The American Institute of Stress

HEALTH AND STRESS

Your source for science-based stress management information

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WHY WE CONTINUE TO BELIEVE MEDICAL MYTHS THAT HAVE BEEN PROVEN WRONG

By Paul J. Rosch, MD, FACP

Editor –In-Chief

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www.stress.org

All truth passes through three stages. First, it is ridiculed. Second, it is violently opposed. Third, it is accepted as being self-evident.

Arthur Schopenhauer

A new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die, and a new generation grows up that is familiar with it.

Max Planck

Convictions are more dangerous enemies of truth than lies.

Friedrich Nietzsche

Others have also pondered why it is so difficult to get people to believe the truth and the explanations above are still valid. But the situation is different today and the following quotations may be more appropriate.

If you tell a lie big enough and keep repeating it, people will eventually come to believe it.

Joseph Goebbels

***It is difficult for a man to understand something when his income depends on not understanding it*.**

H.L. Mencken

***If you don't read the newspaper, you are uninformed. If you do read the newspaper, you are misinformed*.**

Mark Twain

We live in an age where TV advertising and the media tend to shape our beliefs. This is especially true for medical reports that frequently contain misinformation and mendacity, and are sometimes so biased that they are essentially advertorials that are used for promotional purposes. A good example is the lipid hypothesis of coronary heart disease, which proposes that saturated fats are a major cause, despite overwhelming contradictory proof. I recently received the following email from Dr. Fred A. Kummerow:

Dear Dr. Rosch,

I read with interest your article " Cholesterol does not cause coronary heart disease in contrast to stress". I agree with you that cholesterol is not the cause of heart disease. I recently published my findings that support the theory that cholesterol is not responsible for the development of heart disease. You can read it here: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3584645/. I also thought you might be interested in reading the interview on cholesterol I had with Hannah Wilson, editor of *Clinical Lipidology*. It will be published in the June issue 2013. This is one of the Journals published by Future Medicine in Great Britain, so I am attaching it to this email. Most journals are reluctant to publish anything that goes against the hypothesis of cholesterol. I don't know if that happened to you.

Fred

Prior to the 1920s, less than 10% of all U.S. deaths were due to heart disease, but by the 1950's this had escalated to more than 30%.

There was nothing unusual about this, save for the fact that Dr. Kummerow, Professor Emeritus of Comparative Biosciences at the University of Illinois is 98 years old, and if you read the article he provided a link to, and especially the interview he attached, it is obvious that he is still sharp as a tack. I recognized his name immediately, since Fred was one of the first to maintain that eating saturated fats did not cause heart disease, nor did elevated cholesterol. The real culprits were the trans fats found in margarine and foods fried in Crisco and other partially hydrogenated cooking oils. He had explained this in a 1957 article in *Science,* but it attracted little attention. Neither did any of his numerous subsequent publications over the next five decades. And, as he noted in the last two sentences of his email, "*Most journals are reluctant to publish anything that goes against the hypothesis of cholesterol. I don't know if that happened to you*."

Ancel Keys, George McGovern And Demonizing Fat

The reason why Kummerow and others encountered stiff resistance to their research findings was that Dr. Ancel Keys had convinced everyone that saturated fat caused heart attacks because it raised cholesterol. Keys was a famous nutritionist, since the K rations we used in World War II were named after him. He chaired a 1951 UN conference in Rome, during which he asked the participants if diet

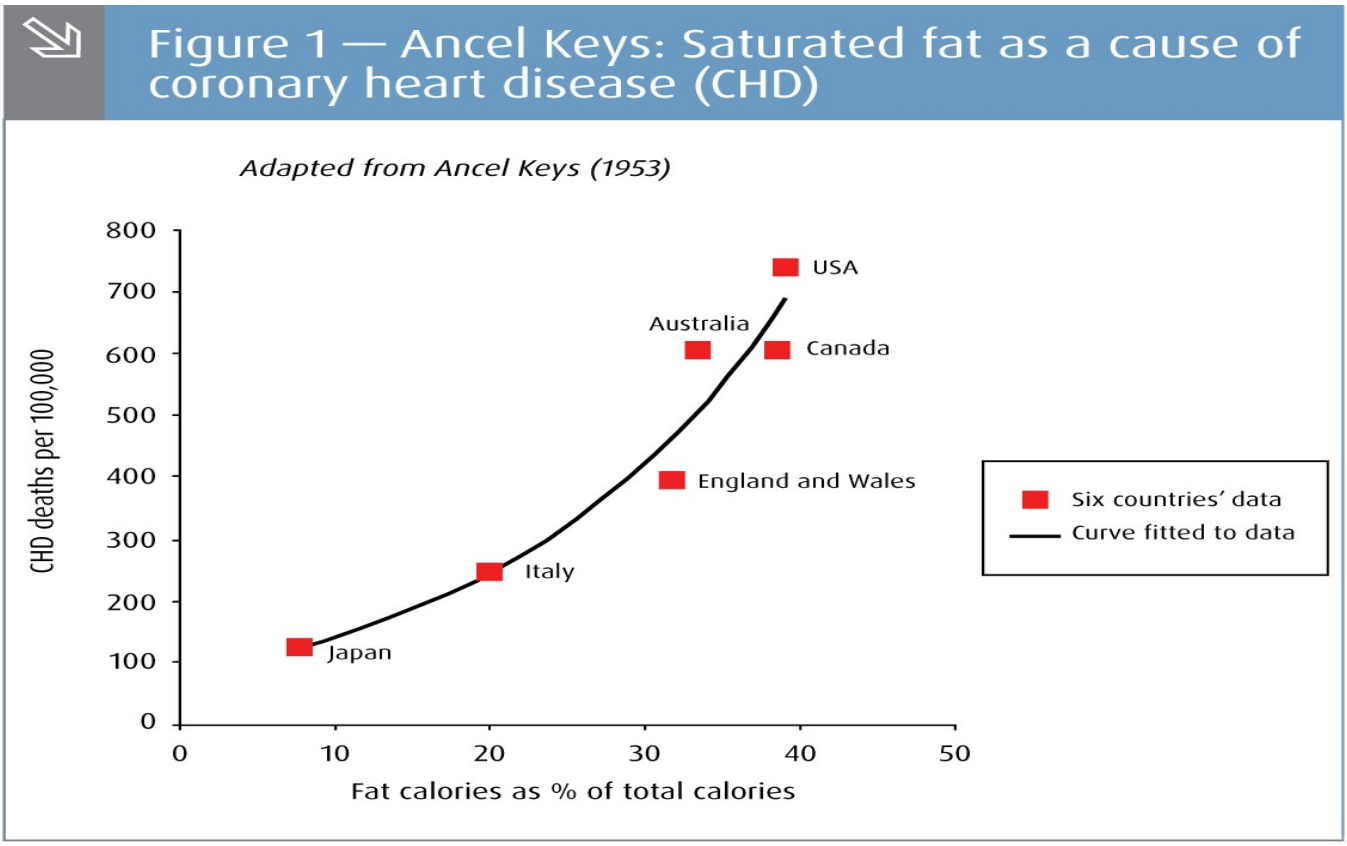
might have anything to do with the epidemic of heart disease then sweeping the United States. *Prior to the 1920s, less than 10% of all U.S. deaths were due to heart disease, but by the 1950's this had escalated to more than 30%.*

A University of Naples professor told him that there was no such problem in his or nearby cities. Keys visited Naples and confirmed that there was almost no heart disease in anyone under the age of 60. The only exception was a class of wealthy people who ate meat almost daily. The general population ate pasta, vegetable and fruit and only had meat once a week. Their cholesterol levels were also lower than the privileged meat eaters. Keys decided to investigate the relationship between fat intake and deaths from heart disease by analyzing statistics from five other countries. He summarized his findings at a 1955 World Health Organization conference by showing Figure 1 below.

As can be seen there is an impressive correlation between fat intake and deaths from heart disease in men that was most pronounced in the 55-59 age group, but was also evident in those ten years younger. Based on this, he embarked on his famous Seven Countries Study in 1958, which confirmed these results and also showed that risk of heart attack and stroke was directly related to serum cholesterol levels. The problem is that Keys had data from 22 countries, but listed only those that supported his theory. Had he selected seven others, he would have come to the opposite conclusion.

As an old adage goes, "Figures don't lie, but liars can figure." It also illustrates the First Law Of Statistics - "Given enough statistics, you can prove anything." Keys was able to convince the public, as well as authorities, that coronary heart disease was a simple plumbing problem.

Figure 1 — Ancel Keys: Saturated fat as a cause of coronary heart disease (CHD)



Saturated fat elevated blood cholesterol, which then clogged up the coronary arteries and caused heart attacks. He was hailed as a hero, was featured on the cover of Time magazine on February 7 1961, and the dangers of dietary fat and cholesterol became firmly entrenched as gospel. In 1977, the US Senate Select Committee on Nutrition and Human Needs, chaired by Senator George McGovern, released its Dietary Goals for the United States. It stated categorically that "the overconsumption of fat, generally, and saturated fat in particular, have been related to six of the ten leading causes of death."

Trans Fats Emerge As A Cause Of Coronary Heart Disease And Cancer

In addition to heart disease, these now included cancer, hypertension, diabetes and obesity. As a consequence, Americans were told to substitute polyunsaturated fats for saturated fat and to use margarine and corn oil instead of butter and lard. Eggs and dairy products should also be avoided, since Dr. Theodore Cooper, head of the NIH, had testified at a 1975 Federal Trade Commission hearing that eggs contained cholesterol and cholesterol caused heart disease. Kummerow testified that he did not know what caused heart disease, but that eggs were a very good source of nutrition and that cholesterol was a vital component that was crucial for numerous functions in the body. Dr. Michael De Bakey provided similar support for eating eggs and dairy products, but they were the only two out of numerous leading physicians who challenged the belief that cholesterol caused heart disease.

In 1979, the editor of the *American Journal of Clinical Nutrition* asked Kummerow to contribute an article explaining the role of nutritional factors and diet in heart disease. In his 25 page comprehensive review, he detailed his own and other studies showing that dietary cholesterol was not the cause of coronary atherosclerosis. Electron microscopy revealed that animals fed a cholesterol free diet developed the same lesions as patients who died from coronary heart disease. Cholesterol caused no damage unless it was oxidized and the major sources of this oxycholesterol were powdered food substitutes and packaged foods, especially those fried in vegetable oils containing trans fats. Trans fats are frequently added to processed foods sold in supermarkets to improve taste and texture. They are also common in many fast foods, especially meats that are fried. A later study showed that hamsters given a diet high in oxycholesterol had elevations in cholesterol levels 22% higher than those on a diet high in non-oxidized cholesterol, as well as more atherosclerotic changes in their arteries. In addition, saturated fats raised HDL good cholesterol while trans fats lowered it.

Mary Enig, a graduate student familiar with Kummerow's research, also disputed the McGovern Committee report claiming a strong link between saturated fat and cancer, and especially breast and colon. As

she noted:

- Saturated fat consumption had steadily declined in America over the past six decades while the incidence of cancer had risen significantly.
- Greece had the same level of dietary fat intake as Israel but only one-fourth the rate of breast cancer.
- Spain had a slightly higher dietary fat intake than France or Italy but only one-third the mortality rate from breast cancer.
- Puerto Rico, with its high animal fat intake, had a very low rate of both breast and colon cancer.
- The Netherlands and Finland both had the same level of animal fat intake – about 100 grams per person per day. But the Netherlands had twice the rate of both breast and colon cancer. The difference was that people in the Netherlands consumed 53 grams of vegetable fat per person compared to only 13 grams in Finland.
- Seventh Day Adventist physicians who avoided meat had significantly higher colon cancer rates than non-Seventh Day Adventist physicians

And when she analyzed the same US Department of Agriculture data that the McGovern Committee had used in more detail, she reached a different and opposite conclusion. There was a strong positive correlation between total fat from vegetable fat and cancer. There was a strong negative correlation between saturated fat and cancer deaths. *In other words, vegetable oils seemed to predispose to cancer and animal fats seemed to have an opposite or protective effect.* Subsequent large and long-term trials such as the Nurses Study in Women and Health Professionals Study in Men conducted by Dr. Walter Willet at Harvard also revealed that the type of fat was more important than the amount of fat with respect to cancer risk. Willett reported that trans fats consumption was directly related to heart disease in 1993 and the following year, wrote an editorial in the *American Journal of Health* that attributed more than 30,000 deaths/year to consumption of the trans fats in partially hydrogenated vegetable oils. The World Health's Organization's mammoth MONICA study, which monitored more than 7 million men and women aged 25 to 64 in 21 countries, found that *all the countries in the top eight for saturated fat consumption had lower death rates from heart disease than all of the eight countries that consumed the least fat!* A recent analysis of studies that included almost 350,000 adults, found no difference in the risks of heart disease or stroke between people with the lowest and highest intakes of saturated fat.

all the countries in the top eight for saturated fat consumption had lower death rates from heart disease than all of the eight countries that consumed the least fat!

Even the ongoing Framingham Study, which began over 60 years ago in an attempt to prove the lipid hypothesis, and which is still cited as showing support, now concludes there is no association between dietary fat intake and heart disease. In addition, a statistically significant correlation

between elevated cholesterol and heart disease was seen in only a small segment of the study population. Similarly, Keys finally conceded in 1997, "*There's no connection whatsoever between cholesterol in food and cholesterol in the* blood. And we've known that all along. *Cholesterol in the diet doesn't matter unless you happen to be a chicken or a rabbit."* That was four decades after numerous "Prudent Diet" studies had failed, starting with the Anti-Coronary Club experiment in New York. The control group was Wall Street brokers and other affluent men who enjoyed and could afford a diet rich in eggs, butter, cheese, and beef. The Prudent Diet group was mostly teaching staff at city universities who ate very little red meat, and butterfat was replaced by margarine rich in polyunsaturated fats that had been especially made for them. The trial was considered a great success, since at the end of four years; cholesterol had been reduced 25% by the Prudent Diet. On the other hand, 8 men had died from heart attacks in contrast to none of the men eating eggs, butter and beef. As George Bernard Shaw, who died at age 94 of complications from a fall while he was pruning trees, once said, "*Everything I eat has been proved by some doctor or other to be a deadly poison, and everything I don't eat has been proved to be indispensable for life. But I go marching on.*"

"Cholesterol in the diet doesn't matter unless you happen to be a chicken or a rabbit."

Why LDL "Bad" And HDL "Good" Cholesterol Are Also Myths That Persist

Faced with the fact that cholesterol does not and could not cause coronary atherosclerosis, lipid hypothesis proponents now claim that LDL "bad" cholesterol is the villain. A corollary of this is that HDL "good" cholesterol will help prevent coronary heart disease. But HDL and LDL are not different types of cholesterol. They are high and low density lipoproteins that are needed to transport cholesterol in the blood to different parts of the body because lipids are not water-soluble. HDL carries cholesterol back to the liver and LDL transports it to parts of the body where it is needed. High or low levels of either HDL or LDL do not cause heart attacks or coronary disease, nor do they help to prevent them. As with high and low cholesterol, this proposal continues to confuse association or some statistical correlation with causation. If it were valid, then lowering LDL and/or raising HDL should decrease coronary disease, but prospective studies designed to demonstrate this have failed miserably.

Current recommendations to prevent heart attacks are to lower LDL as much as possible with statins, which block the production of cholesterol. Drugs like ezetimibe lower cholesterol by interfering with its absorption, and when given with a statin, LDL and cholesterol are lowered much more than with either drug alone. Theoretically, such a combination should result in greater cardioprotection. However, in the ENHANCE study, although patients receiving both drugs had LDL and cholesterol levels lower than controls taking only one, there was no reduction in coronary events. In addition, *atherosclerotic plaque grew twice as fast in those who received both* as assessed by intravascular ultrasound. In the JUPITER study, patients taking Crestor

(rosuvastatin) reduced their risk of coronary events and deaths 44% more than controls receiving a placebo. LDL plunged 50% to an average of 55mg/dL, the lowest levels ever reported in a major statin study. However, there was no significant relationship between reduced risk and either the LDL level or the degree to which it had been lowered. A recent report on 136,000 heart attack patients admitted to hospitals casts additional doubts on the value of LDL, since 75% had normal or low levels.

Clinical trials to demonstrate the benefits of increasing HDL have also boomeranged. A two-year study of 15,000 high-risk patients attempted to confirm that torcetrapib, a drug that raises HDL, would also improve the ability of Lipitor (atorvastin) to reduce the formation of atherosclerotic plaque. The experiment had to be terminated after a little more than a year because of *82 deaths in those taking both drugs, compared to only 51 in those taking Lipitor alone*. The combination group also had higher rates of hypertension, heart failure, angina and revascularization procedures, *despite the fact that they had increased their HDL by close to 60% and reduced LDL 13% over baseline values.*

"82 deaths in those taking both drugs, compared to only 51 in those taking Lipitor alone."

Such negative findings are usually downplayed or hidden in media reports that continue to promote the need to lower cholesterol and LDL with statins based on meta analysis. This approach combines the results of selected previous studies and uses statistical techniques to exaggerate favorable findings and minimize adverse events. Physicians and patients want proof that statins help prevent heart attacks and deaths. Instead, they are told that statins reduce the risk of these and other cardiovascular problems, which seems the same, but is quite different because this is only relative risk. For example, in one five-year study, 56 out of 2,051 (2.7%) of those taking statins had heart attacks compared to 84 out of 2,031 (4.1%) who received a placebo. The relative risk reduction is 34%, since 2.7 is 34% less than 4.1. But when you compare the absolute percentages of 4.1% for placebos and 2.7% for statins, the absolute risk reduction is only 1.4%, In other words, you would have to give 100 people this drug for five years to prevent 1.4 heart attacks. Alternatively, your doctor would have to treat 71 people just like you for five years to prevent one heart attack. This is known as the NNT, or number needed to treat, but the likelihood that this person will be you is pretty slim.

Some statin trials like the Heart Protection Study boast a 50% risk reduction over five years, suggesting you will cut your risk in half, until you look at the data. 50,000 lives would be saved if you treated 10 million people, which is an absolute risk reduction of 0.5%, a one hundred percent difference. If the risk of being struck by lightning was one in five million over a five-year period and you could buy a device that would lower your risk to one in ten million, it would also be an impressive 50% relative risk reduction. However, your absolute risk reduction is only a miniscule .000.01%. Meta-analyses are also useful for statin manufacturers since it allows them to minimize or ignore numerous

side effects such as memory loss and diabetes that have recently been added to warning labels.

Is Inflammation The Cause Of Coronary Disease? Should CRP Replace LDL?

Reduction in future coronary events attributed to statins is similar in patients regardless of whether their cholesterol or LDL is high, normal or even low. Nor do these benefits appear to result from depletion of lipids in atherosclerotic deposits that interfere with blood flow. Since lowering LDL and cholesterol are not the answer, proponents claim that statins have pleiotropic effects that explain and justify their use. These include:

- Inhibiting inflammation
- Preventing clot formation
- Reducing oxidative stress
- Improving endothelial function
- Promoting the stability of atherosclerotic plaque
- Bolstering immune system defenses

Pleiotropy refers to "a drug's actions other than those for which the agent was specifically developed." All drugs have pleiotropic effects, which are usually manifested as adverse side effects. For example, aspirin was developed to reduce pain and fever. But it also causes gastrointestinal bleeding as well as hives or other allergic reactions in sensitive individuals. On the good side, aspirin helps to prevent heart attacks because of its powerful anti-inflammatory and anti-clotting properties. Only a very small dosage is required to provide cardioprotection and risk of GI bleeding can be lowered by taking buffered or enteric-coated aspirin.

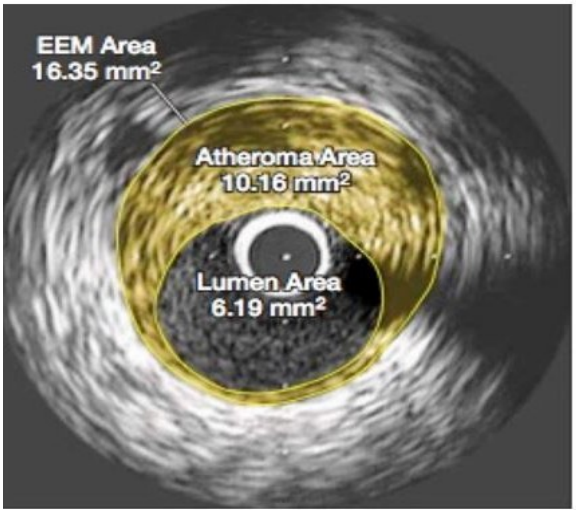
So why take statins when aspirin has these same pleiotropic effects and is much safer? In addition, unlike statins, aspirin is effective in senior citizens, women of any age, and people with no history of cardiovascular disease. Aspirin also has other beneficial pleiotropic effects, since it may reduce the risk of colorectal, esophageal, prostate and lung cancers. In contrast, all statins are carcinogenic in laboratory animals at doses equivalent to those commonly used. Exposure to carcinogens like tobacco may take decades to surface, even when individuals stop smoking. An increased incidence of cancer of the breast and skin associated with statin use in clinical trials lasting only a few years has already been reported. This is not surprising, since these are the two malignancies most likely to be detected early. If statins do cause cancer the true incidence will probably never be known. It is very unlikely that any such association would be recognized in patients in whom a malignancy is diagnosed a decade or more after exposure to statins.

It's also important to note that unanticipated harmful or unpleasant reactions are also pleiotropic effects, and although there are numerous examples for statins, only those that are desirable are listed. At the top of this list is preventing inflammation, which presumes that inflammation causes coronary atherosclerosis and heart attacks. If this were true, then why were powerful anti-inflammatory drugs like Vioxx and Bextra banned because they were found to be associated with an increase in heart attacks? Celebrex and other prescription and nonprescription NSAIDs and pain relievers must now also carry labels warning that they can increase the likelihood of serious cardiovascular

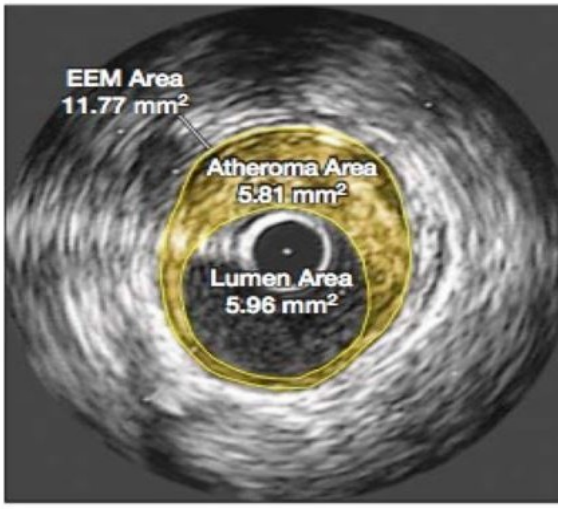
events. Inflammation is a response to injury or irritation that can be seen or felt because it is usually manifested by swelling, redness, heat or pain. But the type of inflammation that statins purportedly prevent has none of these characteristics since it is completely silent and can only be visualized under the microscope. And if it causes coronary heart disease, how can it be detected, much less measured?

CRP (C-reactive protein) was discovered in 1930, and found to be manufactured in the liver in response to inflammation from infections, tissue injury, malignancies and allergic or immune system responses. Normal levels are 0-4mg./L but rise rapidly following inflammation and reach a peak at 48 hrs. In severe infections, they can increase several thousand fold. Since an abnormal value can have so many different causes, it has little diagnostic value. The hs-CRP (high sensitivity CRP) test was developed to measure the same protein, but at levels under 10 mg/L with a sensitivity down to 0.04 mg/L. Proponents claim that hs-CRP can predict risk of heart attack and stroke in healthy asymptomatic people by measuring the degree of this silent inflammation. Levels below 1 represent low risk, 1-3 are moderate risk, and over 3 (but less than 10) signify high risk. In the Harvard Women's Health Study, and subsequently others, an elevated hs-CRP was a more effective predictor of future heart attacks and cardiovascular events than a high LDL or other standard risk factors.

The JUPITER study firmly established this, since it showed for the first time that a statin (Crestor) could reduce coronary events in healthy people, and that this was accomplished by lowering CRP rather than cholesterol or LDL. As detailed in previous Newsletters, JUPITER had numerous serious flaws, but that did not stop the FDA from approving Crestor "to reduce the risk of stroke, myocardial infarction and arterial revascularization procedures in individuals without clinically evident coronary heart disease but with an increased risk of cardiovascular disease (based on age (men ≥50 and women ≥60), high-sensitivity C-reactive protein (hs-CRP) ≥ 2 mg/L, and the presence of at least one additional risk factor, such as hypertension, low HDL-C, smoking, or a family history of premature coronary heart disease." Crestor had previously scored a home run in the ASTEROID study, which allegedly demonstrated that it could actually reverse plaque formation and increase blood flow by the following illustration of a representative case.



Ultrasound Cross-Section of Coronary Artery Before Treatment



Ultrasound Cross-Section of Coronary Artery After Treatment

In actuality, it was the cross-sectional areas of atheroma that were compared before and after treatment, since it was assumed that the area of the lumen would increase proportionally. What was not mentioned in either the press releases or the article was that *the lumen area actually decreased* due to thickening of the arterial wall. In addition to decreased blood flow, a smaller lumen and stiffer arterial wall would both tend to increase blood pressure, an effect that was also not addressed in the published report. Nor was the high dropout rate of 25%, which was likely due to adverse side effects.

"Beyond Cholesterol", a 2002 *Time* magazine feature story, claimed the hs-CRP test measured "the presence and the intensity of inflammation in the walls of the blood vessels". In contrast, cholesterol only "measures how much fat is lodged in the vessels of the heart; an hs-CRP test shows how likely it is that those plaques will burst." As a result of irresponsible statements like this, some feel that CRP is not merely a marker of inflammation, but, as with LDL, it should also be lowered as much as possible to prevent heart disease. Pharmaceutical companies are researching new drugs that will specifically have this effect despite the likelihood this will be futile because there is no supportive scientific rationale.

Pharmacracy, Why Mental Disease Is A Myth, And Follow The Money

Pharmacracy is a term that was coined by Dr. Thomas Szasz over 40 years ago, because "while we have words to describe medicine as a healing art, we have none to describe it as a method of social control or political rule." It is derived from the Greek *pharmakon* (medicine or drug) and *kratein* (to rule or to control), just as theocracy is rule by religious sects and democracy is rule by the majority of people. Pharmacracy refers to:

- The transfer of authority for defining diseases and how to treat them from physicians to politicians and others by drug companies.
- A deliberate blurring of boundaries between disease and health as well as between the medical treatment of disease and using medical personnel or technology to alter non-disease.
- The severing of conventional contractual economic relationships between doctors who deliver medical care and their patients.

The prime example is disease mongering and the selling of sickness in order to convert healthy people into paying patients. In past centuries, quacks and entrepreneurs peddled fake cures for real diseases. Today's quacks peddle pseudo diseases or exaggerate the hazards of trivial complaints to pressure people into taking drugs of dubious value.

The late Dr. Szasz, Professor of Psychiatry Emeritus at the State University of New York Health Science Center in Syracuse, used Pharmacracy to describe how the practice of psychiatry led to diagnostic errors and therapeutic mistakes because of powerful commercial and political pressures. In his book, *The Myth of Mental Illness*, he had previously argued that mental illness was merely a term to describe problems in living and communication with others that were perceived by some, but not all, psychiatrists as abnormal. These were given names like manic-depressive

disorder, involutional melancholia and hysteria that became popular diagnoses, but were later discarded since they were merely descriptive terms based on personal opinion. Unlike other medical diagnoses, they could not be defined using objective criteria that everyone accepted. Effective treatment for any illness obviously depends upon the ability to establish an accurate diagnosis. This can only be obtained by analyzing the results of blood, bacteriologic and other laboratory tests, x-rays, sophisticated imaging studies, or microscopic tissue examination that demonstrates consistent and relevant abnormalities. A diagnosis may be apparent from examining the patient, but confirmation requires support from one or more of these objective criteria. What Szasz objected to most was the widespread belief that mental illness was widely believed to be a physical disease or abnormality of the brain. In 1999, President Clinton declared: "Mental illness can be accurately diagnosed, successfully treated, just as physical illness." Tipper Gore, his Mental Health Advisor, stated: ""One of the most widely believed and most damaging myths is that mental illness is not a physical disease. Nothing could be further from the truth.'' Surgeon

"The fact is that there is no such thing as a mental disease."

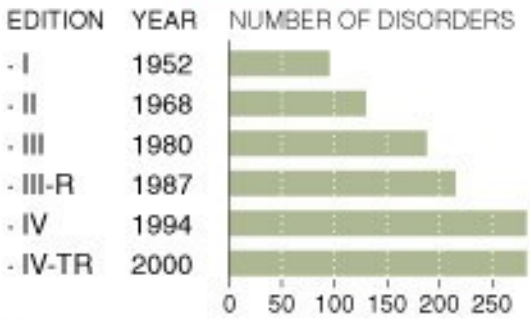
General David Satcher agreed: "Just as things go wrong with the heart and kidneys and liver, so things go wrong with the brain." A White House Fact Sheet on Myths and Facts about Mental Illness asserted: "Research in the last decade proves that mental illnesses are diagnosable disorders of the brain." More recently, Senator (now Vice President) Joseph Biden introduced a bill that would define addiction as a brain disease because "Addiction is a neurobiological disease – not a lifestyle choice – and it's about time we start treating it as such."

The fact is that there is no such thing as a mental disease. Unlike all other diseases, there are no consistent abnormalities in laboratory tests, imaging studies or autopsy results, including microscopic examination of brain tissue for any psychiatric diagnosis. And when they are found, the diagnosis disappears from the psychiatric lexicon and is classified under the appropriate pathological heading. General paresis of the insane was a popular diagnosis in the 19th and early 20th century that accounted for 10% of patients in psychiatric hospitals, until it was discovered to be due to a syphilitic infection of the brain and spinal cord. Psychiatrists have not been able to determine the cause of any mental disorder. Despite the billions of dollars spent on drugs to boost serotonin or alter other brain neurotransmitters in patients with depression and other psychiatric diagnoses, there is no valid evidence that such imbalances exist.

Yet, the number of psychiatric diagnoses keeps increasing. The 1952 DSM-I listed 106; DSM-III from 1980 listed 265 the 1994 DSM-IV had 297 and the number of pages had increased to 886 pages compared to only 130 in 1952. Because of complaints about this trend, the chair of the DSM-5 task force promised the total number would not increase. But it has just been released and is even worse than its

A Growing List Of Mental Ills

Work is progressing on a fifth edition of the Diagnostic and Statistical Manual of Mental Disorders. The current edition describes about three times the number of disorders as the first edition did in 1952.



Source: American Psychiatric Association

predecessors. One way it has been able to add new diagnoses without increasing the total is to classify a disorder in the previous edition as a "subtype" of another disorder, so that it is retained but not counted, which adds to the confusion. And the new disorders added have not only blurred the line between being normal and having a psychiatric diagnosis, they have erased it. Under DSM-5, more than half of us will have a psychiatric disorder at some time during our life, which could affect finding a job or keeping one. Bear in mind that the DSM is the "Bible" for courts and others to decide whether or not you are insane. In fact, insane is no longer a medical diagnosis; it is now a legal term. DSM is a manual of mental disorders, because they could not call them diseases. And as one DSM psychiatrist admitted, they could not define schizophrenia. They only knew what to call a peculiar cluster of symptoms.

We will discuss some of the new inane diagnoses in a future Newsletter. Some are so asinine that it is difficult to understand why they were included, until you realize that an established diagnosis justifies prescribing a drug that will be reimbursed by Medicaid, Medicare and other fiscal intermediaries. The strong financial ties between DSM psychiatrists and pharmaceutical companies is well documented and in one panel was 100%. Similarly, the lipid hypothesis has been perpetuated by the Cholesterol Cartel of drug companies, manufacturers of low fat foods, laboratories that test for various lipids, hs-CRP and other possible risk factors, as well as any entity that can profit from the status quo. Just follow the money.

However, you can't "fool all of the people all of the time" and eventually "truth will out." Due to the persistent efforts of Dr. Kummerow and others, trans fats are banned or strictly limited in over two dozen states and food labels must now include their trans fat content. Meat and dairy associations are getting the message out that their products are not poisons and are healthy rather than harmful. The prospects for reforming psychiatry is not as bright, although there is a surprising rebellion within its ranks, including the chair of the last DSM-IV, the Director of NIMH and other eminent psychiatrists listed in a previous Newsletter. It is unlikely that things will change until regulatory authorities, insurance companies and other fiscal intermediaries recognize the billions of dollars wasted on inappropriate drugs. As noted before, follow the money! That's what makes the world go round, not love or truth - stay tuned for more.

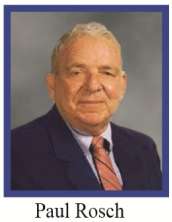
Paul J. Rosch, MD, FACP

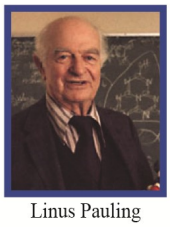
Editor-in-Chief

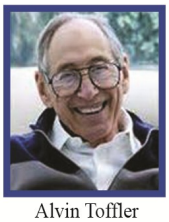
GET INSIDE OUR HEAD

It's Not Our Credentials That Make AIS So Impressive, It's the Fellows That Go with Them.

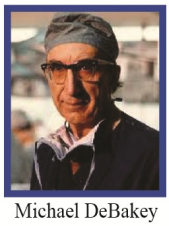
The American Institute of Stress is a non-profit organization established in 1978 at the request of Dr. Hans Selye (the Founder of the Stress Concept) to serve as a clearinghouse for information on all stress related subjects. AIS Founding Fellows include:


Paul Rosch


Linus Pauling


Alvin Toffler


Bob Hope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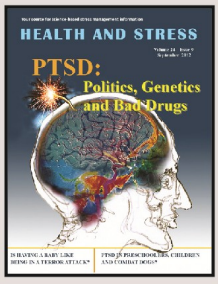

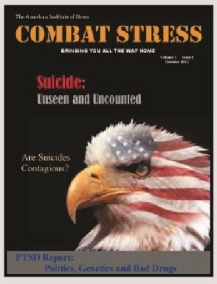

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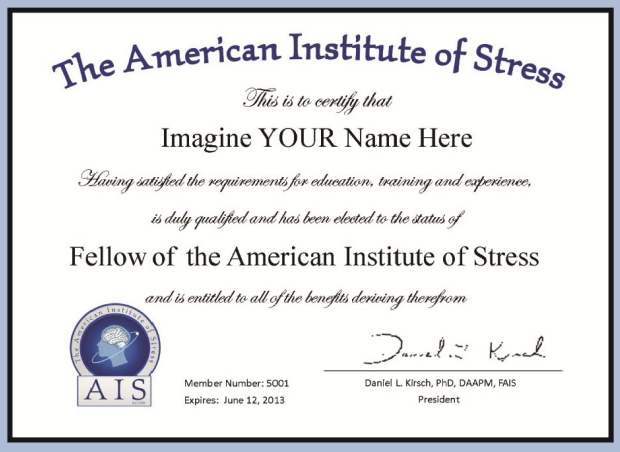
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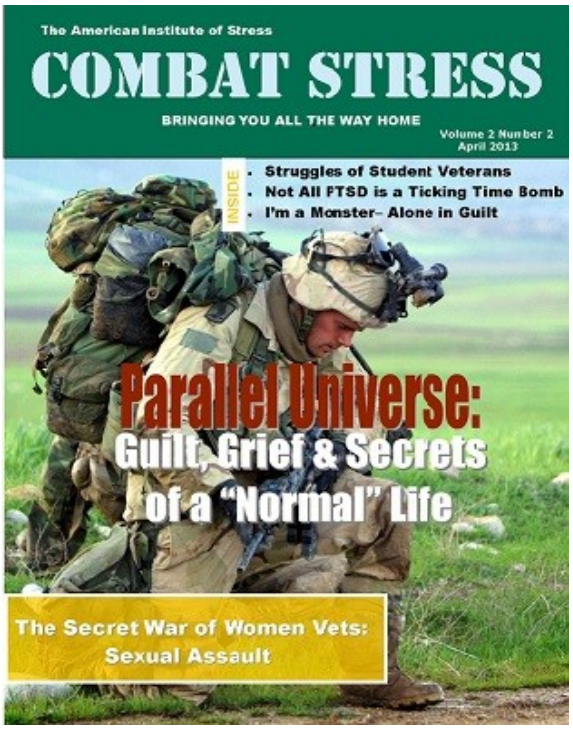

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