

50 Reasons to Oppose Fluoridation

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Abstract Water fluoridation is the practice of adding compounds containing fluoride to the water supply to produce a final concentration of fluoride of 1 part per million in an effort to prevent tooth decay. Trials first began in the US in 1945, but before any of these trials were complete, the practice was endorsed by the US Public Health Service in 1950. Since then fluoridation has been enthusiastically and universally promoted by US health officials as being a "safe and effective" for fighting tooth decay. However, even though most countries worldwide have not succumbed to America's enthusiasm for this practice, their teeth are just as good, if not better, than those countries that have. The "50 Reasons" offered in this article for opposing fluoridation are based on a thorough review of the scientific literature as regards both the risks and benefits of being exposed to the fluoride ion. Documentation is offered which indicates that the benefits of ingested fluoride have been exaggerated, while the numerous risks have been downplayed or ignored.

Introduction

This document, titled "50 Reasons to Oppose Fluoridation," has an interesting history. In October 2000, Dr. Hardy Limeback and I were invited by Ireland's Ministry of Health and Children to present our concerns about water fluoridation to a panel called the "Fluoridation Forum." We accepted. Ireland is the only country in Europe which has mandatory fluoridation and currently, over 70% of the Irish population is drinking fluoridated water.

When fluoridation opponents in Ireland heard that we had agreed to testify they were furious. They believed that this forum had been set up by the government merely to appear to deal with growing discontent about fluoridation. Opponents believed that most of the Forum panel members had been hand picked to "whitewash" fluoridation, and by testifying, Dr. Limeback and I would give an illusion of legitimacy to an illegitimately established process and any product it produced.

We were in a dilemma. Although we also suspected that the opponents were correct in thinking the Forum was merely a rubber stamp for government policy, we both had a strong desire to bring the best science available to the panel. Had we chosen not to appear, proponents could have argued that there was no valid, scientific case to be made against fluoridation.

In the face of fierce opposition we proceeded to testify. In my testimony, however, I explained that many citizens felt the forum was "fixed." Then I offered the panel a challenge that could demonstrate to the Irish people and to us that the panel was truly going to perform an objective review of the issue. I presented the "50 Reasons to Oppose Fluoridation" and asked the panel to prepare a written, scientifically documented response and to make it publicly available.

Initially, the panel agreed and set up a sub-committee to do this. Forum minutes over the next year indicate several exchanges about how much progress was being made with the task. However, shortly before the Forum report was completed, it was announced that the panel didn't have time to complete its answers. The cover excuse was that most of the 50 reasons were actually addressed in their 296 page report. This was blatantly untrue. Subsequently, a group of 11 scientists, including Dr. Limeback and myself, issued a detailed critique of the Forum's report which can be accessed at <http://www.fluoridealert.org/irish.forum-critique.htm>

It now has been three and a half years since the "50 Reasons to Oppose Fluoridation" was presented to the Fluoridation Forum, and even though the Irish Minister of Health and Children, Mr. Michael Martin, has been questioned about this document in the Irish parliament, there still has been no formal answer to the questions. Meanwhile, citizens in other fluoridated countries (e.g. Australia, Canada, New Zealand and the United States) have asked their own local, state and federal health officials to respond to the "50 Reasons" document – also to no avail.

The 50 Reasons (updated April 12, 2004)

1) Fluoride is not an essential nutrient (NRC 1993 and IOM 1997). No disease has ever been linked to a fluoride deficiency. Humans can have perfectly good teeth without fluoride.

2) Fluoridation is not necessary. Most Western European countries are not fluoridated and have experienced the same decline in dental decay as the US (See data from World Health Organization in Appendix 1, and the time trends presented graphically at <http://www.fluoridealert.org/who-dmft.htm>). The reasons given by countries for not fluoridating are presented in Appendix 2.)

3) Fluoridation's role in the decline of tooth decay is in serious doubt. The largest survey ever conducted in the US (over 39,000 children from 84 communities) by the National Institute of Dental Research showed little difference in tooth decay among children in fluoridated and non-fluoridated communities (Hileman 1989). According to NIDR researchers, the study found an average difference of only 0.6 DMFS (Decayed Missing and Filled Surfaces) in the permanent teeth of children aged 5-17 residing in either fluoridated or unfluoridated areas (Brunelle and Carlos, 1990). This difference is less than one tooth surface! There are 128 tooth surfaces in a child's mouth. This result was not shown to be statistically significant. In a review commissioned by the Ontario government, Dr. David Locker concluded:

"The magnitude of [fluoridation's] effect is not large in absolute terms, is often not statistically significant and may not be of clinical significance" (Locker 1999).

4) Where fluoridation has been discontinued in communities from Canada, the former East Germany, Cuba and Finland, dental decay has not increased but has actually decreased

(Maupome 2001; Kunzel and Fischer, 1997, 2000; Kunzel 2000 and Seppa 2000).

5) There have been numerous recent reports of dental crises in US cities (e.g. Boston, Cincinnati, New York City) which have been fluoridated for over 20 years. There appears to be a far greater (inverse) relationship between tooth decay and income level than with water fluoride levels.

6) Modern research (e.g. Diesendorf 1986; Colquhoun 1997, and De Liefde, 1998) shows that decay rates were coming down before fluoridation was introduced and have continued to decline even after its benefits would have been maximized. Many other factors influence tooth decay. Some recent studies have found that tooth decay actually increases as the fluoride concentration in the water increases (Olsson 1979; Retief 1979; Mann 1987, 1990; Steelink 1992; Teotia 1994; Grobler 2001; Awadia 2002 and Ekanayake 2002).

7) The Centers for Disease Control and Prevention (CDC 1999, 2001) has now acknowledged the findings of many leading dental researchers, that the mechanism of fluoride's benefits are mainly TOPICAL not SYSTEMIC. Thus, you don't have to swallow fluoride to protect teeth. As the benefits of fluoride (if any exist) are topical, and the risks are systemic, it makes more sense, for those who want to take the risks, to deliver the fluoride directly to the tooth in the form of toothpaste. Since swallowing fluoride is unnecessary, there is no reason to force people (against their will) to drink fluoride in their water supply. This position was recently shared by Dr. Douglas Carnall, the associate editor of the British Medical Journal. His editorial appears in Appendix 3.

8). Despite being prescribed by doctors for over 50 years, the US Food and Drug Administration (FDA) has never approved any fluoride supplement designed for ingestion as safe or effective. Fluoride supplements are designed to deliver the same amount of fluoride as ingested daily from fluoridated water (Kelly 2000).

9) The US fluoridation program has massively failed to achieve one of its key objectives, i.e. to lower dental decay rates while holding down dental fluorosis (mottled and discolored enamel), a condition known to be caused by fluoride. The goal of the early promoters of fluoridation was to limit dental fluorosis (in its mildest form) to 10% of children (NRC 1993, pp. 6-7). A major US survey has found 30% of children in optimally fluoridated areas had dental fluorosis on at least two teeth (Heller 1997), while smaller studies have found up to 80% of children impacted (Williams 1990; Lalumandier 1995 and Morgan 1998). The York Review estimates that up to 48% of children in optimally fluoridated areas worldwide have dental fluorosis in all forms and 12.5% with symptoms of aesthetic concern (McDonagh, 2000).

10) Dental fluorosis means that a child has been overdosed on fluoride. While the mechanism by which the enamel is damaged is not definitively known, it appears fluorosis may be a result of either inhibited enzymes in the growing teeth (Dan Besten 1999), or through fluoride's interference with G-protein signaling mechanisms (Matsuo 1996). In a study in Mexico, Alarcon-Herrera (2001) has shown a linear correlation between the severity of dental fluorosis and the frequency of bone fractures in children.

11) The level of fluoride put into water (1 ppm) is up to 200 times higher than normally found in mothers' milk (0.005 – 0.01 ppm) (Ekstrand 1981; Institute of Medicine 1997). There are no

benefits, only risks, for infants ingesting this heightened level of fluoride at such an early age (this is an age where susceptibility to environmental toxins is particularly high).

12) Fluoride is a cumulative poison. On average, only 50% of the fluoride we ingest each day is excreted through the kidneys. The remainder accumulates in our bones, pineal gland, and other tissues. If the kidney is damaged, fluoride accumulation will increase, and with it, the likelihood of harm.

13) Fluoride is very biologically active even at low concentrations. It interferes with hydrogen bonding (Emsley 1981) and inhibits numerous enzymes (Waldobott 1978).

14) When complexed with aluminum, fluoride interferes with G-proteins (Bigay 1985, 1987). Such interactions give aluminum-fluoride complexes the potential to interfere with many hormonal and some neurochemical signals (Strunecka and Patocka 1999, Li 2003).

15) Fluoride has been shown to be mutagenic, cause chromosome damage and interfere with the enzymes involved with DNA repair in a variety of cell and tissue studies (Tsutsui 1984; Caspary 1987; Kishi 1993 and Mihashi 1996). Recent studies have also found a correlation between fluoride exposure and chromosome damage in humans (Sheth 1994; Wu 1995; Meng 1997 and Joseph 2000).

16) Fluoride forms complexes with a large number of metal ions, which include metals which are needed in the body (like calcium and magnesium) and metals (like lead and aluminum) which are toxic to the body. This can cause a variety of problems. For example, fluoride interferes with enzymes where magnesium is an important co-factor, and it can help facilitate the uptake of aluminum and lead into tissues where these metals wouldn't otherwise go (Mahaffey 1976; Allain 1996; Varner 1998).

17) Rats fed for one year with 1 ppm fluoride in their water, using either sodium fluoride or aluminum fluoride, had morphological changes to their kidneys and brains, an increased uptake of aluminum in the brain, and the formation of beta amyloid deposits which are characteristic of Alzheimers disease (Varner 1998).

18) Aluminum fluoride was recently nominated by the Environmental Protection Agency and National Institute of Environmental Health Sciences for testing by the National Toxicology Program. According to EPA and NIEHS, aluminum fluoride currently has a "high health research priority" due to its "known neurotoxicity" (BNA, 2000). If fluoride is added to water which contains aluminum, than aluminum fluoride complexes will form.

19) Animal experiments show that fluoride accumulates in the brain and exposure alters mental behavior in a manner consistent with a neurotoxic agent (Mullenix 1995). Rats dosed prenatally demonstrated hyperactive behavior. Those dosed postnatally demonstrated hypoactivity (i.e. under activity or "couch potato" syndrome). More recent animal experiments have reported that fluoride can damage the brain (Wang 1997; Guan 1998; Varner 1998; Zhao 1998; Zhang 1999; Lu 2000; Shao 2000; Sun 2000; Bhatnagar 2002; Chen 2002, 2003; Long 2002; Shivarajashankara 2002a, b; Shashi 2003 and Zhai 2003) and impact learning and behavior (Paul 1998; Zhang 1999, 2001; Sun 2000; Ekambaram 2001; Bhatnagar 2002).

20) Five studies from China show a lowering of IQ in children associated with fluoride exposure (Lin Fa-Fu 1991; Li 1995;

Zhao 1996; Lu 2000; and Xiang 2003a, b). One of these studies (Lin Fa-Fu 1991) indicates that even just moderate levels of fluoride exposure (e.g. 0.9 ppm in the water) can exacerbate the neurological defects of iodine deficiency.

21) Studies by Jennifer Luke (2001) showed that fluoride accumulates in the human pineal gland to very high levels. In her Ph.D. thesis Luke has also shown in animal studies that fluoride reduces melatonin production and leads to an earlier onset of puberty (Luke 1997).

22) In the first half of the 20th century, fluoride was prescribed by a number of European doctors to reduce the activity of the thyroid gland for those suffering from hyperthyroidism (over active thyroid) (Stecher 1960; Waldbott 1978). With water fluoridation, we are forcing people to drink a thyroid-depressing medication which could, in turn, serve to promote higher levels of hypothyroidism (underactive thyroid) in the population, and all the subsequent problems related to this disorder. Such problems include depression, fatigue, weight gain, muscle and joint pains, increased cholesterol levels, and heart disease.

It bears noting that according to the Department of Health and Human Services (1991) fluoride exposure in fluoridated communities is estimated to range from 1.6 to 6.6 mg/day, which is a range that actually overlaps the dose (2.3 - 4.5 mg/day) shown to decrease the functioning of the human thyroid (Galletti & Joyet 1958). This is a remarkable fact, particularly considering the rampant and increasing problem of hypothyroidism in the United States (in 1999, the second most prescribed drug of the year was Synthroid, which is a hormone replacement drug used to treat an underactive thyroid). In Russia, Bachinskii (1985) found a lowering of thyroid function, among otherwise healthy people, at 2.3 ppm fluoride in water.

23) Some of the early symptoms of skeletal fluorosis, a fluoride-induced bone and joint disease that impacts millions of people in India, China, and Africa, mimic the symptoms of arthritis (Singh 1963; Franke 1975; Teotia 1976; Carnow 1981; Czerwinski 1988; DHHS 1991). According to a review on fluoridation by *Chemical & Engineering News*, "Because some of the clinical symptoms mimic arthritis, the first two clinical phases of skeletal fluorosis could be easily misdiagnosed" (Hileman 1988). Few if any studies have been done to determine the extent of this misdiagnosis, and whether the high prevalence of arthritis in America (1 in 3 Americans have some form of arthritis - CDC, 2002) is related to our growing fluoride exposure, which is highly plausible. The causes of most forms of arthritis (e.g. osteoarthritis) are unknown.

24) In some studies, when high doses of fluoride (average 26 mg per day) were used in trials to treat patients with osteoporosis in an effort to harden their bones and reduce fracture rates, it actually led to a HIGHER number of fractures, particularly hip fractures (Inkovaara 1975; Gerster 1983; Dambacher 1986; O'Duffy 1986; Hedlund 1989; Bayley 1990; Gutteridge 1990, 2002; Orcel 1990; Riggs 1990 and Schnitzler 1990). The cumulative doses used in these trials are exceeded by the lifetime cumulative doses being experienced by many people living in fluoridated communities.

25) Nineteen studies (three unpublished, including one abstract) since 1990 have examined the possible relationship of fluoride in water and hip fracture among the elderly. Eleven of these studies found an association, eight did not. One study found a dose-related increase in hip fracture as the concentration of fluoride rose from 1 ppm to 8 ppm (Li 2001). Hip fracture is a very serious issue for the elderly, as a quarter of those who

have a hip fracture die within a year of the operation, while 50 percent never regain an independent existence (All 19 of these studies are referenced as a group in the reference section).

26) The only government-sanctioned animal study to investigate if fluoride causes cancer, found a dose-dependent increase in cancer in the target organ (bone) of the fluoride-treated (male) rats (NTP 1990). The initial review of this study also reported an increase in liver and oral cancers, however, all non-bone cancers were later downgraded – with a questionable rationale – by a government-review panel (Marcus 1990). In light of the importance of this study, EPA Professional Headquarters Union has requested that Congress establish an independent review to examine the study's results (Hirzy 2000).

27) A review of national cancer data in the US by the National Cancer Institute (NCI) revealed a significantly higher rate of bone cancer in young men in fluoridated versus unfluoridated areas (Hoover 1991). While the NCI concluded that fluoridation was not the cause, no explanation was provided to explain the higher rates in the fluoridated areas. A smaller study from New Jersey (Cohn 1992) found bone cancer rates to be up to 6 times higher in young men living in fluoridated versus unfluoridated areas. Other epidemiological studies have failed to find this relationship (Mahoney 1991; Freni 1992).

28) Fluoride administered to animals at high doses wreaks havoc on the male reproductive system - it damages sperm and increases the rate of infertility in a number of different species (Kour 1980; Chinoy 1989; Chinoy 1991; Susheela 1991; Chinoy 1994; Kumar 1994; Narayana 1994a, b; Zhao 1995; Elbetieha 2000; Ghosh 2002 and Zakrzewska 2002). While studies conducted at the FDA have failed to find reproductive effects in rats (Sprando 1996, 1997, 1998), an epidemiological study from the US has found increased rates of infertility among couples living in areas with 3 or more ppm fluoride in the water (Freni 1994), and 2 studies have found a reduced level of circulating testosterone in males living in high fluoride areas (Susheela 1996 and Barot 1998).

29) The fluoridation program has been very poorly monitored. There has never been a comprehensive analysis of the fluoride levels in the bones, blood, or urine of the American people or the citizens of other fluoridated countries. Based on the sparse data that has become available, however, it is increasingly evident that some people in the population – particularly people with kidney disease - are accumulating fluoride levels that have been associated with harm to both animals and humans, particularly harm to bone (see Connett 2004).

30) Once fluoride is put in the water it is impossible to control the dose each individual receives. This is because 1) some people (e.g. manual laborers, athletes, diabetics, and people with kidney disease) drink more water than others, and 2) we receive fluoride from sources other than the water supply. Other sources of fluoride include food and beverages processed with fluoridated water (Kiritsy 1996 and Heilman 1999), fluoridated dental products (Bentley 1999 and Levy 1999), mechanically deboned meat (Fein 2001), teas (Levy 1999), and pesticide residues on food (Stannard 1991 and Burgstahler 1997).

31) Fluoridation is unethical because individuals are not being asked for their informed consent prior to medication. This is standard practice for all medication, and one of the key reasons why most of western Europe has ruled against fluoridation (see appendix 2).

As one doctor aptly stated, "No physician in his right senses would prescribe for a person he has never met, whose medical history he does not know, a substance which is intended to create bodily change, with the advice: 'Take as much as you like, but you will take it for the rest of your life because some children suffer from tooth decay.' It is a preposterous notion."

32) While referenda are preferential to imposed policies from central government, it still leaves the problem of individual rights versus majority rule. Put another way -- does a voter have the right to require that their neighbor ingest a certain medication (even if it's against that neighbor's will)?

33) Some individuals appear to be highly sensitive to fluoride as shown by case studies and double blind studies (Shea 1967, Waldbott 1978 and Moolenburg 1987). In one study, which lasted 13 years, Feltman and Kosel (1961) showed that about 1% of patients given 1 mg of fluoride each day developed negative reactions. Can we as a society force these people to ingest fluoride?

34) According to the Agency for Toxic Substances and Disease Registry (ATSDR 1993), and other researchers (Juncos & Donadio 1972; Marier & Rose 1977 and Johnson 1979), certain subsets of the population may be particularly vulnerable to fluoride's toxic effects; these include: the elderly, diabetics and people with poor kidney function. Again, can we in good conscience force these people to ingest fluoride on a daily basis for their entire lives?

35) Also vulnerable are those who suffer from malnutrition (e.g. calcium, magnesium, vitamin C, vitamin D and iodide deficiencies and protein poor diets) (Massler & Schour 1952; Marier & Rose 1977; Lin Fa-Fu 1991; Chen 1997; Teotia 1998). Those most likely to suffer from poor nutrition are the poor, who are precisely the people being targeted by new fluoridation programs. While being at heightened risk, poor families are less able to afford avoidance measures (e.g. bottled water or removal equipment).

36) Since dental decay is most concentrated in poor communities, we should be spending our efforts trying to increase the access to dental care for poor families. The real "Oral Health Crisis" that exists today in the United States, is not a lack of fluoride but poverty and lack of dental insurance. The Surgeon General has estimated that 80% of dentists in the US do not treat children on Medicaid.

37) Fluoridation has been found to be ineffective at preventing one of the most serious oral health problems facing poor children, namely, baby bottle tooth decay, otherwise known as early childhood caries (Barnes 1992 and Shiboski 2003).

38) The early studies conducted in 1945 -1955 in the US, which helped to launch fluoridation, have been heavily criticized for their poor methodology and poor choice of control communities (De Stefano 1954; Sutton 1959, 1960 and 1996; Ziegelbecker 1970). According to Dr. Hubert Arnold, a statistician from the University of California at Davis, the early fluoridation trials "are especially rich in fallacies, improper design, invalid use of statistical methods, omissions of contrary data, and just plain muddleheadedness and hebetude." In 2000, the British Government's "York Review" could give no fluoridation trial a grade A classification – despite 50 years of research (McDonagh 2000, see Appendix 3 for commentary).

39) The US Public Health Service first endorsed fluoridation in 1950, before one single trial had been completed (McClure 1970)!

40) Since 1950, it has been found that fluorides do little to prevent pit and fissure tooth decay, a fact that even the dental community has acknowledged (Seholle 1984; Gray 1987; PHS 1993; and Pinkham 1999). This is significant because pit and fissure tooth decay represents up to 85% of the tooth decay experienced by children today (Seholle 1984 and Gray 1987).

41) Despite the fact that we are exposed to far more fluoride today than we were in 1945 (when fluoridation began), the "optimal" fluoridation level is still 1 part per million, the same level deemed optimal in 1945! (Marier & Rose 1977; Levy 1999; Rozier 1999 and Fomon 2000).

42) The chemicals used to fluoridate water in the US are not pharmaceutical grade. Instead, they come from the wet scrubbing systems of the superphosphate fertilizer industry. These chemicals (90% of which are sodium fluorosilicate and fluorosilicic acid), are classified hazardous wastes contaminated with various impurities. Recent testing by the National Sanitation Foundation suggest that the levels of arsenic in these chemicals are relatively high (up to 1.6 ppb after dilution into public water) and of potential concern (NSF 2000 and Wang 2000).

43) These hazardous wastes have not been tested comprehensively. The chemical usually tested in animal studies is pharmaceutical grade sodium fluoride, not industrial grade fluorosilicic acid. The assumption being made is that by the time this waste product has been diluted, all the fluorosilicic acid will have been converted into free fluoride ion, and the other toxics and radioactive isotopes will be so dilute that they will not cause any harm, even with lifetime exposure. These assumptions have not been examined carefully by scientists, independent of the fluoridation program.

44) Studies by Masters and Coplan (1999, 2000) show an association between the use of fluorosilicic acid (and its sodium salt) to fluoridate water and an increased uptake of lead into children's blood. Because of lead's acknowledged ability to damage the child's developing brain, this is a very serious finding yet it is being largely ignored by fluoridating countries.

45) Sodium fluoride is an extremely toxic substance -- just 200 mg of fluoride ion is enough to kill a young child, and just 3-5 grams (e.g. a teaspoon) is enough to kill an adult. Both children (swallowing tablets/gels) and adults (accidents involving fluoridation equipment and filters on dialysis machines) have died from excess exposure.

46) Some of the earliest opponents of fluoridation were biochemists and at least 14 Nobel Prize winners are among numerous scientists who have expressed their reservations about the practice of fluoridation (see appendix 4).

47) The recent Nobel Laureate in Medicine and Physiology, Dr. Arvid Carlsson (2000), was one of the leading opponents of fluoridation in Sweden, and part of the panel that recommended that the Swedish government reject the practice, which they did in 1971. According to Carlsson:

"I am quite convinced that water fluoridation, in a not-too-distant future, will be consigned to medical history...Water fluoridation goes against leading principles of pharmacotherapy, which is progressing from a stereotyped medication - of the type 1 tablet

3 times a day - to a much more individualized therapy as regards both dosage and selection of drugs. The addition of drugs to the drinking water means exactly the opposite of an individualized therapy" (Carlsson 1978).

48) While pro-fluoridation officials continue to promote fluoridation with undiminished fervor, they cannot defend the practice in open public debate – even when challenged to do so by organizations such as the Association for Science in the Public Interest, the American College of Toxicology, or the US Environmental Protection Agency (Bryson 2004). According to Dr. Michael Easley, a prominent lobbyist for fluoridation in the US, "Debates give the illusion that a scientific controversy exists when no credible people support the fluorophobics' view" (See appendix 5).

In light of proponents' refusal to debate this issue, Dr. Edward Groth, a Senior Scientist at Consumers Union, observed that "the political profluoridation stance has evolved into a dogmatic, authoritarian, essentially antiscientific posture, one that discourages open debate of scientific issues" (Martin 1991).

49) Many scientists, doctors and dentists who have spoken out publicly on this issue have been subjected to censorship and intimidation (Martin 1991). Most recently, Dr. Phyllis Mullenix was fired from her position as Chair of Toxicology at Forsythe Dental Center for publishing her findings on fluoride and the brain; and Dr. William Marcus was fired from the EPA for questioning the government's handling of the NTP's fluoride-cancer study (Bryson 2004). Tactics like this would not be necessary if those promoting fluoridation were on secure scientific ground.

50) The Union representing the scientists at US EPA headquarters in Washington DC is now on record as opposing water fluoridation (Hirzy 1999). According to the Union's Senior Vice President, Dr. William Hirzy:

"In summary, we hold that fluoridation is an unreasonable risk. That is, the toxicity of fluoride is so great and the purported benefits associated with it are so small - if there are any at all - that requiring every man, woman and child in America to ingest it borders on criminal behavior on the part of governments."

Conclusion

When it comes to controversies surrounding toxic chemicals, invested interests traditionally do their very best to discount animal studies and quibble with epidemiological findings. In the past, political pressures have led government agencies to drag their feet on regulating asbestos, benzene, DDT, PCBs, tetraethyl lead, tobacco and dioxins. With fluoridation we have had a fifty year delay. Unfortunately, because government officials have put so much of their credibility on the line defending fluoridation, and because of the huge liabilities waiting in the wings if they admit that fluoridation has caused an increase in hip fracture, arthritis, bone cancer, brain disorders or thyroid problems, it will be very difficult for them to speak honestly and openly about the issue. But they must, not only to protect millions of people from unnecessary harm, but to protect the notion that, at its core, public health policy must be based on sound science not political expediency. They have a tool with which to do this: it's called the Precautionary Principle. Simply put, this says: if in doubt leave it out. This is what most European countries have done and their children's teeth have not suffered, while their public's trust has been strengthened.

It is like a question from a Kafka play. Just how much doubt is needed on just one of the health concerns identified above, to override a benefit, which when quantified in the largest survey ever conducted in the US, amounts to less than one tooth surface (out of 128) in a child's mouth?

For those who would call for further studies, I say fine. Take the fluoride out of the water first and then conduct all the studies you want. This folly must end without further delay.

Postscript

Further arguments against fluoridation, can be viewed at <http://www.fluoridealert.org>. Arguments for fluoridation can be found at <http://www.ada.org> and a more systematic presentation of fluoride's toxic effects can be found at <http://www.SIweb.org/bibliography.html>

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APPENDIX 1. World Health Organization Data DMFT (Decayed, Missing & Filled teeth) Status for 12 year old by Country

	DMFTs	Year	Water/Salt Status*	Fluoridatic
Australia	0.8	1998	More than 50% of water fluoridated	
Zurich, Switzerland	0.84	1998	Water is unfluoridated, but s: is fluoridated	
Netherlands	0.9	1992-93	No water fluoridation or s: fluoridation	
Sweden	0.9	1999	No water fluoridation or s: fluoridation	
Denmark	0.9	2001	No water fluoridation or s: fluoridation	
UK (<i>England & Wales</i>)	0.9	1996-97	11% of water supplies a fluoridated	
Ireland	1.1	1997	More than 50% of water fluoridated	
Finland	1.1	1997	No water fluoridation or s: fluoridation	
Germany	1.2	2000	No water fluoridation, but s: fluoridation is common	
US	1.4	1988-91	More than 50% of water fluoridated	
Norway	1.5	1998	No water fluoridation or s: fluoridation	
Iceland	1.5	1996	No water fluoridation or s: fluoridation	
New Zealand	1.5	1993	More than 50% of water fluoridated	
Belgium	1.6	1998	No water fluoridation, but s: fluoridation is common	
Austria	1.7	1997	No water fluoridation, but s: fluoridation is common	
France	1.9	1998	No water fluoridation, but s: fluoridation is common	

Data from WHO Oral Health Country/Area Profile Program
Department of Noncommunicable Diseases Surveillance/O
Health WHO Collaborating Centre, Malmö University, Swed
<http://www.whocollab.od.mah.se/euro.html>

APPENDIX 2. Statements on fluoridation by governmental officials from several countries

Germany: "Generally, in Germany fluoridation of drinking water is forbidden. The relevant German law allows exceptions to the fluoridation ban on application. The argumentation of the Federal Ministry of Health against a general permission of fluoridation of drinking water is the problematic nature of compuls[ory] medication." (Gerda Hankel-Khan, Embassy of Federal Republic of Germany, September 16, 1999). www.fluoridealert.org/germany.jpeg

France: "Fluoride chemicals are not included in the list [of 'chemicals for drinking water treatment']. This is due to ethical as well as medical considerations." (Louis Sanchez, Directeur de la Protection de l'Environnement, August 25, 2000). www.fluoridealert.org/france.jpeg

Belgium: "This water treatment has never been of use in Belgium and will never be (we hope so) into the future. The main reason for that is the fundamental position of the drinking water sector that it is not its task to deliver medicinal treatment to people. This is the sole responsibility of health services." (Chr. Legros, Directeur, Belgaqua, Brussels, Belgium, February 28, 2000). www.fluoridation.com/c-belgium.htm

Luxembourg: "Fluoride has never been added to the public water supplies in Luxembourg. In our views, the drinking water isn't the suitable way for medicinal treatment and that people needing an addition of fluoride can decide by their own to use the most appropriate way, like the intake of fluoride tablets, to cover their [daily] needs." (Jean-Marie RIES, Head, Water Department, Administration De L'Environnement, May 3, 2000). www.fluoridealert.org/luxembourg.jpeg

Finland: "We do not favor or recommend fluoridation of drinking water. There are better ways of providing the fluoride our teeth need." (Paavo Poteri, Acting Managing Director, Helsinki Water, Finland, February 7, 2000). www.fluoridation.com/c-finland.htm

"Artificial fluoridation of drinking water supplies has been practiced in Finland only in one town, Kuopio, situated in eastern Finland and with a population of about 80,000 people (1.6% of the Finnish population). Fluoridation started in 1959 and finished in 1992 as a result of the resistance of local population. The most usual grounds for the resistance presented in this context were an individual's right to drinking water without additional chemicals used for the medication of limited population groups. A concept of "force-feeding" was also mentioned.

Drinking water fluoridation is not prohibited in Finland but no municipalities have turned out to be willing to practice it. Water suppliers, naturally, have always been against dosing of fluoride chemicals into water." (Leena Hiisvirta, M.Sc., Chief Engineer, Ministry of Social Affairs and Health, Finland, January 12, 1996.) www.fluoridealert.org/finland.jpeg

Denmark: "We are pleased to inform you that according to the Danish Ministry of Environment and Energy, toxic fluorides have never been added to the public water supplies. Consequently, no Danish city has ever been fluoridated." (Klaus Werner, Royal Danish Embassy, Washington DC, December 22, 1999). www.fluoridation.com/c-denmark.htm

Norway: "In Norway we had a rather intense discussion on this subject some 20 years ago, and the conclusion was that drinking water should not be fluoridated." (Truls Krogh & Toril Hofshagen, Folkehelse Statens institutt for folkehelse (National Institute of Public Health) Oslo, Norway, March 1, 2000). www.fluoridation.com/c-norway.htm

Sweden: "Drinking water fluoridation is not allowed in Sweden...New scientific documentation or changes in dental health situation that could alter the conclusions of the Commission have not been shown." (Gunnar Guzikowski, Chief Government Inspector, Livsmedels Verket -- National Food Administration Drinking Water Division, Sweden, February 28, 2000). www.fluoridation.com/c-sweden.htm

Netherlands: "From the end of the 1960s until the beginning of the 1970s drinking water in various places in the Netherlands was fluoridated to prevent caries. However, in its judgement of 22 June 1973 in case No. 10683 (Budding and co. versus the City of Amsterdam) the Supreme Court (Hoge Raad) ruled there was no legal basis for fluoridation. After that judgement, amendment to the Water Supply Act was prepared to provide a legal basis for fluoridation. During the process it became clear that there was not enough support from Parlement [sic] for this amendment and the proposal was withdrawn." (Wilfred Reinhold, Legal Advisor, Directorate Drinking Water, Netherlands, January 15, 2000). www.fluoridation.com/c-netherlands.htm

Northern Ireland: "The water supply in Northern Ireland has never been artificially fluoridated except in 2 small localities where fluoride was added to the water for about 30 years up to last year. Fluoridation ceased at these locations for operational reasons. At this time, there are no plans to commence fluoridation of water supplies in Northern Ireland." (C.J. Grimes, Department for Regional Development, Belfast, November 6, 2000). www.fluoridealert.org/Northern-Ireland.jpeg

Austria: "Toxic fluorides have never been added to the public water supplies in Austria." (M. Eisenhut, Head of Water Department, Osterreichische Yereinigung fur das Gas-und Wasserfach Schuberting 14, A-1015 Wien, Austria, February 17, 2000). www.fluoridation.com/c-austria.htm

Czech Republic: "Since 1993, drinking water has not been treated with fluoride in public water supplies throughout the Czech Republic. Although fluoridation of drinking water has not actually been proscribed it is not under consideration because this form of supplementation is considered as follows:

- (a) uneconomical (only 0.54% of water suitable for drinking is used as such; the remainder is employed for hygiene etc. Furthermore, an increasing amount of consumers (particularly children) are using bottled water for drinking (underground water usually with fluor)
- (b) unecological (environmental load by a foreign substance)
- (c) unethical ("forced medication")
- (d) toxicologically and physiologically debatable (fluoridation represents an untargeted form of supplementation which disregards actual individual intake and requirements and may lead to excessive health-threatening intake in certain population groups; [and] complexation of fluor in water into non biological active forms of fluor." (Dr. B. Havlik, Ministerstvo Zdravotnictvi Ceske Republiky, October 14, 1999). www.fluoridealert.org/czech.jpeg

APPENDIX 3. Statement of Douglas Carnall, Associate Editor of the British Medical Journal, published on the BMJ website (<http://www.bmj.com>) on the day that they published the York Review on Fluoridation.

See this review on the web at <http://bmj.bmjournals.com/cgi/content/full/321/7265/904/a>

British Medical Journal, October 7, 2000, Reviews, Website of the week: Water fluoridation

Fluoridation was a controversial topic even before Kubrick's Base Commander Ripper railed against "the international communist conspiracy to sap and impurify all of our precious bodily fluids" in the 1964 film *Dr Strangelove*. This week's BMJ shouldn't precipitate a global holocaust, but it does seem that Base Commander Ripper may have had a point. The systematic review published this week (p 855) shows that much of the evidence for fluoridation was derived from low quality studies, that its benefits may have been overstated, and that the risk to benefit ratio for the development of the commonest side effect (dental fluorosis, or mottling of the teeth) is rather high.

Supplementary materials are available on the BMJ 's website and on that of the review's authors, enhancing the validity of the conclusions through transparency of process. For example, the "frequently asked questions" page of the site explains who comprised the advisory panel and how they were chosen ("balanced to include those for and against, as well as those who are neutral"), and the site includes the minutes of their meetings. You can also pick up all 279 references in Word97 format, and tables of data in PDF. Such transparency is admirable and can only encourage rationality of debate.

Professionals who propose compulsory preventive measures for a whole population have a different weight of responsibility on their shoulders than those who respond to the requests of individuals for help. Previously neutral on the issue, I am now persuaded by the arguments that those who wish to take fluoride (like me) had better get it from toothpaste rather than the water supply (see www.derweb.co.uk/bfs/index.html and www.npwa.freeseerve.co.uk/index.html for the two viewpoints).

Douglas Carnall
Associate Editor
British Medical Journal

APPENDIX 4. List of 14 Noble Prize winners who have opposed or expressed reservations about fluoridation.

- 1) Adolf Butenandt (Chemistry, 1939)
- 2) Arvid Carlsson (Medicine, 2000)
- 3) Hans von Euler-Chelpin (Chemistry, 1929).
- 4) Walter Rudolf Hess (Medicine, 1949)
- 5) Corneille Jean-François Heymans (Medicine, 1938)
- 6) Sir Cyril Norman Hinshelwood (Chemistry, 1956)
- 7) Joshua Lederberg (Medicine, 1958)
- 8) William P. Murphy (Medicine, 1934)
- 8) Giulio Natta (1963 Nobel Prize in Chemistry)
- 10) Sir Robert Robinson (Chemistry, 1947)
- 11) Nikolai Semenov (Chemistry, 1956)
- 12) James B. Sumner (Chemistry, 1946)
- 13) Hugo Theorell (Medicine, 1955)
- 14) Artturi Virtanen (Chemistry, 1945)

APPENDIX 5. Quotes on debating fluoridation from Dr. Michael Easley, Director of the National Center for Fluoridation Policy and Research, and one of the most active proponents of fluoridation in the US (Easley 1999). Easley's quotes typify the historic contempt that proponents have had to scientific debate.

"A favorite tactic of the fluorophobics is to argue for a debate so that 'the people can decide who is right.' Proponents of fluoride are often trapped into consenting to public debates."

"Debates give the illusion that a scientific controversy exists when no credible people support the fluorophobics' view."

"Like parasites, opponents steal undeserved credibility just by sharing the stage with respected scientists who are there to defend fluoridation"; and,

"Unfortunately, a most flagrant abuse of the public trust occasionally occurs when a physician or a dentist, for whatever personal reason, uses their professional standing in the community to argue against fluoridation, a clear violation of professional ethics, the principles of science and community standards of practice."

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The 19 studies on the possible association of hip fracture and fluoridated-water.

a) Studies Reporting an Association between fluoridated water (1 ppm fluoride) & hip fracture.

1 a) Cooper C, et al. (1990). Water fluoride concentration and fracture of the proximal femur. *Journal of Epidemiology and Community Health* 44: 17-19.

1 b) Cooper C, et al. (1991). Water fluoridation and hip fracture. *JAMA* 266: 513-514 (letter, a reanalysis of data presented in 1990 paper).

2) Danielson C, et al. (1992). Hip fractures and fluoridation in Utah's elderly population. *Journal of the American Medical Association* 268: 746-748.

3) Hegmann KT, et al. (2000). The Effects of Fluoridation on Degenerative Joint Disease (DJD) and Hip Fractures. Abstract #71, of the 33rd Annual Meeting of the Society For Epidemiological research, June 15-17, 2000. Published in a Supplement of *American Journal of Epidemiology* P. S18.

4) Jacobsen SJ, et al. (1992). The association between water fluoridation and hip fracture among white women and men aged 65 years and older; a national ecologic study." *Annals of Epidemiology* 2: 617-626.

5) Jacobsen SJ, et al. (1990). Regional variation in the incidence of hip fracture: US white women aged 65 years and older. *JAMA* 264(4): 500-2.

6 a) Jacqmin-Gadda H, et al. (1995). Fluorine concentration in drinking water and fractures in the elderly. *JAMA* 273: 775-776 (letter).

6 b) Jacqmin-Gadda H, et al. (1998). Risk factors for fractures in the elderly. *Epidemiology* 9(4): 417-423. (An elaboration of the 1995 study referred to in the JAMA letter).

7) Keller C. (1991) Fluorides in drinking water. Unpublished results. Discussed in Gordon, S.L. and Corbin, S.B.(1992) Summary of Workshop on Drinking Water Fluoride Influence on Hip Fracture on Bone Health. *Osteoporosis International* 2: 109-117.

8) Kurttio PN, et al. (1999). Exposure to natural fluoride in well water and hip fracture: A cohort analysis in Finland. *American Journal of Epidemiology* 150(8): 817-824.

9) May DS, Wilson MG. (1992). Hip fractures in relation to water fluoridation: an ecologic analysis. Unpublished data, discussed in Gordon SL, and Corbin SB. (1992). Summary of Workshop on Drinking Water Fluoride Influence on Hip Fracture on Bone Health. *Osteoporosis International* 2:109-117.

b) Studies reporting an association between water-fluoride levels higher than fluoridated water (4 ppm+) & hip fracture.

Li Y, et al. (2001). Effect of long-term exposure to fluoride in drinking water on risks of bone fractures. *Journal of Bone and Mineral Research* 16: 932-9.

Sowers M, et al. (1991). A prospective study of bone mineral content and fracture in communities with differential fluoride exposure. *American Journal of Epidemiology* 133: 649-660.

c) Studies Reporting No Association between water fluoride & hip fracture:

(Note that in 4 of these 8 studies, an association was actually found between fluoride and some form of fracture – e.g. wrist and hip. See notes and quotes below.)

Cauley J. et al. (1995). Effects of fluoridated drinking water on bone mass and fractures: the study of osteoporotic fractures. *Journal of Bone and Mineral Research* 10: 1076-86.

Feskanich D, et al. (1998). Use of toenail fluoride levels as an indicator for the risk of hip and forearm fractures in women. *Epidemiology* 9: 412-6.

While this study didn't find an association between water fluoride and hip fracture, it did find an association - albeit non-significant 1.6 (0.8-3.1) - between fluoride exposure and elevated rates of forearm fracture.

Hillier S, et al. (2000). Fluoride in drinking water and risk of hip fracture in the UK: a case control study. *The Lancet* 335: 265-2690.

Jacobsen SJ, et al. (1993). Hip Fracture Incidence Before and After the Fluoridation of the Public Water Supply, Rochester, Minnesota. *American Journal of Public Health* 83: 743-745.

Karagas MR, et al. (1996). Patterns of Fracture among the United States Elderly: Geographic and Fluoride Effects. *Annals of Epidemiology* 6: 209-216.

As with Feskanich (1998) this study didn't find an association between fluoridation & hip fracture, but it did find an association between fluoridation and distal forearm fracture, as well as proximal humerus fracture. "Independent of geographic effects, men in fluoridated areas had modestly higher rates of fractures of the distal forearm and proximal humerus than did men in nonfluoridated areas."

Lehmann R, et al. (1998). Drinking Water Fluoridation: Bone Mineral Density and Hip Fracture Incidence. *Bone* 22: 273-278.

Phipps KR, et al. (2000). Community water fluoridation, bone mineral density and fractures: prospective study of effects in older women. *British Medical Journal* 321: 860-4.

As with Feskanich (1998) and Karagas (1996), this study didn't find an association between water fluoride & hip fracture, but it did find an association between water fluoride and other types of fracture - in this case, wrist fracture. "There was a non-significant trend toward an increased risk of wrist fracture."

Suarez-Almazor M, et al. (1993). The fluoridation of drinking water and hip fracture hospitalization rates in two Canadian communities. *American Journal of Public Health* 83: 689-693.

While the authors of this study conclude there is no association between fluoridation and hip fracture, their own data reveals a statistically significant increase in hip fracture for men living in the fluoridated area. According to the authors, "although a statistically significant increase in the risk of hip fracture was observed among Edmonton men, this increase was relatively small (RR=1.12)."