
PC, M.D.: How Political Correctness Is Corrupting Medicine

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She spoke at a Center of the American Experiment luncheon in February 2001.

I first became aware of the encroachment of victim politics into clinical care around 1995, when I was hired as a part-time psychiatrist at a drug treatment program run by the Washington, D.C., Superior Court. The patients were nonviolent offenders who had been charged with minor drug crimes and were given the option of going to a treatment program instead of to trial and, possibly, then on to jail.

The patients were African American men in their twenties and thirties. Most of them did not graduate high school; a number had GEDs. Most were functionally illiterate with poor

math skills. They had minimal work experience. When I got there the clinicians, the counselors, were practicing a kind of therapy called multicultural counseling.

What is multicultural counseling? It is a form of psychotherapy that assumes that one's symptoms of distress, including using drugs, are largely a result of one's being victimized by society, in particular because one is black. Treatment thus required the patients to acknowledge their place in the drama of the dominant and the disenfranchised. They spent many of their five court-ordered hours a day in the program

sitting in counselor-led groups talking about how they felt oppressed as black men. Sometimes they did art projects, like coloring in stenciled pictures of the African continent, as part of an effort to promote ethnic pride.

A fringe phenomenon? Alas, no. Indeed, most alarming to me is its endorsement by the American Counseling Association and its being taught in virtually every graduate-level counseling program in the country. The graduates go on to jobs in school systems and other public service venues, like our treatment program.

Well, the patients knew better. “A waste of our time” was the most polite opinion they expressed. What they wanted, they said, was to get a GED and learn a trade like plumbing or electrical wiring and join a union. And so a precious opportunity to help these men was squandered on feel-good exercises conducted by multiculturally oriented counselors who left them as uneducated, as unemployable, and thus as vulnerable to relapse to drugs—and crime, I should add—as when they came in.

This is one example of how political correctness is infecting the mental health field. Trainees are literally being taught to view patients as members of victim groups rather than as individuals who are suffering.

Women’s Health

Another growing trend in PC medicine is the search for power struggles behind practically every health problem.

Take women’s health. When the women’s health movement took off in

the early 1970s, it was an especially important time for women’s health, particularly in regard to reproductive freedom.

But today, much of the women’s health movement is an industry fueled by misinformation—or “Ms. information”—and aggrievement. Consider: We are constantly being told that women have not been taken seriously by the research establishment. Hillary Rodham Clinton once remarked on the “appalling degree to which women were routinely excluded from major clinical trials of most illnesses.” In June 2000 the Harvard Women’s Health Watch proclaimed that “nearly all drug testing has been done on men.” It’s become a verbal tic in virtually anything you read about women’s health—“women-of-course-have-been-left-out-of-clinical-trials.”

Not true. Let me give you some facts:

- In 1979, over 90 percent of all clinical trials funded by the National Institutes of Health (NIH) contained female subjects.
- Government surveys of the FDA in 1983 and 1988 found that “both sexes had substantial representation in clinical trials.”
- In 1997—the last year for which there are data—over 60 percent of subjects enrolled in NIH-funded clinical trials were female.

The complaints that the government’s investment in breast cancer research is insufficient are similarly hollow:

- Breast cancer research has received more money than any other cancer since 1985, the year the National Cancer Institute began keeping good records of disease-specific funding.
- Breast cancer is one of the five most generously funded illnesses, according to a 1999 *New England Journal of Medicine* article. The other four are heart disease, dementia, AIDS, and diabetes.
- A sample of major medical journals (published in the October 2000 issue of the *Journal of Controlled Clinical Trials*) found that female subjects outnumbered males at a rate of thirteen to one across all cancer trials, with the vast bulk of the women participating in trials specifically for breast cancer.

Good news, right? But don't expect the women's health lobby to admit it anytime soon. The women's health lobby—that is, the network of state and federal “offices of women's health,” the university-based “women's health centers”—must make women appear embattled and shortchanged if it is to gain government support, raise funds, and justify itself in the eyes of the public.

That's the logic behind the myth-making. But truth-telling aside, why is it important to topple the myth that women are shortchanged by medical research? Because the notion that women have been denied their fair share of breakthroughs has been used to lobby for policies and resources that waste money and, worse, unwittingly harm women.

Recall the great mammography debate in the U.S. Senate. A National Institutes of Health consensus group declared in 1997 that women in their forties need not undergo yearly mammograms. The group reasoned that the relatively high rates of false diagnosis in forty- to fifty-year-old women—and the needless surgery that may accompany such a diagnosis—did not outweigh the small reduction in mortality that the mammograms would yield. Women under fifty, then, were advised to make a decision with their doctor.

Reasonable enough, but the lack of firm guidance incensed a cadre of women senators and Health and Human Services Secretary Donna Shalala. They interpreted the lack of firm guidance as yet more evidence that women were second-class medical citizens. In the end, they introduced a nonbinding resolution that essentially forced the National Cancer Institute to issue guidelines approving yearly screening. And now women are unnecessarily exposed to the risk of a false positive mammogram.

Another matter: While breast cancer is, of course, a serious matter, women's health suffers when the emphasis on breast cancer overshadows the fivefold larger risk of death from heart disease.

Finally, the notion that women need to be compensated for being left out has led to the expenditure of millions of federal and state dollars to create “offices of women's health” within health agencies to oversee various expenditures and create new programs for women's health. The money would

be better spent on research or direct delivery of care than on building bureaucracies.

Interpreting Differences

Take so-called health disparities, such as differences in the infant mortality rate, cancer death rate, and longevity, between whites and blacks. These discrepancies are a very real and very vexing public health problem, and Health and Human Services (HHS) is rightly putting lots of resources into narrowing the gap.

The problem arises in interpreting the meaning of the differences in health status. Some see them as de facto evidence of bias in the system or of racial insensitivity on the part of doctors themselves. Take kidney transplantation. It is a fact that black patients with end stage renal disease are slower to be placed on the transplant list and once on the list wait twice as long to receive a kidney. There is no debate that this is a problem that needs fixing.

But there is growing debate about what it means. The U.S. Commission on Civil Rights sees the transplant issue as part of a larger trend, to quote from its 1999 report to Congress and the president: "Racism continues to infect our health care system." The Reverend Al Sharpton and other black leaders warn that health will be "the new civil rights battlefront." A law professor and a prominent nephrologist, writing together in the *Vanderbilt Law Review*, propose suing the federal government for violating Title VI of the Civil Rights Act in the allocation

of organs. Why the federal government? Because organ allocation algorithms and monitoring are under HHS control. The implication is this: we may soon be expected to provide not only equal health opportunities (a worthy goal) but also equal health outcomes (an impossible one).

To assess the fairness of the charges of bias, we must first walk through the steps involved in donating and receiving a kidney. I've gone into detail in my book, but here I will highlight two key elements:

- Placement on a waiting list for an organ. It is one's regular doctor who puts one on the wait list. Black patients are less likely to have a regular doctor.
- Tissue compatibility. Without a good "match," the donor kidney will provoke the recipient's immune system to attack or reject it.

The better the match on biological variables, the better the outcome, but black transplant candidates have lower rates of matching. It's not a conspiracy, it's biology. As a RAND report says, "Once a patient is on the waiting list, biological factors tend to predominate" in explaining chances of receiving a kidney.

In recent years, African Americans represented a little over one-third of the waiting list, donated about 12 percent of all cadaveric kidneys (proportionate to their representation in the general population), and received 27 percent of all donated cadaver kidneys, so about half of the organs came from white donors.

Donation is a gift of life that transcends racial scorekeeping, but it is still important to look closely at the evidence when bias in the allocation of a precious resource like organs is alleged.

Yet the evidence is typically not examined in much depth, and superficial disparities are assumed, in knee-jerk fashion, to be the result of bias. This is especially harmful because there is enough well-grounded distrust of the health care system. After all, some Southern hospitals were segregated—separate but not-so-equal—until the mid-1960s; a handful of medical schools barred black students until the mid-1960s. The forty-year (1932–72) Tuskegee syphilis experiment was an outrage: it included about 400 black Alabama sharecroppers who were not told they had syphilis, were not told to refrain from sex (and risk transmitting it), and were not treated with penicillin when it was discovered during the course of the study.

But claims made *without evidence to back them up* that health disparities in the twenty-first century are due to current bias in the health care system do not help. What *does* help is programs that focus on the public's attitudes and knowledge about health matters.

A wonderful program—the Minority Organ Tissue Transplant Education Program (MOTTEP)—was created in that spirit out of Howard University in Washington, D.C.

Organ donation—especially of kidneys, and especially from living donors—is vital in the black community since black patients represent over

one-third of patients on the renal transplant waiting list. MOTTEP educates the community about the transplantation process and encourages families to discuss organ donation and sign donor cards.

MOTTEP is now active in over a dozen cities, often working with black churches, and the donation rate has increased. The good news is that there are hundreds, maybe thousands, of these community-university medical center partnerships that sponsor, for example, church-based programs in cancer screening, blood pressure screening, smoking cessation, weight loss.

These efforts are key because the so-called lifestyle choices profoundly influence health. About half to two-thirds of all premature deaths (death before age sixty-five) are postponable or preventable. Three factors alone—smoking, being overweight, and drinking too much—account for the largest share of risk. It is not, as one Centers for Disease Control official has charged, “blaming the victim” to acknowledge this. If anything, it is dereliction of duty *not* to acknowledge the lifestyle elements that we can control.

Health and Wealth

Nonetheless, we see more and more public health experts promoting the idea that health is so thoroughly at the mercy of social forces that there is little one can do to safeguard one's health. A doctor with the University of Washington School of Public Health used *Newsweek's* “My Turn” column (February 26, 2001) to prescribe “income

equality” as the cure for the nation’s health problems. He relied for justification on highly questionable data purporting to show that countries with shallow income gradients have longer life expectancies. “Research during the last decade has shown that the health of a group is not affected substantially by individual behaviors such as smoking, diet, and exercise,” he wrote.

Public health experts who see income inequality as a health risk go beyond the notion that poverty is bad for health—something we can agree upon—to the far more questionable notion that relative wealth is a determinant of health. As John W. Lynch and George A. Kaplan of the University of Michigan say, “Even those with good incomes might feel relatively deprived compared to the super rich. . . . Health may be affected through individual appraisals of relative position in social order.” Thus, the associate professor with a brand-new Volvo station wagon and a cottage by the shore is more vulnerable to illness than the college president who lives in a mansion and has a second home in Tuscany.

The idea of relative social position, apart from income, is also believed to have an impact on health. A favorite case used to illustrate the point that good health of the well-off somehow depends on the poor being sick is the Whitehall study. The first phase of the study (conducted from 1967 to 1977 on British civil servants) found a gradient in mortality from heart disease that increased from the top grade of employment and pay down to the low-est-paid, menial jobs.

Death rates were, as expected, highest at the bottom of the five civil service grades. After all, folks at the lower reaches are more likely to smoke and drink, and are less educated about health risks. Access to health care was not an issue because of the National Health Service.

But the researchers were surprised to find that the workers in the second-highest tier—well-educated, well-paid folks—were still substantially more likely than those at the very top to die of heart disease before a certain age. Their interpretation of the top tier versus second tier difference was that the second-tier workers experienced the stress of having “low-control jobs”: a lot of responsibility with minimal authority.

Personally, I find the Whitehall study compelling. We surely know from lab studies that when animals like rats and monkeys are not able to control their environment—to escape a shock, for example—they suffer physically: they lose their fur; their immune systems are suppressed; they become sluggish and passive. It’s called learned helplessness, and it probably occurs in people, too, though it’s harder to study experimentally.

Let me say that the original British researchers who conducted the Whitehall study were cautious and responsible in their interpretation of their data. It is the latter-day indoctrinologists who have used the Whitehall study as a cautionary tale about the perils of economic hierarchy. As Lynch and Kaplan of the University of Michigan speculate, “Health may be affected

through individual appraisals of relative position in social order.”

Richard Wilkinson of the University of Sussex in England, who is considered the father of social production theory, is more emphatic: “The higher health achievement of egalitarian societies makes a persuasive case for the redistribution of income.” Wilkinson bolsters this statement with research that purports to show that countries with higher levels of income inequality have citizens with lower life expectancies.

But wait a minute. What about alternative lessons to be gleaned from Whitehall? For example, couldn't we just as reasonably view the study as an object lesson in the importance of free enterprise, accountability, and opportunities to be creative on the job and the promise of mobility? At the very least, the Whitehall study is a good argument for high job control, a recommendation made by Michael Marmot, the lead Whitehall researcher.

And what about the relentless emphasis on relationships between health and wealth? These academics could just as easily look at the linkage between education and health and take up the fight for school choice in inner cities with failing public schools if they burn to be social activists. And wouldn't it make sense to encourage marriage and religious activity, since both are associated with better health?

The answer by now should be clear: the only acceptable remedies in politically correct medicine are social actions that would disrupt our prevailing economic and social systems.

Cause or Correlation?

To be sure, health is correlated with wealth. Poorer people, of course, have fewer choices—less-safe cars, fewer opportunities for stress reduction, less knowledge about health risks—and give less priority to things like annual Pap smears. They have fewer choices about where to get care and, just as important, when they can get care. We take flexible hours for granted, but many people simply don't get paid when they don't work or can't take two hours off to go for adjustment of their blood pressure medications or get a mammogram.

At the same time, we must keep in mind that the correlation between income and wealth does not necessarily imply a causal relationship. There is much the individual can do to protect his health even within economic constraints.

Take the case of Mexican women who are recent immigrants to the United States. Their babies have a low infant mortality rate (six per 1,000 live births, the same as whites) even though they themselves are among our poorest citizens, are the least likely to have public health insurance, and have the highest rate of births outside of a hospital.

So shocked were the researchers who first made this observation that they called it the “epidemiological paradox.” But it's not really such a mystery. Pregnant Mexican American women make sure they have good nutrition, and they rarely smoke, drink, or use drugs.

Compare this scenario with the dystopic worldview of Sally Zierler of Brown University's Department of Community Health and Nancy Krieger of Harvard's School of Public Health, who write, "In response to daily assaults of racial prejudice and denial of dignity, women may turn to readily available mind-altering substances for relief. . . . Seeking sanctuary from racial hatred through sexual connection as a way to enhance self-esteem may offer rewards so compelling that condom use becomes less of a priority."

According to Zierler, AIDS is a "biological expression of inequality," the ultimate prescription for which is subverting the capitalist meritocracy. Her approach captures the spirit of activist public health: social transformation masquerading as a health solution. Indeed, at a meeting of the American Public Health Association (APHA), Zierler presented her "recommendations" for curbing the spread of AIDS. They included limiting the power of corporations and strengthening labor unions.

Now consider tuberculosis. I suppose one could also refer to it as a biological expression of disenfranchisement since it tends to affect the homeless and addicted, but it was New York City's hard-nosed decision in the early 1990s to require everyone who needed TB medications to take them daily, in front of a health worker. For HIV/AIDS we need consistent partner notification and tracking, something about which the APHA has been silent. Meanwhile, the association has been vocal about the need for campaign finance reform,

pulling out of the war in Nicaragua, and opposing welfare reform.

We all want a healthy and humane society, but people at high risk for infection don't have time to wait for the revolution.

Politics vs. Public Health

I realize that people sometimes turn to reckless sex and drugs and alcohol when they feel distraught or hopeless. But this reality takes us out of the domain of public health and into the realm of the human condition. Surely the latter can be improved—by better schools, stronger families, more optimism about the future—but such is not the proper focus of activities of public health experts whose resources are most productively spent on the traditional and indispensable mission of preventing and tracking diseases.

Public health is losing its clinical moorings as academics and practitioners mount campaigns to influence upstream factors like social injustice, income inequality, racism, and sexism. By defining these as palpable threats to public health, the new public health elite has expanded its purview. Indeed, a former dean at the Harvard School of Public Health said, "A school of public health is like a school of justice." The theme of the APHA's annual meeting a few years ago was "Empowering the Disadvantaged: Social Justice in Public Health." Just how is it that the public health world thinks it has a comparative advantage in defining social justice or in producing the instruments that can attain it?

The harms of embracing a social-justice, all-inclusive agenda are obvious. Classrooms are politicized. The focus of public health—the people who keep us safe from infectious outbreaks and other things that make them unsung civic heroes—is blurred and its resources diluted. Most important, the public is misled by the message that health is at the mercy of social forces.

None of this is to say that public health professionals should not advocate practical interventions. In the early part of the twentieth century the APHA joined the fight in New York City to eliminate decrepit, crowded housing that led to rapid spread of infectious disease. Public clinics are vital for my working-poor patients.

But these are practical reforms and interventions with immediate benefits. By contrast, the politically correct currents now flowing through our schools of public health and health agencies are not about local pragmatism but a global ideology designed to influence the way we think about the origins of disease and its remedies.

The playing out of politics at the expense of patient care is happening elsewhere in health:

- Nurses are rejecting the male medical hierarchy and turning to unproven nonsensical alternative medicine.
- Medical school racial preferences result in accepting underprepared students who fare quite poorly in training.
- A \$100 million center has been established at the National Insti-

tutes of Health to study minority health and health disparities—a perfectly good object of study, but the other twenty-odd NIH agencies are already doing so, as is Centers for Disease Control and other agencies within HHS. This is a waste of millions of taxpayer dollars that could go to a few new clinics in the neighborhoods like Northeast Washington where my drug treatment program is located.

The purpose of my book is to bring awareness of these trends to the public and to embolden my colleagues in public health, medicine, and nursing—most of whom are dedicated professionals who put their patients before their politics—to speak out and reject politically correct trends and programs in medicine. Political correctness already has marched through many of our institutions, but I am hoping that sunlight and common sense will be strong disinfectants against its movement into my profession.

After her speech, Dr. Satel took questions from her American Experiment audience.

Mitch Pearlstein: One of the chapters that worked particularly well in your book—not surprisingly, given the fact that you’re a psychiatrist—was your chapter on mental health. How is political correctness manifesting itself in that field?

Sally Satel: Actually, there are two chapters. One is called “Therapy for

Victims,” and that’s where I talked about multiculturalism.

The other, “Inmates Taking over the Asylum,” is about a group of folks called consumer-survivors. **Consumer** means that they have consumed mental health services, and **survivor** refers to having survived the receipt of mental health services. Consumer-survivors literally call themselves the “last minority”; they talk about their plight as a civil rights issue. Basically, they are former mental patients who have been hospitalized, but they’re pretty functional now. They believe that organized psychiatry is oppressing them and it must be stopped.

I’ll tell you what their mission is, and then I’ll tell you why they’re a threat, even though they probably don’t number more than a thousand. They’re not going to succeed, but their mission is, literally, to take over the mental health system. They really feel that they should be the ones to run the system and that mental illness is a construct. We’ve heard this before; it’s not new. The argument is that mental illness is in the eyes of psychiatrists only and that if the patients didn’t take medication and weren’t seeing psychiatrists, they’d be fine.

Their lobbying efforts are dangerous to severely mentally ill people, to the schizophrenics and bipolar individuals and those with psychotic illnesses. The severely mentally ill are a minority, probably less than 5 percent of all people with psychiatric illness, yet about half of these profoundly ill individuals have little or no insight into the fact that they are deranged. There are situ-

ations in which we need involuntary commitment and required medication.

You must have heard of the case in New York in which a woman was pushed in front of a subway train by a schizophrenic man. When he quit taking his medication, he would become delusional or violent.

The schizophrenic man who shot two guards at the U.S. Capitol two years ago was another classic example of someone who did very well when he was on medication, but when there was nobody watching to make sure that he took that medication, he spiraled back into psychosis.

Many states—more than thirty—have mechanisms to require that people take medications when they have a reliable history of becoming seriously debilitated or a danger to others when they discontinue them. Much legal protection is built in, and experience shows that hospitalization rates do decline when this policy (officially called outpatient commitment) is enforced.

The consumer-survivors are hell-bent on subverting these policies. One of the reasons they’ve been effective—and this gets to the important point—is that they’re getting a fair amount of their funding from the federal government, from Health and Human Services and an institute called SAMSA, the Substance Abuse Mental Health Services Administration. The head of the agency is a great supporter of consumer-survivors and is essentially giving them money to undermine what his organization does: distribute block grants to fund conventional treatment programs. I’d like to see more of our resources going

in a targeted way to the sickest people. But here they are, funding folks who are subverting their message and their mission. The consumer-survivors are quite skilled at getting in the way of the kind of policies that can get some of the sickest people off the street and make them healthier and safer.

I should add that there is nothing wrong with soliciting advice from former patients—they can often suggest helpful improvements—but the radical consumer-survivors are not interested in improving the system; they are invested in dismantling it, as I show in chapter two of my book.

Kimberly Crockett: Is the American Public Health Association getting my tax dollars?

Sally Satel: I'm not sure. I could imagine that they may get some government grants to pursue certain educational programs.

Maureen Pranghofer: In the mid-1990s, I was in graduate school at the University of Minnesota, working on a master's degree in medical social work with an emphasis on working with HIV populations. We had a lot of teaching in our classes about the gay and lesbian lifestyle, and we were repeatedly told that if we were to be effective counselors and work with this population, we had to advocate for them politically.

One day I asked whether it would be a problem if I was a compassionate counselor and provided good care but chose not to advocate for the lifestyle. I was told that the system was working toward

a structure in which you wouldn't be able to be licensed in Minnesota unless you agreed to do that. I didn't finish my degree because of an accident, so I don't know what happened with that. Do you think there are other people who are being forced into doing things that they don't necessarily want to do, and what can be done about it?

Sally Satel: Within the realm of multicultural counseling, it is understood that the good counselors are politically active. I don't know if it's literally a requirement. I learned, to my horror, that in San Francisco General Hospital, people who work as nurses or social workers with a population that's predominantly African American have to be certified as African American health specialists; I got the forms from the county civil service agency. There are so many things wrong with this. One that came to my mind immediately is how it almost sets people up to say to African American patients, "Well, I can't work with you because I didn't take this class—I don't know anything about African Americans." How bizarre to think that our needs are so different, depending on group.

Mitch Pearlstein: When my wife and I were adopting a biracial child, one of the questions we had to answer was "What do black people like to eat?"

Twila Brase: Enforcement of recent federal medical privacy policies—which actually give public health officials access to medical information without patients' consent if the doctors and hospitals are willing to give it

out—has been put into the Department of Health and Human Services Office for Civil Rights. That struck all of us at the Minnesota Citizens Council on Health Care as a bit strange. What will the ramifications be when it comes to data and civil rights?

Sally Satel: That may have the farthest-reaching consequences of all. We are approaching a scenario in which it is not enough to try to guarantee equal health opportunities. Equal health opportunities is a reasonable goal. But we can't begin to try to guarantee health **outcomes**, which I fear is where this is all heading. It's fine to track health—to track anything you want, if you do it competently. Information is information. But you're right: it could be put to a use that would not be constructive.

The two-volume 1999 report from the U.S. Commission on Civil Rights absolutely eviscerated Donna Shalala and the Health and Human Services Office for Civil Rights. Ironically, there are many criticisms of the HHS one might have, but those that the Civil Rights Commission levied were illegitimate.

Luckily, the report got buried. It was a ludicrous document whose conclusions were that racism affects the health care system. It was an angry, unsophisticated, knee-jerk analysis of what disparities mean. Reasoning backwards, it declared that the occurrence of differences meant that there was some sort of bias that produced them.

I just learned that some researchers at George Washington University got several hundred thousand dollars from

the Robert Wood Johnson Foundation, my old benefactor, to develop a blueprint for how to use civil rights laws to approach these disparities. I'm not reading between the lines; the description of the grant notice is explicit.

Merlyn Scroggins: St. Cloud [Minnesota] State University issued a regulation five or six years ago that to enter the social work school, you had to take a politically correct oath. The Catholic Defense League, with two or three other groups, challenged the university, and the university backed down.

Linda Solie: In *Homosexuality and the Politics of Truth*, Dr. Jeffrey Satinover claims that a homosexual lifestyle is more dangerous to one's health than an active alcoholic lifestyle. He also claims that there have been more successful treatments in helping homosexuals have a heterosexual lifestyle than helping alcoholics become sober, but that this isn't talked about or researched anymore because of political correctness. What is your opinion?

Sally Satel: Jeffrey Satinover is a colleague of mine, and he's very, very smart. I'm sure it's true that a homosexual lifestyle may be associated with more health problems than a heterosexual one. But if so, again, it is a correlation. Remember, that doesn't have to be the case: an individual can use condoms, have protected sex, all those sorts of things. I'm not saying the correlations aren't valuable information, because we know which groups are at risk. But again, an individual can avoid and modify the risks.

Political correctness definitely has had a chilling effect on what we can discuss about homosexuality. I didn't write much about that in the book because so much has been written already.

Reparative therapy has a bad name because, the way I understand it, it has a coercive element: a parent or somebody dragging someone into therapy and saying to the therapist, "All right, change this person." That's never going to work, of course. But there is no debate about the fact that therapy can help a man or a woman who has been practicing the gay lifestyle and is

ambivalent about his or her orientation and is open to the possibility of becoming heterosexual.

A wonderful researcher named Robert Spitzer, who has no overt political agenda—his early work was in diagnostic systems—did longitudinal prospective work on a good number of homosexual individuals, many of whom had success in changing their sexual orientation through therapy. He was supposed to present his results at the American Psychiatric Association meeting in May 2000, and at the last minute his talk was "mysteriously canceled." Very chilling. ■