HEALTH AND STRESS

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IS PREVENTING BETTER THAN CURING DISEASE?

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Which is better, prevention or cure? Sounds like a silly question. After all, everyone knows that "An ounce of prevention is worth a pound of cure." Benjamin Franklin was referring to fires in 1736 when he said this during the founding of Philadelphia's first Union Fire Company. Nevertheless, it seems equally obvious that it would be much better to prevent diseases than to try to cure them, as demonstrated by the success of various vaccines to eradicate smallpox, poliomyelitis and common childhood viral infections.

Also Included In This Issue

However, if you ask whether it is better to devote research funding, time and talent to prevention or treatment, the answer is not as clear. One has only to look at the billions of dollars spent to prevent heart disease by reducing cholesterol and other "risk factors" that are merely risk markers for heart disease. There are hundreds of these that are simply statistical associations, rather than causes of coronary disease.

This question has now come under increasing scrutiny because of the current severe economic crisis. The resultant sharp reduction of Federal funds for medical research mandates the need to establish priorities that will guarantee getting the most "bang for the buck." Preventing disease is not apt to be high on the list since such studies take much longer to prove efficacy and safety. Pharmaceutical funding similarly favors finding new drugs to treat disease since it is more profitable, particularly since company

sponsored clinical trials almost always conclude that the product is superior, in contrast to others conducted under unbiased auspices. In addition, prevention could be counterproductive in the long run because eradicating a disease could significantly reduce the need for drugs. Gardasil vaccine to reduce cervical cancer may be an exception, although this is due to a massive media blitz rather than any proven value.

Paying Much More But Getting Less And The Rise In Medical Tourism.

Although the U.S. may lead the world in such medical "advances", the same cannot be said for the delivery of health care, which is far behind other countries. As John Abramson, M.D., author of *Overdosed America: The Broken Promise of American Medicine*, noted in a recent interview:

> It's hard to believe that **despite spending twice as much per person as the other industrialized countries, Americans live an average of 1½ years less in good health.** And if the rate of potentially preventable deaths in the United States were declining as quickly as it is in Austria, Ireland and Norway -- three countries that lead in this respect, and each spend about half as much per person on health care as the United States does -- 100,000 fewer Americans would be dying each year.
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> The core problem with American medicine isn't really access or cost. It's that **medical knowledge itself has been turned into a commodity, produced and disseminated with the primary goal of optimizing profits rather than health.** Eighty-five percent of clinical trials are now commercially funded, and the odds are four to five times greater that the commercially funded trials will conclude that the sponsor's drug is the treatment of choice compared with noncommercially funded trials of exactly the same drugs, according to a lecture given at Harvard Medical School in October by Dr. Catherine D. DeAngelis, the editor in chief of the *Journal of the American Medical Association*.

The Japanese spend about half as much on health care as we do, although they visit doctors about three times more often and can see any specialist they choose because there are no "gatekeepers." Japanese patients also stay in the hospital much longer, love technology like MRIs and undergo nearly twice as many scans per capita as Americans. A neck scan can cost $1,200 in the U.S., but this and other tests may not always be covered if they cannot be satisfactorily justified. In contrast, all medical services in Japan are covered since everyone has health insurance from work or a community based plan that costs the average family around $280/month, far less than we pay. Employers pick up at least half of that and the government pays for others who can't afford coverage.

Personal bankruptcy due to medical expenses is unheard of. If you lose your job, you still keep your health insurance, and at the same price. Insurance

plans must cover everybody, even those with heart disease, and they cannot deny a claim. Unlike the U.S., Japan doesn't spend millions for executive salaries and lobbying efforts for higher reimbursement since they are nonprofit organizations. Any excess funds are transferred to the following year to reduce premiums. Costs are kept low because the Japanese Health Ministry tightly controls prices down to the smallest detail. Every two years, they meet with the health care industry and negotiate a fixed price for every procedure and every drug. In contrast, Medicare is forbidden to negotiate prices for drugs because of aggressive lobbying efforts and payoffs by pharmaceutical companies. In 2002, when expenditures for MRIs were deemed to be too high, the Japanese Health Ministry cut the price by 35 percent to stay within their budget.

However, this is hardly socialized medicine since eighty percent of Japan's hospitals are privately owned (more than in the U.S.), and almost all offices are owned by doctors in private practice. A typical doctor who runs a 19-bed hospital in Tokyo noted, "The best thing about the Japanese medical system is that all citizens are covered . . . . "Anyone, anywhere, anytime — and it's cheap." Unlike the U.S., patients don't have to make appointments at his hospital and foreigners also benefit from the low prices. One foreign worker suffering low back pain, "was examined by a doctor, had a couple of x-rays taken, did a session on a stretching machine and received a bunch of muscle relaxants and pain killers and a belt/girdle. For all of which, I was much relieved, I only had to pay 5,000 yen (40 dollars). Getting married later made me think again about not being insured so I went with an international insurance scheme. This kind of scheme has flat rates, regardless of your income. In my case, this comes to about 15,000 yen (120 dollars) a month, less than I'd pay for Japanese insurance and it covers me abroad, too."

Japan also places an emphasis on prevention. Annual health checks (*kenshin*) are provided free to almost everyone, including foreigners. They are provided once a year for company workers employed for over a year, and at junior and senior high schools. Pre-school children, the elderly and the self-employed receive free or subsidized preventive and other medical care through their local ward or city office. There is a National Health Program for people over 70, who pay around 10 percent of costs. National Insurance is also available to people who are unemployed (expectant mothers, students, retirees etc.) and others who are self-employed, or who work in occupations like forestry, fisheries or agriculture. Members and their families pay 30 percent for inpatient or outpatient costs; there may be minor additional charges for drugs up to a certain ceiling, after which they receive full coverage. Foreign students are entitled to a reimbursement of 80 percent of their medical costs, meaning they pay about 6 percent. And there is little doubt that the system works. Japan enjoys the longest life

expectancy in the world, five years more than the U.S., which spends twice as much for health care. Japan's superior health may be partially due to diet and lifestyle, but most agree that their health care system plays a key role.

American patients have long been going overseas to have non-covered cosmetic procedures such as face-lifts, tummy tucks or gastric bypass because they are much less expensive. Others travel to Mexico for dental care for similar reasons. However, in recent years, bypass surgery, hip replacement and other cardiac, orthopedic and ophthalmologic surgical procedures have been increasingly popular, especially in India and South Asia, where costs are 75% to 90% lower. In many instances, Indian surgeons have been trained, certified and have practiced in the U.S., where their malpractice insurance rates are apt to be at least 96% more expensive. Some Indian hospitals have U.S. Joint Commission Accreditation and all of the medical staff speak English. Convalescence in deluxe hotels or other modern facilities as well as airfare are often included. As a result, some 750,000 Americans now travel abroad for these and other treatments like stem cell therapy that are not available here. A medical tourism industry has sprung up to provide advice on where to go for what, possible insurance coverage, provide comparison prices, and to make all arrangements, including local sight seeing and visits to nearby exotic vacation destinations.

Some corporations are also encouraging their employees to travel abroad to cut health care costs. One company found it could send a worker to New Delhi to fix a leaky heart valve for $28,000 maximum, including, travel, lodging, meals and recuperation. Compare that to the $64,000 to $128,000 estimate from the only American hospital that would provide a quote for total charges. Since saving the company money may not be enough incentive to fly halfway around the world for medical care, it is considering returning up to 25 percent of the cost savings directly to the employee. In this case, it means that the patient might not only pocket $25,000, but also avoid having to worry about charges for deductibles and co-pays. It is not unlikely that some insurance companies and health plans will also soon cover treatment to selected foreign facilities to contain costs.

The cost of U.S. medical care has skyrocketed, as has medical insurance. Despite employee insurance coverage, Medicaid and Medicare, 50 million Americans have no health insurance, 30 million are underinsured, and millions more are joining them due to massive job layoffs. Health care costs have increased over 75% for employers and around 145% for employees since 2000 and continue to rise. High malpractice insurance fees required by both employers and physicians, hospital deregulation and class action medical litigations have exacerbated the problem. The problem is not our medical care, still considered by some to be the best in the world, but its

delivery system, which is controlled by health insurance companies and other fiscal intermediaries. Superimposed on this is the lack of cost restraints by the pharmaceutical industry which charges U.S. patients more for its own medications than any other country in the world.

The U.S. spends far more on health care than any other country but ranks 45th in life expectancy (behind Bosnia and Jordan), close to last in infant mortality, and in last place with respect to health-care quality, access and efficiency, compared to other developed countries, according to the Commonwealth Fund. U.S. regions that spend the most on health care have higher mortality rates than regions spending the least, possibly due to increased hospitalization rates that result in more life-threatening errors and infections. This over utilization is driven by multiple factors, such as practicing defensive medicine by doctors trying to avoid lawsuits; unrealistic demands by patients; the pervasive belief that newer, more expensive drugs and technology are always better; and the current reimbursement system that encourages doctors to do testing and perform procedures that are unnecessary but can readily be justified and billed. Income from sophisticated imaging procedures was around $100 billion in 2004, (an average of $350/per person in the U.S.) and has climbed since then. Our system is now so broken that many senior citizens have to choose between food and essential drugs, and many of these and others have to get their medications from Canada. Other escalating medical care costs will only encourage less access to health care and ultimately result in less disease prevention efforts, that will cost taxpayers much more in the long run.

"Prevention Makes Us Miserable"–"Is Clinical Prevention Better Than Cure?"
It's not only the government that has to decide between preventing or treating a disease since physicians may also have to grapple with this choice. Fiona Godlee's 1995 *British Medical Journal* editorial entitled "Prevention Makes Us Miserable" discussed an article by Iona Heath warning about "the excessive self confidence of preventive medicine, which is making us ill and miserable." As Heath explained, "the more people are exposed to doctors and contemporary health care, including the rhetoric of preventive care, the sicker they seem to feel. Meanwhile the developing world is starved of affordable treatments." As was further emphasized, whether or not preventive medicines prove to be effective, they always bring with them their share of "iatrogenic harms" so that the risk/benefit of any intervention must be carefully considered.

There were numerous responses but one practitioner's was particularly compelling, since it brought the problem down to a personal level as follows:

> As the sole clinician in a rural area you have two patients who come to see you for care. The first, John, age 52, has a longstanding appointment for counseling to reduce risk factors for heart disease. The second, Bill, age 63 and John's brother, is having epigastric pain that in a phone discussion you think may be angina. You have time to see only one of the two patients. If you don't see Bill now he will die at age 65 of an acute myocardial infarction. If you do see him he will die at age 74. If you don't see John now he will die at age 65 of an acute myocardial infarction. If you do see him he will die at age 74. Assume that you know these outcomes – that they are truth. Remember, you can only see either Bill or John, but not both. **Whoever you see will live to age 74. Whoever you don't see will live to age 65. Who is seen is purely up to you. Who will you see?**
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> This scenario is what philosophers call a thought experiment. It fixes the world with certain rules that require us to suspend our belief of the world; we are to consider a problem only within those rules. For physicians it is hard to work in thought experiments because we know the world works differently. But for philosophers thought experiments are used to try to isolate key questions. In this case, the question comes down to, "Does prevention or cure take precedence?" **If the outcomes are the same for Bill and John, choosing to see one or the other must be because of something inherent in the desire to cure someone or the desire to prevent future disease. Why ask the question? Because it is clear that US society clearly favors the cure (or treat) approach to disease over prevention.** (Emphasis supplied)

The author supports his opinion by four documented observations.

1. For every penny the U.S. spends on prevention, 97 to 99 cents are spent on curative treatment.
2. Although there is a shortage of preventive medicine specialists (public health, general preventive medicine, occupational medicine, and aerospace medicine physicians) the number of residents in training is less than 0.4% of all residents, not sufficient for replacement or filling the expanding demand for this specialty.
3. Preventive medicine residencies are the only graduate medical education programs not financed by the U.S. Department of Health and Human Services.
4. When the question "See Bill or John?" is posed to both lay and medical audiences, the response is almost always, "See Bill, he's in distress now."

But since both are patients who expect you to keep your promise to attend, care and help them to the best of your ability, you have as much obligation and duty to see John as Bill. He also emphasizes that,

> Because of the construction of the thought experiment you cannot "cop-out" and say you'll see Bill now because you can see John again in a week or two. Nor can you refer Bill to another physician in the area. Besides, it may very well

> be that there is a threshold date beyond which trying risk reduction for heart disease will not be effective for any particular patient. Our tendency to want to see Bill evolves from several untested but intuitive reasons. First, we have compassion for those in distress. The British philosopher David Hume talks of 'sympathy' (we might today call empathy) as a contagious passion that infects human being-to-human being. Second, instinctively, there seems to be strong intuitive desires to help those we know are likely to have imminent problems. This is similar to our tendency to be more charitable to those who are near than distant. Third, we believe that our preventive acts are only statistical, whereas our curative acts are certain.
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> This mistaken belief perhaps derives from our sense that we have more control over cure outcomes than prevention outcomes – we think that we do cure, whereas we only facilitate prevention. This notion of doing vs. facilitating is an important one, because if we believe that our curative actions are more effective than our preventive ones then we will more likely act toward the more effective. Fourth, generally we are more comfortable with the idea that our attempt to help those in current distress can be riskier than preventing future distress. The editor of the British Medical Journal, Fiona Godlee, expresses this well when she states, "Because it is acted on healthy people, preventive medicine needs even stronger supporting evidence on benefits and harms than therapeutic interventions."

He goes on to explain that these four reasons for preferring Bill over John cannot be ignored, but he believes they are wrong because there are different degrees of short and long term benefits and harms and the timing of the intervention can be crucial. In addition, your decision might be based on the severity of the disease, age, socioeconomic factors, ethnicity, coexisting conditions, medications, and other factors. For example,

> We can perform surgery on a patient that causes harms (from anesthesia, pain from tissue disruption, etc.) and benefits (removal of an infected appendix) today. Similarly, we can have benefits today and harms in the future, like with the higher incidence of secondary cancers following certain chemotherapies. Or we can have harms today and benefits in the future, common to prevention, such as with the usually minimal side effects of vaccinations, or the anxiety of waiting for the results of a mammogram which catches a carcinoma in-situ for a complete cure. Men taking an aspirin a day for cardiovascular disease prevention could be an example of both harms (slightly higher rates of stroke and gastrointestinal bleeding) and benefits (reduced myocardial infarctions) in the future. Of course, many prevention activities also have benefits that accrue almost immediately with minimal harm. Beginning a physical fitness program has benefits not just for avoiding future coronary heart disease or osteoporosis, but also produces a sense of well-being through stress reduction. Vaccinations take only a couple of weeks to a month or two until immunity is established. So why, other than for purely altruistic brotherly reasons, should we think that John would give up his future for Bill's present? It's not clear that he would, or that he

> should. But that's a question for John. My choice: I'd ask the brothers to make their own decision together, because given their known outcomes from this thought experiment, I am indifferent as to who I would see. What do you think?

This prevention vs. cure debate is hardly new and can be found in over a dozen *Lancet* articles dating back to the 1800s. It was revisited a few months ago in another *Lance*t article entitled "Is clinical prevention better than cure?" co-authored by Barbara Starfield from Johns Hopkins, well known for documenting the deficiencies in the U.S. health care system and their causes, including up to 100,000 deaths annually due to preventable medical errors. Another co-author was Iona Heath, who again emphasized the rise of disease mongering that turns healthy people into patients to further increase the huge profits pharmaceutical companies enjoy. With respect to the benefits of preventive medicine, she had previously written,

> Human societies are driven by the effects of greed and fear. The rise of preventive health technologies has opened up a new arena of human greed, which responds to an enduring fear. The greed is for ever-greater longevity; the fear is that of dying. The irony and the tragedy is that the greed inflates the fear and poisons the present in the name of a better, or at least a longer, future. **Ultimately, the only way of combating disease mongering is to value the manner of our living above the timing of our dying.** (Emphasis added)

The Perils Of Prevention And Gardasil

This latest *Lancet* article asked the crucial question of whether the identification of a risk factor was a sufficient reason to implement preventive activities to remove or reduce its presumed harmful effects. As noted in prior Newsletters, several epidemiological studies and clinical trials have shown that lowering elevated cholesterol, the major Framingham risk factor for heart disease, does little to reduce coronary events or deaths. The MRFIT study found no additional benefit even when smoking was curtailed and hypertension was also treated, although, in contrast to lowering cholesterol, these interventions do provide other health benefits. The authors point out that although "Prevention has an aura of omnipotence and good sense . . . . Is it always true that prevention is better than cure?" They cite the example of hypertension, noting that:

> Evidence exists that the benefits of screening and treating substantially outweigh the harms; yet treatment can be complex and expensive, making it difficult for clinicians to carry out the recommended control strategies. Furthermore, treatment for hypertension almost always heightens anxiety and usually needs many consultations and examinations, and drugs that patients must take for the rest of their lives—a particularly important issue for young adults with mild hypertension, and with no guarantee of individual benefit. . . . The principle of "first do no harm" is paramount. Prevention needs more careful

> assessment than does treatment because it is presented as beneficial to people who are well—indeed, it is typically initiated by the doctor rather than the patient—and yet carries a real risk of causing harm.

This is a particular problem in the elderly, who frequently take multiple medications with unknown interactions. Some, such as statins, are for preventive purposes, despite lack of proof that they are effective in senior citizens without a history of heart disease. Depression is another disorder in which treatment harms can outweigh any benefits, so much that they are banned for use in anyone under the age of 18 in the UK and elsewhere. Both hypertension and depression are descriptions rather than discrete diagnoses like diabetes or tuberculosis, where the cause is quite clear, and treatment can be targeted. Hypertension is merely the observation of a blood pressure reading that is above arbitrarily defined normal limits and the diagnosis of depression is based on a confluence of various subjective symptoms. Both can have many causes, which is why there are numerous different treatment options available, but no guarantee which one is best for any given patient. Similarly, since there are multiple causes for hypertension and depression, preventive measures that simply address presumed risk factors for some of these causes are not very likely to be effective. This is particularly true when they are merely risk markers that show some statistical association, like cholesterol for coronary heart disease.

Vaccinations that have reduced or obliterated various childhood diseases are often cited as an example of the value of preventive medicine. But have we gone overboard? Thirty years ago, children received four vaccines, but today that number has skyrocketed to 37-50 vaccines administered during the period when developing immune systems are most vulnerable. While unvaccinated children will never develop every disease for which they are given a vaccine, the Centers for Disease Control mandates that their immune systems must respond to all. The DPT vaccine forces an immune response to diphtheria, tetanus and pertussis on the same day, an event that would never happen in real life. However, there are virtually no studies or scientific research on the effects of multiple viral and bacterial vaccines given in combination or in close succession. The medical profession is extremely reluctant to acknowledge adverse reactions to vaccination, even when they are immediate or occur within a few hours. In addition, no studies have ever tracked long term adverse effects, since reactions that occur days, weeks or years later are almost never attributed to the vaccine.

One example is the polio vaccines used in the 1950s that were found to be contaminated with the SV40 monkey virus in 1960. Despite this discovery, the vaccine continued to be administered with the full knowledge of government health authorities until it was finally withdrawn in 1963. Thirty

years later, SV40 was isolated in bone, brain and lung cancers of disabled and deceased adults, thus proving a direct connection between both the Salk and Sabin vaccines and a slow growing cancer that developed decades later. Unfortunately, no effort was ever made to track any of the estimated 10 to 100 million recipients of the infected vaccines to determine the subsequent incidence of malignancies and other possible adverse health effects. And it was only a few years ago that the use of thiomersal as a preservative to increase vaccine shelf life was acknowledged to be potentially hazardous and removed from most vaccines. Whether this mercury-based chemical may be partially responsible for the rising rates of autism is still a fiercely debated issue, although at least one of the 5,000 such cases pending in Federal Courts has already been decided in favor of the plaintiff.

The value of Gardasil, the new "cervical cancer vaccine" that targets the human papilloma virus (HPV) has also been questioned, especially since attempts have been made to make it mandatory in preteen girls in at least 20 states. Yet, it has never been shown to prevent cervical cancer since the studies that led to its approval did not measure cervical cancer but used cervical intraepithelial neoplasia and adenocarcinoma in situ as surrogates. However, these possible precancerous lesions only prevent invasive cancer around 10 percent of the time, the FDA has admitted that HPV alone does not cause cancer and that the vaccine will not protect against 30 percent of cancers. One million girls would have to be vaccinated to prevent cervical cancer in 4 or 5 individuals and since this is fatal only in a third, you might possibly prevent one or two deaths at a cost of $400 million or more.

Yet, as noted above, **the advertising campaign suggests that a Gardasil vaccination will mean one less case of cervical cancer.** There are more than 100 types of HPVs and Gardasil targets only four. And about 90 percent of women with HPV infection, who are not treated, have normal cervical cells two years later due to normal defense mechanisms. Even Pap smears that show grade II precancerous cells clear up spontaneously 40 percent of the time. Close to 12,000 women are diagnosed with cervical cancer each year

but less than 3,900 die from this, and most have not had Pap smears. Thus, the likelihood of death is very low, and the ability of Gardasil to prevent this is miniscule. Cervical cancer usually develops around the age of 30 and Gardasil only provides its limited protection for 5 years. Thus, if the three vaccinations were given at age 10, at a cost of $500 to $900 not covered by many insurance plans, at least 2 to 4 additional booster shots would be needed for protection at age 30. Nevertheless, Merck is urging vaccination for women up to the age of 45 and now wants FDA approval for treating boys starting at the age of 9, as well as men, to help prevent genital warts.

Many feel that not only have Gardasil benefits been hyped, but also that serious side effects have been suppressed. Some 29 deaths had been reported as of July 2008, with ten in just the previous six months when vaccinations increased due to aggressive advertising. Causes of death included blood clots, acute respiratory failure, cardiac arrest, and unexplained "sudden death". All of these are most unusual in young girls and all deaths occurred shortly after being vaccinated, often within two days. A report released last June revealed that in the two years since Gardasil has been available, over 10,000 adverse reactions have been reported, some of which are life threatening, like paralyzing Guillain-Barre syndrome, for which there is no cure. This is known to be triggered by vaccinations and there were six cases in the prior six months in young girls that had received at least one Gardasil injection. Other side effects included: anaphylactic shock, stroke, grand mal seizures, coma, paralysis, lupus, vasculitis, miscarriage, spontaneous abortion, and outbreaks of warts on the genitals, face and extremities.

Gardasil may be a particularly dangerous vaccine, because Merck was permitted to use an aluminum-containing placebo in place of the standard saline solution in its double blind studies to gain approval. While not as toxic as the mercury in thiomersal, such aluminum adjuvants have been linked to neurological damage, including multiple sclerosis, Alzheimer's disease, and Parkinson's disease. And they certainly gave the company an unfair edge in showing little difference between Gardasil and a presumably innocuous placebo, since about **60 percent of those receiving either the vaccine or the aluminum placebo had systemic adverse effects**, including: headache, fever, nausea, dizziness, vomiting, diarrhea and myalgia (muscle pain). However, only Gardasil recipients had other more serious adverse events, such as gastroenteritis, appendicitis, pelvic inflammatory disease, asthma, bronchospasm and arthritis. That may be because, in addition to being injected with the four types of HPV proteins and the aluminum adjuvants, Gardasil also contains, polysorbate 80, which has been linked to infertility in mice, and sodium borate, a main ingredient in roach killer.

It is also important to note that Gardasil received fast track approval based on a study in less than 1,200 girls under 16, and most of the serious side effects that occurred during this and other clinical trials were considered a "coincidence". Some of the studies on which approval was based will not be completed until next September. Merck has not evaluated Gardasil's potential as a carcinogen, or for other genotoxic damage that could affect future generations, such as birth defects. Since its release in 2006, 40 million doses of the Gardasil vaccine have been distributed worldwide, half of which were in the U.S., where there have been more than 10,000 reported adverse reactions, as noted above. The actual number is probably several times higher, since the vast majority of adverse side effects are never reported. Yet, the FDA and CDC deny any relationship and maintain that Gardasil is safe. The National Vaccine Information Center (NVIC), is now calling for the CDC and FDA to publicly release the study design, data, and names of principal investigators involved. NVIC has been following Gardasil closely, and recently released a study comparing it with the Menactra vaccine for meningitis, which revealed at least twice as many emergency room visit reports (5,021), four times as many death reports (29), seven times as many disabled reports (261) and three to six times more fainting reports. In girls that had received only Gardasil, there were 34 reports of thrombosis, 27 reports of lupus, 23 reports of blood clots, 16 reports of stroke, 11 reports of vasculitis and 544 seizures.

On top of this, in the government's data base of 467 "rechallenge" reports of cases where symptoms worsened after a repeated vaccination, nearly 60 percent were for Gardasil! Most people are also unaware that even if their child dies from anaphylactic shock immediately after receiving the vaccine, Merck cannot be sued. Drug companies manipulated the government to rule that they cannot be prosecuted for vaccine injuries. Taxpayers foot the bill for the hundreds of millions of dollars paid to families of children who are harmed or die every year from vaccines. Although filing for benefits is a long and arduous process, more than $1.5 billion has already been paid out for other vaccines. (The maximum award for death is $250,000). Some Gardasil suits have already been filed and more are sure to follow since girls and young women who immigrate here must be vaccinated if they wish to apply for citizenship and the Centers for Disease Control now want to make a course of Gardasil mandatory for all 11 and 12-year-old girls. Things may change since Spanish health authorities just withdrew nearly 76,000 doses of Gardasil because two girls that were vaccinated as part of a government program targeting adolescents had to be hospitalized. At least two deaths have been reported in the UK, where it has been promoted for girls 11 and 12 years old. An executive order from the Governor of Texas, (who received funding from Merck for his election) that mandated vaccination for all girls entering the sixth grade was subsequently overturned — so stay tuned!

Nothing Succeeds Like Success & Midwest Center For Anxiety & Depression

If you want to prove that something is effective and safe for treating or preventing a disease, the gold standard is a double blind randomized control trial. This insures that any confounding factors are evenly distributed between the treatment groups and that neither anyone who is giving or receiving the treatment knows what is being administered. However, when the comparison placebo is not entirely inert, as occurred with Gardasil, the results can be skewed to favor whatever is being tested. In other instances, an existing drug is used as a surrogate for approving a new antidepressant, since it is only necessary to prove equivalency. And reducing LDL or cholesterol, and increasing HDL have been used as a surrogate for coronary disease when evaluating statins, despite the fact that some studies have shown an increase in coronary events using these criteria.

But if your finger is completely severed in an accident and an unapproved gel concoction is used to reattach it and full function is returned that lasts for decades, you don't need lengthy and expensive double blind clinical trials to confirm that the gel can work. As noted above, double blind studies lack significance for antidepressant drugs and would be particularly difficult to prove the efficacy of cognitive and behavioral approaches. However, such a program offered by the Midwest Center for Anxiety and Depression, that has been available for well over two decades. has been utilized by over 1 million people despite the fact that it costs several hundred dollars. It is doubtful that it would have lasted this long if it was not effective. Can they prove that it works? Can they explain why it works? Are any alleged benefits simply placebo effects? Who cares, as long as it is found to be effective for many stressed out individuals and is obviously much safer than drugs?

Acupuncture has been used to treat more people than any other therapy and would not have persisted for over 5,000 years if it were not effective. Yet, we have no idea how or why it works in so many different disorders. It is not a placebo, since studies comparing it with sham procedures have proven its superiority. As the old saying goes, "Nothing succeeds like success."

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