If we look at the Christian tradition from which this country originally arose, we have two lines. We have the Roman Catholic tradition, and also Middle Eastern religions, this was a tradition of monasticism in which a few people did the abstaining for the entire community. There were hermits and anchorites, monks and nuns. They disciplined the flesh, they abstained from all indulgences, and their rigorous religious observances were believed to help the rest of the community who were allowed to have a good many festivals and live a rather different type of life, and the rest of the communities subsidized them. This was particularly characteristic of many countries that have remained relatively poor.

We also have, as part of our tradition, what is called the Puritan ethic, in which we democratically attempted to spread the practices of abstinence, sobriety and the postponement of all gratifications, hopefully to heaven or at least until a man got rich, throughout the entire population. The Puritan tradition, which has been a very important one in our country, was remarkably successful in promoting economic development and the Industrial Revolution, also includes a very strong bias against any chemical of any sort which alters mood, makes life seem less difficult than it is, puts one to sleep when one is kept awake by worries, relaxes one when one should stay tense, and so forth.

There are very many millions of people in this country who still believe that alcohol, tobacco, and the associated sins of dancing and card playing and things of this sort weaken the character, weaken the fiber of the Nation, and it should be disapproved of.

Now psychotropic drugs get involved in this Puritan tradition, and they also to some extent have gotten involved in the Catholic tradition because the Catholic Church in this country has still stood for facing grief whereas, on the whole, the Protestant and secularized community has abandoned grief or attempted to abandon any recognition of grief for quite a long time.

Additionally, within our religious and moral ethic in the past there has been a tremendous emphasis on self-control, on an individual being his own master, being in control of himself through will power, so that any drug that is regarded as addictive, and this includes alcohol—when one becomes what is called an alcoholic, which means holeplessly addicted—comes under reprobation not only for the other effects that it has on the personality but because of the weakening of the will and the loss of self-control.

These are traditions that came from Europe, they are still very important in Europe, and they are still a very important component of the criticism of this country made by Europeans, and especially by European theologians in many instances, and European psychiatrists who also share the same general cultural position.

But there is also a distinctively American emphasis that has developed out of the frontier and out of the demands that founding a new country made on Americans that is different. It contrasts with our European cultural roots. This is the general belief that if something is wrong you ought to fix it and as against the European notion that if something is wrong you should fix your character and bear it.

This was very well represented in conflicts between the Americans and British during World War II, where the Americans thought the British notion that you fixed your character, you just got a little more willpower and left everything exactly as it was, was ridiculous. The American idea was if this building isn't any good knock it down and build another one.

There is a general emphasis in this country upon finding external solutions to all problems; if you don't like where you are living move somewhere else; if you haven't got any land make it; if you have the wrong shaped nose get it fixed; if you have too big a nose and too small a chin take a piece of your nose and put it on your chin and don't complain that you are going to have to sing in the choir or as a spinster all your life. Right straight through our history we have adopted a policy that invention, technology, ingenuity, resources ought to be available to deal with anything that we want to have dealt with.

These three attitudes occur, in different mixtures in different constituencies, in different parts of the country and in different individuals, including the advertisers who advertise for the pharmaceutical industry and the detail men and the physicians who receive their ministrations. The practical desire to fix things comes into conflict with a belief that some measure of pain is part of man's lot in the world. If you carry that far enough you use no analgesics of any sort in childbrith because pain is what man was *born to* and woman was condemned to and she should continue to bear the pain.

If you carry the Protestant Puritan ethic far enough people take the attitude that everyone should develop enough character so that they never need anything to support them, except vitamins, and it is even doubtful if they should have too many of them because maybe if you depended on vitamins your character wouldn't develop properly. We have had all through this country since the 1960's emphasis on eating the right foods and which means changing your character, and somewhat of a questioning of these synthetic vitamins instead of exercising the moral choice of eating the right food.

All things come into play in the discussion of psychotropic drugs. We have drugs that can act as a sedative, that can relax, that can stimulate, that can energize, and that have enormously altered the population of our mental institutions. Some of these drugs have made it possible to treat people in outpatient situations, to send home very large numbers of people who would have had to stay in institutions and, at the same time, that these particular benefits are well known, we have the operation of these three ethics coming into play, questioning whether there ought to be drugs that make it possible for people not to worry as much or not to lie awake or not to be as tense as they would otherwise be.

And whenever the word "drug," of course, is used crosses over very dangerously in public opinion—and public opinon includes all of us also in our particular predispositions—it crosses over to the use of those drugs which we originally identified as hard drugs, and today, marihuana which is being linked with hard drugs by an act of cultural creation just as smoking cigarettes was once linked to prostitution as it was years ago when people knew that a woman who smoked a cigarette was either a prostitute or would become one. Obviously women who were not prostitutes and didn't want to become prostitutes, didn't smoke cigarettes and the first cigarette which someone persuaded a girl to take was a realistic introduction to a downward path. We put marihuana in the same situation.

Senator JAVITS. Dr. Mead, would you mind one question, if the Chair would allow it; just one?

Dr. MEAD. Any time.

Senator JAVITS. Just one question on marihuana because it happens to intrude in another committee of which I am the ranking minority member. You speak as if the scientific basis for discounting marihuana, according to what the kids say, as being nothing worse than alcohol or tobacco.

Dr. MEAD. Not nearly as bad.

Senator JAVITS. Perhaps even better. However, many people still leave it up in the air. It is not scientifically proved that maybe it is a threshold drug to addiction, et cetera. Would you care to substantiate your statement, which, if you stand by it, is very important, on that subject. Would you say there is not adequate scientific proof to dismiss marihuana as a threshold, addictive of similar drug comparable to hashish, heroin, and so on?

Dr. MEAD. Senator, I would separate hashish and heroin very sharply.

On the question of the use of *cannabis* in various forms we have cross-cultural evidence, we have cultures that have used it for a very long time. There is some evidence that if people use it to excess for 20 years, which mean that they spend their time smoking instead of

doing anything else, they showed some mental deterioration. You can find that with people who do nothing but eat for 20 years let alone people who only use alcohol, that is the excessive use of any piece of chemical intake, even bread and milk is not particularly good for you. We know that *cannabis* has been used for a very long period; we have accounts of the way in which it is used to energize during work and to relax after work. It is my considered opinion at present, and this is not proved because we haven't had instances of where we could follow children whose known situation was, well, authenticated into adult life where we could control all the other aspects of their lives so as to discuss this. But it is my considered opinion at present that marihuana is not harmful unless it is taken in enormous and excessive amounts. I believe that we are damaging this country, damaging our law, our whole law enforcement situation, damaging the trust between the older people and younger people by its prohibition, and this is far more serious than any damage that might be done to a few overusers, because you can get damage from any kind of overuse.

Senator JAVITS. Thank you very much. Thank you very much, Mr. Chairman.

Senator NELSON. It should be noted at this point in the record that the subject of marihuana is not under consideration by this subcommittee. As Senator Javits suggests, this subject is peripheral to the purpose of today's hearing dealing with the use of prescription psychotropic drugs. Please proceed, Dr. Mead.

Dr. MEAD. Now, I noticed in reading earlier testimony before this committee, that the question of side effects in terms of health damage to organs of the body or something of the sort still didn't play as important a role as this question of either the possibility of addiction, overdependence on drugs, which is related to addiction, and the whole moral question of whether it is right to help people escape. That is the reason that I have initially begun by raising these questions. You have discussed psychotropic drugs which are overprescribed, but so are a great many other drugs. When we talk about the side effects of psychotropic drugs we tend to be heavily influenced by the moral and religious and traditional issues involved. I would say at present that our general evidence of the good effects of psychotropic drugs is in the treatment of mental illness. This includes, if you take the hospitalized population a very large proportion of people in this country now who at some point or other are referred to a mental hospital because we have no other way of dealing with various forms of maladjustments. Instead of condemning hundreds of thousands of people to a life which permitted no recovery, these drugs have been exceedingly useful in permitting their treatment.

Senator NELSON. We have already had testimony, which I understand you have read, on the psychotropics. I cannot recall the statistics but they are very dramatic.

That is, we have cut the population of the mental hospitals by some dramatic figure, more than half, something like that, since the psychotropic drugs came into the marketplace sometime in the mid-1930's. I have forgotten the statistics but they are in the record. The testimony was that this has had a dramatic, positive, helpful effect upon the practice of psychiatry, that for the first time psychiatrists were able to get patients who were condemned to a lifetime within an institution out of the institution, so that they could be maintained in a reasonable

fashion within normal society, patients who would never otherwise make it without the drug.

Now, what about the person who does not have an emotional disturbance that would require institutionalizing? Apparently a massive number of people are users, who have prescribed for them psychotropic drugs and just continue to use them all their lives.

Do we know what effect it has upon their personality, their capacity to perform? Do we know how many of these people might be better off if they were off the drug and faced up to whatever problem was causing the tensions? Could they overcome it? Do we know very much about that aspect of the use of the drug by people who are not cases that would be hospitalized?

Dr. MEAD. Yes. You see, today the line between people who are hospitalized and the people who are not as definite as your question would suggest.

Most of the people under sufficient stress would be—would require some kind of help today. It isn't that there is such an increase in mental illness but we define it so differently that people who show minor symptoms of anxiety, worry, the girl who weeps into her typewriter every morning, who would have just been patted on the shoulder 25 years ago, all of these people who are not in mental institutions, and who are not going to psychiatrists would nevertheless if placed under more stress end up in mental hospitals. That is, we use our mental hospitals today in very different ways than we did when we only hospitalized psychotics.

So to make a line between the people who are in mental hospitals and the people who are not is not really something we can do today.

What we are moving toward is more and more treatment of those who appear to be primarily mentally upset in general hospitals or in outpatient departments, so they will never have to enter a regular mental hospital.

This picture of the absolutely sane man, you know, with a fine character who might be undermined by taking psychotropic drugs in contrast to the vulnerable fragile person who is mentally ill, is no longer the kind of distinction we would make.

We have, for example, instances of large numbers of men who, say, in civilian life, might never have broken down but under particular conditions of wartime will break down. Everybody has a breaking point, and psychotropic drugs are used to fend off breaking points.

I wouldn't want to let this pass without making one further comment, we are not certain that returning housewives to their families under the influence of psychotropic drugs which permit them to function at a low level, but nevertheless to function, is a completely good thing for the community. This is a question that has been raised by many psychiatrists. It has been raised in the deliberations of the World Federation for Mental Health, and I think when you are making this complete inquiry here this should be included. If we give *only* drug therapy we are in some instances returning zombies to the community. We have to consider whether it is a good idea for children to be reared by a zombie mother, whether this may be more dangerous than we have thought.

The drugs have made a tremendous difference in the accessibility of patients to psychotherapy but in many cases this is not followed up. There is often no other therapy used except drugs, and drug therapy

needs other sorts of therapy, some of which can be called facing your problems, and in which the ministerial professions have a large role, some of which may be called finding out what are particular anxieties, these patients need pedagogical psychotherapeutic, pastoral treatment, as well as drugs.

It is true that psychotropic drugs made inaccessible patients accessible, they have made wards filled with screaming disturbed people peaceful so that the patients who went there weren't more disturbed, they made it possible for us to begin discharging large numbers of patients from mental hospitals, and they made it possible for us to keep millions of others out. But they are not a panacea all by themselves and should be combined with better follow up, better care for patients in the community, halfway houses all sorts of services that we do not have today.

Senator NELSON. You referred to the individual who may very well get along adequately adjusted under the ordinary stresses of some civilian occupation who, transferred to the military or some other circumstance, may then break down.

Since you have made important studies of cultures all over the world including our own, I would like to ask whether or not the stresses, say, of the modern industrial traffic-jammed, smogged, noisy city are creating more emotional stresses causing more people to need some supportive help of one kind or another, whether it be psychotropic drugs or something else, than the person who lives in a more pastoral situation? In other words, are there higher percentages of people who break down in our metropolitan cultures than in the more quiet pastoral situations?

Dr. MEAD. As far as we know the rate of straight psychotic breakdown has not changed in this country in the last 100 years, that is individuals who would have to be hospitalized because the community is utterly unable to cope with them.

Senator NELSON. You mean the percentage of the population that breaks down?

Dr. MEAD. Psychotically.

Senator NELSON. Psychotically.

Dr. MEAD. And the studies we made in primitive societies (some of the best studies have been made in Taiwan) gave very much the same results that there were, the proportion of psychoses didn't change very much no matter what the community was.

Now, the people who are maladjusted but not psychotic are dealt with very differently in a small village community or remote farming or pastoral community than they can possibly be dealt with in a large city. Furthermore, we are no longer as tolerant of human suffering as we were. A large number of small breakdowns are still tolerated in any rural community, well removed from the pressures of the large cities. In these communities people have always tolerated small breakdowns. They would say, you know, those Jones, well they all had ticks. Old Grandmother Jones' face used to twitch all over the place, three of her daughters have ticks, and now her kids have ticks, and they would accept this.

Under the pressure of our large city of our modern concern which has increased enormously in the last 30 or 40 years we no longer tolerate these degrees of breakdown in the same way. So it is not so much that

there is so much more breakdown as we are less willing to let the breakdown occur, and less willing not to make an attempt to deal with it when it does occur.

There are undoubtedly new forms of stress in the city, noise, air pollution, constant relationships to strangers whose behavior you don't understand so that if you don't know whether they are drugged, crazy or going to murder you, as they reel toward you on the sidewalk, this is the kind of stress that one doesn't get in a small community. But in the small community feuds are carried down three and four generations and people live with organized hate that lasts from generation to generation. So that I think we have to say we have different stresses in our large cities and we have much more willingness to do something about the response to stress. Or you can say it the other way, less willingness to let the highly depressed person, for instance, operate within a business or professional context. But whether one is greater than the other we don't know.

Senator NELSON. Are you saying that there are all kinds of artificial or man-induced stresses in cities that don't exist outside the city, the items you have named, whether it is noise or traffic jams or frustrations of trying to get some place or doing something, that this does not have an effect, does not increase the number, the percentage, of people who live under nervous tensions. That these stresses do not increase the percentage who experience nervous tensions over what you might find in a smaller community?

Dr. MEAD. We don't know. You know, of course, when you make a study of a small community you find a tremendous amount of maladjustment and mental illness. This is partly because the small community does nothing about it, and the city insists on doing something about it in some cases. And it is different, but we don't know how different yet.

You know there are small communities where you think half the people in the village are witches who are intent on killing you. It is a lovely small community, you know everybody in it and everybody shares food unless they are afraid of being poisoned or sorcerized or bewitched. In prince and peasant and rural communities there are orders of stress that are very extreme, The really striking thing about these small communities is that no one did anything about small breakdowns and it is only with the modern mental health movement we have begun to think not only about the people who have been hospitalized but the people who are under too much stress in their daily lives.

Senator NELSON. Thank you.

Mr. GORDON. Dr. Mead, concerning the use of psychotropic drugs for the purpose of enhancing performance, as you know, athletes are not allowed to use psychotropic drugs. What do you think about that?

Dr. MEAD. I think it is more of the general position of which we can't decide whether an athlete is a racehorse or not. It is related to doping racehorses. This we have always felt was one of the wicked practices connected with horseracing which we should stop. You know our attitudes toward horseracing are mixed with our attitude toward gambling. There has been every source of misrepresentation involved. Good people knew horseracing was wicked, but at least one wicked thing we were not going to do, we were not going to dope the horses.

I think this is just one, another one, of these crossovers between traditional Puritanism, on the one hand, and attitudes toward athletic competition. We are not going to let athletes who have a spare chromosome compete. You know these are ways in which our attempt to deal with contests where we, on the one hand, claim that there is fair play and, on the other hand, do our best to have no new factors introduced, that is all. Whether you give antibiotics to chickens, there is a question not only of the effect on the people who eat the eggs or the chicken, but is it good for the chicken? Is it good for chickens to be raised in this sort of welfare state? These are traditional moral problems and they get very seriously raised.

I would like to, if I may, Mr. Chairman, to just lay on the table one other aspect of the whole question and that is the question of the whole health network, the galloping speed with which new drugs have been developed, the virtual breakdown in the country of orderly forms of communication which lead to physicians depending upon advertisements and drug companies promotions as after the only sources of information, very often they are able to handle. I would like to stress the need for a different type of medical education, and different orders of information conveyed to general practitioners. This is exceedingly important and we now have the means to do it if we will use our electronic background now to set up computer systems where real information can be conveyed to a physician.

But it isn't only the psychotropic drugs. We have a total breakdown now of physicians taking life histories of patients and they don't ask them what other drugs they take, and people go in and a doctor working with one part of the body prescribes a drug that if it was combined with a drug prescibed for another part may be lethal.

I know you have touched on these problems in your earlier hearings of psychotropic drugs. I am sure this has been touched upon in other parts of the testimony. I want to emphasize that the only conceivable answer to the population explosion and the drug explosion and the information explosion is using electronic retrieval and presentation methods, and so that a physician can get rapidly the information he needs about the incompatibility of a particular drug with previous disease states, with present drugs that are being prescribed by somebody else, with the other drugs the patient is buying at the drug store and self-prescribing. Each individual patient today is often in greater danger the more clinics or specialists he sees.

This is a very serious situation that needs resolution and it needs resolution in two ways. It needs a resolution in terms of how the information reaches the physician, not in the 2 minutes that the detail man gets into his office, but ways in which he can retrieve rapidly what he needs to know in terms of each patient. And, on the other hand, we urgently need some sort of health card for every person in the country on which it will be compulsory to punch drugs that are being prescribed for that patient, combined with information about allergies and sensitivities to penicillin and the fact that he is a diabetic and the whole series of things that are now being disregarded. In dealing with the drug explosion, I think we can compensate for the deficiencies of medical education by using the new inventions that have accompanied the

modern technological expansion. Unless we do, we have very little hope of keeping this thing in any kind of order.

Finally, I think that we have traditionally fragmented the roles of different parts of our society too deeply. We have looked on industry as looking for nothing but profit, on politicians as looking for nothing but power, and on do-good groups as doing nothing but doing special kinds of good. We have set them all in opposition to each other, and if we are going to build any kind of orderly attack on this tremendous problem of costs of medical care, of production of this great variety of drugs, the problem of testing the large numbers of drugs, and getting the information to physicians and patients, we are going to have to begin to cooperate in ways that we haven't before. We will have to invent some order of cooperation in which the pharmaceutical agencies and government and consumers and the medical profession can work together and assume that there is at least a modicum of good will that can be counted upon in each group if they were differently organized than the way we have organized them today.

Senator NELSON. You have presented the idea that everyone ought to have a health card. Would you elaborate on that a little bit and how would that be managed?

Dr. MEAD. It is managed on a very small scale now. The international health card which people carry around which shows when they had their last inoculations or immunizations in those things that are relevant to international travel. This is a standard card, it is completely set up so that it is possible to see when you had your last vaccination, if you need another booster for tetanus, etc. You can use that card anywhere in the world, where there is an epidemic or an attempt to revaccinate people or reimmunize them. This is on a small scale for those who go abroad, but we need something like this. We need it in a form that a technical assistant or a secretary can elicit the information, because no physician today has time to do even a perfunctory health history of any patient and, therefore, he is prescribing almost entirely in the dark. He may have the kind of skilled diagnostic hunch that this patient doesn't look as if he had something, but he doesn't ask them. Many of the best physicians in the country are not taking health histories that are worth anything in protecting patients from the flood of drugs that other physicians and clinics and pharmacists and their friends are prescribing for them.

Senator NELSON. With the vast number of drugs under trade names in the marketplace there really isn't any way for a physician to know how many of these trade names are actually the same drug.

Dr. MEAD. Well, they could put them on another retrieval system. When the physician encounters a patient who is taking a drug he has never heard of before, the physician ought to have a console in his office, he ought to be able to press a button and say what are the other drugs that are just like this one only have other names or what are the different components, what are the side effects, what are the drugs that are incompatible? This we do now. We can do such things at much less social cost than trying to handle these things that have been produced by our modern technological revolution in a nontechnological way.

The same thing should be done to locate foods that are incompatible with particular drugs.

Senator NELSON. I read a couple of excerpts in my brief opening remarks. One is from testimony by Dr. Daniel Freedman of the University of Chicago. He stated as follows:

> Most societies also use drugs recreationally for rituals, relaxation and escape from everyday reality. Most common are sedative anti-anxiety drugs. Our total attitude should not be not to encourage widespread availability of stimulants and sedatives for these purposes. One thing I think that we do know in psychiatry is that grief is very important to normal experience and that stunted grief, stunted emotional working through these problems, can lead to a serious psychiatric problem. Generally we think in psychiatry in trying to meet the challenge, the ups and downs of life are important to development.

Do you have any observation to make?

Dr. MEAD. I think here we have again the puritan ethic, people ought to meet all ups and downs without help, and the newer American ethic is that you shouldn't have to meet ups and downs that aren't necessary.

Senator NELSON. You are talking about unnecessary ups and downs.

Dr. MEAD. Yes! And we regard this standard American attitude, that differs from these older religious attitudes, is not in favor of a man going through the morning with a headache, which results in wrecked relationships to his colleagues or dictating all his letters incorrectly, he gets into a fight with somebody on the telephone, when he could take a couple of aspirins.

Now, I mean if you really follow these remarks of Dr. Freedman carefully it would be wrong to take aspirin for a headache, you should face the ups and downs of life and one of them is a headache and, on the whole, we think that is nonsense, and that people shouldn't do this. We do not believe as a people in unnecessary suffering, in unnecessary anxiety. It may be good for people to face the ups and downs of life when their children leave home and parents don't know where they are, but we are rather in favor of the children's sending telegrams saying they arrived safely. This argument that says that it is good for human beings to face the ups and downs of life, is then extended to include grief.

I agree that Americans were refusing to face grief. We were refusing to let people grieve, we gave up mourning, everybody was supposed to go back to work 3 days after the funeral and be cheerful. Everybody tried to cheer them up. If the bereaved was a widow they tried to remarry her at once, and standing around the grave people would say "I do hope she marries again." Now, this general denial of grief, the tendency to keep children completely away from any experience of death so that the first death they ever knew might be their parents at middle age, I think has been a bad element in American culture, and in British culture it has been just as bad.

This has changed somewhat in this country now, and we are more willing to deal truthfully with children about death, and we are more willing to permit the bereaved to grieve.

I do not think this point about grief should be tied to problems like anxiety, and relaxation, and the earlier quotation from Dr. Freedman that you read where he said most cultures have used some form of stimulant for relaxation.

With a very few exceptions, every culture we know has used whatever they can get. When they learned how to make a stronger stimu-

lant they used it, and if they then used it to excess they then developed countermeans to convert those that were using it to excess, to a life of abstinence.

We occasionally find a society that will reject anything that leads to any kind of ecstatic state or of people ever getting outside of themselves. This was the history of the Pueblo Indians in relation to peyote. When peyote started to spread they refused it and when alcohol started to spread they refused it. There are societies, usually very small ones, that can be organized around one temperamental emphasis of sobriety or excess. But in general man has sought for ways of changing his moods, of making it possible for him to work longer than he could, to stay up longer than he could, to get through a meeting or a tremendous bout of work better than he could have otherwise. When the work is over, whether it is plowing a field or taking a hazardous journey in a canoe or getting through a terrible board meeting, he very often uses the same drug as a relaxant, which suggests that the relationship between these mood changing drugs is not as simple as we have thought they are. In the West Indies, people smoke marihuana to get through a hard day's work and after they have done the hard day's work they smoke another bit of marihuana to relax and enjoy the evening. And there are many people who do this with cigarettes also, of course.

They smoke to keep working and then they smoke to relax, and all of these things fall under this general question of whether that man has any right to use natural or distilled or pharmaceutically produced aids to permit him to live the kind of life that he wants to live, and in most cases we find this combines work and relaxation or religion, work and relaxation.

Senator NELSON. I don't recall that I asked Dr. Freedman to elaborate on this rather sparse statement. It may very well be that he will agree with your elaboration, I don't know. As I read it, he may have been saying that the use of drugs to avoid almost all stresses in life is a serious matter and that he opposed that. You weren't suggesting that it would be healthy for people to avoid all the stresses.

Dr. MEAD. No; I think it is very unhealthy for them to avoid facing stresses of the order of death or even moving and separating from their friends. But I do believe it is worthwhile to avoid the stress that comes when the plumbing breaks down and both cars are broken and you can't find your husband to telephone him, and the child in nursery school, three children in nursery school, you were going to pick up 15 miles somewhere else, if a pill will permit you not to burst into tears under these circumstances but go next door and borrow another car, I think it is a good idea and I don't think we should confuse the inevitable stresses of the complexity of modern life with the great moments in man's existence which he has to face up to.

I think that a good deal of the testimony against psychotropic drugs, and particularly anxiety reducing drugs, is of this sort and confuses the issues.

Senator NELSON. I had the impression, although I have not reread the testimony, that some of the witnesses, at least, were saying about the same thing about the psychotropics as other witnesses have said

about other prescription drugs. We have had testimony from some distinguished doctors, pharmacologists, who have asserted as much as 50 or 60 percent of the drugs prescribed were unnecessarily prescribed or even, in many cases, prescribed for the wrong purpose.

Now, I have the impression that some of these witnesses on the psychotropics were simply saying, among other things, that a lot of people who are getting these drugs would, in fact, be better off without them. In other words, there is unnecessary prescribing of this type of drug also for many, many people.

Do you have any observations about that?

Dr. MEAD. I think it gets complicated. I agree with you, you know, that our evidence suggests that a great many drugs are prescribed that don't do any good, but I understand from Dr. Modell's analysis of the situation that nothing like the number of useless and poisonous drugs are used today that have been used in the past. That the whole history now of our scientific examination of drugs has been that we are to examine them with far more care, testing them more carefully, and developing drugs that have specific targets and eliminating drugs that are toxic, have dangerous cross effects or side effects, and that are useless.

Now, psychotropic drugs seem to fall in the same class as many other drugs where the purposes or efficacy attributed to them are not as great as it is believed to be, or is still claimed by advertisers at different levels after it has been demonstrated that it isn't useful.

That is a general position with all drugs as we develop and we find drugs we thought were useful are not useful or are dangerous, but if you look at the history of drug use, we are doing much better today than we have ever done before but we have just a large interconnected world with modern methods of diffusion of both the drug and the information so disasters loomed very large.

My only objection, or it isn't so much an objection as what I felt it was necessary to stress, is that in our evaluation of psychotropic drugs we are continually introducing moral judgments that are related to the fact that there is a large element in our culture that believes that whoever is in power, government or the church or a government that is controlled by a large majority of some church, should interfere with other peoples' lives and tell them how they should behave.

This has been going on since the beginning of our history. We passed laws that you couldn't kiss your wife on Sunday or couldn't take a bath in the bathtub in December, we have been systematically interfering with other peoples' lives, and where there is a difference of opinion in the country we have pressure groups which have intruded into wherever there was authoritative process.

I think the most dangerous thing where this has occurred, even more dangerous than prohibition, and prohibition began the breakdown of many of our urban controls of order, but even more than this is the breakdown over marihuana. In the past although the adults, a large number of adults, used certain things that were disapproved of by other members of the society, tea, coffee, tobacco, alcohol, and the children were not allowed to use them, nevertheless the children were told "When you grow up, when you are old enough, you can use them." The little boy who smoked corn silk tobacco in the barn and got a hiding for it or even got sent away to military school, nevertheless

knew some day he would be old enough to exercise the rights that his father and schoolmaster were exercising.

Today by an accident of history we have a break and the drugs that the young people want to use, the stimulants, the energizers, the pacifiers or whatever you wish to call them, are ones that the adults don't want to use so there is now what appears to be a new form of tyranny by the adults over the young, and you have the adult standing with a cocktail in one hand and a cigarette in another saying "I would beat the- - - -out of any child of mine who ever smoked pot."

Now, this position is untenable, and it is leading to a degree of distrust, a breakdown of law and order, that, beside which the prohibition conditions of 1920's in which I grew up pale completely because we now have this vicious relationship between marihuana and hard drugs, which we invented, and which wasn't necessary at all.

This week it was reported in the press that owing to the various operations to stop the importation of marihuana in the country children are now being sold heroin instead, so that instead of a pleasant indulgence that is less noxious than that engaged in by their elders they may be turned into hard drug addicts for life.

I would like to mention at this point an editorial from WIIC in Hartford, Conn., praising the new Connecticut law which makes it possible now for children who have gotten involved in hard drugs or in dangerously manufactured drugs, to go for help without their parents' consent. (See p. 5477.)

Now, the reason we have to have such a law is because of the break between the adult forms of belief of what is legitimate practice and what the young people want as legitimate is so drastic and it is more drastic, I think, than the break that occurred at the time of prohibition.

Senator NELSON. Thank you, Dr. Mead.

I had one question I forgot to ask a little while back. Assume an individual who has prescribed for him one of the tranquilizer drugs for a necessary purpose. What about that individual continuing to rely upon the drug all of his life when he may very well have only needed it for a year. Perhaps he ought to be taken off the drug. I don't know how often this happens but I know of instances where a person who has relied very heavily upon it for awhile thinks he can't get along without it and finally is told by his doctor "You just can't use it any more." He is then taken off the drug, becomes adjusted very well without it.

What do we do about the person who goes on the drug for an appropriate purpose but there is no reevaluation by any physician of his status and he continues to take it for 10 or 15 or 20 years or the rest of his life? Is that harmful? Would he be better off if there was some reevaluation and he was removed from the drug? Do we know much about that problem?

Dr. MEAD. I think it would be very useful to have reevaluation of everyone, that everybody ought to have some kind of periodic checkup, and one of the very serious things in this country is that the average male from the time he leaves his pediatrician until he is so sick it is too late to do anything for him has no doctor of his own. He never goes to a doctor except when he is seriously ill. Women, from the cradle to the grave now, have specialists. They will go from the pediatrician to the obstetrician, to the gynecologist to gerontologist.

But we have no regular system for the whole population. We have no good examination of children. The examination for the draft is simply for purposes of rejection and if people are found to be ill all we do with them is to turn them away. The only defects that we remedy are ones that occur within those who are drafted or who enlist for the Armed Services. Of course, there are some industries that take this kind of responsibility.

Of course, we need to check up on the use of drugs. We need a periodic checkup; we need ways in which we could register, which again could be done now electronically. Somebody was put on this particular drug on May 9, 1969. Automatically, say May 9, 1970, these people will come up the way, you know, a well behaved dentist sends you a little note saying "6 months since I saw you."

But we can't expect this to be done with the existing medical facilities in this country without help, because the average practitioner is too busy and harassed and he has no way of getting at the informtaion and he doesn't know which drugs you ought to watch for a follow-up and which you ought not. That is one side, that is one answer to your question.

The other answer to your question is I would want to be convinced that it did him any harm to take this drug that he was taking for years. There are many people who have taken perfectly useless drugs all their lives, the drugs have kept them nice and well because they believed in them.

Now, if one could demonstrate that the drug itself was bad for one biochemically or inordinately expensive and therefore making a drain on one's budget, I think one can make a case. There are people who believe when they get up in the morning they need a cup of coffee. There are large numbers of people who believe they simply cannot function, they can't think, they can't act without that coffee. Now, there is no proof whatsoever that one cup of coffee supplies all that energy and considerable organization. Would you take that cup of coffee away from them? They also believe after they have drunk that cup of coffee they are alert, bright-eyed and bushy-tailed and ready to deal with the world? Now do you want to take these away from people? I don't see any reason for taking them away merely because there is what we call psychological dependence. If there is an addictive dependence which means you have to continually raise the dose and if you get biochemical addiction, this is a different problem but looking at the psychotropic drugs this potential addiction is true of some and not others.

(The complete prepared statement of Dr. Mead follows:)

EXCERPTS FROM THE TESTIMONY OF MARGARET MEAD, CURATOR EMERITUS OF ETHNOLOGY AT THE AMERICAN MUSEUM OF NATURAL HISTORY AND ADJUNCT PROFESSOR OF ANTHROPOLOGY AT COLUMBIA UNIVERSITY

My credentials for discussing this subject are: I am an anthropologist who has concerned herself with the relationship between culture and practice, in the fields of technological change, nutrition, medicine, specifically, nursing, psychiatry and community mental health. Institutionally, I am Curator Emeritus of Ethnology, in The American Museum of Natural History, Adjunct Professor of Anthropology at Columbia University, and Chairman of the Department of Social Science in Fordham University new liberal arts college at Lincoln Center. I have been for several years, Visiting Professor Anthropology in the

School of Psychiatry at the Menninger Foundation, and I have been for the last ten years, Visiting Professor of Anthropology in the Department of Psychiatry, in the University of Cincinnati College of Medicine.

I was president of the World Federation for Mental Health in 1956, and I was a member for seven years of the group who evaluated research for the National Institute of Mental Health. During World War II, as secretary of the Committee on Food Habits of the National Research Council, I developed the relationship between the human sciences and the field of nutrition. I have also had some experience with the field of the specific training given to detail men, by pharmaceutical companies, and with the relationship between government and industrial practice as chairman, 1965–1969 of the Committee on Science in the Promotion of Human Welfare of the American Association for the Advancement of Science, and as a member of the Board of Directors of the Scientists Institute for Public Information.

Specifically, I have combined intensive anthropological research in eight different primitive cultures, over the last forty-three years, with studies of our own American culture, of sub-groups within American culture and made comparative studies at a distance of other high cultures. I have been specifically concerned with the way in which American values were conveyed, inexplicitly as well as explicitly, by advertising, education, and the particular ethics and style of different professional groups, nutritionists, health educators, nurses, physicians, public relations practitioners, advertisers, architects, etc. both within the United States and in our relationships with the developing countries. I have been and am deeply concerned with the way in which we develop institutional changes by administrative or legislative action, and how styles of commercial behavior, and medical and health education, reverberate—together with United Kingdom, France, Germany, Switzerland, Japan and all industrialized countries—throughout the technologically underdeveloped world. Several years ago I was stranded for a couple of days in Kaboul, Afghanistan, where I met two detail men, one an Indian and the other a Pakistani who were representing exactly the same style of drug salesmanship that has been developed among detail men in the United States. In my testimony I will address myself to the problems of the psychotropic drugs, as they have been defined in previous hearings of this Committee on July 16, 1969 as major tranquilizers, minor tranquilizers, anti-depressants, stimulants and hypnotics.

But while doing so, I count it as my most useful contribution to place the question regarding this particular group of drugs within the wider context of American attitudes towards such problems as whether it is better to make an innovation which improves the chances that an individual will be healthy, happy and wise—to quote a traditional wish for a child—or to continue to cope with unimproved conditions, with our American attitude towards all substances which alter mood, and with our current attitudes towards drugs, which include our panicky response to the present—and inevitably passing as the first generation of Post World War II children move out of adolescence into adulthood—generation gap. It is also necessary to take into account our traditional attitudes which separate the pursuit of profit, appropriate to private enterprise, the pursuit of power, appropriate to politicians, the pursuit of good behavior, appropriate to educational and religious institutions, and the attempt to make a changing society more human and productive of great human well being, appropriate to those public and private agencies explicitly devoted to altering the relationship between current practice and potential for well being, such as public health, social case work, urban planning, etc. The traditional separation of the goals and appropriate practices of these different agencies, has fragmented contemporary life, and made it exceedingly difficult except in wartime. I will, however, relate to a wider cultural context of beliefs about the use of any stimulant or tranquilizer, and more widely still to cultural attitudes towards pain and pleasure, on the one hand, and to the general health network of research-development-distribution-prevention-care and cure on the other.

Psychotropic drugs are only appropriate for this particular inquiry because they have happened to represent a point where our moral attitudes towards stimulants and tranquilizers and other chemically effective agents cross our legitimate concern for the consequences of a health network which is developing at such galloping speed that many aspects of it are out of control. There is a frightening lack of integration of the roles played by medical schools, physicians,

and pharmaceutical companies, research, education, the paramedical occupations, the mass media, governmental legislative, regulative and adminstrative agencies and the public provision for health and welfare. The British experience highlights the problems of a welfare society; our American experience highlights the problems of a mixed economy, where the different roles played by government, medicine, industry and the mass media are seen as competitive and antagonistic, rather than supplementary or complimentary.

Where earlier witnesses were particular to confine their discussion to the use of prescription drugs, excluding the relationship of illegal uses of drugs in drug using contexts of the "youth culture," in the type of discussion which I present, a wider context is necessary.

Throughout the entire western tradition there has been a marked ambivalence toward the body, towards bodily pleasures, and towards pleasure and pain. From the days of Diogenes, when Cynic converts lived a life of the most severe abstinence, dependent upon the bounty which other members of their society gave them, through the traditions of early Christian hermits, to the development of monasticism, there have been some individuals who sought the spiritual life in ways which depended upon bonuses to them as beggars from others who lived in the world. Within this tradition which still survived in some Catholic and Islamic communities, abstinence by the few was matched by cheerful indulgence by the many. However there has been a parallel tradition in which the requirement of abstinence appropriate for the few whose fasts, prayers and medications was believed to benefit the many, has been extended to the entire population. Instead of few religious dependent upon the world, the entire population has been enjoined to live a life of rigid self discipline, to eschew all stimulating intoxicating and relaxing drugs and practices, to meet pain and physical deprivation gladly, and to conduct their lives by excluding related pleasures. Where the countries that permitted gaiety, relaxation and pleasure to the bulk of a population who led seriously constricted lives in terms of actual economic well being, assigned abstinence and monastic lives only to a selected portion of the community, the countries with a puritanical and protestant tradition prospered economically, demonstrating the virtues of a thrifty, sense denying, pleasure avoiding, gratification postponing way of life.

The extreme Protestant sects, Hudderites, Mennonites, and the many other self-denying sects originating in Germany demonstrate this most completely. Plain clothes, no alcohol or tobacco, no card playing, dancing or reading secular literature—the basic tenets of this group-wide self-denial—is occasionally elaborated to forbid even tea and coffee. Also, under the extreme emphasis on self-discipline and self control, any substance not necessary to life, which involves addiction—loss of complete control over the self, is disapproved. So, in an American traditional Protestant setting, drugs which alter moods represent the most reprehensible extreme of a series of indulgences which are seen as ways of escaping the requirements of a sternly moral life. Such groups characteristically seek to legislate the behavior of the entire community, legislating sabbath observances, prohibition of alcoholic beverages and the expression of sex behavior, even going to the extremes of forbidding a married man to kiss his wife on Sunday, or members of a community to take a bath in bathtubs during the winter months. Where the advocates of such rigorous self denial live close by others who believe that life should be enjoyed or its deprivations ameliorated, they attempt to invoke the shared desire to protect the young, so that where prohibition on alcohol, or cigarettes or extramarital sex activities for adults fails, they concentrate on forbidding them to minors.

These attitudes apply also to food necessary for survival, food that is good for you (to eat), and food that is good (to eat) is not good for you. Furthermore weight, even moderate amounts of plumpness are morally derogated as showing a lack of self-control. Medicine, necessary for health should be nasty to take, and medicines that relieve pain, probably richly deserved by our human state if not from recent indulgence in vice, are disapproved of. In my childhood the kind of woman who took headache powders was disapproved of as much as someone who today lives on tranquilizers. The distinction between virtue and vice was clear, virtue was distinguished by pain followed by pleasure, vice was pleasure (indulgence), followed by pain.

Although we are a people whose culture has been shaped by many traditions, our cultural attitudes, and particularly our laws strongly reflect the moralistic position known as the Puritan Ethic, while many of our large cities have been

conspicuously influenced by the complimentary European Catholic tradition based on a distribution between a pleasure seeking majority and a spiritually ascetic minority.

Meanwhile, as our American economy was shaped by the presence of the open frontier and what looked like unlimited resources, a third ethic has grown, the peculiarly American belief that it is better to alter the environment than to continue to cope with unsatisfactory circumstances, that it is moral to take advantage of every possible external aid to the good life, that unnecessary and avoidable pain should be prevented, and that any continued attempt to cope—by altering or exercising one's character with things that could be fixed instead, is at best unenterprising rather than virtuous. Our definition of coping is altering the environment, or our social situation, using something external to the self, a new technique, money, medicine, budgetary arrangements, to attain a better, more human, way of living. Several of these who testified at previous hearings have emphasized that the psychotropic drugs are taken not as a form of escape, but as a new way of coping with life situations. Within this frame of reference Americans approve any dietary supplement, medicine, drug or stimulant, which increases their efficiency.

Physicians in responding to advertising or salesmanship carry these three attitudes in different proportions just as their patients do. Copy writers—also Americans—vary also in which they invoke.

The situation has become further complicated today because the young—instead of surreptitiously tasting the wicked joys reserved for adults—coffee, tobacco and alcohol, which they will later be permitted to use—or righteously forswear—have chosen a different drug—marijuana, which the elders have not used and do not crave. The attempt to restrict the use of this youth choice has resulted in graver social consequences than those associated with prohibition in the 1920's, and with our moralistic attempts to treat the use of hard drugs by adults punitively, instead of medically and socially. By associating marijuana with hard addictive drugs, with youthful premature experimentation, and with the presence of new mood regulating phychotropic drugs—like the amphetamines—we have produced an exceedingly dangerous situation, dangerous to the relationships between youth and age, to the moral fibre of society which permits indulgence to the old and denies indulgence to the young, and which by the handling of all aspects of the drug traffic, steadily involves a larger portion of the population in crime, as criminals and the victims of criminal activities. Speedy legalization of marihuana would break part of this chain, but only the substitution of medical measures for punitive measures can hope to cope with it.

The special emphasis that has been given in these hearings on psychotropic drugs can only be fully explained in the light of these contemporary cultural attitudes. Psychotropic drugs, because they alter mood, because they stimulate or tranquilize, get into the moral category of "drugs," which are considered to be reprehensible basically escapist and liable to undermine our civilization based upon the acceptance of deferred gratification and pain. European comment, coming as it does out of a continuing economics of scarcity, has reinforced the criticism of American use of psychotropic drugs. The over prescription and over use of psychotropic drugs, presenting as it does, dangers of side effects, of conflicts with other medication or sometimes with foods, and involving disproportionately high expenditures, by individuals, in some cases by industries, and where there is governmental underwriting of medical expenses, by taxpayers, *are the same as the problems that arise from other drugs.* They seem different because they have come to symbolize these conflicts between good and evil, between emphasis on production and emphasis upon consumption, between deferring gratification, and enjoying the present moment.

I will now turn to the way in which these drugs, like other drugs less surrounded with moralistic implications, are related to our present confused health network. We are dependent upon the pharmaceutical companies for the initial research which developed the thousands of possible chemical substances, from which new drugs are eventually developed. Because of the nature of competition within these industries, there is an emphasis on rapid high returns. As presently constituted, society is deeply dependent upon this initial experimentation. But for traditional separation of appropriate motives for industry, politics and government create a series of oppositions, in which the pharmaceutical industries are cast in the role of conscienceless profit seekers, their advertisers and salesmen as ruthless exploiters of popular—as opposed to scientific motives—

politicians are cast as seeking causes which will advance their political careers, and physicians as burdened by responsibilities that they can not possibly carry out under today's information and drug explosion, regulative agencies vested with inappropriate and often unenforceable mandates, medical schools, reeling under cuts in Governmental support are enjoined to do a better job of pharmaceutical education, and the general public which cheerfully pays exorbitant amounts for cosmetics, and cars, is pictured as somehow much more victimized when the mass selling is applied to drugs.

What is needed in this situation of incredible productivity in pharmaceutical invention is a modification of these respective limited demands on each sector of the health networks, so that industry can accept more responsibility, politicians will be recognized as seeking the general good as well as continuance in office, government agencies will not be driven frantic by exorbitant work loads, medical schools and schools in general can prepare the public better for choices, and the population of the United States, and of the world be protected against premature or inappropriate or dangerous use of untried drugs.

But in addition to a change towards more cooperation among the different parts of this very complex network, what is most urgently needed are the full use of the modern devices with which the same information explosion that has given us our problems, has provided us.

Some of these are:

(1) Use of retrieval and presentation devices to permit information about new drugs to be processed rapidly so that the practicing physician, be he general practitioner or psychiatrist, can have access to the necessary information.

(2) Legislation to permit formal, computer based and monitored, connections between testing laboratories.

(3) Adequate funding of international drug information through WHO.

(4) An *individual cumulative health card* on which would be registered past health history, blood type, allergies, AND present medication from all sources, other physicians and self medication by prescription drugs and drugs sold over the counter. Such a card should be in form that a medically trained secretary could elicit the information—process it—and present it in an immediately relevant way to the physician.

Psychotropics are drugs of proved worth in giving access to psychotics, improving mental hospitals and helping millions of ordinary individuals to cope better with the anxieties of an exceedingly exacting society. It is ridiculous to worry about their over-use at a period when no physician, or clinic, has time to take a history that will guard against the much more dangerous cross effects of drugs, beside which "side effects" pale.

Our problems in medicine and health care—as in many other fields—are problems of sudden explosive abundance with which we have not been prepared to cope. The methods for coping are already available. I believe that the most useful thing this Committee can do is:

(1) push for more funds for research and medical school education.

(2) push for the installation of devices using modern electronic methods within which each individual receiving any kind of drug treatment will be safe.

(3) push for the substitution of social and medically sound programs for the handling of all presently illegal drug uses which are presently treated punitively.

Senator NELSON. Senator Dole.

Senator DOLE. On page 13 of your statement in the summary of what this committee might do, you indicate the second suggestion would be to push for the installation of advisers using electronic methods. I wonder if you might elaborate on that proposal. I am not certain I understand just what it might do.

Dr. MEAD. It would be possible now to have a card, an individual card, on which these varieties of past medical history, specific sensitivities, disease states that the patient had had, and present medication, could be punched in, if someone who was not a physician was able

to do it, and then the information could be very briefly summarized so when the patient went into the doctor, the doctor would have it in front of him. This could be done by a machine.

One of our great problems today is to put the information in brief and graphic enough form so that the physician can use it. The record of the drugs currently in use, could, of course, be destroyed each year, and the record could start over with new drugs.

One of the things that makes one enthusiastic about our present health system which leaves a great deal to be desired is at least when you are taken into a hospital they usually ask for your hospitalization card. If you can attach to it the fact you are hypersensitive to pencillin or you are a diabetic or all the things they may not find out when they are treating you in an emergency ward there is some chance that it be noticed. That is our present position. And I think a health identity card, with blood type on it also, of course, is one of the first requirements, or where we have these millions of people wandering around in this system going from one doctor to another, in different cities, and going to different clinics, and buying things at the drugstore and taking the advice of their friends and keeping a nice old prescription they were given in 1955, something of this sort is the only way we can lick this problem. It would have to be national and compulsory so that every single person had such a card. A baby would be given it at birth along with their birth registration and it is carried forward.

Senator DOLE. Would you summarize what you have stated very well with reference to psychotropic drugs, of which there are six or seven different categories ranging from stimulants to sedatives, to depressants, antidepressants, and minor and major tranquilizers.

Dr. MEAD. Well, I think there has been over-prescription as there have of most other drugs where physicians are poorly informed or subject to high pressure salesmen methods and have no time and no method to find out what they should find out about each drug, and with the way these drugs come on the market there is just no hope of their understanding it unless it is put in quite different forms from the form that it is in today.

But I also think we are unduly worried about psychotropic drugs, and that we should be thinking about these other things, about the tremendous health hazards of mixtures of drugs, of drugs that are administered in ignorance of the idiosyncracies of the patient, of drugs that administered in ignorance of the foods that are incompatible with it and things of this sort, and that are far more serious. The reason we worry more about psychotropic drugs is a moral reason.

It is connected with our notions of will power, self-control, postponement of gratification and our definitions of virtue and vice. Virtue is when the pain comes first and the pleasure later. Vice is when the pleasure comes first and the pain later, and we feel this very strongly. [Laughter.]

Senator DOLE. Do you have any fear for the person who takes a stimulant in the morning and a sedative at night, aside from the moral reasons?

Dr. MEAD. I think we live through very complicated days under enormous varieties of pressures and unfamiliar situations, and in the morning we may need a stimulant and at night we may need a sedative, and the fact we vary this, that we have at our disposal some kind of pharmacopeia that works seems to me a very important thing, and what we are trying to develop are ways in which people can avoid unnecessary irrelevant suffering, unnecessary and irrelevant inefficiency, and prevent the buildup of the kinds of tensions that may lead to much more severe breakdown.

Senator DOLE. Well, when things go bad in my office, for example, should I take the tranquilizer or give it to my staff?

Dr. MEAD. It depends but I imagine it would be more useful to give it to you.

Senator DOLE. Thank you.

Mr. DUFFY. Dr. Mead, I would just like to pursue briefly one question that was asked you earlier. You were asked for your evaluation of taking certain drugs to improve performance. I think we got into it from the point of view of discussing this as to racehorses. I wonder if you feel there is anything wrong with a tired executive taking a psychotropic drug so that he is better able to enjoy a show or his dinner or something like that?

Dr. MEAD. Of course, I don't. I don't think there is anything wrong at all in this. Then I think this racehorse business, you know, is just a part of the vagaries which go toward our attitude on horseracing which we all know is a pretty suspect activity.

Mr. DUFFY. Thank you.

Dr. MEAD. I don't think there is anything wrong with a high executive taking a drink either if it doesn't befuddle his mind. If it does there is something wrong.

You know the next step, but I don't think it will be quite within the province of this subcommittee, will be a search for knowledge of the relationship between individual temperament, individual biochemical makeup and particular drugs. Now the prescriptions are being made very independently of any knowledge of the patient. It is only in good mental hospitals where very careful records are kept—and most of those are kept now under the impetus of the kind of investigations that are being carried on which have made FDA requirements for more careful records—it is only in such hospitals that you ever know which kind of patient responded to which kind of drugs. What we know at present is a drug is a drug that is good for depression. If that doesn't work you try another antidepressant. I would expect in 10 or 15 years we will have the means of diagnosing the biochemical composition of the body and the temperamental style, and the idiosyncrasies of individuals so that there will be something else for which you can press a console and find out whether a patient who responds in a specific way to a series of tests will do better on one drug than another.

But I am all in favor of anything that will make the high executive function better, that will keep our statesmen when they arrive for overseas conferences awake or put them to sleep for an appropriate amount of time, and any way in which we can control better our functioning in a highly dangerous world at a highly dangerous period in human history.

Senator NELSON. Thank you, Dr. Mead.

The subcommittee appreciates very much your most thoughtful comments and testimony, and we thank you for taking time from your busy schedule to appear here today.

(Subsequent information follows:)

SUPPLEMENTAL STATEMENT OF DR. MARGARET MEAD

I have received many communications and questions about the portion of my testimony of October 27th devoted to marijuana. In the light of these discussions which show that some Americans regard making something legal as a positive sanction for its use, I would now suggest that it would fit better the present mood of the country to substitute for the term *legalizing marijuana*, the phrase *repealing all laws making the use, possession or sale of marijuana illegal.* Appropriate age limits could be established as they are for other activities such as driving a car, drinking beer or purchasing cigarettes; and regulations assuring quality standards could be introduced, and cautions could be required in advertising on such questions as excess use.

BROADCAST-PLAZA, INC.,[1]
Hartford, Conn., Oct. 23, 1969.

It's difficult to do, but try, if you will, to put yourself in the place of a Connecticut teenager who has been using marijuana, LSD or some other drugs, and wants desperately to stop. You know you need help. You're trapped, but you don't know where to turn. Of course, the best person to turn to is your mother or father. But you don't want to face your parents with the awful news that you have been on drugs. You know how it will hurt your mother and your father.

You don't want to go to the police because you've been breaking the law and you know many other people who have been breaking the law with you. You don't want to tell on anyone.

What do you do? Where do you turn? Thanks to a new law that just went into effect in Connecticut, the teenager in this difficult position now has somewhere to go and someone ready to help him . . . and no questions asked.

Since the first of October, if you are a young drug user, you can go to any city health department, any hospital or clinic and get the best of medical attention and treatment without the consent or knowledge of your parents. This is also true—and has been true for some time—of any teenager suffering from a venereal disease.

If you want to free yourself from drugs, you can seek help by approaching your school guidance counselor, school nurse or school doctor. Or, you can walk into any hospital or clinic or city health department and tell the person at the desk that you want to talk to someone about a problem with drugs.

A good place to go is one of the six clinics operated by the state. There are clinics in all sections of Connecticut: in Hartford at 2 Holcomb Street; in New Haven, 412 Orange Street; in Waterbury, 167 Grove Street; in Bridgeport, 50 Ridgefield Avenue; in Stamford, 322 Main Street, and in Norwich, in the Mitchell Building at the Norwich State Hospital. These addresses will be repeated from time to time on WTIC Radio and Television. The clinics are open weekdays from 8:30 in the morning to 4:30 in the afternoon. And we do hope the state will consider keeping them open later in the day and on Saturdays.

If you are a teenage drug user who wants to stop, take advantage of this new protection offered by your state. If you know of a teenager who has been taking drugs, let him know help is available. Tell him all this is confidential and tell him that since treatment is based on ability to pay, he or she won't have to be concerned about finding the money.

Please . . . spread the word about this new program, this new means of escape from drug dependence. You might save a teenager's life.

LEONARD J. PATRICELLI,
President.

(Whereupon at 11:20 a.m., the hearing was adjourned, to reconvene, subject to the call of the Chair.)

---

[1] See p. 5469.