mine promotion campaign that a paper by W. R. Bett listed 39 generally accepted "clinical uses" for the drug, including treatments of schizophrenia, morphine and codeine addictions, "nicotinism" (tobacco smoking), heart block, head injuries, infantile cerebral palsy, irradiation sickness and hypotension. Bett, who further recommended the drug for ailments like sea sickness, persistent hiccup, and even "caffeine mania," was only one of a huge number of physicians who regarded amphetamines as "versatile remedies" which were second only to a few other extraordinary drugs like aspirin in terms of the scope, efficacy and safety of their effects.

Since the therapeutic heyday of the amphetamines at the end of World War II, the list of "accepted" medical indications for these drugs has shrunk, even though per capita consumption has risen dramatically. Even the American Medical Association is slowly realizing that the amphetamines are at best ineffective or minimally effective in the treatment of nearly all the conditions for which they are still prescribed, and that in the relatively uncommon cases where drug therapy is definitely indicated, a safer and more appropriate medication is often available.

Obesity is the condition for which amphetamines are most commonly prescribed, but before I discuss their efficacy in the treatment of this condition, I will briefly consider some of the toxic effects of amphetamines.

Of all the myths surrounding the amphetamines, that of their alleged "non-addictiveness" is today the most transparent, even though when these drugs were first introduced they were almost universally hailed as having little or no addictive potential. This is not surprising; almost every drug which is now condemned as addictive was vouchsafed by the official medical establishment as extremely useful and non-addicting when it was first introduced. For example, when morphine was acetylated in 1898 the