Rory Robertson
12 July 2017

Letter: The scandalous mistreatment of Australians with type 2 diabetes (T2D)

[RR: Highlighting and reproductions of key documents cited have been added to the original letter]

Dear Secretary Martin Bowles, Chief Medical Official Professor Brendan Murphy, other leaders in the Australian Department of Health and independent observers including journalists,

Good morning and happy National Diabetes Week. My name is Rory Robertson. I am concerned about misguided official advice for Australians with or at risk of type 2 diabetes (T2D).

As you know, the growing global pandemic of T2D is causing misery and early death on a massive scale, in Australia as elsewhere. Indigenous families are suffering a disproportionate share of that misery - including via amputations, blindness, stroke, kidney and/or heart failures - and early death [see pp. 5-6, below].

The good news is that T2D is not a "chronic disease". In most cases, it can be fixed by simple changes in diet. The bad news is that the standard T2D advice overseen by the Department of Health is faulty, harmful and expensive. For most people, the advice reinforces rather than fixes T2D, with few ever returning to being non-diabetic and drug free.

My guess is that, unless fixed quickly, the harmful mistreatment of millions of diabetics will ultimately be viewed as the biggest public-health scandal in Australian history. The scandal is that misery and early death are unfolding on a massive scale while a cheap and effective fix for T2D is left sitting on the shelf (see 4., below).

In my opinion, the Department's faulty T2D advice should be retracted immediately, and replaced with an approach proven to reverse T2D and reduce expensive drug use. This alternative approach - based on strong, century-old science - has the potential to produce the biggest improvement in Australian public health since the end of World War 2, while saving taxpayers many billions of dollars each year.

That may seem fanciful, but the claimed benefits of this alternative treatment are testable, and the scientific evidence is strong. Please subject my following 18 claims to intense scrutiny.

1. In Australia, the standard T2D advice provided via Diabetes Australia, the Dietitians Association of Australia and the Royal Australian College of General Practitioners (GPs) - with the Australian Health Practitioner Regulatory Authority requiring GPs to provide that advice, not the superior alternative - **features a reduced fat, high-carbohydrate diet plus glucose-lowering medications** (both of which tend to promote weight gain). Specifically, Diabetes Australia advises that "People with diabetes should follow the *Australian Dietary Guidelines* [ie. 45-65% carbohydrates]" and "Meals that are recommended for people with diabetes are the same as for those without diabetes".

2. This official advice is highly ineffective, with T2D progressing in most cases. Indeed, Diabetes Australia insists there is "no cure" because "Type 2 diabetes is a progressive condition. As time progresses...people with type 2 diabetes are often prescribed tablets to control their blood glucose levels. Eventually it may be necessary to start taking [exogenous] insulin to control blood glucose levels. ...Sometimes tablets may be continued in addition to insulin. ...it is important to note that this is part of the natural progression of the condition": https://www.diabetesaustralia.com.au/managing-type-2

3. Outside Australia, competent and highly credentialed medical doctors are reversing T2D [see overleaf] and obesity (Figure 5b) in a significant proportion of their patients, within a few months and without exercise: http://diabetes.jmir.org/article/viewFile/diabetes_v2i1e5/2 ; http://www.australianparadox.com/pdf/diabetes-type2.pdf

4. The effective cure for many, used in 3. [see overleaf] was standard medical advice across the western world in 1923, via the most authoritative medical text at that time: *The Principles and Practice of Medicine*, by Sir (Professor) William Osler, MD and Professor Thomas McCrae, MD (9th Edition [see pages 3 and 4, overleaf]; p. 82 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf).

JMIR DIABETES McKenzie et al

Original Paper

A Novel Intervention Including Individualized Nutritional Recommendations Reduces Hemoglobin A1c Level, Medication Use, and Weight in Type 2 Diabetes

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Abstract

Background: Type 2 diabetes (T2D) is typically managed with a reduced fat diet plus glucose-lowering medications, the latter often promoting weight gain.

Objective: We evaluated whether individuals with T2D could be taught by either on-site group or remote means to sustain adequate carbohydrate restriction to achieve nutritional ketosis as part of a comprehensive intervention, thereby improving glycemic control, decreasing medication use, and allowing clinically relevant weight loss.

Methods: This study was a nonrandomized, parallel arm, outpatient intervention. Adults with T2D (N=262; mean age 54, SD 8, years; mean body mass index 41, SD 8, $kg \cdot m^{-2}$; 66.8% (175/262) women) were enrolled in an outpatient protocol providing intensive nutrition and behavioral counseling, digital coaching and education platform, and physician-guided medication management. A total of 238 participants completed the first 10 weeks. Body weight, capillary blood glucose, and beta-hydroxybutyrate (BOHB) levels were recorded daily using a mobile interface. Hemoglobin A_{1c} (HbA_{1c}) and related biomarkers of T2D were evaluated at baseline and 10-week follow-up.

Results: Baseline HbA_{1c} level was 7.6% (SD 1.5%) and only 52/262 (19.8%) participants had an HbA_{1c} level of <6.5%. After 10 weeks, HbA_{1c} level was reduced by 1.0% (SD 1.1%; 95% CI 0.9% to 1.1%, P<.001), and the percentage of individuals with an HbA_{1c} level of <6.5% increased to 56.1% (147/262). The majority of participants (234/262, 89.3%) were taking at least one diabetes medication at baseline. By 10 weeks, 133/234 (56.8%) individuals had one or more diabetes medications reduced or eliminated. At follow-up, 47.7% of participants (125/262) achieved an HbA_{1c} level of <6.5% while taking metformin only (n=86) or no diabetes medications (n=39). Mean body mass reduction was 7.2% (SD 3.7%; 95% CI 5.8% to 7.7%, P<.001) from baseline (117, SD 26, kg). Mean BOHB over 10 weeks was 0.6 (SD 0.6) $mmol \cdot L^{-1}$ indicating consistent carbohydrate restriction. Post hoc comparison of the remote versus on-site means of education revealed no effect of delivery method on change in HbA_{1c} ($F_{1,260}$=1.503, P=.22).

Conclusions: These initial results indicate that an individualized program delivered and supported remotely that incorporates nutritional ketosis can be highly effective in improving glycemic control and weight loss in adults with T2D while significantly decreasing medication use.

(JMIR Diabetes 2017;2(1):e5) doi:10.2196/diabetes.6981

THE PRINCIPLES AND PRACTICE OF MEDICINE

DESIGNED FOR THE USE OF PRACTITIONERS AND STUDENTS OF MEDICINE

BY

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NINTH THOROUGHLY REVISED EDITION

NEW YORK AND LONDON
D. APPLETON AND COMPANY
1923

It's been widely known since at least 1923 that the main "risk factor" for diabetes (T2D) is an excessive intake of carbohydrate, including added sugar (100% carbohydrate); accordingly, the optimal treatment for T2D is obvious, and has been well-documented for a century

The following are the conditions which influence the appearance of sugar in the urine:

(*a*) EXCESS OF CARBOHYDRATE INTAKE.—In a normal state the sugar in the blood is about 0.1 per cent. In diabetes the percentage is usually from 0.2 to 0.4 per cent. The hyperglycæmia is immediately manifested by the appearance of sugar in the urine. The healthy person has a definite limit of carbohydrate assimilation; the total storage capacity for glycogen is estimated at about 300 gms. Following the ingestion of enormous amounts of carbohydrates the liver and the muscles may not be equal to the task of storing it; the blood content of sugar passes beyond the normal limit and the renal cells immediately begin to get rid of the surplus. Like the balance at the Mint, which is sensitive to the correct weight of the gold coins passing over it, they only react at a certain point of saturation. Fortunately excessive quantities of pure sugar itself are not taken. The carbohydrates are chiefly in the form of starch, the digestion and absorption of which take place slowly, so that this so-called alimentary glycosuria very rarely occurs, though enormous quantities may be taken. The assimilation limit of a normal fasting individual for sugar itself is about 250 gms. of grape sugar, and considerably less of cane and milk sugar. Clinically one meets with many cases in which glycosuria is present as a result of excessive ingestion of carbohydrates, particularly in stout persons and heavy feeders—so-called lipogenic diabetes—a form very readily controlled.

DIABETES MELLITUS 433

QUANTITY OF FOOD Required by a Severe Diabetic Patient Weighing 60 kilograms. (Joslin.)

Food	Quantity Grams	Calories per Gram	Total Calories
Carbohydrate	10	4	40
Protein	75	4	300
Fat	150	9	1,350
Alcohol	15	7	105
			1,795

STRICT DIET. (Foods without sugar.) Meats, Poultry, Game, Fish, Clear Soups, Gelatine, Eggs, Butter, Olive Oil, Coffee, Tea and Cracked Cocoa.

FOODS ARRANGED APPROXIMATELY ACCORDING TO CONTENT OF CARBOHYDRATES

	5% +	10% +	15% +	20% +
VEGETABLES	Lettuce, Spinach, Sauerkraut, String Beans, Celery, Asparagus, Cucumbers, Brussels Sprouts, Sorrel, Endive, Dandelion Greens, Swiss Chard, Vegetable Marrow, Cauliflower, Tomatoes, Rhubarb, Egg Plant, Leeks, Beet Greens, Water Cress, Cabbage, Radishes, Pumpkin, Kohl-Rabi, Sea Kale	Onions, Squash, Turnip, Carrots, Okra, Mushrooms, Beets	Green Peas, Artichokes, Parsnips, Canned Lima Beans	Potatoes, Shell Beans, Baked Beans, Green Corn, Boiled Rice, Boiled Macaroni
FRUITS	Ripe Olives (20 per cent. fat), Grape Fruit	Lemons, Oranges, Cranberries, Strawberries, Blackberries, Gooseberries, Peaches, Pineapples, Watermelon	Apples, Pears, Apricots, Blueberries, Cherries, Currants, Raspberries, Huckleberries	Plums, Bananas
NUTS	Butternuts, Pignolias	Brazil Nuts, Black Walnuts, Hickory, Pecans, Filberts	Almonds, Walnuts (Eng.), Beechnuts, Pistachios, Pine Nuts	Peanuts, 40%, Chestnuts
Miscellaneous	Unsweetened and Unspiced Pickle, Clams, Scallops, Fish Roe, Oysters, Liver			

http://www.australianparadox.com/pdf/1923-Medicine-Textbook.pdf

Evidence is strong that added sugar and other carbohydrates are causing T2D, misery and early death

RESEARCH VOLUME 198 / ISSUE 7 - 15 APRIL 2013

Characteristics of the community-level diet of Aboriginal people in remote northern Australia

Julie K Brimblecombe, Megan M Ferguson, Selma C Liberato and Kerin O'Dea

Med J Aust 2013; 198 (7): 380-384. || doi: 10.5694/mja12.11407

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AUTHORS
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RESPONSES
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Summary

Objective: To describe the nutritional quality of community-level diets in remote northern Australian communities.

Design, setting and participants: A multisite 12-month assessment (July 2010 to June 2011) of community-level diet in three remote Aboriginal communities in the Northern Territory, linking data from food outlets and food services to the Australian Food and Nutrient Database.

Main outcome measures: Contribution of food groups to total food expenditure; macronutrient contribution to energy and nutrient density relative to requirements; and food sources of key nutrients.

...

2 Estimated energy availability and macronutrient profile, overall and by community

Energy intake	Community A	Community B	Community C	All communities	
Estimated per capita energy intake based on 2010 census population (kJ)	9845	9119	7623	9608	
Estimated per capita energy intake, based on estimated energy requirement* (kJ [SD])	9147 (927)	9480 (1644)	9400 (1740)	9212 (856)	
Macronutrient distribution as a proportion of dietary energy (% [SD])					Recommended range[14]
Protein	12.5% (0.3)	14.1% (0.8)	13.4% (0.6)	12.7% (0.3)	15%–25%
Fat	24.5% (0.6)	31.6% (1.5)	33.5% (1.1)	25.7% (0.6)	20%–35%
Saturated fat	9.4% (0.3)	11.6% (0.6)	12.1% (0.3)	9.7% (0.3)	< 10%
Carbohydrate	62.1% (0.8)	53.3% (1.8)	52.1% (1.1)	60.7% (0.8)	45%–65%
Sugars	34.3% (0.8)	28.9% (2.2)	25.7% (1.8)	33.4% (0.7)	< 10%†

* Estimated energy requirements were calculated by age group (1–3 years; 4–8 years; 9–13 years; 14–18 years; 19–30 years; 31–50 years; 51–70 years; > 70 years) and sex based on Nutrient Reference Values for Australia and New Zealand, tables 1–3.[11] For age 19 to > 70 years, the midpoint height and weight of each adult age group was used. For < 18 years, the midpoint of the estimated energy requirement range across each age and sex category was used. Energy expenditure was estimated at 1.6 basal metabolic rate overall. We estimated 8% of women aged 14–50 years were pregnant and 8% were breastfeeding, based on Australian Bureau of Statistics 2006 births data, table 9.2[16] and 2006 census data for women aged 13–54 years.[15] † Recommendation for "free sugars" — all monosaccharides and disaccharides added to foods by the manufacturer, cook or consumer, plus sugars naturally present in honey, syrups and fruit juices.[17]

https://www.mja.com.au/system/files/issues/198_07_150413/bri11407_fm.pdf

4727.0.55.003 - Australian Aboriginal and Torres Strait Islander Health Survey: Biomedical Results, 2012-13

LATEST ISSUE Released at 11:30 AM (CANBERRA TIME) 10/09/2014 First Issue

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+ Key Findings
+ Diabetes
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Chronic Kidney Disease
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Exposure to tobacco smoke
Anaemia
Iodine
Vitamin D
Feature article: Chronic disease results for Aboriginal and Torres Strait Islander and non-Indigenous Australians
Aboriginal and Torres Strait Islander adults experience diabetes 20 years earlier than non-Indigenous adults (Media Release)
About this Release
History of Changes

MEDIA RELEASE

10 September 2014 Embargo: 11:30 am (Canberra Time) 132/2014

Aboriginal and Torres Strait Islander adults experience diabetes 20 years earlier than non-Indigenous adults

Aboriginal and Torres Strait Islander adults are more than three times as likely as non-Indigenous adults to have diabetes, and they experience it at much younger ages, according to new figures released by the Australian Bureau of Statistics today.

"Results from the largest ever biomedical collection for Aboriginal and Torres Strait Islander adults, which collected information on a wide range of chronic diseases and nutrition, reveal that diabetes is a major concern," said Dr Paul Jelfs from the ABS.

"The voluntary blood test results showed that in 2012–13, one in ten Aboriginal and Torres Strait Islander adults had diabetes. This means that, when age differences are taken into account, Aboriginal and Torres Strait Islander adults were more than three times as likely as non-Indigenous adults to have diabetes."

"What was even more striking was how much earlier in life Aboriginal and Torres Strait Islander adults experience diabetes. In fact, the equivalent rates of diabetes in the Aboriginal and Torres Strait Islander population were often not reached until 20 years later in the non-Indigenous population." said Dr Jelfs.

The survey revealed that diabetes was twice as common among Aboriginal and Torres Strait Islander adults living in remote areas. Around one in five in remote areas had diabetes compared with around one in ten in non-remote areas.

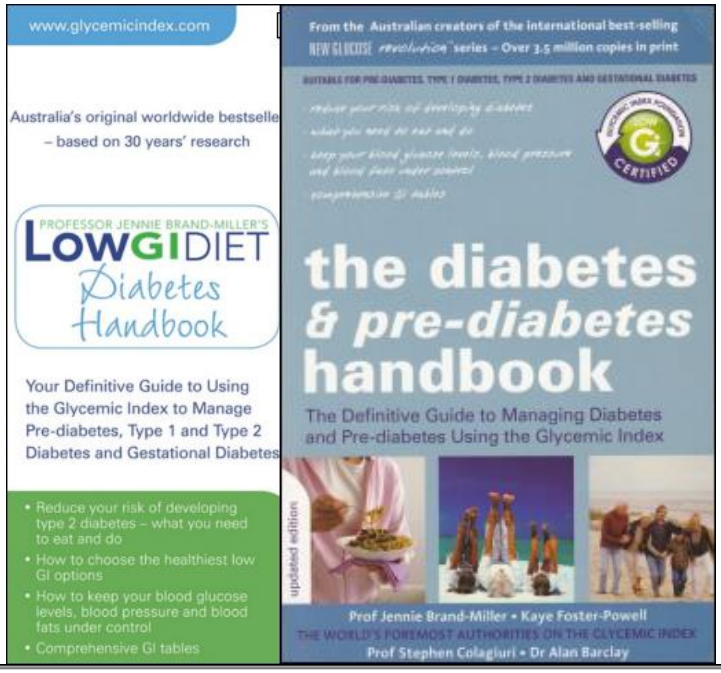
Also of interest was the fact that many Aboriginal and Torres Strait Islander adults with diabetes also had signs of other chronic conditions.

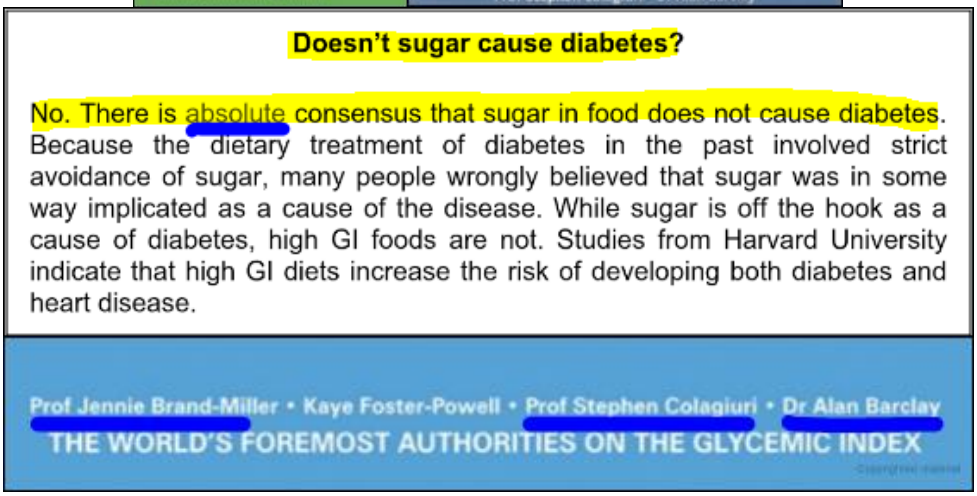
"More than half of all Aboriginal and Torres Strait Islander adults with diabetes also had signs of kidney disease. This compared with a third of non-Indigenous adults with diabetes", said Dr Jelfs.

"Given these findings, it is not surprising that the death rate for diabetes among Aboriginal and Torres Strait Islander people is seven times higher than for non-Indigenous people."

http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4727.0.55.003~2012-13~Media%20Release~Aboriginal%20and%20Torres%20Strait%20Islander%20adults%20experience%20diabetes%2020%20years%20earlier%20than%20non-Indigenous%20adults%20(Media%20Release)~130

Troubling that highly influential Charles Perkins Centre researchers at University of Sydney are recklessly promoting diet-and-health misinformation that is harmful to public health





https://www.booktopia.com.au/low-gi-diet-diabetes-handbook-jennie-brand-miller/prod9780733619380.html

http://www.theaustralian.com.au/higher-education/mice-expose-food-folly/news-story/66ca62c2aba4f641b2ba3a318d63094a

5. This cheap, simple and effective fix is based on the profoundly important fact - largely ignored by Australian diabetes careerists over recent decades - that T2D is a malady of carbohydrate intolerance. Professors Osler and McCrae a century ago observed explicitly that the main cause of diabetes (T2D) is an "Excess of carbohydrate intake" (p. 82). Thus simply removing excess carbohydrate from the patient's diet - while substituting dietary fat to satiety - substantially reduces excess blood glucose (measured via HbA1c), the defining feature of T2D.

6. Patients using this blood-glucose-lowering approach often can stop taking some or all of their medications, for T2D, blood pressure and other complications of insulin resistance (aka "Metabolic Syndrome"). In 3. (above), over 50% of patients had "one or more diabetes medications reduced or eliminated" (Table 2).

7. It also is profoundly important to note that the low-carbohydrate, high-fat (LCHF) diet that reverses T2D by normalising HbA1c is the same diet that reduces obesity and triglycerides, **key markers of risk for cardiovascular disease (CVD)**: pp. 87 and 94 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

8. That these are typical results for humans on carbohydrate-restricted, high-fat diets has been confirmed by **formal randomised controlled trials (RCTs)**. The evidence base for carbohydrate restriction to become the primary treatment for T2D is strong: http://www.sciencedirect.com/science/article/pii/S0899900714003323 ; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2633336/

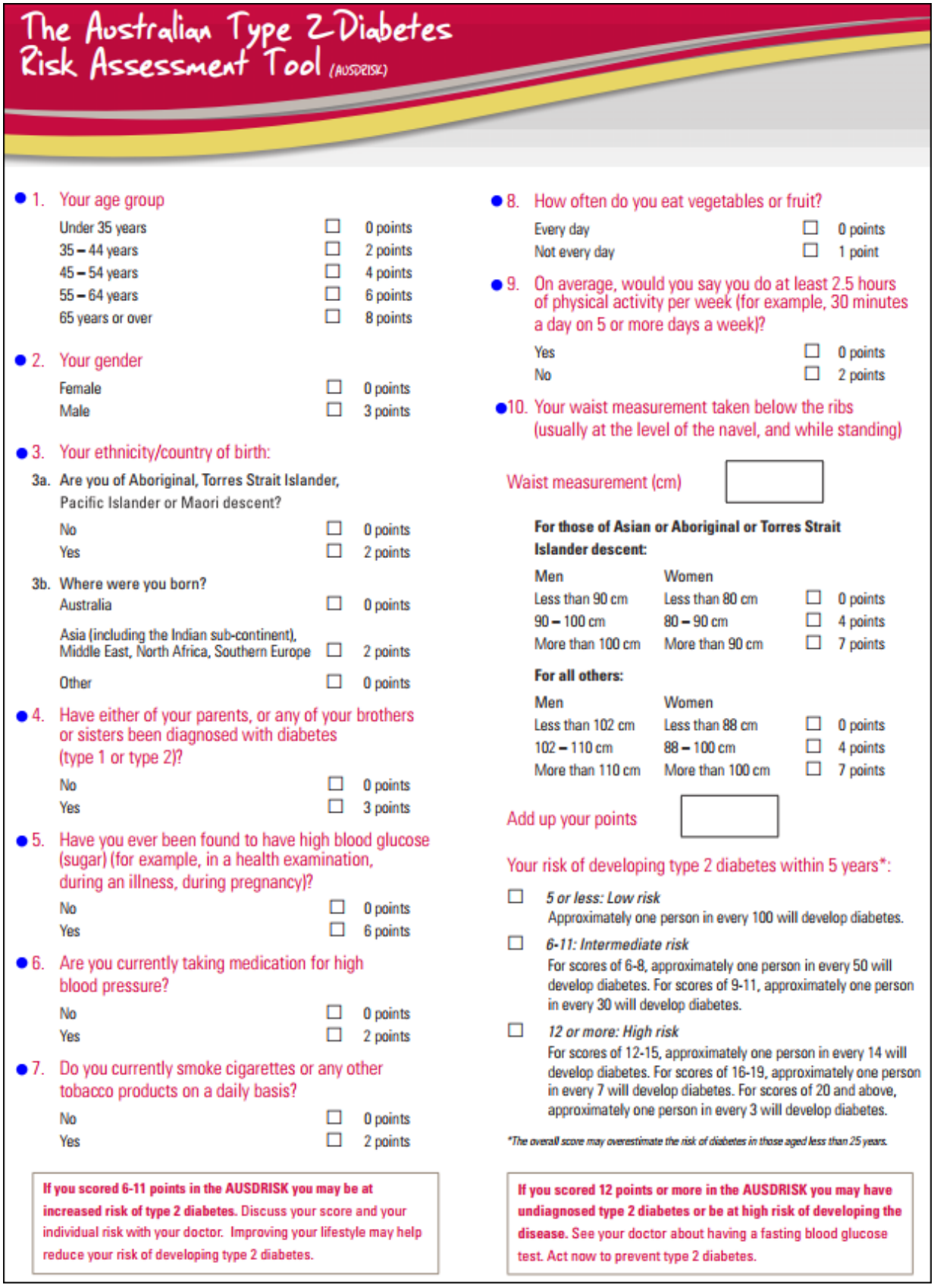
9. Critically, the extent to which patients are "cured" of T2D - a carbohydrate-intolerance malady - is largely a function of their compliance with carbohydrate restriction, in the same way that those with nut allergies do best when not consuming nuts. Thus it is important that public-health entities formally endorse and encourage carbohydrate restriction by those afflicted with T2D. (In my opinion, the Department should suspend Medicare payments to Accredited Practising Dietitians (APDs) until the Dietitians Association of Australia properly corrects its advice for treating T2D.)

10. So, excess consumption of carbohydrates including refined sugar is the main cause of T2D, while removing that excess dose of carbohydrates typically produces major benefits. **Clearly, the main "risk factor" for T2D is the consumption of modern doses of carbohydrates including sugar.** It's thus inexplicable that not one of the 10 "risk factors" listed in "The Australian Type 2 Diabetes Risk Assessment Tool" – a tool "developed by the Baker IDI Heart and Diabetes Institute on behalf of the Australian, State and Territory Governments as part of the COAG initiative to reduce the risk of type 2 diabetes" - mentions either carbohydrates or added sugar [see overleaf]. **If I were a lawyer, not an economist, I could tell you whether or not distributing "The Australian Type 2 Diabetes Risk Assessment Tool" while suppressing the most-important "risk factor" is criminally negligent:** https://static.diabetesaustralia.com.au/s/fileassets/diabetes-australia/6d252140-1ff0-47b2-a83f-3cc3db348131.pdf

11. Regardless, Australians increasingly are adopting highly effective carbohydrate restriction to fix T2D on their own, ignoring official T2D advice in favour of superior advice on the internet via dozens of well-credentialed and competent medical doctors, including:

- **Dr Sarah Hallberg**: https://www.youtube.com/watch?v=da1vvigy5tQ
- **Dr Eric Westman**: https://www.youtube.com/watch?v=oNZsfluh0Uo ; p. 2 http://www.australianparadox.com/pdf/why-we-get-fat.pdf
- **Dr Andreas Eenfeldt**: https://www.dietdoctor.com/low-carb ; https://www.dietdoctor.com/low-carb/keto ; https://www.dietdoctor.com/low-carb/success-stories
- **Dr Jason Fung**: https://www.youtube.com/watch?v=FcLoaVNQ3rc
- **Professor Tim Noakes and Dr Jay Wortman, *et al***: http://www.samj.org.za/index.php/samj/article/view/10136 ; https://www.youtube.com/watch?v=zjUdtK6ukqY ; https://www.youtube.com/watch?v=QjQDFVE5exI
- **Dr Peter Brukner**, recently the Australian cricket team's doctor, provides further background on carbohydrate restriction, and a list of Red and Green foods for those afflicted by T2D and/or metabolic syndrome: http://www.peterbrukner.com/wp-content/uploads/2014/08/All-you-need-to-know-about-LCHF1.pdf

Troubling that Australian Government's *Type 2 Diabetes Risk Assessment Tool* ignores that main "risk factor" for T2D is an excessive intake of carbohydrate, including added sugar (100% carbohydrate)



The Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)

1. Your age group

Under 35 years	0 points
35 – 44 years	2 points
45 – 54 years	4 points
55 – 64 years	6 points
65 years or over	8 points

2. Your gender

Female	0 points
Male	3 points

3. Your ethnicity/country of birth:

3a. Are you of Aboriginal, Torres Strait Islander, Pacific Islander or Maori descent?

No	0 points
Yes	2 points

3b. Where were you born?

Australia	0 points
Asia (including the Indian sub-continent), Middle East, North Africa, Southern Europe	2 points
Other	0 points

4. Have either of your parents, or any of your brothers or sisters been diagnosed with diabetes (type 1 or type 2)?

No	0 points
Yes	3 points

5. Have you ever been found to have high blood glucose (sugar) (for example, in a health examination, during an illness, during pregnancy)?

No	0 points
Yes	6 points

6. Are you currently taking medication for high blood pressure?

No	0 points
Yes	2 points

7. Do you currently smoke cigarettes or any other tobacco products on a daily basis?

No	0 points
Yes	2 points

If you scored 6-11 points in the AUSDRISK you may be at increased risk of type 2 diabetes. Discuss your score and your individual risk with your doctor. Improving your lifestyle may help reduce your risk of developing type 2 diabetes.

8. How often do you eat vegetables or fruit?

Every day	0 points
Not every day	1 point

9. On average, would you say you do at least 2.5 hours of physical activity per week (for example, 30 minutes a day on 5 or more days a week)?

Yes	0 points
No	2 points

10. Your waist measurement taken below the ribs (usually at the level of the navel, and while standing)

Waist measurement (cm) ☐

For those of Asian or Aboriginal or Torres Strait Islander descent:

Men	Women	
Less than 90 cm	Less than 80 cm	0 points
90 – 100 cm	80 – 90 cm	4 points
More than 100 cm	More than 90 cm	7 points

For all others:

Men	Women	
Less than 102 cm	Less than 88 cm	0 points
102 – 110 cm	88 – 100 cm	4 points
More than 110 cm	More than 100 cm	7 points

Add up your points ☐

Your risk of developing type 2 diabetes within 5 years*:

☐ *5 or less: Low risk*
Approximately one person in every 100 will develop diabetes.

☐ *6-11: Intermediate risk*
For scores of 6-8, approximately one person in every 50 will develop diabetes. For scores of 9-11, approximately one person in every 30 will develop diabetes.

☐ *12 or more: High risk*
For scores of 12-15, approximately one person in every 14 will develop diabetes. For scores of 16-19, approximately one person in every 7 will develop diabetes. For scores of 20 and above, approximately one person in every 3 will develop diabetes.

**The overall score may overestimate the risk of diabetes in those aged less than 25 years.*

If you scored 12 points or more in the AUSDRISK you may have undiagnosed type 2 diabetes or be at high risk of developing the disease. See your doctor about having a fasting blood glucose test. Act now to prevent type 2 diabetes.

The Australian Type 2 Diabetes Risk Assessment Tool was developed by the Baker IDI Heart and Diabetes Institute on behalf of the Australian, State and Territory Governments as part of the COAG initiative to reduce the risk of type 2 diabetes. Current from: May 2010:
http://www.health.gov.au/internet/main/publishing.nsf/Content/chronic-diab-prev-aus/$File/austool5.pdf

12. As noted in my introduction above, the burden of T2D and thus the misery and early death associated with faulty treatment falls most heavily on Indigenous Australians: "Aboriginal and Torres Strait Islander adults were more than three times as likely as non-Indigenous adults to have diabetes"; "one in five in remote areas had diabetes compared with around one in ten in non-remote areas"; and "the death rate for diabetes among Aboriginal and Torres Strait Islander people is seven times higher than for non-Indigenous people": http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4727.0.55.003~2012-13~Media%20Release~Aboriginal%20and%20Torres%20Strait%20Islander%20adults%20experience%20diabetes%2020%20years%20earlier%20than%20non-Indigenous%20adults%20(Media%20Release)~130

13. An important question now is how long the Department of Health will choose to be part of the problem rather than part of the solution. In my opinion, it is unethical and reckless for the Department to continue to promote its 45-65% carbohydrate advice to Australia's diabetics, now that its leaders know that such advice is sub-optimal; indeed, it may be **criminally negligent** to advise a diet of 45-65% carbohydrate when you know that a diet with only one-tenth of that dose tends to normalise HbA1c, dramatically reducing the risk of diabetes-related complications, such as amputations, blindness, stroke, kidney and heart failures, and early death. Further, it is unethical for the Department to promote the unnecessary, ineffective and expensive use of doctors, specialists and diabetes drugs at a time when Budget constraints invariably mean less funding in critical areas elsewhere.

14. In deciding how to proceed, it is critical that the Department comes to understand how it came to be providing advice that harms Australians and wastes taxpayer funds. Unfortunately, the Department - like diabetics, Indigenous communities and taxpayers more generally - is a victim of incompetence, scientific fraud and conflicts of interest at the highest levels of nutrition "science" and advice. The Department assumed that the diet and health information provided by highly influential diabetes careerists is trustworthy. Alas, it is not.

15. In fact, public health has been hijacked by hopelessly faulty "science" on matters regarding diet, diabetes, CVD and obesity. In Australia, the problem is centred within Group of Eight universities, particularly the University of Sydney. It [the latter] is behind much of the faulty and harmful nutrition and diabetes advice overseen since 1979 by the Department of Health and the Australian Health and Medical Research Council (NHMRC): pp. 81 and 94 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

16. The problem is that there is no competent quality control in Group of Eight "science" when it matters. In 2016, the then-Chair of the Group of Eight, University of Sydney Vice-Chancellor Michael Spence, confirmed that he has no interest in correcting false Go8 information that is damaging to public health. His priorities appear to include soliciting taxpayer funds for his university - $700m per year! - with false promises of research "excellence" and supporting his underperforming scientists, even those promoting serious scientific fraud in the diet-and-health space: p. 79 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf ; http://www.australianparadox.com/pdf/Letters-USydVCSpenceGoverance.pdf

17. It is ironic and tragic - given the heavy burden of diet-and-health harm falling on Indigenous Australians - that the Charles Perkins Centre at the University of Sydney appears to be Australia's most-influential source of harmful diet misinformation with respect to T2D, obesity and CVD. In particular, the Charles Perkins Centre is a world leader in falsely defending modern doses of refined sugar as harmless, with its most-influential experts explicitly exonerating sugar as a cause of T2D and obesity. Again, this misinformation reflects a mix of incompetence, scientific fraud and conflicts of interest. Further detail is provided in the Appendix, below.

18. University professors moonlighting as paid agents of pharmaceutical companies appear to have been influential in suppressing the known diet cure for T2D from the Department of Health's *National Diabetes Strategy 2016-2020*. Indeed, many of the 600 events per week - yes, per week! - funded by pharmaceutical companies for Australian health practitioners and academics are likely to be designed to suppress any professional inclination to promote the proven diet fix rather than expensive drugs for T2D, obesity, high blood pressure and other aspects of metabolic syndrome: p. 83 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf ; http://www.smh.com.au/comment/australian-doctors-get-a-massive-dose-of-marketing-20170710-gx8b30.html ; http://bmjopen.bmj.com/content/7/6/e016701.full?ijkey=RuirMdhTCCQpbyG&keytype=ref ; https://static1.squarespace.com/static/57e9ebb16a4963ef7adfafdb/t/5812d8cfc534a5e443dd6a56/1477630166923/NovoNordiskPresentation_MichalaFischer-Hansen+.pdf

Charles Perkins Centre scientists falsely promoting added sugar and sugary drinks as harmless

SRAS
SUGAR RESEARCH ADVISORY SERVICE

Does added sugar cause weight gain?

this form may be obesogenic [x] [xi] In Australia, however, added sugar intake and SSB intake have been declining over the same period as obesity has increased – the so-called Australian sugar paradox – suggesting sugar intake is not a primary driver of population obesity levels [xii].

...

This article was reviewed by Professor Jennie Brand Miller from the School of Molecular Biosciences and Charles Perkins Centre and Director, Sydney University Glycemic Index Research Service.

http://www.srasanz.org/sras/news-media-faq/sras-articles/do-carbohydrates-cause-weight-gain/ ; http://www.srasanz.org/sras/sras-advisors/

FOOD POLITICS

by Marion Nestle

MAR 7 2016

Sugar: in Australia, it's "Better for You"

At my lecture at the University of Sydney last week, a member of the audience presented me with a 750-gram package of Low GI [Glycemic Index] cane sugar, labeled "Better for you."

This product is sugar. Its ingredient list says "pure cane sugar."

Australian Beverages

Why a soft drinks tax is not the answer

As the nation's collective waistline continues to expand, through the media there are various calls for a tax on certain products, including soft drinks, as a means to curb obesity. Whilst theoretical modelling might point to taxes as a solution, in reality these punitive measures are ineffective, inefficient and unfair for a range of reasons.

Added sugar consumption declining...

Australia's consumption of added sugar is declining. A recent study identified that the prevalence of obesity has increased 3 fold in Australians since 1980 while per capita consumption of refined sugar (sucrose) decreased by 23% from 1980 to 2003[1]. The research also found that when all sources of

...

2007. The findings confirm an "Australian Paradox"—a substantial decline in refined sugars intake over the same timeframe that obesity has increased. The implication is that efforts to reduce sugar intake *may* reduce consumption but *may not* reduce the prevalence of obesity.

http://australianbeverages.org/for-consumers/soft-drink-tax-answer/

This particular brand of sugar carries a certification seal from the Glycemic Index Foundation, whose motto is "making healthy choices easy." It is supported by the University of Sydney and the Juvenile Diabetes Research Foundation.

> The Foundation generates income by licensing the low GI Symbol to manufacturers of healthier low GI foods.

Is "low GI" cane sugar healthier than cane sugar? The mind boggles.

http://www.foodpolitics.com/2016/03/sugar-in-australia-its-better-for-you/

THE AUSTRALIAN
FOR THE INFORMED AUSTRALIAN

HEALTH AND SCIENCE

A spoonful of sugar is not so bad

The University of Sydney's Jennie Brand-Miller and Bill Shrapnel with a variety of foods, some more nutritious than others, that all contain sugar. Picture: Jane Dempster

LEIGH DAYTON, SCIENCE WRITER
TheAustralian | 12:00AM July 9, 2011

Save

BILL Shrapnel was not amused. He'd logged on to the National Health and Medical Research Council's website a few weeks ago and read the draft dietary guideline recommendations.

"My reaction was that the NHMRC is supposed to be the bastion of evidence-based nutrition," recalls Shrapnel, consultant dietitian and deputy chairman of the University of Sydney Nutrition Research Foundation. "But their dietary work is still laced with the dogma that diminishes our profession."

What raised Shrapnel's ire was the word sugars in recommendation No 3: "Limit intake of foods and drinks containing saturated and trans fats; added salt; added sugars; and alcohol". Limit sugars? "Show us the evidence," he says. "There isn't any."

...

According to Brand-Miller, far too much discussion about diet is out of date, in part as the NHMRC guidelines are out of date. She argues there's growing evidence that - unlike saturated and trans fats, salt and alcohol - eating added sugar is not inherently dangerous.

"It doesn't actually do any direct harm to the human body. It doesn't raise blood cholesterol or raise blood pressure or cause cancer," says Brand-Miller, known for her book The Low GI Diet. The GI stands for glycemic index, a measure of the effects of carbohydrates on blood sugar levels.

...

According to Brand-Miller, these findings sit neatly with data from the UN Food and Agriculture Organisation, national dietary surveys and industry. "Australians have been eating less and less sugar, and rates of obesity have been increasing," she says.

...

In other words, a healthy diet includes plenty of nutrient-rich foods, few nutrient-poor foods and a pinch of sugar to help it all go down. Sugar isn't the "white death" of lore. It's a dietary element that's packaged in foods, healthy and unhealthy alike.

That's a message most experts don't buy, including the NHMRC review panel and Robert Lustig, a pediatric endocrinologist with the University of California at San Francisco. "Saying sugar is not a problem would be laughable, if it weren't so dangerous," he claims.

According to Lustig, sugar is the driving force behind metabolic syndrome, a cluster of risk factors including, hypertension, cholesterol abnormalities, an increased risk for clotting and resistance to insulin, a hormone that regulates blood sugar, fats and proteins.

Brand-Miller rejects this. "Robert's views are based on studies that used extremely large amounts of fructose, not realistic amounts," she says.

Shrapnel goes further: "This guy is saying sugar causes metabolic syndrome. It doesn't. However, excess dietary carbohydrate, sugar or starch, can exacerbate some of the characteristics of the metabolic syndrome. That's very different."

http://www.theaustralian.com.au/news/health-science/a-spoonful-of-sugar-is-not-so-bad/news-story/1f78f8d76736b77a9abab0363504ccfe

Troubling that University professors moonlighting as paid agents of pharmaceutical companies – including the main scientific author (Prof. Colagiuri) - appear to have been influential in suppressing the known diet cure for T2D from the Department of Health's *National Diabetes Strategy 2016-2020*

Appendix 2

Diabetes Mellitus Case for Action - Declarations of Interests

The declarations of interests of Steering Group members, authors and contributors to this Case for Action are listed below.

Name and Role(s)	Interest(s) declared
Prof Stephen Colagiuri • Steering Group member • Author	**Board membership** • Astra Zenica/BMS National Advisory Board; MSD National Advisory Board; Novo Nordisk International and National Advisory Board; Sanofi National Advisory Board; Servier International Advisory Board; Takeda National Advisory Board. **Consultancy fees/honorarium; support for travel/accommodation; meals/beverages** • Speaker engagements - honoraria, travel expenses, accommodation and meals received from: Astra Zenica/BMS; MSD; Novo Nordisk; Sanofi; Servier; Takeda. **Grants** • Chief Investigator, NHMRC Program Grant 2013-2017 • Chief Investigator, NHMRC Project grant • Chief Investigator, NHMRC EU FP7 Health project.
Prof Stephen Twigg • Steering Group member • Contributor	**Consultancy fees/honorarium** I am on/have been on the following Advisory Boards: • 2014-present Sanofi-Aventis International Advisory Board (Insulin glargine U300) • 2014-present Abbott Scientific Advisory Board (flash glucose monitoring) • 2014 Boehringer Ingelheim/Eli Lilly Alliance Advisory Board (Empagliflozin) • 2014 Janssen-Cilag Advisory Board (Canagliflozin) • 2013-Boehringer Ingelheim/Eli Lilly Alliance Advisory Board (Linagliptin) • 2011-2013 AstraZeneca Advisory Board (Onglyza/Dapagliflozin) • 2011-2012 Elixir Advisory Board (BMS and Astra Zeneca) • 2010-2013 Novo Nordisk Advisory Board (Victoza) • 2008-2013 Merck Sharpe & Dohme: Januvia (Sitagliptin) • 2009-2013 Novartis: Galvus (Vildagliptin) • 2010 SanofiAventis (Lixisenatide).
Prof Sophia Zoungas • Steering Group member	**Board Membership** • AstraZeneca Pty Ltd; Boehringer Ingelheim Pty Ltd; Bristol-Myers Squibb Australia Pty Ltd; Merck Sharp & Dohme (Australia) Pty Ltd; Novo Nordisk Pharmaceuticals Pty Ltd; Sanofi-aventis Group; AbbVie. **Consultancy fees/honorarium** • AstraZeneca Pty Ltd; Boehringer Ingelheim Pty Ltd; Bristol-Myers Squibb Australia Pty Ltd; GlaxoSmithKline Australia Pty Ltd; Merck Sharp & Dohme (Australia) Pty Ltd; Novartis Pharmaceuticals Australia Pty Ltd; Novo Nordisk Pharmaceuticals Pty Ltd; Sanofi-aventis Group; Servier Laboratories (Australia) Pty Ltd; MediMark Australia Education; Elixir Healthcare Education.
Prof Timothy Davis • Steering Group member	**Consultancy fees/honorarium** *Speaker fees* • Abbott; Eli Lilly *Speaker fees and advisory board membership* • Astra Zeneca; Boehringer Ingelheim; Bristol Meyer Squibb; GlaxoSmithKline; Merck Sharp and Dohme; Novartis; NovoNordisk; Sanofi Aventis *Advisory board membership* • Janssen **Grants** • Research funding: Eli Lilly; Merck Sharp and Dohme; NovoNordisk; Sanofi-aventis Holds NHMRC grants and intends applying for others during the period of steering group membership. **Support for travel/accommodation; meals/beverages** • Provided as part of attendance at Advisory Board/Scientific meetings from: Abbott; Astra Zeneca; Boehringer Ingelheim; Bristol Meyer Squibb; GlaxoSmithKline; Janssen; Merck Sharp and Dohme; Novartis; NovoNordisk; Sanofi aventis

pp. 31-36 of
https://www.nhmrc.gov.au/_files_nhmrc/file/research/research_translation_faculty/rtf_cfa_diabetes_nhmrc_150320.pdf

In summary, Secretary Bowles, the potential for millions of Australians in coming decades to avoid the misery and/or early death associated with T2D - and metabolic syndrome more generally - is in your Department's hands: http://www.health.gov.au/internet/main/publishing.nsf/Content/24BEDAF18381C86ACA257BF0001E0193/$File/Departmental%20Structure%20Chart%20-%2014%20June%202017.PDF

I respectfully request that the Department acknowledge my letter and subject my 18 detailed claims above, and in my Appendix below, to intense scrutiny. When you have confirmed that what I am saying is correct in all important respects, the Department of Health should immediately retract its misguided high-carbohydrate, high-drug advice for T2D, and introduce carbohydrate restriction as the primary treatment for T2D.

I look forward to your response. In the meantime, please feel free to forward this letter to others interested in improving public health. I am providing this letter to journalists and others.

Best wishes,
Rory

APPENDIX: The Charles Perkins Centre and harmful misinformation on diet and health

The objective of the palatial $500m Charles Perkins Centre at the University of Sydney is "Easing the burden of diabetes, obesity and cardiovascular disease, and their related conditions": http://www.smh.com.au/national/university-sets-up-500m-centre-for-obesity-research-20130724-2qjq8.html ; http://sydney.edu.au/charles-perkins-centre/

Unfortunately, as noted in 17. (above), it is ironic and tragic - given the heavy burden of diet-and-health harm falling on Indigenous Australians - that the Charles Perkins Centre appears to be Australia's most-influential source of harmful diet misinformation with respect to T2D, obesity and CVD.

The early evidence is that the Charles Perkins Centre is an expensive failure. Please consider the following facts:

(i) GPs across the western world knew as early as 1923 that the main cause of T2D in humans (not mice) is an "excess of carbohydrate intake", according to Sir (Professor) William Osler and Professor Thomas McCrae's widely respected medical text: ***The Principles and Practice of Medicine*** (9th Edition; see 4., above).

(ii) Refined sugar (100% carbohydrate) is a key driver of health problems and early death, especially via T2D and CVD. Indeed, "in remote communities and very remote communities sugar is just killing the population", according to Indigenous Affairs Minister Senator Nigel Scullion: http://www.abc.net.au/news/2016-02-12/scullion-says-sugar-is-killing-remote-communities/7162974 ; p. 43 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

(iii) In remote Aboriginal communities, the average diet of around 60% carbohydrate - mostly added sugar (100% carbohydrate) and refined grains - obviously is an excellent recipe for T2D. As noted in 12. above, around **20% of Indigenous people in remote areas suffer diabetes (T2D) compared with around 10% in non-remote areas, while the death rate from diabetes among Indigenous Australians is seven times higher than for non-Indigenous people**: pp. 13-16 http://www.australianparadox.com/pdf/obesitysummit.pdf

What does the Charles Perkins Centre say about those matters of fact?

(iv) Well, the **"Low-GI crew" at the Charles Perkins Centre** - including Professor Jennie Brand-Miller, Professor Stephen Colagiuri and Dr Alan Barclay - falsely insist that "**There is absolute consensus that sugar in food does not cause [T2] diabetes**". In the process, they have sold several million pop-sci Low-GI diet and Low-GI diabetes books: p. 5 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

(v) The Charles Perkins Centre's Academic Head, Professor Stephen Simpson, decided in 2013 that the optimal diet to maximise human longevity involves eating around 60% carbohydrates, 20% protein and 20% fat. Why? **Because "mice are not all that different from humans"**: p.89 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

(vi) Disturbingly, Professor Simpson based his 60%-carbohydrate recommendation for human longevity not on formal research investigating what happens to humans eating a diet of 60% carbohydrates dominated by refined grains and sugar - as in (iii) above - **but instead on what happens when mice are fed a diet dominated by refined grains, sugar and processed soy-bean oil**: Table S1
http://www.cell.com/cms/attachment/2036710794/2051569003/mmc1.pdf

Awkwardly, Professor Simpson ignored published research findings by other researchers, years earlier, that diet-and-health results from **"rodent models" can be highly misleading, adding value mainly by boosting our understanding of how rodents' metabolic mechanisms "can work in ways different from the effect in humans"**: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3488544/

(vii) In 2017, Professor Simpson and his colleagues at the Charles Perkins Centre responded to **a formal diet-and-health research-integrity investigation** by placing fake data in the *American Journal of Clinical Nutrition*, in a dishonest effort that **expanded the infamous pro-sugar *Australian Paradox* fraud to a third journal**: pp. 18, 28, 64 and 78 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

That shocked me because Professor Simpson told me in 2013 - in a face-to-face meeting at the Australian National University in Canberra - that he would do his best to fix - not expand! - the *Australian Paradox* fraud:
http://www.australianparadox.com/pdf/LettersCPCProfSimpson.pdf

(viii) Charles Perkins Centre Professor Stephen Colagiuri - **a distinguished Low-GI co-author of that ridiculous false claim "There is absolute consensus that sugar in food does not cause [T2] diabetes"** - appears to be the most-influential scientific author involved in producing the Australian Health Department's ***National Diabetes Strategy 2016-2020***: p. 84 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

In a face-to face-conversation with me at the Charles Perkins Centre in February 2016, Professor Colagiuri mistakenly insisted that carbohydrate restriction is not particularly helpful in treating T2D. Given his reckless false exoneration of added sugar (100% carbohydrate) as a cause of T2D, and his strong links with a range of large pharmaceutical companies (p. 84), it's probably not an accident that the ***National Diabetes Strategy 2016-20*** **suppresses carbohydrate-restriction as an effective treatment for T2D**.

(ix) Charles Perkins Centre Professor Jennie Brand-Miller and Dr Alan Barclay run the University of Sydney's 50%-owned Low-GI business that gets paid by industry to put healthy low-GI stamps on products that are up to 99.4% sugar. In March 2016, globally famous New York University nutrition scientist Professor Marion Nestle was highly amused by that pro-industry non-science - writing "The mind boggles" - after I presented her with a bag of healthy LoGi sugar at a Charles Perkins Centre event: pp. 49-50 and 66
http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

(x) Professor Brand-Miller and Dr Barclay also are highly influential in the diabetes space. Professor Brand-Miller over recent decades has been awarded millions of dollars of taxpayer funding for diabetes research via the NHMRC, while Dr Barclay was **Head of Research at the Australian Diabetes Council (Diabetes NSW) from 1998 to 2014**: http://sydney.edu.au/science/people/jennie.brandmiller.php

(xi) Further, Dr Barclay is a **prominent sugar-defending spokesperson for the Dietitians Association of Australia**, while sugar-defender Professor Brand-Miller is on the **Scientific Advisory Board of Obesity Australia**, alongside her Charles Perkins Centre boss Professor Stephen Simpson and Low-GI co-author Professor Stephen Colagiuri: https://daa.asn.au/voice-of-daa/daa-spokespeople/ ; http://www.obesityaustralia.org/scientific-advisory-council

(xii) Given the Charles Perkins Centre's recent takeover of Obesity Australia and its boss's strong disinterest in the diet cure for T2D and obesity, it is unsurprising that **the major sponsor of Obesity Australia's "Annual Summit" is a pharmaceutical company**: http://www.obesityaustralia.org/about-oa ;

https://static1.squarespace.com/static/57e9ebb16a4963ef7adfafdb/t/5812d8cfc534a5e443dd6a56/1477630166923/NovoNordiskPresentation_MichalaFischer-Hansen+.pdf ; http://www.obesityaustralia.org/publications-and-documents

(xiii) Over the past several years, the Charles Perkins Centre's high-profile *Australian Paradox* fraud has become notorious, because several highly influential scientists are pretending on the formal scientific record that there is a longstanding "inverse relationship" in Australia between sugar consumption and obesity. Based on fake data and a misreading of up versus down in the authors' own charts, the *Australian Paradox* scandal is perhaps the best-documented case of serious scientific fraud in Group of Eight university history: pp. 18, 28, 64 and 78 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

(xiv) The basics of the *Australian Paradox* fraud have been featured on ABC national radio (*Background Briefing*) and TV (*Lateline*), as well as in a range of newspaper articles: http://www.abc.net.au/radionational/programs/backgroundbriefing/2014-02-09/5239418 ; http://www.abc.net.au/lateline/content/2015/s4442720.htm ; http://www.smh.com.au/business/pesky-economist-wont-let-big-sugar-lie-20120725-22pru.html

(xv) In 2011 and 2012, Professor Brand-Miller and University of Sydney colleague Bill Shrapnel used the false *Australian Paradox* "finding" to **campaign against the NHMRC's proposed toughening of dietary advice against added sugar**: http://www.theaustralian.com.au/news/health-science/a-spoonful-of-sugar-is-not-so-bad/news-story/1f78f8d76736b77a9abab0363504ccfe ; http://www.smh.com.au/national/health/research-causes-stir-over-sugars-role-in-obesity-20120330-1w3e5.html

In 2017, Professor Brand-Miller and the sugar and sugary drinks industries use the *Australian Paradox* fraud to try to kill proposed taxes on sugary drinks: p. 46 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf ; https://www.srasanz.org/sras/sras-advisors/

(xvi) As noted above, Professor Brand-Miller and Dr Barclay's March 2017 placement of fake data in the *American Journal of Clinical Nutrition* was assisted by Charles Perkins Centre boss Professor Simpson. **Also assisting was esteemed nutrition colleague Professor Stewart Truswell. Professor Truswell's role is notable because in 2013 at a Coca Cola event in Sydney I personally explained to him - after he complained to me that I was making a mountain out of a molehill - the problem of fake data in the *Australian Paradox* fraud**: https://engage.vevent.com/index.jsp?eid=3045&seid=12

(xvii) The "big picture" is that Professor Truswell has been highly influential in the provision of faulty dietary advice to Australians in the four decades since he joined the University of Sydney - as the "Chair of Human Nutrition" - from London (via South Africa) in 1978. Importantly, he brought with him a version of the 1977 *Dietary Goals for the United States*. In 1979, that low-fat US advice was pretty much cut-and-pasted into what became the initial version of today's *Australian Dietary Guidelines* (ADGs). Professor Truswell has confirmed that there was no independent Australian assessment of the "science" behind that now-discredited US diet advice. It is not an accident that official efforts since 1979 to encourage Australians to limit their consumption of fat, especially saturated fat in meat and dairy, while eating larger doses of "heart healthy" carbohydrates, have been followed by Australia's post-1980 uptrends in obesity and T2D: pp. 91-106 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

(xviii) In the 1992 version of today's *Australian Dietary Guidelines*, Professor Truswell appears to have been responsible for downgrading sugar as a problem. Saturated fat in meat and dairy was identified as the main dietary evil, with the guideline to avoid excess sugar demoted from number 4 in 1982 to number 6 in 1992 "to reflect the relative importance of the recommendations…"! [RR: The previous sentence has been improved from the original to properly reflect what happened back in 1992 (see bottom right-hand side of p. 19, below).]

Extraordinarily, Professor Truswell appears to have controlled the saturated-fat-causes-CVD chapter for decades, thus allowing influential false information to damage public health. In 2015, the entity representing around 100,000 US nutritionists/dietitians conceded that the central claim in global dietary advice for the past half a century - that saturated fat in meat and dairy causes CVD - is wrong. [RR: p. 20, below.] **The US Academy of Nutrition and Dietetics now explains that an excess intake of carbohydrates including sugar is a more important cause of CVD**: pp. 97 and 101 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

Troubling that Charles Perkins Centre scientists promoting pro-sugar *Australian Paradox* fraud

http://www.abc.net.au/lateline/content/2015/s4442720.htm

http://www.abc.net.au/radionational/programs/backgroundbriefing/2014-02-09/5239418

Charles Perkins Centre's 2017 *Australian Paradox* "update" in *American Journal of Clinical Nutrition* features fake sugar data. Legitimate public scrutiny of *AJCN* draft was stopped via a security guard!

In July 2014, research-integrity investigator Professor Robert Clark AO advised:

I have, however, identified a number of 'lessons learnt' from this case and I recommend that these be considered by the University and discussed with Professor Brand-Miller and Dr Barclay at Faculty level. In particular, I recommend that the University consider requiring Professor Brand-Miller and Dr Barclay to prepare a paper for publication, in consultation with the Faculty, that specifically addresses and clarifies the key factual issues examined in this Inquiry. This new paper should be written in a constructive manner that respects issues relating to the data in the Australian Paradox paper raised by the Complainant.

p. 4 http://www.australianparadox.com/pdf/australian-paradox-report-redacted.pdf

In March 2017, the authors published a different paper, again featuring fake data:

AJCN. First published ahead of print March 8, 2017 as doi: 10.3945/ajcn.116.145318.

Declining consumption of added sugars and sugar-sweetened beverages in Australia: a challenge for obesity prevention[1,2]

Jennie C Brand-Miller[3] and Alan W Barclay[4]*

[3]Charles Perkins Centre and School of Life and Environmental Sciences, University of Sydney, Sydney, Australia; and [4]Accredited Practising Dietitian, Sydney, Australia

10 of 10 BRAND-MILLER

We thank Gina Levy and Bill Shrapnel for making the raw data from their earlier study available (27). We thank Alistair Senior, who gave statistical advice, and Anna Rangan, Jimmy Louie, Stephen Simpson, and Stewart Truswell, who gave constructive comments on the draft manuscript.

The authors' responsibilities were as follows—JCB-M: had primary responsibility for the final content of the manuscript; and both authors: designed and conducted the research, analyzed the data, performed the statistical analysis, wrote the manuscript, and read and approved the final manuscript. JCB-M is President of the Glycemic Index Foundation and manages a food-testing service at the University of Sydney. JCB-M and AWB are co-authors of books about the glycemic index of foods. AWB is a consultant to the Glycemic Index Foundation and Merisant (Australasia) and is a member of the Scientific Advisory Boards of Roche and Nestle (Australasia). AWB received an honorarium from Coca-Cola Ltd. for a presentation in 2011. JCB-M reported no conflicts of interest related to the study.

p.78 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

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THE NATION

University of Sydney threatens to ban Rory Robertson over sugar dispute

Economist Rory Robertson at Sydney University, which has threatened to ban him from campus. Picture: Britta Campion

The Australian | 12:00AM March 6, 2017 | 113 | Save

ADAM CREIGHTON
Economics Correspondent | Sydney | @Adam_Creighton

The University of Sydney has threatened to ban a high-profile financial markets economist and anti-sugar campaigner from its campus, accusing him of intimidating one of its top academics as they feud over the role of sugar in fuelling obesity.

Rory Robertson, a former Reserve and Macquarie Bank economist, has angrily denied the accusation in a series of emails with university officials, including vice-chancellor Michael Spence.

"Rather than threatening to ban me from campus, Dr Spence should simply fix (the issues)," he said, referring to a 2011 research paper, "The Australian Paradox", written by the university's top nutritionist, Jennie Brand-Miller, which finds a negative relationship between Australian obesity and sugar consumption.

Professor Brand-Miller's books have sold millions of copies worldwide and claim there is an "absolute consensus" that sugar in food does not cause diabetes.

Last year Mr Robertson attended two nutrition conferences hosted by the university, at which he says he voiced concerns about Professor Brand-Miller's controversial research, which appears to have drawn the wrong conclusion from sugar consumption data — a view corroborated separately by the ABC's *Lateline* program and author Peter Fitz Simons.

At the second conference, in November, security officials asked Mr Robertson to leave after he tried to question Professor Brand-Miller.

Deputy vice-chancellor Stephen Garton wrote to Mr Robertson in January saying the economist, who has worked in senior finance positions in New York and Sydney, had behaved in an "aggressive and intimidating manner".

"This letter is a warning that if you (repeat this behaviour) the university will revoke its consent for you to enter University of Sydney lands," Professor Garton said.

In his response, Mr Robertson called the accusation "reckless misrepresentations" and demanded the university release a video of the earlier March conference, that showed him asking questions during the Q&A session. "I'm not going to be intimidated by false claims," he wrote on January 30.

Dr Spence confirmed the threat in his February reply, writing, "so far as I have been able to gather, there is no video".

"The university reserves the right … to secure and maintain an environment in which there is appropriate and respectful discourse," he wrote.

Excerpts of the video, which show Mr Robertson asking questions in a reasonable fashion, are on the ABC's website.

The Australian does not suggest Professor Brand-Miller has acted inappropriately.

Mr Robertson has waged a five-year campaign against the university to retract the paper.

The university has cleared Professor Brand-Miller of any "research misconduct".

"There are respectable proposals for a sugar tax to help to reduce the misery of obesity and diabetes. But shonky (university) science is poisoning the important public debate with false information: the sugar and sugary drinks industries are brandishing the Charles Perkins Centre's Australian Paradox fraud as an intellectual spearhead in an effort to kill any such tax," Mr Robertson said.

Professor Brand-Miller did not respond to a request for comment.

http://www.theaustralian.com.au/news/nation/university-of-sydney-threatens-to-ban-rory-robertson-over-sugar-dispute/news-story/0021115ba9b77f2e2e96e86f37ca7fdd

p. 77. http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

A. Low-fat *Australian Dietary Guidelines* based on shonky US demonisation of dietary fat, particularly saturated fat in meat and dairy

Proceedings of the Nutrition Society of Australia (1995) 19 1

DIETARY GUIDELINES: THEORY AND PRACTICE

A. STEWART TRUSWELL

When the first edition of Dietary Goals for the USA was published in February 1977 an early copy was brought across the Atlantic by Dr Hugh Trowell who gave it to the editor of the Lancet. The latter asked me to write an (unsigned) editorial and I welcomed the new goals (Anonymous 1977) without realizing the US political background. My editorial has pride of place in the 869 page volume of supplemental views (Select Committee on Nutrition and Human Needs 1977). It was the first international commentary to appear and a rare positive independent review to balance against a host of critics in the USA. In the next year I tried to pass on my enthusiasm

II. DEVELOPMENT OF DIETARY GOALS AND GUIDELINES IN AUSTRALIA

I came to Australia to start the Chair of Human Nutrition at Sydney University in May 1978 and one of the new ideas I brought with me from the north was dietary goals. I had the opportunity to explain them as opening speaker at a large seminar organized by the Dietitians' Association in Sydney in August (Truswell 1978b). The Association resolved at the end of the seminar to set up a committee to develop proposals for a national nutrition policy. The committee first tried to collect views from 150 people and organizations in Australia who might be interested or affected. But we received very few replies and so decided to draft ourselves a set of dietary guidelines for Australians (Australian Association of Dietitians 1979). Meanwhile I helped with the chapter on diet and health in the report by Davidson et al. (1979) on health promotion for the Commonwealth Department of Health. One of this report's main recommendations was that 'work on the formulation of a national nutrition policy with dietary goals for Australia be continued'.

'Dietary goals for Australia' were first presented on 27 April 1979 by Dr 'Spike' Langsford then First Assistant Director-General of the Public Health Division in the Commonwealth Department of Health. The setting was a two-day double conference on nutrition held at the Australian Academy of Science in Canberra, with support from dietitians' organizations, the food industry, consumer organizations, the National Heart Foundation and a postgraduate medical organization (Australian Commonwealth Department of Health 1979a; 1979b). Dr Langsford dealt with departmental publications, recommended dietary allowances, diet for pregnancy, infant feeding, etc. and concluded 'I would like to propose for your consideration a set of eight dietary goals for Australians, drawn from the Department's food and nutrition policy' (Langsford 1979). The setting was conducive to a positive reaction. These dietary goals were put together in small rooms in the Commonwealth Department of Health. I was the only nutritionist from outside the Department involved in the drafting. After they had been launched the goals were presented to the Nutrition Standing Committee of the National Health and Medical Research Council. They expressed disappointment that they had not been earlier involved, but adopted the goals unmodified (Australian Commonwealth Department of Health 1982). There was no backround review of the scientific literature at the time, though several of the papers at the April 27, 28 conferences served this purpose in an indirect way (Truswell 1982).

The term dietary goals is usually used for national objectives (Truswell 1987), macro-nutrition. They do not advise individuals on food choices. This was done in 1981 by 'Dietary Guidelines for Australians', written mainly by Ruth English, a simple anonymous version, comprehensible by the interested lay person (Australian Commonwealth Department of Health

background papers. The decision was made to try and express the quantity recommended in ordinary language, eg 'Eat a diet low in fat', as the heading for most people, but for professionals and those with a special interest, numbers in technical language were to be found in the full text, eg 'total fat 30% of energy'. The process was completed with only three meetings (one of these by phone), with a lot of drafting and correspondence before, between and after. The only guideline

http://apjcn.nhri.org.tw/server/apjcn/ProcNutSoc/1990-1999/1995/1995%20p1-10.pdf

In 2017, Australia's #1 dietary evil is saturated fat (2013 edition)

EAT FOR HEALTH

Australian Dietary Guidelines

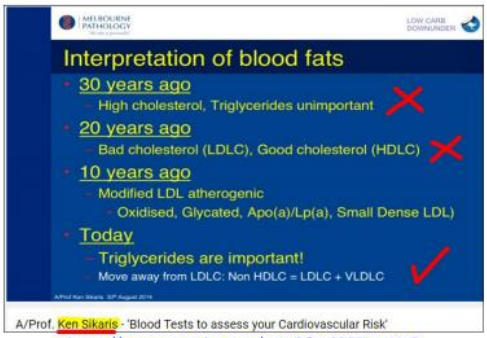
Providing the scientific evidence for healthier Australian diets

3.1 Limit intake of foods high in saturated fat 68
3.1.1 Setting the scene 68
3.1.2 The evidence for 'limit intake of foods high in saturated fat' 69
3.1.3 How limiting intake of foods high in saturated fat may improve health outcomes 71
3.1.4 Practical considerations: limit intake of foods high in saturated fat 71

How the Guidelines were developed

These Guidelines are an evolution of the 2003 edition of the dietary guidelines and build upon their evidence and science base. New evidence was assessed to determine whether associations between food, dietary patterns and health outcomes had strengthened, weakened, or remained unchanged. Where the evidence base was unlikely to have changed substantially (e.g. the relationship between intake of foods high in saturated fat and increased risk of high serum cholesterol) additional review was not conducted.

p5 https://www.eatforhealth.gov.au/sites/default/files/files/the_guidelines/n55_australian_dietary_guidelines.pdf



A/Prof. Ken Sikaris - 'Blood Tests to assess your Cardiovascular Risk'

https://www.youtube.com/watch?v=9BFRi-nH1v8

94.

B. Low-fat *Australian Dietary Guidelines* based on shonky US demonisation of dietary fat, particularly saturated fat in meat and dairy

The New York Times http://nyti.ms/2cynH0S

WELL | EAT

How the Sugar Industry Shifted Blame to Fat

By ANAHAD O'CONNOR SEPT. 12, 2016

The sugar industry paid scientists in the 1960s to play down the link between sugar and heart disease and promote saturated fat as the culprit instead, newly released historical documents show.

The internal sugar industry documents, recently discovered by a researcher at the University of California, San Francisco, and published Monday in JAMA Internal Medicine, suggest that five decades of research into the role of nutrition and heart disease, including many of today's dietary recommendations, may have been largely shaped by the sugar industry.

"They were able to derail the discussion about sugar for decades," said Stanton Glantz, a professor of medicine at U.C.S.F. and an author of the JAMA Internal Medicine paper.

The documents show that a trade group called the Sugar Research Foundation, known today as the Sugar Association, paid three Harvard scientists the equivalent of about $50,000 in today's dollars to publish a 1967 review of research on sugar, fat and heart disease. The studies used in the review were handpicked by the sugar group, and the article, which was published in the prestigious New England Journal of Medicine, minimized the link between sugar and heart health and cast aspersions on the role of saturated fat.

The Harvard scientists and the sugar executives with whom they collaborated are no longer alive. One of the scientists who was paid by the sugar industry was D. Mark Hegsted, who went on to become the head of nutrition at the United States Department of Agriculture, where in 1977 he helped draft the forerunner to the federal government's dietary guidelines. Another was Dr. Fredrick J. Stare, the chairman of Harvard's nutrition department.

http://www.nytimes.com/2016/09/13/well/eat/how-the-sugar-industry-shifted-blame-to-fat.html

Dr Ancel Keys attacks Prof. Yudkin's sugar story in "Sucrose in the Diet and Coronary Heart Disease" (1971):
http://www.australianparadox.com/pdf/keys_1971.pdf

The revelations are important because the debate about the relative harms of sugar and saturated fat continues today, Dr. Glantz said. For many decades, health officials encouraged Americans to reduce their fat intake, which led many people to consume low-fat, high-sugar foods that some experts now blame for fueling the obesity crisis.

"It was a very smart thing the sugar industry did, because review papers, especially if you get them published in a very prominent journal, tend to shape the overall scientific discussion," he said.

Dr. Hegsted used his research to influence the government's dietary recommendations, which emphasized saturated fat as a driver of heart disease while largely characterizing sugar as empty calories linked to tooth decay. Today, the saturated fat warnings remain a cornerstone of the government's dietary

The documents show that in 1964, John Hickson, a top sugar industry executive, discussed a plan with others in the industry to shift public opinion "through our research and information and legislative programs."

At the time, studies had begun pointing to a relationship between high-sugar diets and the country's high rates of heart disease. At the same time, other scientists, including the prominent Minnesota physiologist Ancel Keys, were investigating a competing theory that it was saturated fat and dietary cholesterol that posed the biggest risk for heart disease.

Mr. Hickson proposed countering the alarming findings on sugar with industry-funded research. "Then we can publish the data and refute our detractors," he wrote.

In 1965, Mr. Hickson enlisted the Harvard researchers to write a review that would debunk the anti-sugar studies. He paid them a total of $6,500, the equivalent of $49,000 today. Mr. Hickson selected the papers for them to review and made it clear he wanted the result to favor sugar.

Harvard's Dr. Hegsted reassured the sugar executives. "We are well aware of your particular interest," he wrote, "and will cover this as well as we can."

As they worked on their review, the Harvard researchers shared and discussed early drafts with Mr. Hickson, who responded that he was pleased with what they were writing. The Harvard scientists had dismissed the data on sugar as weak and given far more credence to the data implicating saturated fat.

"Let me assure you this is quite what we had in mind, and we look forward to its appearance in print," Mr. Hickson wrote.

95.

http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

C. Low-fat *Australian Dietary Guidelines* based on shonky US demonisation of dietary fat, particularly saturated fat in meat and dairy

Dietary Fat and Its Relation to Heart Attacks and Strokes

REPORT BY THE CENTRAL COMMITTEE FOR MEDICAL AND COMMUNITY PROGRAM OF THE AMERICAN HEART ASSOCIATION*

Circulation, Volume XXIII, January 1961

Third, the blood cholesterol concentration may also be reduced by controlling the amount and type of fat in the diet without altering caloric intake. Not all fats in the diet have the same effect on the amount of cholesterol in the blood. In the usual diet eaten in the United States, a large part of the fat is of the saturated type (Appendix II). Too much of this type of fat tends to increase the cholesterol in the blood. Considerable amounts of saturated fat are present in whole milk, cream, butter, cheese and meat. Coconut oil and the fat in chocolate also have a high content of fats of the saturated type. Most shortenings and margarines have less than half as much saturated fat, and the common vegetable oils have still less. When the intake of saturated fats is reduced, blood cholesterol levels usually decrease.

In contrast to the above food fats, many natural vegetable oils, such as corn, cotton and soya, as well as the fat of fish, are relatively low in saturated fats and high in fats of the poly-unsaturated type (Appendix II). When these fats are substituted for a substantial part of the saturated fats without increasing calories, blood cholesterol decreases. Finally, some food fats, such as olive oil, are and/or who lead sedentary lives of relentless frustration should consider modifying their diets. A diet moderate in calories and fat (about 25-35 per cent of total calories from fat) may be helpful for these coronary-prone persons. Substitution of poly-unsaturated for a substantial part of the saturated fat in the diet may also be a valuable addition to this program.

C) Those people who have had one or more atherosclerotic heart attacks or strokes may reduce the possibility of recurrences by such a change in diet.

It should be borne in mind that moderate amounts of fat, particularly those containing an appreciable quantity of the poly-unsaturated type, are necessary for good health. Fat is an economical, and in limited amounts, a wholesome food. Food faddism of any sort should be avoided and significant changes in diet should not be undertaken without medical advice.

In Conclusion

The reduction or control of fat consumption under medical supervision, with reasonable substitution of poly-unsaturated for saturated

Circulation, Volume XXIII, January 1961

DIETARY FAT, HEART ATTACKS AND STROKES 135

fats, is recommended as a possible means of preventing atherosclerosis and decreasing the risk of heart attacks and strokes. This recommendation is based on the best scientific information available at the present time.

More complete information must be obtained before final conclusions can be reached. Such information can be obtained only through intensified research into the causes and prevention of atherosclerosis—a program to which the American Heart Association is fully dedicated.

Ad Hoc Committee on Dietary Fat and Atherosclerosis:

Irvine H. Page, M.D., *Chairman*, Cleveland, Ohio
Edgar V. Allen, M.D., Rochester, Minnesota
Francis L. Chamberlain, M.D., San Francisco, California
Ancel Keys, Ph.D., Minneapolis, Minnesota
Jeremiah Stamler, M.D., Chicago, Illinois
Fredrick J. Stare, M.D., Boston, Massachusetts

*The Ad Hoc Committee on Dietary Fat and Atherosclerosis reported to the Central Committee for Medical and Community Program of the Association.

http://circ.ahajournals.org/content/circulationaha/23/1/133.full.pdf?wptouch_preview_theme=enabled

ROSEMARY STANTON

EASY DIET COOKBOOK

THE Low-fat way

What makes people fat?

For many years, nutritionists have taught that too much of almost any kind of food could be converted to body fat. Recent research has shown this to be wrong: in almost all cases, the only thing that adds to body fat is the fat we eat.

It seems the body does not like turning protein into fat, and will only convert carbohydrates into body fat if you eat huge amounts. Carbohydrates are generally used to power the body. Any excess is stored as glycogen in the muscles, and can also increase the energy used for metabolism. It's not until you eat more than 500 grams of carbohydrate at one sitting—the amount in more than 30 slices of bread—that the body converts it to fat.

This means we should stop avoiding bread and blame the spread instead.

Alcohol, so often blamed for excess fat, is not directly converted to body fat. It's obvious, since alcoholics who take in many calories from alcohol but eat little food are almost always thin. Alcohol, however, does contribute indirectly to body fat by making it more difficult for the body to burn up the fats in food. Alcohol plus fat is therefore a bad combination for those who gain weight easily.

Sugar (a rapidly absorbed carbohydrate) when combined with fat may have a similar effect in preventing the body burning fat to provide energy. But in all cases, it's fatty foods that are the root cause of excess weight.

http://www.australianparadox.com/pdf/rosemarystanton.pdf

96.

Stewart Truswell imported shonky US guidelines, converted to ADGs, then controlled false saturated-fat and sugar stories for 40 years?

Dietary Guidelines for Australian Adults

Endorsed 10 April 2003

1.6 LIMIT SATURATED FAT AND MODERATE TOTAL FAT INTAKE

A Stewart Truswell

BACKGROUND

The first *Dietary Guidelines for Australians*[2], published in 1982, recommended, 'Avoid eating too much fat'—that is, total fat. The type of fat was not considered, unlike the 1977 *Dietary Goals for the United States*[3], which recommended 10 per cent of total energy from saturated fats, 10 per cent from mono-unsaturated fats, and 10 per cent from polyunsaturated fats.

In the second edition of *Dietary Guidelines for Australians*[4], published in 1992, the guideline had evolved to 'Eat a diet low in fat and, in particular, low in saturated fat'. The more recent *Dietary Guidelines for Older Australians*[5],

REFERENCES

1. Truswell AS. *Dietary fat: some aspects of nutrition and health and product development*. Brussels: ILSI Europe, 1995.
2. Department of Health. *Dietary guidelines for Australians*. Canberra: Australian Government Publishing Service, 1982.

124 *Dietary Guidelines for Australian Adults*

1.6 LIMIT SATURATED FAT AND MODERATE TOTAL FAT INTAKE

33. Hegsted DM, McGandy RB, Myers ML, Stare FH. Quantitative effects of dietary fat on serum cholesterol in man. *Am J Clin Nutr* 1965;17:281–95.

54. Shrapnel WS, Truswell AS, Nestel PJ, Simons LA. Dietary fatty acids and blood cholesterol. Canberra: National Heart Foundation of Australia, 1994.

[AS Truswell memo item: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3684314/]

Fat is energy dense and as such a high-fat diet can result in a high-energy diet, which may lead to obesity if physical activity is not maintained.

CONCLUSIONS

Total fat is providing about one-third of dietary energy in Australia. Consumption appears to have declined a little but is still relatively high from a world perspective. For anyone who is overweight, a reduction in total fat intake to 20–25 per cent of energy should be part of dietary management, as a contribution to

…Saturated fatty acids raise plasma LDL cholesterol, a major risk factor for coronary heart disease. … Saturated plus trans-fatty acid intakes averaged over 12.5 per cent of energy in Australia in 1995. A population average of 10 per cent of energy is recommended as a realistic target. (pp. 123-124)

https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/n33.pdf

In 1992 ADGs, Stewart Truswell also controlled the sugar recommendation

Coronary heart disease

Sucrose was first implicated as a risk factor for CHD by Yudkin[32] and although the hypothesis gained some popular credibility it was quickly refuted.[33,34,35] Willet, in reviewing the evidence, keeps an open mind and notes 'that the hypothesis has not been securely confirmed or refuted'.[34] Truswell, however, reviewed ten case-control studies of sucrose and CHD and found that none supported the hypothesis.[34] One cause of the confusion has been that sugar is often correlated with fat consumption and therefore becomes a confounding factor in population based studies. As Truswell notes, the international scientific community thinks so little of this hypothesis that 'no prevention trial of CHD with sugar has been completed, started, planned or even contemplated'.[34]

34 Truswell AS. Sugar and health: a review. Food Technol Aust 1987;39:134–40.

35 Yudkin J. Dietary fat and dietary sugar in relation to ischaemic heart disease and diabetes. Lancet 1964;2:4–5.

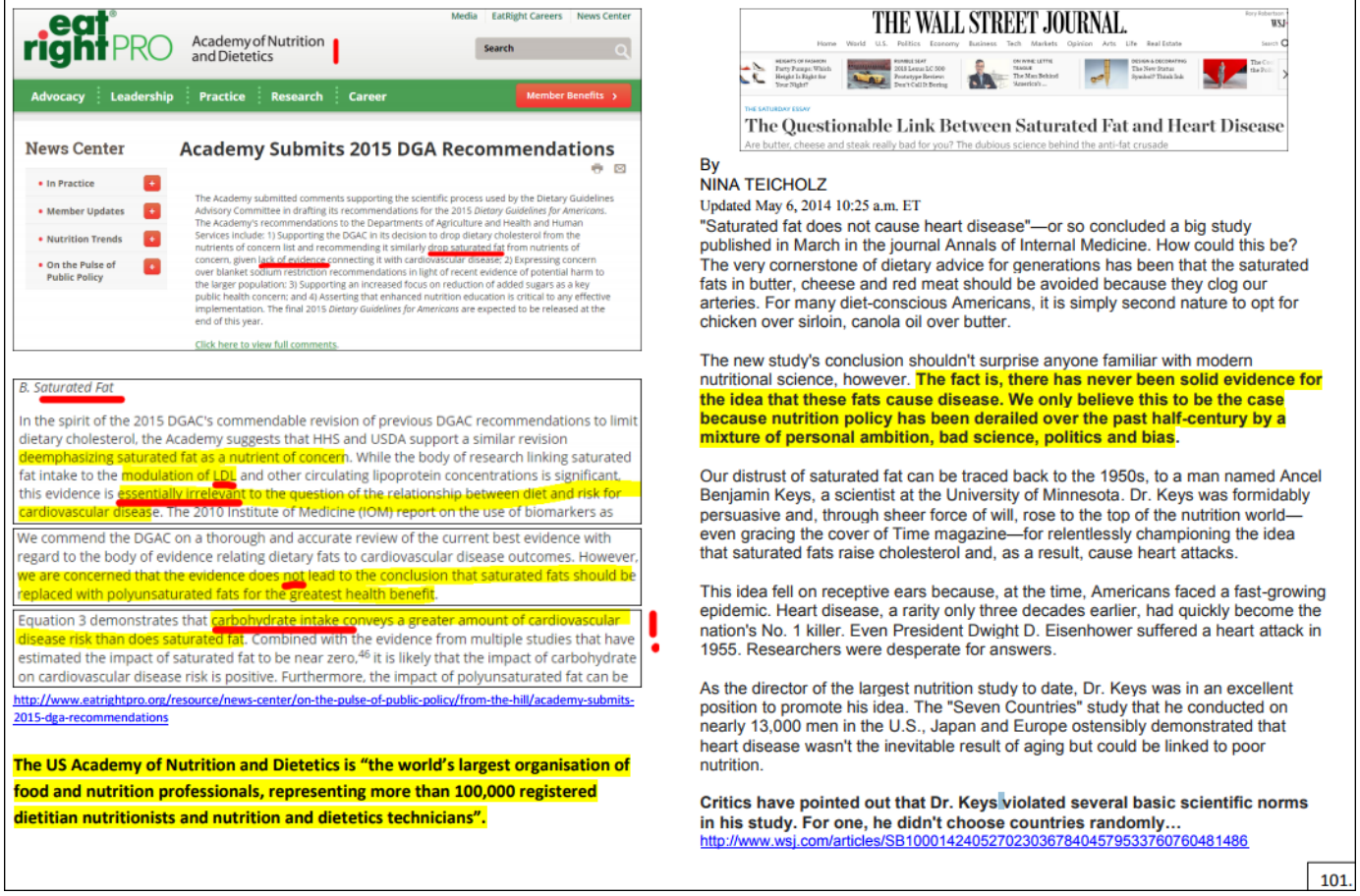
In addition the revision of the dietary guidelines has changed their order, to better reflect the relative importance of the recommendations being made by dietary guidelines to the Australian diet. The guideline on sugars has been moved down from the previous fourth position, to the new sixth position.

https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/n4.pdf

97.

http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

Entity representing 100,000 US dietitians concedes huge errors; meanwhile, NHMRC, DAA and Diabetes Australia pretend all is fine



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Academy Submits 2015 DGA Recommendations

The Academy submitted comments supporting the scientific process used by the Dietary Guidelines Advisory Committee in drafting its recommendations for the 2015 *Dietary Guidelines for Americans*. The Academy's recommendations to the Departments of Agriculture and Health and Human Services include: 1) Supporting the DGAC in its decision to drop dietary cholesterol from the nutrients of concern list and recommending it similarly drop saturated fat from nutrients of concern, given lack of evidence connecting it with cardiovascular disease; 2) Expressing concern over blanket sodium restriction recommendations in light of recent evidence of potential harm to the larger population; 3) Supporting an increased focus on reduction of added sugars as a key public health concern; and 4) Asserting that enhanced nutrition education is critical to any effective implementation. The final 2015 *Dietary Guidelines for Americans* are expected to be released at the end of this year.

Click here to view full comments

B. Saturated Fat

In the spirit of the 2015 DGAC's commendable revision of previous DGAC recommendations to limit dietary cholesterol, the Academy suggests that HHS and USDA support a similar revision deemphasizing saturated fat as a nutrient of concern. While the body of research linking saturated fat intake to the modulation of LDL and other circulating lipoprotein concentrations is significant, this evidence is essentially irrelevant to the question of the relationship between diet and risk for cardiovascular disease. The 2010 Institute of Medicine (IOM) report on the use of biomarkers as

We commend the DGAC on a thorough and accurate review of the current best evidence with regard to the body of evidence relating dietary fats to cardiovascular disease outcomes. However, we are concerned that the evidence does not lead to the conclusion that saturated fats should be replaced with polyunsaturated fats for the greatest health benefit.

Equation 3 demonstrates that carbohydrate intake conveys a greater amount of cardiovascular disease risk than does saturated fat. Combined with the evidence from multiple studies that have estimated the impact of saturated fat to be near zero,[46] it is likely that the impact of carbohydrate on cardiovascular disease risk is positive. Furthermore, the impact of polyunsaturated fat can be

http://www.eatrightpro.org/resource/news-center/on-the-pulse-of-public-policy/from-the-hill/academy-submits-2015-dga-recommendations

The US Academy of Nutrition and Dietetics is "the world's largest organisation of food and nutrition professionals, representing more than 100,000 registered dietitian nutritionists and nutrition and dietetics technicians".

THE WALL STREET JOURNAL.

THE SATURDAY ESSAY

The Questionable Link Between Saturated Fat and Heart Disease

Are butter, cheese and steak really bad for you? The dubious science behind the anti-fat crusade

By
NINA TEICHOLZ
Updated May 6, 2014 10:25 a.m. ET

"Saturated fat does not cause heart disease"—or so concluded a big study published in March in the journal Annals of Internal Medicine. How could this be? The very cornerstone of dietary advice for generations has been that the saturated fats in butter, cheese and red meat should be avoided because they clog our arteries. For many diet-conscious Americans, it is simply second nature to opt for chicken over sirloin, canola oil over butter.

The new study's conclusion shouldn't surprise anyone familiar with modern nutritional science, however. **The fact is, there has never been solid evidence for the idea that these fats cause disease. We only believe this to be the case because nutrition policy has been derailed over the past half-century by a mixture of personal ambition, bad science, politics and bias.**

Our distrust of saturated fat can be traced back to the 1950s, to a man named Ancel Benjamin Keys, a scientist at the University of Minnesota. Dr. Keys was formidably persuasive and, through sheer force of will, rose to the top of the nutrition world—even gracing the cover of Time magazine—for relentlessly championing the idea that saturated fats raise cholesterol and, as a result, cause heart attacks.

This idea fell on receptive ears because, at the time, Americans faced a fast-growing epidemic. Heart disease, a rarity only three decades earlier, had quickly become the nation's No. 1 killer. Even President Dwight D. Eisenhower suffered a heart attack in 1955. Researchers were desperate for answers.

As the director of the largest nutrition study to date, Dr. Keys was in an excellent position to promote his idea. The "Seven Countries" study that he conducted on nearly 13,000 men in the U.S., Japan and Europe ostensibly demonstrated that heart disease wasn't the inevitable result of aging but could be linked to poor nutrition.

Critics have pointed out that Dr. Keys violated several basic scientific norms in his study. For one, he didn't choose countries randomly…
http://www.wsj.com/articles/SB10001424052702303678404579533760760481486

101.

http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

Bottom line: In the 1950s and 1960s, healthy-diet advice took a painful wrong turn, as harmful US low-fat, high-carbohydrate advice began to colonise the world. It has been a long, painful road back, but the signs are clear that Sir (Professor) William Osler, MD and Professor Thomas McCrae, MD were indeed correct - way back in 1923 - to highlight the problems caused by excess carbohydrate including refined sugar (not saturated fat in meat and dairy), as they did with such impressive clarity in what was the most-authoritative and widely distributed medical text of their time: ***The Principles and Practice of Medicine***, 9th Edition:
https://www.australianparadox.com/pdf/1923-Medicine-Textbook.pdf

rgds,
rory
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rory robertson
economist and former-fattie
https://twitter.com/OzParadoxdotcom

Here's me, Emma Alberici and ABC TV's *Lateline* on the University of Sydney's *Australian Paradox*: http://www.abc.net.au/lateline/content/2015/s4442720.htm

Here's my *Five-year Update* on that scientific fraud, including Vice-Chancellor Spence's threat to ban me from campus: (p. 64) http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf
Want to stop trends in your family and friends towards obesity, type 2 diabetes, heart disease and various cancers? Stop eating and drinking sugar:
http://www.youtube.com/watch?v=xDaYa0AB8TQ&feature=youtu.be

Here's the diet advised by Dr Peter Brukner, recently the Australian cricket team's doctor:
http://www.peterbrukner.com/wp-content/uploads/2014/08/All-you-need-to-know-about-LCHF1.pdf ;
http://www.abc.net.au/catalyst/lowcarb/

Evidence from 26 doctors on why low-carbohydrate, high-fat (LCHF) diets MUST become standard treatment for obesity and type 2 diabetes (aka metabolic syndrome):
http://www.sciencedirect.com/science/article/pii/S0899900714003323 ;
http://diabetes.jmir.org/article/viewFile/diabetes_v2i1e5/2

A life in our times: Vale Alexander "Sandy" Robertson (1933-2015):
http://www.australianparadox.com/pdf/AlecRobertson-born2oct33.pdf

Comments, criticisms, questions, compliments, whatever welcome at strathburnstation@gmail.com