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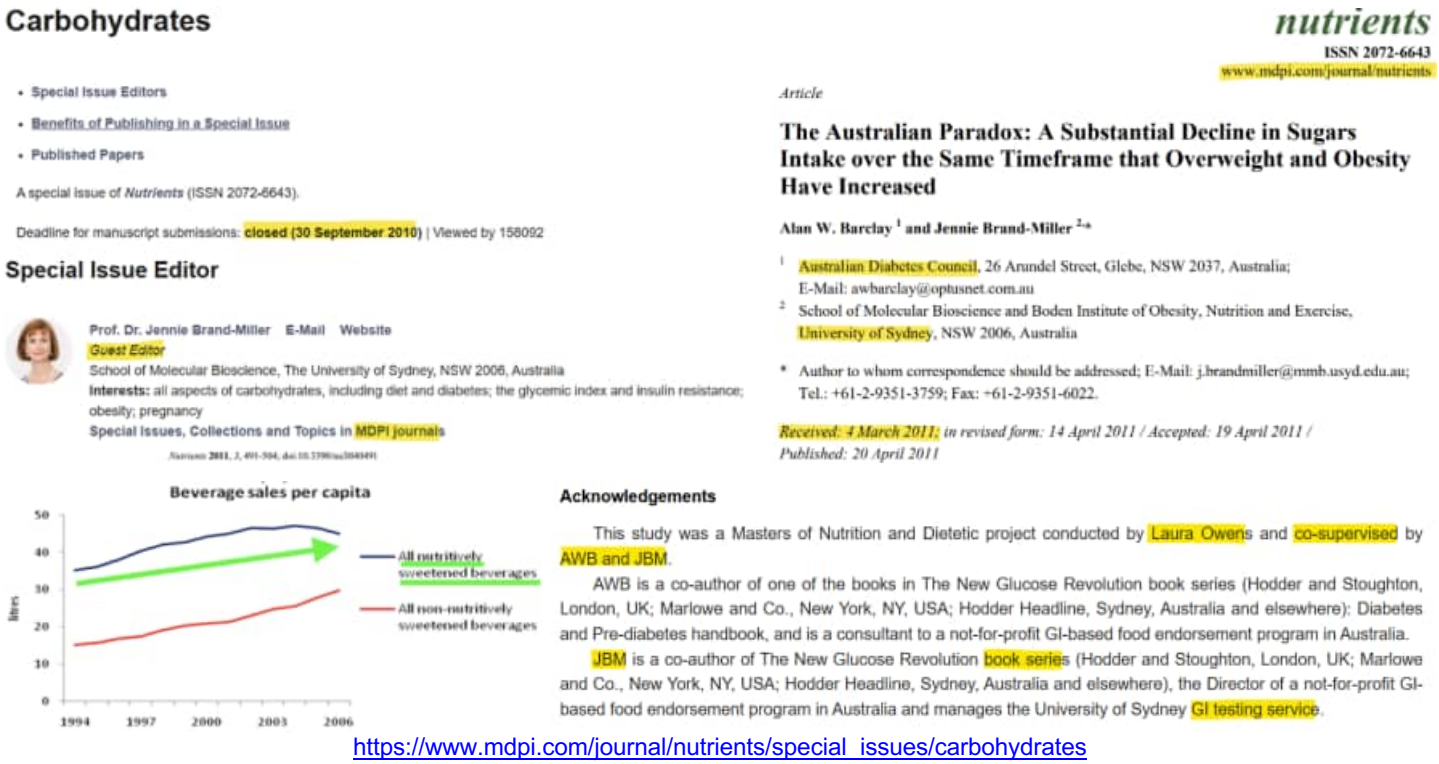
Request to publisher MDPI's officials for formal retraction of extraordinary faulty *Australian Paradox* sugar-and obesity paper

Dear Dr. Shu-Kun Lin, Chairman of MDPI's Board, Prof. Dr. Maria Luz Fernandez and Prof. Dr. Lluis Serra-Majem (joint) Editors-in-Chief of MDPI's *Nutrients* journal, other MDPI officials and editors, and a range of independent observers including journalists,

Hello. My name is Rory Robertson. I'm an economist, writing to request that you please formally retract **MDPI's extraordinarily faulty "*Australian Paradox*" paper** (Ref. 1). As you know, the ability of science to properly progress requires that studies with demonstrably false "findings" be retracted from the scientific record. This is common: *Retraction Watch*'s database has over 59,000 retraction entries (Ref. 2). In this case, the paper's **false exoneration** of modern sugar consumption as a key driver of Australia's obesity and diabetes (T2D) epidemics is secretly linked to Novo Nordisk's efforts to sell T2D (and now obesity) drugs (see pp. 5-7 below). Your faulty paper - published without real MDPI quality control yet cited over 120 times in the literature - is a menace to public health. Please fix this mess.



Carbohydrates

- Special Issue Editors
- Benefits of Publishing in a Special Issue
- Published Papers

A special issue of *Nutrients* (ISSN 2072-6643).

Deadline for manuscript submissions: closed (30 September 2010) | Viewed by 158092

Special Issue Editor

Prof. Dr. Jennie Brand-Miller E-Mail Website
Guest Editor
School of Molecular Bioscience, The University of Sydney, NSW 2006, Australia
Interests: all aspects of carbohydrates, including diet and diabetes; the glycemic index and insulin resistance; obesity; pregnancy
Special Issues, Collections and Topics in MDPI journals

Beverage sales per capita

nutrients
ISSN 2072-6643
www.mdpi.com/journal/nutrients

Article

The Australian Paradox: A Substantial Decline in Sugars Intake over the Same Timeframe that Overweight and Obesity Have Increased

Alan W. Barclay [1] and Jennie Brand-Miller [2,*]

[1] Australian Diabetes Council, 26 Arundel Street, Glebe, NSW 2037, Australia; E-Mail: awbarclay@optusnet.com.au
[2] School of Molecular Bioscience and Boden Institute of Obesity, Nutrition and Exercise, University of Sydney, NSW 2006, Australia

* Author to whom correspondence should be addressed; E-Mail: j.brandmiller@mmb.usyd.edu.au; Tel.: +61-2-9351-3759; Fax: +61-2-9351-6022.

Received: 4 March 2011; in revised form: 14 April 2011 / Accepted: 19 April 2011 / Published: 20 April 2011

Acknowledgements

This study was a Masters of Nutrition and Dietetic project conducted by Laura Owens and co-supervised by AWB and JBM.

AWB is a co-author of one of the books in The New Glucose Revolution book series (Hodder and Stoughton, London, UK; Marlowe and Co., New York, NY, USA; Hodder Headline, Sydney, Australia and elsewhere): Diabetes and Pre-diabetes handbook, and is a consultant to a not-for-profit GI-based food endorsement program in Australia.

JBM is a co-author of The New Glucose Revolution book series (Hodder and Stoughton, London, UK; Marlowe and Co., New York, NY, USA; Hodder Headline, Sydney, Australia and elsewhere), the Director of a not-for-profit GI-based food endorsement program in Australia and manages the University of Sydney GI testing service.

https://www.mdpi.com/journal/nutrients/special_issues/carbohydrates

(a) Solving MDPI's *Australian Paradox* - Simply a matter of recognising misrepresented and faked sugar data over 1980-2010

The University of Sydney's Jennie Brand-Miller (**JBM**) and Alan Barclay (**AWB**) in 2011 self-published "***The Australian Paradox: A Substantial Decline in Sugars Intake over the Same Timeframe that Overweight and Obesity Have Increased***". Their "findings" are presented below. Alas, the latter three are nonsense, contradicted by sugary uptrends in four of the authors' own charts overleaf.

- "*The prevalence of obesity has **increased 3 fold** [from ~10% to ~30%] in Australians **since 1980**.*"
- *"This analysis of apparent consumption, national dietary surveys and food industry data indicates **a consistent and substantial decline** **in total refined or added sugar consumption** **by Australians over the past 30 years**."*
- *"The present analysis indicates the existence of an **Australian Paradox**, i.e., an **inverse relationship** between secular trends in the prevalence of obesity prevalence (**increasing by ~300%**) and the consumption of refined sugar over the same time frame (**declining by ~20%**)."* [RR: As you know, a 3-fold increase = 200% increase; "prevalence of obesity prevalence". Huh?]
- *"The findings challenge the implicit assumption that taxes and other measures to reduce intake of soft drinks will be an effective strategy in global efforts to reduce obesity."* (Ref. 1)

In this piece, I highlight **eight** serious problems that together justify retraction. In summary, a superstar **University of Sydney** scientist in the diet/obesity/diabetes space - acting as a **"Guest Editor" for MDPI** (see #4 on p. 5) – in 2011 rushed to publish her **student's project**, without any genuine MDPI quality control (#6 on p. 7). Alas, uptrends in valid sugar indicators presented in four of JBM and AWB's own charts clearly falsify the paper's main conclusions (#1, overleaf). Further, lead author JBM – who dishonestly hid from MDPI officials her substantial household income via Novo Nordisk diabetes-drug sales (#5 on pp. 5-7) – recklessly relies on a sugar series that was discontinued as unreliable after 60 years and then faked as a dead-ending flat line (#2 and #3 on p. 3). Initially oblivious to these data problems – not having carefully assessed their student's work before publishing it – the authors now dishonestly pretend their "Australian Paradox" finding is robust, untouched by my critique. Indeed, MDPI's Guest Editor JBM and **MDPI *Nutrients*' (then) Editor-In-Chief - JBM's long-time colleague Peter Howe** - published three further pieces – an ***Editorial*** and a faulty, misguided ***Correspondence*** piece (#7), and later a **sham *Correction*** (#8) in their attempt to dupe the scientific community. For example, JBM's false claim of a 10% drop in sales of sugary drinks - via an irrelevant 10pp drop in *market share* - morphed into JBM's new false claim that the conceded ~30% increase in sugary drink sales (chart above) has "no material impact on the conclusions of our paper" (p. 9).

In requesting the paper's formal retraction now – a decade after my first attempt – I am hoping that publisher MDPI's Board of Directors and its fresh slate of highly ethical Editors at *Nutrients* are less inclined today to treat *Nutrients*' readers, the scientific community more generally and the need for reliable diet-and-health facts with utter contempt. **MDPI** says it takes publishing ethics "very seriously" and its editors approach the use of misrepresented and faked data - and sham COIs - with **"zero tolerance"** (see #5 on p.5). We shall see.

(b) Eight serious problems that make the formal retraction of MDPI's *Australian Paradox* paper the only reasonable response

One. MDPI's faulty paper presents no credible evidence for a ***consistent and substantial decline*** in Australians' per capita refined-sugar intake over the ***1980 to 2010 timeframe***. Indeed, JBM's various chosen sugar indicators presented - as evidence - in her charts below mostly ***trend up not down***, thereby directly contradicting the paper's pro-Novo findings and falsifying JBM's silly *Paradox* story.

4. Discussion

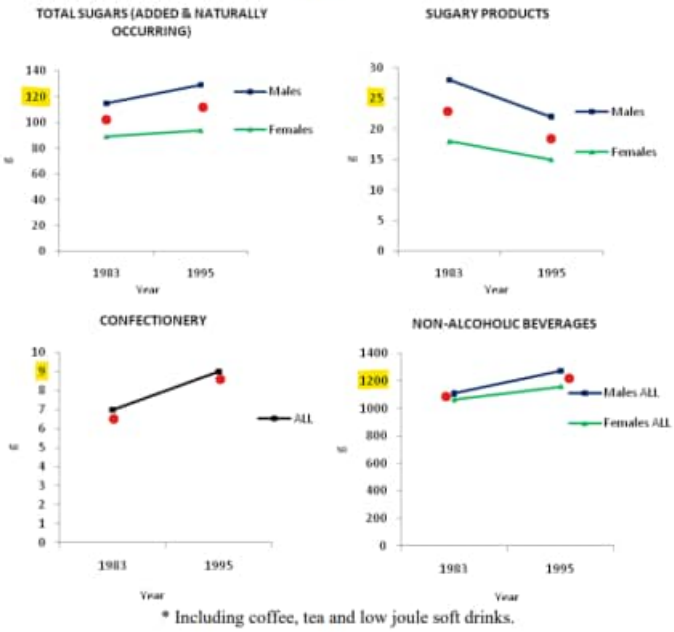
This analysis of apparent consumption, national dietary surveys and food industry data indicates a consistent and substantial decline in total refined or added sugar consumption by Australians over the past 30 years. In this respect, Australia may be unique, although FAO statistics suggest a modest

5. Conclusions

The present analysis indicates the existence of an Australian Paradox, *i.e.*, an inverse relationship between secular trends in the prevalence of obesity prevalence (increasing by ~300%) and the consumption of refined sugar over the same time frame (declining by ~20%). The findings challenge the implicit assumption that taxes and other measures to reduce intake of soft drinks will be an effective strategy in global efforts to reduce obesity.

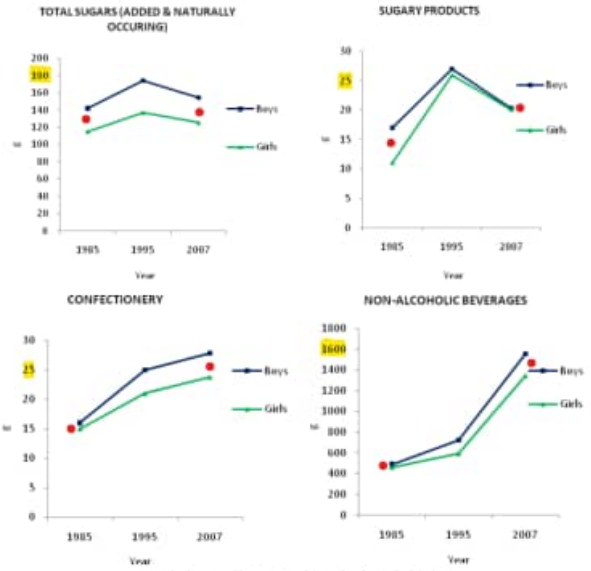
Jennie Brand-Miller's evidence of "consistent and substantial decline" in sugar intake over chosen 1980-2010 timeframe

Figure 3. 24 h mean intake (g) of total sugars, sugary products, confectionery and non-alcoholic beverages * by Australian adults (25–64 years) in 1983 and 1995 [19].



* Including coffee, tea and low joule soft drinks.

Figure 4. 24 h mean intake (g) of total sugars, sugary products, confectionery and non-alcoholic beverages * by Australian children in 1985, 1995 and 2007 [5,19]. Note: the age categories used for comparison where 10–15 year old children in years 1985 and 1995, the 2007 figure is an average between intakes of 9–13 year and 14–16 year categories.



* Including coffee, tea and low joule soft drinks.

Australian Paradox https://www.mdpi.com/2072-6643/3/4/491

Figure 1. Changes in availability of refined sugar from sugar cane (production minus exports) in Australia per capita from 1969–1970 to 2009–2010. Data were derived from statistics published by the Australian Bureau of Agricultural and Resource Economics and Sciences, ABARE [10]. Sugar availability does not account for food wastage, use in animal food, beer and alcohol fermentation, or in non-food industrial use. From 1998–1999 the Australian Bureau of Statistics no longer derived apparent consumption statistics for any foodstuff, including sugar.

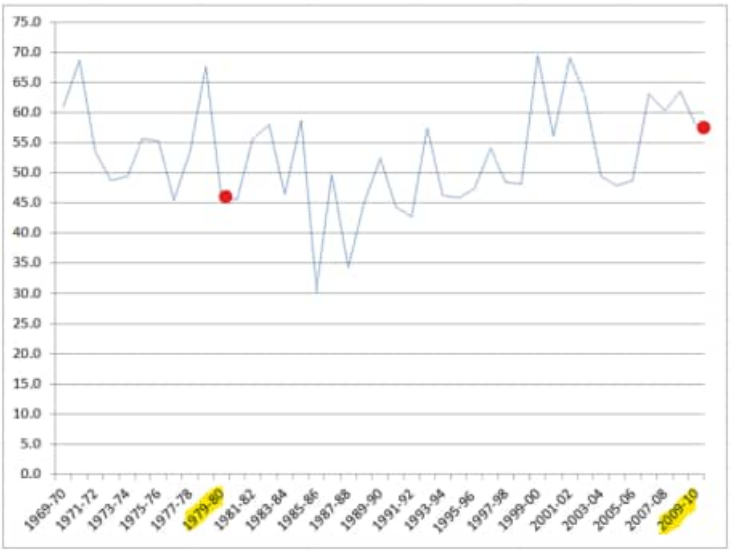
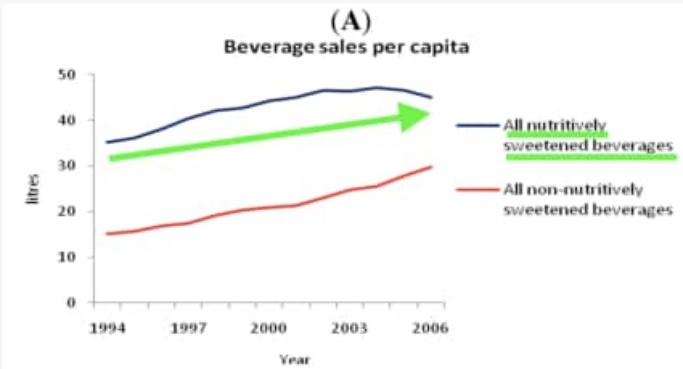
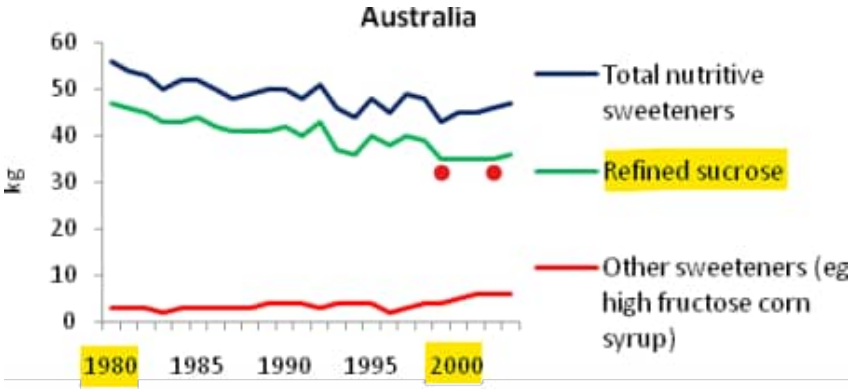


Figure 5. Time trends in sales of nutritively sweetened beverages and non-nutritively sweetened beverages in grocery stores, expressed as (**A**) per capita volume sold in liters and as (**B**) a percentage of total volume sold [15,28,29,30].



Australian Paradox, and then *Australian Paradox* ***Revisited*** https://www.australianparadox.com/pdf/nutrients-03-00491-s003.pdf

Two. Given clear uptrends in the various sugar indicators shown in MDPI's four *Paradox* charts reproduced above on p. 2, the faulty paper's "finding" of a **"~20%"** decline in refined sugar intake over the 1980-2010 timeframe is based *solely* on an **Australian Bureau of Statistics (ABS) apparent consumption of sugar series** (chart below) that was discontinued as unreliable after 1998-99. This is embarrassing for MDPI: the published ABS series does not exist for *more than one-third* of the paper's 1980-2010 timeframe, and even *before* 1998-99 the series was increasingly unreliable. That is, each passing year it became harder and harder for the ABS to measure apparent consumption; increasingly, the ABS struggled to reliably count the rapid growth of added sugar embedded in the many and growing millions of *imported* processed food and drink products. After 1999, the ABS abandoned its increasingly unreliable counting methodology, and stopped even pretending to count. Alas, JBM initially was oblivious to the fact that her preferred ABS sugar series had been discontinued as unreliable by the ABS after 1999, and then ***simply faked as a flat line*** by the UN's Food and Agricultural Organization (FAO). I expressed concerns publicly on this matter in the *Sydney Morning Herald* (Refs 3) only after having: (i) confirmed directly with the ABS that its series – spanning six decades from 1938-39 – had been discontinued as unreliable; and (ii) confirmed directly with the FAO that its truncated series from 1999 to 2003 – the short, flat, dead-ending line segment in the chart below – reflects the FAO simply faking a no-longer-counted sugar series (again, all genuine measuring stopped after the ABS abandoned the field), in order to avoid writing "n.a." (data not available) in its spreadsheet. **The FAO's 2012 email to me** (below) makes clear there are no valid data - no genuine counting, no scientifically meaningful data - available after 1999. Clearly, MDPI's reckless promotion of faked sugar data should be acknowledged and discontinued, via the formal retraction of the hopelessly faulty *Australian Paradox* paper.



LETTER 4

From: **MorenoGarcia, Gladys (ESS)** <Gladys.MorenoGarcia@fao.org>
Date: Mon, Feb 13, 2012 at 9:43 PM
Subject: FW: quick question on basic australian sugar data
To: "strathburnstation@gmail.com" <strathburnstation@gmail.com>
Cc: "Rummukainen, Kari (ESS)" <Kari.Rummukainen@fao.org>

Dear Rory

The "apparent consumption" or better 'food availability' can be found under Faostat Food Supply or Food Balance Sheet domains up to year 2007.
Food supply
http://faostat.fao.org/site/345/default.aspx
Food balance sheet
http://faostat.fao.org/site/354/default.aspx

In the case of Australia I have looked at the time series and there is some food of Sugar & syrups nes and Sugar confectionary the biggest amounts are under Refined Sugar where data is with symbol * but it is calculated with following note:
'calc.on 37 kg.per cap. as per last available off. year level (1999)'
The figure for 1999 and for earlier years come from; ABS - APP. CONS. OF FOODSTUFFS.

Regards

Gladys C. Moreno G.
Statistician
C-428
Statistics Division
Food and Agriculture Organization of the United Nations
? E-mail: Gladys.MorenoGarcia@fao.org
É Phone: 00 39 06 57052548
Fax: 00 39 06 57055615
http://www.fao.org/economic/statistics

Three. Importantly, my scathing assessment of the MDPI paper's fundamental - indeed, catastrophic - problems observed in #1 and #2 above was confirmed independently in two high-profile investigations **by journalists from the Australian Broadcasting Corporation** (ABC; Refs 4). For those interested, please listen to the ABC Radio's *Background Briefing* and/or watch ABC TV's *Lateline* piece:

- **ABC Radio's *Background Briefing*: "Is sugar innocent?"** https://www.abc.net.au/listen/programs/backgroundbriefing/5239418
- **ABC TV's *Lateline*: "Australian Paradox under fire: Health experts hit out at Sydney Uni sugar study"** (video embedded halfway down page) https://www.abc.net.au/news/2016-04-13/the-australian-paradox:-experts-hit-out-at-sydney-uni-study/7319518

ABC journalists Wendy Carlistle and Emma Alberici absolutely skewer JBM's and thus MDPI's credibility. The word "clownish" comes to mind: when interviewed on simple *Australian Paradox* matters of fact, MDPI's Guest Editor JBM comes across as having never previously read the text of her (infamous) sugar-and-obesity paper. (The sections involving her sugary drinks analysis are classic.)

Amusingly, JBM wrote a long letter to ABC management complaining about *Lateline*. The ABC responded with a formal investigation that went point-by-point through her complaint, in the process carefully confirming its journalists' shredding of JBM's credibility. JBM then tried to suppress the ABC's **Audience and Consumer Affairs *Investigation Report*** (Ref. 4), all of which is available below.

ABC AUDIENCE AND CONSUMER AFFAIRS
INVESTIGATION REPORT

Lateline* story *Analysing The Australian Paradox: experts speak out about the role of sugar in our diets* and the ABC News online report *Australian Paradox under fire: Health experts hit out at Sydney Uni sugar study.

13 April 2016

Complaint

Lateline breached the ABC's editorial standards for impartiality with its exclusive, critical focus on the Australian Paradox 2011 paper and failing to recognise updated and new data that supports the authors conclusions in that study. *Lateline* unduly favoured the perspective of that study's most prominent critic and adopted and promoted his critical assessment of the study. *Lateline* unduly favoured the perspectives of critics of the Australian Paradox, by presenting the strong criticism of data analytics expert Rory Robertson and a range of nutrition experts who all denounced its conclusions, and failed to present any dissenting view in support of the study.

ooooo

2.1.1 FAOStat Data

Audience and Consumer Affairs understand that to a significant extent, the Australian Paradox 2011 rests on the use of United Nations Food and Agriculture Organisation (FAO) statistics which showed a fall in apparent sugar consumption in Australia. We also understand the FAO's annual data on Australian apparent consumption of sugar relied to a significant extent on data from an Australian Bureau of Statistics survey that had been discontinued in 1999, because the ABS had concluded that its historical methodology for counting added sugar was no longer reliable, given the fact that more and more sugars are now hidden in processed foods and it is therefore much more difficult to accurately measure personal consumption of sugar in Australia.

We have confirmed that in telephone calls with both the ABS head of health research and her deputy, *Lateline* established that the series was discontinued because the methodology was no longer considered reliable as an indicator of actual added sugar consumed. The ABS did not have the resources to establish a new methodology that could properly and reliably analyse consumption. This conclusion also brought into question the reliability of the data series the ABS had been producing over time, which the FAO relied upon for its conclusions on Australian sugar consumption.

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2.1.1.1 RR statements

We are satisfied that Rory Robertson represented a principal relevant perspective on the issues examined in the broadcast. We note that he is a senior economist with one of the country's leading banks who is a highly credible and respected data analytics expert. It is our view that his extensive research on this issue and critical assessment of the Australian Paradox, particularly the data relied upon by its authors, is based on and substantiated by demonstrable evidence and is compelling.

Audience and Consumer Affairs has confirmed that *Lateline* met the editorial requirement for accuracy by making reasonable efforts to examine and critically assess the research that underpinned Mr Robertson's claims, prior to broadcasting them. That research included his email correspondence with the FAO, where he sought to specifically verify the sources of information upon which the FAO relied for its sugar series for Australia.

Mr Robertson established that the FAO's sugar series for Australia relied to a significant degree on ABS data for several decades until 1998-99, when the ABS discontinued its data collection on the grounds that it was unreliable. The responsible FAO researcher confirmed in writing to Mr Robertson that the FAO had used the last available figure of 35.7kg from its 1998-99 sugar series for Australia and continued to use it for subsequent years. That is, when the ABS stopped counting sugar after 1998-99, the FAO chose to continue publishing data, reproducing its 1999 figure again for 2000, and then continued publishing new data showing a figure of approximately 36kg per year. Audience and Consumer Affairs note that this absence of relevant, reliable data post 1999 appears to be confirmed in Figure 2 (A) of the Australian Paradox, in the form of the conspicuously flat line leading to 2003, where the series ends, despite the study spanning to 2010.

https://www.australianparadox.com/pdf/ABC-A-CA.pdf

Four. Clearly, there was no usual, effective MDPI quality control before publication. Highly influential JBM self-published *The Australian Paradox* paper and its pro-Novo false "findings" (#5 below) while operating as **MDPI's "Guest Editor"** of a "**Special Issue**" of *Nutrients* (Ref. 1). Five months after missing *her* formal Deadline for submission, **JBM submitted her student's paper** (#6) ***to herself*** and then published it as "a rush job" without any *effective* MDPI quality control: "Deadline for manuscript submissions: **closed (30 September 2010)**"; **"Submission received: 4 March 2011** / Revised: 14 April 2011 / Accepted: 19 April 2011 / Published: 20 April 2011". After all, wouldn't any proper MDPI review have vetoed publication, given that the many uptrends in the valid sugar indicators in JBM's various *Paradox* charts clearly falsify her pro-Novo *Australian Paradox* finding? What about MDPI Guest Editor JBM's reliance on the ABS series discontinued as unreliable and then faked as a flat line? Even the simple error on p. 1, earlier - transforming a **"3 fold" increase** (from ~10% to ~30%) into a **"~300%" increase** – effectively confirms that no-one competent double-checked MDPI's paper before publication. The same is true of other basic mistakes belatedly "corrected" in MDPI's sham *Correction* (#8 on p. 9, below).

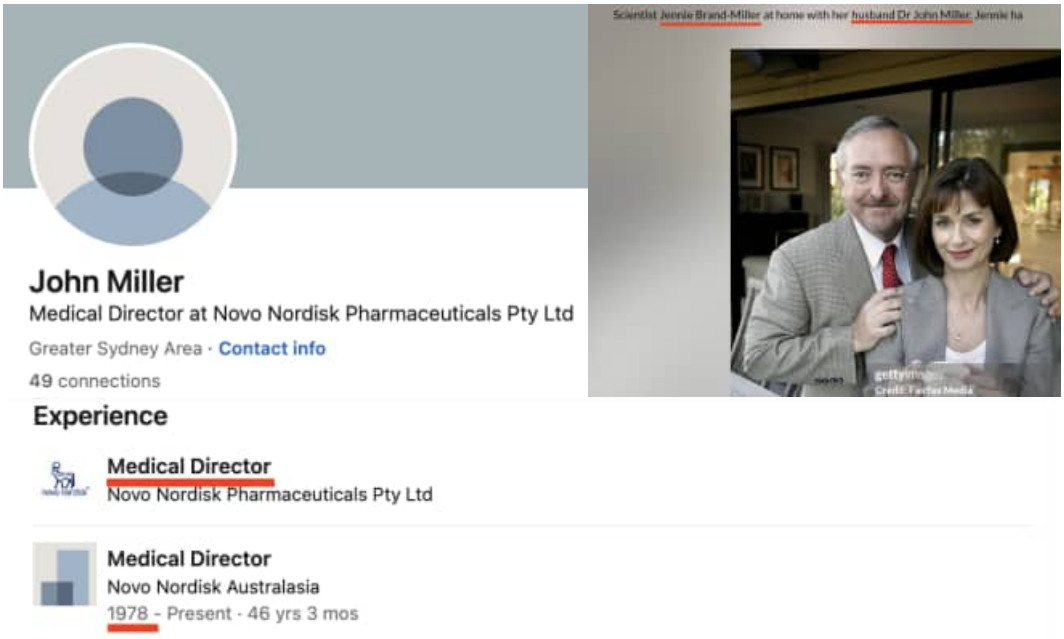
Again, given the many uptrends in the various valid if imperfect indicators of sugar consumption illustrated in the four *Paradox* charts on p. 2 - Novo-secret-agent JBM's blatantly false *Australian Paradox* exoneration of modern sugar consumption as a key driver of our modern obesity/T2D epidemics should be formally retracted. Unreasonably, the much-cited paper remains a menace to public health.

Five. Most stunning of all in this amazing *Australian Paradox* episode was my 2023 discovery that the hopelessly faulty paper includes a **sham conflict-of-interest (COI) statement** by University of Sydney superstar Jennie Brand-Miller (Refs 5). JBM's deliberately false and misleading COI "disclosure" hid from readers the profoundly important matter of fact that in 2011 she was enjoying substantial household income via her lifetime scientific and financial partnership with husband Dr John J. Miller, then and for decades previously the Medical Director of Novo Nordisk Australasia (see below and pp. 6-7 overleaf). Instead of properly informing readers of her profound Novo COI, JBM used her sham COI "disclosure" to advertise her *Novo-friendly Low GI Diet book range*, in which she falsely claims "There is absolute consensus that sugar in food does not cause [type 2] diabetes" (see pp. 12-30 in the Appendix, attached). JBM's dishonest hiding of her Novo-diabetes-drug-driven household income from *Nutrients*' readers – in the process deliberately duping her publisher MDPI's unsuspecting management - is utterly unacceptable, if MDPI's scientific journals are ever to be trusted.

MDPI Board members, editors and officials, MDPI claims to have "zero tolerance" for scientific misconduct. But does it really, when it matters? MDPI: "***Conflicts of Interest*: *Authors must identify and declare any personal circumstances or interest that may be perceived as influencing the representation or interpretation of reported research results***" (Ref. 6); "***MDPI takes such publishing ethics issues* [including misrepresented data, falsified data, and sham COI disclosures (see overleaf)?] - *very seriously and our editors approach these cases with zero tolerance***" (Ref. 7).

"Taking the sweet with the sour"
***SYDNEY MORNING HERALD,* 19 April 2003**
*…It not only led [JBM] to a paper in a prestigious medical journal - a fillip for a young PhD student - it threw her together with her **future husband and collaborator, John Miller, a scientist and businessman…***
https://www.smh.com.au/world/taking-the-sweet-with-the-sour-20030419-gdgmis.html

"Education meeting used to push drug"
***SYDNEY MORNING HERALD,* 17 June 2004**
***…The medical director of Novo Nordisk, John Miller**, described the allegations as "disturbing" and "extremely serious" and said the company has initiated its own investigation. …Invitations to the May 26 "Diabetes Day" were distributed by Quirindi's sole pharmacist.. The invitations asked patients to "Come and make your life a little easier and gain control of your diabetes. **With [Novo Nordisk's] FlexPen, there is no easier way to inject insulin." Mr Miller could not confirm whether Novo Nordisk** or the pharmacist planned the meeting, nor … how often such promotion meetings took place.*
https://www.smh.com.au/national/education-meeting-used-to-push-drug-20040617-gdj53q.html



https://www.linkedin.com/in/john-miller-7ab727a/?originalSubdomain=au
https://www.gettyimages.in/detail/news-photo/scientist-jennie-brand-miller-at-home-with-her-husband-dr-news-photo/540196463

CURRICULUM VITAE

JANETTE (JENNIE) CECILE BRAND-MILLER

PERSONAL DETAILS

Name	Janette (Jennie) Cecile Brand-Miller
Birth certificate	Janette Cecile Pearce
Birth date	30 May 1952
Address	1A Hinkler St Greenwich 2065, Sydney Australia
Phone	+ 61 9351 3759, + 61 417 658 695
Email	jennie.brandmiller@sydney.edu.au
Marriage	John James Miller
Children	Ryan James Honeyman Miller b. 10 July 1983
	Alexandra Emily May Miller b. 3 January 1988

SUMMARY

Professor Jennie Brand-Miller holds a Personal Chair in Human Nutrition in the Charles Perkins Centre and School of Life and Environmental Sciences at the University of Sydney in Sydney. She is recognised for her work on carbohydrates in health and disease, particularly the application of the glycaemic index of foods to diabetes and obesity. She is a Fellow of the Nutrition Society of Australia and the Australian Institute of Food Science and Technology.

https://www.australianparadox.com/pdf/CV-Prof-Jennie-Brand-Miller-2017.pdf

Novo's J. J. Miller and USyd superstar JBM making a getaway after corrupting literature and 100+ bogus COI disclosures

$4m mansion that Ozempic built for sale

The stunning Sydney mansion long owned by a weight loss guru and his bestseller author wife 'GI Jennie' has just hit the market.

KATHRYN WELLING

less than 2 min read August 15, 2024 - 11:50AM Mosman Daily

The house that Ozempic built.

Health gurus John Miller and Dr Jennie Brand-Miller have been at the forefront of weight loss and dieting for decades and for 42 years have lived at the same Greenwich address.

John is retired but was previously the medical director of Novo Nordisk in Australia, which makes diabetes and obesity medicines such as Ozempic and Wegovy.

Ozempic was developed for people with diabetes and Wegovy is the same medicine but sold in a higher dosage injectable pen for obesity treatment.

Wegovy is being launched in Australian pharmacies this month.

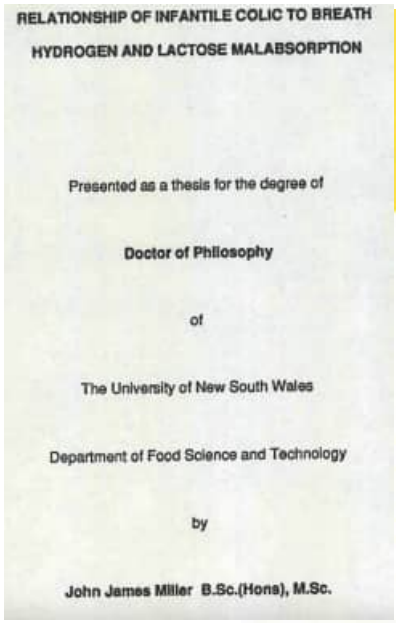
MORE:

How Elon Musk is revolutionising apartment living

Best-selling author Jennie Brand-Miller in the kitchen of her home in Greenwich.

https://www.realestate.com.au/news/ozempic-guru-lists-greenwich-mansion-for-auction/

Novo Nordisk's Medical Director Australasia for decades - Dr John Miller - completed his University of NSW PhD in USyd's Human Nutrition Unit, hosted by its then-boss Stewart Truswell (author of *Australian Dietary Guidelines*); Miller's PhD was co-supervised by his wife, then-USyd employee Dr J. C. Brand, now superstar Jennie Brand-Miller



RELATIONSHIP OF INFANTILE COLIC TO BREATH HYDROGEN AND LACTOSE MALABSORPTION

Presented as a thesis for the degree of

Doctor of Philosophy

of

The University of New South Wales

Department of Food Science and Technology

by

John James Miller B.Sc.(Hons), M.Sc.

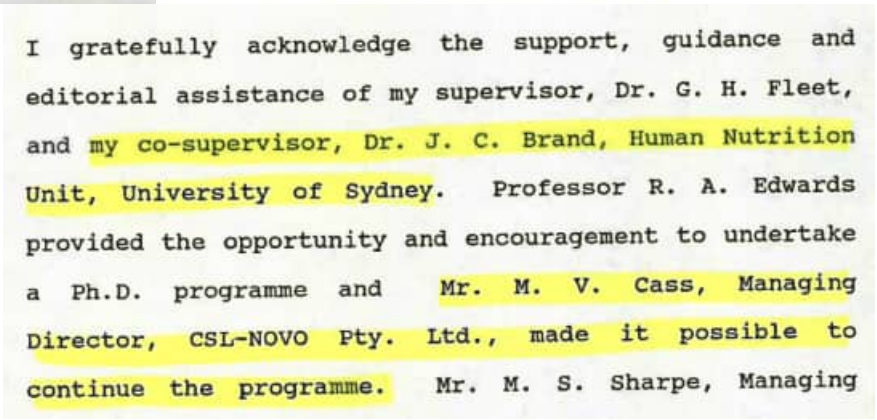
UNSW SYDNEY

Relationship of infantile colic to breath hydrogen and lactose malabsorption

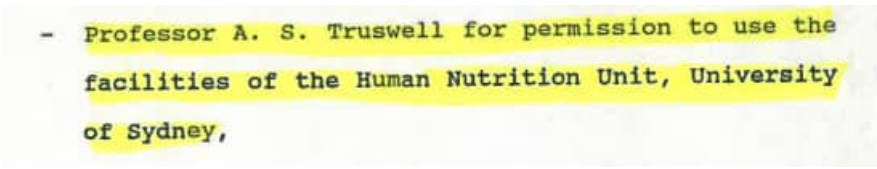
Author:
Miller, John James

Publication Date:
1989

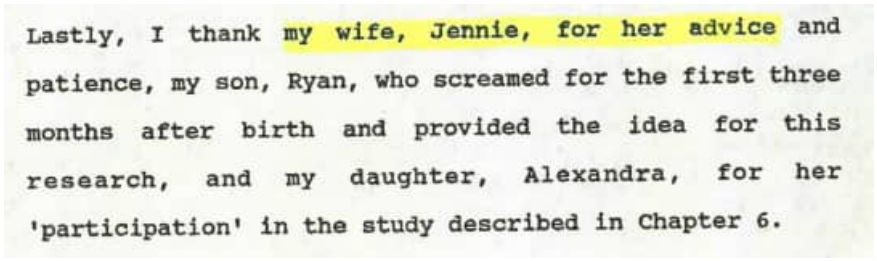
DOI:
https://doi.org/10.26190/unsworks/12434



I gratefully acknowledge the support, guidance and editorial assistance of my supervisor, Dr. G. H. Fleet, and my co-supervisor, Dr. J. C. Brand, Human Nutrition Unit, University of Sydney. Professor R. A. Edwards provided the opportunity and encouragement to undertake a Ph.D. programme and Mr. M. V. Cass, Managing Director, CSL-NOVO Pty. Ltd., made it possible to continue the programme. Mr. M. S. Sharpe, Managing



- Professor A. S. Truswell for permission to use the facilities of the Human Nutrition Unit, University of Sydney,



Lastly, I thank my wife, Jennie, for her advice and patience, my son, Ryan, who screamed for the first three months after birth and provided the idea for this research, and my daughter, Alexandra, for her 'participation' in the study described in Chapter 6.

https://www.australianparadox.com/pdf/PhD-Dr-John-James-Miller-UNSW.pdf
https://unsworks.unsw.edu.au/entities/publication/7fa38e73-2271-43dd-955e-8c253b0262a1/full

Six. Awkwardly, MDPI informs readers: "**This [*Australian Paradox*] study was a [University of Sydney] Masters of Nutrition and Dietetic project conducted by Laura Owens and [merely] co-supervised by AWB and JBM**." What? (Please consider JBM's ***Acknowledgements*** reproduced on p. 1, earlier.) Given the major problems documented in #1 to #5 above, the disputed paper now appears to be just a sloppy, lightweight piece by a student that should never have been rushed to publication in *Nutrients*, into what MDPI insists is a serious journal of science. While JBM's name is on the faulty paper, it is reasonable to ask: did she have any careful involvement in its production? One theory is that JBM and AWB wrote the paper's self-serving title and its pro-Novo false conclusions exonerating sugar, but they didn't actually read the rest of the text before publication. How else to explain the series of conspicuous simple errors (see #8 on p. 9) – not to mention the conspicuous catastrophic ones (see #1, #2 and #3) – that were left conspicuously uncorrected by MDPI's (apparently non-existent) *independent* "peer review" and pre-publication editorial quality control?

Seven. MDPI *Nutrients* officials were alerted to almost all of these problems in 2012. (JBM managed to keep her massive Novo Nordisk conflict of interest hidden from diabetes-industry *outsiders* and most University of Sydney *outsiders* until 2023.) Alas, instead of properly investigating and addressing the profound problems that dominate MDPI's faulty paper, ***Nutrients*' (then) Editor-in-Chief Peter Howe** recklessly published an ***Editorial*** dishonestly pretending there are no serious problems (Ref. 8). Further, Editor-in-Chief Peter Howe chose to allow his colleague JBM to take a fact-free free swing at "**Economist, Rory Robertson**" (me) in MDPI's journal. In that faulty and misguided ***Communication*** (Ref. 9), JBM dishonestly pretends there are no serious problems with the paper, while (clownishly) publishing a new chart of (yet) another sugar indicator that makes a mockery of her silly pro-Novo "finding" of a "consistent and substantial decline" in sugar intake. You can view that *Australian Paradox Revisited* chart again at the bottom right of p. 2, earlier. (And what should we think of JBM hiding her Novo COI while using MDPI to publish her harmful pro-sugar, pro-Novo science fiction?)

Correspondence

The Australian Paradox Revisited

Jennie Brand-Miller [1,*] and Alan W. Barclay [2]

[1] School of Molecular Bioscience and Boden Institute of Obesity, Nutrition and Exercise, University of Sydney, Sydney, NSW 2006, Australia
[2] Australian Diabetes Council, 26 Arundel Street, Glebe, NSW 2037, Australia; E-Mail: alan@australiandiabetescouncil.com

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Received: 25 March 2012 / Published: 30 March 2012

The *Australian Paradox* reported the observation that upward changes in the prevalence of overweight and obesity in Australia run counter to changes in *refined* sugars intake [1]. Economist, Rory Robertson claims there is no Australian Paradox, just unreasonable treatment of the available data [2]. Unfortunately, there are factual errors in Mr. Robertson's essay and misinterpretation of the distinctions between total sugars *vs.* refined sugars, sugar availability *vs.* apparent consumption, sugar-sweetened and diet soft drinks, and other nutrition information. While the terminology, strengths

https://www.australianparadox.com/pdf/nutrients-03-00491-s003.pdf

Nutrients **2012**, *4*, 258; doi:10.3390/nu4040258

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nutrients

ISSN 2072-6643

www.mdpi.com/journal/nutrients

Editorial

The Australian Paradox

Peter Howe

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Received: 25 March 2012 / Published: 10 April 2012

Nutrients recently became the target of an unprecedented internet campaign by an individual who disagrees with the content and conclusions of a paper published in the journal last year, viz. "The Australian Paradox: A Substantial Decline in Sugars Intake over the Same Timeframe that Overweight and Obesity Have Increased" by Alan W. Barclay and Jennie Brand-Miller, *Nutrients* **2011**, *3*, 491–504. Regrettably, his criticism has extended to the journal and its peer review processes for permitting publication of the article.

As you may know, *Nutrients* is one of an extensive series of on-line open access journals published by MDPI, who abide by internationally accepted standards of anonymous peer-review publication. Moreover, as one of the first MDPI journals addressing a field of biomedical/clinical sciences, our editorial team has endeavoured to adopt all appropriate conventions regarding ethics approvals, clinical trial registrations and declarations of perceived conflicts of interest. I have been grateful for the efforts made by members of the MDPI editorial team, our editorial board, our reviewers and our contributors for helping to ensure that the desired standards of publication are attained. I believe these standards were applied to the review of the paper in question and, despite inferences to the contrary, neither author had a role in the editorial process.

Nutrients does not have a policy of inviting correspondence to the Editor, nor has the journal received any formal correspondence regarding this manuscript. However, in view of the widely circulated criticism of the paper by Barclay and Brand-Miller, I believe that it is in the interest of the journal as well as the authors to afford them an opportunity to address these criticisms and provide further clarification of their research. This correspondence now appears on the Nutrients website at http://www.mdpi.com/2072-6643/3/4/491/.

I will leave our readers to judge for themselves.

https://www.mdpi.com/2072-6643/4/4/258

Eight. Later, MDPI *Nutrients* allowed dishonest JBM as Guest Editor to submit, accept and publish her **sham *Correction*** in just three days (Ref. 10, below), with MDPI failing to prioritise truth, scientific integrity or diet-and-health facts. MDPI's "correction" disingenuously addressed a series of basic errors while dishonesty avoiding the data disasters that shred the integrity of MDPI's *Australian Paradox* paper and falsify its pro-Novo "findings". Recall that JBM's drinks chart (see below) shows a big ~30% increase in sales of sugary drinks. Yet shameless JBM's sham "correction" clownishly insists that her chart's ~30% increase in sugary drink sales – replacing the non-existent 10% decrease JBM initially claimed (text below) - does not obviously contradict her story of a "consistent and substantial decline" in sugar consumption: "no material impact on the conclusions of our paper". MDPI's publishing integrity under Peter Howe *et al* was so lacking that Novo-secret-agent JBM was allowed to lie to readers, pretending in MDPI's *Nutrients* that the big fuss around her infamous *Australian Paradox* paper and its Novo-friendly false "findings" flowed from just those three unfortunate "typos" below.

Our findings suggest that Australians have taken seriously public health recommendations to decrease sugars, particularly sugar-sweetened beverages. Food industry data indicate that per capita sales of low calorie (non-nutritively sweetened) beverages doubled from 1994 to 2006 while nutritively sweetened beverages decreased by 10%. At present, one in three soft drinks sold in

Open Access Correction

Barclay, A.W. and Brand-Miller, J. The Australian Paradox: A Substantial Decline in Sugars Intake over the Same Timeframe that Overweight and Obesity Have Increased. *Nutrients* 2011, *3*, 491-504

by Alan W. Barclay [1] and Jennie Brand-Miller [2,*]

[1] Australian Diabetes Council, 26 Arundel Street, Glebe, NSW 2037, Australia
[2] School of Molecular Bioscience and Boden Institute of Obesity, Nutrition and Exercise, University of Sydney, NSW 2006, Australia
* Author to whom correspondence should be addressed.

Nutrients **2014**, *6*(2), 663-664; https://doi.org/10.3390/nu6020663

Submission received: 10 February 2014 / Accepted: 11 February 2014 / Published: 12 February 2014

Download Versions Notes

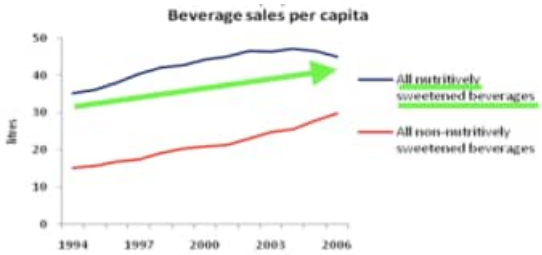
We have found three inadvertent errors in our paper published in Nutrients [1].

- On page 498, text line 8, the words in brackets "~600 g per person *per year*, Figure 6" should be amended to "~600 g per person, Figure 6".
- On page 500, text line 17, some words were missing. The amended sentence reads "Food industry data indicate that per capita sales of low calorie (non-nutritively sweetened) beverages doubled from 1994 to 2006 while *market share of* nutritively sweetened beverages decreased by 10% *points*."
- On page 502, line 2, the words "increasing *by 300%*" should be amended to "increasing *3-fold*".

These changes have no material impact on the conclusions of our paper. We apologize to our readers.

Reference

1. Barclay, A.W.; Brand-Miller, J. The Australian Paradox: A Substantial Decline in Sugars Intake over the Same Timeframe that Overweight and Obesity Have Increased. *Nutrients* **2011**, *3*, 491–504. [Google Scholar] [CrossRef]



https://www.mdpi.com/2072-6643/6/2/663

Finally, on corrupt conduct, does it matter that JBM as a University of Sydney staffer co-supervised her Novo husband John J. Miller's University of NSW PhD - completed in the University of Sydney's Human Nutrition Unit - while John Miller in 1989 pretended to UNSW officials and academia that "Dr J. C Brand" and his wife "Jennie" were two different people? (see p. 7, earlier, and Apprendix, attached)

Endpiece

In summary, there is no reliable evidence presented in MDPI's *Australian Paradox* paper to support University of Sydney superstar Jennie Brand-Miller's silly false claim that Australians' per capita intake of refined sugar suffered a "consistent and substantial decline" over her chosen 1980-2010 timeframe. Indeed, the opposite may well be true: the uptrends in the valid sugar indicators featured in four *Paradox* charts certainly falsify JBM's "consistent and substantial decline" story (#1 and #3). Also shamefully, JBM's preferred ABS apparent consumption of sugar series was discontinued as unreliable by the ABS after 1998-99, leaving JBM no valid let alone reliable preferred series for over one-third of the 1980-2010 period; the FAO then faked new data as a conspicuously dead-ending flat line (#2).

Amazingly, this is elite-level science, University of Sydney style. MDPI's *Australian Paradox* saga from 2011 has become a wonderfully uncomplicated case study of incompetent, dishonest, influential, harmful, and financially corrupted Group of Eight (university) "science".

I believe that the formal retraction of MDPI's faulty sugar-and-obesity paper and its demonstrability false *Australian Paradox* "finding" is the only reasonable response to the **eight issues** documented above. The *Paradox* exercise now looks to have involved JBM secretly supporting her husband Dr John J. Miller's activities selling Novo Nordisk T2D drugs. Again, in 2011 and for decades previously, Dr J.J. Miller was the Medical Director of Novo Nordisk Australasia (see pp. 5-7 earlier). Please also consider the Appendix below, pp. 11-22.

So, MDPI Board of Directors, *Nutrients*' editors and other MDPI officials who care about integrity in science and better public health, please do the right thing: please double-check my claims and then formally retract MDPI's hopelessly faulty *Australian Paradox* paper.

Regards,
Rory Robertson
+61 414703471
strathburnstation@gmail.com
June 2025

References

(1) https://www.mdpi.com/2072-6643/3/4/491 in https://www.mdpi.com/journal/nutrients/special_issues/carbohydrates
https://www.australianparadox.com/pdf/OriginalAustralianParadoxPaper.pdf
https://pmc.ncbi.nlm.nih.gov/articles/PMC3257688/pdf/nutrients-03-00491.pdf

(2) https://retractionwatch.com/2024/12/26/a-look-back-at-2024-at-retraction-watch-and-forward-to-2025/

(3) https://www.smh.com.au/healthcare/research-causes-stir-over-sugars-role-in-obesity-20120330-1w3e5.html
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https://www.smh.com.au/national/education-meeting-used-to-push-drug-20040617-gdj53q.html
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https://www.australianparadox.com/pdf/PhD-Dr-John-James-Miller-UNSW.pdf
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https://michaelwest.com.au/sydney-uni-big-pharma-conflict-of-interest/

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(8) MDPI *Editorial* https://www.mdpi.com/2072-6643/4/4/258
(9) MDPI *Correspondence* https://www.australianparadox.com/pdf/nutrients-03-00491-s003.pdf
(10) MDPI *Correction* https://www.mdpi.com/2072-6643/6/2/663

An Appendix begins overleaf.

APPENDIX

Observations around Jennie Brand-Miller (JBM), JJ Miller, Novo Nordisk, sugary Low GI diets & type 2 diabetes (T2D)

JBM treats her University of Sydney's *External Interests Policy* and *Research Code of Conduct* with utter contempt

15 Public declaration of external interests

Staff members or affiliates whose external, personal or financial interests actually, or potentially, impact or might be perceived to impact upon the objectivity of any academic presentation or publication in which the staff member or affiliate is involved must ensure that the presentation or publication is accompanied by a public declaration of the relevant interest.

16 Failure to declare

(1) Failure fully to disclose information about a conflict of interests may constitute misconduct and result in disciplinary action being taken by the University.

(2) Failure fully to disclose and appropriately manage a conflict of interests may be regarded as corrupt conduct under the *Independent Commission Against Corruption (ICAC) Act 1988*.

p. 6 https://www.sydney.edu.au/policies/showdoc.aspx?recnum=PDOC2011/75&RendNum=0
https://www.australianparadox.com/pdf/External-Interests-Policy-USyd.pdf

20 Definition of research misconduct

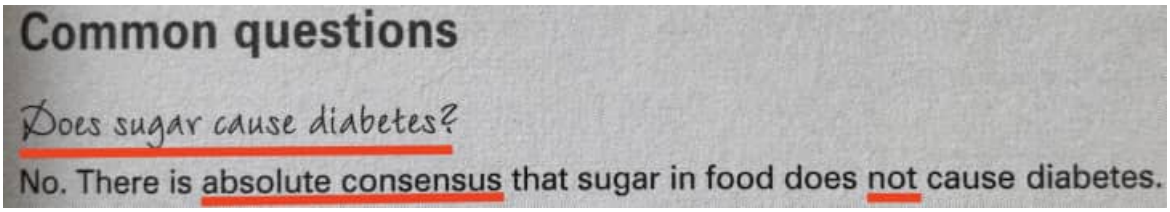
(1) Research misconduct is a serious breach of this policy which is also:

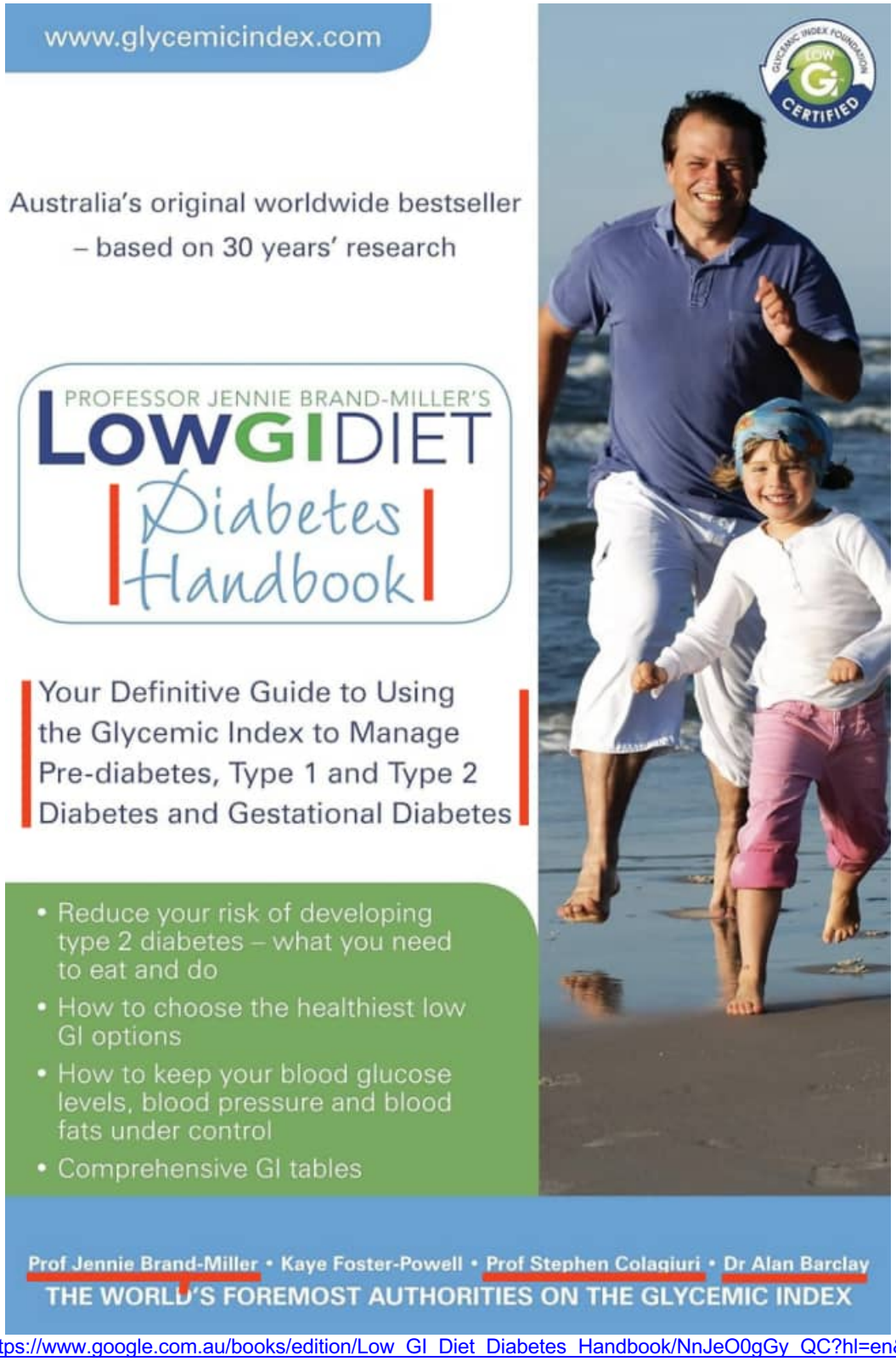
- (a) intentional;
- (b) reckless; or
- (c) negligent.

(2) Examples of conduct which may amount to research misconduct include any of the following on the part of a researcher:

- (a) fabrication, falsification, or deception in proposing, carrying out or reporting the results of research;
- (b) plagiarism in proposing, carrying out or reporting the results of research;
- (c) failure to declare or manage a serious conflict of interests;
- (d) avoidable failure to follow research proposals as approved by a research ethics committee, particularly where this failure may result in unreasonable risk to humans, animals or the environment, or breach of privacy;
- (e) wilful concealment or facilitation of research misconduct by others;
- (f) misleading attribution of authorship;
- (g) intentional, unauthorised taking, sequestration or material damage to any research-related property of another;
- (h) deliberate conduct of research without required human ethics committee approval;
- (i) conduct of research involving animals without required animal ethics committee approval;
- (j) risking the safety of human participants or the wellbeing of animals or the environment; and
- (k) deviations from this policy which occur through gross or persistent negligence.

p. 24 https://www.sydney.edu.au/policies/showdoc.aspx?recnum=PDOC2013/321&RendNum=0





2012: https://www.google.com.au/books/edition/Low_GI_Diet_Diabetes_Handbook/NnJeO0gGy_QC?hl=en&gbpv=0

JBM's main co-author Stephen Colagiuri (paid part-timer for drug coys) was Novo's JJ Miller's main co-author (pp 16,18-21)

Novo Nordisk and other diabetes-drug sellers love JBM and her Low GI Diet books' co-author Dr Stephen Colagiuri making false but authoritative-sounding claims like: "There is *absolute consensus* that sugar in food does *not* cause [type 2] diabetes" (p. 12). Novo especially loves JBM and Dr Colagiuri pushing harmful pro-Novo misinformation – including via *Australian Paradox* nonsense and even via Canberra's faulty official T2D advice - with a straight face while under the University of Sydney's prestigious Group of Eight banner.

Pharmaceutical industry payments to healthcare professionals (May 2016-Apr 2017) (4)

	A	C	D	E	I	O
1	Company	Period	Name	HealthCarePractiti	Service	Total
2588	AstraZeneca	May 2016-Oct 2016	Colagiuri, Stephen	Medical Practitioner	Consultant	431.81
2589	AstraZeneca	May 2016-Oct 2016	Colagiuri, Stephen	Medical Practitioner	Consultant	863.64
2590	AstraZeneca	Nov 2016-Apr 2017	Colagiuri, Stephen	Medical Practitioner	Advisory Board or Co	5454.55
2591	iNova	Nov 2016-Apr 2017	Colagiuri, Stephen	Medical Practitioner	Advisory Board	5440.95
2592	MSD	May 2016-Oct 2016	Colagiuri, Stephen	Medical Practitioner	Educational meeting	1273.00
2593	NovoNordisk	Nov 2016-Apr 2017	Colagiuri, Stephen	Medical Practitioner	Advisory Board or Co	2500.00
2594	NovoNordisk	May 2016-Oct 2016	Colagiuri, Stephen	Medical Practitioner	Advisory Board or Co	3000.00
2595						
2596						18963.95

https://researchdata.ands.org.au/pharmaceutical-industry-payments-apr-2017/968458
http://www.abc.net.au/news/2017-10-24/big-pharma-paying-nurses-allied-health-professionals-millions/9077746

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

p. 83 http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf

https://www.australianparadox.com/pdf/Letter-to-ACCC.pdf

Michael West Media has published on JBM's misconduct with respect to *The Australian Paradox* paper and Novo Nordisk

Big Sugar, Big Pharma: Sydney University compromised by academic research breach

by Andrew Gardiner | Mar 27, 2024 | Business, Latest Posts

Sydney University and Nova Nordisk Image: Wikipedia & Novo Nordisk

Listen to this story

Sydney University has stonewalled claims of failing to police serious conflicts of interest in its academic research which may have benefited Big Sugar and Big Pharma companies such as Novo Nordisk. Who knew what and when, asks **Andrew Gardiner**.

The veil of secrecy around Jennie Brand-Miller – star nutrition academic and for years the face of low glycemic index ('low GI') diets – has been lifted, and it's far from flattering. After months of obstruction, *MWM* can now confirm that 'GI Jennie,' as she's affectionately known, has been married to John Miller (for decades until 2013, the medical director at Novo Nordisk Pharmaceuticals Australasia) from the late 1980s through to at least 2017.

Why does this matter? Economist and bane of Big Pharma and Sydney University, Rory Robertson, believes GI Jennie – who popularised sugary, high-carb ("low GI") diets as somehow lowering blood sugar – helped cause a "public health disaster" of high blood sugar, obesity and rampant type two diabetes (T2D) among Australians, in turn generating a market for Novo Nordisk, the leading seller of insulin used to treat T2D.

Robertson insists that dozens of Brand-Miller's 'peer-reviewed' published papers are based on erroneous and/or misconstrued data and that other, more credible studies associate sugary, high-carb diets with high blood sugar, obesity and T2D, stating that:

> " it has been known at the highest level of medical science and by competent GPs for a century that no-sugar, low-carbohydrate diets "reverse" or "fix" T2D. "

A conflict of interest?

The central point of this investigation is not that Brand-Miller acted in bad faith but that her employer Sydney University, despite being notified many times by Robertson, failed to ensure that the academic complied with university policy on disclosing conflicts of interest, namely her close, very close association with a company which derived financial benefits from selling diabetes medication.

Brand-Miller did not declare what was a serious conflict of interest over the 2011 paper at the centre of this controversy, The Australian Paradox, despite enjoying what Robertson calls "a major multi-decade boost to her household income from her life/financial partner (John Miller's) high-level employment driving Novo Nordisk's diabetes drug sales."

MWM is not suggesting the Millers have acted unethically or allowed any personal relationship to affect their professional work, but it should be noted that Novo Nordisk, the 23rd most valuable company in the world with a profit of $US22.24B for the year ending March 2023, appears not to have been displeased with the scholarly work.

For his part, John Miller also failed to openly acknowledge his marriage to Brand-Miller – despite clear conflict of interest implications – when it was his turn to write a PhD dissertation at UNSW in 1989. Miller was already working for Novo Nordisk's predecessor at the time, and his PhD was co-supervised by a Dr J C Brand.

That's right, readers: in a triumph of arms-length academic integrity, John Miller's supervisor was none other than his spouse, Jennie Brand-Miller. *MWM* confirmed the pair's collaboration and marriage via documents helpfully available online (the latter has since mysteriously vanished from the University of Sydney's website).

"Amazingly, John Miller acquired a UNSW PhD and 'expert' status under the (hidden) 'supervision' of his own wife while embedded in the Human Nutrition Unit at the University of Sydney, with the Unit's taxpayer-funded facilities gifted to him by his wife's boss, Stewart Truswell – notably, the main scientific author for decades of our influential Australian Dietary Guidelines – all while Miller was employed by CSL-Novo, soon to be Novo Nordisk Australasia," Robertson told *MWM*.

Robertson says the Millers' union has long been 'common knowledge' around the corridors of Sydney University's Human Nutrition Unit and the Charles Perkins (medical research) Centre (the latter subsumed the former from 2012), yet the university appears to have given Brand-Miller what he calls:

> " a decades-long free pass to hide her links to Novo Nordisk and its predecessors, allowing her to carefully exclude it from conflict-of-interest disclosures she published in hundreds of formal diet-and-health papers, in clear violation of university policy. "

"The global nutrition, scientific and medical communities are still happlessly unaware that Brand-Miller's sugary 'low-GI' diet research was conducted under the cloud of the Novo Nordisk conflict," he added.

A (sugar) scandal in the making?

With their marriage confirmed, we can sum up what appears to be a hitherto insoluble headache for public health, government waste and academic integrity. Jennie Brand-Miller: (a) popularised sugary, high-carb "low GI" diets, (b) wrongly, in the eyes of many, exonerated sugar as a key driver of Australia's diabetes/obesity epidemic, and (c) may have derived a financial benefit as she and her husband made money from the latter's work in a company which sells the (insulin) T2D drug treatment.

This could turn out to be a massive scandal ... if anyone will listen, says Robertson.

He wants a new, independent inquiry into Sydney University academics' links to Novo Nordisk, claiming they're a party to years of scientific malpractice that significantly benefits Big Pharma and the sugar industry. He persists in the face of what seems like systematic stonewalling from the University, which *MWM* also experienced when researching this story.

Confronted with documents confirming the Millers' marriage and financial relationship, the university's media office had a one-line response: "I've checked, and our statement from last year stands," media manager Rachel Fergus wrote. That earlier statement, sent to *MWM* last July, was that "for over a decade (Robertson) has made ... public claims about a number of our researchers and their scientific work (and) any matters have been appropriately, repeatedly and thoroughly examined ... with no evidence of any misconduct found".

Perhaps the lack of action by the university is where the misconduct lies. Is it not the responsibility of esteemed public institutions to ensure their researchers adhere to ethical and compliance guidelines?

Sydney University 'examination'

One wonders how Sydney University can claim it "thoroughly examined" the matter when startling documentary evidence of massive conflicts was right under its proverbial nose. Earlier recommendations following a 2014 inquiry by Professor Robert Clark – that Brand-Miller's Australian Paradox be "sent to the shredder" and replaced by a new paper prepared for publication, "in consultation with the Faculty, that specifically addresses and clarifies the key factual issues examined in this Inquiry" – were not meaningfully addressed. And there was little media attention.

Neither Brand-Miller nor her bosses ever appeared to do what Clark recommended: "The new paper should be written in a constructive matter that respects issues relating to the data in the Australian Paradox paper raised by the Complainant"

Robertson says the stonewalling of *MWM* and other media over the past decade is part of a strategy to "starve the issue of oxygen" and keep it away from the pages and bulletins of our fourth estate. The strategy has worked: after two brief flurries of interest from mainstream outlets years ago, media interest has dropped off a cliff, with the exception of *MWM*.

'Former fattie' Rory Robertson ups the ante on Sydney Uni's connections with Big Sugar, Big Pharma

Economist Rory Robertson has been waging war on Big Sugar and Sydney University for more than a decade. Nothing if not dogged, Robertson's campaign has taken an unexpected turn over recent days, as James F Sica reports.

M Michael West

Even the modest feat of confirming the Millers' union was like navigating a maze for *MWM*, and little wonder. The promotion of what some see as disastrous nutritional advice has spawned a multi-million dollar industry in academia, government and the private sector.

"Over the past decade, three successive (Sydney University) vice-chancellors have accepted research grants of around $400 million per annum from Canberra – much of it funding studies which asked the wrong nutritional and health questions," Robertson told *MWM*.

> " That's a lot of money that would dry up if the truth were widely known. "

Robertson said Brand-Miller's co-dependent ties with senior faculty members at the university's Charles Perkins Medical Research Centre further drove this circling of the Camperdown wagons. "When she thrived, they thrived; it's a cabal dating back to the 1980s," he told *MWM*.

Media ambivalence on what could turn out to be a massive scandal is a complicated subject to explain, although it can be noted that the university is a large-scale advertiser on commercial outlets and that Mark Scott, once the ABC's managing director/editor-in-chief but now the Vice Chancellor of Sydney University, briefly helped along media interest in Robertson's quest in 2016.

Moreover, Big Sugar – from cereals to soft drink and sweets manufacturers – are among the biggest advertisers in commercial media. Robertson also points out significant commercial conflicts of interest on the part of at least one leading health and medical journalist.

At the end of the day, what Robertson calls the "sheer scale of this scandal" and the involvement – wittingly or not – of "heavy hitters" at the university and beyond may be forestalling the "critical mass" required for it to get the full forensic treatment. Faced with such seemingly immovable obstacles, others might toss in the towel, but Robertson is nothing if not determined.

"Why do I persist?" Robertson said, "I suspect it's because my mother and her two sisters, and my own sister, were all country nurses, and I grew up in remote locations, often with Indigenous kids (who now) bear the brunt of this T2D plague – the amputations, the people going blind."

> " It may be the biggest scandal in Australian medical history. People don't need Novo Nordisk's insulin; they just need a low carb diet. "

https://michaelwest.com.au/sydney-uni-big-pharma-conflict-of-interest/

Letter of Complaint to ABC Board members, ABC journalists, and others: Reporter Norman Swan prioritised his private client's needs over reporting scientific misconduct to ABC audiences

Rory Robertson (+61 414 703 471)
Sydney NSW
17 July 2023

Dear ABC Chair Ita Buttrose, Managing Director David Anderson, Board Member Laura Tingle, Media Watch's Paul Barry, other ABC officials and journalists, and interested observers,

I am writing to make a formal complaint about your reporter Norman Swan, for prioritising his personal-business interests over reporting to the ABC's audience a stunning incident involving University of Sydney superstar Professor "GI Jennie" Brand-Miller's increasingly obvious scientific misconduct.

If Norman Swan is indeed still an ABC employee, I believe he should be fired for dereliction of ABC duty. This week, he failed to report an incident of national significance, and **unethically helped to suppress stunning new evidence for what I've called "The biggest medical scandal in Australia's history", and the associated governance crisis - involving corrupt conduct - at the University of Sydney** (which enjoys a disproportionate ~$400m worth of research funding each year from Australian taxpayers).

In June, I provided evidence on the latter two matters to the **Chancellor of the University of Sydney, Belinda Hutchinson**: pp. 9, 34 and 70-77 at https://www.australianparadox.com/pdf/Letter-to-BelindaHutchinson.pdf

Beyond the broader research fraud and institutional corruption documented in my letter to Ms Hutchinson, the "**stunning new evidence**" to which I refer involved my latest effort to give Professor Jennie Brand-Miller (JBM) the opportunity to deny that she has published false and deceptive conflict-of-interest statements for decades. **Spoiler: In front of ~600 people last Wednesday evening, superstar Professor JBM chose not to deny my claim that she has deceived the global scientific community for decades; instead, remarkably, she stood up and walked silently towards the exit, and out of a Diabetes Australia event in the Warrane Theatre at the Museum of Sydney.**

As a courtesy, I have CC'd Norman Swan; Jennie Brand-Miller (JBM); Justine Cain, CEO of Diabetes Australia; Stephen Simpson, founding Academic Director of the Charles Perkins Centre (overseeing ~1200 taxpayer-funded researchers at the University of Sydney); and Mark Scott, Vice-Chancellor of the University of Sydney (and formerly Managing Director of the ABC). I encourage each of them to publicly dispute any of my observations in this letter, any of the detailed evidence provided in my letter last week to the *American Journal of Clinical Research* (*AJCN*; attached, below), and any aspect of my 12 years' worth of evidence published at https://www.australianparadox.com/ .

Is Norman Swan still an ABC reporter, or is he now devoted to his private clients and business interests?

Importantly, before I proceed, this formal complaint assumes Dr Norman Swan is still an employee of the ABC and still receives an income from taxpayers as a reporter and producer of content, not now retired from the ABC and 100% devoted to his private business interests, including public speaking:
https://au.linkedin.com/in/drnormanswan

I've been told Norman's public-speaking engagements command payment of up to $10,000 per night. Good luck to him - "Dr Norman Swan AM is a multi-award-winning producer, broadcaster and investigative journalist" - except to the extent that his devotion to private interests - including staying cosy-cosy with his customers in the "health" space - interferes with his taxpayer-funded job as an ABC reporter.

The issue here is that Australians are still expecting ABC reporter Norman Swan to report to them serious misconduct by dodgy scientists when it is paraded in front of him, but Norman's private business in the "health" space means that no longer happens. Australians now need to be told that Norman Swan can no longer be trusted to "call out" scientific fraudsters or corrupt conduct by institutions harming public health.

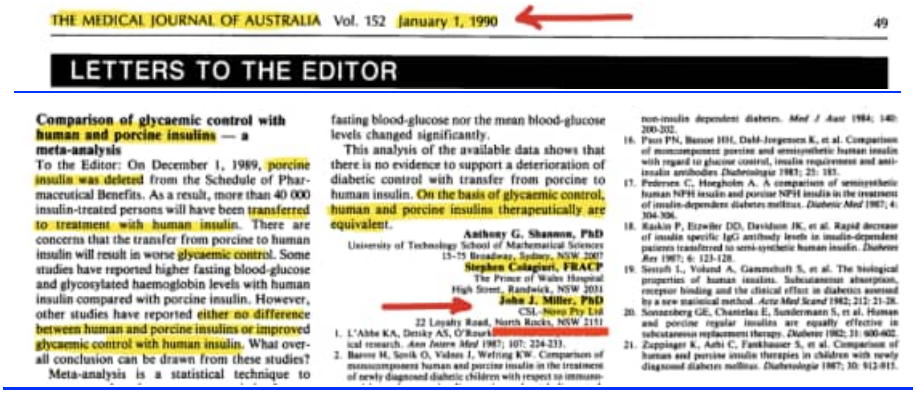
Once a fearless investigative reporter - who brought great credibility to the ABC by famously taking down prominent gynaecologist Dr William McBride and his fraudulent research - Dr Norman Swan appears to have become a meek puppy devoted to servicing his private clients in the "health" sector.

What am I talking about? ABC reporter helping suppress - rather than report - evidence of scientific misconduct

Exhibits: Diabetes Australia event (pre drama) + RR's evidence in letter to *American Journal of Clinical Nutrition*

Below are seven points of evidence for Jennie Brand-Miller's marriage to Dr John Miller, Medical Director, Novo Nordisk Australasia since 1978, taken from RR's letter to *American Journal of Clinical Nutrition*, 11 July 2023 (full letter reproduced p. 8, below). Sarah L. McCormack, Director of Scholarly Publications, American Society for Nutrition (Ph: 1 240-428-3616; email: SMcCormack@nutrition.org) has advised that an investigation has begun.
https://www.australianparadox.com/pdf/RRLetter-to-ABC-re-NormanSwan.pdf

Accidentally on purpose? Around when JBM started using Miller surname, JJ Miller's Novo address became "United States"



THE MEDICAL JOURNAL OF AUSTRALIA Vol. 152 January 1, 1990 49

LETTERS TO THE EDITOR

Comparison of glycaemic control with human and porcine insulins — a meta-analysis

To the Editor: On December 1, 1989, porcine insulin was deleted from the Schedule of Pharmaceutical Benefits. As a result, more than 40 000 insulin-treated persons will have been transferred to treatment with human insulin. There are concerns that the transfer from porcine to human insulin will result in worse glycaemic control. Some studies have reported higher fasting blood-glucose and glycosylated haemoglobin levels with human insulin compared with porcine insulin. However, other studies have reported either no difference between human and porcine insulins or improved glycaemic control with human insulin. What overall conclusion can be drawn from these studies?

Meta-analysis is a statistical technique to

fasting blood-glucose nor the mean blood-glucose levels changed significantly.

This analysis of the available data shows that there is no evidence to support a deterioration of diabetic control with transfer from porcine to human insulin. On the basis of glycaemic control, human and porcine insulins therapeutically are equivalent.

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https://pubmed.ncbi.nlm.nih.gov/2136763/

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LETTERS TO THE EDITOR | VOLUME 340, ISSUE 8814, P301-303, AUGUST 01, 1992

Human insulin and hypoglycaemia

Matthias Egger • GeorgeDavey Smith • Arthur Teuscher • Ernst Von Kriegstein • Stephen Colagiuri • JohnJ Miller et al. Show all authors

Published: August 01, 1992 • DOI: https://doi.org/10.1016/0140-6736(92)92387-U

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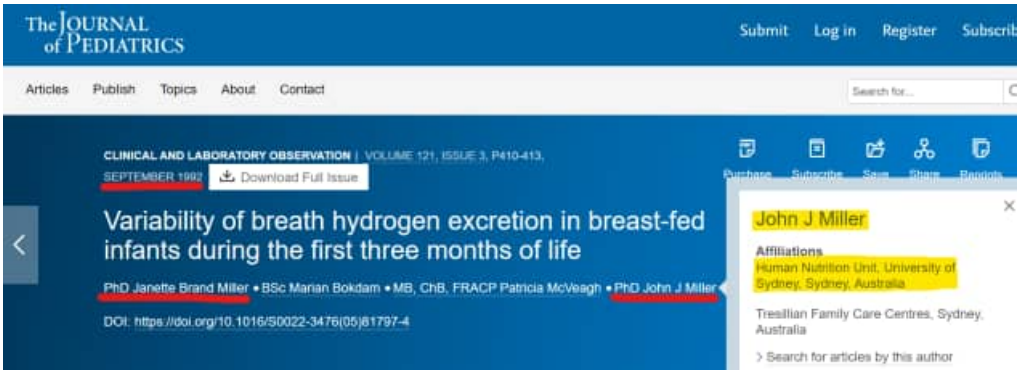

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CLINICAL AND LABORATORY OBSERVATION | VOLUME 121, ISSUE 3, P410-413, SEPTEMBER 1992 Download Full Issue

Variability of breath hydrogen excretion in breast-fed infants during the first three months of life

PhD Janette Brand Miller • BSc Marian Bokdam • MB, ChB, FRACP Patricia McVeagh • PhD John J Miller

DOI: https://doi.org/10.1016/S0022-3476(05)81797-4

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Corrupt pro-Novo cabal hid JBM's Novo household income COI while thanking Novo for funding its Low GI study

ACKNOWLEDGMENTS

We thank the Sydney University Nutrition Research Foundation, CSL-Novo Pty., Ltd., and the Apex-Australian Diabetes Foundation for financial support.

Low-Glycemic Index Foods Improve Long-Term Glycemic Control in NIDDM

Janette C. Brand, PhD
Stephen Colagiuri, MBBS, FRACP
Shirley Crossman, BSc, CertDiet
Annette Allen, RN
David C.K. Roberts, PhD
A. Stewart Truswell, MD, FRCP

Objective: To compare high- and low-glycemic index (GI) diets in the treatment of non-insulin-dependent diabetes mellitus (NIDDM). **Research Design and Methods:** Sixteen subjects with well-controlled NIDDM and normal lipid profile, 10 of whom continued oral hypoglycemic medication, participated in the study. A diet that emphasized low-GI foods (e.g., porridge, pasta) was compared with a high-GI diet (e.g., processed cereals, potatoes). The GI of the low-GI diet was 15% lower than the high-GI diet (77 ± 3 vs. 91 ± 1) but otherwise similar in macronutrient composition and fiber, as determined by a 4-day weighed record. The diets were instituted under instruction from a dietitian who visited subjects at home on a weekly basis. Body weight was maintained within 1–2 kg. **Results:** Glycemic control was improved on the low-GI diet compared with the high-GI diet (statistically significant findings, $P < 0.05$). Mean glycosylated hemoglobin at the end of the low-GI diet was 11% lower (7.0 ± 0.3%) than at the end of the high-GI diet (7.9 ± 0.5%), and the 8-h plasma glucose profile was lower (area under the curve above fasting 128 ± 23 vs. 148 ± 22 mmol · h^{-1} · L^{-1}, respectively). Mean fasting plasma glucose, total cholesterol triglycerides, and lipoproteins did not show important differences. **Conclusions:** A low-GI diet gives a modest improvement in long-term glycemic control but not plasma lipids in normolipidemic well-controlled subjects with NIDDM. Diabetes Care 14:95–101, 1991

https://diabetesjournals.org/care/article/14/2/95/17926/Low-Glycemic-Index-Foods-Improve-Long-Term

Check out JBM's corrupt COI in 2009 RCT study into her Low (vs High) GI, JJ's Novo insulin and Gestational Diabetes

Clinical Care/Education/Nutrition/Psychosocial Research

ORIGINAL ARTICLE

Can a Low-Glycemic Index Diet Reduce the Need for Insulin in Gestational Diabetes Mellitus?

A randomized trial

ROBERT G. MOSES, MD[1]
MEGAN BARKER, APD[1]
MEAGAN WINTER, APD[1]
PETER PETOCZ, PHD[2]
JENNIE C. BRAND-MILLER, PHD[3]

OBJECTIVE — A low–glycemic index diet is effective as a treatment for individuals with diabetes and has been shown to improve pregnancy outcomes when used from the first trimester. A low–glycemic index diet is commonly advised as treatment for women with gestational diabetes mellitus (GDM). However, the efficacy of this advice and associated pregnancy outcomes have not been systematically examined. The purpose of this study was to determine whether prescribing a low–glycemic index diet for women with GDM could reduce the number of women requiring insulin without compromise of pregnancy outcomes.

RESEARCH DESIGN AND METHODS — All women with GDM seen over a 12-month period were considered for inclusion in the study. Women (n = 63) were randomly assigned to receive either a low–glycemic index diet or a conventional high-fiber (and higher glycemic index) diet.

RESULTS — Of the 31 women randomly assigned to a low–glycemic index diet, 9 (29%) required insulin. Of the women randomly assigned to a higher–glycemic index diet, a significantly higher proportion, 19 of 32 (59%), met the criteria to commence insulin treatment (P = 0.023). However, 9 of these 19 women were able to avoid insulin use by changing to a low–glycemic index diet. Key obstetric and fetal outcomes were not significantly different.

CONCLUSIONS — Using a low–glycemic index diet for women with GDM effectively halved the number needing to use insulin, with no compromise of obstetric or fetal outcomes.

Diabetes Care 32:996–1000, 2009

Acknowledgments — This study was funded by internal revenue from the Illawarra Diabetes Service and the University of Sydney.

J.B.M. is a coauthor of The New Glucose Revolution book series (Hodder and Stoughton, London; Marlowe and Co, New York; and Hodder Headline, Sydney and elsewhere); President of the GI Foundation, a nonprofit glycemic index–based food endorsement program in Australia; and Director of the University of Sydney glycemic index testing service.

No potential conflicts of interest relevant to this article were reported.

When indicated, insulin treatment was initiated with twice-daily premixed insulin (NovoMix 30, Novo Nordisk) using a disposable pen device. The dose was adjusted regularly to achieve glycemic goals.

https://pmc.ncbi.nlm.nih.gov/articles/PMC2681032/pdf/zdc996.pdf

Medical Director of Novo Nordisk Australasia - JBM's financial partner - secretly collaborated on JBM's Low GI Diet

Original Investigation FREE

July 24, 2006

Comparison of 4 Diets of Varying Glycemic Load on Weight Loss and Cardiovascular Risk Reduction in Overweight and Obese Young Adults

A Randomized Controlled Trial

Joanna McMillan-Price, MNutrDiet; Peter Petocz, PhD; Fiona Atkinson, MNutrDiet; Kathleen O'Neill, BSc; Samir Samman, PhD; Katherine Steinbeck, MD, PhD; Ian Caterson, MD, PhD; Jennie Brand-Miller, PhD

Author Affiliations | Article Information

Arch Intern Med. 2006;166(14):1466-1475. doi:10.1001/archinte.166.14.1466

Article Information

Back to top

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Accepted for Publication: April 12, 2006.

Author Contributions: Ms McMillan-Price and Drs Petocz and Brand-Miller had full access to all the data and take responsibility for the integrity and accuracy of the data analysis.

Financial Disclosure: Ms McMillan-Price and Dr Brand-Miller are coauthors of *The Low GI Diet Revolution* (Marlowe & Co., New York, NY, 2005). Dr Brand-Miller is a coauthor of *The New Glucose Revolution* book series (Hodder and Stoughton, London, England; Marlowe & Co; and Hodder Headline, Sydney, and elsewhere).

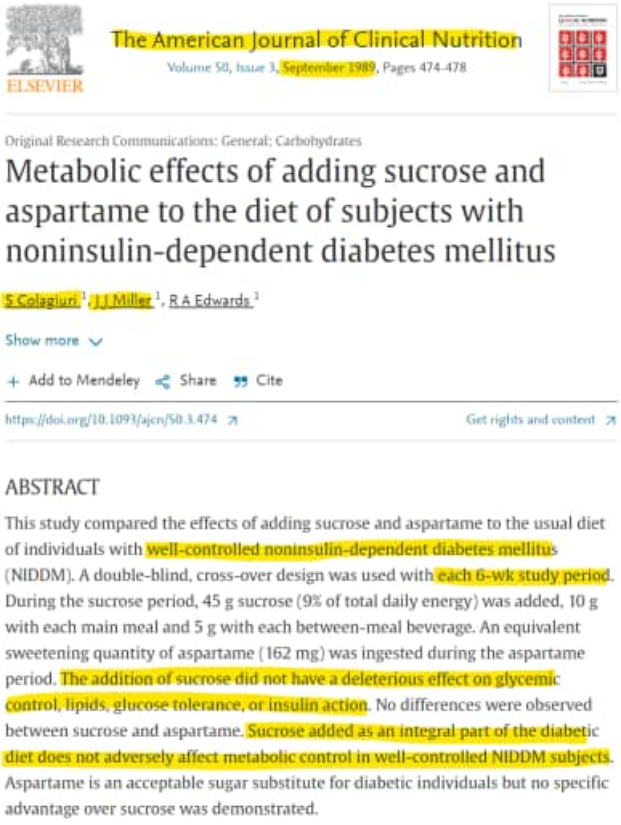
Funding/Support: This study was supported in part by the National Heart Foundation of Australia and Meat and Livestock Australia.

Role of the Sponsors: The funding bodies did not participate in the study design; the collection, analysis, or interpretation of the data; the writing of the manuscript; or the decision to submit the article for publication.

Acknowledgment: We thank Stephan Jacob, MD, Abdullah Omari, MD, Paul Nestel, MD, and John Miller, PhD, for comments on the manuscript and Zia Ahmed, MAppSc, for technical assistance.

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410671

Novo secretly pioneered feeding sugar to T2D victims, thus maintaining T2D, killing potential for remission (+ pp. 19, 22-24)



The American Journal of Clinical Nutrition

Volume 50, Issue 3, September 1989, Pages 474-478

Original Research Communications: General: Carbohydrates

Metabolic effects of adding sucrose and aspartame to the diet of subjects with noninsulin-dependent diabetes mellitus

S Colagiuri [1], J J Miller [1], R A Edwards [1]

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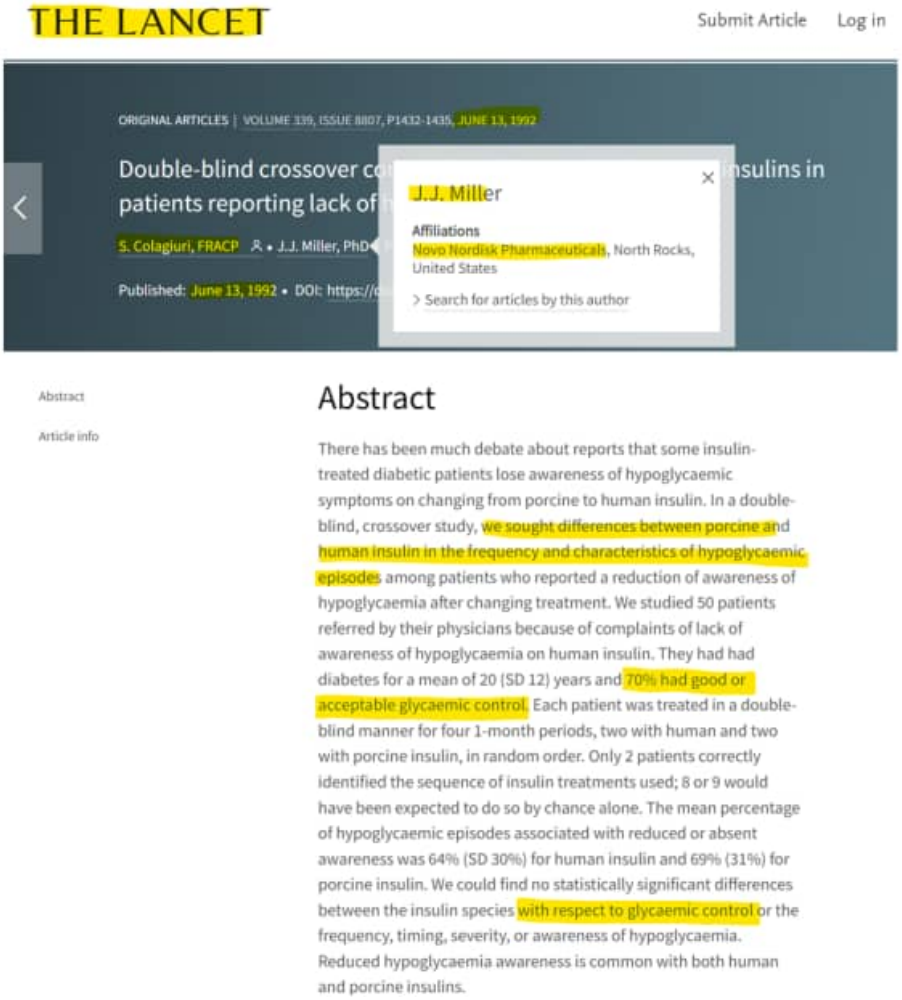
ABSTRACT

This study compared the effects of adding sucrose and aspartame to the usual diet of individuals with well-controlled noninsulin-dependent diabetes mellitus (NIDDM). A double-blind, cross-over design was used with each 6-wk study period. During the sucrose period, 45 g sucrose (9% of total daily energy) was added, 10 g with each main meal and 5 g with each between-meal beverage. An equivalent sweetening quantity of aspartame (162 mg) was ingested during the aspartame period. The addition of sucrose did not have a deleterious effect on glycemic control, lipids, glucose tolerance, or insulin action. No differences were observed between sucrose and aspartame. Sucrose added as an integral part of the diabetic diet does not adversely affect metabolic control in well-controlled NIDDM subjects. Aspartame is an acceptable sugar substitute for diabetic individuals but no specific advantage over sucrose was demonstrated.

https://www.sciencedirect.com/science/article/abs/pii/S0002916523435800?via%3Dihub

Further evidence of Novo Nordisk's undisclosed involvement in JBM/Colagiuri's sugary "Low GI" dietary approach



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ORIGINAL ARTICLES | VOLUME 339, ISSUE 8807, P1432-1435, JUNE 13, 1992

Double-blind crossover c… …nsulins in patients reporting lack of…

S. Colagiuri, FRACP • J.J. Miller, PhD

Published: June 13, 1992 • DOI: https://…

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Abstract

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Abstract

There has been much debate about reports that some insulin-treated diabetic patients lose awareness of hypoglycaemic symptoms on changing from porcine to human insulin. In a double-blind, crossover study, we sought differences between porcine and human insulin in the frequency and characteristics of hypoglycaemic episodes among patients who reported a reduction of awareness of hypoglycaemia after changing treatment. We studied 50 patients referred by their physicians because of complaints of lack of awareness of hypoglycaemia on human insulin. They had had diabetes for a mean of 20 (SD 12) years and 70% had good or acceptable glycaemic control. Each patient was treated in a double-blind manner for four 1-month periods, two with human and two with porcine insulin, in random order. Only 2 patients correctly identified the sequence of insulin treatments used; 8 or 9 would have been expected to do so by chance alone. The mean percentage of hypoglycaemic episodes associated with reduced or absent awareness was 64% (SD 30%) for human insulin and 69% (31%) for porcine insulin. We could find no statistically significant differences between the insulin species with respect to glycaemic control or the frequency, timing, severity, or awareness of hypoglycaemia. Reduced hypoglycaemia awareness is common with both human and porcine insulins.

https://www.thelancet.com/journals/lancet/article/PII0140-6736(92)92028-E/fulltext

Comparison of Plasma Glucose, Serum Insulin, and C-Peptide Responses to Three Isocaloric Breakfasts in Non-Insulin-Dependent Diabetic Subjects

STEPHEN COLAGIURI, M.D., JOHN J. MILLER, M.Sc., JENNY L. HOLLIDAY, B.Sc., AND ELLEN PHELAN, R.N.

While differences in glucose and insulin responses to specific carbohydrate foods have been reported, few data are available for mixed meals incorporating such foods. This study compared the plasma glucose (PG), serum insulin (SI), and C-peptide (CP) responses to three different isocaloric test breakfasts given in random order to eight insulin-treated non-insulin-dependent diabetes mellitus (NIDDM) patients. The test meals were selected from a hospital food exchange list and contained similar quantities of carbohydrate, protein, fat, and dietary fiber. The postprandial PG, SI, and CP responses to two of the test breakfasts (meal A: eggs, toasted wholemeal bread, orange juice, margarine, and milk; meal B: wheatflake biscuits, toasted wholemeal bread, milk, and margarine) were similar (meal A: 104.3 ± 23.0 mg · h · dl^{-1}, 5996 ± 1108 μU · min · ml^{-1}, and 89.8 ± 25.4 pmol · min · ml^{-1}, respectively; meal B: 104.9 ± 21.6 mg · h · dl^{-1}, 6268 ± 1161 μU · min · ml^{-1}, and 99.8 ± 26.4 pmol · min · ml^{-1}, respectively). Meal C, consisting of toasted muesli and skim milk, produced smaller glycemic and insulin responses (46.8 ± 8.8 mg · h · dl^{-1}; $P < .02$, and 4369 ± 700 μU · min · ml^{-1}; $P < .05$, respectively) than meals A and B and less endogenous insulin secretion (CP response 62.8 ± 19.9 pmol · min · ml^{-1}; $P < .05$ compared with meal A, NS compared with meal B). The lower glycemic response after meal C could be explained by differences in method of food processing resulting in a decreased availability of starch to amylolytic enzymes, the higher content in meal C of sucrose, lactose, and fructose, which are associated with a low glycemic index, and by quantitative and qualitative differences in fiber. While food exchange lists are generally useful in planning diets for diabetic persons, some modification to current lists may be necessary to take into account the processing method and nature of the carboyhydrates in the food when considering the equivalence of individual food items.

DIABETES CARE 1986; 9:250–54.

Food exchange lists are commonly used for planning the diet of a person with diabetes. The basic assumption of such lists is that isocaloric quantities of foods grouped according to their basic nutrient content can be exchanged with one another and have similar effects on postprandial glycemia. The validity of the exchange system for carbohydrate foods has been challenged by recent studies that have demonstrated that the physiologic effects of food ingestion cannot be predicted simply from their chemical composition.[1–4] Factors such as the way food is prepared or processed, the nature of the food carbohydrates, certain types of dietary fiber, interactions of carbohydrate with proteins and lipids, and the presence of antinutrients affect postprandial glycemia and insulinemia.[5–10]

While individual food items have been studied, few data are available for mixed meals.[4,11] The aim of the present study was to compare postprandial glucose (PG), serum insulin (SI), and C-peptide (CP) responses to three meals selected from food exchange lists containing similar amounts of carbohydrate, fat, and protein in insulin-treated persons with non-insulin-dependent diabetes mellitus (NIDDM).

PATIENTS AND METHODS

Eight patients (four women and four men) who fulfilled the National Diabetes Data Group criteria for NIDDM[12] and were being treated with insulin were studied. The clinical details of the patients are shown in Table 1. All subjects were being treated with twice-daily injections of insulin. Six were receiving a bovine/porcine biphasic insulin (Rapitard MC, Novo

TABLE 1
Clinical details of subjects studied

Subject	Sex	Age (yr)	BMI (kg/m^2)*	Glycosylated hemoglobin (%)	Duration of diabetes (yr)	Duration of insulin treatment (yr)	Insulin binding capacity (%)
1	M	69	26.6	7.9	7	5	3
2	M	42	27.1	8.9	2	0.5	0.1
3	F	79	18.8	7.8	10	8	1.4
4	F	63	27.9	6.0	1.5	0.5	0
5	F	68	27.6	11.6	18	6	3
6	M	65	23.2	6.9	2	1	4
7	M	51	26.5	11.7	6	2	0
8	F	54	27.9	10.7	5	3	4
Mean ± SEM		61.4 ± 4.2	25.7 ± 1.1	8.9 ± 0.8	6.4 ± 2.0	3.3 ± 1.0	1.9 ± 0.6

*Body mass index.

TABLE 2
Composition of test meals

	Meal A	Meal B	Meal C
Carbohydrate (g)			
Total	54	55	60
Starch and dextrins	24	38	28
Sugars	30	17	32
Glucose	10.2	0.2	3.3
Fructose	8.9	0.2	3.0
Lactose	1.4	16.2	14.3
Sucrose	9.5	0.4	11.4
Protein (g)	21	20	17
Fat (g)	18	19	19
Dietary fiber (g)	3.6	5.1	5.4
Energy (kcal)	470	470	480

https://diabetesjournals.org/care/article/9/3/250/32757/Comparison-of-Plasma-Glucose-Serum-Insulin-and-C

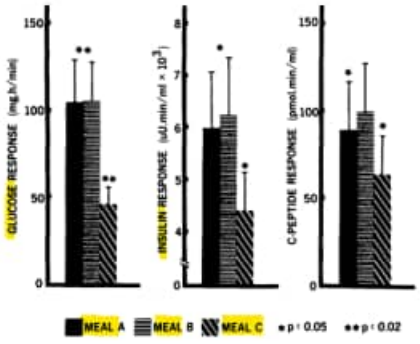

FIG. 2. Glycemic, insulin, and C-peptide responses to 3 different breakfast meals.

after meal C (0.54 ± 0.18 pmol/ml) than after meal A (0.88 ± 0.27 pmol/ml, NS) or after meal B (1.07 ± 0.29 pmol/ml, $P < .02$). Figure 2 shows the CP response to each meal. Meals A and B produced similar responses (89.8 ± 25.4 and 99.8 ± 26.4 pmol · min · ml^{-1}, respectively). The CP response after meal C (62.8 ± 19.9 pmol · min · ml) was significantly less than that after meal A ($P < .05$). The CP response paralleled the glycemic responses to meals.

DISCUSSION

This study has shown that breakfast meals selected from food exchange lists and containing similar amounts of carbohydrate, protein, and fat do not necessarily produce equivalent PG responses in insulin-treated persons with NIDDM. The glycemic responses to meals A and B were almost identical, but the response to the muesli and milk breakfast (meal C) was approximately half that observed with the other two test meals. These differing responses in insulin-treated patients were associated with changes in SI and CP responses, which indicated diminished endogenous insulin secretion during meal C.

Differences in the methods of processing, the nature of the carbohydrates, and the type of dietary fiber of the food items included in the test meals may account for the observed differences in PG, SI, and CP responses.

During processing, the wheat starch in bread (meals A and B) and wheatflake biscuits (meal B) is fully gelatinized (hydration and swelling of the starch granule) and partially digested by native and exogenous amylases (dextrinization).[15] In contrast, the starch in the rolled oats, which is the major ingredient of the muesli (meal C), is only partially gelatinized, despite the heat treatments applied during processing.[15] Milling of oats to produce rolled oats results in less mechanical disruption of the oat grain compared with the disruptions caused by the milling of wheat to produce flour for use in breadmaking and the cooking at high temperatures and pressure and flaking of wheat used in the making of the wheatflake biscuit.[15] Gelatinization of starch and mechanical disruption of grain structure increase the digestibility of starch presumably by increasing the availability of starch to amylolytic enzymes during both processing and digestion.[4,5] The lower PG and endogenous insulin effects of the muesli and milk breakfast may in part be due to the reduced availability of the starch in the rolled oats. Our finding is consistent with other studies that have indicated that the nature of starch is an important determinant of blood glucose and insulin responses to foods in normal and diabetic individuals.[1,3,7] For example, Collings et al.[7] demonstrated a greater glycemic response to cooked (i.e., gelatinized) starch compared with raw ungelatinized starch.

Although the total carbohydrate intake provided by each meal was similar, there were differences in the proportion of simple and complex carbohydrate among the test meals. Meal C contained more simple carbohydrate in the form of lactose, sucrose, and fructose than the other meals. These sugars have less effect on PG than either glucose or cooked starch and the proportionately higher content of these sugars in meal C may have contributed in part to the lower glycemic response after that meal.[11,16] However, comparison of the glycemic responses to meals A and B demonstrates that other factors are operative. Meal B, which contained the largest amount of complex carbohydrate and the least amount of simple carbohydrate, produced an equivalent glycemic response to meal A, which contained the least amount of complex carbohydrate.

While dietary fiber intakes provided by the test meals were similar, oats contain oat gum.[17] This storage polysaccharide hydrates to produce an extremely viscous solution like guar. Fibers of this type delay the absorption of carbohydrates and result in less postprandial hyperglycemia.[18] Although fiber intakes were small in our study compared with those that have shown such effects, the difference in the type of dietary fiber in meal C may have made a minor contribution to the lower glycemic response to this meal.

The validity of currently available exchange lists for carbohydrate foods has been challenged on the basis of the glycemic index of individual food items. However, Coulston et al.[19] have questioned the use of the glycemic index of individual food items in predicting the glycemic response to mixed meals incorporating these foods. Nuttall et al.[11] noted only small differences when comparing the glycemic effects of four test breakfasts selected using the American Diabetes Association Food Exchange Lists in untreated NIDDM patients. The demonstration that one of our test breakfasts did not produce the predicted response does not undermine the general usefulness of exchange lists. However, some modification may be necessary to take into account the processing method and the nature of the carbohydrates when considering the equivalence of individual items. Until the results of further studies are available, individuals who use self-monitoring of blood glucose are in a position to identify potentially equiv-

alent mixed meals that may not produce the theoretically equivalent PG response and make the necessary and important adjustments to their diet.

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THE MEDICAL JOURNAL OF AUSTRALIA Vol. 152 January 1, 1990 49

LETTERS TO THE EDITOR

Comparison of glycaemic control with human and porcine insulins — a meta-analysis

To the Editor: On December 1, 1989, porcine insulin was deleted from the Schedule of Pharmaceutical Benefits. As a result, more than 40 000 insulin-treated persons will have been transferred to treatment with human insulin. There are concerns that the transfer from porcine to human insulin will result in worse glycaemic control. Some studies have reported higher fasting blood-glucose and glycosylated haemoglobin levels with human insulin compared with porcine insulin. However, other studies have reported either no difference between human and porcine insulins or improved glycaemic control with human insulin. What overall conclusion can be drawn from these studies?

Meta-analysis is a statistical technique to fasting blood-glucose nor the mean blood-glucose levels changed significantly.

This analysis of the available data shows that there is no evidence to support a deterioration of diabetic control with transfer from porcine to human insulin. On the basis of glycaemic control, human and porcine insulins therapeutically are equivalent.

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BOX 1: Novo's Sydney University Low GI Diet made sugary high-carb diets popular, as T2D reversal was "cancelled"

***Low GI Diet* is an undisclosed Novo Nordisk/Sydney University JV designed to grow market for T2D drugs, esp. Insulin**

My detailed Timeline (starts p. 49) documents that the University of Sydney's "Low GI" (Glycemic Index) diet approach was developed as an **undisclosed joint venture** between **Dr John J. Miller,** Medical Director Australasia for diabetes-drug seller **Novo Nordisk**, his lifetime collaborator and financial partner (global superstar) Dr J. C. Brand aka **Prof. Jennie Brand-Miller (JBM)**, and their lifetime scientific collaborator, **Prof. Stephen Colagiuri**, Novo's University of Sydney diabetes-drug expert.

Given the role of carbohydrate in T2D (p. 28) and Dr J. J. Miller's expertise (unethically undisclosed) deep in the process, JBM's high-carbohydrate Low GI advice appears to have been **designed by Novo Nordisk to ensure T2D reversal is rare**, thus helping to boost unneeded taxpayer-funded purchases of ineffective T2D medicines especially Insulin, until the patient's death.

JBM and Stephen Colagiuri *et al* (1996), *The GI Factor*
(via Novo Nordisk's Medical Director Australasia, John J. Miller) "The message is simply this: if you believe you are at risk of being overweight, **you should think seriously about minimising fat and eating more carbohydrate**"; "It was widely (and wrongly) believed for many years that sugar and starchy foods like potato, rice and pasta were the cause of obesity"; "**Twenty years ago, every diet for weight loss advocated restriction of these carbohydrate-rich foods**"; "Sugar has been blamed as a cause of people becoming overweight largely because it is often found in high-fat foods, where it serves to make the fat more palatable and tempting. Cakes, biscuits, chocolate and ice-cream contain a mixture of sugar and fat"; "**Current thinking is that there is little evidence to condemn sugar or starchy foods as the cause of people becoming overweigh**t" (pp. 60-61).

JBM and Stephen Colagiuri *et al* (2012), *Low GI Diet Diabetes Handbook (revised edition)*
"Doesn't sugar cause diabetes? No. There is ***absolute consensus*** that sugar in food does ***not*** cause [type 2] diabetes" (p. 43).

JBM and Stephen Colagiuri *et al* (2015), *Low GI Diet: Managing Type 2 Diabetes (Revised edition)*

"Having diabetes doesn't mean you need less carbohydrate than anyone else" (p. 57). "What to snack on … The best snacks are …An apple, a banana, a bunch of grapes, a pear or a nectarine or a mandarin or orange" (p. 81). "Old-fashioned sugar stands up well under scrutiny - it is the second sweetest after fructose, has only moderate GI, is the best value for money and is the easiest to use in cooking" (p. 94).

JBM and Stephen Colagiuri *et al* (2003), *The New Glucose Revolution: Losing Weight*
"Do you eat enough carbohydrate? …Between 13 and 16 serves a day: Great - this should meet the needs of most people." (One serve is a medium-sized piece of fruit or a slice of bread. p. 47)

"**The GI only relates to carbohydrate-rich foods**. …It is *impossible for us to measure a GI value* for foods which contain negligible carbohydrate. These foods include meats, fish, chicken, eggs, cheese, nuts, oils, cream, butter and most vegetables" (pp.52-53) [**RR: The glycemic response to those nutritious wholefoods (easily seen via CGM) is super-low, which is exactly the point: those nutritious "no GI" wholefoods are central to a range of low-carbohydrate diets that fix T2D.**]

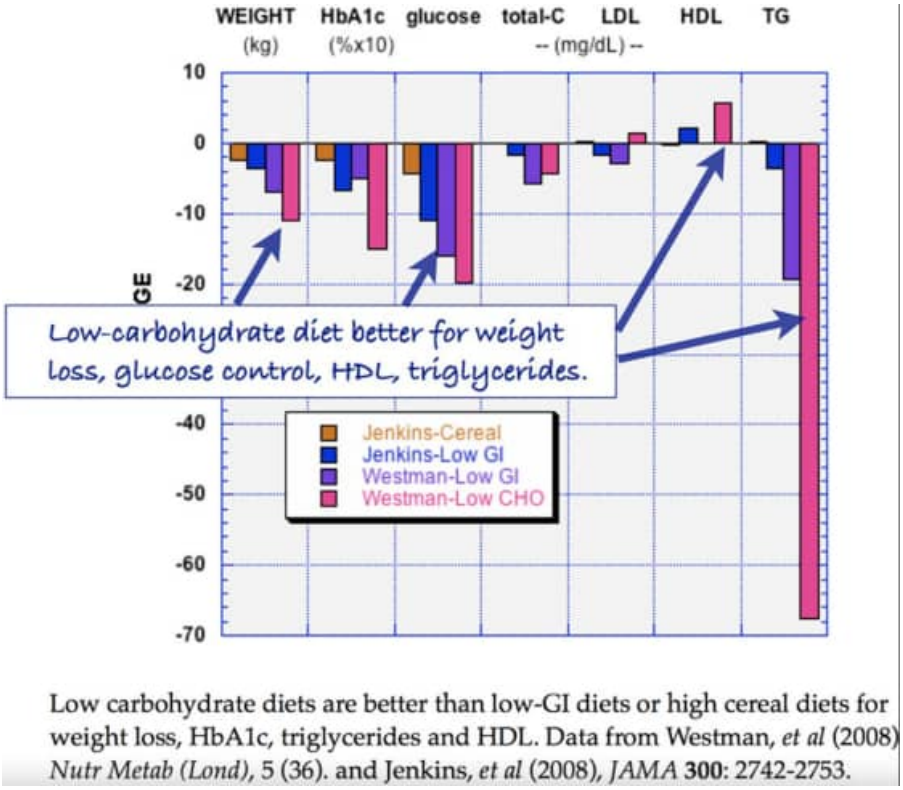
On meals, JBM and Colagiuri (in their undisclosed joint venture with Novo Nordisk's Dr John J. Miller) advise: **Breakfast -** "Start with a bowl of low GI cereal …like All Bran, rolled oats or Guardian". Or non-toasted muesli. And "Add a slice of toast made from a low GI bread (or 2 slices for a bigger person)" (p. 60); **Lunch -** "Try a sandwich or a roll, leaving the butter off …choose a bread with lots of whole grains… Finish your lunch with a piece of fruit…" (p. 62); and **Dinner -**"The basis of dinner should be carbohydrate foods. Take your pick from rice, pasta, potato, sweet potato, couscous, bread, legumes or a mixture" (p. 65).

JBM *et al* (2005), *The Low GI Diet Revolution*
"For people in industrialized countries, **avoiding carbs is a tricky business**, because the alternative sources of energy are often high in saturated fat, and by eating them we run the risk of doing long-term damage to blood vessels and the heart. Indeed, there is more evidence against saturated fat than against any other single component of food [**yes, sugar is innocent!**]" (p. 18). "**Low-carb diets don't work** in the longer term, because they represent such a huge departure from our normal eating habits. Most of us would find it **simply too difficult** to live in a modern world without our carbs and starchy staples, be they bread, pasta, noodles, or plain old rice. Avoiding sugars is twice as hard, because enjoying sweetness is programmed into our brains" (p. 33). "In people losing weight on a low-carb diet, the level of ketones in the blood rises markedly, and this state, called *ketosis,* is taken as a sign of 'success'. The brain, however, is definitively not at its best using ketones, and one result is that mental judgment is impaired" (p. 35) [RR: This of course is nonsense, from the University of Sydney's corrupt and rather ignorant JBM, backed by her financial partner Dr Novo Nordisk. Evidence on Low Carb/Keto diets is at pp. 27-34.]

JBM and Stephen Colagiuri *et al* (2007), *The New Glucose Revolution for Diabetes*
***The New York Times* Bestselling series. Over 3 Million Copies in Print (in 2007!)**
"You might wonder why a relatively high-carb diet was ever recommended for people with diabetes when this is the very nutrient they have trouble metabolizing [RR: Exactly]. **There are two important reasons**. **One** is that your glucose tolerance, or carbohydrate tolerance, improves the higher your carbohydrate intake. The reason for this is increased insulin sensitivity: **the more carbohydrates you eat, the better your body gets at handling them.** This effect is particularly apparent at high carbohydrate intakes (greater than 200 grams/day) **[RR: locking-in T2D]**. This led to the general health recommendation to eat at least 250 grams of carbohydrates a day for maximum glucose tolerance and insulin sensitivity." **Second**, if you don't have a high carbohydrate intake, you run the risk of eating a high-fat diet instead… This can increase your insulin resistance and make your blood glucose levels worse." What's more, saturated fat… CVD, etc (p. 74). [RR: Again, pro-Novo nonsense; pp. 47, 27-34]

https://www.australianparadox.com/pdf/Submission-HoR-DIABETES-INQUIRY.pdf

Novo agent JBM pushed sugary High-Carb Low GI diets despite knowing Low Carb outperforms, reduces Novo drugs
For decades, Novo Nordisk's University of Sydney diet experts have pushed a clearly inferior and infective diet for T2D



Low carbohydrate diets are better than low-GI diets or high cereal diets for weight loss, HbA1c, triglycerides and HDL. Data from Westman, *et al* (2008) *Nutr Metab (Lond)*, 5 (36). and Jenkins, *et al* (2008), *JAMA* **300**: 2742-2753.

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Please also see "The Glycemic Index: Not the most effective nutrition therapy intervention": 1 August 2003
https://diabetesjournals.org/care/article/26/8/2466/22716/The-Glycemic-IndexNot-the-most-effective-nutrition

Novo's Sydney University pushing sugary High-Carb Low GI diets despite RCTs showing inferior to no-sugar Low Carb

How the glycemic index has changed the meaning of healthy food

World-first findings on diet changes and lifestyle diseases

Charles Perkins Centre researchers are leading the world in using the Glycemic Index (GI) as a game changer in weight control, type 2 diabetes and cardiovascular disease.

Lifestyle diseases have rocketed to epidemic levels in recent times – one Australian develops type 2 diabetes every five minutes, according to Diabetes Australia.

Could we delay or dodge these diseases – and prevent complications for people living with type 2 diabetes – simply by changing our diet and following a healthy lifestyle, with regular exercise?

The University's Charles Perkins Centre and a University of Sydney spin-off not-for-profit The Glycemic Index Foundation have spearheaded a paradigm shift in approaches to healthy eating and lifestyle diseases that could motivate many people worldwide to change how they choose carbohydrate foods – cereal foods in particular.

Professor of Human Nutrition, Jennie Brand-Miller, has been a leading contributor to several world-first studies that have advanced the Glycemic Index (GI) – which ranks carbohydrates in foods according to how they affect blood glucose levels – from scientific theory to practice.

Her findings are significant because they show the world for the first time how we can use the GI to have a positive impact on weight control, type 2 diabetes and cardiovascular disease, and even diabetes prevention.

Can we prevent diabetes?

The landmark PREVIEW Study was the first type 2 diabetes prevention study to use total diet replacements (Cambridge Weight Plan®) for the weight loss phase. Participants who consumed four shakes a day – formulated to give them everything they needed – lost an average of 11 percent of their overall body weight in just eight weeks.

Over the following three-year weight loss maintenance phase, the PREVIEW team found that both higher protein/low GI diets as well as conventional healthy diets – combined with exercise and behavioural therapy – produced remarkable weight control.

Explore our nutrition research
Charles Perkins Centre
→

Professor Jennie Brand-Miller
Academic profile →

Facts_

1

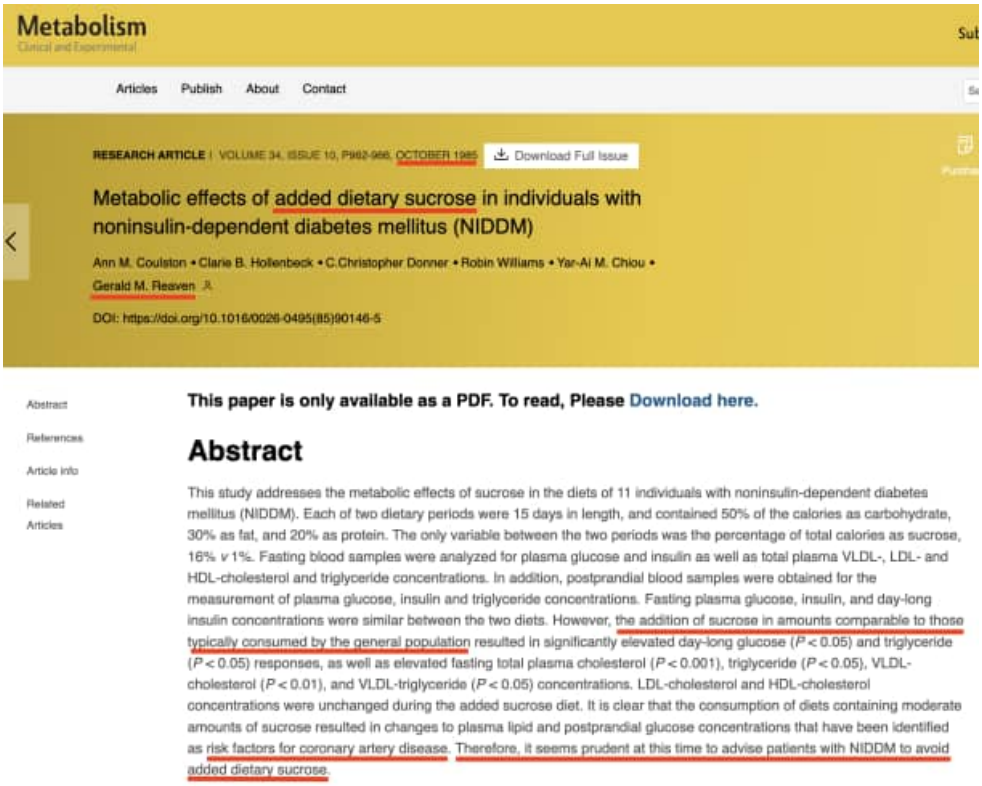
Australian develops type 2 diabetes every 5 minutes

https://www.sydney.edu.au/research/our-research/impact/how-the-glycemic-index-has-changed-the-meaning-of-healthy-food.html

JBM & JJM ignored warnings from world-renowned Gerald Reaven ("Syndrome X") against sugary high-carb for T2D victims

Back in the 1980s when Novo's John J. Miller, Stephen Colagiuri and JBM were just starting their work "managing" T2D victims with sugary "Low GI" high-carbohydrate diets, world-renowned ("Syndrome X") diabetologist Gerald Reaven published studies confirming "Deleterious metabolic effects of high-carbohydrate, sucrose-containing diets in patients with non-insulin-dependent diabetes mellitus [T2D]" and advising the avoidance of the sorts of sugary high-carb ("Low GI") diets that Novo's University of Sydney associates were starting to popularise: **"it seems prudent to avoid the use of low-fat, high-carbohydrate diets containing moderate amounts of sucrose in patients with NIDDM [T2D]**".

Oh dear! Talk about worse than useless. Spare a thought for the countless Australian T2D victims over the past four decades who have been forced to suffer lifelong misery before an early death, with millions more in the pipeline.



Metabolism

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RESEARCH ARTICLE | VOLUME 34, ISSUE 10, P982-986, OCTOBER 1985 Download Full Issue

Metabolic effects of added dietary sucrose in individuals with noninsulin-dependent diabetes mellitus (NIDDM)

Ann M. Coulston • Clarie B. Hollenbeck • C.Christopher Donner • Robin Williams • Yar-Ai M. Chiou • Gerald M. Reaven

DOI: https://doi.org/10.1016/0026-0495(85)90146-5

Abstract
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Abstract

This study addresses the metabolic effects of sucrose in the diets of 11 individuals with noninsulin-dependent diabetes mellitus (NIDDM). Each of two dietary periods were 15 days in length, and contained 50% of the calories as carbohydrate, 30% as fat, and 20% as protein. The only variable between the two periods was the percentage of total calories as sucrose, 16% *v* 1%. Fasting blood samples were analyzed for plasma glucose and insulin as well as total plasma VLDL-, LDL- and HDL-cholesterol and triglyceride concentrations. In addition, postprandial blood samples were obtained for the measurement of plasma glucose, insulin and triglyceride concentrations. Fasting plasma glucose, insulin, and day-long insulin concentrations were similar between the two diets. However, the addition of sucrose in amounts comparable to those typically consumed by the general population resulted in significantly elevated day-long glucose ($P < 0.05$) and triglyceride ($P < 0.05$) responses, as well as elevated fasting total plasma cholesterol ($P < 0.001$), triglyceride ($P < 0.05$), VLDL-cholesterol ($P < 0.01$), and VLDL-triglyceride ($P < 0.05$) concentrations. LDL-cholesterol and HDL-cholesterol concentrations were unchanged during the added sucrose diet. It is clear that the consumption of diets containing moderate amounts of sucrose resulted in changes to plasma lipid and postprandial glucose concentrations that have been identified as risk factors for coronary artery disease. Therefore, it seems prudent at this time to advise patients with NIDDM to avoid added dietary sucrose.

https://www.metabolismjournal.com/article/0026-0495(85)90146-5/abstract

The American Journal of Medicine

RESEARCH ARTICLE | VOLUME 82, ISSUE 2, P213-220, FEBRUARY 1987 Download Full Issue

Deleterious metabolic effects of high-carbohydrate, sucrose-containing diets in patients with non-insulin-dependent diabetes mellitus

Ann M. Coulston, M.S. • Clarie B. Hollenbeck, Ph.D. • Arthur L.M. Swislocki, M.D. • Y-D.Ida Chen, Ph.D. • Gerald M. Reaven, M.D.

DOI: https://doi.org/10.1016/0002-9343(87)90058-1

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Abstract

The effects of variations in dietary carbohydrate and fat intake on various aspects of carbohydrate and lipid metabolism were studied in patients with non-insulin-dependent diabetes mellitus (NIDDM). Two test diets were utilized, and they were consumed in random order over two 15-day periods. One diet was low in fat and high in carbohydrate, and corresponded closely to recent recommendations made by the American Diabetes Association (ADA), containing (as percent of total calories) 20 percent protein, 20 percent fat, and 60 percent carbohydrate, with 10 percent of total calories as sucrose. The other diet contained 20 percent protein, 40 percent fat, and 40 percent carbohydrate, with sucrose accounting for 3 percent of total calories. Although plasma fasting glucose and insulin concentrations were similar with both diets, incremental glucose and insulin responses from 8 a.m. to 4 p.m. were higher ($p < 0.01$), and mean (± SEM) 24-hour urine glucose excretion was significantly greater (55 ± 16 versus 26 ± 4 g/24 hours $p < 0.02$) in response to the low-fat, high-carbohydrate diet. In addition, fasting and postprandial triglyceride levels were increased ($p < 0.001$ and $p < 0.05$, respectively) and high-density lipoprotein (HDL) cholesterol concentrations were reduced ($p < 0.02$) when patients with NIDDM ate the low-fat, high-carbohydrate diet. Finally, since low-density lipoprotein (LDL) concentrations did not change with diet, the HDL/LDL cholesterol ratio fell in response to the low-fat, high-carbohydrate diet. These results document that low-fat, high-carbohydrate diets, containing moderate amounts of sucrose, similar in composition to the recommendations of the ADA, have deleterious metabolic effects when consumed by patients with NIDDM for 15 days. Until it can be shown that these untoward effects are evanescent, and that long-term ingestion of similar diets will result in beneficial metabolic changes, it seems prudent to avoid the use of low-fat, high-carbohydrate diets containing moderate amounts of sucrose in patients with NIDDM.

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"A vitally important book, destined to change the way we think about food."
—MICHAEL POLLAN, AUTHOR OF *IN DEFENSE OF FOOD*

"Gary Taubes is a brave and bold science journalist who does not accept conventional wisdom." —*THE NEW YORK TIMES*

GOOD CALORIES, BAD CALORIES

FATS, CARBS, AND THE CONTROVERSIAL SCIENCE OF DIET AND HEALTH

GARY TAUBES

Jenkins and Wolever's research, first published in 1981, led to a surprisingly vitriolic debate among diabetologists on the value of the glycemic index as a guide to controlling blood sugar. Reaven argued that the concept was worthless if not dangerous: saturated fat, he argued, has no glycemic index, and so adding saturated fat to sugar and other carbohydrates will lower their glycemic index and make the combination appear benign when that might not quite be the case. "Ice cream has a great glycemic index, because of the fat," Reaven observed. "Do you want people to eat ice cream?" Reaven also disparaged the glycemic index for putting the clinical focus on blood sugar, whereas he considered insulin and insulin resistance the primary areas of concern. The best way for diabetics to approach their disease, Reaven insisted, was to restrict all carbohydrates.

Paradoxically, the glycemic index appears to have had its most significant influence not on the clinical management of diabetes but on the public perception of sugar itself. The key point is that the glycemic index of sucrose is *lower* than that of flour and starches—white bread and potatoes, for instance—and fructose is the reason why. The carbohydrates in starches are broken down upon digestion, first to maltose and then to glucose, which moves directly from the small intestine into the bloodstream. This leads immediately to an elevation of blood sugar, and so a high glycemic index. Table sugar, on the other hand—i.e., sucrose—is composed of both glucose and fructose. To be precise, a sucrose molecule is composed of a single glucose molecule bonded to a single fructose molecule. This bond is broken upon digestion. The glucose moves into the bloodstream and raises blood sugar, just as if it came from a starch, but the fructose can be metabolized only in the liver, and so most of the fructose consumed is channeled from the small intestine directly to the liver. As a result, fructose has little immediate effect on blood-sugar levels, and so only the glucose half of sugar is reflected in the glycemic index.

That sugar is half fructose is what fundamentally differentiates it from starches and even the whitest, most refined flour. If John Yudkin was right that sugar is the primary nutritional evil in the diet, it would be the fructose that endows it with that singular distinction. With an eye toward primitive diets transformed by civilization, and the change in Western diets over the past few hundred years, it can be said that the single most profound change, even more than the refinement of carbohydrates, is the dramatic increase in fructose consumption that comes with either the addition of fructose to a diet lacking carbohydrates, or the replacement of a large part of the glucose from starches by the fructose in sugar.

Because fructose barely registers in the glycemic index, it appeared to be the ideal sweetener for diabetics; sucrose itself, with the possible excep-

For 100+years, highest levels of medical science and competent GPs across western world have known that T2D is caused by excess intake of sugar/carbohydrate and that T2D is readily fixed by removal of that excess intake

THE PRINCIPLES AND PRACTICE OF MEDICINE

DESIGNED FOR THE USE OF PRACTITIONERS AND STUDENTS OF MEDICINE

BY

THE LATE SIR WILLIAM OSLER, BT., M.D., F.R.S.

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NINTH THOROUGHLY REVISED EDITION

NEW YORK AND LONDON
D. APPLETON AND COMPANY
1923

Type 2 — ~95% of all diabetes

II. DIABETES MELLITUS

Definition.—A disease of metabolism in general with especial disturbance of carbohydrate metabolism in which the normal utilization of carbohydrate is impaired with an increase in the sugar content of the blood and consequent

Etiology.—The enzymes of the intestinal mucosa convert the starches and sugars of the food into monosaccharides—dextrose, galactose and levulose—which pass into the portal circulation, but the major portion remains in the liver, where it is converted into glycogen. The percentage of sugar in the systemic blood remains constant—0.06 to 0.11 per cent. Part of the sugar passes to the muscles, where it is stored as glycogen. The total storage capacity of the liver is estimated at about one-tenth of its weight, *i. e.*, about 150 gms. for an ordinary organ weighing 1,500 gms. Not all of the glycogen comes from the carbohydrates; a small part in health is derived from the proteins and fats. This treble process of transformation, storage and re-transformation of the sugars is effected by special enzymes, which are furnished by internal secretions, chiefly of the pancreas and hypophysis, and are directly influenced by the nervous system. According to Claude Bernard the sugar is simply warehoused on demand in the liver, and given out to the muscles which need it in their work. In any case, the sugar, one of the chief fuels of the body, is burned up, supplying energy to the muscles, and is eliminated as CO_2 and water. The nature of the intermediate stages of the transformation is still under discussion.

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.

(*b*) DISTURBANCES IN THE NERVOUS SYSTEM.—Bernard shows that there was a centre in the medulla—the diabetic centre—puncture of which is fol-

and diacetic acid determined, as they usually indicate a serious disturbance in the fat metabolism. It is well to remember that the acetone bodies may be only temporarily present, and it is not necessary to sign the patient's death warrant so soon as they appear. A patient may live for many years with traces, and they may disappear after having been present for months.

Treatment.—In families with a marked predisposition to the disease the use of starchy and saccharine articles of diet should be restricted. The personal hygiene of a diabetic patient is of the first importance. Sources of worry should be avoided, and he should lead an even, quiet life, if possible in an equable climate. The heat waste should be prevented by wearing warm clothes and avoiding cold. A warm, or, if tolerably robust, a cold, bath should be taken every day. An occasional Turkish bath is useful. Systematic, moderate exercise should be taken. When this is not feasible, massage should be given.

DIET.—Each patient presents his own problem and must be studied individually. The endeavor should be made to keep the urine sugar free and acid free. In this the proper use of fasting, as advocated by Allen, is of great aid but it should not be employed carelessly. The object of treatment is to increase the carbohydrate tolerance; it is important not to overtax the patient's powers of using carbohydrates by giving more than he can utilise. In mild cases the carbohydrate intake may be gradually reduced, sugar as such being cut off first and the carbohydrate intake reduced by a certain proportion each day until the urine is sugar free. In the medium and severe cases fasting is useful. The purpose of it should be explained to the patient and

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

For 100+years, highest levels of medical science and competent GPs across western world have known that T2D is caused by excess intake of sugar/carbohydrate and that T2D is readily fixed by removal of that excess intake

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, Oysters, Scallops, Liver, Fish Roe			

30 grams (1 oz.) CONTAIN APPROXIMATELY	Protein	Fat	Carbohydrates GRAMS	Calories
Oatmeal	5	2	20	110
Meat (uncooked)	6	2	0	40
" (cooked)	8	3	0	60
Potato	1	0	6	25
Bacon	5	15	0	155
Cream, 40%	1	12	1	120
" 20%	1	6	1	60
Milk	1	1	2	20
Bread	3	0	18	90
Rice	3	0	24	110
Butter	0	25	0	240
Egg (one)	6	5	0	75
Brazil Nuts	5	20	2	210
Orange (one)	0	0	10	40
Grape Fruit (one)	0	0	10	40
Vegetables from 5-6% groups	0.5	0	1	6

1 gram protein contains 4 calories.
1 " carbohydrate contains 4 calories.
1 " fat contains 9 calories.
1 " alcohol contains 7 calories.

1 kilogram—2.2 pounds.
6.25 grams protein contain 1 gram nitrogen.
A patient "at rest" requires 30 calories per kilogram body weight.

CHART XIV.—DIABETIC FOOD TABLES. (JOSLIN.)

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

For 100+years, highest levels of medical science and competent GPs across western world have known that T2D is caused by excess intake of sugar/carbohydrate and that T2D is readily fixed by removal of that excess intake

Sustained "Carbohydrate Restriction" was the highly effective fix for type 2 diabetes (T2D) known to medical science and thousands of MDs/GPs in 1923. What worked readily to fix T2D in 1923 still works readily now. Following that proven "no GI" diet, fast-growing **US firm Virta Health is reversing T2D in most victims**, while collapsing the use of T2D medicines, including Novo's insulin. Importantly, Virta Health outperforms in a head-to-head comparison between Virta and DiRECT's diabetes trials.

VIRTA & DiRECT diabetes trials (2018) confirmed T2D & Metabolic Syndrome readily fixed via Carbohydrate Restriction

DETAILS OF TYPE 2 DIABETES (T2D) PATIENTS IN LOW-CARBOHYDRATE TRIALS		VIRTA	DiRECT	
Number of T2D patients in intervention cohort		262	149	
Average age of T2D patients		54	53	
Average years since patients diagnosed with T2D		**8.4**	**3.2**	**Virta outperform**
DETAILS OF DIETS AND PROTOCOLS IN COMPETING LOW-CARBOHYRATE TRIALS		**VIRTA**	**DiRECT**	
Ketogenic diet via strict carbohydrate restriction (ongoing<30g/d or episodic<130g/d)		**Yes**	**Yes**	
Strict ban on common sugary drinks, breakfast cereals, potato chips, bread, cakes, lollies, biscuits, ice cream, chocolates, rice, pasta, potatoes, bananas, apples, oranges, beer, etc		**Yes**	**Yes**	
Features **ultra-processed** drinks and **severe energy restriction** (~840 kcal/d, 59% carbs)		No	**Yes**	**Virta outperform**
Features wholefoods - including meat, eggs and green vegetables - eaten to satiety		**Yes**	No	**Virta outperform**
This particular low-carbohydrate diet featured in most distinguished US/UK medical text in history and has been **advised for diabetes remission by competent GPs for >100 years**		**Yes**	No	**Virta outperform**
PROTOCOLS		**VIRTA**	**DiRECT**	
Patients **rountinely** kept on oral diabetes/CVD drug Metformin via formal ADA advice re CVD		**Yes**	No	
"All oral antidiabetic and antihyperintensive drugs were **discontinued on day 1**..."		No	**Yes**	
Excluded **all long-duration** T2D patients, all those diagnosed **7 to (say) 25 years** earlier		No	**Yes**	**Virta outperform**
Excluded **all particularly troubled** T2D patients, including all of those on **insulin therapy**		No	**Yes**	**Virta outperform**
Meals provided free to patients, from food-industry partner favoured by researchers		No	**Yes**	
Intervention cohort given "**step counters**" and a target of "up to 15 000 steps per day"		No	**Yes**	
Individual T2D patients **randomised** to either intervention or control		**No**	**No**	
A. RESULTS - Profound progress normalising key aspects of Metabolic Syndrome		**VIRTA**	**DiRECT**	
HbA1c, noting <6.5% is key threshold in T2D diagnosis	baseline	7.5	7.7	
	after 12 months	6.2	6.8	
	% decline	**-17**	**-12**	**Virta outperform**
Share of T2D patients HbA1c <6.5%	baseline	~20%	~15%	
	after 12 months	**72%**	**51%**	**Virta outperform**
Weight kg	baseline	115.4	100.4	
	after 12 months	101.2	90.4	
	% decline	**-12**	**-10**	**Virta outperform**
Triglycerides	baseline	2.3	2.1	
	after 12 months	1.7	1.7	
	% decline	**-25**	**-15**	**Virta outperform**
Blood pressure	baseline	132.5	134.3	
	after 12 months	125.8	133.0	
	% decline	**-5**	**-1**	**Virta outperform**
HDL-cholesterol	baseline	1.1	1.1	
	after 12 months	1.3	1.2	
	% increase	**17**	**12**	**Virta outperform**
B. RESULTS - Massive reductions in antidiabetic drug usage		**VIRTA**	**DiRECT**	
Share of T2D patients struggling on insulin therapy	baseline	28%	0%	
	after 12 months	15%	0%	
	% decline	**-47**		**Virta outperform**
At 12 months, insulin therapy in Virta was stopped or reduced in 94% of completers				**Virta outperform**
Intervention also prompted massive de-prescribing of various oral antidiabetic drugs		**Yes**	**Yes**	
NB: ADA protocol in Virta meant Metformin still prescribed for CVD risk in 64% completers, yet proportion T2D patients' HbA1c <6.5% + no antidiabetic drugs including insulin & Metformin =		25%	49%	
Fewer symptoms depression at 1 year **or** 40% greater use of **antidepressants**, versus Control		**Former**	**Latter**	**Virta outperform**
Increase to 4.0 from 3.5 in mean number other "prescribed medications", incl. **antidepressants**		No	**Yes**	**Virta outperform**

Table author is Rory Robertsoon (strathburnstation@gmail.com ; 61 414 703 471)

Published (with original sources cited) at: https://www.australianparadox.com/pdf/Colagiuri-misconduct-diabetes-2022.pdf

Widespread use of Carbohydrate Restriction ('no GI') method of reversing T2D and obesity while ditching drugs could become biggest advance in public health in 50 years but so far blocked here by Novo's corrupt USyd cabal

BLUE SHIELD OF CALIFORNIA ADDS VIRTA HEALTH TO ITS PROVIDER NETWORK TO HELP REVERSE THE STATE'S GROWING TYPE 2 DIABETES EPIDEMIC

Blue Shield is first health plan in California to implement digital diabetes reversal solution across multiple lines of business.

By Mashi Nyssen

FEBRUARY 07, 2023

OAKLAND, Calif. (Feb. 7, 2023) – Blue Shield of California today announced an expanded partnership with Virta Health, the leader in type 2 diabetes reversal, as Virta joins the nonprofit health plan's statewide provider network for 2023. Virta is the first digital diabetes solution to be fully covered for eligible members under Blue Shield's benefits program.

Combining advanced telehealth technology and clinically proven personalized nutrition, Virta's approach helps patients reverse type 2 diabetes and other chronic metabolic diseases. It becomes available this month to Blue Shield members enrolled in Preferred Provider Organization (PPO) plans for Individual and Family, Fully Insured, Administrative Services Only (ASO), and Medicare Advantage. Blue Shield is the first health plan in the state to offer Virta's solution to members across multiple lines of business.

Virta member Maureen O'Connor

Since 2019, Blue Shield members with diabetes who enrolled in the nonprofit health plan's Wellvolution digital apps lifestyle program have had access to Virta. Since then, Virta has helped Wellvolution participants achieve positive outcomes in blood sugar control and weight loss while reducing or eliminating the need for diabetes medications.

"After seeing the life-changing results achieved for our members through Virta and Wellvolution, we were convinced we should offer Virta more broadly under Blue Shield's benefits program," said Susan Fleischman, M.D., chief medical officer at Blue Shield of California. "We believe this virtual diabetes-specific network partnership will produce positive lifestyle changes and improved health for our members who suffer from diabetes."

For Blue Shield members who have already been using Virta Health on Wellvolution, results after one year include:

- Fewer Medications: Members eliminated more than half of diabetes medications (not including metformin). Insulin dosages were reduced by nearly 70%.
- Clinically Significant Weight Loss: Members saw an average 7% weight loss (5% is considered clinically significant).
- Blood Sugar Reduction: Estimated A1c improved by 1.1% on average. Every one-point decrease in A1c (a measure of blood sugar) reduces risk of long-term diabetes complications—such as eye, kidney, and nerve disease—by up to 40%.

As part of Blue Shield's provider network, Virta will serve as just one arm of a member's care team. Eligible Blue Shield members can choose both a traditional provider and Virta, which will work alongside traditional providers as a virtual diabetes specialist. In-network physicians can also refer their patients to Virta. To enroll in Virta, eligible members simply go to the Virta landing page on Blue Shield's website and sign up.

"The health outcomes we've seen among members with diabetes who have used Virta through Wellvolution are dramatic and sustainable," said Dr. Fleischman. "Members see a real improvement in the quality of their health, life, and optimism about the future because they typically reduce or eliminate their diabetes medications with Virta."

Diabetes is among the most expensive diseases in the world. In the U.S., more than 11% of the population has diabetes, some 37.3 million people, according to the Centers for Disease Control and Prevention.

"More than 3.2 million Californians are suffering unnecessarily from type 2 diabetes," said Sami Inkinen, CEO and co-founder at Virta Health. "Our expansion with Blue Shield is a great step towards finally reversing the human and financial toll of diabetes in the state."

According to the American Diabetes Association, California has the largest population with diabetes and the highest costs, at nearly $40 billion. Care for people diagnosed with diabetes accounts for one in four healthcare dollars in the U.S., and more than half of that expenditure is directly attributable to diabetes.

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About Blue Shield of California

Blue Shield of California strives to create a healthcare system worthy of its family and friends that is sustainably affordable. Blue Shield of California is a tax-paying, nonprofit, independent member of the Blue Shield Association with 4.7 million members, 7,800 employees, and $22.9 billion in annual revenue. Founded in 1939 in San Francisco and now headquartered in Oakland, Blue Shield of California and its affiliates provide health, dental, vision, Medicaid, and Medicare healthcare service plans in California. The company has contributed $120 million to Blue Shield of California Foundation in the last three years to have an impact on California communities. For more news about Blue Shield of California, please visit news.blueshieldca.com. Or follow us on LinkedIn, Twitter, or Facebook.

About Virta Health

Virta Health helps people reverse type 2 diabetes and other chronic conditions. Current approaches manage disease progression through increased medication use and infrequent doctor visits. Virta reverses type 2 diabetes through innovations in technology, nutrition science, and continuous remote care from physicians and behavioral experts. In clinical studies, 94% of patients reduce or eliminate insulin use, and weight loss exceeds FDA benchmarks by nearly 150%. Virta works with the largest health plans, employers, and government organizations and puts 100% of its fees at risk based on clinical and financial outcomes. To learn more about how Virta is transforming lives by reversing type 2 diabetes and other chronic diseases, visit www.virtahealth.com or follow us on Twitter @virtahealth.

https://news.blueshieldca.com/2023/02/07/blue-shield-of-california-adds-virta-health-to-its-provider-network-to-help-reverse-the-states-growing-type-2-diabetes-epidemic

Dedication

Charlie Perkins was born in Alice Springs near the red centre of Australia in June 1936. I was born there 30 years later in March 1966. I dedicate my decade's worth of efforts exposing the Charles Perkins Centre's disastrous sugary high-carbohydrate advice for diabetes to my now-dead parents. My wonderful, kind indefatigable mother, **Elaine Lucas** (14 March 1937 to 14 March 2021) nursed Aboriginal and other Australians in remote places - including Katherine, Alice Springs, Balcanoona, Woorabinda and Baralaba - from the early 1960s to the late 1980s, while my father, **Alexander "Sandy" Robertson** (2 October 1933 to 26 April 2015) grew up on a farm near Peebles in Scotland, and in the Scots Guards, then shipped briefly to Melbourne and Coogee in Sydney, before working with cattle, sheep and wheat across country Australia for half a century. He taught me (and my brother and sister) much about what is right and much about what is wrong, often by example. (A longer piece on Dad's life and times can be found in one of the links below.)

I also have firmly in mind people like Bonita and Eddie Mabo, Faith Bandler, Charlie Perkins (who Dad often said he knew briefly - so too his brother Ernie - in The Territory over half a century ago), Waverley Stanley and Lou Mullins of Yalari, and especially Noel and Gerhardt Pearson, all of whom worked or are working indefatigably for decades to improve the lot of their mobs, their peoples left behind. Finally, I wonder whatever happened to the many Aboriginal boys and girls I met across country Australia when I was a boy, especially the big Woorabinda mob with whom I shared classrooms and sports fields back in Baralaba, central Queensland, in the late 1970s. Much of the news over the years has been tragic and depressing. https://www.australianparadox.com/baralaba.htm

Please note: In this and other documents, I have detailed influential incompetence and much worse in nutrition and health "science", and by Go8 university senior management. Importantly, if you read anything here or elsewhere from me that is factually incorrect or otherwise unreasonable, please contact me immediately and, if I agree, I will correct the text as soon as possible. This all matters because up to two million or more hapless Australians today already have T2D, the number growing rapidly. Many of these vulnerable Australians can expect mistreatment, misery and early death, harmed by high-carbohydrate T2D advice promoted by Australian governments and a range of respected entities, all advised by highly influential but inept and/or corrupt Go8 science careerists. The unfolding diabetes tragedy can be seen most clearly in the quiet suffering of short-lived Indigenous Australians.

Using the word "corrupt", I rely on an **Oxford definition** - **"**having or showing a willingness to **act dishonestly** in return for money or personal gain" (including protecting reputations) – and **USyd's *External Interests Policy***: "Failure fully to disclose and appropriately manage a conflict of interests may be regarded as **corrupt conduct** under the Independent Commission Against Corruption (ICAC) Act 1988" https://www.sydney.edu.au/policies/showdoc.aspx?recnum=PDOC2011/75&RendNum=0

Finally, I confirm again that I am happy to be interviewed publicly on all matters covered in all the material I have published here and elsewhere.

Best wishes,
Rory
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Four years ago, I wrote to University of Sydney Vice-Chancellor Mark Scott, asking him to please stop Charles Perkins Centre research misconduct that is working to suppress medical science's most-effective fix for type 2 diabetes, thus promoting misery and early death for millions of vulnerable Australians: https://www.australianparadox.com/pdf/RR-letter-to-new-USyd-VC-Scott-July-2021.pdf

Here's me, Emma Alberici and ABC TV's *Lateline* on the University of Sydney's Australian Paradox: https://www.youtube.com/watch?v=OwU3nOFo44s

Here's the diet advised by Dr Peter Brukner, formerly the Australian cricket team's doctor: https://www.australianparadox.com/pdf/PeterBrukner.pdf

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