Therapy or Degradation?

Seek Ban on ‘Aversives’

Painful methods are used in some institutions to control violent and self-injurious behaviors by severely mentally retarded patients.

The methods, which are quite controversial, include “spanks” delivered to a bare buttock by hand or the flat edge of a cooking spatula; deep muscle pinches; water or ammonia sprays in the face; forced tastes of hot pepper sauce; confinement in phone booth-sized spaces while white sounds are played through a helmet; electric shocks delivered directly, and — more recently — shocks triggered by a therapist through a remote control device.

Efforts to ban these methods could prove successful this month in two states, New York and Massachusetts. Bans already have been enacted in Florida, California, Pennsylvania and South Dakota, according to the Coalition for Legal Rights for the Disabled, an advocacy group in Northampton, Mass. The group says aversive methods are “torture.”

But a researcher who currently uses aversive electric shock devices strongly disagrees. He has lobbied forcefully — and thus far successfully — against the proposed Massachusetts ban. He insists, based on case records from his institution, and the clinical literature, that aversives provide a last — and in some instances life-saving — option for a small number of severely disabled patients who are not helped by other methods.

“The only reason we do it is that we take the kids the others don’t want to take, and we work with them,” said psychologist Matthew L. Israel, Ph.D., in a phone interview. He is executive director of the Behavior Research Institute (BRI), which has offices in Providence, R.I. and residential facilities nearby in Massachusetts.

All treatment regimens that use aversives are approved in advance by the patient’s parents, and by a probate judge, Israel said. “It is a procedure that is very carefully planned, organized and executed.”

Chairman Testifies

But officials at the New York State Commission on Quality Care for the Mentally Disabled, a watchdog agency in Albany, say bluntly that aversives are abusive. The commission chairman, attorney Clarence J. Sundram, said recently in testimony favoring legislation in Massachusetts to ban them (H. 1695):

“The seductive argument in favor of the infliction of pain to change behavior is that it works, at least for as long as the pain or the threat of pain is present. So does torture. But [that] is hardly a reason for a civilized society to tolerate it.”

The Massachusetts bill, currently in committee, would ban any technique that “causes obvious signs of physical pain, including ... hitting, pinching, and electric shock, for the purpose of changing ... behavior.” A legislative aide, Arthur Lambert, said last month from Boston that it was not clear whether the bill will be acted on before adjournment, Jan. 5.

New York State officials meanwhile have been moving slowly along the regulatory route to change. An oft-revised set

Clashing Views on Painful Methods:

Pro — “[The Massachusetts bill] deprives the developmentally disabled of a right which competent, non-disabled persons enjoy: the right to obtain aversive therapy when medically required .... Clients needing this therapy do life-threatening things, e.g., bang head against sharp objects, gouge out eyes, vomit to the point of starvation ... Aversive therapy involves applying a brief aversive stimulus after the behavior .... Removal of the therapy is life-threatening for some.”

— Testimony submitted by Matthew Israel, Ph.D.

Con — “When we permit, and indeed require staff to hit, slap, pinch or otherwise inflict pain, degradation and humiliation upon a disabled person, it weakens and confuses [the] message that we ought to be clearly and consistently communicating. Both staff and residents are left confused about the justification for striking a person they are supposed to be protecting. And it further devalues and erodes respect for the human dignity of residents.”

— Testimony of Clarence Sundram
Our New Year’s Rx: Less Health Advice

Following seasonal gluttony — for those who can afford it in this lean year — many Americans will make New Year’s resolutions. These self-imperatives often deal with health.

We are urged on in these resolutions by a tidal wave of health advice from government, academia, industry, and special interests. Unfortunately, these advisories reflect ideological biases more often than one might think. To cite just one:

A recent blast against feeding babies with cow’s milk got front page play in newspapers across the country. It was issued by a group that is active in behalf of animal rights. Many animal righters object to human “exploitation” of cattle for meat, hides, or milk. But this special interest was barely noted, when it was noted at all, in the news accounts.

Context Sought

We think that the onslaught of health advice and, particularly nutritional advice, needs to be seen in a more critical context. Editors readily publish health advice (except where it counts most, which is on smoking) because it is fairly cheap, risk-free copy. No reporting, and not much thinking, is required to counsel better health through fruits and veggies. But of course publishers wouldn’t print this stuff if the public wasn’t buying, and it is this question — Why are we buying it? — that needs exploration.

Our sense is that the massive public-private debate about health expresses the intense frustration many Americans feel about their inability to shape the real world outside of their bodies. They feel that they can’t improve their own, their families’ and their nation’s wealth and well being.

Many Americans have responded to these threats by recommitting themselves to religion and other irrational value systems, some harmless, some not. Many also committed themselves to rigorous self-maintenance regimens.

Nutrition or Magic?

Pro-active self-health efforts are praiseworthy. But we think they are being much overused as mantras against illness and fear. These self-help regimens also serve as retaliation for perceived shortcomings of science and medicine, which have failed to cure or prevent much-feared ills like AIDS and cancer. People seem to be saying to themselves and to each other: “We’re not sure they work, but we feel better when we swallow some vitamins, or some traditional herbs, to strengthen our bodies.”

The mania for diets — a gastronomic form of puritanism and self-denial — is part of this same mass hysteria. It is as if, by severely restricting themselves, normally healthy men and women — and even children — hope to protect themselves from dissolution and death. First it was butter. Then eggs. Later red meat. Now, recently, milk. No food has escaped unscathed — at least, none that is much fun to eat.

But now the contradictions inherent in all of this unproven, and hence premature, health advice have begun to emerge: The first target, starting decades ago, was butter. Most people prefer it to margarine. It tastes better, and, after all, we pass this way but once and eating and drinking are (or were) one of the basic pleasures.

For safety, however, most of us cut down on, or cut out butter and use margarine instead. Now, however, the experts are saying that margarine may be risky!

What is one to think — or do!

The nutritionists, in other words, have run amok. Consumers who try to follow their zig-zagging precepts may go amok, too, from the confusion.

We think the nutritionists need to go back to their lab benches. They should slam the door behind themselves, and not re-emerge until they reach a consensus on some simple, do-able nutritional steps that ordinary people can comfortably take to protect and preserve their health.

(The craziest result of nutritional overkill is the federally mandated new labelling that will appear on foods over the next year. Over a dozen nutritional elements will be quantified on each label — many more itsy-bitsy data than anyone can keep track of. The implicit pointilist method for choosing one’s food is absurd: People eat food; not reference daily intakes of nutrients.)

Balance Helpful

We would make this bow to current research trends:

Our sense is that what normal and healthy individuals need to do in terms of diet — and what can be supported by science — can be encapsulated in the simple instruction: Eat a balanced diet. But, while the evidence is far from conclusive...
Despite Prodding, RU-486 Maker Drags Its Feet on U.S. Licensing

Four American companies have notified Hoescht A.G., the German company that controls the abortion pill RU-486, that they would like to be the U.S. licensees.

Meanwhile, abortion advocates in New York, in a move to prod Hoescht, are trying to produce the drug for “research” use within New York State. This conceivably could preclude FDA approval, but well might infringe Hoescht’s patent if the homemade drug were sold for clinical use.

These developments come at a moment when pro-choicers are hopeful that President-elect Clinton will remove Bush Administration barriers against RU-486. Hoescht has not applied for FDA approval for RU-486 since it has been taken for granted that it would be blocked, despite extensive data from France — where the drug was developed — that show it to be a safe and effective abortifacient.

Step Is Symbolic

President-elect Clinton already has indicated he will relax the present ban on importing the drug for personal use. But this could be only a “symbolic” step forward, according to New York City pro-choice activist Lawrence Lader. He said last month, by phone, that 90-day residency requirements are in place in countries where RU-486 is approved for clinical use. These rules make it hard for Americans to fly in, obtain the drug, and quickly return home.

Hoescht has declined to apply for U.S. approval in part because it fears a Pro-life boycott of its other products. An official of its affiliate company in France, Roussel-Uclaf, which actually manufactures the drug, was quoted in the New York Times (Nov. 15) as saying the change in administration in Washington “will certainly have an effect on whether RU-486 may be available in the U.S. — but it is still too early to say what effect.”

This official, endocrinologist André Ulmann, M.D., said that large U.S. companies had turned down Hoescht’s offer to license the drug. He added that only a few small companies here could dedicate themselves to the product, and serve as potential distributors. He said he could not name any U.S. companies that have discussed a licensing arrangement with Hoescht.

Company Disputed

Early last month, however, Congressman Ron Wyden (D.-Ore.), chairman of the House subcommittee on regulation, business opportunities, and energy, wrote to Roussel-Uclaf, saying he found it “disturbing” to read that Hoescht was having difficulty finding a U.S. distributor. Wyden forwarded the names of four companies whose officers say they are eager to license and develop RU-486 for the U.S. market. They include Gynex Pharmaceuticals of Vernon Hills, Ill., Adeza Biomedical, of Sunnyvale, Cal., and Cabot Medical of Langhorne, Pa.

Gynex president and CEO, Stephen M. Simes, had written to Wyden last August, saying “we have been interested in RU-486 for many years, and have expressed our interest to Roussel-Uclaf...”

Homemade Pill Planned

Pro-choice activist Lader, meanwhile, revealed by phone that the drug “is being made in laboratories” in New York State. But, he stressed, it is not being tested in women — which would require, at the least, approval by state officials.

“We are only trying to push Roussel [Hoescht] to come in faster,” Lader said.

He noted that the drug already is being produced in China, which, he said, is outside the international patent agreements. More than 5,000 women have been treated there, Lader said.

An alternative, Lader and other advocates have said, would be to develop a similar anti-progestational agent that would not infringe Hoescht’s patent.

But another strong advocate of abortion pills, obstetrician Louise B. Tyrer, M.D., a former medical director of Planned Parenthood, said by phone, from her home, in Nevada, that an alternate drug would have a significant disadvantage: The clinical testing would have to be repeated, which could take eight to 10 years. The RU-486 data, by contrast, is good enough that FDA would not need further studies in order to approve it.

“That’s what we really need to get,” Dr. Tyrer said.

Advice...

continued from page 2

... sive, we do now accept that eating less fat, and particularly less saturated fat, and eating more fiber is good for the heart and probably for one’s general health, too.

Our suggested New Year’s Health Resolutions, in the box on page 2, are simple and conservative. But they have the virtue of strong support from specialists in each particular realm — as well as from generalists.

This list, of course, violates a basic axiom of the health advice field: It summarizes, in fewer than fifty words, what health writers and editors each year spend thousands of pages to tell — and consumers spend millions of dollars to buy and read. This may be why several magazines we’ve worked for have declined to publish this list; having done so, what would they publish in February?

But PROBE is short of space, and we — and, perhaps you, too — are short of patience with the endless tugging and pulling over simple health prescriptions. So we hope this list is welcome and useful. If changes are required, based on new medical findings, we’ll update this list next year.

Meanwhile, we wish all PROBE readers Good Health and Prosperity for the New Year!
New Research Prompts Rethinking Of Breast Cancer Screening Methods

Much is being published this season about breast cancer. Much, but by no means all of it, is bleak.

The worst news may be that women’s justifiable fears are being hyped to an almost palpable mass hysteria by self-appointed activists — and by the press.

Breast cancer is being politicized, as AIDS was. This may serve advocacy interests. But it is unlikely to serve science, or the many American women who look to it for ways to control this dread disease (See boxes).

Calm is what is needed, we think, so that experts and lay persons alike can sift and weigh the mountains of new data that are appearing in the technical press.

Canadian Findings Published

The major news, in terms of prevention, has been the publication of two research reports from the Canadian National Breast Cancer Screening Study, a large scientifically-controlled evaluation of mammography and clinical breast examination, based on a seven-year study of more than 50,000 women. But the reports, published in the Canadian Medical Association Journal on November 15, were discounted in advance by some experts, because of doubts about the mammographic methods that were used.

In the U.S., the National Cancer Institute (NCI) issued a press advisory that summarized the studies and suggested that judgments be deferred until a conference next month, where the findings and other new data will be carefully assessed.

As summarized by NCI, the Canadian studies are bad news for mammography: In younger women, ages 40-49, the study failed to show any benefit in survival, after seven years, for women who had had annual mammograms and breast exams, compared to a matched control group who received only one breast exam plus ordinary care. Similarly, for women 50 to 59, there was no significant advantage in annual mammography and breast exams, compared to just the clinical exams.

These results could change as years pass, and mammography may in fact turn out to be more helpful than the study suggested. The study in older women, particularly, seems open both to new data and reinterpretation, and we think NCI is correct when it says it’s still too early to say anything definitive about it. But the findings for women 40-49 appear more clear-cut.

Editorial Says ‘Stop’

The NCI asks that current recommendations, including mammograms and clinical exams for women in their 40’s, be continued at least until the meeting next month. But editorialists in the prestigious Annals of Internal Medicine (Dec. 1), whose readers — internists — provide many middle-aged women’s medical care, see no reason to wait.

They write, bluntly, that the Canadian trial “showed no reduction in mortality”; they note that “the risk of dying of breast cancer was actually higher in the group of women who were screened than in the control group,” albeit this negative finding may be a statistical fluke.

What is compelling, editors Suzanne W. Fletcher, M.D., and Robert H. Fletcher, M.D., write, is that the study fails to confirm mammograms’ benefit. What is more, almost all other random studies of women in their forties have also failed to show any benefit. So, the Fletchers write:

Regardless of the reasons for the findings in all these studies, the simple fact is that a universal hope has not stood up to scientific scrutiny .... Medical scientists and physicians do not do modern women a service by promulgating a screening practice that medical science has not been able to substantiate after so many tries. We serve them far better by continuing the search for a practice that does work.

These editorialists do recommend mammograms for women over 50, and they make one suggestion:

They note that the breast exams in the Canadian study were conducted by highly-trained examiners, most of them nurses. This might explain why the clinical exams alone were as effective as mammography. So, the Fletchers say, doctors should learn to perform this exam more proficiently — and then do it more often.

The third early intervention method, besides mammography and clinical exams, is breast self-examination (BSE). In our report (PROBE, October) on Glamour magazine’s misleading anti-breast cancer campaign, we noted that there is no statistical evidence BSE is useful before age 40, and we questioned the wisdom of urging young women, 18 to 34, to do it. Breast cancers are rare in this age range, and repetitive self-examination, we felt, could be unduly frightening.

We cited one expert who had put forth this view. We also allowed that for women at high risk, because of a family history of breast cancer, BSE might nevertheless be worth-

Politicization Decried

"[T]he increasingly crass politicization of biomedical research looms as something of a menace, for it presupposes first that more money for more scientists is the way to medical salvation, and second that well-meaning groups of citizen-activists and professional lobbyists have a scientifically useful role in deciding where research money should be directed.

"There is, alas, inadequate evidence to support either proposition."

— Barbara Culliton in Nature, Nov. 5
Novel DNA Discovery Stays Surgeon’s Hand

In an exciting advance, dramatically described by Wall Street Journal reporter Michael Waldholz (Dec. 11), researchers at the University of Michigan Medical Center, in Ann Arbor, have told a young woman that she could safely cancel her plans for preventive surgery to remove both of her breasts.

We now find that we had missed a whole debate, in the pages of the Journal of the National Cancer Institute, which indicates that even — or it might be better to say particularly for — these high-risk younger women, BSE may be so frightening that it discourages compliance with other cancer detection efforts. It thus may be counterproductive.

Women Are Scared

These conclusions are based on studies of high-risk women:

At Johns Hopkins, in Baltimore, cancer prevention specialists found that the more that women worried about cancer, the less competent the BSEs they performed. "Increased worry about breast cancer and nervousness about BSE may serve as an energizing, motivational function when [this worry is] mild to moderate, but perhaps becomes disabling as anxiety worsens," they wrote (NCI Journal, vol. 15, pp. 379-84).

In a follow-up comment, in a recent issue of the Journal (July 18), the study’s senior author, psychologist Michael E. Stefanek, Ph.D., writes:

While mammography may be less help for younger women [than for older ones], we should not assume that BSE is preferable, given the very low occurrence of breast cancer in younger women (particularly among those ages 20-30 years), and [given, too] the high frequency, psychological consequences, and possible negative impact of false-positive results [in which a woman detects a "lump" that turns out not to be cancer] on subsequent breast cancer screening.

In a second study, clinical psychologist Kathryn M. Kash, Ph.D., and her colleagues at Memorial Sloan-Kettering and the Strang Center, in New York City, found that in the well-informed, very high-risk women they studied, "high anxiety predicted poor adherence to monthly BSE." They add that over one quarter of the 217 women they followed were so terrified of breast cancer that they needed psychological counseling to reduce their fear.

"One would expect that women who thought that their chances of developing breast cancer were extremely high would engage in more preventive health care behaviors," Kash and her colleagues say (emphasis in original). On the contrary: "Those women ... were least likely to use preventive behav-

iors [like BSE]" (NCI Journal, vol. 84, pp. 24-31).

One possible explanation, the researchers add, is that these women feel so powerless that they think there’s not much they can do to help themselves — and so they don’t do very much.

Researcher Kash’s conclusion, therefore, is in variance with conventional wisdom:

"Being at high risk may not be a cue to initiate surveillance behaviors; it may increase a woman’s fears and thereby act as a deterrent."

Psychologist Kash is firm in her belief, as she writes in a follow-up comment (NCI Journal, vol. 84, p. 725), that the fearful women “are anxious and distressed about their family histories of breast cancer prior to entering our program — not as a result of engaging in surveillance behaviors.” Her agenda therefore is to improve these programs — perhaps by providing a counseling component — so women will participate more fully.

Harm Feared

But a Journal editorialist interprets her data as indicating that BSE “also appears to induce psychological harm,” as the editorialist we quoted in October suggested. The recent editorial is by an astute observer of the interface between medicine and human behavior, psychologist Barrie R. Cassileth, Ph.D., of the Behavioral Resources Corp., in Chapel Hill, N.C. She notes that among Kash’s high risk and frightened women, almost all (94%) went regularly for mammograms, and two-thirds (69%) had regular clinical exams. But fewer than half (40%) performed monthly BSE.

"It may be that these educated women are cognizant of mammography’s ability to detect a tumor long before it can be felt, and that they opt to ignore BSE and use only the less anxiety-provoking, more accurate mammogram," she writes.

"Mammography makes ... early diagnosis ... at a curable stage ... possible. BSE is vastly inferior to [it]. By the time a breast tumor can be felt by even the most sensitive of human continued on page 8
New Drugs May Temper Aggression

Opponents and proponents of aversive conditioning agree on this: Anti-psychotic drugs like thorazine and haloperidol often are little help for mentally disabled inpatients who are not psychotic (See main story).

Harvard psychiatrist John J. Ratey, M.D., who is research director of Medfield State Hospital, near Boston, recently told colleagues, in New Orleans:

"Aggressive, impulsive and self-injurious behavior can serve to discharge some of these patients' hyperarousal, leading to a downward spiral of antagonistic behavior, negative reactions from others, and further offensiveness." The researcher added:

"The [antipsychotic] drug treatment is employed to remedy this negative behavior often serve only as cognitive treatment programs and training activities, and thus experiences negative behavior often serve only as cognitive and behavioral straitjackets .... The patient is left unable to benefit from treatment programs and training activities, and thus experiences a compromised quality of life."

When you stick a needle into someone's buttocks, and force in medication - that's aversive!

— Psychologist M. Israel, Ph.D. of BRI

The better way may be a new class of drugs that stimulate or modulate activity of the neurotransmitter serotonin. They are being found, experimentally, to quell hostile and self-destructive behavior in mentally challenged patients, without turning them into zombies. One such drug is buspirone (BuSpar, Mead), which is marketed as an anti-anxiety agent.

Very low doses of buspirone, Dr. Ratey reported, significantly diminish aggression and impulsive behavior. Five out of six Medfield patients in one study experienced lessened aggression while on it. One 29-year-old autistic man with a long history of self-injurious behavior experienced a remarkable two-thirds reduction in these self-destructive outbursts.

Drugs that quell aggression are unlikely to win FDA approval for that use, however. For one thing, Dr. Ratey explained recently by phone, the FDA does not recognize aggression as a disorder that can be diagnosed, measured, treated, and then remeasured. So it has never approved a drug to relieve it.

Drug makers, what is more, are likely to be shy about seeking "anti-aggression" approvals, even for current drugs such as buspirone, for fear of attack by special interest groups. The maker of one drug prescribed to treat attention deficits (Ritalin, CIBA), has been attacked for years by Scientologists, who are critical of this use.

Prescribing drugs to reduce aggression is politically incorrect now, Dr. Ratey noted. It is resisted in government because of concerns raised by advocacy groups. So progress has been slow — while uncontrollable patients continue to mutilate themselves and each other.

‘Aversives’...

continued from page 1

of amendments prepared by the NYS Office of Mental Retardation and Developmental Disabilities (OMRDD) states:

"The use of aversive conditioning is prohibited."

The comment period for these regs closes on January 8, according to OMRDD staffer Maryclare, who drafted them over the past six years. These regs define — and ban — as "aversive" methods for "the application to a person's body of a physical stimulus to modify or change behavior with such stimulus being extremely uncomfortable or painful, or which may be noxious to the person."

Simple Definition Given

Psychologist Israel defines aversives much more simply:

"An aversive is a punishment, in lay terms," he said.

The new NYS regs, if issued, will apply only to institutions in New York where, quality of care watch-dog Sundram said, in a phone interview from Albany, the use of these methods has declined sharply in recent years — in large part because of his agency's prodding. The regs would not apply to out-of-state institutions to which NYS patients might be sent at taxpayers' expense. But, Sundram said, his goal is to stop such referrals:

"Why would we allow things to be done to our kids out of state that we would not allow to be done in New York?"

In his campaign to block H.1695, Israel has put together persuasive evidence to support the methods. One document is a report on a BRI patient from New York named Brandon, age 12, with a "pervasive developmental disorder, profound mental retardation" and seizures, who had bit, scratched, pinched and hit himself violently since childhood, and would bring up his food (ruminate) and vomit on himself and others at least several times a day.

Life Was Threatened

As a result, Brandon was starving to death, Israel said. He showed the legislators dramatic photographs of Brandon, who had wasted away to 53 pounds; another photo showed his tongue: He had bitten a big piece of it away.

Several aversive methods failed to quell the destructive behaviors. A new electro-aversive device, designed by Israel, "almost completely stopped the vomiting, allowed Brandon to gain substantial weight, and improved his socialization, Israel and several colleagues say in a case report. "After treatment" photos show a calmer, happier-looking Brandon. Israel makes

Rationale Discounted

"The seductive argument in favor of the infliction of pain to change behavior is that it works, at least for as long as the pain or the threat of pain persists. So does torture, but it is hardly a reason for a civilized society to tolerate it."

— Clarence Sundram, Esq.,
NYS Quality of Care Commission

Page 6
these additional points against the Massachusetts bill, which he says is aimed at his program:

- Studies show that about half of the severely disturbed patients for whom these methods may be appropriate are not helped by non-aversive methods.
- The Autism Society of America, representing parents of some of these children, has changed its stance, and now supports parents’ right to choose appropriate therapies, without restriction.
- A recent NIH consensus panel declined to rule out aversive treatment for patients who hurt themselves or others.
- Aversive therapy is approved by many professionals — and already is well-regulated by law.

Advocates for the mentally disabled take sharp exception to these arguments favoring aversives.

"Some will argue that an absolute ban is inappropriate because it will exclude certain types of treatment for those few individuals for whom nothing else allegedly is effective," attorney Steven L. Schwartz, of the Center for Public Representation, in Northampton, Mass., said in testimony on H. 1695 last year. "I think this argument is specious and factually inaccurate.

"There is very little evidence that there are handicapped individuals for whom a more caring and well-structured program would not effectively respond to some or all of their most difficult needs."

Data Are Not Clear

Professional views are mixed as to whether aversive methods work, and depend in part on what is meant by working. Proponents and opponents agree that these methods will stop a mentally disabled person from performing a specific aggressive or self-destructive behavior. But they differ on whether the conditioning is retained after the painful or noxious stimulus is stopped.

Psychologist Israel said by phone that sometimes it does — and sometimes it doesn’t. Attorney Schwartz said, by phone, that it’s never been shown scientifically to work. Quality of Care chairman Sundram said the scientific literature “is enormously confusing.” Efficacy, however, is not the issue, Sundram declared. Rather:

"This is a value question: Should you treat human beings in this fashion?"

In his testimony, Dr. Sundram cited a school in Somers, N.Y., called Opengate, Inc., that relied heavily on aversive conditioning in the mid ’80s. Patients nevertheless remained refractive and resistant.

After the Commission published a negative report on the facility, a new director was hired; the aversive conditioning stopped.

"The same residents, who were thought to be incapable of living without aversives, are doing fine," Sundram said.

"In my opinion," Sundram testified, "the license to hit and hurt becomes a self-fulfilling prophecy .... Programs that believe such conduct is abuse and thus abhorrent will find other, non-harmful ways to manage and change the same [unacceptable] behavior. It’s that simple!

# # #

But it’s not.

January 1, 1993

Medical Student Sees ‘Religion’ In Animal Rights

A University of Washington medical student, Michael Kerr, went to a local meeting of PAWS, the Progressive Animal Welfare Society. His report in the Seattle Times (May 1, 1991), contained in a recent Foundation for Biomedical Information briefing package for educators, is headlined: "Facts don’t matter to the true believers in animal rights."

"People talked of ‘conversions,’ how their friends were ‘smitten’ with truth, and how much better their lives are now that they ‘are on the correct side.’"

"This ... was ... the latest, fastest-growing, and most politically correct religion on the block — the religion of animal rights ..."

"I sat through the meeting in a state of shock. The information fed to the audience was so exaggerated, misinformation, inflammatory, and sometimes so wrong that I kept wondering if it were some kind of joke — but the people in the audience believed every word ...

"[F]acts don’t matter to the true animal-rights activist. They are on a holy mission of intimidation and misinformation to spread the Truth."

We phoned PAWS, and asked animal issues director Mitchell Fox to comment on Kerr’s article. He said it was “completely baseless,” and “just a lot of bluster.” He said that the preacher was “a parody,” but Kerr “doesn’t get the joke.”

Asked if PAWS and the Animal Rights Movement are politically correct religions, Fox laughed and replied: “A politically correct movement, perhaps.”

Companies Will Pay FDA For Fast New Drug Okays

Congress has passed a bill that in the next few years would levy fees of up to $250,000 from companies with new drugs in the pipeline. The FDA will use the money to hire 600 new scientists and other staff to speed up the drug review process so new drugs can get to market faster.

This legislation has received wide praise from the pharmaceutical industry and others. Editorial reaction has been positive.

We demur. Drug companies are devilishly persistent and clever when they lock horns with FDA on new drug applications (NDAs). Letting them pay, in part, for the NDA reviews increases their edge — and the public’s risk.

We agree drug approvals should be speeded up. But the funding for this relatively modest federal expenditure should come from the general fund, not the companies FDA is charged to regulate. He who pays the piper ...
Cancer...
continued from page 5

hands, it will have advanced well beyond its earliest mammographic-detection stage” (NCI Journal, vol. 84, pp. 2-3).

Mammography Preferred

Cassileth's recommendation: Dump BSE altogether, for both high- and low-risk women: “BSE — taught, publically urged, and studied for many years — is outmoded. It has consumed substantial financial and other resources that now should be diverted to encourage and support mammography.”

We phoned Cassileth and asked if she still holds these views, in light of the Canadian study's failure to confirm that mammography helps. She said she had not changed her mind. The issue now is to improve mammographic technology, Cassileth said.

The proposal to drop BSE is rarely voiced in public discussions about breast cancer control. We think it merits serious thought.

Why Women Don’t Comply

"Despite the pamphlets, the urging, and the importance placed on monthly BSE, surveys continue to document women's widespread lack of willingness to comply. Their reluctance is not surprising .... We are asking women to try hard to find cancers in themselves .... Essentially, we are asking [them] to try, regularly, to locate something in their bodies that will result in some degree of mutilation.”

— Barrie R. Cassileth, Ph.D., in NCI Journal

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