January 23, 1975

Dr. Oglesby Paul
Northwestern Medical Associates
222 East Superior St., Room 318
Chicago, Ill. 60611

Dear Oley:

I will, of course, be glad to conduct the steering committee meeting in Miami, and you do indeed deserve a break. I suggested to your secretary that we put Marc Kjelsberg on alert in case I am not travelling. I just got out of the hospital after a Christmas Day back injury. I am still quite disabled but am hopeful, and fairly sure it's not a herniated disc.

If you, indicate a desire to touch on the three major anti-MRFIT views in your article, I summarize them briefly:

The Feinstein view is that behavioral factors may influence selection into, adherance and drop-out rate with incidence results falsely attributed to MRFIT intervention. But the behavioral factor is not known, defined, or measurable; there could be innumerable other unknown variables and the adoption of this posture is to do nothing in testing the hypothesis, in the face of current evidence about the importance of known factors, and the urgent need.

The Eliot Corday view in press in the American Journal of Cardiology is that the chances of MRFIT intervention are dubious and that first priority should be given to continued searches for fundamental "breakthroughs" in atherosclerosis and sudden death, in an unnecessarily negative blast and appeal that "heredity" is the main factor.

The Winklestein view is similar except that it laments the lack of greater support for other epidemiological researches on causation, but it proposes no original hypothesis to be tested by such studies. It erroneously equates the limited ends of the MRFIT trial in the high risk population with a national policy public health action which would be limited to high risk persons.

Cordially,

Henry Blackburn, M.D.

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