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Submission to 2023 Parliamentary Inquiry into Diabetes: Embracing “Carbohydrate Restriction” and eschewing sugary “Low GI” and other high-carbohydrate diets to start reversing Australia’s type 2 diabetes (T2D) disaster (features 8-page timeline documenting an epic diabetes fraud, a University of Sydney/Novo Nordisk joint venture)

Dear Chair Dr Mike Freeland, Deputy Chair Mrs Melissa McIntosh and other esteemed Committee members,

Thank you for the opportunity to provide a Submission to your Inquiry into the readily fixed disaster that is our type 2 diabetes (T2D) epidemic. This is an exciting time to have an Inquiry, as the situation is ripe for change: we already have all the needed knowledge and expertise to start reversing our T2D disaster. I’m hopeful your Inquiry will embrace the critical scientific and clinical facts that will allow *your* Recommendations to drive a T2D revolution. **My Recommendations are presented on p. 16.**

With your help, the disastrous ongoing increase in the number of T2D victims – now perhaps 2 million or more - can be stopped, and over half of today’s victims can be rescued without extra “health spending” – indeed, spending can be reduced. As noted, we already have the insights and expertise that, if properly scaled using all Australian health entities, doctors, nurses and dietitians etc, could see many thousands rescued from T2D within months. Within a few years, we could collapse the number of victims suffering a life of T2D misery, amputations, blindness, and/or kidney disease before an early death. Here’s **Dr Penelope Figtree** (whose Medical degree with First Class Honours is from University of Sydney) explaining how many victims are readily reversing their own T2D with little more than a piece of paper and kind words of encouragement from a doctor deprecating their unneeded medications: <https://www.youtube.com/watch?v=11x9PhlZuK0> ; <https://www.youtube.com/watch?v=BSKqPTsl7fw&t=821s>

Chair, Deputy Chair and Committee members, my name is Rory Robertson. As an economist, I should have no scope to tell you anything useful on the cause of, and remedy for, our T2D disaster. **But medical, diabetes and public-health careerists have been so bad at their main job** – promoting improved health – that outsiders have been forced to investigate and address the problem, in my case to rescue myself in my early 40s from pending obesity and worse. I became the economist who solved the University of Sydney’s sugar-and-obesity “paradox”, documenting that its infamous **“Australian Paradox”** is a simple matter of misrepresented, unreliable and even faked sugar data promoted by inept and dishonest “scientists” (pp. 11-13, 32-38). To give you further confidence that insights I bring to the table may be useful, my background includes a First Class Honours degree in Economics (1987) and a Master of Economics from ANU (1991), six years at the Reserve Bank of Australia (1988-94) under then-Governor Bernie Fraser and future Governors Ian Macfarlane, Glenn Stevens and Michele Bullock, and now 35 years (and counting) as a full-time macroeconomic and financial analyst in banks in Sydney and New York, after living in maybe 20 homes across much of country Australia before age 18. There’s more detail (and boyhood photos of me) on pp. 2-4 of the **“evidence base”** I am providing to support my Submission: <https://www.australianparadox.com/pdf/Letter-to-BelindaHutchinson.pdf>

My Submission will highlight critical aspects of the evidence base I’ve carefully gathered and documented over the past dozen years. Since **fixing T2D is simple** (see ToR 1, below), the bulk of my Submission addresses your ToR 5, explaining the origins of harmful taxpayer-funded diet misinformation that since 1980 has helped make most Australians fat and sick. **I highlight the ignorance, dishonesty and conflicts of interest (COIs) of an “untouchable” cabal of University of Sydney diet/health careerists.** This corrupt cabal has provided faulty, harmful and influential diet and diabetes advice to the American Diabetes Association (ADA), the NHMRC, the Department of Health and the rest of us. Three members enjoyed **special financial relationships with global drug-seller Novo Nordisk** (p. 17). Amazingly, my **Timeline (pp. 8-14)** documents that University of Sydney superstar Jennie Brand-Miller (JBM) from the early 1990s developed her influential yet highly ineffective **high-carbohydrate Glycemic Index (“Low GI”) approach to “diabetes management” while secretly working hand-in-glove with diabetes-drug seller Novo Nordisk**, not disclosing even when providing advice to the ADA and NHMRC. Even today, Novo Nordisk’s involvement remains dishonestly hidden from the global scientific community, despite my ongoing pressing of JBM, ABC reporter Norman Swan and University of Sydney Vice-Chancellor Mark Scott (p. 14). My estimate is that JBM in her Glycemic Index “Low GI” joint-venture with Novo Nordisk has **published false and deliberately deceptive COI disclosures** in more than 100 diet-and-health papers in over a dozen journals. Outrageously, JBM’s corrupt cabal - including her boss Stephen Simpson AC, Academic Director of the Charles Perkins Centre, a position overseeing ~1200 taxpayer-funded researchers; Stewart Truswell, the main scientific author of our **Australian Dietary Guidelines** from 1978; and Dr Stephen Colagiuri, an excessively influential drug-company “owned” scientific author of our unhelpful **National Diabetes Strategy 2016-2020** and of our T2D-risk calculator **AUSDRISK** – has dishonestly helped JBM to hide her pro-sugar “Low GI” approach’s deep links with Novo Nordisk from the global scientific, medical, diabetes and taxpaying communities (pp. 8, 14, 17, 28; pp. 4-39 in **BelindaHutchinson.pdf** above).

ADDRESSING 2023 PARLIAMENTARY INQUIRY’S FIVE TERMS OF REFERENCE (ToR)

ToR 1. The causes of diabetes (T1D, T2D and gestational) in Australia (the latter two represent ~90% of all diabetes)

The main cause of T2D – including earlier “pre-diabetes” and “gestational diabetes” - remains the excess consumption of dietary sugar and other carbohydrate, as was widely known a century ago. In the most distinguished medical text in the western world back then - ***The Principles and Practice of Medicine***; 9th Edition, 1923 - Sir William Osler MD and Thomas McCrae MD observed: **“The healthy person has a definite limit of carbohydrate assimilation”** and **“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 [T2D] — a form very readily controlled”**.

So, fixing T2D typically is straightforward: Osler and McCrae saw the problem as “EXCESS OF CARBOHYDRATE INTAKE” so advised a “STRICT DIET” of nutritious wholefoods: “(Foods without sugar [carbohydrate]). Meats, Poultry, Game, Fish, Clear Soups, Gelatine, Eggs, Butter, Olive Oil, Coffee, Tea and Cracked Cocoa” and plants incl. Cabbage, Lettuce, Olives, Berries, Nuts, etc”. Overleaf are snippets from my 1923 Medical text: <http://www.australianparadox.com/pdf/1923-Medicine-Textbook.pdf>

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

II. DIABETES MELLITUS

~90% of all diabetes

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 CO₂ 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 hyperglycemia 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, par-

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ticularly 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-

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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 utilize. 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

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

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

Food	Quantity Grams	Calories per Gram	Total Calories
Carbohydrate.....	10 X	4	40
Protein.....	75	4	300
X 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

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

30 grams (1 oz.)	Protein	Fat	Carbohydrates	Calories
CONTAIN APPROXIMATELY			GRAMS	
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.)

ToR 2. New evidence-based advances in the prevention, diagnosis and management of [type 2] diabetes [T2D]

"New evidence" on T2D reversal – produced by simply removing excess dietary sugar/carbohydrate - is impressive and reliable but not really new. Again, **sustained "Carbohydrate Restriction"** was the highly effective fix 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 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-CARBOHYDRATE 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 routinely 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

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

BLUE SHIELD OF CALIFORNIA ADDS VIRTUA 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.

###

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>

BOX 1: Sydney University's "Low GI" (Glycemic Index) diet made high-carb diets fashionable but blocked T2D reversal

Low GI Diet is undisclosed Novo Nordisk/Sydney University JV that has grown market for T2D drugs including Insulin

My detailed Timeline (starts p. 8) documents that the University of Sydney's "Low GI" (Glycemic Index) diet approach was developed as an **undisclosed joint venture** between (now-global superstar) **Janette Brand aka Jennie Brand-Miller (JBM)**, **JBM's scientist husband**, lifetime collaborator and financial partner **Dr John J. Miller, a Medical Director at global diabetes-drug seller Novo Nordisk**, and **his** main scientific collaborator, University of Sydney diabetes careerist **Dr Stephen Colagiuri**.

Given the role of carbohydrate in T2D (pp. 2-5) and Dr J. J. Miller's expertise (unethically undisclosed) in the background, JBM's high-carbohydrate Low GI advice appears to have been **designed with Novo Nordisk to ensure T2D reversal is impossible**, thus fuelling ongoing prescriptions for expensive-yet-ineffective T2D medicines especially Insulin, until the T2D victim's death.

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. 56). **"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. 85).

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. 73).

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 excellent "no GI" foods 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).

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 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. 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 a 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... cardiovascular disease, etc (p. 74).

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 [RR: Silly stuff from Australia's finest, JBM, backed by her financial partner at Novo Nordisk]" (p. 35)

ToR 2. New evidence-based advances in the prevention, diagnosis and management of T2D ...continued

To help rescue say half or more of Australia's two million T2D victims, all that is required is for your Inquiry to **carefully assess, accept and then recommend a nation-wide embrace of the latest hard scientific and clinical evidence** from highly competent, qualified and experienced professionals, including **Dr Penelope Figtree** who is driving improved health at Port Macquarie, **Dr Peter Brucker** and his team at Defeat Diabetes, **Ray Kelly** whose Too Deadly for Diabetes program is promoting world-leading change in many of our Indigenous communities, and **Dr Alex Petrushevski, Dr Deepa Mahananda** and the team at Sydney Low Carb Specialists. In the UK, there's Low-carb GP **Dr David Unwin**, while in the US there's clinician **Dr Eric Westman** and, on a much larger scale, **fast-growing firm Virta Health**. Again, highly competent practitioners at the cutting edge of improved public health are having great success using the **eat-to-satiety wholefood Carbohydrate Restriction ("no GI") approach to reverse T2D**, while collapsing victims' prescriptions for expensive, ineffective, unneeded T2D drugs.

As an economist, one key focus is "value for money" for hapless taxpayers. Some methods of Carbohydrate Restriction are more effective and less expensive than others. In my important head-to-head comparison of the results of **the widely cited Virta Health (US) and DiRECT (UK) diabetes trials** (see table, p. 4), we find that Virta's wholefood low-carbohydrate approach **impressively outperforms** the liquid "shakes" low-carbohydrate approach used in the DiRECT trial. **That's despite the T2D victims in Virta's trial being fatter (115 vs 100kg) and suffering T2D five years longer on average than the recently diagnosed T2D victims in the DiRECT trial. Critically, the Virta Health trial saw 94% of completers on "Insulin therapy" reduce their Insulin dosages, with around half discontinuing Insulin use completely. Please note: Insulin is lifesaving for T1D, unhelpful for T2D; indeed, there is a good reason why T2D used to be known as "Non-Insulin-Dependent Diabetes Mellitus (NIDDM)".**

That the widespread official promotion of eat-to-satiety low-carbohydrate diets to fix T2D would wreck Novo Nordisk's and other companies' cynical-but-lucrative **T2D business model – "Fill victims with expensive yet ineffective T2D diabetes drugs until death, no T2D reversal allowed"** – probably explains why Pharma-"owned" Stephen Colagiuri blatantly misrepresented the Virta-versus-DiRECT results in Diabetes Australia's deliberately misleading **Position Statement on Type 2 diabetes remission** in October 2021: pp. 23-38 in <https://www.australianparadox.com/pdf/Letter-Health-Minister-n-Secretary-Feb23.pdf>

The Virta Health (US) versus DiRECT (UK) trial evidence suggests that Canberra's T2D funding for Insulin and "total meal replacement" shakes should be limited: **dramatically better results** are readily obtained when T2D victims are simply assisted to remove problem foods from their lives. **From an optimal public-policy perspective, there is absolutely no substitute for starting to focus T2D victims on wholefoods that support good health while helping them avoid the foods that fuel T2D harm.** I'm not saying it is easy. Dramatically changing my decades-old diet was not easy for me. But success is all about using reliable diet information and improving "compliance" over time. **When official diet advice starts promoting critical facts – including (i) excess consumption of carbohydrate/sugar causes T2D; and (ii) fresh meat and eggs are healthful and work to fix T2D – taxpayers are unlikely to support funding expensive band-aids including "total meal replacements" and Insulin for T2D victims.**

Perhaps the most helpful thing that taxpayers could fund is **"Continuous Glucose Monitors"**, using savings from unneeded drugs and unneeded visits to dietitians and doctors, especially poorly trained "endocrinologists". **Virta used CGMs tell T2D victims exactly what they need to know: no-one competent can then be duped into thinking "Low GI" foods including breakfast cereals, pastas, rice, bread, bananas and apples, etc, are anything but problematic for T2D victims, despite JBM's widely advised but sadly ineffective Low GI Diet having greatly boosted JBM's household wealth via her lifetime financial and scientific partner's longtime employment in Novo Nordisk diabetes-drug-selling business (see Timeline).**

ToR 3. The broader impacts of [reversing T2D] diabetes on Australia's health system and economy

Chair, Deputy Chair and esteemed Committee members, as noted above, with your Inquiry Recommendations helping, **our T2D revolution can stop Australia's T2D epidemic in its tracks, and rescue more than half of today's roughly two million victims.** With the number of T2D victims trending lower towards one million or fewer, the number suffering misery, heart attacks, amputations, blindness, kidney disease/dialysis and/or dementia before early death ultimately could be halved or better. I'm cautious in saying one million - not two million - T2D victims can be fixed. You can lead a horse to water, but you can't make it drink; nor can well-meaning practitioners force T2D victims to eat low-carb diets - but we must provide reliable diet advice.

What would be the broader effects on Australia's health system and economy of, say, one million fewer T2D victims within a decade? **Well, on top of stopping mountains of misery and early death, your/our T2D revolution would save tens of billions of dollars of public money each year.** A million fewer T2D victims would mean massive drug deprescribing (tens of millions fewer prescriptions), less need for expensive "multidisciplinary health-care teams", dialysis machines and amputations, alongside fewer heart attacks, millions fewer days of T2D hospitalisation, and with rescued T2D victims needing much less NDIS help. **Today's extreme pressures on Medicare and our broader health systems would be massively reduced.**

One of the greatest societal benefits from our/your T2D revolution will be that many in Indigenous communities can be rescued and many thousands of Indigenous children will forever avoid T2D harm. So too, many hundreds of thousands of oldies can be rescued from being forced onto unhelpful "usual care" treatments based on drug-funded experts' self-serving false claim that T2D is a "chronic, progressive disease", with elderly T2D victims forced to live out bleak lives in aged-care homes fed excess sugar/carbohydrate and expensive, ineffective taxpayer-funded diabetes drugs.

Importantly, after our hundreds of thousands of GPs, nurses, dietitians and diabetes educators have been provided with two-page handouts describing the main cause of T2D and the simple effective fix for T2D – both have been hiding in plain sight since 1923 in the world's most distinguished medical text – Canberra will not need to keep funding worse-than-useless T2D "research".

ToR 4. begins on p. 14, after my eight-page Timeline (starts overleaf)

BOX 2: Timeline to disaster: Shonky origins of ADGs, to University of Sydney/Novo Nordisk's epic diabetes fraud

On top of long-ago mistakes at the centre of our *Australian Dietary Guidelines*, my timeline below includes a **ground-breaking focus** on longtime Medical Director for Novo Nordisk Australasia, Dr John J. Miller's deep involvement in the development of the University of Sydney's ineffective high-carbohydrate "Low GI" (Glycemic Index) diet. My timeline shows **the "Low GI" approach to "diabetes management" was for decades an undisclosed "joint venture" between emerging superstar JBM, JBM's lifetime financial partner, Novo Nordisk scientist Dr John J. Miller and their scientific partner Dr Stephen Colagiuri. Dr Novo Nordisk benefited from the widespread scientific/medical embrace of his partners' "Low GI" advice, as it made unhelpful high-carb diets more respectable, stalling any move to helpful low-carb ("no GI") advice, and killing prospects for widespread T2D reversal, thereby fuelling the lucrative boom in taxpayer-funded prescriptions for ineffective T2D drugs especially Insulin.**

1921: Banting and Best discover Insulin, a lifesaver when people with T1D can't produce sufficient Insulin to metabolise sufficient food for survival. T2D victims suffer the *opposite problem*: excess intake of carbohydrate/sugar forces their bodies to produce excessive amounts of blood glucose and Insulin, day after day, month after month, for decades, until premature death.

1923: Nordisk Insulinlaboratorium – which later became Novo Nordisk - commercialises the production of insulin.

1961: Ancel Keys and Fred Stare *et al* authored and began promoting the **American Heart Association's** then-speculative and now-discredited story on "**Dietary Fat and Its Relation to Heart Attacks and Strokes**". To reduce CVD, AHA advised less fat from red meat and dairy, more seed oils and carbohydrates: <https://www.ahajournals.org/doi/pdf/10.1161/01.CIR.23.1.133>

1967: Harvard University science careerists, Fred Stare (head of Harvard's nutrition department) and **Mark Hegsted** (later the head of nutrition at the US Department of Agriculture, where in 1977 he helped draft US Dietary Goals) were paid by the sugar industry to formally downplay the role of sugar in causing heart disease, falsely promoting saturated fat in meat, eggs and dairy as the main dietary villain: <https://www.nytimes.com/2016/09/13/well/eat/how-the-sugar-industry-shifted-blame-to-fat.html>


1971: Ancel Keys delivered a false and unscientific smackdown of English scientist **John Yudkin's** (correct) claim that modern doses of refined sugar (sucrose) - not total dietary fat or saturated fat - are the main dietary evil. The infamous journal article is called *SUCROSE IN THE DIET AND CORONARY HEART DISEASE*: https://www.australianparadox.com/pdf/keys_1971.pdf

1977: The first US Dietary Goals were published by the US Government, prioritising a big reduction of total fat intake (saturated fat in particular) alongside a big increase in carbohydrate intake: <https://naldc.nal.usda.gov/catalog/1759572>

1977: London University professor Stewart Truswell was given a copy of the new US Dietary Goals. He praised them in *The Lancet*, "a rare positive independent review to balance against a host of critics in the USA". But when he promoted those US dietary goals as a plan for the UK, "The British [nutrition] establishment was unmoved". Moving to Sydney, Truswell quickly invented/authored Australia's 1982 diet guidelines: <https://www.australianparadox.com/pdf/Truswell-Origins-Diet-Guidelines.pdf>

1977: JBM's first big publication in the *Medical Journal of Australia*, co-authored with her soon-to-be husband, lifetime financial partner and scientific collaborator John J. Miller: <https://onlinelibrary.wiley.com/doi/abs/10.5694/j.1326-5377.1977.tb107779.x> Pre-marriage, JBM was **Janette C Brand, only becoming Jennie Brand-Miller (JBM) after marrying Dr John J Miller, Medical Director of Novo Nordisk Australasia:** <https://www.linkedin.com/in/john-miller-7ab727a/?originalSubdomain=au> (Source: "It not only led 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>)



Scientist Jennie Brand-Miller at home with her husband Dr John Miller.
Jennie ha



John Miller
Medical Director at Novo Nordisk Pharmaceuticals Pty Ltd
Greater Sydney Area · [Contact info](#)
50 connections

[Connect](#) [Message](#) [More](#)

Experience

-  **Medical Director**
Novo Nordisk Pharmaceuticals Pty Ltd
-  **Medical Director**
Novo Nordisk Australasia
1978 - Present · 45 yrs 2 mos

1978/1979: After hitting stiff resistance in the UK, Stewart Truswell abandoned the UK for Australia, arriving in May 1978 as the University of Sydney's first eminent Professor in Human Nutrition. Cultural cringe came alive, and doors opened. After hijacking our local dietitians' union, Truswell wrote his dietary guidelines for Australians. In April 1979, within a year of his arrival, our Department of Health helped the excessively confident - and ultimately inept - Truswell launch his low-fat, high-carbohydrate Dietary goals for Australia. **Truswell's observation that "There was no background review of the scientific literature at the time..." largely explains why we have two million T2D victims – and counting - in Australia today** (see pp. 20-21 below)

1980: The first US Dietary Guidelines were published in the United States, converting 1977's dietary goals into dietary advice for roughly 200 million Americans: <https://health.gov/sites/default/files/2019-10/1980thin.pdf>

1981: Early in her time at the University of Sydney, **JBM accidentally stumbled onto the Glycemic Index (GI) as a topic for research**. "In 1981 the first paper outlining the concept, by Dr David Jenkins of the University of Toronto, landed on her desk at the University of Sydney by mistake." JBM's lifetime financial partner **Dr John Miller** and his sci-partner **Stephen Colagiuri** also began collating GI responses to breakfasts of eggs, bread, muesli, sugar and exogenous Insulin (Timeline below and pp. 22-30)

Late 1970s/early 1980s: **Stewart Truswell** explained to **easily persuaded colleague JBM** that sugar is not really a problem. "The young researcher was encouraged to challenge dietary dogma after watching Professor Stewart Truswell, the university's head of nutrition, happily adding a spoonful of 'white death' to his coffee. He pointed Brand-Miller to research backing his choice to have sugar in moderation. 'I realised views about sugar were not based on science' " (see SMH link below).

Late 1970s/early 1980s: Given our definitive evidence that no-sugar Carbohydrate Restriction fixes T2D, **JBM's own 2003 assessment** conveys impressive ignorance on diet-and-T2D matters: "A diagnosis of diabetes was bad enough, she figured, without the directive to give up everything sweet. 'I thought people would be more likely to have [high-carb] porridge if they could sprinkle [high-carb] sugar on it and more likely to eat [high-carb] wholemeal bread if it had a dollop of [high-carb] honey.' Some of her most vocal early critics were hospital dieticians working on the same campus who were worried people might think they could eat lots of sugar." (Indeed.) <https://www.smh.com.au/world/taking-the-sweet-with-the-sour-20030419-gdgmis.html>

1982 to today: Sydney University's **Stewart Truswell** imposes shonky US high-carb advice on hapless Australians, with **NHMRC publishing his first version of our Australian Dietary Guidelines** (then "Dietary Guidelines for Australians"). Sadly, our **ADGs** were doomed to fail from Day One. As you saw above, they were essentially a direct steal from the nonsense-based US low-fat, high-carbohydrate advice invented by Ancel Keys and promoted by other ambitious but ultimately inept diet careerists, including Stewart Truswell. The **"fatal flaw"** known back then but ignored by the zealots is that the evidence for saturated fat in meat, eggs and full-fat dairy causing cardiovascular disease (CVD: heart disease and stroke) was always fluffly to non-existent: "there is **no significant evidence** for concluding that dietary saturated fat is associated with an increased risk of CHD or CVD." <https://pubmed.ncbi.nlm.nih.gov/20071648/> Alas, the false and misguided demonisation of saturated and total dietary fat from the 1950s drove official dietary guidelines across the western world, pushing hundreds of millions of humans to shift to eating heaps of carbohydrate/sugar for breakfast, lunch and dinner, plus between-meal snacks. That's where today's T2D disaster came from, reflecting/confirming the century-old medical observation that excess carbohydrate/sugar causes T2D.

February 1984: **Stephen Colagiuri and John J. Miller** publish in the *Medical Journal of Australia* on "Human (semisynthetic) insulin and porcine **insulin** in the treatment of **non-insulin-dependent diabetes**"[!] <https://pubmed.ncbi.nlm.nih.gov/6363896/>

May 1986: **Stephen Colagiuri and John J. Miller** publish in American Diabetes Association's *Diabetes Care* on "Comparison of Plasma **Glucose, Serum Insulin**, and C-Peptide Responses to Three Isocaloric **Breakfasts in Non-Insulin-Dependent Diabetic Subjects**": <https://diabetesjournals.org/care/article/9/3/250/32757/Comparison-of-Plasma-Glucose-Serum-Insulin-and-C> (see pp. 22-32)

June 1986: **Jennie C. Brand and Stewart Truswell** publish in the *Medical Journal of Australia* on "The glycaemic index of foods" – "The glycaemic index is a measure of the extent to which the carbohydrate in a food can raise the blood glucose concentration and helps to **identify foods which may be beneficial to a diabetic patient**. This paper reviews the results that have been obtained so far with the glycaemic index approach, the factors that affect the glycaemic response...and its value in **planning diabetic diets**." <https://onlinelibrary.wiley.com/doi/abs/10.5694/j.1326-5377.1986.tb112314.x>

September 1989: **Stephen Colagiuri and John J. Miller** publish in *American Journal of Clinical Nutrition* on "Metabolic effects of **adding sucrose** and aspartame to the diet of subjects with **noninsulin-dependent diabetes mellitus** - 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. ... **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**." <https://www.sciencedirect.com/science/article/abs/pii/S0002916523435800>

January 1990: **Stephen Colagiuri and John J. Miller** in *Medical Journal of Australia* (MJA) on "Comparison of **glycaemic control** with human and porcine insulins — a meta-analysis", with **John J. Miller disclosing his employer as "CSL-Novo Pty Ltd, 22 Loyalty Road, North Rocks, NSW 2151"**: <https://onlinelibrary.wiley.com/doi/epdf/10.5694/j.1326-5377.1990.tb124433.x>

February 1991: **John J. Miller** in MJA on "Human insulin": <https://doi.org/10.5694/j.1326-5377.1991.tb121118.x>

February 1991: **Janette C Brand, Stephen Colagiuri and Stewart Truswell** et al in the American Diabetes Association's journal *Diabetes Care* on "**Low-Glycemic Index Foods Improve Long-Term Glycemic Control in NIDDM**": <https://diabetesjournals.org/care/article/14/2/95/17926/Low-Glycemic-Index-Foods-Improve-Long-Term>

June 1992: **Stephen Colagiuri and John J. Miller** publish in top UK journal *The Lancet* on "Double-blind crossover comparison of human and porcine **insulins** in patients reporting lack of hypoglycaemia awareness", with **John J. Miller disclosing his employer as "Novo Nordisk Pharmaceuticals, North Rocks, United States"** [Is switch from "NSW 2151" to **United States** a sneaky deliberate error?]: [https://www.thelancet.com/journals/lancet/article/PII0140-6736\(92\)92028-E/fulltext](https://www.thelancet.com/journals/lancet/article/PII0140-6736(92)92028-E/fulltext)

August 1992: **Stephen Colagiuri and John J. Miller** publish in top UK journal *The Lancet* on "Human insulin and hypoglycaemia", with **John J. Miller again disclosing his employer as "Novo Nordisk Pharmaceuticals, North Rocks, United States"** [A sneaky deliberate error?]: [https://www.thelancet.com/journals/lancet/article/PII0140-6736\(92\)92387-U/fulltext](https://www.thelancet.com/journals/lancet/article/PII0140-6736(92)92387-U/fulltext)

September 1992: "Janette Brand Miller" aka JBM publishes with husband **John J. Miller**, on an early occasion that JBM added her financial partner's surname Miller to her surname, Brand. Why, despite earlier being a Novo Nordisk employee, does Dr J J Miller now disclose a University of Sydney affiliation? (p. 26) [https://www.jpeds.com/article/S0022-3476\(05\)81797-4/pdf](https://www.jpeds.com/article/S0022-3476(05)81797-4/pdf)
March 1994: "JC Brand Miller" publishes "Importance of glycemic index in diabetes" in *AJCN*, observing "The time has come to reassess the value of GI in planning meals for diabetics." **A full text is hard to obtain but a serious investigation by AJCN almost certainly will find no mention in any COI disclosure of JBM's lifetime financial and scientific partnership with Novo Nordisk's Dr J. J. Miller:** <https://www.sciencedirect.com/science/article/abs/pii/S0002916523194871?via%3Dihub>

1995: JBM advised: "In 1995, we joined forces with Dr Stephen Colagiuri [Novo Nordisk's Dr John J. Miller's main scientific co-author], an endocrinologist, to write *The GI Factor* (now called *The New Glucose Revolution*), the first book for the general public about the glycemic index of foods. ... We knew from our own work that understanding the GI of foods made an enormous difference to the **diet and lifestyle of people with diabetes**." (From p. 7 of JBM's book *New Glucose revolution Life Plan*, 2002). *Unreasonably, there is no mention anywhere of JBM's relationship with diabetes-drug seller Dr Novo Nordisk.*

2002: Janette C Brand-Miller published "International table of glycemic index and glycemic load values: 2002" in *AJCN* <https://www.sciencedirect.com/science/article/pii/S0002916523058409> *Unreasonably, there is no mention of JBM's lifetime financial and scientific partnership with Australia's greatest-ever diabetes-drug seller, Novo Nordisk's Dr John J Miller.*

2003: JBM and Stephen Colagiuri published "Low-glycemic index diets in the management of diabetes: a meta-analysis of randomised controlled trials" in the American Diabetes Association's journal *Diabetes Care*. *Unreasonably, JBM and Dr Colagiuri dishonestly hid JBM's financial and scientific partnership with drug-seller Novo Nordisk Australasia's Medical Director, Dr John J. Miller:* "Acknowledgments—J.B.M. and S.C. are coauthors of...books about the glycemic index (*The New Glucose Revolution*. New York, Avalon, 2002). J.B.M. is the director of ...Sydney University Glycemic Index Research Service, SUGIRS)." <https://diabetesjournals.org/care/article/26/8/2261/22776/Low-Glycemic-Index-Diets-in-the-Management-of>

June 2004: JBM's lifetime financial partner fixed a tangle. The *SMH* reported: "invitations asked patients to 'Come and make your life a little easier and gain control of your diabetes. With [Novo Nordisk] FlexPen, there is **no easier way to inject insulin**.' **Mr Miller** could not confirm whether **Novo Nordisk** or the pharmacist planned the meeting, nor could he say how often such promotion meetings took place." <https://www.smh.com.au/national/education-meeting-used-to-push-drug-20040617-qdj53q.html>

September 2004: JBM – acting as a representative of the American Diabetes Association while dishonestly hiding her Novo Nordisk COI - falsely declared Carbohydrate Restriction simply cannot fix T2D: "Although dietary carbohydrate increases postprandial glucose levels, avoiding carbohydrate entirely will not return blood glucose levels to the normal range": <https://diabetesjournals.org/care/article/27/9/2266/22648/Dietary-Carbohydrate-Amount-and-Type-in-the>

Below are five more of scores of journal articles in which JBM and/or colleagues/co-authors unethically hid JBM's lifetime financial and scientific partnership with Novo Nordisk's longtime Medical Director Australasia, Dr J. J. Miller.

2006: JBM published in *AJCN* on "Effect of a low-glycemic-index diet during pregnancy on obstetric outcomes": "JCB-M is a coauthor of *The Low GI Diet* [etc]. ... **None of the other authors had any potential conflict of interests relevant to the conduct of this research [JBM hid the fact her lifetime financial partner was seeking to grow Novo Nordisk's market by selling Insulin for pregnant women with 'gestational diabetes'.]**" <https://www.sciencedirect.com/science/article/pii/S0002916523291017>

2006: JBM, Joanna McMillan-Price, Peter Petocz, Fiona Atkinson and Ian Caterson et al published in *Archives of internal medicine* on "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." How's this? "We thank...John Miller, PhD, for comments on the manuscript".

2007: JBM published in the *British Journal of Nutrition* "The use of glycaemic index tables to predict **glycaemic index of breakfast meals**". <https://www.cambridge.org/core/journals/british-journal-of-nutrition/article/use-of-glycaemic-index-tables-to-predict-glycaemic-index-of-breakfast-meals/64ED65A47DA128C1B13326DD2984CA22>

2008: JBM published "International Tables of Glycemic Index and Glycemic Load Values: 2008" in *American Diabetes Association journal Diabetes Care*. "J.B.M. is the director of a not-for-profit GI-based food endorsement program in Australia."

2008: JBM, Alan Barclay, Peter Petocz, Joanna McMillan-Price et al published in *AJCN* on "Glycemic index, glycemic load, and chronic disease". JBM's Novo Nordisk COI is again hidden by her Low-GI crew. <https://pubmed.ncbi.nlm.nih.gov/18326601/>

2008: Renowned science investigator Gary Taubes - unaware that JBM and her globally influential pro-sugar Glycemic Index "science" had been "owned" for years by Novo Nordisk - observed in his tour-de-force book *Good Calories, Bad Calories*, "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**" (p. 197). He detailed what some have called "**the fructose loophole**", by explaining that table sugar (i.e., sucrose) is 50% glucose and 50% fructose; critically, the former boosts "blood sugar" while fructose mostly does not, being metabolised in the liver. Accordingly, sugar is relatively "low GI" and so deemed healthy by JBM and others who wilfully refuse to understand the substantial direct harm via the liver (including "Fatty Liver" aka NAFLD) caused by **modern doses of fructose**. Taubes wrote: "If **John Yudkin** was right that sugar is the primary nutritional evil in the diet, it would be the fructose [half] that endows it with that singular distinction." **Alas, scope to eat heaps of sugar is another fatal flaw in JBM's Low GI diet:** <https://www.australianparadox.com/wp-content/uploads/2023/08/Gary-Taubes-Sugar-and-GI.pdf>

December 2008: Prominent US clinician Dr Eric Westman published a randomised-controlled T2D trial in which his Low-carbohydrate ("no GI") diet **impressively outperformed** JBM's Low-GI diet. In "The effect of a low-carbohydrate, ketogenic diet versus a low-glycemic index diet on glycemic control in type 2 diabetes mellitus", Westman reported: "The diet lower in carbohydrate led to greater improvements in glycemic control, and more frequent medication reduction/elimination than the low glycemic index diet." **JBM - enjoying undisclosed financial and scientific support from Novo Nordisk** – simply ignored that (standard) result and unethically kept going with her *inferior* Low-GI diet approach. **Why did JBM not embrace Low Carb?**

2009: JBM “jumped the shark” and started to be paid to put “Low GI” healthy stamps on a “Better for You” product that is 99.4% not 100% refined sugar (sucrose): <https://www.foodpolitics.com/2016/03/sugar-in-australia-its-better-for-you/>

2010: Stephen Colagiuri *et al* and multiple drug companies (pp. 27-30) helped exclude mention of word carbohydrate from our national diabetes-risk calculator **AUSDRISK**: https://www.mja.com.au/system/files/issues/192_04_150210/che10062_fm.pdf

2010: JBM and Stephen Simpson *et al* in *Appetite* on “Design and testing of foods differing in protein to energy ratios”; JBM *et al* again dishonestly hid her lifetime financial and scientific partnership with Novo Nordisk’s Medical Director Dr John J. Miller.

2011: JBM and Walter Willett *et al* published “Dietary insulin index and insulin load in relation to biomarkers of glycemic control plasma lipids, and inflammation markers”. JBM *et al* again dishonestly hid her lifetime financial and scientific partnership with Novo Nordisk’s Dr John J. Miller. <https://www.sciencedirect.com/science/article/pii/S0002916523023092?via%3Dihub>

Below are three more of scores of journal articles in which JBM and/or colleagues/co-authors unethically hid JBM’s lifetime financial and scientific partnership with Novo Nordisk’s longtime Medical Director Australasia, Dr J. J. Miller.

2011: JBM, Kate Marsh, Alan Barclay and Stephen Colagiuri published in *Current Diabetes Reports* on “Glycemic Index and Glycemic Load of Carbohydrates in the **Diabetes Diet**”. <https://link.springer.com/article/10.1007/s11892-010-0173-8>

2011: JBM published in ADA journal *Diabetes Care* on “A Randomized Controlled Trial Investigating the Effects of a Low–Glycemic Index Diet on Pregnancy Outcomes in Gestational Diabetes Mellitus”. “J.B.M. is a coauthor of The New Glucose Revolution ... [etc]. “No other potential conflicts of interest relevant to this article were reported [no partner selling Novo Nordisk diabetes drugs for young women with gestational diabetes?]” <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3198285/>
2011: JBM and Kate Marsh published in *American Journal of Lifestyle Medicine* on “**Vegetarian Diets and Diabetes**”, claiming benefits from “more whole grains, legumes, nuts, and soy protein”. <https://journals.sagepub.com/doi/abs/10.1177/1559827610387393>

2011: JBM and Dr Alan Barclay self-published in *MDPI Nutrients* journal “**The Australian Paradox: A Substantial Decline in Sugars Intake over the Same Timeframe that Overweight and Obesity Have Increased**”, their extraordinarily faulty first paper <https://www.mdpi.com/2072-6643/3/4/491> in their *Australian Paradox* “sugar-is-innocent” fraud series of papers. This paper features clownish confusion between up and down and faked, dead-ending data (pp. 32-38). JBM again dishonestly hid her financial and scientific partnership with Dr Novo Nordisk: “JBM is a co-author of The New Glucose Revolution..., manages University of Sydney GI testing service”. (“Self-published”: JBM was **Guest Editor** of publishing journal with sham peer review.)

2012: Peter Howe, Editor-In-Chief of *MDPI Nutrients* wrote an “**Editorial**” - *The Australian Paradox* - in which he dishonestly pretended <https://www.mdpi.com/2072-6643/4/4/258> there are no problems with JBM and Alan Barclay’s embarrassingly faulty paper: “*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. ... Regrettably, his criticism has extended to the journal and its peer review processes for permitting publication of the article ... 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 .. helping to ensure that the desired standards of publication are attained. I believe these standards were applied ...and, despite inferences to the contrary, neither author had a role in the editorial process*”. Meanwhile, the paper is an utter embarrassment. Peter Howe refused to address my concerns about fake data and JBM’s valid sugar series trending **up** not down, refusing to formally retract the paper. JBM **falsely claims “sugar is innocent”** while hiding her financial and scientific partnership with Novo Nordisk’s Dr John J. Miller from the global scientific community. What a disgrace (pp. 32-38)

2012: JBM campaigned against NHMRC’s proposed toughening of advice for refined sugar in the revised ADGs (below), supported by her hidden pro-sugar Novo Nordisk relationship, and using her extraordinary faulty *Australian Paradox* “sugar is innocent” paper: <https://www.smh.com.au/healthcare/research-causes-stir-over-sugars-role-in-obesity-20120330-1w3e5.html>

From 2012 until now: JBM, her boss Stephen Simpson AC and three successive University of Sydney Vice-Chancellors - Michael Spence, Stephen Garton and now Mark Scott – all dishonestly pretend there is no problem with misrepresented, faked and otherwise unreliable data; and now VC Scott dishonestly pretends JBM and Novo Nordisk’s John Miller were never financial partners, so all is well. Evidence: pp. 17-19, 32-38; and <https://www.australianparadox.com/pdf/Letter-to-BelindaHutchinson.pdf>

2013: JBM and Alan Barclay published in journal *BMC Public Health* on “Trends in added sugar supply and consumption in Australia: there is an Australian Paradox; The Australian Paradox has not been refuted” in which they **dishonestly pretended** their infamous paper is not extraordinarily faulty (see overleaf), while JBM again dishonestly hid her lifetime financial and scientific partnership with Dr Novo Nordisk. <https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-898>

2013: “Updated” *Australian Dietary Guidelines* (ADGs) published by NHMRC and Australian Department of Health. Our ADGs promote diets with **45–65%** of total energy from carbohydrate, reflecting those unfounded concerns about saturated fat in meat, eggs and dairy. Again, “there is no significant evidence ... saturated fat is associated with an increased risk of CHD or CVD.” <https://pubmed.ncbi.nlm.nih.gov/20071648/> The producers of our 2013 ADGs – including **Professor Amanda Lee** and **ADGs’ veteran Rosemary Stanton** – were utterly disingenuous, pretending the ADGs were revised to reflect modern scientific knowledge. Yet the main dietary advice – eat 45-65% carbohydrate – was not thrown out because our diet careerists unethically refuse to concede that Stewart Truswell’s ADGs were **fundamentally flawed and harmful for many from Day One in 1982**. This 2013 travesty was snuck through by stating: “These Guidelines are an evolution of the 2003 edition... New evidence was assessed to determine whether associations between food, dietary patterns and health outcomes had strengthened, weakened, or remained unchanged. **Where the evidence base was unlikely to have changed substantially (e.g. the relationship between intake of foods high in saturated fat and increased risk of high serum cholesterol) additional review was not conducted.**” We all now know from **actual evidence** that any link between saturated fat and “high serum cholesterol” is neither here nor there for CVD or public health, but 45-65% carbohydrate is still a killer for T2D. (Oh well, only 2 million living in misery.)

2013: JBM, Kate Marsh and Robert Moses publish *The Low GI Eating Plan for an Optimal Pregnancy: The Authoritative Science-Based Nutrition Guide for Mother and Baby*, omitting mention of JBM’s financial partnership with Dr Novo Nordisk.

March 2014: World-famous insect specialist and founding Academic Director of University of Sydney's Charles Perkins Centre since 2012, **Stephen Simpson, AC** blatantly misrepresented the median-lifespan results from his career-defining 30-diet, 900-mouse experiment, in top US journal *Cell Metabolism*: [https://www.cell.com/cell-metabolism/pdf/S1550-4131\(14\)00065-5.pdf](https://www.cell.com/cell-metabolism/pdf/S1550-4131(14)00065-5.pdf) Simpson's main hypothesis in his widely admired pre-experiment book was that **insect-friendly low-protein diets will extend lifespan** in mice and thus humans. Alas, it turned out that: (i) **5 of the top-7 diets for median lifespan are high-protein diets (table)**; and (ii) **5 life-extending low-protein diets caused malnutrition and early death for 143 hidden mice (via euthanasia)**. Outrageously, dishonest Simpson AC **hid those two critical clinical results** and "found" what he "needed": **"Median lifespan was greatest for animals whose intakes were low in protein and high in carbohydrate"** (see pp. 39-48).

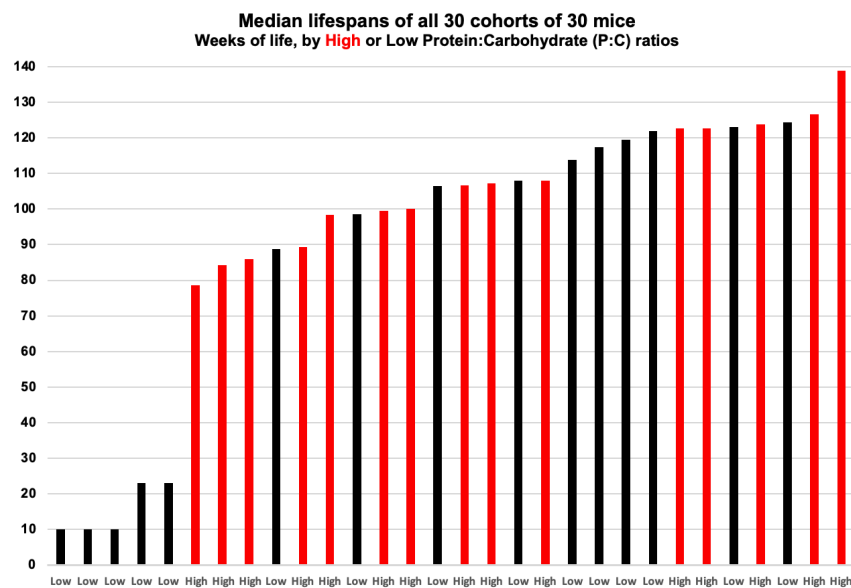


Table S2, related to Figure 2. Survival analysis by dietary composition.

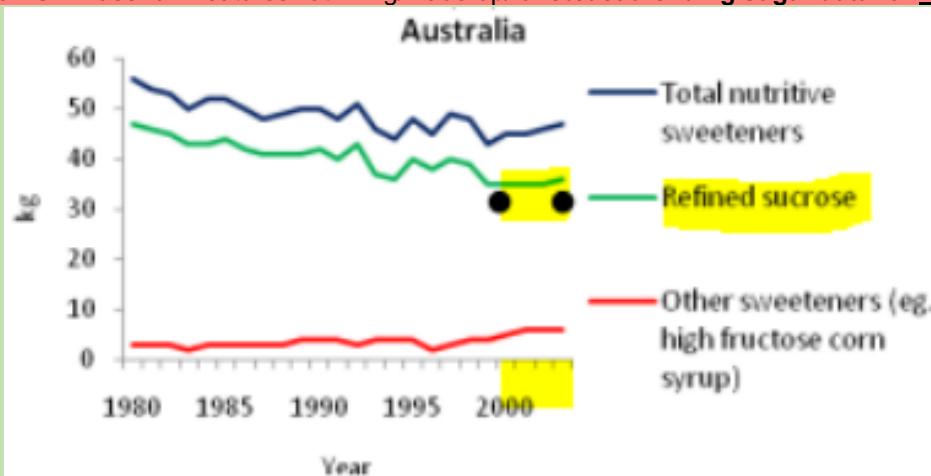
Median and maximum lifespan in weeks (w). Maximum lifespan was determined as the average of the longest lived 10% (n=2-3) of each cohort.

Energy Density	Protein (%)	Carb (%)	Fat (%)	Protein: Carb ratio	Median lifespan (w)	Maximum lifespan (w)
MEDIUM	5	75	20	0.07	121.86	157.43
HIGH	5	20	75	0.25	106.43	154.21
HIGH	5	75	20	0.07	119.43	151.79
MEDIUM	14	57	29	0.25	123.00	151.57
HIGH	42	29	29	1.45	138.86	151.14
MEDIUM	42	29	29	1.45	122.57	148.00
MEDIUM	14	29	57	0.48	113.86	147.36
HIGH	5	48	48	0.10	124.43	146.21
MEDIUM	33	48	20	0.69	122.57	145.71
MEDIUM	23	38	38	0.61	123.86	143.07
HIGH	33	48	20	0.69	98.29	141.00
HIGH	14	57	29	0.25	117.43	140.07
HIGH	33	20	48	1.65	107.14	136.86
LOW	33	48	20	0.69	126.57	134.14
MEDIUM	33	20	48	1.65	106.57	133.79
HIGH	14	29	57	0.48	108.00	133.71
MEDIUM	60	20	20	3.00	108.00	129.50
HIGH	60	20	20	3.00	99.57	127.57
HIGH	23	38	38	0.61	100.00	124.57
LOW	14	57	29	0.25	98.57	119.43
LOW	33	20	48	1.65	78.57	116.36
LOW	14	29	57	0.48	88.71	115.07
LOW	42	29	29	1.45	85.85	104.00
LOW	60	20	20	3.00	84.29	102.86
LOW	23	38	38	0.61	89.29	100.36

Table S2: <https://www.cell.com/cms/10.1016/j.cmet.2014.02.009/attachment/e2d00ae0-845a-4f9e-99a4-a831d55dd569/mmc1.pdf>

2014: Novo Nordisk funded Obesity Australia (OA), as Charles Perkins took over OA, **Steve Simpson AC** made Director (p. 37)

June 2014: University of Sydney's senior management - DVC(R) Jill Trehwella and Vice-Chancellor Michael Spence - allowed integrity **Investigator Robert Clark AO** to "disappear" my evidence that JBM's *Australian Paradox* sugar-and-obesity "finding" for **1980-2010** – "sugar is innocent" - features flat-lining/made-up/faked/dead-ending sugar data for **2000-2003** (pp. 32-36).



Source: Figure 2a in *Australian Paradox* <http://www.australianparadox.com/pdf/OriginalAustralianParadoxPaper.pdf>

Investigator Clark AO correctly observed: "This is the so-called 'flat line' data, also described as 'falsified' and 'erroneous' data by the Complainant...[etc]". **But the fix was in**, with Clark AO, Trehwella and Spence, and now Stephen Simpson AC and current Vice-Chancellor Mark Scott **all choosing to "disappear" my evidence**: "Statements made by the Complainant alleging that the United Nations FAO has falsified data are serious, and **do not appear to be based on detailed evidence or inquiry**".

The Complainant draws specific attention to FAO data points shown in the Australian Paradox paper Figure 2 for the years 2000-2003, beyond the time at which the ABS ceased to publish apparent consumption of sugar data. **This is the so-called 'flat line' data, also described as 'falsified' and 'erroneous' data by the Complainant; the implication being that the FAO simply re-issued the 1999 figure for these years in the absence of new ABS data, and that Professor Brand-Miller and Dr Barclay should have realised and checked this issue as part of their due-diligence.**

Statements made by the Complainant alleging that the United Nations FAO has falsified data are serious, and **do not appear to be based on detailed evidence or inquiry** (see analysis of evidence above).

pp. 9 and 21 <https://www.australianparadox.com/pdf/australian-paradox-report-redacted.pdf>

Readers, the fact that **JBM's sugar data for 2000-03** are conspicuously flat/made-up/faked/unreliable/dead-ending (see chart) – the data “existing” despite the **ABS discontinuing as unreliable** its sugar series after 1998-99, after 60 years! - is self-evident to most, but the FAO quickly provided **written confirmation, after I wrote to it and inquired way back in 2012** (pp. 32-36)

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>

<https://www.australianparadox.com/pdf/FAOfalsifiedsugar.pdf>

<http://www.australianparadox.com/pdf/RR-response-to-inquiry-report.pdf>

2014-2017: Dishonest Stephen Simpson AC and Stewart Truswell oversaw JBM producing another shonky *Australian Paradox* “sugar is innocent” paper - dominated by faked and other clearly unreliable data - for the *American Journal of Clinical Nutrition (AJCN)*. JBM, Simpson and Truswell dishonestly pretended (one honest scientist refused to pretend) that integrity Investigator Robert Clark AO's formal *Australian Paradox* Inquiry had recommended **an update** rather than a new paper that **“specifically addresses and clarifies the key factual issues”**, including my unambiguous evidence that several valid sugar series trend up not down in JBM's own published charts, alongside JBM's use of faked, flat-lining, dead-ending data for 2000-2003: pp. 17 and 32-38 below and pp. 41-49 in <https://www.australianparadox.com/pdf/Letter-to-BelindaHutchinson.pdf>

2015: Professor Richard Feinman *et al* published “*Dietary carbohydrate restriction as the first approach in diabetes management: Critical review and evidence base*”, trying to shift the medical community towards fixing the T2D epidemic with Carbohydrate Restriction: <https://www.sciencedirect.com/science/article/pii/S0899900714003323> The must-read paper's Figure 9 is an impressive demonstration that for fixing T2D and Metabolic Syndrome, Carbohydrate Restriction (“no GI”) outperforms high-carbohydrate “Low GI” diets (and everything else). **Why has JBM kept wasting lives and scare resources promoting her clearly inferior “Low GI” approach? Would NHMRC have funded JBM if her Dr Novo Nordisk had been disclosed?**

2015: Key scientific author Stephen Colagiuri helped exclude “carbohydrate” from *National Diabetes Strategy 2016-2020*: https://www.health.gov.au/sites/default/files/documents/2019/09/australian-national-diabetes-strategy-2016-2020_1.pdf

2015: Novo Nordisk funded Obesity Australia (OA), as Charles Perkins took over OA, Steve Simpson AC made Director (p.38)

2018: Virta Health and DiRECT diabetes trials emphatically confirmed that T2D and Metabolic Syndrome are readily fixed via Carbohydrate Restriction. Charles Perkins is supposed to be fixing T2D yet responded to Virta by pretending nothing happened.

15 December 2018: University of Sydney promoted Stephen Simpson AC's 30-Diet, 900-Mouse Lifespan Fraud in a full-page advertisement in the *Sydney Morning Herald*. Without mentioning anything about mice (or hidden results), the ad claimed: **“...our researchers have discovered that a low protein, high carb diet can...help us live a longer and healthier life”** (p. 41)

17 December 2019: University of Sydney Senior Deputy Vice-Chancellor Stephen Garton and Deputy Vice-Chancellor (Research) Duncan Ivison published their 7-page “Initial Inquiry” report on Stephen Simpson AC's 30-Diet Lifespan Fraud.
8 May 2020: University of Sydney Vice-Chancellor Stephen Garton, DVC Duncan Ivison, Provost Barbara Messerle and CPC boss Stephen Simpson AC all refuse to address critical fact that 5 of the top 7 diets for median lifespan are high-protein diets, falsifying Simpson's career-defining claim that low-protein, high-carbohydrate (low P:C) diets extend median lifespan in mice; they all clownishly insist 143 hidden severely malnourished low P:C mice “were not sick when culled” (pp.39-48)

2020: 35% of Australians pushed to begin “Insulin therapy” to “treat their diabetes” in 2020 were pregnant young women with “gestational diabetes” (aka pre-diabetes, T2D/NIDDM). Medical advice to inject *more* unhelpful excess Insulin into their bodies is unconscionable. <https://www.aihw.gov.au/getmedia/5f4dcfa1-4420-4d54-8618-948ce2d6ac4d/AIHW-CDK-11-Factsheet-2020.pdf.aspx>

12 July 2023: JBM's stunning "walk of shame". After being asked by me directly - during Diabetes Australia's "Great Debate" in the Museum of Sydney - about her undisclosed lifetime financial partnership with Novo Nordisk's longtime Medical Director Dr John J. Miller, JBM thought for a bit, then stood up from her seat and walked slowly and silently across the room, with her male acquaintance, in front of our Master of Ceremonies Norman Swan (MC photo in link below), a six-person DiabetesAus panel and an audience of ~600, to the exit, and out. **This sensational "walk of shame" was merely JBM's latest pitiful effort in hiding her corrupt Novo-Nordisk deception of everyone in the global scientific, medical and diabetes communities.** Were taxpayers/NHMRC misled re funding? pp. 2-4 <https://www.australianparadox.com/pdf/Letter-to-ABC-re-NormanSwan.pdf>

18 July 2023: In response to questioning from Michael West Media reporter James F. Sice, Vice-Chancellor Mark Scott's University of Sydney **dishonestly pretended** that JBM's hiding of her Novo Nordisk "External Interest" for decades from the early 1990s is a non-issue, involving no serious breach of any of the University's formal research-integrity policies. "At the heart of Robertson's claims is his takedown of Brand-Miller's Australian Paradox and **her alleged relationship with Novo Nordisk's John Miller. This latter point has proven difficult to fully pin down. Both Brand-Miller and Sydney University declined to confirm it.** Other evidence however, such as happy internet snaps of the pair together, suggest they are a couple or at least have been." <https://michaelwest.com.au/former-fattie-rory-robertson-ups-the-ante-on-sydney-unis-connections-with-big-sugar/>

28 August 2023: Vice-Chancellor Mark Scott, in his latest letter to me, again dishonestly insisted JBM and Stephen Simpson AC have never been in serious breach of any of his University's formal anti-research-misconduct policies (see pp. 17-19 below).

Timeline truths: Misguided ADGs fuelled T2D disaster, with Sydney Uni/Novo Nordisk's epic T2D fraud adding to harm

Summarising, the faulty 1977 US dietary goals that became today's low-fat, high carbohydrate *Australian Dietary Guidelines* were brought to Australia by Stewart Truswell from London in 1978. Truswell remained our ADGs' main scientific author for several decades, with the primitive false claim that saturated fat in meat, eggs and full-fat dairy causes CVD still dominating our fatally flawed ADGs. **Unconscionably, Diabetes Australia, RACGP and Dietitians Australia still promote NHMRC's clearly harmful 45-65% carbohydrate advice to millions of Australian victims with or at risk of T2D.**

Notably, the Charles Perkins Centre's four most influential diet-and-health "scientists" all have had careers devoted to **high-carbohydrate diets that tend to fuel not fix T2D**: (i) Truswell promoted a **low-fat, high-carbohydrate** diet; (ii) JBM and Stephen Colagiuri promote sugary **"low GI" high-carbohydrate** diets; and (iii) CPC boss Simpson AC promotes a sugary **low-protein, high-carbohydrate** diet that is said to be excellent for insects and mice, and thus humans. These *high-carbohydrate* diets all are utterly inconsistent with medical science's Carbohydrate Restriction ("no GI") approach that fixes T2D. **Devastated by Charles Perkins' high-carb diets, Indigenous Australians die from T2D at a rate seven times the rest of us** (pp 39-45)

Amazingly, the development of the University of Sydney's high-carbohydrate "Low GI" (Glycemic Index) approach was an undisclosed joint venture between JBM, Stephen Colagiuri and Novo Nordisk, the global leader in diabetes-drug selling. The Timeline confirms Janette C. Brand partnered with Novo Nordisk's local Medical Director, Dr John J. Miller, who became probably Australia's greatest-ever seller of Insulin/drugs for T2D victims seeking "glycemic control". For decades, JBM and her corrupt cabal hid JBM's financial and scientific partnership with Novo Nordisk's Dr John Miller, duping the world's scientific, medical, diabetes and taxpaying communities: (i) JBM and Dr Colagiuri sold millions of **Low GI Diet** books without even hinting at their deep Novo Nordisk links; (ii) JBM published false and deceptive conflict-of-interest statements in over 100 "peer reviewed" papers and over a dozen journals, dishonestly hiding her Novo Nordisk COI; and (iii) JBM's dishonest boss Stephen Simpson AC, Stephen Colagiuri, Stewart Truswell and John J. Miller (himself) all have co-authored publications with JBM without anyone ever requiring that she disclose her Novo Nordisk COI. So too, Kate Marsh? Alan Barclay? Joanna McMillan-Price? Peter Petocz? Fiona Atkinson? Ian Caterson? Walter Willett? The whole Low GI crew? (pp. 8-14 and 22-31).

Clearly, University of Sydney governance is in crisis: managers are dishonestly protecting what I've called "the biggest medical scandal in Australia's history" (summarised on p. 17 and in <https://www.australianparadox.com/pdf/Letter-to-Belinda-Hutchinson.pdf>). Vice-Chancellor Mark Scott insists his **External Interests Policy** has been properly enforced, but that clearly is not true (pp. 17-19). Further, the 2014 and 2019 "Initial Inquiry" reports were shams, with the University "disappearing" my definitive evidence (even fabricating fake evidence: "the mice were not sick when culled") in order to falsely exonerate JBM and Simpson AC of career-ending research misconduct (pp. 32-48). VC Scott now pretends Simpson AC's dishonest protection of false and harmful "findings" – **"sugar is innocent"** (by expanding JBM's *Australian Paradox* fraud into AJCN); and **low P:C diets "extend lifespan"** (via Simpson's own blatant misrepresentation of lifespan data for 900 mice fed 30 diets) - is consistent with NHMRC's anti-fraud policies. **My Recommendation #8 is that dishonest Simpson AC and VC Scott be removed** (p. 16)

ToR 4. Any interrelated health issues between diabetes and obesity in Australia, including the relationship between type 2 and gestational diabetes and obesity, the causes of obesity and the evidence-base in the prevention...

As has been well-documented for decades, **T2D** - including "pre-diabetes" and "gestational diabetes" - **and obesity** are deeply related, essentially representing **two of the five main aspects of Metabolic Syndrome or Insulin-Resistance Syndrome**. As with T2D, the modern epidemic of Metabolic Syndrome is fuelled by modern doses of dietary sugar/carbohydrate. **Accordingly, Metabolic Syndrome – typically defined as excess girth/weight (aka obesity), excess blood pressure, excess blood glucose/insulin (aka T2D), excess blood triglyceride, and inadequate HDL cholesterol – is readily fixed via strong compliance with a wholefood low-carbohydrate ("no GI") diet:** <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1323303/>

Confirmation of that "Carbohydrate Restriction ('no GI') fixes everything" claim can be seen in my p. 4 table showing the outperformance of Virta Health's low-carbohydrate approach: over 12 months, mean **weight** declined by 12%, **HbA1c** declined by 17% (from 7.5% to 6.2%), **Triglycerides** declined by 25%, **Systolic blood pressure** declined by 5% to 126, while

HDL cholesterol improved by 17% to 1.3. Again, Virta's eat-to-satiety low-carbohydrate approach dramatically outperformed the DiRECT approach - using highly processed liquid "shakes" - on every aspect of Metabolic Syndrome, while weaning T2D victims from ineffective Insulin and other unneeded T2D drugs. Participants in the DiRECT trial - on and off low-energy liquid "shakes" - reported a ~10% increase in usage of **antidepressants and other prescription drugs** (see bottom of table on p. 4).

Importantly, please notice that **neither "Cholesterol" nor LDL-cholesterol (LDL-C)** are listed above as an aspect of Metabolic Syndrome or Insulin-Resistance Syndrome. **That's because LDL-C is not reliably related to anything that matters.** My Timeline (p. 8) reminds us that the misguided focus on saturated fat, "cholesterol" in the blood and LDL-C grew from primitive, false claims (promoted by Ancel Keys *et al* in the 1950s and 1960s) that came to dominate faulty official dietary guidelines that colonised the western world over the 1970s and 1980s. In Australia, the US fiction that saturated fat in meat, eggs and dairy - rather than smoking and excess sugar/carbohydrate intake - causes heart attacks and strokes arrived from the UK in 1978 and quickly became our low-fat, 45-65% carbohydrate *Australian Dietary Guidelines*. Primitive, pretend US "science" on fatty meats and dairy still dominates our faulty ADGs today, despite "no significant evidence" for concluding saturated fat causes CVD.

For the sceptics, here is an excellent presentation from Dr Ken Sikaris on "**Blood Tests to assess your Cardiovascular Risk**", explaining that **LDL-C is an anachronism**: minute 16:23 <https://www.youtube.com/watch?v=9BFRI-nH1v8> (Dr Ken Sikaris is a Principal Fellow, Department of Pathology at Melbourne University, and Director of Chemical Pathology, Melbourne Pathology.) And finally, here are 26 prominent doctors and nutrition scientists fixing T2D who argue that low-carbohydrate diets should be the **standard first treatment** for all T2D victims: "**Carbohydrate restriction is the single most effective intervention for reducing all of the features of metabolic syndrome**": <https://www.sciencedirect.com/science/article/pii/S0899900714003323>

ToR 5. The effectiveness of current Australian Government ... programs to prevent, diagnose and manage diabetes

With respect, the kindest description of current Australian Government policies on T2D is "**worse than useless**". After all, we have two million or more victims - and counting - suffering T2D misery, despite T2D being readily fixable within months simply by encouraging victims to *restrict carbohydrate*, while eating meat, eggs, green vegetables and other low-carb foods to satiety.

Critically, there is a strong relationship between diet-and-health "experts" with financial links to drug companies and nonsense-based dietary advice. Like JBM with Novo Nordisk, **Canberra's relied-upon diabetes careerist Professor Stephen Colagiuri** has been "owned" by drug companies for much of his long career: his lucrative "moonlighting" as a paid part-timer for multiple drug-sellers including Novo Nordisk is on the public record (p. 28). **Those financial links likely explain Colagiuri's helping to exclude the word "carbohydrate" from both the useless National Diabetes Strategy 2016-2020 and our unreliable AUSDRISK "Australian Type 2 Diabetes Risk Assessment Tool"**. And what to say about University of Sydney "scientists" JBM and Colagiuri helping to expand the T2D-drug market by selling millions of highly influential **Low GI Diet** books falsely insisting: "**There is absolute consensus that sugar in food does not cause [type 2] diabetes**"? (pp. 6 and 27-31). Seriously.

Then there's Stephen Simpson AC and Stewart Truswell dishonestly assisting JBM to expand her *Australian Paradox* "**sugar is innocent**" **obesity fraud** into the *American Journal of Clinical Nutrition* while Novo Nordisk (JBM's partner's longtime firm) was funding Obesity Australia (OA), **as OA was being absorbed into Simpson's Charles Perkins Centre**, with Simpson becoming the new Director of Obesity Australia (and then President of a new, broader lobby group, The Obesity Collective). **Simpson AC promotes low-protein, high-carb diets that fuel obesity/T2D, he protects JBM and so Novo Nordisk delivers?** (pp. 32-48)

For T2D victims over recent decades, **the tragedy of "usual care"** - essentially Diabetes Australia, RACGP and Dietitians Australia advising victims to eat 45-65% carbohydrate diets from *Australian Dietary Guidelines* and/or the University of Sydney's sugary high-carbohydrate "Low GI" diet - is that following such advice **almost never puts T2D into remission**. That is, usual care typically involves a food plan featuring 45-65% carbohydrate - the thing that caused the T2D problem in the first place - followed by heaps of T2D drugs and exogenous Insulin. Novo Nordisk and other drug companies love today's T2D usual-care nonsense: **usual care** = "chronic and progressive disease" = **perfect for drug-sellers!** (*Low GI Diet* advice is outlined on p. 6.)

One profound US analysis concluded that any sort of T2D remission via usual care is "very rare". Indeed, T2D victims trapped in high-carbohydrate usual care have been more likely to die while treated than to have their T2D reversed: "...To provide context, 1.7% of the cohort died, while only 0.8% experienced any level of remission... the chances of dying were higher than the chances of any remission." <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4237974/>

In Australia over recent decades, the probability of T2D reversal for a victim following Diabetes Australia's dietary advice and guided onto Novo Nordisk's diabetes medications probably also has been <1%. **Meanwhile, the latest fast-growing tragedy is "gestational diabetes"**, which - as with other "pre-diabetes" and full-blown T2D - is caused mainly by the excessive intake of dietary sugar/carbohydrate. **I was stunned recently to discover the tragic statistic that roughly one-third of all new Australian starters on T2D "insulin therapy" each year are pregnant young women said to have "gestational diabetes".**

What are the stages of treatment? **Well, medical advice is so unforgivably corrupted by incompetence and drug-company COIs that pregnant women with gestational diabetes are pushed towards the University of Sydney's highly ineffective high-carbohydrate "Low GI" diet** - <https://baker.edu.au/-/media/documents/fact-sheets/baker-institute-factsheet-gestational-diabetes.pdf> - rather than towards Medical science's time-tested remedy of sensible Carbohydrate Restriction. And when that sugary high-carbohydrate diet approach "locks in" their elevated "blood sugar", many of those pregnant young women are pushed towards T2D "**Insulin therapy**", the **unhelpful process of pumping more excess Insulin into people without T1D**, a treatment popularised for T2D in Australia by diabetes-drug seller Novo Nordisk and its friends. Why does this happen? Well, it turns out that the people behind the **ineffective high-carbohydrate "Low GI" diet** are some of the same people who have benefitted from selling ineffective Insulin for young women stuck with gestational diabetes (see Timeline from 1977 onwards).

RECOMMENDATIONS TO START RESCUING ONE MILLION T2D VICTIMS AND MASSIVELY IMPROVE PUBLIC HEALTH

Chair Freeland, Deputy Chair McIntosh and other esteemed Committee members, as explained above, Canberra's basic T2D policy for four decades – promoting unhelpful high-carbohydrate diet and diabetes advice, and then funding growing doses of ineffective T2D drugs – has fuelled a public-health disaster. **The need for a huge change in approach is obvious; amazingly, the outlook is bright, because a cheap-and-effective T2D solution is available:** highly competent practitioners at the cutting edge of improved public health are using the **eat-to-satiety wholefood Carbohydrate Restriction (“no GI”) approach to reverse T2D**, while collapsing victims' use of ineffective, taxpayer-subsidised drugs including Insulin, from Novo Nordisk and other drug sellers. **On the basis of all that I have come to know over the past dozen years, I recommend the following:**

1. **To help rescue at least half of Australia's two million T2D victims, your Inquiry Report must explain that our modern T2D epidemic is driven by modern doses of sugar/carbohydrate.** You must embrace the hard scientific and clinical evidence of T2D reversal via *wholefood Carbohydrate Restriction* provided by highly qualified practitioners, including at US firm Virta Health, the world leader in T2D reversal. You must reject Dr Colaguri's dishonest claim that Virta did not outperform DiRECT in reducing T2D, Metabolic Syndrome and unneeded drugs (p. 4). You must stop the harmful feeding of high-carb diets and Insulin to pregnant women, instead advising sensible Carbohydrate Restriction.
2. **Urgently instruct** Diabetes Australia, the RACGP and Dietitians Australia to stop promoting our *Australian Dietary Guidelines* – harmful 45-65% carbohydrate advice - to millions of Australians with or at risk of T2D.
3. **Oversee the formal retraction of our Australian Dietary Guidelines**, which were introduced without proper scientific oversight and still feature a false “disease model”: the harmful US science fiction that “saturated fat in meat, eggs and dairy causes heart disease while huge doses of carbohydrate are heart healthy” (pp 8-9 and 11). The main outcome from four decades of ADGs is the tragic four-decade uptrend in obesity and T2D. **We need to write new Anti-Disease Eating Guidelines (ADEGs) from scratch:** only a fresh start will allow Australia to produce helpful new diet advice that improves public health. **The “disease model” that must feature in our ADEGs is Metabolic Syndrome, the cluster of genuine risk factors pointing to T2D, CVD, obesity, obesity-related cancers and Dementia aka T3D** (pp 14-15).
4. **For the upcoming public stages of your Parliamentary Inquiry**, I suggest that you invite to Canberra, for face-to-face interviews, practitioners Penny Figtree, Ray Kelly, Peter Brukner, Alex Petrushevski and Deepa Mahananda; from the US, Stephen Phinney, Richard Feinman, Gary Taubes and Eric Westman; and from the UK, David Unwin. These individuals are all true experts in what is known and needed to reverse “chronic diseases” in fat and sick humans. I also would be happy to appear before your Committee in Canberra for questioning, if invited to further explain some of the extraordinarily troubling diet-and-T2D and COI problems that I have identified and highlighted in this Submission (p.17).
5. To understand the misguided opposition to low-carbohydrate diets, **the Committee should also interview Australia's prominent proponents of high-carbohydrate diets**, including key promoters of our faulty *Australian Dietary Guidelines* and those involved in the development of the University of Sydney's widely used “Low GI” approach. What evidence do they claim supports their stance, given high-carb diets fuel harm in the T2D space? What is the nature of any existing or past links with drug-sellers benefiting from high-carb advice blocking T2D reversal? (pp. 2-11, 27, 38-39)
6. **Investigate the University of Sydney/Novo Nordisk's epic diabetes fraud (summary p. 17).** Was the joint-venture development of the high-carb *Low GI Diet* designed to help grow the market for T2D drugs including Insulin, or it just turned out that way? (p. 6) Was it Jennie Brand-Miller (JBM) or her partner - Novo Nordisk Medical Director Dr John J. Miller - who decided JBM for decades would hide her deep links with Novo Nordisk? (pp. 8-14) What is the **estimated amount by which JBM's household income/wealth** was lifted via her partner's Novo Nordisk salary, pension and/or shares over their long financial partnership? So too, please estimate Canberra's high-carb “Low GI” diabetes expert **Dr Colaguri's total personal gain in 2023 dollars** from all extra household income and any shares, travel and hospitality enjoyed via drug-company payments over his long career (p. 27). And which of JBM's colleagues and/or co-authors – besides Stephen Colaguri, Stewart Truswell, Stephen Simpson AC and John J. Miller (himself) - knew that JBM had a substantial Novo Nordisk financial relationship she needed to disclose (the dishonest suppression of which allowed the multi-decade deception of global scientific, medical, diabetes and research-funding communities)? Alan Barclay? Kate Marsh? Johanna McMillan-Price? Fiona Atkinson? Peter Petocz? Ian Caterson? Walter Willett? (pp. 8-14) Those found to have helped JBM conceal her financial partnership with Novo Nordisk Medical Director Dr John J. Miller should be reported to anti-corruption authorities (p. 18). Finally, was dishonest **Stephen Simpson AC** always going to protect JBM's shamefully faulty *Australian Paradox* paper and assist JBM to **expand her “sugar is innocent” fraud into the AJCN** (pp. 32-36), or was that linked to Novo Nordisk funding supporting his takeover of Obesity Australia (pp. 37-38)?
7. **Correct the scientific record** by requiring the University of Sydney to instruct semi-retired Jennie Brand-Miller (JBM) to fix her 100+ false and deceptive COI disclosures and formally retract her faulty original *Australian Paradox* “sugar is innocent” paper (pp. 32-38). Similarly, dishonest Stephen Simpson AC should be instructed to retract his faulty 30-Diet Lifespan paper, then write a new paper highlighting *actual* lifespan data from all 900 mice to duped readers (pp. 39-49).
8. **Fix the University of Sydney's governance crisis by removing Stephen Simpson AC and VC Mark Scott.** Their corrupt administration prioritises the dishonest protection of false and harmful scientific “findings” over the rescuing of up to two million T2D victims. The recent removal of Stanford University President Marc Tessier-Lavigne is instructive: **neither Simpson AC nor VC Mark Scott can be trusted by taxpayers** to honestly oversee the University's ~\$400m per year of research funding. Indeed, given Sydney University/Novo Nordisk's epic diabetes fraud, how much NHMRC funding for cabal members since say 1992 was **obtained via false and deceptive conduct?** (pp. 10, 17, 45 and 48)

Please investigate University of Sydney's "Research Excellence" corruption, a scandal fuelling T2D epidemic and Novo Nordisk's T2D drug fraud

Evidence supporting all statements by [Rory Robertson at www.australianparadox.com](http://www.australianparadox.com)

A. Professor "GI Jennie" Brand-Miller AO: Australia's globally famous diet-and-health "scientist" has spent decades falsely exonerating modern doses of sugar as a major driver modern obesity/T2D epidemics

1. *Australian Paradox* sugar-and-obesity fraud began with JBM's extraordinarily faulty "peer reviewed" original paper
2. Valid JBM sugar charts trend up 1980-2010, falsifying unsupported "finding" of "consistent and substantial decline"
3. JBM's preferred sugar series dead-ended 2003: discontinued as unreliable by ABS after 1999 then faked by FAO
4. In dishonest defence of false *Australia Paradox* "finding", several further papers were published avoiding key facts
5. Lied to formal inquiry by Robert Clark AO, claiming shonky dead-ending ABS/FAO series "robust and meaningful"
6. Prof Clark Recommended JBM write a new paper overseen by "Faculty" (incl. boss SJS, below) that "specifically addresses and clarifies" key factual matters including RR's misrepresented-data critique above. Helped by USyd management (including via USyd security guard spoofed onto RR; p. 74), JBM, SJS and Stewart Truswell published new sham paper that dishonestly avoided Clark's Recommendation and knowingly placed fake sugar data in AJCN
7. Beyond scientific fraud, JBM (99.99% likely) in stunning breach of USyd's *External Interests Policy* (p. 28), hiding millions of dollars of undisclosed household income/wealth via spousal link to Novo Nordisk's T2D insulin/drug sales

Guide to arrows:

URM = University Research Misconduct

\$\$\$\$ = Financial support from Novo Nordisk

Arrows show direction of benefit

C. Professor Stephen Colagiuri on "money train" moonlighting for Novo Nordisk while University of Sydney's most-eminent diabetes careerist

1. Long-time paid part-timer for Novo Nordisk and various other drug companies
2. Co-author with JBM of millions-sold pop-sci Low GI Diet books falsely claiming "There is absolute consensus that sugar in food does not cause [T2] diabetes"
3. Helped exclude word "Carbohydrate" from *AUSDRISK* and *National Diabetes Strategy 2016-2020*; now assisting Novo Nordisk further by misrepresenting *Virta Health's* profoundly impressive clinical data, in *Diabetes Australia T2D Statement*
4. Aiding JBM's misconduct by helping her hide Novo Nordisk "External Interest"

NOVO NORDISK (NN long-time Medical Director Australasia is Dr John Miller, whose famous pro-sugar spouse Jennie Brand-Miller promotes pro-NN false claim Carbohydrate Restriction does not fix T2D)

1. Novo Nordisk (NN) business model for decades has involved expanding sales of T1D medication Insulin to victims of modern T2D epidemic, despite T2D victims being readily fixed via no-sugar, Carbohydrate Restriction
2. Poor strategy: "Educate" T2D patients directly via evening events at local pharmacies (see *SMH* report, 2004)
3. Effective strategy: Financial support to "useful idiots" and otherwise corrupt "scientists" to encourage them to suppress medical facts: (i) T2D caused by excess sugar/carbohydrate; (ii) Carbohydrate Restriction fixes T2D
4. Stephen Colagiuri was paid to help exclude word "Carbohydrate" from Canberra's diabetes documents; most recently he has misrepresented key clinical facts re "Virta approach", in *Diabetes Australia's Statement* on T2D
5. NN provided "easy money" to Obesity Australia/The Obesity Coalition as Charles Perkins absorbed OA - with SJS as Chair - while SJS protecting Mrs John Miller's pro-NN *Australian Paradox* fraud, expanding it into *AJCN*

B. Professor Stephen J. Simpson AC; Academic Director, Charles Perkins Centre

1. As dishonest boss of Charles Perkins, SJS is devoted to suppressing "Virta approach" that in US is delivering mass T2D-reversal, collapsing use of T1D drug Insulin by T2D victims (~70%)
2. SJS's 30-Diet Lifespan fraud misrepresents results *career-defining* 900-mouse experiment
3. Pushes low-protein high-carb diet that fuels T2D in Indigenous and aged-care communities
4. Promoted misrepresented results involving 715 mice to rob taxpayers of \$13m via NHMRC
5. As SJS as "Faculty" head protected JBM's fraud, and helped JBM to place fake data in *AJCN*
6. As SJS dishonestly protected JBM's fraud, JBM's husband's firm Novo Nordisk financially supported SJS's *career-expanding* move into Chair of Obesity Australia/The Obesity Coalition
7. SJS also assisting JBM's research misconduct by helping hide her (their) "External Interest"

D. Professor Stewart Truswell; main scientific author of *Australian Dietary Guidelines* (ADGs) since he wrote ADGs for/in/with our Department of Health in 1978 and 1979

1. Influential ST dominated "health" space for decades via confident false claim "saturated fat in meat, eggs and dairy causes heart disease". That sci-nonsense still dominates ADGs
2. ~45 years ago, ST ominously advised novice colleague JBM that sugar not a dietary evil
3. At a Coca Cola "science" event, ST told me I was "making a mountain out of a molehill" fussing about JBM misrepresenting up versus down and promoting fake data in her faulty *Australian Paradox* paper. I advised he help JBM formally retract hopelessly flawed paper
4. Instead, ST helped JBM expand her fraud, helping JBM place fake sugar data into *AJCN*
5. ST also supporting JBM's misconduct by helping hide Novo Nordisk "External Interest"

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>

The four Charles Perkins Centre “scientists” I’ve named all have seriously breached *Research Code of Conduct*

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>

Re: Letter to USyd's Belinda Hutchinson AC on harmful misconduct by Prof. Stephen Simpson AC and his Charles Perkins Centre "scientists" 



← **Vice Chancellor** <vice.chancellor@sydney.edu.au>
to me, Chancellor, Research ▾

Tue, Jun 27, 3:46 PM ☆ ↶ ⋮

Dear Mr Robertson,

Thank you for your emails of 14 and 21 June 2023 in relation to the work of researchers at the University of Sydney's Charles Perkins Centre.

You have referred in your emails to your previous complaints about Professors Jennie Brand-Miller, Stephen Simpson, Stewart Truswell and Stephen Colagiuri and have expressed your dissatisfaction with the University's assessment of your allegations. To address your continuing concerns you have proposed an independent investigation, and have suggested that this could be undertaken by way of a Senate inquiry.

It is not clear from your emails whether you have in mind an inquiry by the University's Senate or a Parliamentary inquiry. Either way, we do not agree that any such inquiry is warranted.

We are satisfied that the University has robust policies and procedures regulating the conduct of research in accordance with the requirements of the Australian Code for the Responsible Conduct of Research 2018 (the Australian Research Code), and that your previous complaints have been appropriately and thoroughly examined.

We have been advised that your emails of 14 and 21 June 2023 and accompanying documents do not include any new information that warrants investigation.

As you know, the Australian Research Integrity Committee (ARIC) provides an avenue of review of institutional processes for dealing with allegations of breaches of the Australian Research Code, and it is open to you to contact ARIC (aric@arc.gov.au) to request a review of any of the issues you have not previously pursued through that mechanism.

Regards,

Belinda Hutchinson and Mark Scott

Belinda Hutchinson AC
Chancellor
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Acknowledging the traditional owners upon whose ancestral lands the University of Sydney campuses stand.

This email plus any attachments to it are confidential and are subject to a claim for privilege. Any unauthorised use is strictly prohibited. If you receive this email in error, please delete it and any attachments.

Mark Scott AO | Vice-Chancellor and President
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vice.chancellor@sydney.edu.au | sydney.edu.au

----- Forwarded message -----

From: **Vice Chancellor** <vice.chancellor@sydney.edu.au>
Date: Mon, Aug 28, 2023 at 10:23AM
Subject: Re: Letter to Belinda Hutchinson: Top US journal AJCN confirms key aspect of epic diabetes fraud protected by USyd VC Mark Scott & ABC reporter Norman Swan
To: rory robertson <strathburnstation@gmail.com>
Cc: Chancellor University of Sydney <chancellor@sydney.edu.au>

Dear Mr Robertson,

We refer to your email of 22 August 2023 to the Chancellor concerning Professor Jennie Brand-Miller and other researchers based at the University of Sydney's Charles Perkins Centre. The Chancellor has asked us to reply on her behalf.

You have not raised any new matters warranting further consideration and the University does not have anything further to add to the information set out in previous replies to you.

Regards,

Office of the Vice-Chancellor and President

The University of Sydney
Office of the Vice-Chancellor and President
Level 4, F23 Michael Spence Building | The University of Sydney | NSW | 2006
vice.chancellor@sydney.edu.au | sydney.edu.au

DIETARY GUIDELINES: THEORY AND PRACTICE

A. STEWART TRUSWELL

When I first became a professor of human nutrition in 1971 at London University, public health nutrition seemed to be drifting without a compass (Truswell 1980). The first era of vitamin research was over. Some people thought there were no more nutritional problems to solve (Dubos 1979). Concern about meeting the protein gap for developing countries was thought by some to be a fiasco (McLaren 1974). Public advice on prevention of coronary heart disease was in conflict between the fat and sucrose theories (Lewis et al. 1974). The new dietary fibre hypothesis was attracting middle class interest ahead of a scientific structure for it. Carbohydrates had a bad press and low carbohydrate diets were fashionable for treating obesity!

When the first edition of Dietary Goals for the USA was published in February 1977 an early copy was brought across the Atlantic by Dr Hugh Trowell who gave it to the editor of the Lancet. The latter asked me to write an (unsigned) editorial and I welcomed the new goals (Anonymous 1977) without realizing the US political background. My editorial has pride of place in the 869 page volume of supplemental views (Select Committee on Nutrition and Human Needs 1977). It was the first international commentary to appear and a rare positive independent review to balance against a host of critics in the USA. In the next year I tried to pass on my enthusiasm for the US dietary goals to colleagues in Britain (Truswell 1977; Truswell 1978a) at the Nutrition Society and the British Nutrition Foundation. The British establishment was unmoved. Some of the ideas were, however, embodied in suggestions called 'the Better British Diet' (Passmore et al. 1979) published soon after I came to Australia.

II. DEVELOPMENT OF DIETARY GOALS AND GUIDELINES IN AUSTRALIA

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

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

III. REACTION TO FIRST EDITION OF AUSTRALIAN DIETARY GUIDELINES

The first edition of the Australian dietary guidelines was widely accepted, adopted, approved or quoted by nearly all Australian organizations concerned with nutrition, food or health. They were close to the guidelines drafted by the Dietitians' Association — the main difference in the latter is encouragement of water as a drink. The Association did not push its own guidelines. Instead it gave full support to those of the Commonwealth Department of Health, which had more resources to distribute material. The guidelines were supported by the Royal Australasian College of Physicians; adopted by the Australian Nutrition Foundation; used by the Australian Consumers Association for grading nutritiousness of foods; adopted for home economics curricula in high schools; written into the standard biology textbook for schools. Dietary advice by the National Heart Foundation was harmonious and so was that of the cancer societies. The health departments of all the states adopted the federal Health Department's guidelines, some with minor changes (Queensland Health Department 1982; Department of Agriculture Victoria 1984) eg New South Wales added three extra guidelines (Department of Health NSW 1984) but these state versions seem to have gradually disappeared. The Commonwealth Department of Health evidently regarded their dietary guidelines as a success and used the words of the guideline headings, like a sort of wallpaper on the cover of the Annual Report of the Director-General of Health for 1982-83 (Commonwealth Department of Health 1983).

Why were the Australian dietary guidelines accepted so well by all concerned with nutrition here?

- i) The scientific nutrition establishment was small and new.
- ii) Australians are more receptive to new food ideas than people in the longer established countries. All the foods eaten by the white majority of the population are exotic. There is no deep rooted peasant agriculture or cuisine (Symons 1982).
- iii) Introduction of the Australian goals was well staged and tactfully presented.
- iv) The USDA/USDHHS dietary guidelines for Americans (US Department of Agriculture 1980) were published at about the same time and the seven elements in this booklet were very similar (minus the breast feeding) and gave international confirmation.
- v) The goals and guidelines were reinforced by public support of senior members of the nutrition establishment (Truswell 1980; 1983; Hetzel 1983; Wahlqvist 1981).
- vi) Most of the guidelines coincided with the recommendations of other bodies or committees in the country.
- vii) Dietary guidelines answered a deep need for the emerging profession of community nutritionists/dietitians.
- viii) The Australian guidelines were moderate, not stated in quantitative terms, not 'draconian' (English 1984).

How University of Sydney's Stewart Truswell and pretend diet science have "owned" Australian Dietary Guidelines for ~40 years

Here is how the ADGs came into being, as told by the University of Sydney's highly influential Professor Stewart Truswell, the person who made it happen and who has been the dominating scientific author of every version of the ADGs over the past four decades:

- *When I first became a professor of Nutrition in 1971 at London University, public health nutrition seemed to be drifting without a compass. ... Carbohydrates had a bad press and low carbohydrate diets were fashionable [RR: highly effective] for treating obesity...*
- *When the first edition of Dietary Goals for the USA was published in February 1977...the editor of the Lancet...asked me to write an (unsigned) editorial and I welcomed the new goals...without realising the US political [RR: that is, unscientific] background. ...*
- *It was the first international commentary to appear and a rare positive independent review to balance against a host of critics in the USA. In the next year, I tried to pass on my enthusiasm ... to colleagues in Britain... The British establishment was unmoved. ...*
- *[So] I came to Australia to start the Chair of Human Nutrition at Sydney University in May 1978 and one of the ideas I brought with me from the north was dietary goals. ... [Soon after arriving I set myself up as the lead speaker at a seminar after which the Australian Association of Dietitians and I] decided to draft ourselves a set of dietary guidelines for Australians. ...*
- *'Dietary goals for Australia' were first presented on 27 April 1979...at the Australian Academy of Science in Canberra, with support from dietitians' organizations...[etc]". ... The setting was conducive to a positive reaction. [RR: All "sciency" but without real science!]*
- ***These dietary goals were put together in small rooms in the Commonwealth Department of Health. I was the only nutritionist from outside the Department involved in the drafting. [RR: ST got to include exactly the things he wanted!]***
- ***After they had been launched the goals were presented to the Nutrition Standing Committee of the National Health and Medical Research Council. They expressed disappointment that they not been earlier involved, but adopted the goals unmodified... There was no background review of the scientific literature at the time...** [RR: "Look mum, no real science"!]*
- *[Beyond "goals", we needed to] advise individuals on food choices. This was done in 1981 by 'Dietary Guidelines for Australians'...*
- *[RR: So, within three years of landing in Australia from the UK (where there was little interest), Truswell had transformed the unscientific Dietary Goals for the USA into the first version of our ADGs. One highly motivated and domineering science careerist got things done quickly, helped greatly by the fact that "There was no background review of the scientific literature at the time...". Excellent. What could go wrong, given that increasing one's carbohydrate intake while reducing dietary fat tends to promote obesity and type 2 diabetes?]*
- *The first edition of the Australian dietary guidelines were widely accepted, adopted approved or quoted by nearly all Australian organizations concerned with nutrition, food or health. ...The guidelines were supported by the Royal Australasian College of Physicians [RR: now RACGP]; adopted by the Australian Nutrition Foundation; used by the Australian Consumers Association for grading nutritiousness of foods; adopted for home economics curricula in high schools; written into the standard biology textbook for schools ...*
- *The health departments of all the states adopted the federal Health Department's guidelines... There was therefore widespread acceptance of the Australian dietary guidelines. ...We did not have anything like the spate of criticisms in [the US and the UK]...*

Truswell pondered: "Why were the Australian dietary guidelines accepted so well by all concerned with nutrition here?" His answer includes:

- *The scientific nutrition establishment was small and new. [RR: Truswell quickly dominated the space and imposed his unscientific US nonsense - eat less fat and saturated fat, eat more carbohydrates - on NHMRC and the rest of us for the next four decades, to this day.]*
- *Introduction of the Australian goals was well staged and tactically presented. [RR: In 1979, a big two-day conference in Canberra would have been a fabulous taxpayer-funded head-nodding exercise, given Truswell had already done all "the science". Interstate attendees would have loved flying in an aeroplane; many would have stayed at the Hyatt and visited Parliament House, quite a treat back then.]*
- *The [US] dietary guidelines for Americans ... were published at about the same time...and gave international confirmation. [RR: So the unscientific 1977 US dietary goals became Australian goals, then the 1980 US guidelines "gave international confirmation". Perfect.]*
- *The goals and guidelines were reinforced by public support of senior members of the nutrition establishment. [RR: Yep, Truswell and his new eminent Aussie sci-friends - dazzled locals suffering cultural cringe - all cluelessly embraced the unscientific US guidelines.]*
- *Dietary guidelines answered a deep need for the emerging profession of community nutritionists/dietitians. [Even back then, the (now) Dietitians Association of Australia had no capacity of critical thinking: it didn't know or care about valid science, it just needed something structured to parrot to its customers. And too bad high-carbohydrate, low-fat diets tend to fatten people vulnerable to being overweight.]*
- *This history is directly from Sydney University's Truswell: <https://www.australianparadox.com/pdf/Truswell-Origins-Diet-Guidelines.pdf>*

After the **1982 ADGs** had been published by NHMRC, Truswell retained control of the main advice (reduce fat intake and eat much more carbohydrate) for decades. In the **1992 ADGs**, the advice on dietary fat changed to: "EAT A DIET LOW IN FAT AND, IN PARTICULAR, LOW IN SATURATED FAT", with saturated fat said to be the main driver of coronary heart disease (CHD). Truswell promoted the story that saturated fat causes heart disease by **dominating the story on sugar, ridiculing the idea that excess sugar causes CHD**: "As Truswell notes, the international scientific community thinks so little of this hypothesis that "no prevention trial of CHD and sugar has been completed, started, planned or even contemplated". Truswell was Australia's Ancel Keys in the pretend science of fat or saturated fat being the main diet evil driving chronic disease: <https://webarchive.nla.gov.au/awa/20170819041659/https://www.nhmrc.gov.au/guidelines-publications/n4>

In the **2003 ADGs**, Truswell (again) wrote the chapter on saturated fat. He observed: "The first Dietary Guidelines for Australians, published in 1982, recommended, 'Avoid eating too much fat' - that is, total fat. ... In the second edition of Dietary Guidelines for Australians, published in 1992, the guideline had evolved to 'Eat a diet low in fat and, in particular, low in saturated fat'": p. 120 of 283
<https://webarchive.nla.gov.au/awa/20170816084823/https://www.nhmrc.gov.au/guidelines-publications/n29-n30-n31-n32-n33-n34>

Even for the **2013 ADGs** - when Truswell wasn't formally part of the "updating" process - his influence looks to have ensured that version is as flawed as all previous versions. In particular, the dominant thing driving the harmful 45-65% advice for carbohydrate - the mistaken claim that total fat and particularly saturated fat are the main dietary cause of heart disease - was **guaranteed from scrutiny**, allowing that false assumption to dominate again despite the story having been exposed - every step of the way for decades - as unscientific nonsense. The evolution of Keys's silly fat phobia is documented in Taubes' *Good Calories, Bad Calories* (2018) and Teicholz's *The Big Fat Surprise* (2015).

How the Guidelines were developed

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

p. 5 https://www.eatforhealth.gov.au/sites/default/files/files/the_guidelines/n55_australian_dietary_guidelines.pdf

<https://www.australianparadox.com/pdf/RR-letter-CEO-NHMRC-May-2021.pdf>

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

Double-blind crossover comparison of human and porcine insulins in patients reporting lack of awareness of hypoglycaemia

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

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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.

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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 Colagiuri¹, J.J. Miller¹, R.A. Edwards¹

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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 glycaemic 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>

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 \cdot h \cdot dl $^{-1}$, 5996 ± 1108 μ U \cdot min \cdot ml $^{-1}$, and 89.8 ± 25.4 pmol \cdot min \cdot ml $^{-1}$, respectively; meal B: 104.9 ± 21.6 mg \cdot h \cdot dl $^{-1}$, 6268 ± 1161 μ U \cdot min \cdot ml $^{-1}$, and 99.8 ± 26.4 pmol \cdot min \cdot ml $^{-1}$, respectively). Meal C, consisting of toasted muesli and skim milk, produced smaller glycemic and insulin responses (46.8 ± 8.8 mg \cdot h \cdot dl $^{-1}$; $P < .02$, and 4369 ± 700 μ U \cdot min \cdot ml $^{-1}$; $P < .05$, respectively) than meals A and B and less endogenous insulin secretion (CP response 62.8 ± 19.9 pmol \cdot min \cdot 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 carbohydrates 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 NIDDM¹² 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 (Rapidard MC, Novo

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DIABETES CARE, VOL. 9 NO. 3, MAY-JUNE 1986

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 \pm SEM		61.4 \pm 4.2	25.7 \pm 1.1	8.9 \pm 0.8	6.4 \pm 2.0	3.3 \pm 1.0	1.9 \pm 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

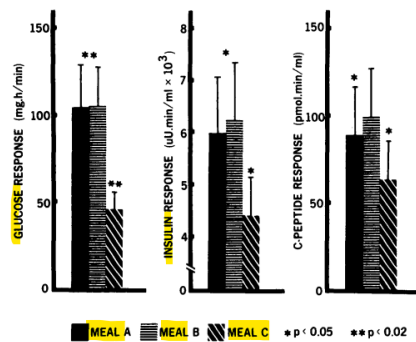


FIG. 2. Glycemic, insulin, and C-peptide responses to 3 different breakfast meals.

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 \cdot min \cdot ml $^{-1}$, respectively). The CP response after meal C (62.8 ± 19.9 pmol \cdot min \cdot 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 wheatflour 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 wheatflour 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.^{6,9} 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.¹ 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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Novo Nordisk

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Novo Nordisk A/S is a Danish multinational pharmaceutical company headquartered in Bagsværd, Denmark,^[3] with production facilities in nine countries and affiliates or offices in five countries. Novo Nordisk is controlled by majority shareholder Novo Holdings A/S which holds approximately 25% of its shares and a relative majority (45%) of its voting shares.^[4]

Novo Nordisk manufactures and markets [pharmaceutical](#) products and services, specifically [diabetes](#) care medications and devices.^[5] Novo Nordisk is also involved with [hemostasis](#) management, [growth hormone](#) therapy, and [hormone replacement therapy](#). The company makes several drugs under various brand names, including [Levemir](#), [Tresiba](#), [NovoLog](#), [Novolin R](#), [NovoSeven](#), [NovoEight](#), and [Victoza](#).^[2]

Novo Nordisk employs more than 48,000 people globally, and markets its products in 168 countries.^[2] The corporation was created in 1989, through a merger of two Danish companies which date back to the 1920s. The Novo Nordisk logo is the **Apis bull**, one of the sacred animals of **ancient Egypt**.

Novo Nordisk is a full member of the [European Federation of Pharmaceutical Industries and Associations \(EFPIA\)](#).^[6]

The company was ranked 25th among the [100 Best Companies to Work For](#) in 2010 and 72nd in 2014 by [Fortune](#).^[7] In January 2012, Novo Nordisk was named the most sustainable company in the world by the business magazine [Corporate Knights](#), while spin-off company [Novozymes](#) was named fourth.^[8]

Novo Nordisk is the largest pharmaceutical company in Denmark.^[9]

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Nordisk Insulinlaboratorium commercialises the production of insulin.^[10]

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Novo Nordisk A/S



The Novo Nordisk Company's logo (used for the past years to present), a bull with a sun disk between his horns, is based on the Egyptian deity Apis.

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LETTERS TO THE EDITOR

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

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How not to select a candidate. Richard Williams

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

Human insulin and hypoglycaemia

Matthias Egger • George Davey Smith • Arthur Teuscher • Ernst Von Kriegstein • Stephen Colagiuri • John J Miller et al. Show all authors

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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

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It has been simply amazing to see Charles Perkins' boss Stephen Simpson AC, Stewart Truswell and three successive sets of Vice-Chancellors and Deputy Vice-Chancellors step up to **dishonestly protect an obviously false scientific "finding"**. The basic problems behind JBM, Simpson AC and VC Mark Scott's infamous **"sugar is innocent"** fraud are presented on pp. 32-36.

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

by  **Alan W. Barclay**¹ and  **Jennie Brand-Miller**^{2,*} ✉

¹ Australian Diabetes Council, 26 Arundel Street, Glebe, NSW 2037, Australia

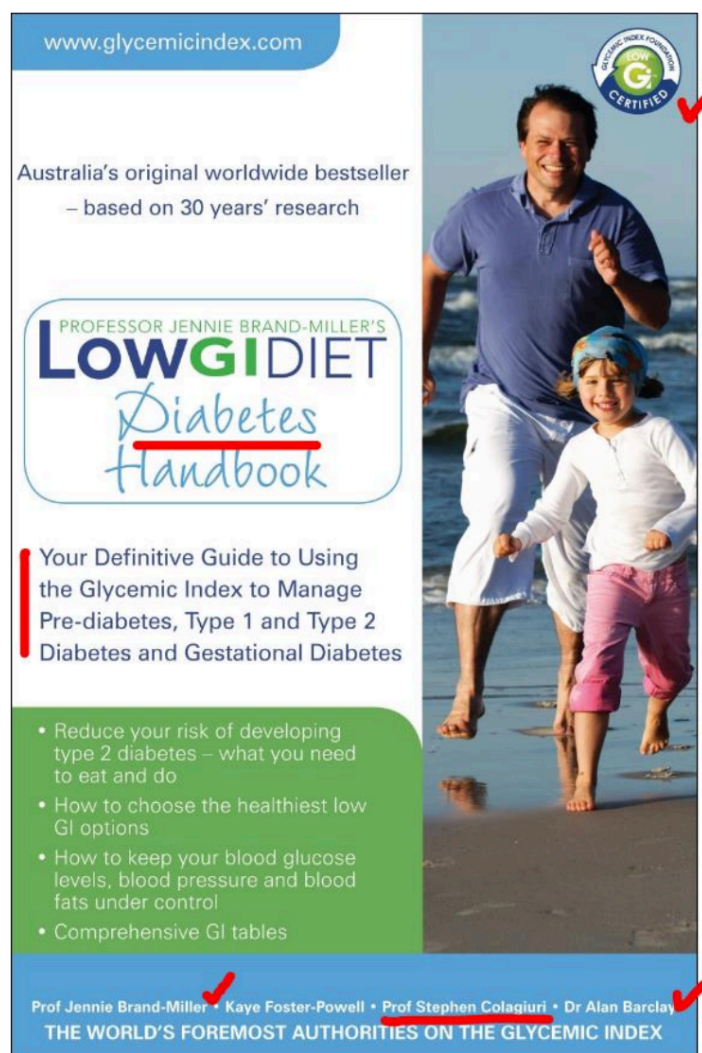
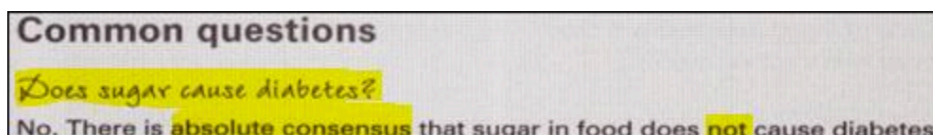
² School of Molecular Bioscience and Boden Institute of Obesity, Nutrition and Exercise, University of Sydney, NSW 2006, Australia

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Nutrients **2011**, *3*(4), 491-504; <https://doi.org/10.3390/nu3040491>

<https://www.mdpi.com/2072-6643/3/4/491>

Novo Nordisk loves "useful idiots" falsely exonerating excess sugar/carbs as main cause of our T2D/obesity disaster (Did JBM or Colagiuri disclose their drug-company COIs in Low GI books, as required by *External Interests Policy*? No)



<https://www.hachette.com.au/stephen-colagiuri/low-gi-diet-diabetes-handbook>

<http://www.australianparadox.com/pdf/diabetes.pdf>

<https://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf>

Novo Nordisk pays to encourage Colagiuri to claim things like “absolute consensus” sugar doesn’t cause T2D

Canberra’s most-relied-upon and eminent diabetes expert, Dr Stephen Colagiuri, enjoyed a decades-long association with Novo Nordisk’s Medical Director Dr John Miller (see pp. 6, 8-10), and has been on multiple drug companies’ “money trains” for years (see below). Novo Nordisk and other diabetes-drug sellers give easy money to Dr Colagiuri because they like his brain: “There is *absolute consensus* that sugar in food does *not* cause [type 2] diabetes” (see previous page) is a silly but serious-sounding false claim. Novo Nordisk enjoys JBM and Dr Colagiuri telling that special lie with a straight face, especially under the University of Sydney’s prestigious banner. Novo Nordisk also enjoys Dr Colagiuri’s somewhat corrupt efforts to pretend that Virta Health’s low-carbohydrate (“no GI”) diabetes trial (2018) did not notably outperform DiRECT’s diabetes trial (2018) in **reducing T2D and Metabolic Syndrome, while collapsing the use of ineffective, taxpayer-funded Insulin and other drugs** (pp. 2-6 again).

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.and.s.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 <ul style="list-style-type: none"> Steering Group member Author 	Board membership <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Speaker engagements - honoraria, travel expenses, accommodation and meals received from: Astra Zenica/BMS; MSD; Novo Nordisk; Sanofi; Servier; Takeda. Grants <ul style="list-style-type: none"> Chief Investigator, NHMRC Program Grant 2013-2017 Chief Investigator, NHMRC Project grant Chief Investigator, NHMRC EU FP7 Health project.
Prof Stephen Twigg <ul style="list-style-type: none"> Steering Group member Contributor 	Consultancy fees/honorarium <p>I am on/have been on the following Advisory Boards:</p> <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Steering Group member 	Board Membership <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Steering Group member 	Consultancy fees/honorarium <p>Speaker fees</p> <ul style="list-style-type: none"> Abbott; Eli Lilly <p>Speaker fees and advisory board membership</p> <ul style="list-style-type: none"> Astra Zeneca; Boehringer Ingelheim; Bristol Meyer Squibb; GlaxoSmithKline; Merck Sharp and Dohme; Novartis; NovoNordisk; Sanofi Aventis <p>Advisory board membership</p> <ul style="list-style-type: none"> Janssen <p>Grants</p> <ul style="list-style-type: none"> 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. <p>Support for travel/accommodation; meals/beverages</p> <ul style="list-style-type: none"> 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>

Paid by pharmaceutical companies - including Novo Nordisk - to suppress profound fact that excess consumption of sugar/carbohydrate is main (only?) cause of type 2 diabetes, main scientific author Stephen Colagiuri managed to exclude word "carbohydrate" from *National Diabetes Strategy*. To confirm, try "control F" in 28-page document below



Australian Government
Department of Health

Australian National Diabetes Strategy 2016–2020

https://www.health.gov.au/sites/default/files/documents/2019/09/australian-national-diabetes-strategy-2016-2020_1.pdf

p. 8 <https://www.australianparadox.com/pdf/Letter-Health-Minister-n-Secretary-Feb23.pdf>

RESEARCH

AUSDRISK: an Australian Type 2 Diabetes Risk Assessment Tool based on demographic, lifestyle and simple anthropometric measures

Lei Chen, Dianna J Magliano, Beverley Balkau, Stephen Colagiuri, Paul Z Zimmet, Andrew M Tonkin, Paul Mitchell, Patrick J Phillips and Jonathan E Shaw

Diabetes, particularly type 2 diabetes, is a global epidemic.¹ In Australia, the prevalence of diabetes more than doubled during the past two decades² and the number of people with diabetes is projected to reach 2 million in 2025.³

Progression to manifest type 2 diabetes in people with impaired glucose tolerance or impaired fasting glucose can be prevented or delayed by lifestyle and pharmaceutical interventions.⁴ However, using the oral glucose tolerance test (OGTT) to identify high-risk individuals is impractical at the population level. Furthermore, nearly 40% of incident diabetes arises in people who had normal glucose tolerance 3–5 years earlier.⁵ Hence, a simple approach to identifying people who are asymptomatic but at risk of developing diabetes would be an advantage.

A number of risk scores for predicting incident diabetes based on self-assessed information have been derived from cohorts in Europe and Asia.^{6–10} However, the validity and applicability of these tools to the Australian population is questionable as they were derived from circumscribed populations with different risk-factor profiles and ethnicities.

Our aim was to use data from the 5-year follow-up of the Australian Diabetes, Obesity and Lifestyle study (AusDiab) to develop and validate a simple risk score to predict incident diabetes based on demographic, lifestyle and simple anthropometric information. Here, we describe this process.

ABSTRACT

Objective: To develop and validate a diabetes risk assessment tool for Australia based on demographic, lifestyle and simple anthropometric measures.

Design and setting: 5-year follow-up (2004–2005) of the Australian Diabetes, Obesity and Lifestyle study (AusDiab, 1999–2000).

Participants: 6060 AusDiab participants aged 25 years or older who did not have diagnosed diabetes at baseline.

Main outcome measures: Incident diabetes at follow-up was defined by treatment with insulin or oral hypoglycaemic agents or by fasting plasma glucose level ≥ 7.0 mmol/L or 2-hour plasma glucose level in an oral glucose tolerance test ≥ 11.1 mmol/L. The risk prediction model was developed using logistic regression and converted to a simple score, which was then validated in two independent Australian cohorts (the Blue Mountains Eye Study and the North West Adelaide Health Study) using the area under the receiver operating characteristic curve (AROC) and the Hosmer–Lemeshow (HL) χ^2 statistic.

Results: 362 people developed diabetes. Age, sex, ethnicity, parental history of diabetes, history of high blood glucose level, use of antihypertensive medications, smoking, physical inactivity and waist circumference were included in the final prediction model. The AROC of the diabetes risk tool was 0.78 (95% CI, 0.76–0.81) and HL χ^2 statistic was 4.1 ($P = 0.85$). Using a score ≥ 12 (maximum, 35), the sensitivity, specificity and positive predictive value for identifying incident diabetes were 74.0%, 67.7% and 12.7%, respectively. The AROC and HL χ^2 statistic in the two independent validation cohorts were 0.66 (95% CI, 0.60–0.71) and 9.2 ($P = 0.32$), and 0.79 (95% CI, 0.72–0.86) and 29.4 ($P < 0.001$), respectively.

Conclusions: This diabetes risk assessment tool provides a simple, non-invasive method to identify Australian adults at high risk of type 2 diabetes who might benefit from interventions to prevent or delay its onset.

MJA 2010; 192: 197–202

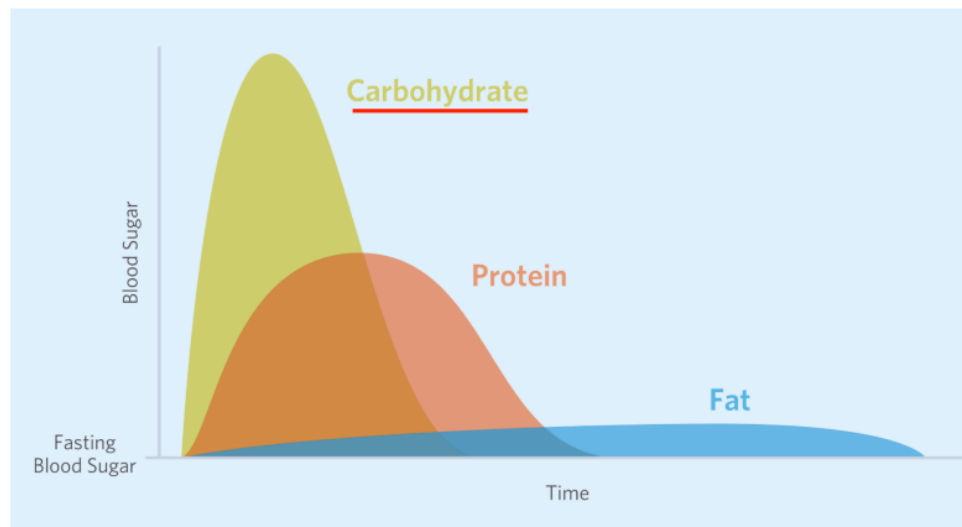
(1999–2000) was a cross-sectional, national, population-based survey of 11 247 adults aged 25 years or older from 42 completed a telephone questionnaire. The incidence of self-reported diabetes, after adjusting for age and sex, was the same in

As noted in the introduction, the AUSDRISK has been converted into a points-based, patient-friendly questionnaire¹¹ (available at http://www.bakeridi.edu/aus_diabetes_risk) and an online interactive risk assessment tool (available at <http://health.gov.au/internet/main/publishing.nsf/Content/diabetesriskassessmenttool>). These versions include a risk factor pertaining to fruit and vegetable consumption, which was not a significant predictor of diabetes in the final model but was added for its value as a public health message; one point is allocated for those who consume less than one serve of fruit or vegetable per day. The AUSDRISK was adopted for use by the Australian Government Department of Health and Ageing in July 2008 and attracts a Medicare rebate (Medicare Benefits Schedule item 713) for its application in people aged 40–49 years.

In conclusion, the AUSDRISK provides a valid and reliable method to estimate the risk of developing type 2 diabetes and also to identify asymptomatic individuals who are likely to have undiagnosed diabetes in cross-sectional settings.

So why does Carbohydrate Restriction (“no GI”) work to fix T2D, and what should we do now that we all know?

So, why does carbohydrate restriction work? Well, most obviously because carbohydrates are the thing driving elevated blood-glucose readings. Virta Health provides a simple but profoundly useful “blood sugar chart” showing stylised human responses to eating carbohydrate (blood glucose way up), protein (up moderately) and dietary fat (up minimally). Thus a diet restricted in carbohydrate and higher in dietary fat naturally tends to reduce blood-sugar readings and thus reduce HbA1c. (HbA1c readings >6.5% **define** type 2 diabetes.)



<https://www.virtahealth.com/reverseddiabetes>

Importantly, the emergence of **continuous blood-glucose monitors (CGM)** will end up being a **MASSIVE GAME-CHANGER** for public health. Everyday people now can see exactly what foods and drinks – try a healthy banana! – boost blood-sugar readings (HbA1c), and so boost the risk of type 2 diabetes, CVD and obesity. Doctors across the globe increasingly are advising carbohydrate-restricted, no-sugar diets, and patients are seeing success unfold minute-by-minute, hour-by-hour, week-by-week, indefinitely. While CGMs are an optional extra, they are a really useful resource for anyone starting out. (I now have a FreeStyle Libre kit.)

To be clear, Virta Health has commercialised low-carb Ketogenic diets to reverse type 2 diabetes and obesity, reduce CVD risks and restore patients' health. Virta sells its services in the US: CEO Sami Inkinen says Virta is working “with more than a hundred large clients, including the Department of Veterans Affairs, the state of Alabama, Blue Cross and Blue Shield of North Carolina, and employers like General Electric Co.” Virta’s “pitch” to US employers providing healthcare to their millions of employees is “Pay for results, not promises. Virta only gets paid if we are successful in delivering real health improvement—the way all payment should work in healthcare”.

Already valued in excess of \$2b in 2021, Virta's business is booming, using Keto diets to restore health to millions of Americans. Alas, I have no conflict of interest with Virta Health, beyond admiring the scientists and others involved, its profound health results and its rapid business success: <https://www.forbes.com/sites/katiejennings/2021/04/19/this-2-billion-digital-health-startup-aims-to-reverse-type-2-diabetes/?sh=364ae6287044>

4. Recommendations and requests: Please stop Sydney Uni's high-carb sci-frauds, fix type 2 diabetes and fix fatally flawed ADGs

NHMRC CEO Kelso, having provided you with hard evidence on the relevant matters, I urge you, please, to do several important things:

1. Force the formal retraction of Professor Simpson's faulty influential paper at the centre of the 30-Diet Lifespan Fraud (the study towards which NHMRC contributed \$1m). Require the University of Sydney to return the \$13m of new research funding it has been stealing from taxpayers via NHMRC since 2019 (*Submission*, p. 11). To do these things, NHMRC will need to initiate an independent investigation into the University's research and management misconduct. The findings of that investigation – including that the University promotes harmful high-carb dietary advice that suppresses the effective cure for type 2 diabetes - will help everyone understand why NHMRC's ADGs have failed;
2. (again) Urgently instruct Diabetes Australia, the RACGP and the Dietitians Association of Australia to stop promoting your NHMRC's clearly harmful 45-65%-carbohydrate advice to millions of Australians with and at risk of type 2 diabetes;
3. (again) Urgently assemble a panel of competent doctors and scientists - including Dr Peter Brukner who recently launched Defeat Diabetes: <https://www.defeatdiabetes.com.au/our-experts> - to write new low-carbohydrate NHMRC guidelines for the proper treatment of type 2 diabetes, in an effort to start rescuing the millions of vulnerable Australians being harmed by your current official dietary advice;
4. Retract the 2013 *Australian Dietary Guidelines*. As documented above, your ADGs were introduced without proper scientific oversight and have always featured a false “disease model”. Every version since 1980 was imposed on NHMRC and the rest of Australia by the mistaken enthusiasm of Stewart Truswell, Australia's leading promoter of Ancel Keys's pretend science of “saturated fat in meat, eggs and dairy causes heart disease, while huge doses of carbohydrate are heart healthy”. The end result from the ADGs after four decades of making false claims about what foods are healthful and which are not is the tragic four-decade uptrend in obesity and type 2 diabetes (“diabesity”); and
5. Start to write new *Australian Dietary Guidelines*. First, please disqualify from involvement every individual and entity previously involved in the failed ADGs. The community needs no further help from NHMRC's many “experts” who for decades have been in the business of causing not fixing type 2 diabetes and obesity. Only a fresh start will give the NHMRC any real chance of producing new guidelines that improve public health. NHMRC should not expect Truswell, Simpson, Stanton or the Dietitians Association of Australia, etc, to do anything other than pretend everything is fine. Obviously, the valid “disease model” that must feature in NHMRC's “new era” ADGs is **Metabolic Syndrome – aka Insulin Resistance** – focused on the cluster of indicators that highlight an elevated risk of type 2 diabetes, CVD, obesity-related cancers and probably Dementia. For the upcoming review of your fatally flawed ADGs, I suggest NHMRC organise seminars involving Sarah Hallberg, Richard Feinman, Eric Westman and/or other true experts in fixing chronic disease in fat and sick humans. Finally, the new ADGs should be a simple affair, advising Australians to eat “real food” including meat, eggs, dairy and not too many carbohydrates.

<https://www.australianparadox.com/pdf/RR-letter-CEO-NHMRC-May-2021.pdf>

Key aspects of JBM and Stephen Simpson AC's infamous *Australian Paradox* sugar-and-obesity fraud (pp 32-38)

In her original *Australian Paradox* paper, world-famous "GI Jennie" Brand-Miller (JBM) insists that Australian added-sugar consumption per person suffered "**a consistent and substantial decline**" over the 1980-2010 timeframe, and so there existed "**an inverse relationship**" between Australians' (declining) sugar intake and (rising) obesity rates. Of course, that is nonsense.

JBM's infamous "paradox" is solved in coming pages by noting that several of JBM's own published charts show valid sugar indicators trending **up** not down over the 1980-2010 timeframe (p. 33), falsifying her "finding". So, we know JBM is incompetent.

Troublingly, JBM later told research-integrity Investigator Robert Clark AO that her preferred series – one discontinued as unreliable by the Australian Bureau of Statistics after 1998-99 (60 years after it began in 1938-39) and then faked by the United Nations' Food and Agriculture Organization (FAO) – is "robust and meaningful". I confirmed in writing with the FAO back in 2012 that the FAO had indeed faked JBM's preferred series after 1998-99 (see the chart on p. 34, below). Here is the multiple-email exchange that I had with FAO officials way back in 2012: <https://www.australianparadox.com/pdf/FAOfalsifiedsugar.pdf>

For a decade, JBM has known her key data are faked, and Stephen Simpson (SJS) has known those 2000-2003 data are faked. How do I know that they know? I told each of them in face-to-face conversations at an Obesity Australia annual summit at ANU in Canberra back in November 2013 (see letter p. 44 in BelindaHutchinson.pdf link earlier). Accordingly, the original *Australian Paradox* paper and subsequent *Paradox* papers still all exist only because Australia's finest and most-distinguished diet-and-health "scientist" and her dishonest Charles Perkins Centre boss Stephen Simpson AC are determined to recklessly pretend that modern doses of sugar consumption have nothing to do with our obesity and T2D epidemics.

Also outrageous is that three successive sets of dishonest University of Sydney management since 2012 have refused to stop the misconduct I'm highlighting, by refusing to simply instruct JBM and Simpson AC to formally retract their extraordinarily faulty papers (standard scientific practice). Instead, management chooses to dishonestly pretend a devotion to Research Excellence.

RED FLAGS: As an example of University of Sydney "Research Excellence", the original *Australian Paradox* paper is one of the greats. For starters, notice that JBM is the "Guest Editor" of the publishing MDPI journal:

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



As Guest Editor, JBM self-published her own extraordinarily faulty paper, despite her submitting it five months late:

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

Deadline for manuscript submissions: closed (30 September 2010) Published: 20 April 2011

Then, stunningly, we are advised:

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

AWB is Dr Alan Barclay, another Charles Perkins Centre shonk who operated as JBM's sidekick for a decade or so and wrote harmful pro-sugar, high-carbohydrate nonsense-based advice for Diabetes NSW and ACT (aka Australian Diabetes Council).

Australian Diabetes Council, 26 Arundel Street, Glebe, NSW 2037, Australia;

E-Mail: awbarclay@optusnet.com.au

On JBM's conflicts of interests, there is no disclosure of her deep financial relationship with drug-seller Novo Nordisk:

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

All that before seeing that several valid sugar indicators in JBM's published charts (reproduced as Charts 1-3 overleaf) trend **up** not down. Again, JBM's own published charts falsify her silly "finding" of a "consistent and substantial decline". Further, notice on p. 34 below the **short, faked-flat line for "Refined sucrose" in Figure 2A (Australia) after 1999**, after the ABS discontinued its series as unreliable. That is, for JBM's preferred series there are no valid data between 1998-99 and 2010 – no data for more than one-third of the 1980-2010 timeframe. Again, that dead-ending-then-faked-then-non-existent series is the one that JBM dishonestly promoted as "robust and meaningful" to research-integrity Investigator Robert Clarke AO in 2014: p. 59 of 86 at <https://www.australianparadox.com/pdf/australian-paradox-report-redacted.pdf>

Australian Paradox paper must be formally retracted: JBM's obviously false "finding" of a "consistent and substantial decline" in sugar intake over 1980-2010 is falsified by the evidence in JBM's own published charts

Chart 1: Australian sugary drink sales (litres per person per year)

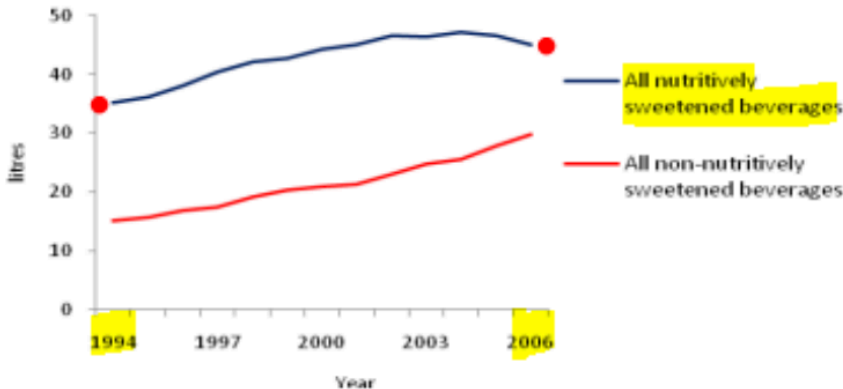
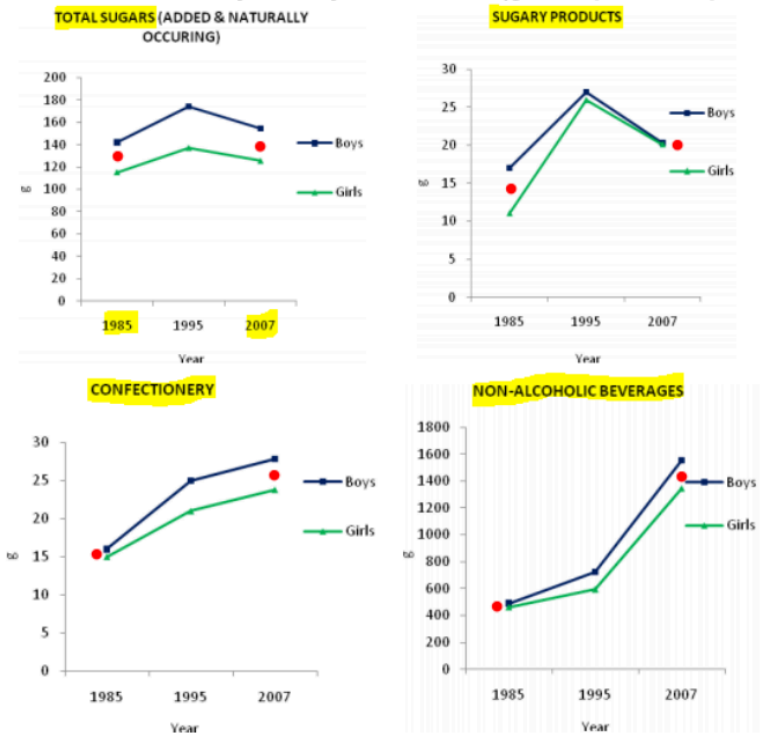
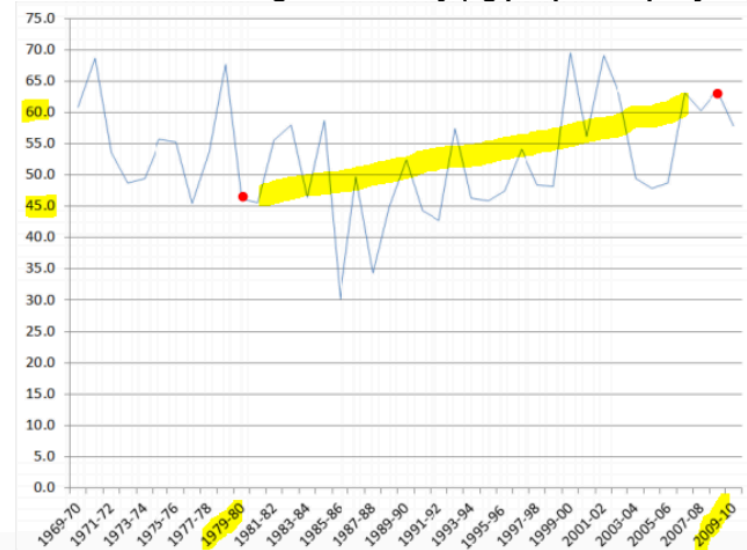


Chart 2: National Dietary Surveys – Children (grams per child per day)



Source: <http://www.australianparadox.com/pdf/OriginalAustralianParadoxPaper.pdf>

Chart 3: Australian sugar availability (kg per person per year)

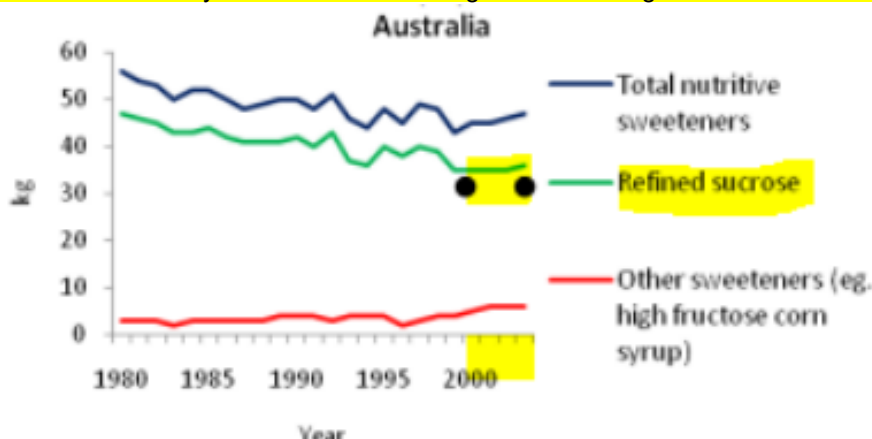


Source: <http://www.australianparadox.com/pdf/nutrients-03-00491-s003.pdf>

<https://www.mdpi.com/2072-6643/3/4/491>

p. 25 <https://www.australianparadox.com/pdf/USyd-Misconduct-June19.pdf>

It's been amazing to watch several University of Sydney "scientists" and a succession of Vice-Chancellors dishonestly pretend that a conspicuously flat, faked/invalid/faulty/unreliable dead-ending 2000-2003 sugar series is valid and reliable. Just amazing!



Source: Figure 2A in *Australian Paradox* <http://www.australianparadox.com/pdf/OriginalAustralianParadoxPaper.pdf>

Readers, the fact that JBM's data for 2000-03 are conspicuously flat/made-up/faked/unreliable/dead-ending – somehow "existing" despite the ABS discontinuing as unreliable its sugar series after 1998-99, after 60 years! - is self-evident (see chart), but the FAO quickly provided written confirmation, after I wrote to it and inquired way back in 2012. (Several letters in link.)

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>

<https://www.australianparadox.com/pdf/FAOfalsifiedsugar.pdf>

<http://www.australianparadox.com/pdf/RR-response-to-inquiry-report.pdf>

Investigator Clark AO and University of Sydney senior managers dishonestly "disappeared" my evidence confirming the FAO's invention of fake data (ie., no actual counting occurred). But Clark also recommended a new paper be written that "specifically addresses and clarifies the key factual issues examined in this Inquiry". Simpson AC – "the Faculty" - oversaw a shonky update.

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

p. 4/86 <https://www.australianparadox.com/pdf/australian-paradox-report-redacted.pdf>

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.

OOOOOO

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.

We observe Professor Clark's acknowledgement that the ABS ceased its data collection in 1999 "due to an unfunded need to update the methodology to account for changing consumption and production factors that were not captured (and which could presumably affect the accuracy of data points in years approaching this cessation point)" and "from my email exchange with ABS, I believe the ABS data collection ceased due to lack of resources to address an emerging data reliability issue."

Audience and Consumer Affairs is also satisfied that *Lateline* made reasonable efforts to confirm that, despite the fact the FAO stopped receiving data from the ABS in 1999, it continued to publish a series for Australian sugar supply/consumption for the 2000s by re-producing the ABS series from the previous decade.

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.

Despite the complainant's claim that Professor Clark's investigation "presents a comprehensive rebuttal of these allegations", we note his acknowledgement that the ABS ceased collecting data beyond 1999 because of its unreliability and his concern about the Australian Paradox authors' uncritical assessment "about the detailed methodology underpinning the FAO data in Figure 2, and had 'assumed' that it accounted for total sugar intake from their earlier research leading up to publication. I indicated that we both needed to check the facts."

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

Stephen Simpson AC and Stewart Truswell – representing “the Faculty” - responded dishonestly to Investigator Clarke AO’s key recommendation for a new paper that “specifically addresses and clarifies” critical factual matters (including clearly faked FAO data), by pretending JBM was asked for an update, then helping her place faked sugar data in AJCN

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

Jennie C Brand-Miller^{3*} and Alan W Barclay⁴

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

Am J Clin Nutr 2017; 105:854–63. Printed in USA. 2017 American Society for Nutrition

<https://www.sciencedirect.com/science/article/pii/S0002916522048316?via%3Dihub>

<https://www.australianparadox.com/pdf/USyd-March-2017.pdf>

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

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

<https://www.australianparadox.com/pdf/USyd-March-2017.pdf>

ACKNOWLEDGMENTS

My first professor, Ron Edwards gave me my first taste of confidence; my next professor, Stewart Truswell, gave me more still. Dr Dorothy Mackerras showed me how to write an NHMRC application. Professor Wayne Bryden encouraged me to apply for Associate Professorship when it was the last thing on my mind. Professor Graeme Clark gave me the gift of hearing. Professor Stephen Simpson has stood quietly by me through the challenges of the last few years.

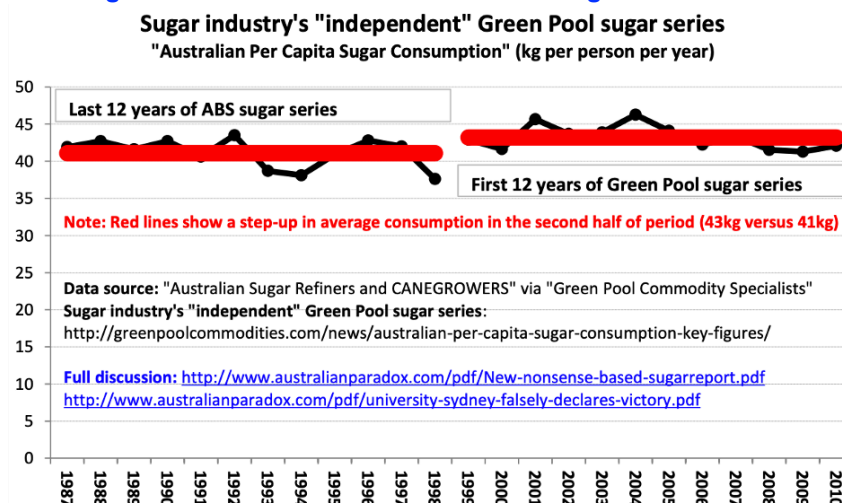
16

BRIEF CURRICULUM VITAE - The University of Sydney

Google: Brand Miller CV sydney.edu

<https://www.australianparadox.com/pdf/USyd-Misconduct-June19.pdf>

Back in 2012-2015, I documented JBM’s sugar-industry friend Bill Shrapnel and consultancy Green Pool contriving a sham “robust” sugar series using a broken and abandoned ABS counting tool that the ABS had told them is unreliable



Please see 36-39 in <http://www.australianparadox.com/pdf/Big-5-year-update-Feb-2017.pdf> and <http://www.australianparadox.com/pdf/New-nonsense-based-sugarreport.pdf>
<http://www.australianparadox.com/pdf/GraphicEvidence.pdf>


Please investigate: While Simpson AC was dishonestly rescuing JBM's career and expanding her pro-sugar *Australian Paradox* fraud into AJCN, Novo Nordisk (JBM's partner's longtime firm) in 2014 and 2015 was gifting easy money to Obesity Australia as Simpson's Charles Perkins Centre absorbed OA, with Simpson new Director



worldobesity.org/our-network/our-members/the-collective-for-action-on-obesity-obesity-australia

The Obesity Collective, Australia

OUR NETWORK OUR MEMBERS THE OBESITY COLLECTIVE, AUSTRALIA



The Obesity Collective is the peak body for obesity in Australia. It is a national umbrella coalition with a vision to reduce the health and wellbeing impacts of obesity in Australia. Working together to raise awareness of the science and reality of obesity and promote evidence-based prevention and treatment action through a strong, cooperative and inclusive network.

The Obesity Collective is an Associate Member of World Obesity Federation.

President: Professor Stephen Simpson

Director: Tiffany Petre

Email: the-collective.info@sydney.edu.au

2014 - No Time to Weight; 2015 - Weighing the cost of obesity: A case for action; 2018 - The Obesity Collective

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Foreword

The mission of Obesity Australia is to drive change in the public perceptions of obesity, its prevalence and its treatment. Currently in Australia 63% of the adult population is overweight or obese, with 28% obese. Public perceptions - commonly, that obesity is merely a personal issue - must change if as a community we are to address the escalating medical and societal costs, and the often hidden productivity losses. Key to changing public perceptions are the media and medical practitioners, in particular general practitioners.

"Obesity: A National Epidemic and its Impact on Australia" charts the three-fold increase in overweight and obesity over the past 30 years, its genetic, epigenetic and environmental drivers, and the ways in which we have attempted to address the issue to date. It is aimed at the widest possible audience, as an accessible source and quick reference for all those in the area who interact with overweight and obesity, in the media, in the consulting room, in schools and workplaces, in the community as a whole.

We thank Novo Nordisk for their untied support, and commend this report to the widest possible readership.

Prof John Funder OA
Executive Chairman
Obesity Australia

Obesity Australia Scientific Advisory Council:

Prof. Jennie Brand-Miller (University of Sydney)

Prof. Stephen Colagiuri (University of Sydney)

Prof. Michael Cowley (Monash University)

Prof. John Dixon (Baker-ID)

Prof. Joe Proietto (Melbourne University)

Dr. Matt Sabin (Murdoch Children's Research Institute)

Prof. Steve Simpson (Charles Perkins Centre)

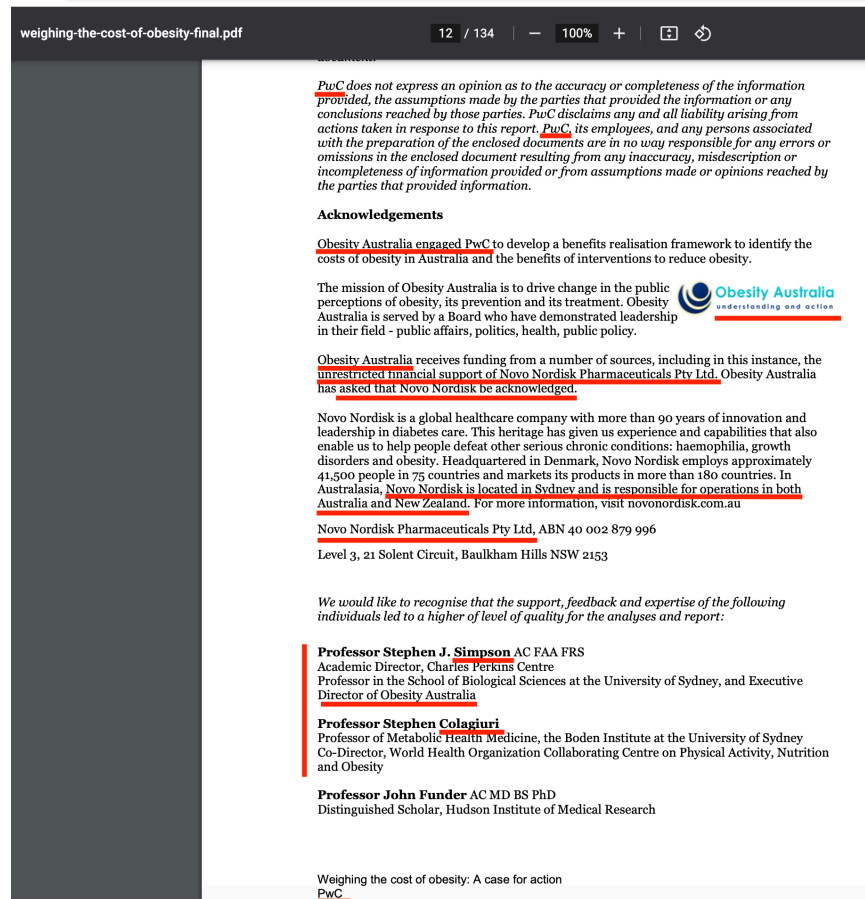
Prof. Gary Wittert (University of Adelaide)

Written by Jason Leung PhD, Project Officer, Obesity Australia and Professor John Funder OA, Executive Chairman, Obesity Australia. Edited by Professor John Funder OA, Executive Chairman, Obesity Australia and A/Professor Stella Clark, CEO Obesity Australia.

Obesity: A National Epidemic and its Impact on Australia (2014) has been supported by an unrestricted grant from Novo Nordisk Pharmaceuticals Pty Ltd.

Please investigate: While Simpson AC was dishonestly rescuing JBM's career and expanding her pro-sugar *Australian Paradox* fraud into AJCN, Novo Nordisk (JBM's partner's longtime firm) in 2014 and 2015 was gifting easy money to Obesity Australia as Simpson's Charles Perkins Centre absorbed OA, with Simpson new Director

• [pwc.com.au/pdf/weighing-the-cost-of-obesity-final.pdf](https://www.pwc.com.au/pdf/weighing-the-cost-of-obesity-final.pdf)



2018

The Obesity Collective launched - a cross-sectoral national initiative to change the way we think and act on obesity

2015 <https://www.pwc.com.au/pdf/weighing-the-cost-of-obesity-final.pdf>

2014 - No Time to Weight; 2015 - Weighing the cost of obesity: A case for action; 2018 - The Obesity Collective

Why Simpson AC ignoring Virta despite massive success reversing obesity/T2D, collapsing Insulin/drug usage?

604

Diabetes Ther (2018) 9:583–612

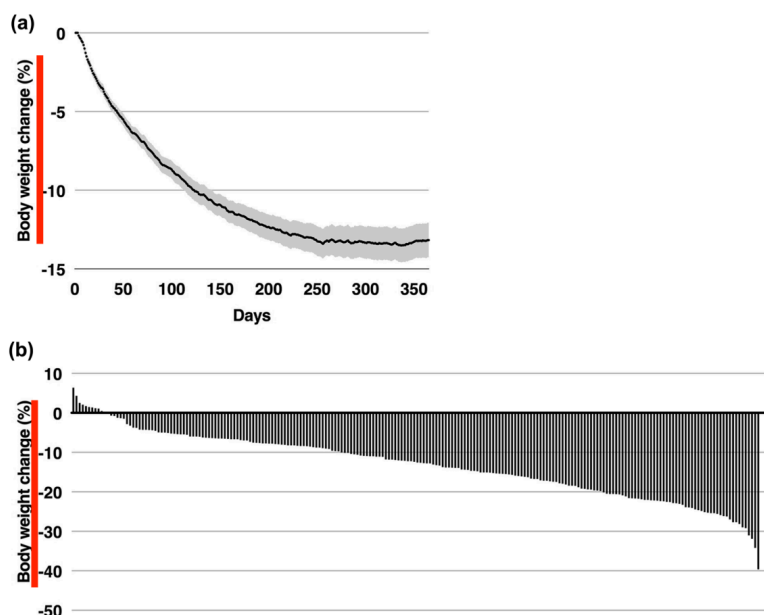


Fig. 2 Body weight change over the course of 1 year in CCI completers. **a** Mean (95% CI) change in body weight for completers over the course of 1 year. For each individual, weight on a given day was computed as the 3-day trailing mean (to reduce day-to-day variation). On

dates where no weights were recorded during the 3-day time window for a given participant, the most recent 3-day mean preceding the date was used. **b** Histogram depicting individual body weight changes at 1 year

<https://link.springer.com/article/10.1007/s13300-018-0373-9>; <https://www.virtahealth.com/reverseddiabetes>

In his widely cited career-defining paper reporting his epic 30-diet, 900-mouse experiment, Simpson claims: **“Median lifespan was greatest for animals whose intakes were low in protein and high in carbohydrate [that is, low P:C]... The results are consistent with recent reports in invertebrates showing that the ratio of protein to carbohydrate in the diet influences lifespan (Lee et al., 2008; Piper et al., 2011). The survival curves for the different ratios of protein to carbohydrate ... show that the longest median survival occurred in cohorts of mice on the lowest [P:C] ratio diets, and there was a clear correlation between the ratio and lifespan. Median lifespan increased from about 95 to 125 weeks (approximately 30%; Table S2) as the protein-to-carbohydrate ratio decreased.”** p. 421 <https://www.cell.com/action/showPdf?pii=S1550-4131%2814%2900065-5>

Alas, my chart below shows Simpson’s preferred story is **falsified by the experiment’s actual median-lifespan results, data carefully hidden by Simpson et al from the scientific community**. Unreasonably, Simpson’s shonky paper does not allow readers to readily see – as in the chart and tables below - that **the longest-lived median mouse across all 30 cohorts of 30 mice was fed a high P:C diet (42% protein, 29% carbohydrate); that cohort’s median lifespan of ~139 weeks is 10% greater – a full decade in “human years” - than the next best diet, another high P:C diet. In fact, five of the top seven diets are high not low P:C diets.**

Simpson AC also hid 143 dead mice fed five of his preferred “lifespan extending” low-protein diets. **I think Simpson AC is an utter fraud**, because in response to my correct critique, Simpson lied to Cell’s scientific advisory board: “Rory’s concerns are in every respect unfounded”. Later, he issued a sham “Correction” (pp. 46-48). I believe Simpson suppressed the *actual* lifespan results from his career-defining “900 mice fed 30 diets” experiment to “find” what he “needed”, given his **pre-experiment book’s** (decisively falsified) hypothesis: **Low P:C insect-friendly diets extend lifespan** in mice as in insects, and thus humans (overleaf).

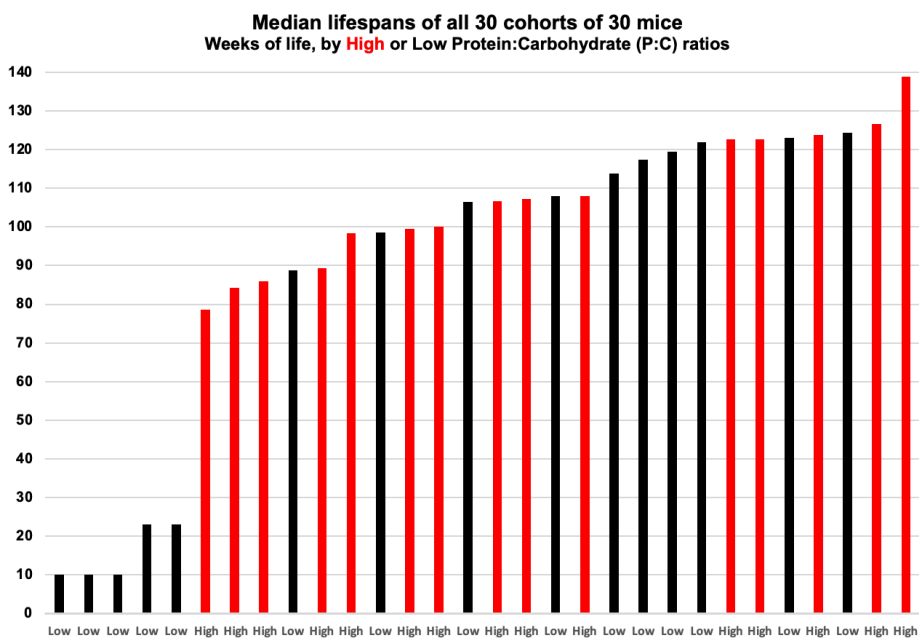


Table S2: <https://www.cell.com/cms/10.1016/j.cmet.2014.02.009/attachment/e2d00ae0-845a-4f9e-99a4-a831d55dd569/mmc1.pdf>

Table S2, related to Figure 2. Survival analysis by dietary composition.

Median and maximum lifespan in weeks (w). Maximum lifespan was determined as the average of the longest lived 10% (n=2-3) of each cohort.

Energy Density	Protein (%)	Carb (%)	Fat (%)	Protein: Carb ratio	Median lifespan (w)	Maximum lifespan (w)
MEDIUM	5	75	20	0.07	121.86	157.43
HIGH	5	20	75	0.25	106.43	154.21
HIGH	5	75	20	0.07	119.43	151.79
MEDIUM	14	57	29	0.25	123.00	151.57
HIGH	42	29	29	1.45	138.86	151.14
MEDIUM	42	29	29	1.45	122.57	148.00
MEDIUM	14	29	57	0.48	113.86	147.36
HIGH	5	48	48	0.10	124.43	146.21
MEDIUM	33	48	20	0.69	122.57	145.71
MEDIUM	23	38	38	0.61	123.86	143.07
HIGH	33	48	20	0.69	98.29	141.00
HIGH	14	57	29	0.25	117.43	140.07
HIGH	33	20	48	1.65	107.14	136.86
LOW	33	48	20	0.69	126.57	134.14
MEDIUM	33	20	48	1.65	106.57	133.79
HIGH	14	29	57	0.48	108.00	133.71
MEDIUM	60	20	20	3.00	108.00	129.50
HIGH	60	20	20	3.00	99.57	127.57
HIGH	23	38	38	0.61	100.00	124.57
LOW	14	57	29	0.25	98.57	119.43
LOW	33	20	48	1.65	78.57	116.36
LOW	14	29	57	0.48	88.71	115.07
LOW	42	29	29	1.45	85.85	104.00
LOW	60	20	20	3.00	84.29	102.86
LOW	23	38	38	0.61	89.29	100.36

SUPPLEMENTAL TABLES

Table S1, related to experimental procedures. The macronutrient composition of the diets.

The % of protein (P), carbohydrate (C) and fat (F) (as a % of total energy). Each diet was replicated at 8 kJ g⁻¹ (low energy), 13 kJ g⁻¹ (medium energy) and 17 kJ g⁻¹ (high energy). Diets varied in content of P (casein and methionine), C (sucrose, wheatstarch and dextrinized cornstarch) and F (soya bean oil). All other ingredients were kept similar. Other ingredients include cellulose, a mineral mix (Ca, P, Mg, Na, C, K, S, Fe, Cu, I, Mn, Co, Zn, Mo, Se, Cd, Cr, Li, B, Ni and V) and a vitamin mix (vitamin A, D3, E, K, C, B1, B2, Niacin, B6, pantothenic acid, biotin, folic acid, inositol, B12 and choline) supplemented to the same levels as AIN-93G. ^aDiets 2 low energy and 6 medium energy were discontinued within 23 weeks. ^bDiets 3 low energy, 3 medium energy and 6 low energy were discontinued within 10 weeks of treatment. These diets were discontinued due to weight loss (≥ 20%), rectal prolapse or failure to thrive.

Diet	1	2 ^a	3 ^b	4	5	6 ^a	7	8	9	10
%P	60	5	5	33	33	5	14	14	42	23
%C	20	75	20	47	20	48	29	57	29	38
%F	20	20	75	20	47	48	57	29	29	38
Low 8 kJ g ⁻¹	P 5.03	0.42	0.42	2.77	2.77	0.42	1.17	1.17	3.52	1.93
	C 1.67	6.28	1.67	4.02	1.67	4.02	2.43	4.77	2.43	3.18
	F 1.67	1.67	6.28	1.67	4.02	4.02	4.77	2.43	2.43	3.18
Medium 13 kJ g ⁻¹	P 7.54	0.63	0.63	4.15	4.15	0.63	1.76	1.76	5.28	2.89
	C 2.51	9.41	2.51	6.02	2.51	6.02	3.64	7.15	3.64	4.77
	F 2.51	2.51	9.41	2.51	6.02	6.02	7.15	3.64	3.64	4.77
High 17 kJ g ⁻¹	P 10.06	0.84	0.84	5.53	5.53	0.84	2.35	2.35	7.04	3.86
	C 3.35	12.55	3.35	8.03	3.35	8.03	4.85	9.54	4.85	6.36
	F 3.35	3.35	12.55	3.35	8.03	8.03	9.54	4.85	4.85	6.36

Charles Perkins boss Simpson AC outlined his preferred 30-diet results in a 2009 paper and his 2012 pre-experiment book: In mice as in insects (and so humans), “the ratio of protein to carbohydrate [P:C] is crucial”. Indeed, “protein restriction ... extends life span” while “increasing the ratio of protein to non-protein energy ... decreases life span...”

The Nature of Nutrition

A Unifying Framework from Animal Adaptation to Human Obesity



Stephen J. Simpson AND David Raubenheimer

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eight for locusts. Omission of only one of these eight amino acids from an otherwise complete supplementary mix rendered a diet “low protein” so far as the animal was concerned. Signaling elevated protein status, whether to induce protein satiety in locusts or to trigger pathways involved in **shortening life span in flies**, therefore requires a specific mixture of amino acids.

Taken together, **the results from insects** provide overwhelming evidence that caloric restriction is not responsible **for life span extension**. Instead, **the ratio of protein to carbohydrate in the diet is crucial**, with the protein component of the response mediated by a mixture of key amino acids, which includes, but is not exclusively, methionine. An important message from the insect results is that experiments in which single amino acids are manipulated in the diet without taking account of interactions with other amino acids (or with other macronutrients, notably carbohydrate) are at risk of being misinterpreted—a message that applies to studies on other animals too.

What about mammals? Although it is widely held that caloric restriction, not specific nutrient effects, is responsible for life span extension in mammals (Weindruch and Walford 1988; Masoro 2005; Everitt et al. 2010), no experiment to date has contained sufficient dietary treatments to disentangle calories from specific nutrients (Simpson and Raubenheimer 2007). There have been numerous reports, stemming back to early work by Ross (1961), that **protein restriction**, and restriction of methionine in particular, **extends life span in rodents** (Orentreich et al. 1993; Zimmerman et al. 2003; Miller et al. 2005; Ayala et al. 2007; Sun et al. 2009), so it is at least plausible that **the response of mammals—including humans—is similar to that of insects**.

Spurred on by the need for a geometric analysis of aging in mammals, **we have embarked upon just such a study in mice with David Le Couteur at the ANZAC Research Institute in the University of Sydney**. A full design for rodents has required expanding from two to three macronutrient dimensions with the inclusion of dietary lipid in addition to protein and carbohydrate. **At the time of writing, the 30-diet experiment is still under-way**, but the data are already proving to be instructive.

4.1 HOW DOES MACRONUTRIENT BALANCE AFFECT LIFE SPAN?

We have seen that eating excess protein relative to nonprotein energy shortens life span, at least in insects and perhaps also in mammals. The mechanisms causing this effect are not yet understood, but there are some tantalizing candidates. These include altered production of radical oxygen species (“free radicals”) with associated damage to DNA and cellular pro-



**We're unlearning
diet to help us
live longer**

By questioning how the body processes different foods,
our researchers have discovered that a low protein, high carb
diet can delay chronic disease and help us live a longer and
healthier life.

Find out how we're unlearning the world's greatest challenges.
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THE UNIVERSITY OF
SYDNEY

Leadership for good starts here

Source: The Sydney Morning Herald, 15 December 2018

<https://www.australianparadox.com/pdf/RR-letter-CEO-NHMRC-May-2021.pdf>



AAP NOVEMBER 20, 2013 9:45PM

Prof uses 1000 mice to expose food folly

THE key to good health is a balance between protein, carbohydrates and fat, says an expert on obesity, diabetes and cardiovascular disease.

Clifford Fram, AAP National Medical Writer

BELIEF that single nutrients such as omega-3s, sugar or salt can cure or cause all ills is folly, says a leading health scientist.

The key, Professor Stephen Simpson says, is for people to think about food as food and to seek a healthy balance between protein, carbohydrates and fat.

Too much of one for too long can make you fat and unhealthy, or even thin and unhealthy, says Prof Simpson, academic director of the new \$500 million Charles Perkins centre set up at the University of Sydney to fight obesity, diabetes and cardiovascular disease.

"The balance really matters," he told colleagues at an Australian Society for Medical Research conference in Victoria.

His team conducted a study in which 1000 mice were fed 30 different diets with different ratios of protein, carbohydrates and fat.

"If you want to lose weight as a mouse, you go onto a high-protein diet. But if you stay on that too long you will have poor circulating insulin and glucose tolerance.

"If you go too low on protein, you will drive over-consumption and be prone to obesity."

A good balance for a mouse is about 20 per cent protein, about 60 per cent carbohydrates and about 20 per cent fat.

"And mice are not that different from humans," he said.

An interesting finding was that a low-protein diet coupled with high carbohydrates led to obesity. But these mice lived longest and had a healthy balance in their gut.

Prof Simpson said he was concerned about the emphasis on micronutrients such as vitamins, sugar and salt.

"It is unhelpful when people argue everything is the fault of sugar or fat or salt or whatever when what we are dealing with is a balancing problem."

The best type of carbohydrates and fat is limited amounts of sugar and complex, low GI, hard-to-digest foods.

Prof Simpson said healthy fats such as omega-3 were also important.

Originally published as [Prof uses 1000 mice to expose food folly](https://www.news.com.au/national/breaking-news/prof-uses-1000-mice-to-expose-food-folly/news-story/403238e7cccc57b86b689aaa18fa4b95)

<https://www.news.com.au/national/breaking-news/prof-uses-1000-mice-to-expose-food-folly/news-story/403238e7cccc57b86b689aaa18fa4b95>

Research

13.

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

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

Med J Aust 2013; 198 (7): 380-384.

doi: 10.5694/mja12.11407

Abstract

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

Design, setting and participants: A multisite 12-month assessment (July 2010 to June 2011) of community-level diet in three remote Aboriginal communities in the Northern Territory, linking data from food outlets and food services to the Australian Food and Nutrient Database. ~2600 people

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

Results: One-quarter (24.8%; SD, 1.4%) of total food expenditure was on non-alcoholic beverages; 15.6% (SD, 1.2%) was on sugar-sweetened drinks. 2.2% (SD, 0.2%) was spent on fruit and 5.4% (SD, 0.4%) on vegetables. Sugars contributed 25.7%–34.3% of dietary energy, 71% of which was table sugar and sugar-sweetened beverages. Dietary protein contributed 12.5%–14.1% of energy, lower than the recommended 15%–25% optimum. Furthermore, white bread was a major source of energy and most nutrients in all three communities.

Mean: 61% carbs, including ~24% refined sugar!

Conclusion: Very poor dietary quality continues to be a characteristic of remote Aboriginal community nutrition profiles since the earliest studies almost three decades ago. Significant proportions of key nutrients are provided from poor-quality nutrient-fortified processed foods. Further evidence regarding the impact of the cost of food on food purchasing in this context is urgently needed and should include cost-benefit analysis of improved dietary intake on health outcomes.

Dietary improvement for Indigenous Australians is a priority strategy for reducing the health gap between Indigenous and non-Indigenous Australians.¹ Poor-quality diet among the Indigenous population is a significant risk factor for three of the major causes of premature death — cardiovascular disease, cancer and type 2 diabetes.² The 26% of Indigenous Australians living in remote areas experience 40% of the health gap of Indigenous Australians overall.³ Much of this burden of disease is due to extremely poor nutrition throughout life.⁴

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

Energy intake

Community A Community B Community C All communities

Macronutrient distribution as a proportion of dietary energy (% [SD])

Protein	12.5% (0.3)	14.1% (0.8)	13.4% (0.6)	12.7% (0.3)
Fat	24.5% (0.6)	31.6% (1.5)	33.5% (1.1)	25.7% (0.6)
Saturated fat	9.4% (0.3)	11.6% (0.6)	12.1% (0.3)	9.7% (0.3)
Carbohydrate	62.1% (0.8)	53.3% (1.8)	52.1% (1.1)	60.7% (0.8)
Sugars	34.3% (0.8)	28.9% (2.2)	25.7% (1.8)	33.4% (0.7)

<https://www.mja.com.au/journal/2013/198/7/characteristics-community-level-diet-aboriginal-people-remote-northern-australia>

Indigenous Australians are perhaps hardest hit by the Charles Perkins Centre's pro-sugar incompetence and fraud. It's tragic that the sorts of outsiders Charlie worked so hard to help often live in misery and die prematurely via type 2 diabetes and CVD, driven by excess consumption of sugar and other carbohydrate

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

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³School of Population
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⁴Menzies School
of Health Research.

Dietary improvement for Indigenous Australians is a priority strategy for reducing the health gap between Indigenous and non-Indigenous Australians.¹ Poor-quality diet among the Indigenous population is a significant risk factor for three of the major causes of premature death — cardiovascular disease, cancer and type 2 diabetes.² The 26% of Indigenous Australians living in remote areas experience 40% of the health gap of Indigenous Australians overall.³ Much of this burden of disease is due to extremely poor nutrition throughout life.⁴

Comprehensive dietary data for Indigenous Australians are not available from national nutrition surveys or any other source. Previous reports on purchased food in remote Aboriginal communities are either dated,⁵ limited to the primary store^{5,6} and/or short-term or cross-sectional in design.^{7,8} These studies have consistently reported low intake of fruit and vegetables, high intake of refined cereals and sugars, excessive

Abstract

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

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

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

Results: One-quarter (24.8%; SD, 1.4%) of total food expenditure was on non-alcoholic beverages; 15.6% (SD, 1.2%) was on sugar-sweetened drinks. 2.2% (SD, 0.2%) was spent on fruit and 5.4% (SD, 0.4%) on vegetables. Sugars contributed 25.7%–34.3% of dietary energy, 71% of which was table sugar and sugar-sweetened beverages. Dietary protein contributed 12.5%–14.1% of energy, lower than the recommended 15%–25% optimum. Furthermore, white bread was a major source of energy and most nutrients in all three communities.

Conclusion: Very poor dietary quality continues to be a characteristic of remote Aboriginal community nutrition profiles since the earliest studies almost three decades ago. Significant proportions of key nutrients are provided from poor-quality nutrient-fortified processed foods. Further evidence regarding the impact of the cost of food on food purchasing in this context is urgently needed and should include cost-benefit analysis of improved dietary intake on health outcomes.

was prohibited in the three study communities at the time of our study.

Monthly electronic food (and non-alcoholic beverage) transaction data

was categorised into food groups derived from the Australian Food and Nutrient Database AUSNUT 07 food grouping system¹⁰ and beverages were further

<https://www.mja.com.au/journal/2013/198/7/characteristics-community-level-diet-aboriginal-people-remote-northern-australia>

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

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

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Feature article: Chronic disease results for Aboriginal and Torres Strait Islander and non-Indigenous Australians
Aboriginal and Torres Strait Islander adults experience diabetes 20 years earlier than non-Indigenous adults (Media Release)
About this Release
History of Changes

10 September 2014

MEDIA RELEASE

Embargo: 11:30 am (Canberra Time)

132/2014

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

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

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

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

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

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

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

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

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

[http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4727.0.55.003~2012-13~Media%20Release~Aboriginal%20and%20Torres%20Strait%20Islander%20adults%20experience%20diabetes%200%20years%20earlier%20than%20non-Indigenous%20adults%20\(Media%20Release\)~130](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4727.0.55.003~2012-13~Media%20Release~Aboriginal%20and%20Torres%20Strait%20Islander%20adults%20experience%20diabetes%200%20years%20earlier%20than%20non-Indigenous%20adults%20(Media%20Release)~130)

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

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Adva

gran

The nutritional geometry of ageing in a rodent model [2009 - 2013]

Also known as: Nutrition and Ageing

Funded by National Health and Medical Research Council

Managed by University of Sydney

Provided by National Health and Medical Research Council

Research Grant [Cite as <http://purl.org/au-research/grants/nhmrc/571328>]

Researchers: Prof David Le Couteur , Prof David Raubenheimer , Prof John William Ballard (Participant) Prof Stephen Simpson (Principal investigator)

Brief description

A central belief in ageing research is that eating fewer calories prolongs life, and that the source of calories (carbohydrate, fat or protein) is irrelevant. However, a critical assessment indicates that this conclusion is premature. We will use recent techniques in nutrition to define for the first time in mammals the relationship between diet and ageing in a normal and a prematurely ageing strain of mice. The project will provide a novel nutritional approach for promoting healthy ageing.

Funding Amount

SAUD 979,269.18


Funding Scheme

NHMRC Project Grants


Notes

Standard Project Grant

<https://researchdata.and.s.org.au/nutritional-geometry-ageing-rodent-model/77306>



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GNT1149976 | Nutrition and Complexity

GA ID: GA971

Agency: National Health and Medical Research Council (NHMRC)

Publish Date: 30-Jan-2018

Category: Medical Research

Grant Term: 1-Jan-2019 to 31-Dec-2023

Value (AUD): \$12,981,420.00

Recipient Name: University of Sydney

Last Updated: 30-Jan-2018 9:33 am (ACT Local Time)

Purpose:

Nutrition shapes the relationship between genes and health, and failure to attain dietary balance has profound biological consequences leading to disease. This Application proposes an integrated program that harnesses advances in nutritional theory, systems metabolism, and data modelling that evaluates the effects of macro- and micro-nutrients on mice, cells and humans. This will provide the scientific foundations necessary for the development of evidence-based precision nutrition.

<https://www.grants.gov.au/?event=public.GA.show&GAUID=A88D3135-0238-7750-40C0D7DCFCCCF9B9>
<https://pdfs.semanticscholar.org/8d58/7c7cb42378e6e263223edd4abc8e5bc9d801.pdf>
<https://www.australianparadox.com/pdf/RR-letter-CEO-NHMRC-May-2021.pdf>

45

Stephen Simpson AC hid basic data falsifying claim cohorts fed low-protein, high-carb diets had “greatest median lifespan”

Table S2, related to Figure 2. Survival analysis by dietary composition.

Median and maximum lifespan in weeks (w). Maximum lifespan was determined as the average of the longest lived 10% (n=2-3) of each cohort.

Energy Density	Protein (%)	Carb (%)	Fat (%)	Protein: Carb ratio	Median lifespan (w)	Maximum lifespan (w)
MEDIUM	5	75	20	0.07	121.86	157.43
HIGH	5	20	75	0.25	106.43	154.21
HIGH	5	75	20	0.07	119.43	151.79
MEDIUM	14	57	29	0.25	123.00	151.57
HIGH	42	29	29	1.45	138.86	151.14
MEDIUM	42	29	29	1.45	122.57	148.00
MEDIUM	14	29	57	0.48	113.86	147.36
HIGH	5	48	48	0.10	124.43	146.21
MEDIUM	33	48	20	0.69	122.57	145.71
MEDIUM	23	38	38	0.61	123.86	143.07
HIGH	33	48	20	0.69	98.29	141.00
HIGH	14	57	29	0.25	117.43	140.07
HIGH	33	20	48	1.65	107.14	136.86
LOW	33	48	20	0.69	126.57	134.14
MEDIUM	33	20	48	1.65	106.57	133.79
HIGH	14	29	57	0.48	108.00	133.71
MEDIUM	60	20	20	3.00	108.00	129.50
HIGH	60	20	20	3.00	99.57	127.57
HIGH	23	38	38	0.61	100.00	124.57
LOW	14	57	29	0.25	98.57	119.43
LOW	33	20	48	1.65	78.57	116.36
LOW	14	29	57	0.48	88.71	115.07
LOW	42	29	29	1.45	85.85	104.00
LOW	60	20	20	3.00	84.29	102.86
LOW	23	38	38	0.61	89.29	100.36

<https://ars.els-cdn.com/content/image/1-s2.0-S1550413114000655-mmc1.pdf>

Importantly, Investigator Koopman confirmed my claim that over 100 dead mice fed 5 “killer” low-protein-diets were hidden

Through the course of assessing this issue, Professor Koopman also identified a discrepancy between the total number of animals reported in the paper (N=858) and the actual number of animals used (N=715). However, he found no evidence to suggest that

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p. 3 <https://www.australianparadox.com/pdf/2014-2019-USyd-enquiry-report.pdf>

Simpson told *Cell Metabolism* officials in Jan.2019 that “malnutrition” prompted independent vet to cull mice on 5 killer diets

Comment 3:

Table 3 (on p.6, below) confirms that the authors have skilfully misrepresented their 30-diet longevity results, including by obscuring 100+ dead mice on five low-protein diets.

Response 3:

As we pointed out at the time of publication in an online response to Mr Robertson, these diets were discontinued within the first 10-23 weeks of the study because the young mice assigned to them from weaning were not growing, and according to the independent veterinary office overseeing the study, would soon have died from malnutrition. Under the terms of the ethics protocol this mandated their immediate removal from the experiment.

Consideration of the composition of the excluded diets reveals the reason. As can be seen in Table S1 (and visualized in Figure S1), the 5 diets excluded from the 30 all combined a low or very low protein macronutrient ratio with high cellulose content (hence low energy content):

- Diet 2 Low energy density 5:75:20 (P:C:F, i.e. very low protein, high carb, low fat)
- Diet 3 Low energy 5:20:75 (very low protein, low carb, high fat)
- Diet 6 Low energy: 5:48:48 (very low protein, medium carb, medium fat)
- Diet 3 Medium energy: 5:20:75 (very low protein, low carb, high fat)
- Diet 6 Medium energy: 5:48:48 (very low protein, medium carb, medium fat).

To have attained sufficient nutrient intakes for growth would have required the mice on these low-energy, low-protein diets consuming more food than they were able to achieve. In short, these diets were not viable for a young, growing mouse.

Simpson’s email to a journalist, *Cell Metabolism* and me <https://www.australianparadox.com/pdf/USyd-mouse-diet-response.pdf>

Later, Stephen Simpson AC, Investigator Koopman and three of his bosses - Deputy Vice-Chancellors Garton, Ivison and Messerle - all got paid while embracing newly fabricated story: independent vet mistakenly culled 143 healthy mice

- (a) In the 2014 Cell Metabolism paper the authors referred to 'weight loss ($\geq 20\%$), rectal prolapse or failure to thrive' as reasons why the mice were euthanised;
- (b) The authors provided additional submissions to Professor Koopman regarding this issue to the effect that the mice on discontinued diets were not sick when culled, and those that were not losing weight may well have lived long and healthy lives, albeit as smaller mice;

p. 7 <https://www.australianparadox.com/pdf/RR-outcome-letter-7May20.pdf>

To protect Simpson, University embraced newly fabricated fake evidence that 143 hidden dead mice healthy as horses

Professor Garton noted that as euthanasia of the mice in the 2014 study was mandated by the responsible ethics committee, it could not be known whether mice fed these diets would have died, or whether they would have lived long and healthy lives had they not been euthanased.

p. 7 <https://www.australianparadox.com/pdf/2014-2019-USyd-enquiry-report.pdf>

University insisted mice suffering rectal prolapse, severe weight-loss, failure to thrive “were not sick” or malnourished

- (e) Professor Garton's report largely relied on that of Professor Koopman. In turn, Professor Ivison's decision largely relied on Professor Garton's report. As such, it can be said that the substantive assessment was made by Professor Koopman.

Assessment

- 39. It is understandable that you have queried how Professors Koopman, Garton and Ivison have made or supported the conclusion that the lifespan of the relevant mice was unknown. This issue arises in part because, while in the Cell Metabolism paper itself the authors mentioned multiple reasons for the exclusion of the mice, in their initial written response they only referred to malnutrition and also stated that the mice would soon have died. As discussed above, it appears that this was a cursory response that did not address the full reasons for the exclusion.

8 May 2020

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<https://www.australianparadox.com/pdf/RR-outcome-letter-7May20.pdf>

University oversaw sham “Correction”, insisted no misconduct, unethically refusing to address fact 5 of top-7 diets for median lifespan are high-protein diets, falsifying SJS's career-defining claim that low-protein (P:C) diets extend lifespan

CellPress

Cell Metabolism
Correction

The Ratio of Macronutrients, Not Caloric Intake, Dictates Cardiometabolic Health, Aging, and Longevity in Ad Libitum-Fed Mice

Samantha M. Solon-Biet, Aisling C. McMahon, J. William O. Ballard, Kari Ruohonen, Lindsay E. Wu, Victoria C. Cogger, Alessandra Warren, Xin Huang, Nicolas Pichaud, Richard G. Melvin, Rahul Gokarn, Mamdouh Khalil, Nigel Turner, Gregory J. Cooney, David A. Sinclair, David Raubenheimer, David G. Le Couteur,* and Stephen J. Simpson*

*Correspondence: david.lecouteur@sydney.edu.au (D.G.L.C.), stephen.simpson@sydney.edu.au (S.J.S.)
<https://doi.org/10.1016/j.cmet.2020.01.010>

(Cell Metabolism 19, 418–430; March 4, 2014)

In the originally published version of this article, the number of mice stated to be used for analysis was mistakenly given as 858 instead of 715. This error does not affect the data, analysis, or conclusions reported in the paper. The authors apologize for any confusion that this error may have caused.

[https://www.cell.com/cell-metabolism/pdf/S1550-4131\(20\)30011-5.pdf](https://www.cell.com/cell-metabolism/pdf/S1550-4131(20)30011-5.pdf)

Please investigate University of Sydney's "Research Excellence" corruption, a scandal fuelling T2D epidemic and Novo Nordisk's T2D drug fraud

Blatant research misconduct by University of Sydney "scientists" promoting harmful falsehoods
 Again, ongoing misconduct by a cabal of Charles Perkins Centre science careerists - "Gi Jennie" Brand-Miller (JBM), Stephen Simpson (SJS), Stephen Colagiuri and Stewart Truswell - suppressing profound medical matters of fact: (i) T2D caused by excess sugar/carbohydrate; and (ii) Carbohydrate Restriction fixes T2D. This misbehaving cabal's harmful misinformation - including insisting up is down and using fake sugar data in formal papers; putting "healthy" Low GI stamps on products up to 99.4% sugar; promoting low-protein, high-carb mouse diets that cause T2D, misery and early death in humans in Indigenous and aged-care communities; helping exclude critical word "Carbohydrate" from Canberra's diabetes documents; and faulty high-Carbohydrate ADGs - works to block the biggest advance in public health in over 50 years. Colagiuri today is misrepresenting profoundly impressive results from *Virta's* 2017-18 diabetes trial, blocking highly effective "*Virta approach*" that in US today - now! - is producing mass-reversal of T2D for health insurers such as *Blue Shield of California*, while collapsing unneeded spending on Novo Nordisk's insulin/drugs for T2D victims. JBM's infamous *Australian Paradox* sugar-and-obesity fraud continues to mislead, by dishonestly exonerating modern doses of sugar as a major driver of our modern obesity/T2D epidemics. Meanwhile, VC Mark Scott refuses to stop Charles Perkins' harmful 30-Diet Lifespan Fraud despite Simpson using it to steal \$13m from taxpayers over 2019-2023. Recall that USyd advertised low-protein, high carb (LPHC) mouse-killing diet to general public via *SMH*. Again, SJS hid five "killer" low P:C diets/143 dead mice, while avoiding critical fact that *five* of top seven diets for median lifespan are *high* not low in protein. Why? The *wrong* median mice died first and last! SJS's **career-defining experiment** falsified low-protein story he **needs** to tell: his pre-experiment book insisted low P:C diets would "extend lifespan" in mice as in insects, and thus humans. In the real world, SJS's sugary LPHC mouse diets cause T2D, misery and early death in our Indigenous and aged-care communities. Did I mention JBM hiding multi-million-dollar Novo Nordisk "External Interest"? (pp 27-31)

Novo Nordisk Australasia's business model has long involved giving easy money to influential science careerists to suppress key medical fact - T2D readily fixed via Carbohydrate Restriction - in order to expand unneeded sales of T1D medication Insulin/drugs to victims of T2D epidemic
 Being caught (illegally) "educating" T2D victims in after-hours 2004 meeting at *Quirindi* pharmacy helped NN to decide that best way to expand sales is giving easy money to "useful idiots" and otherwise corrupt "scientists", to suppress critical medical facts: (i) T2D caused by excess sugar/carbohydrate; and (ii) Carbohydrate Restriction fixes T2D. USyd's eminent diabetes careerist Stephen Colagiuri has been an excellent "investment", helping to exclude the word "Carbohydrate" from several of Canberra's national diabetes documents, including *AUSDRISK* and *National Diabetes Strategy 2016-20*. NN now benefits from SC-driven misrepresentation of key clinical results from 2017-18 *Virta* trial, in Diabetes Australia's *Statement* on T2D. Notably, NN (employer of Dr John Miller) gave easy money to Obesity Australia/The Obesity Coalition as Charles Perkins absorbed OA - with SJS installed as Chair - while SJS sneakily protected Mrs John Miller's pro-T2D *Australian Paradox* fraud, expanding it into AJCN. Meanwhile, JBM has enjoyed decades of undisclosed NN "External Interest" involving millions of dollars of undisclosed household income/wealth via NN's T2D-drug sales. Max Gillies as "Minister for Everything" Russ Hinze reckoned: "That's not a conflict of interest, that's a CONVERGENCE of interest!" So, what is corruption?

Dishonest management helping University and Novo Nordisk to steal billions from taxpayers
 Over the past decade, USyd Chancellor Belinda Hutchinson's senior management has used false and deceptive claims of "Research Excellence" to steer a disproportionate share of taxpayer funding to our USyd/Go8. Hutchinson's managers unethically prioritise "global rankings" over academic standards and "Research Excellence". Successive sets of Vice-Chancellors and Deputy Vice-Chancellors (Research) - VC Michael Spence and DVC(R) Jill Trehwella; VC Stephen Garton, DVC(R) Emma Johnston Ivison and Provost Barbara Messerle; and now VC Mark Scott and shiny new DVC(R) Emma Johnston - have sneakily refused to honestly apply their *Research Code of Conduct*, in a dishonest effort to hide serious misconduct by their elite "scientists". The "suits" worry that the **required formal retractions** of influential, harmful and false research "**findings**" will harm USyd's (undeserved) shiny reputation. So, VC Scott continues to provide dishonest institutional support for two harmful research frauds and other pro-Novo Nordisk misconduct that fuel our T2D epidemic. In latest formal letter to me, dated 15 May, USyd refused to address its *Paradox* fraud (pp 51-57). Again, VC Scott won't address critical fact that Charles Perkins' pro-sugar *Australian Paradox* "finding" is blatantly false; and he's okay with JBM, Stephen Simpson and Stewart Truswell colluding to place fake sugar data into AJCN. Even JBM's unmanaged and undisclosed NN conflict of interest is no problem. So Chancellor Belinda Hutchinson's unethical "suits" continue to dishonestly squeeze billions of dollars of research funding from taxpayers. Tragically, USyd misconduct is fuelling our T2D epidemic, with Canberra duped into funding unhelpful T2D drugs. Alas, VC Scott's best "scientists" are Novo Nordisk's "useful idiots", using USyd prestige to block massive gains via "*Virta approach*", to keep pumping unneeded T1D medication Insulin into T2D victims. VC Scott and DVC(R) Johnston simply play dead on key issues. It's all so blatant: JBM is exempt from *External Interest Policy*, not required to disclose multi-million-dollar NN "External Interest" to global scientific and diabetes communities, in COI disclosures in "peer reviewed" diet/health papers.

Millions of vulnerable Australians and taxpayers harmed by this shameful multi-pronged scandal that exists only because USyd senior management is dishonest

- Millions of everyday Australians are becoming T2D victims via USyd management's ongoing sneaky refusal to honestly implement USyd Research Code of Conduct and External Interests Policy. Elite "scientists" are exempt, their misconduct protected
- Taxpayers robbed of billions by dishonest USyd pretending "Research Excellence"
- Taxpayers robbed by Novo Nordisk and other drug companies duping Canberra into heavily subsidising mass purchases of unneeded Insulin for victims of T2D epidemic
- Medicare and other health insurers are blocked Insulin for huge gains via "*Virta approach*"
- Tragically, ironically, misconduct by cabal of Charles Perkins' sci-shonks has delayed by decade our best chance of stopping Indigenous T2D victims dying by the truckload
- Priority: Retract harmful false claims, embracing Carbohydrate Restriction to fix T2D
- Aussie Champions: Dr Penny Fytrees, Too Deadly for Diabetes and Defeat Diabetes

Evidence supporting all statements by Rory Robertson at www.australianparadox.com

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 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 Group of Eight 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 Group of Eight 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 **Sydney University's 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=PDOCT2011/75&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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economist and former-fattie
<https://twitter.com/OzParadoxdotcom>

I have written 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

www.strathburn.com

Strathburn Cattle Station is a proud partner of YALARI, Australia's leading provider of quality boarding-school educations for Aboriginal and Torres Strait Islander teenagers. Check it out at <http://www.strathburn.com/yalari.php>