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The McDougall Newsletter

THE NEWSLETTER WITH JOHN & MARY McDOUGALL

INSIDE

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PROTECT YOURSELF
FROM MEDICAL ERRORS

The December 1994 issue of the Journal of the American Medical Association (272:1851) carried an article titled "Errors in medicine" by Lucian Leape. The focus was on how doctors might cut down on the life threatening errors made almost daily in a hospital setting. You as the patient, or friend or family member of the patient, can join the team and help cut down on errors in the hospital setting.

A family member of ours, my father, was recently hospitalized. During the entire stay one of us (mostly my dedicated sister, a nurse) was at the bedside checking every medication and questioning every order for every test and treatment. I also have two brothers who are doctors so we have had years of direct experience that testify to the hazards from the medical business to the patient. You probably do not have the medical experience we have, but that doesn't mean you have to sit back and remain completely out of control of the situation. There are many things you can do to get better health care and the most important one is to become involved every step of the way.

> "...20% of patients admitted to a university hospital medical service suffered iatrogenic injury (i.e. injury caused by the treatment itself) and that 20% of those injuries were serious or fatal."

How Common Are Errors?

This article in the Journal of the American Medical Association brought out some startling statistics:

"...20% of patients admitted to a university hospital medical service suffered iatrogenic injury and that 20% of those injuries were serious or fatal." (Iatrogenic means caused by the treatment itself)

"...36% of patients admitted to a university medical service in a teaching hospital suffered an iatrogenic event, of which 25%were serious or life-threatening. More than half the injuries were related to the use of medication."

"...reported the results of an analysis of cardiac arrests at a teaching hospital. They found 64% were preventable. Again, inappropriate use of drugs was the leading cause of the cardiac arrests."

"...In the Harvard Medical Practice Study, 69% of injuries were due to errors (the balance was unavoidable)."

"...medication errors occur in 2% to 14% of patients admitted to hospitals, but most do not result in injury."

"Autopsy studies have shown high rates (35% to 40%) of missed diagnoses causing death."

"One study of errors in a medical intensive care unit revealed an average of 1.7 errors per day per patient, of which 29% had a potential for serious or fatal injury."

Stay Well

The obvious and best way to avoid becoming one of these frightening statistics is to stay well and avoid the medical business completely. This is accomplished, as you well know, by eating a starch-based diet (The McDougall Plan), exercising, and avoiding "bad" habits. Even if you are sick, living by these principles will usually resolve serious health problems and help you stay away

from doctors and hospitals in the future.

Avoid Being Hospitalized

Is this hospitalization or operation really necessary to handle my problem? For example, if you find you have prostate cancer, the recommended treatment may be major surgery, and/or radiation,and/or chemotherapy. Whereas, the best choice, according to the scientific literature is to do nothing. They euphemistically call this conservative approach, "watchful waiting." If you have breast cancer, the treatment of choice is a lumpectomy, which can be performed in a doctor's office. Elective surgeries, from hair implants to bunion removal are performed in an office setting. In Britain, if you have a heart attack, without complications, you are treated at home. Home childbirth for uncomplicated deliveries is becoming more popular these days, and one of the reasons is fear for the welfare of mother and child in the hospital.

Someone must be overseeing the care and caring for the patient rather than the individual organ systems Therefore you must insist one doctor take charge and be responsible.

In some situations the doctor is debating in his own mind whether or not your condition warrants hospitalization. Your opinion on the subject may be the deciding factor. Especially if you can convince your doctor that you are a responsible person, who will keep in close contact, letting him know how you are doing, and that you have support at home from family members and friends.

Minimize Hospital Stays

In my early years of medical training (25 years ago), after suffering even a minor heart attack you were confined to the hospital for 2 to 3 weeks. These days, you go home after a heart attack followed by bypass surgery in a week. My mother was placed at bed rest for a week after childbirth. Now women are leaving the hospital hours after a normal delivery.

It was not the harm to the patient from prolonged hospitalization that shortened hospital stays, but the need to save money for the government (Medicare) and private insurance companies. They stipulated financial penalties for prolonged hospital stays. Medicare has a form of reimbursement called Diagnostic Related Groups (DRG), where each illness or surgery is assigned a specific amount of money to be paid, based in part upon the number of days that are expected for the treatment and recovery. If the patient does better and leaves earlier, then the hospital makes money. If the stay is prolonged (especially if unjustified) then the hospital loses money. Insurance companies control length of stay by a processed called "Managed Care." Prolonged hospitalization becomes costly for the hospital under their payment scale. Both government and private insurance refuses to pay for hospitalizations that fail to meet the criteria for acute hospital care. Convince your doctor that you are going to a home where you can recover as well or better than in the hospital. Make arrangements for home care that may shorten your stay in the hospital. Rent a hospital bed or hire a visiting nurse. Arrange for care at your community rehabilitation center (such programs are commonly used after hip replacement, heart attacks, and heart surgery). Some doctors even make house calls.

Most hospitals now have "out patient surgery programs." The patient is released after the surgery and a short stay in the recovery room. Ask if this is an option.

You must ask the doctor about these options. Sometimes you may have to change doctors, because your first doctor may not make house calls, work with the outpatient programs you need, or perform your treatment without hospitalization.

Make One Doctor in Charge

A good friend of mine, who is a medical doctor, recently went through a serious illness with his wife. She was hospitalized for an elective surgery; complications of bowel obstruction and a life-threatening abdominal infection followed. Four specialists were called in to help. Her condition slowly deteriorated and he felt out of control. He began demanding answers from the doctors and quickly discovered nothing was getting done because no one was in charge; taking responsibility for his wife. Each doctor was doing his "specialty thing" and no one doctor knew enough about the patient's condition to make the decisions necessary for her to get well. He fired all the doctors, brought in a new team with one doctor specifically assigned to manage her care along with the advice of appropriate specialists.

With so many doctors involved the patient soon becomes a heart problem for one specialist, and a kidney problem for another. Orders written by the heart doctor may damage the kidneys, and vice versa. Someone must be overseeing the care and caring for the patient rather than the individual organ systems. Therefore you must insist one doctor take charge and be responsible. This doctor should be a generalist, like an internist, or specialist very knowledgeable in the patient's major problem; for example, a cardiologist for a person in heart failure (who may also call in a lung, kidney, and intestinal specialist for help).

Make the Best Out of the Situation

Don't hesitate to ask for second opinions, and to ask that additional specialists be called in to help. Your doctor's ego may be put in jeopardy by asking for other doctors' opinions, but this doesn't matter when the life of a loved one is at stake! If things seem completely out of control, then don't hesitate to fire the whole team and start again (this is done, but in my opinion not often enough).

While in the hospital you are in an excellent position to find out who are the best doctors to care for you or your loved one. Be an investigator. Observe the interactions between the hospital personnel. See which doctors hold the respect of the nursing staff and their patients. Don't be afraid to ask the nurses what they think of various doctors. Who's the best? How's the doctor you're with? Facial expressions may tell more than the words.

Keep Close Communication with the Nurse

The nurses are running the show. They have the direct contact with the patient—they are the key to his safety and well being. Drug dispensing, monitoring, personal care, and interfacing with the doctor and other hospital personal are the nurses responsibility. You need to become very close to them to become part of the loop. Immediately, learn their names. Use all your Dale Carnegie skills to win them over. Make it clear that you want to know as much as possible—about all the medications given, and any tests or treatments ordered. If the nurse is reluctant to share, then ask your doctor to put an order in the chart that you are to be kept informed

of all details. Your close involvement can prevent the administration of the wrong medication, and the performance of costly and potentially dangerous tests and treatments.

Choose the Right Hospital

Do you want to be in a teaching hospital, often known as a university affiliated hospital? These hospitals attract many of the community's best doctors, but they also have students (interns and residents) taking care of you. The advantage of having these trainees around is they often bring in fresh ideas and they are also in the hospital 24 hours a day to provide immediate service. However, the service may be the wrong kind of care, because they are trainees, and they are often overworked.

If you do decide to use a teaching hospital for an elective surgery you will want to consider your timing carefully. Each year, in July, when the house staff turns over and a "fresh" group of interns starts, the patients fare much worse. After a few months they have learned from their mistakes (on the patients). After about 6 months—some time after the first of the year—is probably your safest time to enter a teaching hospital. Fortunately, the seasoned staff of nurses help prevent many of the tragedies of those early days of training beginning each July.

Most doctors admit their patients to several hospitals, so you do have a choice of teaching or private institutions. In most cases I would elect a private (non-teaching hospital). If I had a very rare problem or one that required tests and treatments that could only be provided by a university setting then that would have to be my choice.

I would like to share one more personal observation of mine. After years of working in several dozen hospitals I prefer those with religious affiliations, such as a Jewish hospital, a Catholic hospital, or an Adventist hospital. There is a much more caring atmosphere in these places. Non-religious hospitals usually have a sterile "factory" atmosphere.

Insist Training Doctors Watch

Unless you insist otherwise, your anesthesia and surgery may be performed by an intern or resident, a "student doctor," not the experienced professional you hired. It has long been acceptable practice in hospitals for the trainee to do the operation as long as your doctor is in the room watching. If you are in a teaching hospital setting, insist that the trainee's role is strictly limited to observation. It may seem the righteous thing to do to help young doctors with their education, but "not at my family member's expense."

You must be very clear with your doctor on this point. You might even jot a note on the release form you sign before surgery, that "the specific doctor you hired will personally provide all the services—supervising a training doctor to do the work is unacceptable."

Give Close Attention

When our father was in the hospital, someone stayed with him day and night (usually my caring sister). When the situation is critical, if possible, stay in the room, even if you must sleep in a chair (sometimes a bed or cot will be provided). When staying in the patient's room is not permitted, then someone should always be in the waiting room. This extraordinary attention conveys to everyone of the hospital staff that this an important person, who many people are very concerned about; and they had better show the same concern and do their best. Yes, you may become a nuisance, but "the squeaky wheel always gets the grease."

We also brought in his food. The hospital diet is a killer. Even foods in the cardiac care unit are laden with cholesterol and fat—threatening the patient's life. The first two orders on most routine order sheets are standard: DIET, followed by LAXATIVE. The laxative is necessary to compensate for the fiber-deficient, constipating foods served to hospital patients. At no other time is it more important that the food is right then when you're sick or trying to recover.

Leave the Hospital ASAP

Sick people are in hospitals. And they often get sicker by being there (iatrogenic illnesses). Antibiotic-resistant germs breed on the wards. In their sincere effort to help you the hospital personnel will often kill you. The food served to the patients is the very stuff that brought them there in the first place (but much worse tasting). Your whole focus, and hopefully that of your doctor's, should be for you to leave as soon as possible, as healthy as possible.

RESEARCH

Kidney and Liver Damage from Tylenol

Two articles: "Risk of kidney failure with the use of acetaminophen, aspirin, and nonsteroidal antiinflammatory drugs" by Thomas Perneger in the December 1994 issue of the NewEngland Journal of Medicine (331:1675); and "Association of acetaminophen hepatotoxicity with fasting and ethanol use" by David Whitcomb in The December 1994 issue of the Journal of the American Medical Association (272:1845) found health risks with frequent use of the popular over the counter pain medication, acetaminophen (for example, Tylenol).

The study on kidney damage found heavy users of acetaminophen had an increased risk of kidney failure in a dose-dependent fashion. People who took more than one pill a day (366 pills a year) had twice the risk of losing their kidneys as those who took fewer than 104 pills a year. Furthermore, people who had taken more than 1000 pills in their lifetime had twice the chance of kidney failure compared to those who took fewer than 1000 pills. Approximately 8 to 10 percent of the cases of kidney failure are believed to be due to heavy use of acetaminophen. The authors estimate elimination of this cause of kidney failure would reduce health care costs by $500 million to $700 million yearly. Aspirin and other nonsteroidal antiinflammatory agents were not found to increase the risk of kidney failure in this study.

Liver failure due to a massive overdose, such as seen with an attempted suicide with acetaminophen, is commonly treated in emergency rooms. It is also recognized that ingestion of greater than 15 grams a day (45 tablets daily) may result in liver toxicity. Maximum recommended dosage is 8 tablets a day in divided doses. This study found severe liver toxicity with even smaller doses, of as little as 4 to 10 grams (12 to 30 tablets) in 24 hours. Most of the individuals who developed liver damage with lower dosages of acetaminophen had been consuming very little food. Alcohol use was also linked to a greater chance of liver damage with small

amounts of acetaminophen. Toxicity was more common in women.

COMMENT:
Because the gastrointestinal side effects, especially bleeding, from aspirin and nonsteroidal antiinflammatory drugs are so well publicized, many people have turned to acetaminophen thinking it's use is perfectly safe. Obviously, this is not the case.

Symptoms of overdose that cause liver damage include nausea, vomiting, sweating, and generalized fatigue. Laboratory tests show elevations of liver enzymes due to the damaged liver tissue. The actual amount of acetaminophen in the blood can be measured by laboratory testing. Treatment of massive overdose includes emptying of the stomach and administration of acetylcysteine (Mucomyst).

Kidney disease was first found to be caused by acetaminophen in the 1950s. Symptoms are usually gradual in onset, and include nausea and fatigue. Laboratory tests for kidney function (creatinine and BUN) reflect the extent of kidney loss. Treatment includes discontinuing the offending substance, a low protein diet, and in later stages kidney dialysis. The authors of this article on kidney disease and acetaminophen concluded by recommending that warning labels be placed on packaging, or prescriptions be required for large amounts of acetaminophen. They also suggest those people requiring large dosages of analgesics or prone to kidney failure use aspirin.

Most of these pain relievers are taken for relief of symptoms caused by a poor diet—especially, headaches, body aches, and arthritis. The most prudent approach to chronic pain is to remove the cause of the pain by switching to a starch-based, animal-product-free diet. After making all the dietary and life-style changes possible, then pain relievers should be used as second-line therapy. All medication, including over-the counter pain killers, have side effects. They should be used sparingly, and then only in recommended doses.

Smoking Destroys a Woman's Physical Performance

"Smoking, alcohol, and neuromuscular and physical function of older women" by Heidi Nelson in the December 1994 issue of the Journal of the American Medical Association (272:1825) studied 9704 white women 65 years and older from four areas of the United States. Only 10% were current smokers, and 29.6% were former smokers. Of the current drinkers 92.2% drank fewer than4 drinks a week, and 7.8% drank more than 14 drinks a week.

They found current smokers had significantly poorer function on all of the performance measures, except grip strength. Women who smoked were weaker and had poorer balance and had poorer physical performance than nonsmokers. Former smokers also showed a slight decrease in performance. Surprisingly, non-drinkers, compared to current drinkers, had significantly poorer function on all of the performance measures, except tandem walking.

The battery of tests used checked for muscle strength of the grip, right triceps, right quadriceps, and right hip; agility and coordination with rapid step-ups, rapid chair stands, and foot taps; and gait and balance by walking speed, tandem stand and tandem walking. These tests are reflective of activities performed in a person's daily life.

COMMENT: Preserved physical condition and performance as we age is one consequence of how we care for ourselves throughout life. Maintaining physical activity with regular exercise and a healthy diet are important for sustaining vigor through our later years. The elderly also lose function as a consequence of medications they are prescribed, especially sedatives, tranquilizers, diabetic pills, and some types of blood pressure and heart medications (B-blockers). Need for these medications is a direct consequence of poor nutrition and unhealthy lifestyle.

Smoking takes away from performance by increasing artery disease, especially disease in the legs and heart disease. Overall health is also impaired by smoking. Increased incidence of small strokes in smokers may also have played a role in robbing them of their physical abilities.

But why would alcohol help with performance? First, it must be made clear that this study only looked at light to moderate
drinkers. Heavy alcohol consumption would be expected to lead to serious deterioration of health and neuromuscular function. Moderate alcohol has been shown to have a protective effect on cardiovascular disease. Women involved in social activities were more likely to be in the alcohol drinking group. This social interaction positively contributed to the person's physical, mental, and emotional well being.

Often I hear the comment, "If I would have known I would have lived so long I would have taken better care of myself." The wise person would take the effort throughout life to live as healthy as possible. Unfortunately, too few of us fit this ideal. As a doctor dealing with thousands of people, I can tell you without hesitation it's never too late. The body is an absolute miracle in its ability to recover. Even if you're fifty, sixty, seventy, or eighty by the time you get the strength and wisdom to change, it's never too late. A change to a good diet, exercise and/or quitting smoking will take years of aging off you. Your younger appearance and increased vigor will be obvious to you and those around you in a few short days. At my 12-day live-in program at St. Helena Hospital, people leave looking and feeling years younger than when they arrived two weeks earlier.

Say "No" to Prostate Tests

"Screening for prostate cancer: A decision analytic view," by Murray Krahn in the September 14, 1994 issue of the Journal of the American Medical association (272:773) concluded "Our analysis does not support using PSA, TRUS, or DRE to screen asymptomatic men for prostate cancer. Screening may result in poorer health outcomes and will increase costs dramatically." They gathered data from various sources to compare three screening approaches PSA (prostate specific antigen), TRUS (transrectal ultrasound), and DRE (digital rectal examination), with not screening. The authors state: "Our analysis shows that screening may marginally reduce prostatic cancer mortality for men ages 50 to 70 years, but it suggests that the benefits of reduced prostatic cancer mortality are more than offset by the morbidity of prostate cancer treatment." Even in populations of high prevalence of prostate cancer they found screening had similar results and therefore

selecting people at high risk will not improve the benefit of screening.

COMMENT: I have written many articles over the past few years on the failure of early detection and treatment for prostate cancer, because men keep demanding the tests and accepting the treatments. When you stop, I'll stop writing this kind of article.

Even though the science is clear that early detection methods are a harmful failure, there is still a major campaign in the United States and Canada to have men over the age of 50 screened for prostate cancer. Radical surgery for prostate disease in the US has increased sixfold between 1984 and 1990. Not only are the tests costly and inconvenient, but they lead to deadly and disabling treatments. Common complications are incontinence (requiring use of a diaper or catheter), and impotence. Other complications include: chronic cystitis, chronic prostatitis, and death.

In a time when health care dollars are precious we cannot waste money on treatments that do more harm than good. One screening of all US men between the ages of 50 and 70, including treatment for those with localized prostate cancer would be 27.9 billion dollars (Urol Clin North Am 17:719, 1990). Because of these poor results many health organizations decline to recommend the PSA and TRUS for screening. These organizations include: the Canadian Task Force on Periodic Health Examination, the US Preventive Services Task Force, the British Columbia Office of Technology Assessment, and the International Union Against Cancer.

One of the major problems with testing is we have no effective treatments that will change the course of the cancer once detected. For a cancer to grow big enough to feel on digital rectal examination takes 10 years on the average; the TRUS will detect the cancer a few months earlier than 10 years; and tumors must grow for many years before producing enough prostatic antigen to be read as abnormal. By the time the tumor is detected it has spread to the rest of the body, and is therefore, beyond help from present day treatments.

In many cases the tumor detected is indolent and would have never spread and threatened the man's life. In this common situation, according to the authors, "...many men will be given a diagnosis of cancer who would otherwise have lived out their full life span without knowing of or suffering any of the complications of their cancer." And I would add, without suffering from the treatments—major surgery, testicle removal, radiation, hormone therapy, and/or chemotherapy.

One might argue for earlier detection because this could lead many men to change their diets sooner. Since prostate cancer is caused by the "rich western diet," one of the fundamental treatments should be to stop the cause and change to a "starch-based" diet (The McDougall Plan). Most of us shouldn't need to be hit over the head with a hammer to come to our senses.

The Lighter Side

A graduation song from the May 22 1994 McDougall Program at St. Helena. (People referred to in the song are the McDougall Program staff)

Sung to the tune of "Country Roads:"

Almost heaven, St Helena

McDougall Mountain, Napa Valley sunshine

Life is old here, older than the trees

Makes me healthy, growing like a breeze

Chorus:

Clear arteries, I am taking home

From this place that I love

McDougall Mountain, Napa Valley

Take me home, my healthy heart

All my bad cholesterol has left me

Triglycerides are strangers like high fat

Dark and dusty, we hiked each day

Misty taste of Carol's cooking brought us back each day

(Chorus)

I hear her voice, in the morning hours

Vicki on nutrition, Linda in the gym

DorAnne in the office, Linda having fun

Hap with his rappin, Lynn with his breathin

Terry with his hands, Judy with her prayers

Terry with our business, Mary with her recipes

and Carol with her love

(Chorus)

Drivin down the road, I get a feeling

I should have come here sooner for my healin'

John McDougall and his loving team

have cleaned up my mortal machine

(Chorus)

And a graduation song from the October 9th 1994 McDougall Program:

Sung to the tune "Hit The Road Jack."

Hit the road fat and don't you come back no more, no more, no more, no more

Hit the road fat and don't you come back no more!

Oh cholesterol, triglycerides don't treat me so mean, you're the meanest old stuff that I've ever seen.

If you can't get down and real low; then you'll have to pack your bags and go.

That's Right!

Hit the road fat and don't you come back no more, no more, no more, no more

Hit the road fat and don't you come back no more!

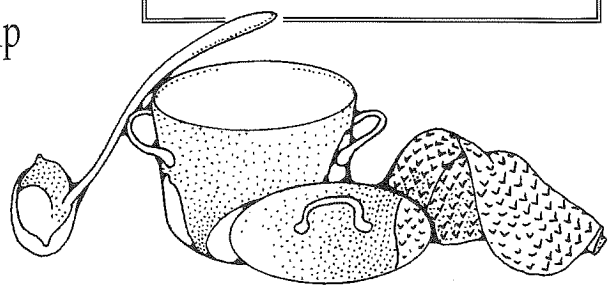
What you say?!

Hit the road fat and don't you come back no more, no more, no more, no more

Hit the road fat and don't you come back no moooore!

RECIPES

Dilled Broccoli Soup



Servings: 8
Preparation Time: 30 minutes
Cooking Time: 40 minutes

1 medium onion, chopped
1/4 cup water
5 cups vegetable broth
3 cups peeled, chopped potato
6 cups chopped broccoli
4 cups small broccoli florets (bite sized)
3 cups non fat soy or rice milk
1 teaspoon dill weed

Saute onion in the water in a large soup pot for 5 minutes. Add vegetable broth, potatoes and chopped broccoli. Cover, bring to a boil, reduce heat and simmer for 30 minutes, until potatoes and broccoli are tender.

Meanwhile, place the small florets in a saucepan with water to cover. Bring to a boil, cover and cook over low heat for 5 minutes. Remove from heat, drain and set aside.

Blend soup in batches in a blender until smooth and creamy. Return to pan. Add small cooked broccoli florets, soy or rice milk, and dill weed. Heat through. Serve at once.

Hint: Use frozen chopped hash brown potato to save chopping time. Use prepared chopped broccoli if available.

Hearty Bean Soup

Servings: 4
Preparation Time: 15 minutes
Cooking Time: 35 minutes

1/3 cup water
1 medium onion, chopped
2 celery stalks, chopped
2 carrots, chopped
1 medium zucchini, chopped
2 15.5 ounce cans cannellini beans, drained and rinsed
1 15.5 ounce can stewed tomatoes
2 cups vegetable broth or water
1/2 teaspoon basil
fresh ground black pepper to taste
1 cup packed chopped spinach

Place the water, onion, celery, carrots and zucchini in a large soup pot. Cook, stirring occasionally, until vegetables are fairly tender, about 15 minutes. Take one of the cans of beans and mash until fairly smooth. Add to soup pot along with tomatoes, whole beans, vegetable broth, basil and pepper. Reduce heat to low, cover and cook for 15 minutes. Add spinach and cook an additional 5 minutes.

Tex-Mex Spaghetti

Servings: 4
Preparation Time: 15 minutes
Cooking Time: 20 minutes

1 15.5 ounce can Mexican style stewed tomatoes
1 15.5 ounce can kidney beans, drained and rinsed
1 4 ounce can diced green chilies
1 tablespoon chili powder
1 teaspoon paprika
1 teaspoon ground cumin
1/2 teaspoon ground oregano
1/2 cup water
1/4 cup sherry
1 large onion, sliced
1/2 pound mushrooms. sliced
1 tablespoon cornstarch mixed in 1/4 cup cold water
3/4 pound spaghetti or linguini

Combine the first 7 ingredients in a bowl. Set aside.

Place the water and sherry in a medium sauce pan. Add the onions and mushrooms, cook stirring frequently until liquid has evaporated and onions are softened, about 15 minutes. Add the reserved tomato mixture and cook over low heat until heated through, about 5 minutes. Add the cornstarch mixture, cook and stir until thickened.

Meanwhile, cook spaghetti according to directions. Drain. Pour the tomato-vegetable mixture over the spaghetti and toss gently to mix, Serve at once.

Spinach-Cilantro Dip

Servings: makes about 1 1/2 cups
Preparation Time: 15 minutes
Chilling Time: 1 hour

3 cups finely chopped spinach
1/2 cup chopped cilantro
2 cloves garlic, crushed
4 scallions, chopped
2 tablespoons lemon juice

Combine all ingredients. Refrigerate at least 1 hour to blend flavors.

Hints: Use a food processor to save time chopping. If you don't like cilantro, try this with parsley instead. This is excellent with oil-free tortillas.

Garbanzo Spread

Servings: makes 1 pint
Preparation Time: 15 minutes
Chilling Time: 1 hour

1 15.5 ounce can garbanzo beans, drained and rinsed
1 stalk celery, chopped
1/4 cup finely chopped onion
1/4 cup finely chopped green onions
2 tablespoons oil free salad dressing
fresh ground pepper to taste

Mash beans with bean masher, do not use food processor. Stir in remaining ingredients and mix well. Chill for 1 hour to blend flavors. Stuff into pita bread, use as a dip for oil free chips, or use as a sandwich spread.

Aram Spread

Servings: makes 1 1/2 cups
Preparation Time: 10 minutes
Chilling Time: 1 hour

1 15.5 ounce can garbanzo beans, drained and rinsed
2 green onions, chopped
1 tablespoon soy sauce
3 teaspoons grated fresh gingerroot
1/2 teaspoon minced garlic
1 teaspoon rice vinegar
1/2 teaspoon honey (optional)
dash of Tabasco sauce

Combine all ingredients in a food processor and blend until smooth. Refrigerate at least 1 hour before using. Use as a spread on bread, crackers, or rolled up in a tortilla.

Hint: To make Aram Rolls, spread Aram Spread on the bottom of a large whole wheat tortilla. Follow with a layer of grated carrots, grated red cabbage, a few alfalfa sprouts, and some julienned green onions. Roll up like a log, then slice into thick slices, 1-2 inches. These are a wonderful appetizer, great to take to a potluck or picnic.

BULLETIN BOARD

Alaska Cruise

The 7-Day Cruise to Alaska leaves from Anchorage on May 24, 1995; arrives Vancouver May 31, 1995 on Royal Odyssey by Royal Cruise Lines. Prices start at $1269 double occupancy, plus airfare. Call for information and reservations - the McDougall Cruise Desk at (800) mon-trose or (800) 666-8767. If you live in the Los Angeles area, call (213) 245-3158 or (818) 248-9081. All McDougall Food and great McDougall Educational opportunities. Book early, as this will fill up very soon, just like our cruise to Mexico in the Summer of 1994.

Upcoming Half-Day Classes

39.95

A lively and informative presentation that may change your life! See and hear John and Mary McDougall present the latest information on health and diet.

Call (800) 570-1654 or (707) 576-1654 for reservations

February 12
Los Angeles: LAX Marriott

February 25
San Diego: Marriott Mission Valley

March 4
Palm Springs: Hilton

March 26
San Jose: Hilton Towers

April 22
Honolulu: Hawaiian Village Hilton

Upcoming McDougall Programs at St. Helena Hospital

Call (800) 358-9195 for information and reservations

12-Day Live-in Programs for 1995

February 26

March 26

April 16

May 7

June 18

Alumni Programs - 3 Day
March 12

June 4

McDougall Radio Shows

Daily show on KSRO 1350 from 11 AM until noon PST. You can call in with your questions from anywhere in the country and talk to Dr. McDougall (often there is a guest the first half hour, so call at 11:30 AM PST) at (707) 270-1350.

FOR YOUR GOOD HEALTH is a syndicated Sunday evening radio show between 7 PM to 9 PM throughout California (and we're starting to go national). Listen on:

NEW STATIONS:
KPIX 95.7 FM, San Francisco
KPIX 1550 AM, San Francisco (heard from north of Santa Rosa to south of San Jose)

KXLY 920 AM Spokane, WA

KABC 790 AM, Los Angeles

KSDO 1130 AM, San Diego (replayed Sunday 1-3 PM)

KSTE 650 AM, Sacramento

KQMS 1400 AM, Redding

KSCO 1080 AM, Monterey/ Santa Cruz

KVEN 1450 AM, Ventura

KVON 1440 AM, Napa

KGLW 1340 AM, San Luis Obispo

KYSO 1480 AM, Modesto/ Merced

KINS 980 AM, Eureka

KSRO 1350 AM, Santa Rosa

KPSL 1010 AM Palm Springs

Donations to the McDougall Program

The McDougall Lifestyle Change Research Fund - 2574.1040 will be money I personally manage for research and education. The McDougall Program Fund - 2574.1039 will be money managed by The McDougall Program administrative staff, and used for research and education. Send to The McDougall Program, c/o St. Helena Hospital, Deer park, CA 94576. ALL TAX DEDUCTIBLE.

McDougall Quick Recipe Search

We are looking for recipes to be included in a new "Quick Cuisine" book. Recipe preparation times (apart from cooking times) should be less than 15 minutes. Please send us your recipes to be considered - you will receive credit in the book if they are used! Send to: McDougall Quick Recipes, P.O. Box 14039, Santa Rosa, CA 95402

McDOUGALL ORDER FORM

ITEM	PRICE/UNIT	QUANTITY	TOTAL
The McDougall Program for Maximum Weight Loss	$23.95		
The New McDougall Cookbook	$24.00		
The McDougall Program	$12.00		
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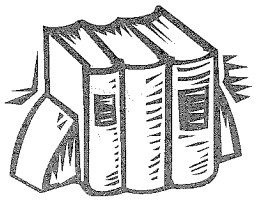

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