Every possible means was taken to determine the true action of this drug and to avoid bias on the part of myself or the patient.

Dr. O'Brien suggests that my patients were badly neglected and that I had lost interest in them until I suddenly presented them with a wonder drug. All of my patients with rheumatoid arthritis continually receive the most personalized attention from me, regardless of what drugs or therapies I have been or am employing. No change whatsoever was made in our approach or routine management. As I have previously stated, most of these patients have at various times been subjected to one or another type of clinical experimentation. In accordance with my own scruples and ethics, and with the law, I did explain to each patient that he was undertaking a new experiment, and often this was done in the presence of a spouse or a near relative, and the patient was then required to sign an appropriate release form.

Dr. O'Brien would lead you to think that some poor miserable arthritic had staggered into my examining room, discouraged and depressed by my indifference to his disease activity, and that I suddenly burst into the examining room, wildly elated and exclaiming to the patient that I had found a wonder drug and that the patient was about to be miraculously cured. Such an ugly implication is dangerous at worst and naive at best.

The fact is that our whole setup was geared to achieve the greatest objectivity in our evaluation of this drug. Of course, as stated previously, I informed the patient fully that an experimental drug trial was to be initiated, but that no patient should feel in any way coerced into joining in this trial, because I think that a patient must give informed consent. I think if there was any bias in our study, it was as a result of this informed consent of the patient, which tended to eliminate the timid and the weak of heart, but this is now required by law and a necessary part of any drug trial.

Under such circumstances, the subjective response of the patient, in my opinion, is about equally divided between some 20 percent on the one hand who want very much to have a good result and therefore get an unrealistic benefit from the drug, and about 20 percent on the other end of the spectrum who, because of their great fear of the nature of experimentation, would like to have the drug discontinued as soon as possible and tend to report minor or imagined ill-effects, or even tend to minimize possible good effects. Only long-term trial with these patients can effectively bring their results into true perspective. Achieving this true perspective can be greatly aided and solidified by the liberal use of placebos, both single-blind and double-blind, as well as by the gradual but systematic reduction or withdrawal of other effective therapies, most notably the corticosteroids, or cortisone.

Likewise, evaluation of side effects of a drug can only be determined in patients on the basis of long-term observation. These side effects must be carefully appraised, keeping in mind at all times the safety of the patient, but weighing and balancing out as far as possible the need for truth and knowledge about the nature of the drug under investigation. In my opinion, it is wrong to suddenly thrust at a patient a double-blind study without some prior preliminary trial of the drug. Such an early double-blind trial is bound to have the built-in problem of the patient's first experiences with the good and