Hysterectomy, an operation that was once infrequently performed and which did not usually remove all the reproductive organs, is now one of the most-commonly done surgeries. Therefore, it becomes a question with which every woman is concerned, since each now sees herself as a potential candidate for this wielding of the surgeon's knife. And yet, even though the operation has become so frequent, little time and effort is spent on assessing its physical and mental aftereffects on women. Perhaps the best judges of that are the women themselves, some of whose poignant statements to me I share with you in this Newsletter.

In 1971, I had a complete hysterectomy. About three months later, my husband told me I was no longer a woman and could never satisfy him again. Of course, he apologized later, but I was unable to forget what he said.

I am now 40 and he is 43. I take hormone pills, but ever since my surgery, intercourse has been painful for me, and I never reach a climax. The doctors I've seen tell me the problem is all in my mind. My husband is a good man and a good provider, but when it comes to sex, he's a different person than he was before my hysterectomy. I know that my marriage can't last like this. Is my condition normal? I'm a miserable person in need of help, and I don't know where to get it.--Unhappy

Although it will be of small comfort to you personally, your situation is not at all unusual. It surprises me that even when conscientious doctors discuss the risks of hysterectomy in advance with their patients, they fail to mention the negative and often disastrous effects on a woman's sex life. After the fact, they ascribe post-hysterectomy sexual difficulties to psychologic causes--an unsatisfactory explanation as far as I'm concerned.

Creams and lotions may help, but they may solve only part of your problem, and treatment by psychiatrists or other counselors can do more harm than good. Since you have not been helped by doctors, I would...
suggest that you turn to other women who have had the same surgery. Self-help organizations have been springing up all over the country: "Reach for Recovery" is directed toward women who have had mastectomies, and similar groups exist for victims of such diseases as ulcerative colitis and lupus erythematosus. If you find that no such group exists for women who have undergone hysterectomies, perhaps you can start one.

The diseases and surgeries mentioned above carry tremendous implications for a person's sex life, and your association with other people caught in the same situation should prove educational and supportive, regardless of the viability of your own marriage.

I know that my response is far from adequate, but I hope your eloquent words will set to thinking every woman who faces the hysterectomy decision.

I want to have a hysterectomy because that is the only foolproof way to avoid having children. My doctor refuses to do the surgery because he says he will not remove a healthy uterus. Can you refer me to a physician who will be more considerate of my right to control my own body?--G. S.

I'm with your doctor. Even though I am not a gynecologist, it doesn't take a specialist (or even a doctor) to know deep down that hysterectomy for birth-control purposes, which involves the removal of healthy organs at the risk of surgical trauma or even death, is an unconscionable act. Furthermore, I disagree with those who would argue that the risk of pregnancy is greater than the risk of hysterectomy. Physicians are increasingly finding themselves in the moral dilemma posed by women who wish to control their own bodies despite the physician's medical and ethical scruples against removing healthy organs.

I am a 30-year-old mother of two children, ages 6 and 2. My gynecologist says I have a distended uterus, and he wants to perform surgery to correct it (tighten the vaginal muscles, tie up the bladder, do a posterior something or other, and perform a hysterectomy). He calls this a third-degree distention and says that if I don't have the surgery soon, my condition could worsen to the point where no muscles would be left, making reconstruction impossible, and the entire uterus could drop through the vagina.

Since a hysterectomy at my age seems like such a drastic step, I have consulted another doctor. This second gynecologist asked what symptoms I wanted to alleviate by surgery, and he mentioned several, including loss of urine and poor sexual relations. When I told him I had none of those symptoms, he said he saw no need for surgery either now or ever, as long as I remain symptom-free. He says that the chances of the distention worsening to the severe point the first doctor foresees are practically nil.

How could two doctors disagree so totally? What is your advice?--S.S.

You have had two opposite opinions regarding whether to keep your uterus or take it out. In my opinion, you have the following options:

1) Go back to each gynecologist and ask him what he thinks of the other's opinion.

2) Ask your general practitioner to hold an old-fashioned consultation meeting at which all three doctors are present with you and your husband.
Some may say that this procedure is too time-consuming to be practical, yet a snap decision made by a young woman on the basis of two widely differing opinions may lead to a lifetime of regret.

You have no problem with sexual relations now, but this may not be the case after your uterus has been removed. In an important paper describing reactions to hysterectomy, Niles Newton, Ph.D., professor at Northwestern University Medical School, reports that a number of investigators have determined a surprisingly high rate of TOTAL abstinence from sexual intercourse following hysterectomy. Before you assume this risk, as well as others that may result from the surgery you are contemplating, I think you need a large consensus.

I just read the letter from the 30-year-old woman who asked your advice about having a hysterectomy. If I had it to do over again, I would never have one. I had a complete hysterectomy when I was in my 30s. I went to several doctors before I consented to the surgery, and they all agreed the surgery had to be done and that hormones would take care of any subsequent problems I might have. The surgery not only wrecked my sex life, but also ruined my nerves. Hormones did not help. We had had a good sex life before the surgery, but now it gets worse each year. It's a bitter pill to swallow when you know you're a failure, and your husband tells you that you're a poor sex partner. The harder I try, the worse things get.

I know there aren't any miracle drugs to solve this problem, but is there a vitamin or anything I can take? I appreciate any advice you can give me as well as anyone else before they jump into this situation.

--Frustrated Failure

There is plenty of evidence that hysterectomy can play havoc with a person's sex life, and your letter serves as vivid personal testimony that supports the scientific information on this subject.

You already know hormones don't help. I could glibly recommend counseling, but that kind of advice also has become tarnished with age. I am tempted to recommend that you return to those doctors who advised surgery and ask them what to do now.

Perhaps you might benefit from discussing your situation with other women who have had hysterectomies without subsequent sexual difficulties or who have found methods of dealing with such difficulties. However, I would guess that you have already met plenty of women in both categories. It might help things if one of them (or their husband) had a talk with your husband.

I wish I had the magical cure you are looking for, but until such a marvelous potion is devised, perhaps you may obtain some satisfaction from the knowledge that your letter has served to inform many young women about one aspect of hysterectomy they may never have considered.

I just read about the woman who had a hysterectomy and regretted it. I had the same surgery when I was 25, and I never regretted it a day of my life (I am now 40). I had almost hated sex before I had the surgery, but now I am a completely different woman. My sex life is wonderful, and my husband would be the first to agree--I am always at ease, never nervous and I feel remarkably well. I have never had to take any hormones, and I take only vitamins. I work at a job I like, and I love coming home to my husband in the evening.

--Happy Louisiana Lady
I am not aware of any evidence that hysterectomy produces sexual dysfunction, except in rare cases of radical hysterectomy where a portion of the vagina may be removed. Non-radical hysterectomy often improves sexual function by removing the fear of pregnancy or by removing conditions such as endometriosis or pelvic tumors, which may have produced pain with intercourse.—W.A., M.D.

The first letter does not surprise me since the effect of hysterectomy on one's sexual behavior can be extremely variable. The second letter, however, does surprise me since there is plenty of evidence describing post-hysterectomy sexual problems. In her publication "Reactions to Hysterectomy: Fact or Fiction" (Primary Care V.3, No. 4, Dec. 1976) Professor Niles Newton of Northwestern University Medical School summarizes some of this research, complete with references on this subject.

This is an extremely important subject since, as Dr. Newton points out, "Elective hysterectomy has become culturally patterned as a normal part of the lifestyle, with more than half of all American women destined for hysterectomy if current rates continue." Dr. Newton cites one investigator who states that fears about the ability to attract men after hysterectomy are frequent; only about one-third of the women in that study felt themselves to be "full women" after hysterectomy.

Another researcher found a statistically significant difference in pain on intercourse between post-hysterectomy and control patients, while 20 percent of women in one study and 42 percent in another study stopped having sexual intercourse after surgery.

It seems that short-term follow-up studies (the most common type) fail to identify the negative consequences of hysterectomy that become evident when patients are questioned two or more years after surgery.

I remain firm in insisting that before a woman goes under the knife to remove the uterus—an organ that has recently been shown to have an important effect on endocrine function—she must have full disclosure of all arguments pro and con. The evidence, Dr. A., does indeed exist, and I (and all physicians) have a moral, and very likely a legal, responsibility to make sure our patients have access to that evidence.

In my opinion, the Amish are getting a bum rap. Even as they cave in to the pressure of doctors who work for the government and line up for polio vaccine, the federal government is spreading the word to the inhabitants of 21 states to shun the Amish (and Mennonites), alleging that they may be spreading the disease.

While the newspaper headlines scream warnings, the reports themselves show quite a different picture (as is typical in medicine), and raise more questions than they answer. So I wonder about the following:

Why are the Pennsylvania Amish, or indeed any of us, relying on a diagnosis made only by the Center of Disease Control in Atlanta?
After all, this is the same outfit that fumbled the ball on Legionnaire's Disease and which sponsored the swine flu fiasco. Since the clinical and laboratory diagnosis of polio is so difficult to arrive at, why aren't the Amish leaders insisting that the diagnosis be thoroughly reviewed and either confirmed or rejected by state and private laboratories with a much cleaner record?

Four people have been diagnosed as "carrying" the polio virus, three of these "carriers" showing no symptoms of polio. Have people other than the Amish been tested to see whether they also are carriers without symptoms?

A 14-month-old child with a fever and a paralyzed left leg "is undergoing tests for polio at Hershey Medical Center (as of May 27, 1979)." Since every pediatrician knows there are lots of conditions more common than polio which will result in a feverish infant who does not move one of his legs, I wonder who is conducting the tests at Hershey Medical Center and whether outside independent consultants are being called in.

Government doctors are claiming that the reason this "epidemic" broke out among the Amish is because they are not vaccinated. Yet since government statistics reveal that approximately 1/3 of all school-children in this country are not immunized against polio, I wonder why the polio virus chose to pick on the Amish.

In 1977, Dr. Jonas Salk testified along with other scientists that most of the polio cases which have occurred in the U.S. since the early 1970's probably were the by-product of the polio vaccine itself. The January 23, 1978 issue of the Journal of the American Medical Association reported that of the 18 cases of polio in 1977, three of the patients were persons who were in the United States, but not residents, and two of the other 15 victims apparently contracted the disease abroad. Three cases occurred in recent vaccine recipients, and 10 cases had been in close contact with recently immunized people. Only three cases occurred in persons "without known vaccine associations."

Dr. Larry Schonberger, a virologist with the CDC, has been quoted as saying that polio caused by the vaccine itself has become more common recently than the natural virus. Schonberger's statement certainly is borne out by 1978 statistics which show that of seven paralytic polio cases in the United States last year, five were vaccine-associated.

Using 1977 and 1978 polio statistics, it is only reasonable to wonder whether the number of future vaccine-induced polio cases in the hundreds of thousands of Old Order Amish and Mennonites now lining up for free state vaccine may well outnumber the natural cases of polio, if any of the latter are proven conclusively.

To my knowledge, I am the only physician in the country to publicly raise these questions, but I deeply feel that before we further endanger the health and lifestyle of one of the most valuable populations in our nation, it is the government's responsibility to come up with some meaningful answers to the questions I've posed.

Breastfeeding has won the day in American medical circles. No longer must medical students learn the kind of double-think I was taught, namely, breastfeeding is best, but bottle feeding is just as good. No longer do scientists spend research money comparing Similac
to Enfamil. Indeed, everyone in the field of pediatric nutrition has become almost obsessed with studying the newly discovered qualities of human milk. And everyone with a bent towards psychology is on the "bonding" bandwagon. Even more surprising, eminent pediatricians, now convinced of the absolute superiority of breastfeeding, are speaking out about the desirability, even necessity, of engendering guilt feelings in mothers who reject this health- and life-preserving measure.

However, problems remain. Doctors may favor breastfeeding in theory, but it still takes a mother to breastfeed in practice. And while breastfeeding in some mothers may run counter to their psychologic nature (desire for "fulfillment," etc.), in many it runs smack up against economics. Two-income families are the rule throughout our country, and for doctors, however well-meaning, to advise mothers to sacrifice income for nursing conjures up visions of "let them eat cake." The fate of Marie Antoinette, who came up with that historical piece of nutritional counseling, should serve as a grim warning to moderns who would offer similar impossible alternatives. Breastfeeding need not and should not be linked to poverty.

Over the years, voices have been raised which propose a variety of programs designed to improve the economic lot of mothers. Among such proposals have been subsidized motherhood, child-care allowances, "motherhood as an occupation," work-located child care centers and increased income tax exemption levels. But none of these proposals required serious consideration as long as the high priests of American culture—the doctors—gave their sanction to infant formulas, thus enabling young mothers to go to work. But now that loophole is plugged with the universal agreement that chemical formulas are dangerous to life, limb and brain.

Thus, there is a new urgency demanding solutions that will enable mothers to enhance their infant's lives, health and intellect through breastfeeding. New alternatives, options, and choices are necessary. Breastfeeding, once considered a medical problem, now becomes a political issue. And breastfeeding means more than just "mothering" and a lot more than that newly-fabricated word "parenting." The unique, non-transferable physical closeness of breastfeeding reveals the silliness of words like "mother substitute" and "mother surrogate" and challenges the American ethic that forces mothers to work (mostly at jobs which are as unfulfilling as those held by their husbands) outside the home.

Answers are unlikely to come either from doctors or from politicians. As usual, they will have to come from mothers. After all, doctors didn't spontaneously decide breastfeeding was best; mothers virtually pushed doctors into their present pro-breastfeeding stance. La Leche League was 21 years ahead of the pediatric establishment in advising that infants be nursed by their mothers and light years ahead in helping to carry out this recommendation.

Although it may be difficult to believe that the political and economic policy changes necessary to enable babies to nurse at their mothers' breasts will transpire soon, it is important to remember that physicians have become converted to this position, and doctors are at least as hard to influence as politicians. As a matter of fact, I predict that our political leaders will be quicker to respond than physicians were.

If I were to make a master plan of how to convince political leaders of the necessity of their support for breastfeeding mothers, I would first encourage such mothers, singly and through their organizations, to ask candidates for the Presidency, Congress, state houses, and municipal offices such policy questions as: What are your plans for legislative and/or executive action to develop realistic
alternatives for nursing mothers? Where do you stand on paying mothers to stay home rather than go to work? Have you evaluated the real costs of underwriting workers at day-care facilities as compared to providing stay-at-home mothers with bonuses? Mothers might even ask their candidates some personal questions, such as, "Were you breastfed? How about your own children--and grandchildren?"

Just like doctors, politicians will react--some negatively, some positively. But all will have undergone some consciousness raising as breastfeeding becomes identified and recognized as the keystone to good mothering. The right political answers will emerge in response to the same forces that produced the right medical answers--the mothers themselves.

An important beginning in highlighting breastfeeding's political implications will be made this month at the International Convention of La Leche League in Atlanta where Professor John McKnight of Northwestern University's College of Urban Affairs has accepted LLL's President Marian Tompson's invitation to lead a discussion on the policy and programmatic implications of breastfeeding. Such discussions may help usher in an era in which the unparalleled success this organization of millions of mothers and their families has had with doctors will be mirrored in their future encounters with government. Just as the courage and persistence of breastfeeding mothers has helped change pediatrics and obstetrics, so these mothers are destined to help change the face of industrial and political America. However, there will be one important difference. Unlike the amount of time it took La Leche League to persuade doctors--21 years--this time the change will come about more quickly.

According to the May 25, 1979 American Medical News, a house-to-house survey is being taken of nearly 50,000 people who live near the Three Mile Island nuclear plant. The survey is planned by the Pennsylvania Health Department which will take a census to identify area residents and to determine where they were immediately after the March 28 nuclear plant accident. Scientists will keep track of the residents' health problems for the next 20 years, focusing on cancer cases and on pregnancy problems which might be related to exposure to the radiation which leaked from the plant.

Just as I predicted, the beneficial fallout of this nuclear accident will accrue to the scientists who may well reap the greatest benefits from these follow-up studies.

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Your questions about the medical problems that trouble you most will be answered by Dr. Mendelsohn. Please send your questions to: The People's Doctor, 664 N. Michigan Ave., Suite 720, Chicago, Ill. 60611.

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Despite the well-known hazards of surgery, a hysterectomy sometimes is indicated. This was the decision my friend Alice reached after she was diagnosed as having early invasive cancer of the cervix. The doctor who made the diagnosis originally suggested radiation treatments instead of a hysterectomy, and while the idea of avoiding surgery was an attractive one, Alice decided to investigate the pros and cons of both methods before making up her mind. For a time, she even considered the more unorthodox methods of dealing with disease. But she quickly saw she would have little back-up support from those closest to her if she chose such a method, and she realized that her own convictions might not be strong enough to carry her through.

So Alice began to question her doctors and the experts they recommended about radiation vs. surgery. The consensus of the first handful of doctors was that it really didn't matter which treatment she chose; both had their advantages and disadvantages. But as she continued her quest, new information came to light that made her doubt the wisdom of radiation. She learned, for example, that radiation also affected tissue surrounding the diseased area, and there was a very real possibility of problems with healing in that area if surgery were indicated in the future. It was also pointed out to her that the effects of radiation could cause problems in a sexually active married woman. For Alice, in her middle 40's, this too was a consideration. So she chose surgery.

Next came the search for a surgeon, which wasn't as simple as you might think. Alice and her family doctor had agreed that, although her uterus had to be removed, her ovaries should not be removed, unless medically indicated. You would be surprised at the number of doctors who were contacted before a competent surgeon was found who would agree with this precept--most surgeons she consulted wanted to remove everything at once.

When it seemed as though everything finally was settled, Alice found one more hurdle to overcome. When she entered the hospital the evening before her surgery, a resident came in with a surgery consent form for her to sign which stated that she would be having a "complete hysterectomy." Alice wanted to make sure there would be no last minute misunderstanding, so she wrote in "leaving the ovaries intact unless medically indicated." When the resident, who was a woman, saw this, she hit the ceiling. "You have no business writing anything on this slip except your name," she shouted. "Now surgery will have to be cancelled until a new form is written up! What do you want your ovaries for anyway? In a few years you'll be going through menopause."

But despite the resident's dire predictions, the surgery did go as planned. Alice woke up in the recovery room to find her surgeon chuckling at the side of her bed as he reassured her that, not only had the surgery gone well, but her ovaries were still intact. And today, more than four years later, Alice has still to experience her first hot flash!
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