Post Mortem on a $24 Million Lawsuit:

Ex-Editor Reiman and Three Colleagues Sued for Giving Cancer Care Warnings

Purveyors of “alternative” therapies use public opinion and political pressure to silence scientific critics (PROBE, Jan.). They also file lawsuits against their critics. They may have little chance of winning these cases. But their suits are time consuming, anxiety provoking, and costly for the critics to defend.

The defendants say these suits have a chilling effect on constitutionally protected free speech, and on their ability to inform the public. Here is a recent case in point:

Early in 1992, reporter Jeffrey Weiss of the Dallas Morning News heard radio ads for an organization called Cancer Treatment Centers of America (CTCA), in Tulsa, Okla., and in Zion, Ill. The commercials promised “comprehensive, innovative” treatment programs for cancer cases that “others call ‘hopeless.’”

Weiss, to his relief, was not sued. But the four doctors were. The suit, filed by CTCA’s attorneys in the U.S. District Court for the Northern District of Texas, on August 4, 1992, charges:

- “Defendant Reiman is quoted in the article as stating: ‘This kind of advertising clearly implies they can do things other people can’t do. It’s reprehensible. It’s sleazy … You can get testimonials for snake oil.”

- “Defendant Herbert is quoted ... as stating “[CTCA] has a long history of promoting questionable to worthless but lucrative procedures for cancer.”

- “Defendant Moertel is quoted ... as stating that ‘large numbers of very expensive laboratory tests’ were given despite [their] having ‘no established value’. … In one case I reviewed, a bill of almost three-quarters of a million dollars was accumulated while the patient deteriorated and died over a period of six months. …”

- “Dr. Winn is quoted … as stating he was ... ‘aghast to see that [a CTCA patient] had been hospitalized five days a month to receive chemotherapy by infusion. … That’s fraudulent. They should be arrested for that. There is absolutely no data to suggest that has any benefit.”

The Treatment Centers charged that all four quotes were “false, malicious and libelous per se.” They charged that the defendants “knew or should have known” that the [quotes] would be published, and “would be adverse to CTCA and defamatory of it,” and “would be likely to adversely affect

continued on page 3
Finding Scifrauders: We goofed last month when we failed to indicate how PROBE readers can subscribe to the online Scifraud bulletin board via the Internet. The address, according to the board’s founder, sociologist Al Higgins, Ph.D., is: listserv@Albnyvmil.

At the prompt, enter: subscribe scifraud john doe, using your first and last name. Besides the bulletin board, which yields several or more communiques daily, scifrauders have access to a database called rachel, on which Higgins has stored 7.5 megabytes of annotations on both obscure and well-known “scifrauds.”

Self-destruct needles (cont.): We commented last September on the early commercial success Bio-Plexus, Inc., of Tolland, Conn., is having with its Punctur-Guard hypodermic needle. This needle locks permanently, with the point safely covered by a blunt cowling, after just one use, so it cannot be reused or penetrate a second person’s skin. Bio-Plexus is selling it as a safety device for doctors, nurses and other medical phlobotomists; it protects them from accidental needlesticks that could transmit AIDS.

These needles, we pointed out, are not currently available to those at greatest risk of needle-borne AIDS infections: intravenous (IV) drug users who share needles with other drug users. We recently received a letter from Bio-Plexus president Carl R. Sahi, Punctur-Guard’s inventor. He writes: “Since we are a new company, we must target the market that is requesting our product [health care workers, hospitals]. Obviously, the IV drug users will not be asking for our product by name. Nor will they be willing to pay a higher price for a single-use needle.”

Sahi adds: “We believe that legislation requiring single-use hypodermic needles and/or legislation raising the cost of [competing] non-protective single-use needles to mirror the cost of protective needles will be necessary to put our product in the hands of this reluctant market [of IV drug users].”

Sahi thus is saying, as we have for many years, that a political decision is needed to introduce this technology. It could save tens of thousands of lives and billions of dollars by curtailing HIV virus spread among drug users and their sexual partners — who account for most of the women infected by the virus.

We favor a legislative initiative, and the public debate it would stimulate. But the initial steps may be simpler. The first step, which may require only administrative action, would be to make hypodermic needles non-prescription purchases in the few, heavy-drug-use states like New York, where an Rx still is needed to buy them.

Then, companies like Bio-Plexus may need some encouragement and incentive to put their self-destruct (SD) products into drugstores. Perhaps IV drug users aren’t total fools, and will pay a dime or so more for non-reusable needles. If this non-coercive, free-market approach is not enough, it then might be time to consider the more radical legislative steps — such as banning non-safety needles, or equalizing the prices — that Sahi suggests.

The virtue of self-destruct needles, like condoms, is that they are immediately effective: The first time an lllV-positive drug user with shared needles contacts an lllV-positive partner, it is effective. The virtue of self-destruct needles, like condoms, is that they are immediately effective: The first time an lllV-positive drug user with shared needles contacts an lllV-positive partner, it is effective.

Need Rising
A major shift in the AIDS epidemic underscores the need for self-destruct (SD) hypodermic needles and syringes: Preliminary figures for 1994 indicate that three-quarters of new HIV infections now are in drug addicts (N.Y. Times, Feb. 28). New infections among gay men have fallen proportionately. (Total new infections remain stable.)

The change prompts psychologist Don Des Jarlais, Ph.D., an AIDS-in-addicts expert at Beth Israel hospital, in Manhattan, to urge that AIDS prevention efforts be refocused on the impoverished black and Hispanic communities where most AIDS transmission among addicts occurs. Des Jarlais supports needle exchanges and expanded drug treatment facilities. But he has opposed SD needles, saying they would make it hard for addicts who run out of needles to shoot up. Since Des Jarlais is one of the few recognized experts in this field, his opposition has scotched SD development plans.

As the AIDS crisis wanes elsewhere, but deepens among his constituents, we hope Des Jarlais will change his mind, and lend his considerable influence to SD needles.

Thalidomide Redux: We reported exclusively two years ago (Dec. ’92) that immunologist Gilla Kaplan, M.D., at Rockefeller University, in Manhattan, was finding early promise for thalidomide in controlling cancer and AIDS symptoms. It previously had been shown to relieve severe nerve pain in leprosy sufferers.

Thalidomide, old-timers will recall, is the sleeping pill that was yanked from the market thirty years ago when women who continued on next page
Ex-Editor...

continued from page 1
CTCA's business."

CTCA demanded $1 million in compensatory damages and $5 million in punitive damages from each defendant: a total of $24 million for the four doctors' quotes.

Defenses Mounted

In phone interviews, Relman and Herbert said they were defended by their medical centers' lawyers. Winn was defended by the state of Texas, according to officials, because M.D. Anderson is part of the University of Texas, a state school.

Moertel died late last year, of cancer; a Mayo spokeswoman declined to comment on the case.

The out-of-state defendants' lawyers argued, successfully, that since they did not do business in Texas, and rarely visited the state, the federal court there had no jurisdiction.

On December 21, 1992, these cases were dismissed.

Oncologist Winn, in Houston, appears to have been the defendant who was most upset by the lawsuit. Reporter Weiss said by phone:

"He may not be willing to talk to anybody associated with any publication for the rest of his life!"

Winn, reached by phone at M.D. Anderson, confirmed that the case against him was closed, but declined to discuss it.

He said:"
"[Like 3] is a non-answer that will answer your questions:
I'm referring all calls on that incident to the lawyers."

He added:
"If they agree, I'll talk to you."

Attorney Karen Blinka, at M.D. Anderson, checked with Texas attorneys in the state capital, Austin. In a follow-up phone conversation, she quoted them as saying:

"The last time we got into this story, we got sued. Let's stay out of it."

Blinka added, "We just went through so much on that," and "we don't need any more problems."

At the university's office of general counsel, in Austin,

Follow-Up...

continued from preceding page

took it gave birth to grotesquely deformed babies, some of whom have flipper-like little appendages in place of arms or legs (phocomelia).

The drug has been studied off and on ever since. Kaplan and her colleagues have found that it reduces high levels of a substance called tumor necrosis factor, which causes weight loss, fever, and other symptoms in sufferers of AIDS, cancer, and TB. This research appears to be progressing nicely.

Kaplan and an associate have just been awarded U.S. patent 5,385,901 for thalidomide's use against these disease symptoms. The patent is assigned to Celgene, a Warren, N.J., biotech company that is conducting clinical trials of the drug against AIDS and cancer.

March 1, 1995

attorney Richard Webb said that being the defendant in this kind of suit "is most definitely not a pleasant experience." Webb said that, except in rare and specific circumstances, such as whistle-blower suits, plaintiffs cannot recover damages from Texas state agencies, like the university, for intentional wrongdoings. Recovery of exemplary damages, demanded by CTCA, is similarly restricted.

Webb said that the case was handled by attorneys from the Texas Attorney General's office, who did "a good and aggressive job of defending the university."

The state requested summary judgment on September 23, 1993, which was granted, according to records at the Attorney General's office, in Austin.

Attorney Webb declined to comment on the CTCA suit, saying that it was in Winn's best interests, "not to have any further statements or comments of any kind" on the case.

M.D. Anderson vice president for public affairs, Steve Stuyck, said, however, from Houston, that there has been "no change at all" in M.D. Anderson policy with regard to informing the public. As a state university, he said, the University of Texas is accountable to the public — and encourages communication with it.

Relman Speaks Out

Internist Relman, in Boston, was less reticent than Winn.

In retrospect, he said recently by phone from his office at Brigham and Women's Hospital, "a lot" of his time and effort went into defending the suit. Harvard's lawyers told him from the start that CTCA's case was "without merit," so he need not worry about it, he said. He nevertheless was concerned.

"It was a nuisance, and a cause of some anxiety and concern, even though I knew I was indemnified [by Harvard]," Relman explained, adding that CTCA's action was the first such suit he had faced.

Asked if the experience had changed the way he now would respond to a similar query, Relman said:

"I'm not sure I'd be entirely honest if I said it hasn't affected me."

He added:

"I guess it would depend on the circumstances."

If the issue he was asked to comment on was "an egregious one," and "I thought some public response was needed," Relman continued, "I think I would go ahead and risk some legal action because I would want to do my public duty."

But under less compelling circumstances, he added, "I think I would hold back."

Herbert Is Not Afraid

Dr. Herbert, who is an attorney (J.D.) as well as a physician, has had a long and confrontational relationship with alternative health care providers. Asked recently by phone if he was cowed by CTCA's suit, he replied:

"Absolutely not!"

Herbert explained that because he is a lawyer, "I know what I can say that is not actionable, and I speak only the truth and do not elaborate on it. I state the sources."

None of the health centers' administrators divulged the cost
Feds Pin "Scientific Misconduct" Flags On Dozens of Fisher's Medline Cites

Early this month, cancer researcher Bernard Fisher, M.D., sued the National Institutes of Health, the National Cancer Institute and its chief, Samuel Broder, M.D., the director of the Office of Research Integrity, and other federal officials. The suit, filed in U.S. District Court in Washington, charges the officials intentionally smeared his name — in violation of the federal Privacy Act — by putting incorrect flags saying “scientific misconduct” on over 100 bibliographic citations of his work in federally maintained databases (See below).

The Privacy Act prohibits federal agencies from disseminating incorrect information in government databases. Fisher, through his attorneys, is seeking damages, a temporary restraining order, and permanent injunctive relief, according to an announcement from his office in Pittsburgh.

The Bernard Fisher case continues to produce bombshells.

Here’s the latest:

Three federal agencies collaborated last spring to place warnings such as "Scientific Misconduct - Data To Be Reanalyzed," in citations for over 100 of Fisher’s publications in the important Medline and Cancerlit databases. These databases are maintained by the National Library of Medicine (NLM), a part of the National Institutes of Health (NIH).

The blacklisting came to light after Fisher’s Washington attorney sent NIH an ultimatum on February 15, saying that if the tags were not removed in 48 hours, Fisher would sue the government. The flags still were in place at month’s end.

The agencies cited no legal authority for the tampering.

Fisher Not Guilty

Fisher has never been found guilty of scientific misconduct. One contributor to his multi-center breast cancer clinical studies, surgeon Roger Poisson, M.D., of Montreal, has been found guilty of entering falsified data. But several reanalyses have since shown that his entries did not skew the results.

Only 65 of the flagged Fisher papers include Poisson’s data; some are editorials and think pieces, of which Fisher alone is the author.

Error Acknowledged

Bivens, according to a report in the fax publication Cancer Letter (Feb. 24), has since concluded that the wording was an oversight, and has ordered that the "scientific misconduct," but not the "data to be reanalyzed" phrase be removed.

"We didn’t ask for a ‘scientific misconduct’ flag on it," Bivens is quoted by Cancer Letter as saying. "NLM is used to that [label] when they get a request from my office, because usually it is as a result of a misconduct finding.

"I was not explicit enough in what the statement should have been."

But Colaianni disagreed. She told Cancer Letter that ORI explicitly requested the words “scientific misconduct.”

An NCI spokeswoman, Linda Anderson, said by phone that her agency initially asked NLM to flag the appropriate articles, and that ORI then stepped in to make the selections.

Asked if NCI had statutory authority to do so, Anderson said no.

"There’s no statutory authority at NCI," she said. "It’s in ORI’s hands."

Fisher Published

Fisher discovered the flags late in January, while he and an associate were checking citations for a book chapter on breast cancer he is writing, according to his daughter Beth, who is a physician. Two weeks later, two of the flags appeared in print in the citations for an article in NCI’s The Journal of the National Cancer Institute (Feb. 15, p. 318).

Fisher’s Washington attorney, Robert Charrow of Crowell &
Did ‘Integrity’ Chief Commit Misconduct?

There is wide agreement that fabrication, falsification, and plagiarism — or FFP — are, by definition, scientific misconduct.

Lyle W. Bivens, Ph.D., a psychologist — a scientist — is Director of the Office of Research Integrity (ORI). This is the Public Health Service agency that investigates scientists, and judges whether they are guilty of misconduct.

Last year, Bivens, in consultation with National Cancer Institute director Samuel Broder, M.D., sent the National Library of Medicine a list of publications "which required correction" because, he said, Montreal breast surgeon Roger Poisson, M.D., had falsified data. In his memo Bivens recommended that the affected publications be flagged in Medline to indicate that a reanalysis... may be needed based on a finding of scientific misconduct on the part of one of the contributors — Poisson — to the National Surgical Adjuvant Breast Cancer Project.

The memo did not cite any legal or regulatory basis for the black-flagging, probably because there was — and is — none.

There is some dispute about who made up the wording for the flags — and who, if anyone, approved it. But there is no doubt, based on Bivens' memo, dated May 20, 1994, that he ordered it.

Surgeon Fisher, however, has never been found guilty of scientific misconduct.

The Medline and Cancerlit databases, and the bibliographic citations that appear on them are part — a key part in fact — of the scientific literature. They are science.

Many, if not most, of these flagged citations and the research reports they represent contain no trace of scientific misconduct. For those few that do, it is Poisson's misconduct, not anything that Fisher did, that has been censured.

Bivens knew this, and if he didn't, he had but to read the papers to find out.

Either way, ORI for now is the federal agency authorized to investigate and judge these matters: Did Bivens commit scientific misconduct by falsification in black-flagging Fisher's scientific papers?

We think ORI should find out.

Obviously, Bivens can't lead an investigation of himself. In these circumstances, elsewhere in government, an independent special investigator is appointed. The person who would make this appointment probably is Health and Human Services chief Donna Shalala.

We think she should.

Feds...

continued from preceding page

Moring, immediately wrote to NIH Legal Advisor Robert Lanman, Esq., demanding the flags be pulled. The flags are "illegal," Charrow explained by phone from Washington. They violate the Privacy Act, a federal criminal statute, which requires that notification procedures be set up and followed in changing federal databases.

Error Charged

"They failed to do it," Charrow said. "It's one of the most ludicrous things I have ever seen in my life. It is beyond the pale!"

NLM's Colaianni said, by phone, that the library has procedures for flagging database citations, usually after the author of the journal has published additions, corrections, or notifications when, say, a drug dosage is incorrect as originally published.

"Generally, we only pick up comments when they are published in the journals in which the original article appears," she explained. "We don't try to go back and give any Good Housekeeping Seal of Approval."

Colaianni, obviously upset, said NLM doesn't comment on the literature it indexes. "In this case, and in one or two others, we were asked to do so to alert people," she said.

Authority In Doubt

Asked on what authority flags were added, she replied: "I don't know the specific statutory authority for [it]."

No authority is cited in Bivens' memo. An ORI spokes­woman, Barbara Bullman, said last month by phone that her "unofficial non-answer" is that ORI "provide[s] the information to the NLM when there is a need to correct the literature, and the NLM makes the corrections. So my understanding of it is that the authority for it lies with NLM."

Phone and fax requests to NIH legal advisor Lanman to explain the legal basis for the flagging were not returned. But an associate in his office noted, by phone, that one issue might be whether the flagged papers were published by the government or rather by private parties, as many, if not most, in fact were.

In sum, by month's end the flags had not been removed, and the federal officials, acknowledging that they erred, were pointing fingers at each other. No authority has been cited for the action — which damages Fisher, but, more importantly, significantly distorts and damages science.

Policy Explained

Librarian Lois Ann Colaianni, of NLM, has published the procedures through which its indexers add retractions, comments, and errata notices to Medline (Lancet, Aug. 29, 1992, pp. 536-7). In each case, she writes, NLM "links the citations to... published retraction notices, errata, or comments [emphasis added]."

Each type of emendation must be labeled, for example "retraction," she writes. "Comments" are defined as "substantive articles, editorials, or letters that have as their major purpose to challenge, refute, support, or expand upon another article or letter."

No provision is made in these guidelines for flags, tags, or other unpublished special warnings from NLM or other federal agencies.
We're changing the name of this occasional column on health care delivery from Clinton Health Watch, by deleting the President's name. The reason should be clear: The Clintons' health reform bill is dead. No replacement is in sight. Major changes are now unlikely to come from the White House.

But the health care crisis continues. Managed care is making matters worse.

One of the major sources of health care, now, and for the foreseeable future, is the federal Veterans Administration (VA) medical system. According to Elliott S. Fisher, M.D., and H. Gilbert Welch, M.D., who are health care planners at the VA Medical Center in White River Junction, Vermont, the VA's $15 billion annual budget represents less than 2% of annual U.S. health care expenditures. But, they add, in a Feb. 22 report in the Journal of the American Medical Association (JAMA), the VA is a major provider through its 171 hospitals, 350 outpatient clinics, and 126 nursing homes.

**Future Is Weighed**

The question, Fisher and Welch — and many others — ask is: What should the VA's future be? In particular, what should its future be in the event that veterans' use of its facilities peaks, and then begins to decline, as the veterans from major wars — particularly World War II, Korea, and Vietnam — gradually age and die? (See Box, below).

One answer has been: Expand the VA to serve wider numbers of Americans who are, or may become entitled to medical care (PROBE, Oct. '94). Such expansion was foreseen under national health care reform, but now is considered moot in light of the Clinton plan's failure.

The opposite proposal is to disband the VA. Given the powerful veterans lobby, and the nation's widely shared sense of obligation to the vets, this seems unlikely, at least for now. When New York Times columnist William Safire raised this option in print (Jan 12), he was sharply attacked from all sides.

**Morale Is Low**

After Safire's comments appeared, we phoned PROBE readers with VA experience, and some other health-care-delivery experts. None was very enthusiastic about expanding the VA's role. They cited its bureaucracy, inefficiency, rigidity, and the low morale that infects the VA system. On the other hand, one noted, the cost of bureaucratic inefficiency at the VA now may be no more than the cost of HMOs' business practices and profits.

Why, in this circumstance, should we — or anyone without a direct stake in it — care about what happens to the VA? Our answer, which we share with Karl Marx and the Republican Party is: Waste. An abhorrence of waste!

Tens of billions were spent to build the VA system; billions more have been spent to maintain it. So it seems wasteful to allow these facilities to decline until, finally, there is no choice but to close them.

Several alternative plans are discussed by VA doctors Fisher and Welch, in JAMA:  
- The VA reduces its role, to deliver only specialized services — such as rehabilitation medicine — to veterans only.  
- The VA forms partnerships with other primary providers to offer fairly comprehensive services to veterans.  
- The VA mounts its own independent plan to provide care for veterans and perhaps other consumers, such as veterans' families.

Currently, there are 27 million armed services vets. They and their families constitute 40% of the population, according to University of Alabama physician James A. Pittman, Jr., M.D., in an editorial that accompanies the Vermont VA doctors' JAMA report. But, as they indicate, fewer than 10% of the vets currently use the VA — and these are some of the very sickest due to substance abuse, mental illness, joblessness and poverty.

Many vets are ineligible for VA care because the service gives first priority to service-related injuries and illness. Many others are eligible, but don't know it, and many, too, are probably eligible, but the VA hospitals they apply to don't understand their eligibility, Fisher and Welch say. The eligibility rules are confusing both to vets and to VA administrators, they add. Many vets, too, receive care through Medicare or other entitlement programs, some in conjunction with the VA, some not.

**Decentralization Urged**

In short, it is a costly, confusing system. The Vermont doctors favor decentralization of the VA hospitals.

This could allow the hospitals “to offer a fully competitive health plan to attract any veteran, and perhaps even other populations,” wrote Fisher and Welch. “Alternatively, the VA could be encouraged to offer more modest benefits to some portion of those currently underinsured” — that is, the 39 million Americans who would have been covered under the Clintons' original reform bill.

The VA is unlikely to be disbanded, if only for political reasons, JAMA commentator Pittman points out. But reforms, if any, will not be easy.

Nevertheless, the number of people without adequate insurance coverage is likely to increase. We would like to see the VA and the department of Health and Human Services create a combined high-quality health care system to serve the many Americans that they are, or may become, responsible for.
King George's Madness Was Mistreated

In The Madness of King George, now playing in movie theaters, the British monarch is depicted as suffering from porphyria, a hereditary metabolic condition. New York psychoanalyst Shale Brownstein, M.D., who has studied the historical record, disagrees. His diagnosis: manic-depressive (bipolar) psychosis. Here is Brownstein's review of the film.

At the end of October 1788, a psychosis took hold of George III, paralyzing the central government of Great Britain for most of that winter. Nicholas Hytner's The Madness of King George emphasizes the violence that was inflicted on this interesting, manic-depressive (bipolar) psychosis. Here is the king's mental disturbance and radically reform what he was saying and doing.

**Review**

While we follow Dr. John Willis — authentically portrayed by Ian Holm — at his work, and watch his misguided attempts to force the king's behavior into the mold of a previous rational self, we feel privileged to think how much wiser we would be. In the end we have a welcome, happy conclusion:

The king is graced with a return to health.

The film's best triumph is that we can see Nigel Hawthorne from really up close, as we could not in Alan Bennett's play. There, the distressing scenes did have a far more oppressive effect. But the film does convey the full impact of how a devoted husband was forcibly separated and removed from his anxious wife. He is kept from his most intimate caretakers; all is contingent on his compliance with the medical regime.

**Doctors Are Abusive**

George is exiled from the home he loves best, mainly in fact for the doctor's convenience. We watch how his body is used as an object of arbitrary, pointless abuse. We are drawn into the forced submission of this gentle, formal, robust soul, and are persuaded — against our will — that Willis's regimen could be a worthwhile "catharsis" for this poor patient.

In history as in the film, Willis is a sinister figure, who is determined to gain the upper hand by arbitrarily thwarting his king, a psychotic patient whom he does not know. From the first moments they are together he uses coercive logic, and imposes mechanical force. He looks for the thing you can put your finger on. The Willis treatment is grounded in an incoherent, dead-end theory of personality. We are not given more than a hint of the good that could emerge in a face-to-face care giving situation that does not rely on direct confrontation with George III's manic behavior.

There is such a suggestion. It is in the journal of Frances Burney, who at that time was second keeper of the robes to the queen and an intimate acquaintance of the royal family. Burney, who is not portrayed in the film, remained fondly and constantly allied with his Majesty, even when she found him tumbling into a psychosis.

Unlike Dr. Willis, Burney responds to the complexity of the mad monarch. Nigel Hawthorne's portrayal of George III convinces us that the sick king is always more socially awake to nuance than the simple and stern Dr. Willis. In the midst of "losing control," George always remains acutely attuned to all the implications of his predicament. When I read the descriptions of the king's madness in Burney's diary, I imagined I was listening to Nigel Hawthorne.

Here is Burney's diary entry of October 25, 1788, at the start of the illness:

> I had a sort of conference with his Majesty, or rather I was the object to whom he spoke, with a manner so uncommon, that high fever alone could account for it; a rapidity, a hoarseness of voice, a volubility, an earnestness — a vehemence, rather — it startled me inexpressibly; yet with a graciousness exceeding even all I ever met with before — it was almost kindness.

Burney's words convey the excesses of the king's altered mood, his pressured speech, and his uncharacteristic inability to relate to her directly — his lack of social integration with her. A state of stormy, intense, sleepless, manic excitement continued for three full months after this.

Burney's judgment of the king she knew stands in sharp contrast to Willis's persevering for months to master the patient he serves. The difference is especially striking, since Burney was regularly responsible for informing the queen of the direct reports she received from the doctor.

An utterly surprising chance encounter between the king and Frances Burney on the morning of February 2, 1789 confirmed for both of them that recovery was certain and imminent. The two happened to meet in a place where the king could frantically pursue her, and then doggedly insist on an unauthorized, continued on next page

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**Recovery Bound**

> "[His Majesty] now spoke in such terms of his pleasure in seeing me, that I soon lost the whole of my terror. Astonishment to find him so nearly well, and gratification to see him so pleased, removed every uneasy feeling, and the joy that succeeded, in my conviction of his recovery, made me ready to throw myself at his feet to express it!"

> "What a conversation followed! When he saw me fearless, he grew more and more alive, and made me walk close by his side, away from the attendants, and even the Willisises themselves, who, to indulge him, retreated . . . ."

> "[H]e seemed to have just such remains of his flightiness as heated his imagination without deranging his reason, and robbed him of all control over his speech, though [he was] nearly in his perfect state of mind as to his opinions."

King George . . .
continued from preceding page
extended conversation. All this happened while two doctors and three attendants hovered about.

King Is Joyous

The king began, completely out of character, by holding Burney's shoulders, and, with "the joy of a heart unbridled," kissed her cheek. Most of his initial conversation was to inquire about her well being, and reassure her. He described what he had endured in the course of his illness, and then directed his talk to her father (a musician), Handel, the oratorios. He attempted to sing from them.

He spoke movingly about a recently deceased mutual friend. Then he went on about other friends, matters of state, and again about his wish to assist her father. He promised that "When once I shall get away, I shall rule with a rod of iron!", which "was very unlike himself." She judged him to be "so nearly himself — so little removed from recovery!!"

When Burney told this to the queen and all the court, the doctors followed her judgment and began to permit the king privileges they had withheld up to the time of this encounter. The very next morning, George was allowed to shave himself for the first time, at Kew.

Three weeks later the king met Burney again, in the queen's dressing room. He was now very much at home, and at ease. By March, life was altogether normal.

Serious mental illness struck again when the king was twelve years older, age 62, in February 1801. A third episode occurred in 1804. The last began in 1810, ending with his death in 1820.

— Shale Brownstein, M.D.

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