High Tech Initiatives Are Favored By Clinton Over Basic Science

Washington, D.C.

The forecast for science in the Clinton presidency is change.

The scope and the meaning of this change for scientists and citizens are not yet wholly clear. Capitol Hill experts said in a media briefing set up here last month by the American Association for the Advancement of Science (AAAS). But some sense of the new direction — and the pivotal role that may be played by Vice President-elect Al Gore — is starting to emerge.

One thing is clear, the briefers said: The forty-year-old “consensus” in government and Congress that science is critically important to the nation now appears to be dead — even though, they added, it is truer, in fact, than before. The bases of this defunct consensus, explained historian Roberta B. Miller, Ph.D., of the National Science Foundation (NSF), were the certitude that science played key roles in national defense and economic development, and in bolstering the nation’s international prestige. The end of the Cold War has diminished the perceived need for military science and public relations toppers for Russia’s space program, she said.

Economics Now Rules

Economic development is the new administration’s main theme and mandate, she noted. Science is seen as playing only a supportive role. Technological development through joint ventures between government and industry have a far higher priority.

This loss of interest in science is evident in newly-elected

Saying It in Capitolese ...

“The President-elect should emphasize his personal commitment to effective government-wide coordinating processes for S&T [science and technology] policymaking, budgeting and program priorities. He should make clear that he expects a team approach, cutting across agency ‘turf’ and mission objectives, in addressing S&T issues in the larger context, and especially the relationship of S&T to economic revitalization and competitiveness.”

— William Wells and an associate in recommendations to Clinton

Representatives’ requests for committee seats: None of the 110 new members listed the once sought-after House Committee on Science, Space, and Technology as his or her first choice, according to management specialist William G. Wells, Jr., Ph.D., a former congressional aide who now teaches at George Washington University (GWU) here. Yet, Wells said, science and technology play a “pervasive” role in the indus­trial base that President-elect Bill Clinton and the Democrats want to energize, in order to pull the economy out of the pits.

Public Relations Needed

If scientists and science administrators are to contribute to, and help shape these developments, Wells suggested, they need to mount a “broad-based and vigorous” public relations campaign. One place these science advocates might focus their effort, he added, is on the one hundred representatives — many newly-elected — who are women, blacks, or members of other minorities.

Basic research, which several briefers said has done quite well under Presidents Reagan and Bush, is likely to fare less well under Clinton. The present Washington perception, they noted, is that basic science’s spokesmen have had only one message for government — “More money!” — but have been quite diffident in answering urgent questions put to them from the government side.

Despite this disenchantment, the NSF and the National Institutes of Health (NIH) — the two main federal sources of basic science funding — still retain strong support in Congress, reported Radford Byerly, Jr., who is chief of staff for the House Committee on Science, Space and Technology. He and other panelists forecast that budgets for basic science agencies are not likely to be cut. But they also are not likely to be hiked significantly, as AAAS leaders and others have urged.

The Clinton administration is not interested in basic research and its fiscal plight, explained GWU political scientist John M. Logsdon, Ph.D., who quipped:

“The price of staying pure is staying poor!”

The Democrats’ main effort, all agreed, will be in the areas of technology, engineering, and other science-based activities continued on page 5

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Our Opus on Breast Cancer & Diet

We are not unfamiliar with the dietary strategy to prevent breast cancer for which we criticized Glamour Magazine last month. Not at all!

In 1984, we co-authored a book, The Doctors’ Anti-Breast Cancer Diet (Simon and Schuster), which proposed low-fat, high-fiber diets. We made the unproven claim that a woman who followed such a diet “can cut [her] risk of breast cancer by 50 percent.”

The book’s scientific and medical assessments came from our friend and associate, internist Sherwood L. Gorbach, M.D., of Tufts, in Boston, who is the senior author; nutritionist Margo Woods, D.Sc., provided the dietary information.


Meanwhile, the hope that this dietary approach would prove out scientifically has not been fulfilled. A major National Cancer Institute (NCI) intervention study which might have confirmed it by maintaining women on low-fat, high-fiber diets for several years was cancelled. Then last month Harvard researcher Warren C. Willett, M.D., and his associates published the findings of their ambitious, but non-interventionist Nurses’ Study.

Fat Didn’t Matter

They reported that women who consumed less fat did not fare any better than women who ate more fat. Dietary fiber consumption didn’t matter either.

The Willett study specifically confutes some of the earlier scientific findings by Dr. Gorbach and others. So we phoned Dr. Gorbach for comment:

The trouble with Willett’s “disturbing” findings, he said, is that most of the nurses followed fairly typical, high-fat American diets. Few if any had the very low fat intakes characteristic of native Japanese women, who have very low breast cancer rates.

However, Dr. Gorbach agreed with Willett that a modest reduction in dietary fat is not going to make any difference.

“Thirty percent of calories as fat may not be enough,” Dr. Gorbach said. “You may have to go below 25 percent.

“It is going to have to be a very, very substantial reduction in fat — and it is going to be very, very difficult to achieve.”

Benefit Not Proven

Even if American women could — and would — reduce fat consumption to levels seen in “dedicated vegetarians,” Dr. Gorbach acknowledged, it has not been shown that changing one’s diet in mid-life, or even as a teenager, will reduce one’s risk.

We asked Sherry Gorbach if he thinks, now, our book was correct.

“I think we’re still right,” he replied. “We’re left with these enormous differences between countries [in breast cancer rates], and it can’t be genetics, because when Japanese women move to Hawaii [and switch to more Western diets], they keep the same genes. But their breast cancer rates increase four-fold.”

But, he said, it still isn’t clear just what raises these women’s risk. Neither, we think, is it clear whether and how these factors can be translated into health advice that native-born American women can use to prevent breast cancer. So in our view the dietary advice in our book, like Glamour’s, is premature at best.

Follow-Up . . .

Handguns & homicide: Our February report on a study in the American Journal of Epidemiology, which said that banning handguns probably won’t decrease homicide, raised some readers’ eyebrows. The Journal now has published (Sept., pp. 617-21) critical comments on the study, which was conducted by Seattle psychiatrist Brandon S. Centerwall, M.D.

We’re pleased to say, having gambled on it, that none of the critics found a fatal flaw in the study. One commentator acknowledges that Centerwall’s finding — that the prevalence of registered handguns is not correlated with the frequency of homicides — “is upsetting to those who feel that the possession of handguns is an unnecessary evil.” Others concur with Centerwall, and one, a lawyer, sums matters up this way:

“Criminological literature teaches that societal violence simply reflects the differences in the numbers of violent people that various societies produce. The differences between societies in availability of firearms have, at most, negligible import since in all societies the number of weapons illegally available will always suffice to arm those inclined toward violence.”

In a final comment, Dr. Centerwall says the Journal editors’ “willingness to guide this article through to publication on the basis of its scientific merits, despite a personal distaste for the conclusions, represents an adherence to a high ideal of scientific integrity and objectivity . . .”

Since banning handguns apparently won’t help, some other solutions will be needed. Dr. Centerwall, we have noted with disquietude, fingers TV as the source of much of America’s violence (PROBE, August). Commentators in the Journal point rather to America’s “poverty and social disintegration” as the core problem.

PROBE

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PROBE is written and published independently, initially on a monthly schedule. Subscription: $53 per year. Editorial office: 121 E. 26th St., New York City, NY 10010. Phone: 212-545-0088. For subscriptions, Box 1321, Cathedral Station, New York, NY 10025. Contents of this newsletter may not be reproduced without permission. ISSN 1062-4155

MEMBER, NEWSLETTER PUBLISHERS ASSOCIATION

npa
Expert Proposes Plan That Could Rejuvenate CDC

In October, we summarized public health specialist Donald P. Francis, M.D.'s bitter retirement speech from the U.S. Centers for Disease Control and Prevention (CDC) in Atlanta. He lashed the Reagan-Bush administrations for politicizing the agency, and thus sabotaging the war against AIDS.

We promised that if Bill Clinton won, we would present Dr. Francis's proposals to rejuvenate CDC and restore its leadership role. We do so here with pleasure.

The first task, Dr. Francis writes (Journal of the American Medical Association [JAMA], Sept. 16, pp. 1444-47), is to recognize, at the highest levels of government, the extraordinary danger of HIV, and launch prevention programs to meet this challenge. This is the federal government's obligation and responsibility, Dr. Francis says.

Model Suggested

The fed needs to set up "a separate line of public health authority that allows for accountability, yet is protected from extremist interference." He suggests the Federal Reserve as a model for this new AIDS directorate.

(We note that President-elect Clinton already has taken the first step in this direction by promising to appoint an AIDS "czar," and we wonder whether Francis' speech showed up in JAMA, eight months after it was delivered — and just weeks before the election — simply by happenstance.)

Categorical, government-financed health care must be provided for detection and treatment of AIDS, Dr. Francis says. One reason is that "as the epidemic increases, and services for sick and dying patients are required, resources are [being] taken away from prevention" to pay for this patient care. Without guaranteed treatment, he adds, many young HIV positive people will not seek medical care — and will go on infecting others.

Consistency Sought

A logical and consistent policy is needed on drug addiction. It must recognize that addictions, whether to heroin, alcohol, or nicotine, are chronic and recurring conditions that may require repeated interventions, Dr. Francis says.

A more "enlightened model for drug treatment," including medically prescribed heroin, would dramatically reduce HIV transmission. He adds:

"The provision of sterile injection equipment for drug users should be the standard of public health practice in the U.S." (See stories, pp. 6-7).

The federal government must provide major new incentives for private manufacturers to develop and market vaccines for AIDS and other infectious diseases, Dr. Francis writes. The federal government should work actively with industry in this effort.

Public Must Be Served

Clear channels of responsibility need to be established in the Public Health Service, Dr. Francis writes, because the AIDS epidemic has seriously weakened its previously successful structure. CDC must recommit itself to being an organization that is solely an advocate for the public's health — and not a politician's tool. CDC also must reestablish its leadership role in HIV prevention.

This preventive effort, Dr. Francis adds, should focus on the care and counseling of HIV positive individuals. They must be encouraged and helped not to transmit the disease to others.

Francis says preventive efforts must be directed at both the HIV-infected person and his or her contacts. This intervention is best delivered in a medical setting, he says, where steps also can be taken to prevent tuberculosis.

A New Play in Name Game

Anticipating (we hope) a rebirth, Public Health Service officials have again renamed their flagship agency in Atlanta: It now is the Centers for Disease Control and Prevention — but will still be called, officially, "CDC."

This acronym originated in 1946, when the agency changed from the Office of Malaria Control to the Communicable Disease Center, the name some older folks still think of when they see these initials. In 1970, CDC became the Center for Disease Control, and after another reorganization in 1980 it was pluralized to Centers . . .

Adding "for Prevention" may more accurately describe CDC's new mission. But it perpetuates the miserable trend in government toward ever longer, line-filling names that bore journalists and their readers. So: We think we'll stay with the older, shorter Centers for Disease Control when we spell out what's behind the initials CDC.

January 4, 1983 . . .

"Don Francis pounded the table with his fist. The other officials from the Centers for Disease Control exchanged vaguely embarrassed glances. The blood bankers were becoming visibly angry.

"How many people have to die?" shouted Francis, his fist hitting the table again. "How many deaths do you need? Give us the threshold of death that you need in order to believe that this is happening, and we'll meet at that time and we can start doing something."

"The blood banks refused to believe that transfusion-associated AIDS existed, and now they were going to kill people because of it, Francis thought. It was that simple.

Privately, almost all the [CDC] officials agreed with Don Francis, although they were groaning to themselves that he had shown so little politeness as to say it aloud."

—as reconstructed by Randy Shilts, in And the Band Played On.
Thalidomide may be making a medical comeback:

This drug is the sleeping pill that was banned in the early 1960s after it was shown to cause gross malformations in babies whose mothers took it while pregnant. Many babies were born with grotesque flipper-like appendages (phocomelia) in place of arms or legs.

Since then, thalidomide has led a largely hidden, but not unforgotten life. A handful of researchers have begun to exploit it for new medicinal uses. Provocative but still very preliminary evidence now indicates that it may relieve tuberculosis (TB), and slow down the AIDS infections with which many new TB cases are linked.

**First Step Is Leprosy**

Thalidomide’s comeback started with leprosy. This disfiguring biblical illness still claims millions of victims in the Third World, but is quite rare in the U.S. When lepers are treated with drugs that kill the causal organisms, Mycobacterium leprae, some develop a severe and dangerous inflammatory syndrome called ENL (erythema nodosum leprosum). Thalidomide had been found in the 1960s and ’70s to be the most effective drug for relieving ENL. But no one knew why.

This puzzle drew the attention of Rockefeller University immunologist Gilla Kaplan, Ph.D.; she reasoned that figuring out how the drug fights ENL might provide a clue to ENL’s cause, and lead to ways to prevent it.

Working with colleagues in Brazil, and more recently in Thailand, Kaplan and her Rockefeller co-workers pursued this lead:

ENL is associated with high levels of the body protein cachectin, which is produced by the immune system. It is secreted by white blood cells called macrophages. These cells produce cachectin either in direct response to the leprotic infection, or as part of the activation of the immune system to combat it, Kaplan said in a phone interview last month.

**Cachectin Levels Fall**

The immune system may, however, produce more cachectin than needed. Kaplan and her associates discovered that cachectin levels correlate with ENL symptoms. Patients with ENL symptoms have high cachectin levels. What is more, they discovered that when these patients are treated with thalidomide, their cachectin levels fall, and their symptoms abate — or vanish.

Having made this key connection between thalidomide, inhibition of cachectin release, and symptom relief, Dr. Kaplan asked herself if there were other conditions that might be similarly relieved:

“We asked: Is this a more general effect? Would thalidomide relieve cachectin-induced symptoms in other diseases?”

One obvious target: TB. It is caused by an organism (M. tuberculosis) similar to leprosy’s M. leprae. As in leprosy, cachectin has been linked to major TB symptoms such as fever, muscle-wasting, and the destruction of lung tissue.

The next question Dr. Kaplan asked and now is trying to answer is: Will thalidomide also inhibit cachectin in tuberculosis patients?

**Women Excluded**

It took Kaplan a year to get FDA clearance to use the dangerous drug — under a protocol that strictly excludes women of childbearing age. The thalidomide tablets come from Europe, where the drug continues to be manufactured for leprosy and other rare uses.

Kaplan and her associates now are treating TB patients with thalidomide at Rockefeller University’s small research hospital. A half dozen men have been assessed thus far, under a double-blind protocol: neither staff nor patients know which patients get thalidomide and which get placebos. Results may be a year or more away.

Meanwhile, Dr. Kaplan flew to Thailand last month to start an open-label study, so she will know which patients are receiving the active drug. She anticipates some earlier indications of
May Find New Role Against TB

Thalidomide’s effectiveness from this experiment.

The initial TB patients in the Rockefeller study were not infected with the AIDS virus. But the first HIV positive patient was treated last month.

Dr. Kaplan foresees a “possible bonus” because cachectin also has been shown to stimulate the AIDS virus (HIV), which may be why AIDS patients who become infected with TB get precipitously worse. The thalidomide might stop this.

AIDS May Be Eased

“We are hoping not only to reduce the clinical symptoms of cachectin, but also to slow down the progression of HIV diseases in these patients,” Kaplan said.

Because the clinical experiments have just started — and also because of medical editors’ strictures against telling results to reporters before scientific publication — Dr. Kaplan is circumspect about discussing her findings. Nevertheless, she said, “based on the preclinical data that we have” — on animals and in humans — “I am encouraged.”

# # #

The rehabilitation of a dangerous and disparaged drug obviously tickles a reporter’s sense of irony. More important, it confounds the tendency toward categorical judgments, and confirms that a piece that fits badly in one research puzzle may fit perfectly in another.

Science . . .

continued from page 1

that they hope can be pumped up quickly to provide jobs and stimulate the economy. Locking the technology debate into the economic debate is however a very significant step forward, declared Daniel F. Burton, Jr., of the industry-supported Council on Competitiveness (which, he stressed, is not to be confused with the similarly-named body headed by Vice President Quayle).

Productivity Is Promised

The opportunities foreseen in the new alliance between government and technology account for many business leaders’ switch to the Democrats last month, Burton said. These prospects, he predicted, “will drive a lot of the policies and politics in the new Administration.”

This new alliance thus may be more productive for the nation than the previous consensus. It was based on the assumption that investments in military science and technology would trickle down to civilians’ advantage. In retrospect, Burton said, it seems clear that military research contributed little to civilians’ well-being.

The task now, he said, is to involve the private sector in setting R&D priorities, which formerly were set by the military. The R&D infrastructure must be strengthened, he added. Enhanced computational power is one short-term need. What is required beyond that, Burton acknowledged, still is unknown.

Domestically, technology must be developed and expanded to improve manufacturing processes. Internationally, the urgent need is to scout out new markets for the products. The U.S. now maintains 50,000 combat troops in Japan, but only five commercial attaches. “This is wrong,” he said.

Brokering campaign promises and economic recovery plans into measurable economic progress won’t be easy, the briefers agreed. But Bill Clinton may have a unique resource: Al Gore, who already has been assigned the critical role of point man for science and technological development.

“Having someone who’s that smart” playing this key role is an advantage, Logsdon said. Gore “likes this stuff,” and has been listening to it for years as chairman of the Senate Commerce, Science and Transportation Committee. So, Logsdon added — perhaps tongue in cheek — Gore’s expertise may be a mixed blessing: He may be hard to snow.

Health Network Of Old Scourges

programs that public health officials once relied on to ensure compliance with TB drug regimens no longer exist, Dr. Hamburg said. One current health department initiative, borrowed from the drug addiction field, is to train and employ recovered TB patients for frequent followup on those still being treated.

Despite “full knowledge of how to control this disease,” Dr. Hamburg said, “we’re struggling” to catch up.

Babies Are Dying

Infectious diseases are not the only preventable problems. The high infant mortality rate, particularly in Central Harlem, could be lowered through adequate prenatal care. Asthma is on the rise. Although black and Hispanic women have lower breast cancer rates than white women, Dr. Hamburg noted, they have higher death rates from this disease, due to late diagnoses.

New York City has the highest concentration of sophisticated medical resources in the world, Dr. Hamburg said. But the primary care resources in many parts of the city are worse than those in the Third World. Two million New Yorkers live in neighborhoods with inadequate health care facilities.

The control methods are known. What is lacking, in New York and elsewhere in the nation, the health commissioner said, are public health and primary care medical resources. In sum: social commitment and cash are needed.

# # #

To combat TB, the National Institute of Allergy and Infectious Diseases has just declared it a “research emergency.” The Agency’s TB research budget will be tripled, to $15 million in the current fiscal year.

December 1, 1992
AIDS Prevention Plan Criticized in

A very disparaging report on the proposal to use self-destruct (SD) syringes to stop intravenous drug users (IVDUs) from sharing their implements and infecting others was issued last month by Congress's Office of Technology Assessment (OTA). The OTA "background paper" was written by a long time critic of SDs.

Proponents of the SD initiative — which has yet to be tested — include C. Edward Koop, M.D., the former surgeon general of the U.S. Public Health Service. The author of the OTA report is social psychologist Don C. Des Jarlais, Ph.D., of Beth Israel Medical Center, in Manhattan. He is a veteran substance abuse specialist and a strong supporter of syringe exchanges to supply IVDUs with sterile injection equipment, and so discourage sharing.

Value Doubted

Des Jarlais concludes in the OTA report that SDs are "unlikely to reduce the spread of HIV," and may have the "unintended" effect of actually increasing sharing. But no evidence for this "possible" negative factor is given in the report.

The OTA report may well discourage members of Congress who have been considering SDs from pursuing this option. We hope that it doesn't. We also should say, here, that we have long advocated the development of SDs as a means to stop AIDS' spread.

Des Jarlais presented his case against SDs at an international conference two years ago. He argued that if they were introduced, and imposed universally, the number of syringes and/or needles that IVDUs would need would rise precipitously, since each instrument — by definition and by design — could be used but once. The shortage of injection instruments that would follow, he warned, might force IVDUs to share their equipment even more often than they do now — which would increase HIV transmission. His OTA paper expands on this view.

He also claims, on the basis of what he concedes is fragmentary technical information, that SDs can be defeated — and reused — by IVDUs. This risk has not been well tested. But, if true, it would seem to us that it negates his first argument, since, in a pinch, IVDUs could simply reuse their own SD equipment.

Inventors and developers believe that they can make undefeatable SD syringes.

SD Maker Hits New Report

The OTA report by Don Des Jarlais has been harshly criticized by a pioneer SD syringe manufacturer, Fredrick L. Plouff, president of FLP Enterprises in Andover, Mass. FLP makes the Lokshot syringe, which displays a red signal, and locks after its first use to warn off and frustrate reusers.

FLP's current model is intended for hospitals; the company is vying for contracts in Massachusetts, which has passed a law making SD equipment mandatory in many health care settings, starting in 1994. Plouff's associate, Maurice Landry, says the company also has designed, but is not yet producing an SD syringe that would be appropriate for sales or distribution directly to addicts.

Plouff, in a written statement, disagreed with Des Jarlais. He charged that OTA assessor's warning that health care facilities' switch to SDs would increase syringe sharing and HIV infections is "not fact, but an assertion."

"From what I can see," Plouff said, "he has no data to support this."

Using the Lokshot device in hospitals will protect patients from AIDS infection through accidentally reused needles, said Plouff; he noted that a half dozen such cases have occurred in recent years.

Addicts who steal used Lokshos from hospital red-bag trash will be protected — by the red signal and lock — just as patients are, Plouff said.

Des Jarlais' view, Plouff said by phone, "represents an opinion of a guy who's on the side of the intravenous drug user (IVDU). Who has an opinion in [the OTA report] that's on the side of society!"

He added, in his written statement: "The desires or needs of the IVDUs are irrelevant at this point in the public policy decision-making process."

... Asked to comment on Plouff's statement, Des Jarlais said, by phone: "Certainly, with respect to AIDS, it's the virus against society. Attempts to split the drug users from the rest of society only help spread the virus."

##

The Lokshot for hospitals, which has been favorably reviewed by the Veterans Administration — a major syringe consumer — may well protect patients, and any addicts who may scavenge the devices. But it will make little dent in the AIDS epidemic on the streets. The key test will come when FLP or some other maker tests and markets SD designed for street users. We think this is the priority role for these devices.

Issue is Access

Reuse, however, is not the most important question, Des Jarlais writes. Rather, the critical question is whether legal injection equipment should be supplied to persons who want to inject illicit drugs. We agree, but we think this policy decision ought to be made by Congress, or by public health officials, without the burden of an unduly negative OTA report.

We asked Michael E. Gluck, Ph.D., a public policy specialist who is project director for OTA's HIV-related publications, if he thinks Des Jarlais was qualified to write about SD technology. Gluck said:

"Dr. Des Jarlais at this point knows as much about difficult-to-reuse needles [which is what they are called in the report] as anyone."

OTA Is Satisfied

We asked Gluck if he felt that Des Jarlais' report was objective. He said: "We had no problems about his objectivity. When we sat down and talked about it [in advance] he was quite objective .... But he had a point of view and a conclusion that he came to after he had evaluated the evidence."

But Des Jarlais' critical views are vir-
OTA Report

In his conference paper two years ago, Des Jarlais strong support, that IVDUs have legal access to sterile equipment. If enacted (and we think it should be) this proposal would eliminate the shortages that Des Jarlais foresees. But it would not deter sharing among IVDUs who were too needy or too lazy to search out a fresh syringe.

Having initially condemned SDs as futile and dangerous, Des Jarlais then doubles back, and the OTA report — like his earlier conference paper — lists some scenarios where they might be protective. OTA’s Gluck, and a government administrator who favors SD development, but who asked not to be quoted by name, both said last month that reviewers of the report’s original draft made comments that have balanced it somewhat, so both sides now are represented. They pointed to a paragraph near the end of the document, which says:

The overmentioned problems with a blanket approach to distributing [SD] infection equipment to drug users do not necessarily imply, however, that the approach would fail to reduce HIV transmission among the drug users. Rather, these potential problems merely indicate that this strategy could not be expected to work perfectly (i.e., in such a way that all injections are with new equipment and that no “needle sharing” transmission of HIV occurs). Nonetheless, a blanket [SD] equipment distribution system, even though it might be far from perfectly implemented, could still reduce HIV transmission sufficiently to justify its costs.

In our view, Des Jarlais’ all-or-nothing assumption is a handy straw man, which can be kicked over to disparage the SD option. It would be terrific, we think, if every syringe and/or needle that addicts use worked only once: Transmission of AIDS along this route would cease.

This however is unlikely to happen. But, as with condoms, each time a barrier is put in place to prevent contact between an infected person and one who is not, a possible AIDS case is prevented. In New York City, half the IVDUs are HIV positive. The first time one of these addicts uses an SD, rather than an ordinary syringe, the method would be operative.

The OTA report suggests a more profound issue, however, and one that has bedeviled AIDS control measures for more than a decade: the use of the AIDS crisis to empower a socially disdained high-risk group.

It has been very difficult under Reagan and Bush to argue that society needs to provide de facto recognition of illicit or unpopular behaviors and life styles for the overriding purpose of disease prevention. We think society needs to recognize that addicts shoot up, share needles, and spread AIDS — and take the steps necessary to reduce this hazard.

Recognition Sought

But one senses in the OTA report that IVDUs are demanding, de jure, as an act of empowerment, that they be consulted in the design and deployment of these instruments. We see a de facto need, but not a de jure right for society to grant IVDUs this recognition — and we think this is an important distinction.

It may be possible to persuade society that it is in its best interest to provide safe syringes to keep IVDUs and their sexual partners uninfected and alive. But society probably will not — and ought not be asked — to legitimize this addictive behavior. Previously, as Des Jarlais reminds us, addicts made their own “works” out of a medicine dropper by drawing the tip out to a sharp point in a flame. When they could get them, they used medicinal hypodermic syringes stolen from hospital storerooms or waste containers — and they still do.

Consultation Not Needed

In recent decades, as diabetics have begun injecting themselves with insulin, the small “disposable” — but not self-destructing — syringes that they use have become widely available. These syringes, which are often shared, have come to be IVDUs’ favored injection instruments.

The IVDUs were not consulted in the design of this syringe. We can’t see any reason why society owes them consultation.

Risk Seen

The analyses in this paper indicate that redesigning injection equipment is unlikely to reduce the spread of HIV .... This situation might actually lead to more ... sharing ... of illicit drug-injection equipment, and hence an increase in HIV transmission ....” — The OTA report

Page 7
Prevention . . .
continued from p. 7

Prevention . . .
continued from p. 7

tion rights on syringes that may supplement or succeed it. But:

What society must do, if it wants IVDUs to use safe syringes, is to design and set out—in drug stores where legal, in "shooting galleries" where not—a syringe that meets addicts' needs; it must be a syringe that they will want to use. We do agree with Des Jarlais that SDs should be available in sufficient quantity to obviate the need for sharing—for to fail to do so would defeat their purpose.

The IVDUs' special needs, Des Jarlais reports, are to be able to "draw back" the syringe plunger after they have placed the needle; the sight of blood rising in the barrel shows that the needle has hit a vein. They also want to "boot"—which means to pull blood up into the barrel while injecting, in order to dissolve and flush the drug all out into the bloodstream. They would want SDs to accommodate this needle play, and not self-destruct until an injection was completed.

Manufacturers say they can meet these specifications.

We hope that Congressman Ron Wyden (D-Ore.), who requested the OTA report, is not discouraged by what Des Jarlais has written. There are precious few weapons available to stop AIDS' spread. The urgent question when approaching any one of them should not be, Why won't it work? Rather, the question should be, How can we make it work to protect us all?

Should sterile—and by this we mean SD—equipment be supplied to IVDUs, through legal channels? In about 40 states they already are, since syringes may be purchased in drug stores without a prescription. In the other states SDs, but perhaps not multi-use syringes, should be made available without prescription.

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