

Subject: The Arrogance of Fluoridation
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FLUORIDEALERT.ORG
Fluoride Action Network

MAY 5, 2014

Dear Karl:

Organized dentistry, which includes the American Dental Association [ADA], the Oral Health Division of the Centers for Disease Control and Prevention [OHD] and state dental directors, is the only health profession that seeks to deliver its services via the public's water supply.

The practice of artificial water fluoridation is the height of arrogance when one considers the following undisputed facts and scientifically supported arguments.

- a) Fluoride is not a nutrient. Not one biochemical process in the human body has been shown to *need* fluoride.
- b) The level of fluoride in mother's milk is exceedingly low (0.004 ppm, NRC, 2006, p.40). Formula-fed infants receive up to 175 to 250 times more fluoride than a breast-fed infant if using water fluoridated with .7 or 1 ppm of fluoride. Does the dental community really know more than nature about what the baby needs?
- c) Fluoride accumulates in the bone and in other calcified tissues over a lifetime. It is still not known what the true half-life of fluoride is in the human bone, but an estimate of 20 years has been made (NRC, 2006, p 92). This means that some of the fluoride absorbed by infants will be retained for a lifetime in their bones. Early symptoms of fluoride poisoning of the bones are identical to arthritis. Lifelong accumulation of fluoride in bones can also make them brittle and more prone to fracture.
- d) Once fluoride is added to the water supply, there is no way of controlling the dose people get daily or over a lifetime and there is no way of controlling who gets the fluoride – it goes to everyone regardless of age, weight, health, need or nutritional status.
- e) The addition of fluoride to the public water supply violates the individual's right to informed consent to medical or human treatment. The community is doing to everyone what a doctor can do to no single patient. (<http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000445.htm>).
- f) Fluoride is known to have toxic properties at low doses (Barbier et al, 2010).
- g) Children in fluoridated countries are being over-exposed to fluoride as demonstrated by the very high prevalence of dental fluorosis. According to the CDC (2010) 41% of American children aged 12-15 have some form of dental fluorosis. Black and Mexican American children have significantly higher rates (CDC, 2005, Table 23).
- h) A 500-page review by the National Research Council in 2006 revealed that several subsets of the population (including bottle-fed babies) are

exceeding the EPA's safe reference dose (0.06 mg / kilogram bodyweight/day) when drinking fluoridated water at 1 ppm (NRC, 2006, p85). The NRC panel also indicated that fluoride causes many health problems at levels close to the exposure levels in fluoridated communities (NRC, 2006).

- i) An un-refuted study conducted at Harvard University shows that fluoride may cause osteosarcoma (a frequently fatal bone cancer) in young men when boys are exposed to fluoridated water in their 6th, 7th and 8th years (Bassin et al., 2006). Despite promises by Bassin's thesis advisor (Chester Douglass) a subsequent study by Kim et al. (2011) did not refute Bassin's key finding of the age-window of vulnerability.
- j) There are many animal and human studies, which indicate that fluoride is a neurotoxin and 37 studies that show an association between fairly modest exposure to fluoride and lowered IQ in children. Twenty-seven of these studies were reviewed by a team from Harvard University (Choi et al., 2012). In an article in *Lancet Neurology*, Grandjean and Landrigan (2014) have since classified fluoride as a developmental neurotoxicant. All these papers can be accessed at www.FluorideAlert.org/issues/health/brain
- k) For many decades no health agency in any fluoridated country has made any serious attempt to monitor side effects (other than dental fluorosis). Nor have they investigated reports of citizens who claim to be sensitive to fluoride's toxic effects at low doses.
- l) No U.S. doctors are being trained to recognize fluoride's toxic effects, including low dose-reversible effects in sensitive individuals.
- m) Dental caries is a disease, according to the ADA, CDC's OHD, and the American Association of Pediatric Dentistry, and others. Fluoridation is designed to treat a disease but has never been approved by the FDA. The FDA has never performed any trial to ascertain the safety of fluoride. FDA classifies fluoride as an "unapproved drug."
- n) The effectiveness of swallowing fluoride to reduce tooth decay has never been demonstrated by a randomized control trial (RCT) the gold standard of epidemiology (McDonagh et al., 2000).
- o) The evidence that fluoridation or swallowing fluoride reduces tooth decay is very weak (Brunelle and Carlos, 1990 and Warren et al., 2009).
- p) The vast majority of countries neither fluoridate their water nor their salt. But, according to WHO figures, tooth decay in 12-year olds is coming down as fast –if not faster – in non-fluoridated countries as fluoridated ones (<http://fluoridealert.org/issues/caries/who-data/>).
- q) Most dental authorities now agree that the predominant benefit of fluoride is TOPICAL not SYSTEMIC (CDC, 1999, 2001)– i.e. it works on the outside of the tooth not from inside the body, thus there is no need to swallow fluoride to achieve its claimed benefit and no justification for forcing it on people who do not want it.
- r) Many countries (e.g. Scotland) have been able to reduce tooth decay in low-income families using cost-effective programs without forcing fluoride on people via the water supply (BBC Scotland, 2013).
- s) While organized dentistry (i.e. the ADA/OHD) claims that fluoridation is designed to help low-income families, it is hard to take such sentiments seriously when,
 - i) 80% of American dentists refuse to treat children on Medicaid.
 - ii) The ADA opposes the use of dental therapists to provide some

basic

services in low-income areas.

Moreover, such a practice can hardly be considered equitable when low-income families are less able to afford fluoride avoidance strategies and it is well-established that fluoride's toxic effects are made worse by poor diet, which is more likely to occur in low-income families.

- t) Compounding the arrogance of this practice, neither the ADA, nor the OHD will deign to defend their position in open public debate nor provide a scientific response in writing to science-based critiques (e.g. *The Case Against Fluoride* by Connett, Beck and Micklem).

Conclusion: It is time to get dentistry out of the public water supply and back into the dental office. It is also time the U.S. media did its homework on this issue instead of simply parroting the self-serving spin of the dental lobby.

Sincerely,

Paul Connett, PhD
 Director of the Fluoride Action Network
 Co-author, *The Case Against Fluoride* (Chelsea Green, 2010)

Postscript:

"It is not only what we have inherited from our father and mother that 'walks' in us. It is all sorts of dead ideas, and lifeless old beliefs, and so forth. They have no vitality, but they cling to us all the same, and we cannot shake them off. Whenever I take up a newspaper, I seem to see ghosts gliding between the lines. There must be ghosts all the country over, as thick as the sands of the sea. And then we are, one and all, so pitifully afraid of the light." *Henrik Ibsen, The Ghosts*

Note: readers can view a videotape of a recent presentation Paul Connett gave on fluoridation in Seattle, Washington at <http://youtu.be/ZEVLLTxxmI0>

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