

2 February 2015

The Rt Hon Dr Sarah Wollaston MP  
Chair, Commons Health Select Committee  
14 Tothill Street  
London SW1H 9NB

Dear Dr Wollaston

### **Doubts about dietary/medical guidance & research funding**

I am writing to you in your capacity as Chair of the Commons Health Select Committee. While trying to help my father's frontotemporal dementia, I have come across evidence suggesting that certain Government policies may have increased the risk of dementia and other modern chronic diseases (cardiovascular disease, obesity, diabetes and cancer).

My hope is that the Committee will expand its existing lines of inquiry and will insist that the UK Government takes any necessary corrective action urgently.

The evidence is presented in an accessible way in my film *You must be nuts! - the business of dementia*<sup>1</sup>, which is published on YouTube. I have provided some of the underlying references in the annexes to this letter, which concern:

- the dietary advice against eating fat and cholesterol;
- the routine prescription of drugs such as statins and antacids to older people;
- medical research.

All of these raise the question of how such practices could have been allowed to continue over several decades. In an article published yesterday<sup>2</sup>, cardiologist Dr Aseem Malhotra has suggested that there has been a failure of health regulation. I believe the problem may indeed be even wider, as I suggest in the fourth annex (Chronic regulatory failure affecting the nation's health).

As you know, dementia and other major modern chronic diseases have harmed the lives of millions of UK citizens in recent years, especially older citizens like my father. Their treatment and care cost the NHS and local authorities billions of pounds each year.

As our MP and former Health Minister Paul Burstow says in my film, "We need a much, much more ambitious research endeavour to better understand the disease mechanism. Because

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<sup>1</sup> *You must be nuts! - the business of dementia*: [3-minute prequel](#); [81-minute film](#)

<sup>2</sup> [Is the failure of health regulation damaging our well-being?](#) - Guardian, 1 February 2015

if we understood the disease mechanism and discovered that it was related to some imbalance caused by a lack of particular elements in our diet, then obviously that would be very good news from the point of view of health interventions because it would allow many people to be able to adjust their diets and probably do that at no great cost to themselves, but probably no great profit to others.”

## Dietary advice

I am aware that the Committee is currently exploring the impact of physical activity and diet on health.<sup>3</sup> I note that the Committee’s call for evidence itself suggested that a diet containing “too much fat” is unhealthy.<sup>4</sup> The NHS dietary advice encourages us to eat carbohydrates and discourages eating fats. However, as set out in Annex 1, this advice has never been substantiated by detailed scientific evidence.<sup>5</sup>

Meanwhile, Prime Minister David Cameron recently revealed that he has decided to cut carbohydrates and to stop eating bread to lose weight.<sup>6</sup> Clearly, he believes this works based on his past experience, unlike adherence to a low fat diet. Looking online, many people have arrived at the same conclusion.

I suggest that the Committee should extend its inquiry to consider:

- how the 'low fat, high carbohydrate' dietary advice given by the NHS came to be introduced based on population surveys, which have since been found to be flawed; and
- how this advice has remained largely unchanged for over three decades, in spite of several randomised, controlled trials over the past decade which have compared the health effects of such a diet unfavourably with those of a 'low carbohydrate, high fat' diet.<sup>7</sup>

I believe that the answer may be related to the need to justify prescribing statin drugs systematically to older people. Another factor may be that any food marked ‘low fat’ is more profitable: a ‘low fat’ label can encourage people to eat 50% more.<sup>8</sup>

## Standardised medical guidance

Even before the latest NICE guidance on statins, the OECD had described the UK as the ‘statins capital’ of Europe, with the second highest statin prescribing levels in the Western

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<sup>3</sup> [Inquiry: The impact of physical activity and diet on health](#) - 19 November 2014

<sup>4</sup> [Study: Doubling saturated fat in the diet does not increase saturated fat in blood](#) - 21 November 2014

<sup>5</sup> [Are some diets “mass murder”?](#) - Dr Richard Smith, BMJ, 15 December 2014

<sup>6</sup> [David Cameron on his ‘patriotic struggle’ to quit bread](#) - 14 January 2015

<sup>7</sup> [23 studies on low-carb and low-fat diets - time to retire the fad](#) - Authority Nutrition

<sup>8</sup> [Health halo: How low-fat foods can make you fatter](#) - Cornell University

world.<sup>9</sup> Some senior health professionals have already called on the Health Select Committee to investigate how the guidance provided by NICE is established.<sup>10</sup>

I would ask the Committee to go further and consider whether standardised medical guidance is ever useful, since doctors should be making informed judgements about their patients on an individual basis. It would seem that standardised medical guidance could be extremely susceptible to commercial practices, especially if the guidance is based on incomplete knowledge of the adverse effects of a drug.

In combination with the lack of access to full research results, it seems extremely likely that doctors find themselves prescribing drugs on the basis of an unreliable algorithm while facing targets to do so without being fully aware of the adverse effects those drugs might have on their patients.

This seems to me to be a recipe for mass harm by the NHS, especially of older people. For more details, see Annex 2: Medical guidance.

### **Who really benefits from the public funding of medical research?**

The Government is investing heavily in dementia research. However, as the Rt Hon Norman Lamb MP replied to me, the Government does not specify how this funding should be applied.

Unfortunately, it would seem that the bodies entrusted with the allocation of these funds also suffer from the conflicts of interest mentioned above. According to its accounts, the majority of the funding of the Medical Research Council comes from pharmaceutical companies. The allocation decisions of the relevant charities are made by their scientific panels, whose members may have conflicts of interest and ties with pharmaceutical companies.

As a result, it seems likely that public funding for medical research could be an indirect public subsidy for patentable, commercial research by pharmaceutical companies. This implies that non-drug solutions (which may well be more effective and have fewer side-effects than pharmaceutical drugs) or indeed prevention are unlikely to be allocated much research funding - however promising they may be.

Even if public funding is directed towards commercial research, it would seem normal that the results of such research are shared with other researchers. However, this often does not appear to happen, especially if the results are unfavourable to the pharmaceutical company doing the research. For more details, see Annex 3: Medical research.

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<sup>9</sup> [Britain becomes statins capital or Europe according to study](#) - 25 December 2013

<sup>10</sup> [Letter re: NICE guidelines from Dr Kailash Chand OBE et al](#) - 21 November 2014

Both aspects could be tackled by placing a pre-condition when awarding public funding to research that the results of the research will be published in full, in line with the G8 Open Data Charter.<sup>11</sup> Even if the research does not result in a drug, its results could be of interest to other researchers.

## Conclusion

I regret to have to say that I believe the UK Government's dietary advice, standardised medical guidance and medical research have all been influenced unduly by commercial lobbying and/or by people with conflicts of interest. Similar problems may have led to the under-regulation of industrial farming methods, which have had a detrimental impact on the food chain, on the environment, and hence on our health.

The strategy of prescribing drugs systematically based on statistical analysis rather than physiological need relies heavily on the accuracy of the data and assumptions underpinning those analyses. In the absence of all relevant research results, there would appear to be considerable scope for such a strategy to both undermine the health of the public at large and drain the resources of the NHS.

I therefore urge the Committee to investigate what I consider to be the chronic regulatory failure which has led to the current dietary advice, the medical guidance to doctors and the near-exclusive allocation of public research funding to commercial medical research, without any obligation to publish the results. I believe that this regulatory failure over at least three decades has allowed or even caused major chronic diseases (dementia, cardiovascular disease, obesity, diabetes & cancer) to reach epidemic proportions.

Of course, as I suggest in the final part of Annex 4, I do see signs of a possible way forward which could improve the lives of many and save the NHS money. This would require a more human approach to health within the NHS, which could find considerable support among both staff and patients, as Dr Kate Granger's #hellomynameis campaign illustrates.<sup>12</sup>

Yours sincerely

Obhi Chatterjee FRSA

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<sup>11</sup> [G8 Open Data Charter](#) - 18 June 2013

<sup>12</sup> [Terminally ill doctor Kate Granger's 'my name is' campaign wins support](#) - BBC News, 2 February 2015

## Annex 1: Dietary advice

Various NHS web pages continue to discourage people from eating saturated fat, including the following:

<http://www.nhs.uk/Livewell/Goodfood/Pages/Fat.aspx>

<http://www.nhs.uk/video/pages/fat-the-facts.aspx>

<http://www.nhs.uk/Livewell/Goodfood/Pages/Eat-less-saturated-fat.aspx>

<http://www.nhs.uk/Livewell/SouthAsianhealth/Pages/Fat.aspx>

<http://www.nhs.uk/chq/pages/1124.aspx?categoryid=51>

<http://www.nhs.uk/conditions/Obesity/Pages/Introduction.aspx>

<http://www.nhs.uk/news/2014/03March/Pages/Saturated-fats-and-heart-disease-link-unproven.aspx>

Meanwhile, various NHS web pages advocate eating carbohydrates, including the following:

<http://www.nhs.uk/Livewell/Goodfood/Pages/starchy-foods.aspx>

<http://www.nhs.uk/conditions/pregnancy-and-baby/pages/healthy-pregnancy-diet.aspx#close>

<http://www.nhs.uk/Livewell/Goodfood/Pages/eight-tips-healthy-eating.aspx>

<http://www.nhs.uk/livewell/loseweight/pages/the-truth-about-carbs.aspx>

<http://www.nhs.uk/Livewell/Goodfood/Pages/Healthyeating.aspx>

<http://www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx>

<http://www.healthystart.nhs.uk/food-and-health-tips/healthy-eating-in-pregnancy/>

Neither the recommendation to avoid saturated fat nor the recommendation to make carbohydrates a significant portion of the diet can be derived from the scientific evidence to date.<sup>13</sup> In particular, as was established in September 2013 by the Swedish Government's Expert Committee on Dietary Treatment for Obesity<sup>14</sup>, they are contradicted by the clinical trials of the effects of nutrition on heart disease in the past decade.

The evidence against saturated fat amounted to:<sup>15</sup>

1. Very poorly controlled trials from the 1970s, whose flaws have since been revealed; and
2. The fact that saturated fats raise total cholesterol.

In the late 1980s, it was discovered that total cholesterol is not, actually, a reliable predictor of heart disease, so the conversation shifted to LDL-cholesterol, which saturated

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<sup>13</sup> Patty W. Siri-Tarino et al., "Saturated Fat, Carbohydrate, and Cardiovascular Disease," *The American Journal of Clinical Nutrition* 91, no. 3 (March 1, 2010): -, doi:10.3945/ajcn.2008.26285; Rajiv Chowdhury et al., "Association of Dietary, Circulating, and Supplement Fatty Acids With Coronary Risk," *Annals of Internal Medicine* 160, no. 6 (March 18, 2014): 398–407.

<sup>14</sup> [Swedish Expert Committee: A Low-Carb Diet Most Effective for Weight Loss](#)

<sup>15</sup> With thanks to Nina Teicholz, investigative journalist and author of *The Big Fat Surprise*

fat also raises. However, over the past decade, many studies have shown that LDL-C has also failed to be a reliable predictor of risk.

The new science shows that certain subfractions of LDL are more accurate—and saturated fat has a good effect on these. Plus, saturated fat is the only kind of food that is known to increase HDL, the “good” kind of cholesterol.

In short, saturated fat was condemned when the science was still primitive. The science has evolved, but experts are stuck in old paradigms due to longtime biases and support from the statin industry.<sup>16</sup>

Indeed, a study by Ohio State University recently concluded that more than doubling saturated fat in the diet doesn’t increase saturated fat in the blood, while “increasing levels of carbohydrates in the diet during the study promoted a steady increase in the blood of a fatty acid linked to an elevated risk for diabetes and heart disease”.<sup>17</sup>

Avoiding fats has led to eating more carbohydrates – 25% more since adopting the low-fat diet – and this shift (not only to more sugar but also more whole grains and fruit) has led to today’s diabetes and obesity epidemics.<sup>18</sup> Cutting back on saturated fat has also meant that we are now eating far more vegetable oils, like soybean, canola and corn. These oils didn’t even exist in 1900 and now are 7-8% of all calories we eat. They have always been associated with health problems, including cancer.<sup>19</sup> When heated, they oxidize and cause inflammation and gastric damage.

As a result, the NHS dietary advice has been pushing people away from saturated fats towards genuinely unhealthy trans fats and their substitutes, and a high carbohydrate diet. Apart from increasing the risk of diabetes, obesity and heart disease, high carbohydrate diets have been found to lead to an almost four-fold increase in dementia in people over 70, compared to a low carbohydrate high fat diet.<sup>20</sup>

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<sup>16</sup> [The Big Fat Surprise: A conversation with Nina Teicholz](#)

<sup>17</sup> [Study: Doubling Saturated Fat in the Diet Does Not Increase Saturated Fat in Blood](#)

<sup>18</sup> Christopher D Gardner et al., “Comparison of the Atkins, Zone, Ornish, and LEARN Diets for Change in Weight and Related Risk Factors among Overweight Premenopausal Women: The A TO Z Weight Loss Study: A Randomized Trial,” *JAMA: The Journal of the American Medical Association* 297, no. 9 (March 7, 2007): 969–77, doi:10.1001/jama.297.9.969; Iris Shai et al., “Weight Loss with a Low-Carbohydrate, Mediterranean, or Low-Fat Diet,” *The New England Journal of Medicine* 359, no. 3 (July 17, 2008): 229–41, doi:10.1056/NEJMoa0708681.

<sup>19</sup> Christopher E. Ramsden et al., “Use of Dietary Linoleic Acid for Secondary Prevention of Coronary Heart Disease and Death: Evaluation of Recovered Data from the Sydney Diet Heart Study and Updated Meta-Analysis,” *BMJ* 346, no. feb04 3 (February 4, 2013): e8707–e8707, doi:10.1136/bmj.e8707; Christopher E. Ramsden et al., “N-6 Fatty Acid-Specific and Mixed Polyunsaturate Dietary Interventions Have Different Effects on CHD Risk: A Meta-Analysis of Randomised Controlled Trials,” *The British Journal of Nutrition* 104, no. 11 (December 2010): 1586–1600, doi:10.1017/S0007114510004010; Anita R. Alivheim et al., “Dietary Linoleic Acid Elevates Endogenous 2-AG and Anandamide and Induces Obesity,” *Obesity (Silver Spring, Md.)* 20, no. 10 (October 2012): 1984–94, doi:10.1038/oby.2012.38.

<sup>20</sup> [Eating lots of carbs, sugar may raise risk of cognitive impairment, Mayo Clinic study finds](#)

Consequently, the dietary advice from the NHS appears to have:

- contributed to the increase of chronic diseases
- provided guidance which is incompatible with adequate essential nutrition
- represented a narrow approach to food and nutrition inconsistent with the nation's diverse cultures, ethnicities, and socioeconomic classes
- been based on weak and inconclusive scientific data;

To avoid further damage to human health, I suggest that the above web pages should be taken offline as soon as possible and fundamentally revised in line with the latest scientific research. A low carbohydrate diet has been shown consistently to reduce obesity, Type 2 diabetes, and heart disease.<sup>21</sup>

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<sup>21</sup> [23 studies on low-carb and low-fat diets - time to retire the fad](#) - Authority Nutrition

## Annex 2: Medical guidance

According to *Wikipedia*, Cholesterol, ‘is an essential structural component of animal **cell membranes** that is required to maintain both membrane structural integrity and **fluidity**’.

Nonetheless, NHS web pages, such as the following, are contributing towards paranoia about cholesterol:

<http://www.nhs.uk/Conditions/Cholesterol/Pages/Introduction.aspx>

<http://www.nhs.uk/Conditions/Cholesterol/Pages/Diagnosis.aspx>

<http://www.nhs.uk/Conditions/Cholesterol/Pages/Causes.aspx>

<http://www.nhs.uk/conditions/cholesterol/pages/treatment.aspx>

<http://www.nhs.uk/Livewell/Healthyhearts/Pages/Cholesterol.aspx>

<http://www.nhs.uk/Conditions/Cholesterol/Pages/Prevention.aspx>

<http://www.nhs.uk/conditions/nhs-health-check/Pages/Understanding-your-NHS-Health-Check-results.aspx>

<http://www.nhs.uk/video/Pages/Cholesterolexpert.aspx>

Since the 1950s, studies have shown that **triglyceride** levels are a far better predictor of heart disease than cholesterol levels. There are several other markers which may be much better predictors of modern chronic diseases than cholesterol or LDL. For example:<sup>22</sup>

- high levels of **homocysteine** are associated with cardiovascular disease and Alzheimer’s;
- high levels of **gamma glutamyl transferase** and low levels of **vitamin D** are a more accurate predictor of heart disease and other chronic diseases than high serum LDL;
- high levels of **oxalate** are linked to kidney stones; and
- high levels of **ferritin** point to iron overload.

Regrettably, none of these is tested routinely by doctors. The medical guidance from NICE continues to require doctors to be obsessed about cholesterol levels, making their patients similarly obsessed about cholesterol levels. It would appear that this obsession has been inspired less by any scientific evidence that high levels of cholesterol are harmful (in fact, higher cholesterol is associated with greater longevity, especially for women)<sup>23</sup> and more by the revenue generated for the pharmaceutical industry by cholesterol-lowering statin drugs (at the expense of the NHS).

The daily prescription of statin drugs to millions of people in the UK (which has been identified by the OECD as the statin capital of Europe)<sup>24</sup> and elsewhere has made them the most lucrative drugs for pharmaceutical companies. The British Medical Association and a majority of UK doctors are sceptical about prescribing statin drugs to even more people, as

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<sup>22</sup> With thanks to Dr Stephanie Seneff, Senior Research Scientist at MIT

<sup>23</sup> [Is the use of cholesterol in mortality risk algorithms in clinical guidelines valid?](#) - J Eval Clin Pract. 2012 Feb; 18(1): 159-168. doi: 10.1111/j.1365-2753.2011.01767.x

<sup>24</sup> [Britain becomes statins capital of Europe](#)

recommended by NICE in 2014.<sup>25</sup> Only last week, leading heart specialists recommended that doctors are transparent with their patients about the risks of taking statin drugs.<sup>26</sup>

In February 2014, Zoë Harcombe had identified the potential conflicts of interests of the members of the panel responsible for setting the UK guidance on statins.<sup>27</sup> In June 2014, a group of doctors and academics wrote an open letter to NICE and to the UK Health Secretary about their concerns about the latest NICE draft guidance on statins.<sup>28</sup>

Apparently, the Department of Health thought it was up to NICE to manage any conflicts of interest and NICE saw no problems with conflicts of interest in the guidance.<sup>29</sup> In October 2014, following a letter from senior health professionals,<sup>30</sup> the Commons Health Select Committee decided to look into the claims of conflicts of interest.<sup>31</sup>

The Chair of NICE, Professor David Haslam, replied to the criticisms in November 2014.<sup>32</sup> His first observation was that “For almost thirty years, statins have been widely used in developed healthcare systems to protect people from cardiovascular disease (coronary heart disease and stroke). Their use in people who have established cardiovascular disease is not controversial.”

That presumes that there has been no advance in understanding what really causes cardiovascular disease over the past thirty years. In the rush to find a ‘cure’ for heart disease (which statins have failed to provide in spite of thirty years of mass prescription), their effects on the rest of the body seem to have been put to one side. Dementia is one of them.<sup>33</sup> Cataracts another.<sup>34</sup> Muscle weakness yet another<sup>35</sup> - and one of the most important muscles in the body is the heart.

As mentioned in Annex 3, in her interview for my film, Dr Stephanie Seneff, Senior Research Scientist at MIT, has described<sup>36</sup> how she was unable to get a paper published suggesting that a low fat diet and statin drugs could cause Alzheimer’s. You may wish to regard the interview and her original paper as an example of “not all the data on adverse effects [being] included in the published material.”

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<sup>25</sup> [BMA remains sceptical of lower statin threshold](#)

<sup>26</sup> [‘Warn all patients of dangers of statins’ say experts](#) - Daily Express, 27 January 2015

<sup>27</sup> [Statins: just say no. Sensible reasons why they are stupid medicine](#)

<sup>28</sup> [Open letter from health professionals regarding 2014 recommendations from NICE on statin drugs](#)

<sup>29</sup> [NICE has ended any debate about its independence](#)

<sup>30</sup> [Open letter to Rt Hon Sarah Wollaston MP calling for an independent investigation of NICE](#)

<sup>31</sup> [MPs probe claims of NHS drugs conflicts of interest](#)

<sup>32</sup> [NICE reply to Rt Hon Sarah Wollaston MP](#)

<sup>33</sup> [It’s not dementia, it’s your heart medication - cholesterol drugs and memory](#)

<sup>34</sup> [Statin drugs increase the risk for cataracts](#)

<sup>35</sup> [Severe muscle weakness improves after stopping statin drug for cholesterol](#)

<sup>36</sup> [Dr Stephanie Seneff, Senior Research Scientist MIT: getting a paper establishing a causal link between statin drugs and Alzheimer’s published](#) - interviewed for *You must be nuts! - the business of dementia*

In his book *The trouble with medical journals*, Dr Richard Smith, a past editor of the BMJ, explains the conflict of interests faced by editors of medical journals, whose main revenue source is pharmaceutical companies. This leaves them reluctant to publish papers which could damage sales of the drugs made by their sponsors.

Meanwhile, the main argument for statins is based on the theory that more cholesterol in the blood causes heart disease. As noted in Annex 1, this has been known not to be the case since the late 1980s. Indeed, the rationale for prescribing statins has usually been based on the reduction in the ‘relative risk’ of heart disease mortality.

For example, in refuting the arguments against wider statin use,<sup>37</sup> Professor David Haslam, Chair of NICE, argues that “statins have a material impact on reducing cardiovascular risk, where that risk is greater than 10% over a ten year period.” His reply also points out that the NICE guidelines are similar to those of the American College of Cardiology (ACC) and the American Heart Association (AHA).

Of course, the question is how anyone is supposed to know whether the risk of cardiovascular risk of anyone is greater than 10% over a ten year period. Unfortunately, the algorithm recommended by NICE to estimate that this risk appears to be based on that proposed by the ACC and AHA, which seems to imply giving statin drugs to all men over 58 and all women over 63 for the rest of their lives.<sup>38</sup> Note that the patient information leaflets for statin drugs urge caution for patients over 70<sup>39</sup> or even over 65<sup>40</sup>.

However, research in Norway has shown that such algorithms may need to be revised.<sup>41</sup> In particular, the case for women to take statins to prevent a first heart attack is extremely weak: post-menopausal women increase their risk of developing diabetes by 71%.

Although Professor Haslam suggests that “adverse effects are no more common in people on statins than on placebo”, according to Dr Patrick Moriarty, Director of Clinical Pharmacology at the University of Kansas Medical Center, “as many as half of the patients who present at his clinic are statin intolerant. In other studies, 10 percent to 25 percent of patients report being statin intolerant, making the need for an alternative treatment acute.”<sup>42</sup>

This would seem to be well beyond the ‘sensitivity analysis’ Professor Haslam points to in his reply: “We have, for example, tested the health economic model to see if our

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<sup>37</sup> [NICE response to HSC regarding statin guidance criticism](#) - Professor David Haslam, 5 November 2014

<sup>38</sup> [You need a statin - now what was the question?](#) - Dr Malcolm Kendrick, 18 November 2013

<sup>39</sup> [Patient information leaflet for Lipitor](#)

<sup>40</sup> [Patient information leaflet for Simvastatin](#)

<sup>41</sup> [Statin use and risk of diabetes mellitus in post-menopausal women in the Women’s Health Initiative](#) - Arch Intern Med. 2012 Jan 23;172(2):144-52. doi: 10.1001/archinternmed.2011.625

<sup>42</sup> [AHA.14: PCSK9 inhibitor safe, effective in statin-intolerant patients](#) - Cardiovascular Business, 17 November 2014

recommendations would remain cost-effective if, for instance, the frequency and severity of adverse events was twice as common as has been reported.”

It is difficult to imagine why guidance which relies so heavily on algorithms, risk assessments and assumptions about benefits should be published without underlying data to substantiate it.

Having previously helped to set the rules for evaluation panels awarding public contracts worth millions of pounds, I would expect every member of an evaluation panel to be (and to be seen to be) objective. The presence of potential conflicts of interest of any member (let alone the majority of members) of such a panel should have been enough to require these members to be excluded from the panel. Otherwise, there could be serious risk of corruption (whether direct or indirect).

NICE’s endorsement of bariatric surgery as a treatment for diabetes has been criticised for similar conflicts of interests of panel members.<sup>43</sup> The guidance appears to overlook growing evidence that a low carbohydrate diet would reverse diabetes, and indeed avert it from developing in the first place.<sup>44</sup> Yet diabetes charities and doctors continue to advocate a low fat, high carbohydrate diet, which has been shown to increase the risk of diabetes.<sup>45</sup>

NICE guidance would seem to have a credibility problem, even among doctors.<sup>46</sup>

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<sup>43</sup> [Gastric bands are as useful as a plaster on a severed artery](#)

<sup>44</sup> [High fat, low carb diets reverse type 2 diabetes in new program that bans sugar](#)

<sup>45</sup> [Low-carbohydrate diet and risk of type 2 diabetes in women](#)

<sup>46</sup> [Why I’ve ditched statins for good](#)

## Annex 3: Medical research

### *Allocation of public research funding*

In his reply to my questions of 28 February 2013, Norman Lamb had noted that the UK Government funds ‘research for health policy development, clinical and applied health research in the NHS, and the NHS costs incurred in supporting research funded by other bodies, such as the Research Councils and charities. However, we do not specify the exact nature of such research. ... One of the main agencies through which medical and clinical research is supported is the Medical Research Council (MRC).’

The Medical Research Council notes in its Annual Reports that it is ‘a publicly funded organisation dedicated to improving human health.’ and ‘receives its core funding allocation from the Department for Business, Innovation and Skills (BIS), in line with the Government’s spending review cycle. We receive additional funding from other partners to take forward collaborative projects and joint initiatives which increase the impact of our work and the public funding we receive.’

However, the MRC had total income<sup>47</sup> of £169.4m in 2013/14 (£194.1m in 2012/13) from its programme. £20.2m of this (£36.6m in 2012/13) came from other Government departments. Meanwhile £60.3m (£62.5m in 2012/13) came from ‘Contributions and grants from other bodies’ and £85.4m (£79.0m in 2012/13) came from commercial activities.

The largest source of income for the MRC is therefore commercial activities, which ‘include royalties from licence agreements relating to intellectual property’. The net income from commercial activities was £43.7m in 2013/14 (£41.8m in 2012/13). The second largest source of income is for ‘co-fund[ed] research both of a collaborative and non-collaborative nature’.

If over 88% of the MRC’s income is not coming from other Government departments, and just over 50% comes from commercial activities including royalties, the MRC would appear to have a major incentive to invest public research funding in commercial research (usually by pharmaceutical companies) so as to continue its source of royalty income. Moreover, the scope for pharmaceutical companies to control the allocation of public funding for research would appear to be very high.

Similarly, the 14 members of the Council (which decides the strategic and commercial direction of the MRC) include two members who are senior managers of pharmaceutical companies. Another member resigned in April 2014, at around the same time as he resigned from another public body for failing to declare his bankruptcy in 2012.<sup>48</sup>

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<sup>47</sup> [MRC Annual report & accounts 2013/14](#), [MRC Annual report & accounts 2012/13](#)

<sup>48</sup> [Quango chief bankruptcy: Tony Caplin resigns from Public Works Loans Board following revelations](#)

The combined value of the NIHR, MRC and the Economic and Social Research Council funding for research into dementia is £66.3 million in 2014-15. The amount is impressive. The basis on which it is allocated, less so.

### *Access to research findings*

Dr Richard Smith, former editor of the British Medical Journal, has identified a number of problems with medical journals in his book *The Trouble with Medical Journals*.<sup>4950</sup> He points out that medical journals are ‘over influenced by the pharmaceutical industry’. He has also suggested that the process of peer review is ‘deeply flawed’ and that many authors of studies published in medical journals ‘have conflicts of interest that are not declared’. He has even alleged that ‘the whole business of medical journals is corrupt because owners are making money from restricting access to important research, most of it funded by public money.’

Doctors have come to rely on medical journals as their source of information about the latest research. However, as Dr Smith points out, medical journals are entirely dependent on pharmaceutical companies for their revenue (whether from advertising or from reprints of articles). As a result, pharmaceutical companies could control whether or not studies are published, when studies are published and how the study results are analysed.

If pharmaceutical companies can decide what is researched, what is published about the research, how favourably research into their products is presented in medical journals, when/if unfavourable results are published and how results are analysed, it seems to me that all regulatory checks and balances would have been removed.

In her interview for my film *You must be nuts!*, Dr Stephanie Seneff revealed that she could not get her 2009 paper on how a low fat diet and statin drugs could cause Alzheimer's disease<sup>51</sup> published by any medical journal. In the end, the paper was published in 2010 with a neutral title and after all references to statin drugs had been deleted.<sup>52</sup>

As Dr Smith notes, although the peer review process is supposed to ensure that papers have been thoroughly vetted before publication, it too could be used to silence or tone down criticism of drugs.

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<sup>49</sup> [The trouble with medical journals - introduction](#)

<sup>50</sup> *The Trouble with Medical Journals* by Dr Richard Smith, first published in 2006 by the Royal Society of Medicine. ISBN 978-1-85315-673-1

<sup>51</sup> [APOE-4: The Clue to Why Low Fat Diet and Statins may Cause Alzheimer's](#)

<sup>52</sup> [Nutrition and Alzheimer's Disease: The Detrimental Role of a High Carbohydrate Diet](#)

## Annex 4: Chronic regulatory failure affecting the nation's health

The points raised in Annexes 1-3 point to chronic regulatory failure over at least the past 30 years. During this period, millions of people in the UK have been advised by the NHS and doctors to change their dietary habits on the basis of weak and inconclusive scientific data. As you will recall, the Committee on Safety of Medicines (for which my mother worked until her retirement) was established in 1963, in the aftermath of the Thalidomide birth defects scandal. And yet it seems that commercial lobbies could now by-pass all of the checks and balances which were installed at the time to protect public health.

I understand that UK GPs are given targets for the numbers of older people to whom they prescribe statin drugs and other medication. As mentioned in Annex 3, the recent NICE guidance to doctors on statins has been to prescribe statins to even more people. The data on which this is based are unavailable to doctors, apparently on the basis of an agreement with a pharmaceutical company which retains absolute control over the way the data are analysed.

Dr Ben Goldacre<sup>53</sup> and the All Trials campaign<sup>54</sup> have drawn attention to the incomplete information available to doctors about the drugs they prescribe. The consequence of this incomplete information is that, when a body like NICE advocates prescribing more drugs (in spite of opposition from those such as the British Medical Association), doctors feel obliged to follow the guidance without being aware of the consequences.

And yet the case against cholesterol as regards heart disease is very flimsy. Indeed, people with higher cholesterol tend to live longer, as well as having a lower risk of developing dementia.

Statistically, it seems to me that the benefits of statin drugs have been considerably overstated. Moreover, the risks have been not only understated but suppressed, according to the experience of Dr Stephanie Seneff<sup>55</sup> and others.

The other drugs commonly prescribed to be taken daily by older people seem to suffer from similar problems.<sup>56</sup> As far as I am aware, the physiological impact of the typical cocktail of drugs prescribed to older people has never been studied.

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<sup>53</sup> TED talk by Dr Ben Goldacre: [What doctors don't know about the drugs they prescribe](#)

<sup>54</sup> [alltrials.net](#)

<sup>55</sup> [Interview by Dr Stephanie Seneff for You must be nuts! about her experience of getting her findings about statin drugs published](#)

<sup>56</sup> For example, in such long-term use, [according to US consumer group Public Citizen](#), proton pump inhibitors have serious adverse effects including magnesium deficiency, vitamin B12 deficiency and addiction, as well as increased risks of fractures and infection.

### *A possible way forward*

The original purpose of the NHS was "to secure an improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness".<sup>57</sup>

Unfortunately, over the years, prevention, diagnosis, treatment and care seem to have become fragmented. It would appear that this has had a dehumanising effect for NHS staff and patients alike.

At Frederic Laloux' recent RSA talk 'How to become a soulful organisation',<sup>58</sup> GP Dr Paquita de Zulueta asked him whether he could "please come and talk to NHS England".

In his talk, Mr Laloux referred to Buurtzorg, the revolutionary district nursing organisation in the Netherlands.<sup>59</sup> Its founders went back to the purpose of nursing: 'to help patients lead the richest and most autonomous lives that they can'. By doing so, it attracted both nurses and clients, who were fed up with the industrial approach to care which had turned the nurses into 'robots of care', following a closely-timed, highly impersonal schedule.

The approach has also been a financial success. Buurtzorg nurses need less than 40% of the hours prescribed by doctors to help the patients become autonomous. With some 80% of district nurses in the Netherlands now working for Buurtzorg, this is now saving Dutch taxpayers hundreds of millions of euros every year.

Similarly, Dr Atul Gawande has described<sup>60</sup> how developing and applying a checklist for surgery had cut complication rates by 35% and death rates by 47%. In his final 2014 Reith lecture, Dr Gawande proposed that medicine should focus on wellbeing - "protecting, insofar as possible, people's abilities to pursue their highest priorities in life".<sup>61</sup>

Maybe going 'back to first principles' with the NHS as a whole would remove the risk of commercial influence (including the failure to use existing knowledge) and put the interests of patients first.

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<sup>57</sup> [National Health Service Act 1946](#) - Article 1.1

<sup>58</sup> [RSA Event: How to become a soulful organisation](#) - Frederic Laloux, 22 January 2015

<sup>59</sup> [Buurtzorg - what's it all about?](#) - Anne Cooper, Lead Nurse for Informatics at NHS England

<sup>60</sup> [How do we heal medicine?](#) - TED talk by Dr Atul Gawande

<sup>61</sup> [The future of medicine: The idea of wellbeing](#) - 2014 Reith Lecture by Dr Atul Gawande