As part of its large and effective public relations effort, the American Medical Association (AMA) runs an annual several-day conference for science reporters. These forums focus mostly on medical and scientific news, as distinct from medical economics and politics. We detected — and felt — a sense of loss and regret at this year’s event, held here over the Columbus Day weekend: The feeling was that the medical news beat has shifted from scientific discovery to health care delivery.

Ironically, the Clintons’ plan, in whatever form it is finally enacted, depends on continuing — perhaps even accelerating — research to raise the current level of care. But thus far we have seen little recognition of this dynamic by the Clintons.

To illustrate this research need, here are several new developments, presented here by AMA, that may improve the care doctors deliver to patients; some may also save money:

AIDS vaccine advances — Scientists are moving toward wide testing of AIDS vaccines, perhaps starting next year. “We need an AIDS vaccine,” explained immunologist Patricia Fast, M.D., an R&D specialist at the National Institute of Allergy and Infectious Disease (NIAID), in Bethesda, Md. Progress on AIDS control through behavioral means, such as increased use of condoms, has been “very elusive,” Fast said. She revealed that one new immunologic method to prevent AIDS — in new babies — has been tried for the first time in recent weeks (see story, p. 5). Fast also described work-in-progress on several methods to block or attenuate AIDS virus (HIV) infections in adults. Fourteen vaccine trials of 10 vaccines are now under way in the U.S., Fast said. Some 900 volunteers are participating. The time frame for a usable vaccine? At least five years, Fast said. Maybe 20 years.

Could this effort use more money? Yes, she replied.

Sounds for the deaf — Children who are born, or become profoundly deaf before they speak often end up irrevocably isolated from their parents — who in most cases have normal speech and hearing — and from the wider world. In many, but not all of the youngsters it now is possible “to restore some degree of hearing,” albeit “not cure” the deafness, according to ear, nose and throat specialist Noel L. Cohen, M.D., of New York University in Manhattan.

The method: using surgically-implanted devices that deliver sound-generated electrical impulses directly to the auditory nerve. These cochlear implants are getting better, and two thousand have been implanted in young children in the last several years, Cohen said.

The sound signals delivered through the implants increase

continued on page 4

Doctors Playing ‘Catch-Up’ Game

Major decisions on medical and hospital practice once were made by doctors. They ran most medical institutions. The American Medical Association (AMA) spoke — and acted — for them, although some physicians disagreed vehemently with its policies.

The AMA invited three University of Pennsylvania health care experts to its recent science reporters conference here, for a roundtable on health policy changes. The experts were asked to assess doctors’ role in the current health reform.

“The medical profession was, at one time, in control,” recalled internist Alan L. Hillman, M.D. “Somewhere along the line we lost that ability to take control.”

Hillman said he was worried because doctors now are playing a “catch-up” game. “Physicians should have helped to

continued on page 3
Americans need and should have a universal health care system. The Clintons’ plan is well thought out, and it, or something like it, seems likely to be enacted next year.

But: It may be the wrong health plan for the goal that is sought.

The plan accelerates a changeover, already in progress, in which American medical care is being transformed from a service to a commodity. A commodity, like wheat by the ton, is a standard and undifferentiated product that can be traded sight unseen. The object is to buy low and sell high.

Care Is Diluted

Health maintenance organizations (HMOs), through which most care will be delivered, treat patients as commodities. The physician’s responsibility and the patient’s trust are deflected and thus diluted. We think that’s a poor model for health care.

The trade-off, of course, is that guaranteed treatment at an HMO is likely to be far better than many Americans now get or can afford.

HMOs, insurance companies, and other intermediaries between patient and doctor tend to restrict access to quality care because they always are concerned with the bottom line and cutting costs. At present, President Clinton says, insurance companies deny needy Americans medical care by cancelling policies on people whom they decide are poor risks or are too costly to carry.

But it will be some of these same insurers — the largest of them, which are thought to have the best chance to survive — that will, with the government, squeeze the HMOs and other care providers in the Clintons’ competitive system.

Cutbacks and the rationing of services, are bound to result.

Is General Practice Best?

There are other problems in their plan. The sudden shift toward general practice medicine, as against specialty care, ignores recent major studies — most of them conducted with federal funding — which show clear benefit from specialists’ treatment. This means specialization in the medical and paramedical personnel who deliver care, and also in the setting and format in which care is delivered.

These specialty services will be difficult to organize and maintain in a commodity-care medical setting. Yet they improve patients’ health and safeguard their lives.

One clear example is the “intensive” treatment of insulin-dependent diabetes. A major study, just published in the New England Journal of Medicine (Sept. 30, pp. 977-986), shows that diabetics treated in labor-intensive multi-specialty centers, with input from internists, eye specialists, foot doctors, nutritionists and others, fared far better than control patients who were given standard care.

In a carefully phrased editorial comment on these findings, Roz D. Lasker, M.D., a physician in the U.S. Department of Health and Human Services, the lead agency pushing the Clintons’ plan, writes, wryly we think:

The importance of the patient-centered team in achieving [these] results ... suggests that the policies affecting the way care is organized, assessed, and paid for are likely to be as important as those affecting benefits, insurance coverage, and access to care.

The Clintons’ plan focuses mainly on the latter considerations, not the former ones — which are where we think the focus should be in developing an optimal health delivery program.

Projections Doubt

Few analysts believe the Clintons’ projection that the cost of coverage for 30 million uninsured and many more poorly-insured Americans can be recouped by cigarette taxes, competition between care-providing organizations, and waste reduction and cutbacks of Medicaid/Medicare payments. Experts at Harvard’s Center for National Health Program Studies say that significant savings could be made by removing the middlemen: the insurance companies, accountants and clerks who now stand between patient and doctor.

The Harvard Center’s director, internist David U. Himmelstein, M.D., advocates the single-payer, or Canadian plan: Patients select their own doctors, and the doctor — rather than a high-school educated clerk, working from a manual — decides what service is appropriate and provides it. The bill for

Follow-Up. . .

In June we described how the former director of the National Institutes of Health (NIH), Bernadine Healy, M.D., and an associate blocked the funds for an NIH grant to the University of Maryland. The school had planned a conference on genetics and violence. Black activists attacked it as “racist”.

We thought that the arguments against the conference were mostly specious, and that NIH’s action threatened free inquiry.

The university appealed the cutoff of funds. A Public Health Service appeals panel now has provisionally restored some of the money, pending a decision by the school on whether it will try to reschedule the conference or conduct an alternative program. If NIH approves the University’s plan, full funding will be restored.
The Clash of the Paradigms . . .

Three views — and probably conflicting — models, or patterns of practice, are emerging in American medicine.

The historian Thomas Kuhn used the word paradigm to describe these models (in science). He wrote that such changes, while rare, are wrenching for those caught up in them — just as a major change in life can be devastating for an individual.

These new medical paradigms, according to Lancet commentator L.S. Rothenberg (May 29, pp. 1379-80), are:

• The dramatic movement of medical diagnosis and therapy from the levels of organs, tissues and cells to that of molecules and genes. This is leading to a vast revolution in care, in which refractory diseases will be brought under control through gene therapy and related means. But, Rothenberg suggests, “molecular medicine” will require highly-trained specialists.

• The standard “disease model” of care is shifting toward a focus on health, functioning, and well-being. In Rothenberg’s view, this new paradigm “neatly coincides” with the Clintons’ plan to increase primary care physicians from 25% of doctors, today, to up to 70% in the near future. The number of specialists will drop accordingly.

• The shift, now in progress, from individual doctor/patient relationships to the “corporatisation” of U.S. health care, as envisioned by the Clintons.

Commentator Rothenberg foresees conflict between these paradigms. The Lancet wonders if it even is possible for three paradigms to shift simultaneously.

# # #

We worry about the chaos that may result. Was it Lenin who said, “To make an omelette, you need to break a few eggs!”

We wonder, too, if doctors are necessary, or even appropriate mentors for the trendy wellness movement. In the cost-controlled world of Clintonian health care, we don’t think we’ll need — or get — a physician to teach us yoga!

---

AMA Hits ‘Single Payer’

“The AMA strongly opposes the establishment of a single-payer health care system, whether on a state or national level as part of national health system reform legislation. No centralized decision-making authority can control costs and ensure adequate access to quality services . . .”

—AMA policy statement on Clinton health plan

Doctors . . .

continued from page 1

drive the train, along with the economists and politicians,” he said.

A colleague, J. Sanford Schwartz, M.D. said the loss occurred because the AMA “has failed in taking leadership positions that would have required real reforms.”

Now, he declared, the decisions must be shared:

“I would argue that physicians ought not be the only driving force.”

Many social forces, outside the medical profession, have important stakes in the health debate, Schwartz suggested; health decisions must reflect their interests.

Because of the high public cost, added health management specialist Mark Pauly, Ph.D., medical financing is a public policy decision that must be based on fiscal allocations. It’s a matter, he said, of how much money the society wants to spend on treating disease — and how much it wants to spend on mending roads.

He said, however, that the current drive toward consolidation and integration of health services — in anticipation of health care reform — reflects political more than economic concerns.

“There isn’t enough [savings] in inefficiency to fund a cost-containment program,” Pauly said.
Research . . .
(continued from page 1)

the kids' safety. Access to sound and spoken language also enhances their intellectual, expressive, and social interactions, Cohen said.

(He rejected the objection of some advocates for the deaf, who say the implants alienate users from the culture of the deaf, which is their rightful place. Parents have "the right and responsibility" to make medical decisions for their children, Cohen said. The implants, he added, are much more effective if implanted in early childhood, when the ability to speak and understand language still are developing.)

Keeping arteries open — All too often, after the coronary arteries of heart attack patients have been reopened with angioplasty or bypass surgery, these vessels close up again. Repeat operations are needed, at a current annual cost of $2 billion.

The drug heparin forestalls reclosure. But it can't be taken by mouth and is too dangerous for routine use. However, a different, heparin-like compound, called b-CDT, has been de-

Research Funding Sources
Are News, Biologists Say
Philadelphia

Science reporters ought to include in their stories the sources of funding for research studies they describe.

This new recommendation has been issued by the Federation of American Societies for Experimental Biology, the umbrella organization of biologic researchers, in Bethesda, Md. It was disclosed here at the AMA's annual Science Reporters Conference, by pathologist George D. Lundberg, M.D., editor of JAMA, the AMA journal.

Lundberg said that he supports the proposal, which, he explained, will create public recognition and awareness of funding agencies like the National Institutes of Health. It also will indicate drug companies' interest in clinical studies reported to the public, he said.

Asked if reporters should also identify financial backers of scientific conferences they attend, Lundberg answered: "Sure!"

So: The AMA's writers conference here was supported by Burroughs Wellcome, a drug company. This was clearly noted on the program.

One talk, by neurologist Ilo Leppik, M.D., of the University of Minnesota, described three new "breakthrough" drugs for epilepsy. One of them, lamotrigine, which is slated to gain FDA approval in the near future, is made by Burroughs Wellcome, Leppik said.

A Burroughs Wellcome representative said that his company "considers you science reporters to be an integral part of the health care delivery system."

# # #

We're not sure that we are — or should be. Are White House reporters an integral part of the political system?

Do Doctors Help?
The temper of the times is to disparage medical science and the physicians and drug companies who deliver its products. Controls on these providers, and alternative, non-scientific remedies are in fashion.

We ask this question: In your close circle of family and friends, whom do you know whose life has not been saved or significantly improved by a drug, surgical operation, or other medical method?

Developed that "quite dramatically suppresses" the growth of the smooth muscle cells that re-block these vessels, an expert reported: The b-CDT reduced new blockage by two-thirds when given to rabbits in their drinking water, University of Pennsylvania cardiologist Elliot Barnathan, M.D., said. He foresees clinical trials of b-CDT in the next couple years.

This oral drug, he noted, costs only one-two-hundredths as much as heparin.

New drugs for seizures — One American in every hundred suffers seizures. It recently has been found, too, that older people are more likely to be afflicted than youngsters, reported neurologist Ilo Leppik, M.D., of the University of Minnesota, in Minneapolis. But there have been no new drugs for this condition, epilepsy, for the last 15 years. Current drugs have significant side effects, and some harm the fetus. So women who need them face a dilemma if they get pregnant.

Now, suddenly, there are three new anti-seizure medications, one of which, felbamate, already is approved by FDA, Leppik said. These drugs are proving to be helpful in a number of seizure disorders; have fewer side effects than some older drugs; and appear not to cause birth defects, he added.

Transplants for the brain — Efforts to transplant fetal brain cells directly into people with parkinsonism and other neurologic diseases have been stymied by federal restrictions — and may be difficult to use for logistic reasons, even if fully legalized. A pathologist, John Q. Trojanowski, M.D., at the University of Pennsylvania, here, thinks he may have a preferable way to put replacement cells into the brains of people who have stopped making an essential neurochemical.

He is working with a cell line, maintained for a decade in lab dishes, that makes nerve cells (neurons) when transplanted into brain tissue.

Trojanowski said he was encouraged by the fact that these cells seem to receive and respond to developmental signals from the animals into which he is now transplanting them. This suggests that critically needed areas of brain tissue, not just pockets of transplanted cells, might be provided.

The cultured cells can be genetically engineered to produce a missing neurochemical, such as the dopamine that parkinsonian patients need to quell their tremors. Or, better, they might be programmed to produce a substance that would keep the original cells from degenerating in the first place.

Eventually, Trojanowski said, many brain disorders might be treated in this way — including Alzheimer's disease.

# # #

We hope research is not lost in the health-delivery shuffle.
New Approach to AIDS Prevention: Mothers Injected to Protect Babies

On October 1, a pregnant woman in Los Angeles, and another in San Juan, were given experimental injections of gamma globulin. Both women were infected with HIV (human immunodeficiency virus), which causes AIDS, but were not yet ill.

This clinical experiment, which will eventually include several hundred mother-infant pairs, is designed to see if the injections will stop HIV transmission between generations, so the tots don't follow their moms to an early grave.

About one out of five American babies born to HIV-infected mothers becomes infected in the womb — an estimated 1800 each year. It is believed that in most cases this occurs at or near delivery. The new clinical trial, long in the works — and long delayed — is modeled on a strategy that was shown years ago to protect babies from infection with hepatitis B virus from their infected mothers:

Injecting mothers and babies with potent doses of antihepatitis antibody, in the form of immunoglobulin, will kill the viruses and protect most babies, according to virologist Alfred M. Prince, M.D., of the New York Blood Center, in Manhattan. He developed this method for hepatitis prevention, and has, with colleagues, performed the animal experiments that undergird its initial trial against AIDS.

The method is called passive immunization. This means that the virus-killing antibodies are not produced by the host — in this case the mother (who may by now be immunodeficient, and thus unable to do so), or by the baby. The antibody-rich immunoglobulin rather is obtained by bleeding HIV-infected patients for plasma.

Preparation Is Purified

These donors are at an early stage of infection when — unlike the mothers — they still are producing high amounts of naturally-protective antibodies that neutralize HIV. This antibody is extracted from the donors’ plasma, concentrated, and rigorously purified so that it does not contain any HIV particles that could cause rather than prevent the illness.

The start of the mother-baby passive antibody study was disclosed in Philadelphia last month by immunologist Patricia Fast, M.D., of the National Institute of Allergy and Infectious Diseases, in Bethesda, Md.; it is one of several NIH institutes working on the project (see story, p. 1). A colleague, hematologist Elaine Sloand, M.D., of the National Heart, Lung, and Blood Institute later explained that the study will enroll 400 HIV-infected women, all rather far along (low T-cell counts) on the grim road to AIDS. Half will get the passive antibody, called HIV-IG, for HIV immunoglobulin. The other half will get ordinary immunoglobulin from individuals not infected with HIV. All the women also get the drug AZT.

Each woman will be injected with one or the other of the two preparations every 28 days until she delivers. The babies will receive an injection of the same material within 12 hours of birth — and they too will be treated with AZT.

The trial is designed to assess both the safety and the efficacy of HIV-IG, Sloand said recently by phone from Bethesda. The hope is, she explained, that the injections into the mothers will eliminate or at least diminish the levels of the deadly virus that is circulating in their bloodstream, which might prevent the baby from being infected. The injections into the baby, it is hoped, will neutralize virus that may have invaded them during delivery, when there is significant interchange of fluids between mother and infant.

The first women in the study are being followed closely to see how long the injected antibody remains in their bloodstream at effectively high levels. This is a major concern, virologist Prince, in New York, said by phone, because in his preliminary experiments in chimpanzees, the levels fell off quickly. Asked whether HIV-IG would neutralize virus that appeared in the mother’s circulation two weeks after the antibody injection, he replied without hesitation, “No!”

For that reason, he added: “I think the probability of success in this trial is extremely small.”

Approach Called Promising

The basic approach, however, well may be sound, Prince said. He and his New York Blood Center colleagues now are working with immunodeficient mice to develop genetically-engineered antibody molecules that might remain in the bloodstream longer, or, alternatively, might be given more often than HIV-IG. The naturally-derived HIV-IG costs “mega-bucks,” he noted.

“We’re betting that some of these [other things] are going to be a lot better than HIV-IG.”

Concept is Old

The possibility of providing passive antibody protection to block AIDS in young babies has been around quite awhile. It continued on page 8

Vaccines Tried, Too

Active immunization trials to protect HIV-positive pregnant women’s unborn babies also have started: Under NIH auspices, the women are being given injections of vaccines that contain a non-infectious fragment of the AIDS virus (HIV) plus a booster (adjuvant). The aim is to stimulate the women’s immune system to produce antibodies that will neutralize HIV in their bloodstream before they can cross the placenta and infect their babies.
Tobacco Foe Hits Our Reporting

We published in July an analysis questioning—but not denying—an assertion by ASH (Action on Smoking and Health) that second-hand cigarette smoke "kills a ... a staggering 53,000 innocent victims" each year.

We have received a strong rebuttal from ASH's director and chief counsel, John F. Banzhaf III; he says our article was "factually incorrect in its major premise," and contained "a number of misleading statements or suggestions."

We wrote about ASH because the 53,000 figure and other statements in its special report on sidestream smoke raise important issues on the use of scientific data in influencing public opinion and policy. Banzhaf's reply speaks to some of these issues, and so we welcome it for the light it sheds on them.

Complaints Cited

These are his complaints:

Banzhaf says we were "factually incorrect" in stating that the widely cited estimate of 53,000 annual deaths among non-smokers exposed to others' smoke is based solely on one study, which has not received general acceptance in the medical community. The study, which we described in some detail, was by retired chemist A. J. Wells, Ph.D.

We said Wells was the original source. We did not say he was the sole source.

Glantz Backs Wells

Banzhaf acknowledges that Wells was one of the first to arrive at this number, but says that the "most widely cited and clearly the major source for the estimate" is a later paper by cardiology researcher Stanton A. Glantz, Ph.D., and a colleague, in the widely-circulated and important journal Circulation (vol. 83, pp. 1-10, 1991), published by the American Heart Association (AHA). Banzhaf had sent us a reprint, which we did not cite.

The Glantz paper was based on "a number of other research findings," Banzhaf writes now, published after Wells' paper, and went beyond Wells because it identified and discussed "in substantial detail" at least five ways that second-hand smoke contributes to heart attacks. Glantz and his co-author, what is more, are widely respected, and were chosen to write a section on environmental tobacco smoke (ETS), which is what Banzhaf prefers to call it, for an important Environmental Protection Agency (EPA) report. The recent report, he notes in his letter, "cited the 53,000 estimate" in a thus-far unreleased compendium.

But, as we reported here, EPA says explicitly that it does not subscribe to or support this estimate, and the number does not appear in the body of the report released to the public.

We did not cite Glantz's paper. But we did refer to a similar correlative paper, published in JAMA, and we said that AHA, the American Lung Association and others endorse the number.

We did not cite Glantz because his conclusion—that "these results suggest that heart disease is an important consequence of exposure to ETS"—did not seem to us to be substantively stronger than Wells' conclusion [emphasis added]. What is more, he listed Wells as his source for the 53,000.

Consensus Claimed

Banzhaf says we are "factually incorrect!" in saying the 53,000 figure "does not enjoy any consensus in the scientific/medical community, nor among any government agencies."

Yet he acknowledges that we said that AHA, and the lung association, among others, have endorsed it.

We thus think we indicated, correctly, that health agencies that are in Banzhaf's words "concerned with the issue of smoking" accept this estimate, albeit other authorities, such as the New England Journal of Medicine do not—at least not yet. He reiterates in his letter that "the U.S. surgeon general, the chief medical officer of the U.S. ... endorsed the 53,000 estimate."

But, as we reported, ASH's citation came from an informal comment in a newspaper, and the SG's office told us explicitly, that it has no official position now on this number.

This, then, is one source of disagreement between Banzhaf and ourselves. In our view, an informal comment by a health official does not commit that official and his or her agency to a position. Banzhaf appears not to share this view.

Evidence Called Strong

Banzhaf's third major criticism is that we "strongly imply that the evidence regarding the health hazard of ETS is too weak to justify regulatory action; i.e., presumably that it is weaker than the evidence upon which health policy decisions are normally based." He adds: "This also is factually incorrect!"

The evidence Banzhaf then cites regards the cancer risk, not the heart disease risk, of ETS. This includes a generally-agreed-
Anti-smoking advocate John Banzhaf "has provided help" to non-smoking parents who seek court orders to prevent a spouse from smoking in their child's presence, the New York Times reports (Oct. 16).

The Times says there have been more than a dozen such cases in courts around the country, some of them efforts to deny custody in a divorce to a parent who smokes. These cases are increasing since the Environmental Protection Agency earlier this year blamed thousands of cases of childhood bronchitis, pneumonia, and asthma on parental smoking.

"We don't know how many of these cases there really are, because most of them are settled quietly with the smoking parent agreeing not to smoke in front of the child," Banzhaf told the Times. "But it is clear that this has started to come up more and more often, especially where the child is asthmatic."

However, the lawyer for a smoking mother in a California divorce case objects: "It's extending the court too far into the family," said C. Clay Greene. "The logical extension is that police should go into homes where parents smoke, whether or not they're divorcing. . . . And there's data to suggest that high cholesterol diets cause problems for children. . . . Does that mean that it's O.K. for the courts to forbid parents to serve bacon?"

upon 3,000 lung cancer deaths annually from ETS. We do not quarrel with this figure, which has been endorsed by the federal health agencies as well as by non-profits like AHA. We did not offer any opinion on whether this level of risk should engender stronger government anti-smoking intervention, although we, and Banzhaf, and the President and most other reasonable people believe that, taken together with all of the other evidence, it should.

We do see this fault in our argument: We said the federal agencies had not accepted the 53,000 number, of which about 37,000 are the heart deaths studied by Wells, Glantz and others. On the one hand, it is naive to think that a federal agency will act on the basis of a scientific finding, like the 53,000, until it has explicitly endorsed it. On the other hand — and this is the point we failed to make — the agencies are under enormous pressure not to endorse scientific findings that offend powerful interest groups, like the tobacco industry.

We can foresee the time when there is a broad scientific consensus on the 53,000, which the fed then should be coerced to accept and act on. But — and this is our difference with Banzhaf and ASH — we don't think that moment has come yet for sidestream smoke and heart disease deaths.

Politics Blocks Regulation

Banzhaf is understandably angry that the levels of risk that have been endorsed — 3,000 annual lung cancer deaths — probably are higher than with other so-called Group A carcinogens, such as asbestos, for which far-more-rigid restrictions already are in place than is the case with tobacco. Due to politics, the government simply has not been willing to regulate smoking with similar rigor.

But the asbestos analogy also reveals a regulatory hazard that concerns us: Banzhaf points out that a Group A carcinogen is one for which there is no lower limit of risk. The data behind the 53,000 which indicates a low, but quite real added risk of 1.2 or 1.3 risk of death from heart attack or coronary heart disease, is based on studies of married people who lived for twenty or more years in close proximity to spouses who smoked. But the ASH publication seems to us to suggest that even a brief, casual encounter — such as walking through a puff of someone else's smoke stream at a ball game — might be risky.

Common sense suggests to us that this risk must be vanishingly small. What is more, we are very worried, as with asbestos, that the damage — particularly fear and hysteria — may be all out of proportion to the reality.

Fear Is a Risk Factor

News reports indicate that the delay in opening the public schools this fall in New York and other cities because of residual asbestos has created fears that may damage these youngsters far more than a short-term physical exposure to asbestos fibers. We are concerned in the same way that anti-smoking zeal not create a similar hysteria about an occasional whiff of cigarette smoke.

As the asbestos story demonstrates, it is important to develop rational and cost-effective ways to translate scientific finding into public policy (if for no other reason than to prevent backlash). We understand anti-smoking advocates' anger and impatience. We think their purpose will be best served by staying within rational bounds.

Banzhaf's fourth major criticism is that even if ETS caused only 3,000 annual U.S. deaths, it still would be a major killer, albeit our headline asked "Is it?" Three thousand is an order of magnitude less than 53,000. But we agree with Banzhaf that this is a "major" — and unnecessary — cause of death.

We join him in hoping it will soon be ended as Americans are persuaded and, yes, coerced to stop smoking.

Press Often Cites 53,000 ETS Deaths

ASH chief Banzhaf points out, correctly, that the 53,000 figure ... has been widely cited — often even without specific attribution — in many leading newspapers and magazines, [and] in broadcasts by major TV and radio news organizations. . . . This also tends to show that it has ... met the standards of those major journalistic institutions, regardless of the conclusions reached by PROBE."

This is precisely our point: One job journalists have is to question widely disseminated statements about science — particularly unattributed ones — even when they are cited by the most correct and praiseworthy sources. We wondered how many of our colleagues had thought to probe the 53,000, rather than just cite it — and that was one of the main reasons why we looked into it briefly in our pages. — D.Z.
Approaches . . .
continued from page 5

was discussed, for example, in a symposium on neonatal medi-
cine at the Columbia-Presbyterian Medical Center, in Manhat-
tan, in the mid-1980s.

First Experiment Failed

Several factors account for the long lead time in bringing it
to clinical testing. For one, Prince said, NIH was reluctant to
allot chimps for the requisite animal studies until there was
some indication the method would work — and the first experi-
iment failed, perhaps because the high dose of HIV that was
used overwhelmed the antibody. The next, lower-dose study
did work; additional animals then were allocated.

The drug company Abbott Laboratories had indicated, early
on, that they would collect the plasma and prepare the HIV-
IG. Then, in about 1990, Abbott decided they didn’t want to
do it, Prince said. But NIH continued to negotiate with them,
in vain.

By the time the federal agency switched gears, selected a
new bidder — North American Biologicals, of Miami — and
that company had come on line, another year or so had passed.
The study thus was delayed by more than two years, he said
— and it may not work.

A Los Angeles immunologist who is working on the HIV-
IG effort, E. Richard Stiehm, M.D., of UCLA, is more optimis-
tic than basic researcher Prince:
“If we can get a handle on transmission, we are going to
wipe out pediatric AIDS .... This [HIV-IG] protocol is the
best shot we have!”

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