best drug for a given patient. It suggests that the most rational way to begin therapy is with the least expensive drug, switching to something else only if the least expensive drug doesn't work or if idiosyncratic side effects should be encountered.

Of course, this will be a very important issue in a year or two when chlorpromazine comes off patent, because it will be less expensive than others. I feel diffident to suggest such a simple approach to antipsychotic therapy in view of the enormous promotion which different companies have given to the nuances of their competing products and of the clinical lore which has grown up in the wake of this promotion, but, at the present time, evidence for predictable differences in therapeutic effect does not exist.

I haven't really addressed myself much to side effects, because there have been no extensive studies of apparent differences. But apparently while they do differ somewhat in their side effects this doesn't interfere with or potentiate the therapeutic effect.

Exhibit 1,[1] which is attached in a Xerox copy to our statement is a good example of the current promotional effort. This advertisement (American Journal of Psychiatry, June 1969) recommends the combination of two phenothiazines, chlorpromazine and trifluoperazine. It says:

> Often extends control when single agents prove less than satisfactory. When the schizophrenic patient's progress is hampered by persistence of certain symptoms, consider switching to Combined Stelazine-Thorazine Therapy.

Senator NELSON. Where is that quote from? Is that in the ad?

Dr. PILLARD. It is in the advertisement, and it is hooked on to the copy at the end of your exhibits, which are Xeroxed.

Senator NELSON. Exhibit 1, page 2. I see.

All right. It is all part of the same ad?

Dr. PILLARD. Yes, those two sentences that I quoted at the bottom of page 4 and page 5 are direct quotes from that advertisement.

Senator NELSON. Is there any evidence to support that claim?

Dr. PILLARD. I don't think there is. And I am going to address myself to that in the next two paragraphs.

Casey and others tested precisely this claim. They studied 520 schizophrenic patients who had not responded satisfactorily to chlorpromazine alone. These patients were given different combinations of drugs including the Stelazine-Thorazine combination recommended in the ad. The authors conclude: "None of the drug combinations was superior to chlorpromazine and placebo." Again, this was highly competent research, a phrase of the VA cooperative studies of chemotherapy in psychiatry. It was published 8 years ago. long before the Stelazine-Thorazine campaign was started and nothing has been discovered since then to cause Casey's conclusion to be revised.

You may wonder how this advertisement—how such a campaign could have ever have been conceived. It does happen that a patient may be started in treatment with a dose of drug A, which is too low, so that when a similar drug B, is added, the patient improves. This improvement is most likely to result in an optimum total dose of phenothiazine, not to result in any special virtues in the drug com-

[1] See p. 5419.