Please return to Ruth Lockshin

VOL. 10, NO. 1

the People's Doctor

A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

P.O. Box 982 Evanston, Illinois 60204

IN THIS ISSUE: **STROKES AND THE DISCREDITING OF STROKE SURGERY**
UPDATES: Caesarean Sections, AIDS

Q My husband has suffered what the doctor diagnosed as probably a cerebral vascular accident--brain stem with depressed blood pressure--which I understand to be a stroke. Fortunately, he is not paralyzed, but mentally he goes back in time. Since he is an engineer, you can imagine how hard this is on him. He had been in good health (no high blood pressure) and in very good spirits before his stroke. On the day he had it, he just passed out and was in a coma for three days in the intensive care section of the hospital.

Please write about what causes strokes and what chances a person so afflicted has to recover his mental capacity.--Mrs. R.T.

A *Causes of strokes*

Doctors can give you a long list of diseases that cause strokes, but they often forget to mention prescribed medications which can cause strokes. These drugs include (but are not limited to) the tranquilizers Elavil, Tofranil and Triavil, and, although this does not apply in your husband's case, the contraceptive pill.

As far as recovery is concerned, my advice is to always expect and work for full recovery of physical and mental functions. In accordance with the well-known principle of the self-fulfilling prophesy, the higher one's expectations, the more likely the performance will meet them. I think the most damaging advice a physician can give a patient is to tell him to "accept" his condition. I prefer rebellion, rejection, and denial, indeed, any mechanism that will lead to continual striving for better achievement rather than acceptance of the status quo. Therefore, my answer to you is to behave as if, with your help, your husband has every chance of recovering fully.

In 1981, a State of Washington appeals court upheld a jury's decision to award $1.1 million to a patient who suffered a massive bilateral stroke while she was taking an oral contraceptive. The woman had been prescribed Searle's Ovulen-21 at age 19 and was stricken after taking the contraceptive for 16 months. The prescribing physician admitted he had not informed the woman of any of the drug's possible side effects. (His colleagues probably rose to his defense with their tranquilizing reassurance, "After all, it's safer than a pregnancy.")

Q My 70-year-old wife has had one or two small strokes. She suffers from arteriosclerosis, high blood pressure, and Parkinson's disease. Do you know of any diet or any vitamins she could take to build up her system so that she will be able to walk and to overcome the slight confusion she suffers from?--J.M.

Treating strokes

A Head right over to your public library, book store, or local health food store and look for the works of such authors as Nathan Pritikin, Paavo Airola, Carlton Fredericks, Roger Williams, or Emory Thurston. They (and many others) can provide you with the kind of nutritional advice that can help your wife during her next 70 years.

Discrediting stroke surgery

In case one of your near or dear ones suffers a stroke, and the doctor recommends an operation on the blood vessels in the neck (referred to as brain bypass surgery), ask him if he is familiar with the report of Henry Barnett, M.D., Professor of Neurology at the University of Western Ontario, at the July, 1985, Eighth International Congress of Neurologic Surgery in Toronto, Canada.

Dr. Barnett has proven through a controlled clinical trial that this surgery, performed on the carotid artery, is worthless (Washington Post, July 17, 1985). Dr. Murray Goldstein, director of the National Institute of Neurological and Communicative Disorders agrees, "There are no ifs, ands, or buts. The extracranial-intracranial bypass (another name for this operation) is not efficacious." Indeed, the final analysis of the data showed that the surgical patients actually had fared worse; i.e., the patients who underwent surgery suffered more strokes and fatalities than those who did not.

Later in 1985, Dr. Barnett addressed the annual meeting of the Royal College of Physicians and Surgeons. He stated that 15 percent of patients die or suffer a stroke as a result of this surgery. Only four percent would die or have a stroke if they did not have the operation. Dr. Barnett claimed that any surgical procedure which carries more than a three or four percent risk of death or permanent damage is too risky. He added that any hospital in which such operations are performed should have an audit by outside independent neurosurgeons to make certain that too many brain bypasses are not being performed needlessly.

While Dr. Goldstein predicts that this study will persuade the majority of neurosurgeons in the U.S. and Canada to stop performing this operation, I wouldn't bet on that. After all, doctors will be doctors--and it takes a long time for them to give up worthless, dangerous operations. They still are likely to insist that, without these brain bypass operations, the patient will die. Before you sign the consent form for this operation on any relatives, be sure your doctor knows about this study which shows that exactly the opposite is true.

Since the brain bypass surgery, now 20 years old, has finally been proven useless, can the coronary bypass be far behind?

Q Having had an endarterectomy (both arteries) about three years ago, I was shocked and astonished to read your comments about stroke surgery. The opinion of Dr. Barnett, whom you quoted, is positively frightening.

In my case, my internist found an aberration in my carotid arteries. He recommended a neurologist who concurred with his findings after doing an ultrasound test. After suffering three blackouts, I was scheduled for an endarterectomy. The surgery was performed by a highly regarded neurosurgeon who had developed the procedure and who is considered an expert

in this field. All went very well for me; I feel good, and I have had no recurring symptoms.

You stated that the procedure is not effective and that the patient is worse off after the surgery. The article offered no advice on what to do when the carotid arteries are full of plaque. Dr. Barnett offered no alternatives. I would appreciate your response.--M.K.

A

You have learned the truth about one of the most highly touted--and now proven to be worthless--operations in modern medicine, i.e., the brain artery bypass.

Dr. Barnett's study did indeed offer medical alternatives. You might ask your own doctors to share with you the report of this $9 million study (which was carried out in hospitals on three continents and was published in the New England Journal of Medicine) so that both you and they can learn about the non-surgical management of strokes. You also might want to look into the many books written by nutritionists to learn how certain kinds of diets can remove the blockages which impede blood flow through clogged arteries.

You also might go back to your surgeons who performed that endarterectomy in 1982 and ask them why they think some U.S. surgeons refused to participate in this study, which was financed by the U.S. National Institute for Neurological and Communicative Disorders and Strokes. Regarding those U.S. surgeons, Dr. Barnett speculates, "They were so convinced that the operation was going to work that they didn't join."

The lesson to be learned from this magnificent controlled study extends far beyond this particular operation. Rather, the exposure of brain artery bypass surgery as an unproven remedy should remind every patient who faces any operation to ask his surgeon whether that operation was ever subjected to controlled study and whether he would participate or refuse to participate in such a controlled study. Then one will know whether an operation is justified on the basis of solid evidence or whether the surgeon is ready to make that first incision purely on the basis of an enthusiastic guess.

Why doctors do C-sections

Why is today's Caesarean section rate 10 times higher than it was when I received my training 25 years ago? In the 1940's and '50's, any physician whose C-section rate exceeded three or four percent was called on the carpet. Today, the section rate nationally is around 30 percent, and in many large research and teaching hospitals is 40 percent or even higher.

Cynical critics of modern medicine attribute this explosion in Caesarean sections to the greed of doctors who get paid more to perform a C-section than to assist at a vaginal birth. Yet in Canada, where doctors get paid just about the same for either route of childbirth, the Caesarean section rate is also around 30 percent.

Critics claim that the epidemic of C-sections is a result of the doctor's desire to schedule his life in a more orderly fashion. And while it is true that, in some hospitals, many more sections are done between 9 a.m. and 5 p.m. Mondays through Fridays, in other hospitals there is a more even distribution between day and night, weekdays and weekends.

Doctors themselves have a long list of reasons--including fear of malpractice suits--for the escalation of Caesarean sections. Because all of these explanations portray the doctor as venal, money-grubbing, hedonistic, and less-than-honorable, I am not happy with them. For years, I have argued that, even though it's nice that the money goes the right way, the doctor (with exceptions of course) isn't in it just for the money. He does not operate on a Marxist basis, i.e., motivated exclusively by his own ecomonic interest.

If such were the case, one could change the behavior of doctors by altering their economic incentives. But, over the years, experience with many different compensation schemes (fee for service, salaried practice, HMO's, DRG's, etc., etc.) has demonstrated the futility of trying to change physician behavior by altering economic incentives. No, the physician is not in it for the money. Rather, he does what he does because he believes in what he is doing. In the case of Caesarean sections, the physician deeply believes that he is doing the right thing.

The question is--the right thing for whom? For the mother? For the baby? For both?

In whose interests were Caesarean sections done years ago? Obviously, in the overwhelming majority of cases, they were done in the interest of the mother (toxemia, contracted pelvis, etc.). Doctors did Caesarean sections to save the life--or to preserve the health--of the mother. And legitimately so. After all, with few exceptions (e.g., German measles), no one knew what was going on with the baby. The primitive stethoscope gave little information about the baby's condition. There was no ultrasound or other form of fetal monitoring. Sections were seldom performed for fetal indications.

In contrast, today the doctor has all kinds of technologies at his command to give him information about the fetus--the Doppler (ultrasound) stethoscope; ultrasound scanning; amniocentesis, certain maternal blood tests; chorion villus sampling, and external/internal fetal monitoring. This information explosion about the baby has led directly to the explosion in the Caesarean section rate.

Today, most Caesarean sections are done for fetal indications rather than maternal indications. The obstetrician promises the mother "a perfect baby." He regards (whether correctly or wrongly) a Caesarean section as the best guarantee of a perfect baby.

Let us for the purpose of argument concede that the obstetrician is right in his belief that Caesarean sections really do save infants from death and disability. (When one considers the dangers to the fetus of C-section--maternal anesthesia, iatrogenic prematurity (labor induced too early by doctors), hyaline membrane disease (respiratory distress syndrome), lower incidence of breastfeeding--the "benefits" to the fetus of a Caesarean section become highly questionable.)

The obstetrician then is faced with a serious ethical decision. He knows that the maternal mortality from vaginal birth is in the neighborhood of 1/30,000 to 1/50,000. He further knows that the maternal mortality from Caesarean sections is in the neighborhood of 1/2,000 to 1/4,000.

Although the exact statistics are a matter of controversy, no doctor will disagree that, as far as the mother's life is concerned, Caesarean sections are more dangerous than vaginal births. Therefore, the obstetrician should know that, in order to get that "perfect baby" (the quotes are here because the infant mortality rate has dropped just as much in countries with low Caesarean section rates as here in the U.S.), he must sacrifice a certain number of mothers. This should pose an ethical problem, i.e., whose life takes precedence, the mother's or the baby's?

Throughout the ages, various ethical systems have addressed this dilemma in different ways. My Jewish tradition teaches that fetal interests are held subservient to the life of a mother. If necessary, the fetus must be destroyed if he/she threatens the mother's life. Other religions have their ethical systems. And today's doctors, consciously or unconsciously, have their own ethical system. They have decided that the "perfect baby" takes precedence over the life of the mother.

Obviously much, perhaps all, of this decision-making remains subconscious. Otherwise, a doctor who was concerned over a fetus's well-being, or even its life, would spell it out for the husband: "I am worried about the baby. We can try to save the baby, but the trade-off is an increased chance of your wife dying. What is your choice?"

I wonder whether any doctor puts it this way to prospective parents--or to himself. How does he himself evade this reality? Does he waffle by saying, "We can save them both." Does he substitute his limited personal experience ("I never had a mother die") for the reality of a large statistical sample? After all, doctors have seen plenty of babies die during birth. But how often do they see a mother die? Even with a 30 percent Caesarean section rate, the average obstetrician could practice for decades (his entire professional lifespan) without having a maternal death. But the fact that he himself has never seen such a catastrophe must not lead him to deny that it can, and does, occur.

My conclusion is that the basic issue in the ever-increasing Caesarean section rate is not the personality of the physician, not malpractice insurance, not new technology. The basic issue is ethical--which life is worth more? And this ethical issue deserves to be highlighted so that every mother and father will be able to make a fully conscious decision. Those who opt for a perfect baby at the expense of an occasional maternal death will do as much as they can to find out how the baby is getting along before birth. On the other hand, those who place the mother's interests paramount will shun monitoring and will go for midwives and home births. In both cases, parents must ask doctors about the documented risks of their interventions--Caesarean section in particular--to the mother's life.

Maybe the silver lining in this dark cloud will emerge when the bloom is off the rose of both obstetrical interventions and pediatric interventions (neonatal intensive care units). When high-tech births are revealed as unproven methods of achieving perfect babies, what now appears to be an ethical issue will turn out to have a simple medical solution.

Q

I am in complete accord with your recommendation that AIDS patients be quarantined, and I admire your courage to stand up for the truth. Whom do we concerned citizens write to in order to make our opinions known?--P.Z.

A

Allies in AIDS fight

Rather than writing to any federal health agency, I recommend you contact your elected officials, i.e., those for whom you personally have cast a ballot. These people are more likely to be sensitive to public opinion about quarantine measures for AIDS victims than are government bureaucrats who do not owe their primary loyalty to the voters.

You might tell those elected officials that Dr. Mendelsohn now has plenty of company among his peers in his call for immediate quarantine. (With every passing day of unrestricted sexual contact involving proven AIDS patients, the chance of containing the spread of this always-fatal disease slips away.) Neurologist Richard Restak in the Washington Post, radiologist Olav Alvig of Cumming, Georgia, in the AMA News, doctor of public health Deborah Freeman of Baltimore, Maryland, and plenty of other doctors have publicly expressed their support of quarantine measures.

The same already holds true for some law-makers. In San Antonio, Texas, it has been made a felony for AIDS-infected patients to have sexual intercourse. By the action of Governor Mario Cuomo and the legislature, the State of New York has taken action to close bathhouses and other places where AIDS can be transmitted by means of sex. A bill has been introduced in the Illinois legislature which would require quarantine of those who have AIDS. Sam Vinson, assistant minority leader of the Illinois House, warns that unless efforts are stepped up to control the disease, AIDS "could become the bubonic plague of the 20th century."

FDA releases AIDS information

For the past two years, I have tried to raise your consciousness about the strange behavior of the government doctors in relation to the AIDS epidemic. In accordance with my policy of relying chiefly on informa-

tion from their own publications, I now call to your attention the October 1985 FDA Drug Bulletin. Optimistically headlined, "Progress on AIDS," the Bulletin article is introduced by a statement from Margaret M. Heckler, former Secretary of Health and Human Services. Ms. Heckler proclaims, "We have accomplished much in a short time." But past that self-serving hype lies a treasure trove of new information.

First, do you remember government reassurances about the accuracy of the HTLV-III AIDS antibody tests? Regular readers will recall that I brought to your attention the 50 percent false positive rate of this test many months ago, i.e., of those people whose blood gave a positive reading, 50 percent were reacting to something other than AIDS. Now, this FDA Bulletin tells us that the false positive rate is even higher--somewhere around 66 percent. Let me quote: "Thus of the approximately three in 2,900 blood donors found to be repeatedly reactive, about one in 1,200 will likely be infected with HTLV-III, while about two in 2,300 will probably be representative of nonspecificity in the test rather than infection."

What does the word "nonspecificity" mean? In the very next sentence, the government doctors tell us that "the reason for this nonspecificity is unknown." They do proceed to hazard a guess, saying that it "probably represents, at least in part, the effect of antibody directed against the human cells used to grow the virus in producing test re-agents." In other words, if you turn out to be positive for this AIDS test, the chances are only one in three that your blood is really reacting against AIDS, and two in three that your blood is simply reacting against the human cells which are used in producing the AIDS test. Therefore, you have some questions to ask the very next person who tells you that there are one or two million AIDS carriers in this country:

1) Are you talking about true-positive reactors? Or are you talking about false-positive reactors? Are you lumping together oranges and apples? Or are you carefully analyzing the various groups?

2) Have you heard about the government doctors' new recommendations for "safe sex'? If so, you should know that the FDA Drug Bulletin clearly states, "The efficacy of condoms in preventing infection with HTLV-III is unproven."

3) Have you watched the government doctors' use of the words "casual" and "intimate"? The FDA Drug Bulletin warns us against "intimate kissing" while reassuring us about "casual kissing." But in neither case are we told the definition of these two forms of osculation.

The dictionary definition of casual is "occurring by chance; without regularity; occasional; random." On the other hand, intimate is defined by the dictionary as "belonging to one's deepest nature; marked by very close association, contact, or familiarity; warm friendship developing through long association; informal warmth or privacy of a very personal nature."

Perhaps these dictionary definitions are helpful to you in deciding between two kinds of kissing, but I would expect the learned government doctors to provide a more clear-cut distinction, as well as the evidence for condoning one form of kissing and not the other. To be more specific, what is the evidence that casual kissing does not result, at least sometimes, in exchange of saliva? What if, in closed mouth kissing, the lips are moist or even wet? The FDA Drug Bulletin warns against the sharing of toothbrushes and razors, I assume on the grounds that this represents intimate contact. Does this mean that I cannot casually shave with another person's razor? And what about the whole concept in recent years of "casual sex"? Is there really any kind of sex that can be termed "casual"?

I recommend that we doctors stop using those two words which now have been rendered at best confusing and at worst meaningless by doctors.

4) There now are three forms of AIDS--AIDS itself, ARC (AIDS Related Complex) and another set of diseases that had not previously been identified as being associated with AIDS. Even if a person does not have the

common opportunistic diseases associated with AIDS (Kaposi's sarcoma, pneumocystis carinii pneumonia, etc.), any of the following diseases is considered indicative of AIDS if the patient has a positive HTLV-III (AIDS antibody) test: Disseminated histoplasmosis, isosporiasis (a form of coccidia infection), bronchial or pulmonary candidiasis (yeast infection), certain types of lymphoma (Non-Hodgkins, diffuse, undifferentiated).

This new, expanded definition of AIDS, of course, raises a new set of questions. The government doctors have reassured us that no cases of AIDS have been found in members of families of AIDS victims. However, with this new definition, those old studies become worthless until the families are restudied for these additional diseases.

Perhaps even more important, the HTLV-III test, like any other laboratory test, produces not only false-positive results, but also false-negatives. Therefore, if a person has one of these diseases now listed under the AIDS umbrella, how do the doctors know that, even in the absence of a positive AIDS blood test, the patient does not have AIDS?

In case you aren't confused enough by now, the FDA Drug Bulletin states: "In addition, idiopathic thrombocytopenia (a blood condition) is probably associated with HTLV-III infection, as are a variety of non-life-threatening fungal and bacterial infectious processes..." The doctors call these manifestations "lesser AIDS."

So now we have AIDS, ARC, and lesser AIDS. When it comes to the causes of AIDS or its symptomatology, do any researchers or government doctors really know what they're talking about?

5) Do you remember the government's reassurances that AIDS victims came from certain high-risk categories (promiscuous homosexuals, intravenous drug abusers, hemophiliacs, Haitians at one time, etc.), with only four percent of all patients in the "unclassified" category? Months later, that four percent became five percent. Now the FDA tells us the unclassified number has risen to six percent (829 patients). This represents a 50 percent increase in cases where no one knows how the patients contracted AIDS over the original statistics.

Even more startling is the eight percent of pediatric cases which fall into the "unclassified" categories. How do the researchers know that these growing percentages do not represent AIDS which is spread by casual contact?

If you want to read this statement in full, including frightening information on the side effects of the drugs (Suramin, Ribavirin, Interferon, PFA, HPA-23, etc.) currently being used on AIDS patients, write the FDA Drug Bulletin (Circulation Department HFI-43, 5600 Fishers Lane, Rockville, MD 20857).

While the FDA states that its Drug Bulletin is mailed "primarily" to health professionals, perhaps they will mail it secondarily to the taxpayers who underwrite it, health amateurs though they may be.

1986 SPEAKING ITINERARY—ROBERT S. MENDELSOHN, M.D.

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FEB 20	**CHICAGO: NORTHWESTERN UNIVERSITY KELLOGG GRADUATE SCHOOL OF MANAGEMENT** Contact: Professor Hilmon Sorey 312-491-1350	**APR 11**	**ATLANTA: NORTH AMERICAN NUTRITION & PREVENTIVE MEDICINE ASSN.** Contact: Bonnie Jarrett 404-475-0582	**MAY 22**	**TORONTO: CANADIAN NATURAL HYGIENE SOCIETY** Contact: Joseph Aaron 416-781-0359
FEB 23	**TAMPA:** Dr. Donald Carrow 813-536-3531	**APR 12-19**	**MEXICAN CRUISE SEMINAR** Contact: Katherine Smith 406-442-8196	**AUGUST 10**	**CHICAGO: NATIONAL HEALTH FEDERATION** Contact: Hal Card 818-357-2181
MAR 2	**SEATTLE:** Dr. John Bly 206-775-4533	**APR 22**	**MOORHEAD, MINNESOTA: "Humans and Animals: Ethical Perspectives" Moorhead State University** Contact: Robert S. Badal 218-236-2762	**SEPT 11**	**CHICAGO: NATIONAL FEDERATION OF CATHOLIC PHYSICIANS' GUILDS** **Westin Hotel** Contact: Dr. William White 312-383-2854
MAR 6	**CHICAGO: CHICAGO PUBLIC LIBRARY** Contact: Nita Salutillo 312-269-3097	**MAY 15**	**CHICAGO: National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC), Marriott Hotel** Contact: Dr. David Stewart 314-238-4273	**SEPT 28**	**CHICAGO: NATIONAL NATURAL FOODS ASSOCIATES** Contact: Max Huberman 216-746-5000
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Another View

by Marian Tompson

When we are threatened by a health crisis, we are more likely than ever to become as little children and begin anew. Our lives, which were working, suddenly aren't working. Everything is held in check--we've been derailed.

We can take advantage of such a situation to learn more about ourselves and to become more whole, and therefore more alive. To just get back on the rails to where we were before we got sick ultimately is not healing and perhaps is even destructive.

Say "yes" to a better diet, and say "yes" to exercise and anything else that is beneficial, but also say "yes" to going through that doorway of life through which might be discovered a new relationship to ourselves and the kind of human beings we really are. We are more than we seem to be. Our physical bodies obey biological laws, but these laws change as our consciousness changes.

This is the message in Richard Moss, M.D.'s, thoughtful book, "How Shall I Live (Transforming Surgery or Any Health Crisis into Greater Aliveness)," Celestial Arts, $7.95. It's a book I found myself underlining frequently.

Among the situations Moss describes is the dilemma of Earl, a young advertising executive who is facing surgery for a benign tumor. Earl has attended personal growth workshops and has read many books on health and spirituality. While he is certain that there must be a better way to heal himself than with surgery, he is confused: "One part of him saw the situation as a simple biological event for which he had no responsibility; another part believed that we create our own reality and was therefore questioning how he created his disease." If he admitted he needed surgery, then he had failed to heal himself. Putting natural or self-healing on one side and surgery on the other, he had put himself into a "damned if you do, damned if you don't" situation. Operating from his usual level of consciousness, he had reached the limits of his capacity to encompass his experience so a solution could only be found in a transformative shift of consciousness.

Instead of blaming himself for causing the problem, Earl was helped to turn intuitively and wholeheartedly into the immediacy of the dilemma, and there he found the solution. Not only was his recovery quick and painless, but it was quickly apparent that Earl had also found new direction and balance in his life.

In his book, Dr. Moss, speaking as both patient and physician, describes this transformation process. His is not a simplistic approach. And transformation, centered around a health crisis, is not accomplished alone. It requires sharing with family, doctors, nurses and friends. Dr. Moss describes exercises which, by creating contrast to our usual consciousness, help us to shift from one level of consciousness to another and to free up energy, e.g., fear or confusion, bound in one state and make it available as aliveness. The Ultimate Hospital, as Dr. Moss describes it, would be a school for empowering aliveness and awakening higher human potential. There would be no social or professional hierarchy based on education or skill, but a hierarchy of responsibility based on spiritual maturity and the capacity to help relationships between the healers and the healed to reach their fullest potential. "Hospitals can be temples, and the dark moments doors to new potential, if only we will it to be so."

Granted, "How Shall I Live" is more mystical and "new age" than books which are usually recommended here, but because he helps us maximize the transformative elements in a health crisis, I feel Richard Moss presents a perspective we would do well to consider with our head and with our hearts.

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2) How to Raise a Healthy Child . . . In Spite of Your Doctor
Maintaining that 90 percent of pediatric office visits are unnecessary and often even dangerous, Dr. Mendelsohn carefully instructs parents on how to diagnose and treat their children without medical intervention, how to determine when a child is sick enough to need a doctor, and how to avoid unnecessary and potentially hazardous treatment when a doctor is consulted.

3) MalePractice: How Doctors Manipulate Women
In this book Dr. Mendelsohn examines the condescending attitude of doctors toward their female patients. Over-prescription of drugs, unnecessary surgical intervention, and the ordering of dangerous x-rays are only a few of the many common practices Dr. Mendelsohn questions. A chapter on "Fifty Drugs Every Woman Should Think Twice About Before Taking" is included.

4) Confessions of a Medical Heretic
Dr. Mendelsohn believes that your own doctor is usually the greatest danger to your health. He believes that the methods of modern medicine are rarely effective and in many instances are more dangerous than the diseases they are designed to diagnose and treat. In this book, he discusses the over-prescription of drugs, home vs. hospital birth, unnecessary surgery, the dangers of hospital care, so-called preventive medicine, and modern medical ethics in general.

Please send me:

_____ copies of **Dissent in Medicine** at $10.95 each
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by Robert S. Mendelsohn MD

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