I think we have here the problem of the baby in the bath. And this, I think is what Dr. Freyhan has been trying to say. The problem is how to get positive information across to the physician, authoritative and clear and in a form that will register under the conditions of active medical practice. And it resolves itself into a problem of education of the physician. And I think also it resolves itself into a problem of education of the public, because pressure from the public has a great deal to do with what goes on. In England, for example, where they have a different situation about medical practice, the public exerts even greater pressure on the physician. And it results in problems of medication of the type we are speaking about.

Senator NELSON. Do you wish to comment, Dr. Freyhan.

Dr. FREYHAN. Not long ago I attended a clinical conference in which a very talented and competent psychiatric resident presented a case and his choice of drug for treating the patient. As I was a bit surprised about his particular choice, I asked him how he had reached his decision. He referred to a very popular advertisement recommending this drug, an advertisement found in the pages of our most prestigious psychiatric journals.

The truth of the matter is, and I tried to point this out in my introductory statement, that we now prescribe drugs on an astronomical basis, yet do not train physicians in either the science of clinical pharmacotherapy nor even in the techniques of drug treatment. Nor do we have developed drug therapeutic facilities and services which transcend conventional setups in outpatient departments, clinics, and so forth.

At a recent international congress on psychoactive drugs, I was asked to evaluate the influence of modern drugs on the longterm outcome of schizophrenia. After surveying the literature, and adding my own observations, I had to state that no conclusions could be drawn because of lack of authoritative studies. This was not so much due to lack of scientific effort as to the absence of innovations in clinical facilities which could have provided a setting for longitudinal studies.

You asked a little while back how many drug-treated patients go home and how many are actually able to go to work. I have done research in this area for quite a few years. I generally agree with Dr. Brill's estimate but I believe that the results may be better if one includes housewives who in response to drug treatment function adequately. From a statistical point of view it is always easier to judge results in terms of jobs obtained by patients previously unable to work, but there is a large group of housewives whose improvement must be measured not in terms of jobs, but in regard to their capacity for being well-functioning housewives.

Treatment does not only depend on giving drugs, but on an understanding of the influence of drugs not only on illness, but on change in social functions as well. And there are not really yet the kind of clinical facilities that have conceptually caught up with more sophisticated treatment and evaluation of therapeutic results. On one hand, comprehensive mental health centers lean on drug treatment involving up to 90 percent of all patients treated. But the treatment often merely amounts to a visit lasting a few minutes in which the patient is given a prescription. He is asked to come back in a few weeks or a month, and