A Word to My Profession: Converting to a Starch-based Diet Medical Practice

On the day of my graduation from my Internal Medicine Residency at the University of Hawaii in 1978 I had a memorable conversation with my boss, Irwin Schatz, MD, the medical director of my residency program. He said, "John, I like you and your family. But, I am concerned that you will starve to death with your crazy ideas about food. All you will collect for patients is a bunch of bums and hippies." My response was, "So be it. Then I will starve, because I cannot prescribe drugs and surgeries that I know will do my patients more harm than good." More importantly, I think that what Dr. Schatz was really trying to tell me was that I was going to fail financially because I was not playing by the traditional rules set by years of economic pressures for a successful medical practice.

The way general doctors make a secure living is to collect a bunch (herd, flock, school, etc.) of patients and get them hooked on medications for blood pressure, diabetes, cholesterol, pain, etc., which require that they return for a refill every one to three months. By keeping the customer coming back again and again, each visit results in an office charge of $80 to $170. Making people healthy and free from medications would appear to be economic suicide for any medical doctor. PAGE 2

Mammography Screening: Truth, Lies and Controversy [Paperback] By Peter C. Gotzsche, MD.

Women often ask me how they should explain to their doctor why they do not want a mammogram. *Mammography Screening: Truth, Lies and Controversy* may help. I consider Dr. Gotzsche the world's foremost expert on mammography research. His book is about ethics in medicine and the influence of self-interest, power, and money on scientific publication. Dr. Gotzsche correctly describes many of the people behind current recommendations for mammogram as liars involved in scientific misconduct that has killed and maimed millions of women. His work shows that routine mammograms (1) do not save women's lives, (2) increase the number of women over-diagnosed with cancer (they would never have known they were sick if not for the mammogram testing), and (3) increase a women's chance of having a mastectomy. PAGE 7

The Diet Book to End All Diet Books by George Lundberg, MD

In his widely published Internet review, Dr. Lundberg tells us: "Yes, I have been using a modified (not fanatically dedicated) version of Dr. McDougall's starch diet since he sent me a prepublication version earlier in 2012 and asked for a marketing cover blurb. PAGE 8

Featured Recipes

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The way general doctors make a secure living is to collect a bunch (herd, flock, school, etc.) of patients and get them hooked on medications for blood pressure, diabetes, cholesterol, pain, etc., which require that they return for a refill every one to three months. By keeping the customer coming back again and again, each visit results in an office charge of $80 to $170. Making people healthy and free from medications would appear to be economic suicide for any medical doctor.

I departed Dr. Schatz's office with these stinging words for him: "I believe you are wrong. My practice will be made up of successful people who have made great sacrifices to get an education, build businesses, and develop successful family and community relationships. These people will say to themselves, 'Look at me, and all that I have achieved. Why then, if I am such a big success, am I so fat and sick? Why have I failed in my health, without which I have nothing?'" I continued with Dr. Schatz (who himself carried a prospering belly), "When these people ask this question, I will be there with a new set of rules that will allow them to be winners in their health, too." History shows that I was right and he was wrong. I am the luckiest doctor in the world. Not only do I make an adequate income (like most doctors do), but I also have the satisfaction of seeing my patients heal and stay healthy (like most doctors don't).

In order to spread the fun around, I am happy to share with my colleagues how to set up a successful general practice based on a starch-based diet. This practice has two major distinctions from the usual practice: doctors must now do a whole lot of unprescribing of medications and a lot more of patient education.

Medication Facts (United States)

- Percent of persons using at least one prescription drug in the past month: 48%
- Percent of persons using three or more prescription drugs in the past month: 31%
- Percent of persons using five or more prescription drugs in the past month: 11%
- Percent of physician's office visits involving drug therapy: 74%
- Among children (under age 12), less than 10% used two or more prescription drugs in the past month.
- Among older Americans (aged 60 and over), more than 76% used two or more prescription drugs and 37% used five or more.
- Women were more likely to use prescription drugs than men.
- People with regular healthcare, medical insurance, and prescription benefits take more prescriptions.
- In the United States, spending for prescription drugs was $234.1 billion in 2008.
- Number of drugs ordered or provided during physician's office visits: 2.3 billion annually

Sick People Take Medications—Healthy People Do Not

Medical doctors have no trouble adding more drugs to our medicine cabinet or changing brands. Our formal education teaches us that drugs are the solution to most ailments; un-prescribing medications is unheard of. Doctors fear being criticized by their colleagues, and even more, they fear a malpractice lawsuit if something were to go wrong while making important adjustments toward fewer medications. Dying with a large bagful of drugs at the bedside is one accepted sign of a diligent and caring doctor, even when those efforts ultimately killed the patient.

My experience has been that most of the medications prescribed, even for fat, sick people, do no good, result in significant harms, and are overpriced. The scientific research that supports my observations is freely available to curious professionals and the general public at the National Library of Medicine (www.pubmed.gov). To avoid inappropriate conclusions, it also is important to recognize that there are some good, and a few "miracle," drugs, especially when they are used for acute conditions, such as when antibiotics are used for infections.

Overprescribing is universally seen in chronic conditions, such as elevated cholesterol, hypertension, type-2 diabetes, gastrointestinal distress, and arthritis. By great fortune these are the same chronic conditions that are most amenable to a healthy diet. Thus adding diet therapy to a doctor's practice substantially increases the likelihood that medications can and should be stopped. The healing effects of a starch-based diet enhance the potency of many medications by relieving their original purposes (high blood pressure, sugar, and cholesterol are all reduced by the diet). Without timely reductions in medications, serious harm can be done. A precipitous fall in blood pressure will cause hypotension with fainting and falling. Blood sugars forced down by too much insulin results in mind-numbing hypoglycemia. Once off the medication the body will quickly regulate itself. Any real needs for medication will be determined by observing the patient carefully during this adjustment period.

I have the luxury of closely observing the effects of any changes that I recommend. My interaction with patients begins with a history and physical examination. At that time most medications are stopped. Over the next seven days at my residential center in Santa Rosa, CA, blood pressures are taken, blood sugars are recorded if they are diabetic, and patients are weighed. With this constant overview, if I make an incorrect decision, then I can make new recommendations—daily or hourly when needed. Fortunately, only on rare occasions do I need to restart a medication or even start a new one.

Developing a Successful Practice

In 2006 I gave a lecture in Los Angeles to a group of scientists and medical doctors titled "How to Make as Much Money as a Bypass Surgeon and Still Feel Good about Yourself." I reason that rewards should come to honest doctors, too. Starting a live-in center like mine may not be a possibility for most physicians, but fortunately, in an office setting any doctor can make the transition to a starch-based diet practice with little sacrifice. I recommend that most physicians start out with a part time practice and gradually shift to seeing only patients interested in dietary change.

This is the model:

Step 1: The doctor continues his or her regular practice of seven-minute office visits. This keeps the cash flowing uninterrupted. These routine office visits will serve as the time and place to make the same kinds of medication adjustments that I make at my clinic. In this outpatient setting, patients will need to do their own monitoring at home (BP, sugars, weight, etc.). Timely reports will be made to the doctor (at the next office visit, or more frequently by phone or email). Based on this information, the doctor will recommend further adjustments in medications. New patients will begin with a full half-hour history and physical examination.

Step 2: Evening or weekend classes are set up for ongoing group education. During group meetings, patients learn the basic principals of the McDougall Diet. The McDougall website provides downloads, DVDs, and written materials for this education.

Shopping trips to cookware stores, supermarkets, and health food stores, and restaurant excursions can be arranged. Cooking DVDs and/or live cooking demos are performed at meetings. Classes can be taught by the doctor, a dietitian, chefs, and by similarly talented instructors. I recommend that *The Starch Solution* book be used as the primary classroom textbook. *The McDougall Quick and Easy Cookbook* would be a helpful addition (at least offered as an option). The enthusiasm that develops among participants encourages everyone to adhere to the diet and improve their health.

Example Schedule for Out-patient Classes:

Meeting 1:
Main Talk: My Best Arguments for the Starch Solution
Cooking Demo: Segments from McDougall Made Easy DVD or live demo. Breakfast: Fantastic Overnight Oatmeal, Your Kids Will Love These Pancakes, and Fabulous French Toast

Meeting 2:
Main Talk: Science Behind the Maximum Weight Loss Program
Cooking Demo: Segments from McDougall Made Easy DVD or live demo. Sandwiches with Eggless Salad and Mexi Soup

Meeting 3:
Main Talk: Marketing Milk and Disease
Cooking Demo: Segments from McDougall Made Easy DVD or live demo. Dinner: Confetti Rice, Mashed Potatoes with Gravy, Bean Burritos, and Tofu Tacos.

Meeting 4:
Main Talk: When Friends Ask: Where Do You Get Your Protein?
Cooking Demo: Segments from McDougall Made Easy DVD or live demo. Desserts: Lemon and Chocolate Puddings.

Meeting 5:
Main Talk: Soy Is Food, Not A Poison or A Miracle Drug
Cooking Demo: Segments from McDougall Made Irresistible DVD or live demo. Breakfast: No Huevos Rancheros, Veggie Benedicts and Pumpkin Muffins

Meeting 6:
Main Talk: Save Money and Your Health – Don't Buy Vitamins (Except for One)
Cooking Demo: Segments from McDougall Made Irresistible DVD or live demo. Lunch: McVeggie Burgers, Falafels with Tahini and Hummus, Quinoa, Dal, Potato and Split Pea Soups

Meeting 7:
Main Talk: President Clinton—You Should Not Have Agreed to Heart Surgery
Cooking Demo: Segments from McDougall Made Irresistible DVD or live demo. Dinner: Baked Penne Florentine, Easy Mayan Black Beans, Creamy Pasta Primavera, Thai Green Curry Rice

Meeting 8:
Main Talk: Osteoporosis and the Broken Bone Businesses
Cooking Demo: Segments from McDougall Made Irresistible DVD or live demo. Dips and Sauces: Tofu Dips and Artichoke Spread, Walnut Sauce and Peanut Dressing. Desserts: Lemon and Chocolate Puddings

*All of these lectures are available free or at low cost in the McDougall online store as video downloads and DVDs. By including different lectures from my web site this schedule can be shortened, lengthened, changed, and/or improved.

Step 3: Developing a larger diet-oriented clientele may take a little effort. During office visits, by email communications, newspaper advertisements, or other promotions, patients learn about the opportunity of becoming well through better eating. As patients become trimmer, healthier and drug-free they will spread the word and others will join the medical practice of doctors who know how to make them well and medication-free.

Medication Changes I Usually Recommend:

How a patient feels about his/her medications is important: Many want off of them and others are afraid to stop them. The patient's expectations must be considered seriously when the physician makes a decision. If unsure of the need for continued use of a medication, it is generally better to stop or reduce it (maybe slowly) and to observe the response. Remember, sick people take medication and the goal of a starch-based diet medical practice it to have healthy patients who don't take medications, whenever possible. The Hot Topics on my web site is filed with information on treating patients. See www.drmcdougall.com and use the "search" feature. Questions can also be emailed to me at drmcdougall@drmcdougall.com.

Hypertension:

Typically, I ask patients to stop all medications that are used to treat hypertension on the first day they start the diet. I may recommend a more gradual reduction if the patient's initial blood pressure in the office is very high (for example 170/110 mmHg or greater) or the patient is on several different brands of medications. Either finding suggests the patient is more severely ill. I also recommend gradual reduction for a class of medications called beta-blockers: I cut their dosage in half every three to five days. Beta-blockers "block" the effects of adrenaline on the heart, weakening this muscle (that's how they lower the pressure). Rapid withdrawal of this class of drugs can leave the heart very sensitive to the effects of adrenaline and rarely can result in a rapid heartbeat. This may be frightening, but seldom has important health consequences. If this symptom occurs (and it rarely does), then I ask the patient to take a small extra dose of their beta-blocker. This stops the fast heartbeat. Reductions in the beta-blocker are then resumed.

When medication is needed to lower BP, I like to use an inexpensive and time-honored medication called chlorthalidone. It is relatively safe and very effective at lowering numbers. A good blood pressure goal with medication is about 140/85 mmHg (and not lower). (Without medication the blood pressure ideally would be 110/70 mmHg or less.) I do not start or increase medications unless the blood pressure is 160/100 mmHg or greater, and expected to remain at those high levels for months. While making changes, blood pressure should be checked every morning at the patient's home and the results should be periodically relayed to the doctor. For more information see: http://www.drmcdougall.com/misc/2009nl/nov/bp.htm

Type-2 Diabetes:

Generally I stop all oral medications (pills) on the first day. If the patient is clearly type-2, I also stop all of his/her insulin on day one. Generally, the more overweight a person is, the more likely they have type-2 diabetes (a condition of insulin resistance, where generous amounts of insulin are produced by the body). Thin patients with elevated blood sugars are likely to be producing insufficient amounts of insulin and may need this hormone delivered as a medication at some point. If I am unsure about the patient's insulin needs (in other words, significant insulin insufficiency may exist), then I am more conservative and cut their insulin dosage by one-half to two-thirds the first day. Type-1 diabetics will always need to take insulin, however, I usually reduce their insulin dosage by one-third with the initiation of the diet.

A normal blood sugar level is 100 mg/dL or less, fasting in the morning without medications. In general, while on medication, my goal is to have the morning blood sugar for a diabetic at about 150 mg/dL. A lower goal will result in a greater likelihood of harmful hypoglycemia. Regardless of the blood sugar numbers, most people with type-2 diabetes lose weight faster and feel better without any medications. There are three reasons that I prescribe insulin for type-2 diabetes: If the patient loses too much body weight, develops symptoms of diabetes like excessive urination, or the patient worries about their blood sugar numbers.

Research on type-2 diabetics consistently shows aggressive treatment with medications causes an increase in complications, death, hypoglycemia, and weight gain. Low blood sugar (hypoglycemia) causes confusion and has resulted in death due to accidents. Under suspicion of drinking while driving, the police have arrested many diabetics over-treated with medication. In addition to the physical dangers, diabetics commonly have their lives destroyed by the acts of testing and treating. A blood sugar monitor becomes the center of attention for the diabetic and all those nearby.

When insulin is needed I try to use a regime of one to two shots a day, using long-lasting insulin (like Lantus). I err on the side of under-treating in order to avoid hypoglycemia. Blood sugars will be self-monitored daily and reported to the doctor as needed. For more information see: http://www.drmcdougall.com/misc/2009nl/dec/diabetes.htm

Cholesterol:

Taking statins can result in greatly reduced cholesterol numbers. If these medications (statins) are stopped the first day when a patient starts the diet, then he/she will often be disappointed if their cholesterol goes up on the next test. For this reason I often leave them on their current dosage until after the second blood test. Then after the second blood test, they can see the extra cholesterol-lowering benefits of their new diet, and I will stop these medications (especially in otherwise healthy people). However, if they are not healthy—they have a history of serious heart disease, stroke, or other artery disease—I will continue the statins with a goal of lowering their cholesterol number below 150 mg/dl. For more information see: http://www.drmcdougall.com/misc/2007nl/may/statins.htm

Coumadin (Warfarin):

Coumadin is an antivitamin K drug helpful for preventing blood clots in a few medical conditions, including atrial fibrillation. Vegetables are loaded with vitamin K and as a result, patients on Coumadin are usually told to avoid vegetables. But, vegetables are healthy. There is no real contradiction with proper treatment. When changing to a starch-based diet, the Coumadin dosage is simply adjusted in order to accomplish the desired blood thinning effects (based on periodic blood tests). Taking a little more Coumadin when needed is not a health hazard. In most cases, however, I find the change to a starch-based diet (high in vitamin K vegetables) requires no adjustment in dosage of Coumadin.

I also try to get patients with atrial fibrillation off of Coumadin. As with most conditions, many patients are over-treated. With this drug, the benefits for reducing stroke are small and the side effects (mainly bleeding), drug costs, and inconvenience (frequent blood tests) are great. The CHADS score is a helpful tool for deciding who should not be on these powerful blood-thinning drugs. (I have too little experience with the new drug Pradaxa to comment.)

Indigestion:

I usually stop the regular use of antacids on day one. I ask patients to take an antacid only as needed, and then to switch to the milder over-the-counter brands like Zantac or TUMS. I also instruct patients to raise the head of their bed using four-inch blocks. Gravity keeps the stomach acids out of the esophagus at night. Raw vegetables (onions, green peppers, cucumbers, radishes), fruit juices and hot sauces are foods on the McDougall Diet that commonly cause GI distress. Emphasize starches.

Laxatives:

Generally these can be stopped and used only as needed. However, it is not unusual for patients to have hard stools from their previous eating habits when they begin their new diet. A glass of prune juice will help the bowels empty. I will occasionally order a dose of Milk of Magnesia (MOM) to force stubborn movements.

Thyroid:

Generally I leave patients on their supplement of thyroid and adjust the dosage based on their TSH level. However, many patients

on medication have a perfectly functioning thyroid gland and no need for supplementation. If in question, the only way to tell those who need medication from those who do not is to stop the thyroid supplement and recheck the TSH level in three to four weeks. Treat based on the results.

Antidepressants:

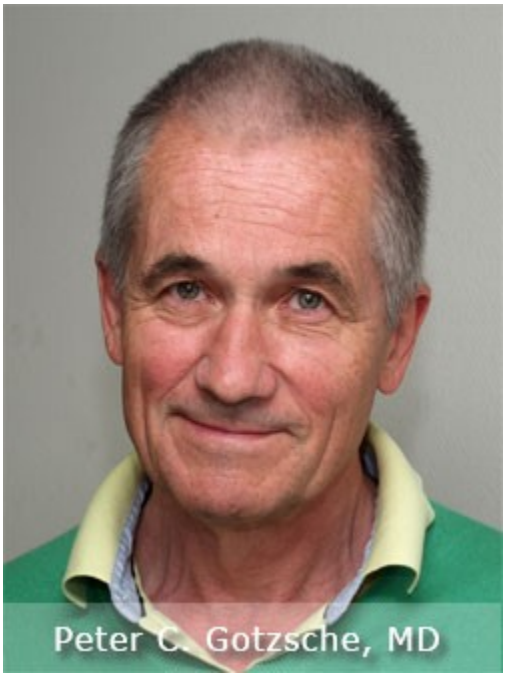
Generally, I do not change these. When patients do stop them, they are almost always unhappy with their decision after a few days. Patients wanting off antidepressants should stop them slowly. Lithium is a very effective medication for manic-depressive disorders. A low-salt diet reduces lithium excretion and may cause toxicity. Adjustments are made by lithium blood tests.

Pain:

I try to get patients to minimize their use of pain medications. In most cases the patient self-regulates the dosage with the goal of taking as little as possible. Aspirin is a highly effective, but almost forgotten, medication.

Mammography Screening: Truth, Lies and Controversy [Paperback]
By Peter C. Gotzsche, MD

Women often ask me how they should explain to their doctor why they do not want a mammogram. *Mammography Screening: Truth, Lies and Controversy* may help. I consider Dr. Gotzsche the world's foremost expert on mammography research. His book is about ethics in medicine and the influence of self-interest, power, and money on scientific publication. Dr. Gotzsche correctly describes many of the people behind current recommendations for mammogram as liars involved in scientific misconduct that has killed and maimed millions of women. His work shows that routine mammograms (1) do not save women's lives, (2) increase the number of women over-diagnosed with cancer (they would never have known they were sick if not for the mammogram testing), and (3) increase a women's chance of having a mastectomy.



Dr. Gotzsche started his work on breast cancer screening (mammograms) in 1999 and has been published in most of the relevant major medical journals since then. He is a Danish medical researcher, and leader of the Nordic Cochrane Center at Rigshospitalet in Copenhagen, Denmark. He has written numerous reviews within the Cochrane collaboration, which is considered by most doctors as the most unbiased source of medical reviews.

If you have been reading the news, then you are well aware that screening for prostate cancer in men with the PSA test has fallen into disrepute. For example, on Monday, May 25, 2012, the United States Preventive Services Task Force (USPSTF) put forth its final recommendations for men of all ages to stop getting this test done. The reasons are that this test, and the treatments that follow, fail to save lives and cause tremendous harm for the 20 million American men who get tested each year. After treatment, men are commonly left with urinary leakage and erectile dysfunction. Some also are killed by treatment.

Breast cancer in women is analogous to prostate cancer in men. These diseases share the same environmental causes (the Western diet), natural history of growth (about 10 years before the cancer is big enough to find), and treatment failures. I predict these similarities will continue and that within the next 3 years most health organizations worldwide will con-

demn mammograms.

I especially enjoyed the book because it served as a great review of the science I have been following in the medical journals over the past three decades. Even back then, the research was so sufficiently convincing that in 1985 I wrote in my book *McDougall's Medicine—A Challenging Second Opinion* that, "…teaching women to follow a low-fat diet is a more sensible approach to preventing breast cancer deaths than annual mammography, and a better way to spend our limited health dollars." These words are even truer today. But money still rules.

This book is very technical and will mostly appeal to readers interested in a detailed story of flawed science and crooked researchers. The evidence will sway most doctors, causing them to stop harping on you to get a mammogram. You might expect medical doctors to act more ethically than the rest of us humans, especially when it comes to something as personal as the female breast. But they don't and won't until forced to by work, such as Dr. Gotzsche's new book.

The matters surrounding all this forced testing are made worse because physicians are graded on performance based on how many mammograms and other screening tests that they order, and patients are penalized if they do not participate in recommended early detection programs. For example, Brenda recently sent me this e-mail: "At my job I am hounded by the health advocacy division to participate in their Health Preventative Program which includes clinical breast cancer screening, mammography, colorectal cancer screening, cervical cancer screening, etc. I wrote them many letters and told them I will not be taking any prescreening tests. The penalty is that I will have to pay $200.00 each extra annually for health insurance for my husband and myself. A penalty for taking a stand for myself!" My response to Brenda was: "Fight your company and their Health Preventative Program for all of our sakes." If she insists that they read *Mammography Screening: Truth, Lies and Controversy* by Dr. Gotzsche (especially with the encouragement of a good attorney), she will change the practice of medicine in her community, help her fellow workers, and save her company a bunch of money. And the $200.00 extra premium penalty she has been awarded by her company for her sensible behavior will be removed (hopefully with an apology and a few words of gratitude).

I purchased my copy of *Mammography Screening: Truth, Lies and Controversy* at Amazon.

The Diet Book to End All Diet Books by George Lundberg, MD, Editor-at-Large, *MedPage Today* and former editor of *JAMA* recommends *The Starch Solution*

In his widely published Internet review, Dr. Lundberg tells us: "Yes, I have been using a modified (not fanatically dedicated) version of Dr. McDougall's starch diet since he sent me a prepublication version earlier in 2012 and asked for a marketing cover blurb.

The N is 1, me, but it worked -- I have lost 13 pounds, mostly fat, and added substantial muscle. Of course, I also have a personal trainer and work out a lot. Living in the California wine country, my modified 'vegan' diet lets me still enjoy my wine."

He graciously reviews our book within these insights: "Eat all you want; any time you want. Statements that sound too good to

be true usually are ... too good to be true. But, *The Starch Solution*, richly referenced for science, but gracefully written for consumers, just might be both good and true."

Dr. Lundberg's experience emphasizes an important principle of *The Starch Solution*: "this is not an all-or-nothing approach."

I am honored by his words, especially considering that they are from such a famous, highly-educated, critical, and science-oriented source.

*Dr. Lundberg served as the editor of the *Journal of the American Medical Association* for 17 years (1982 to 1999). His editorial responsibility included its 39 other medical journals, including *American Medical News*. He was past president of the American Society of Clinical Pathologists.

Featured Recipes

All of the recipes this month were developed by Tiffany Hobson. Tiffany is becoming a very creative cook and we have had many brainstorming sessions about food and recipes lately. Hope you enjoy these recent recipes from her and look forward to more in the future. Mary

Tiffany is the executive assistant to the McDougall's. She heads operations for all McDougall Programs, is the tour director for McDougall Adventures, and oversees the Nursing Continuing Education. Tiffany has a BA in Rhetoric from University of California, Berkeley and is nationally certified as a Pharmacy Technician. She has the pleasure of assisting Dr. McDougall when seeing patients. Tiffany also helps Mary with recipe development.

Macro Bowl with Ginger Miso Dressing

The clean and simple flavors of Japanese cooking inspired this recipe.

Preparation Time: 25 minutes
Cooking Time: 30-45 minutes
Servings: 6-8

4 cups brown rice, cooked
6-10 potatoes (fingerling, new or blue potatoes work well), chopped
2 yams , peeled and chopped
6-8 carrots, peeled and chopped
1 15 ounce can white beans (butter, cannellini, or garbanzos), drained and rinsed
2 bunches of kale, stripped from its vein and chopped
1 package extra firm tofu, sliced (optional)

Preheat oven to 400 degrees. Clean the root vegetables and chop into bite size pieces. Place vegetables on a baking sheet (you may want to use parchment paper for easier clean up) and cook for 30-40 minutes. When you can easily pierce the vegetables with a fork, they are done. Remove from oven and set aside.

While the root vegetables are cooking, steam kale over boiling water for 2 minutes. Remove from steaming basket, place kale in a colander, rinse with cold water and allow to drain. Add the beans to the steamer basket and warm them for 5 minutes. Remove from steaming basket, rinse with cold water and drain. To prepare tofu, place sliced tofu in a non-stick pan over medium heat. Cook the tofu dry (adding no liquid to the pan) for 5-9 minutes on each side. The tofu should have a nice golden brown color. Remove from pan and cut into bite-size pieces. Set aside.

Ginger Miso Dressing

1 cup vegetable broth
4 tablespoons white miso soybean paste
6 teaspoons ginger, microplaned (grated)
3-4 small cloves of garlic, minced

Place dressing ingredients in a saucepan, over medium heat. Continuously whisk the ingredients together until the white miso paste has dissolved, about 5 minutes. Set aside.

To assemble bowls; in each bowl place ½ - ¾ cup brown rice, equal amounts of each vegetable, ¼ cup beans, and a few pieces of tofu. Add some of the Ginger Miso Dressing, toss ingredients together and serve.

Note: White miso soybean paste may be found in the refrigerated section at natural food stores.

Shirazi

This delightful salad (pronounced she-raw-zee) is a staple in the hot summer months in Iran because of its light, cool and refreshing taste.

Preparation Time: 20 minutes assembling, 2 hours to chill
Cooking Time: None
Servings: 4-6

6 large firm tomatoes, diced
1 large yellow onion, diced
2 large cucumbers, peeled and diced
6 tablespoons lemon juice
2 tablespoons parsley, diced (optional)
2 teaspoons white or red wine vinegar (optional)
Salt to taste
Black pepper to taste (optional)

Combine all the ingredients in a bowl and mix well. Cover and place in the refrigerator for 2 hours. Mix ingredients again and salt to taste before serving, if desired. This dish tastes even better when its been refrigerated for 24 hours.

Roasted Garlic Croutons/Bread Crumbs

The amount of garlic you decide to use for this dish depends on two things: how much do you love garlic and how long do you want to smell like garlic! The first time I made this, I used 12 heads of roasted garlic. It took about a week for the smell to dissipate! I do love the taste of roasted garlic, and it keeps well in the refrigerator. I tend to make a lot at once and it usually lasts about a week in my house before I need to make more.

Preparation Time: 25 minutes, plus 1-3 days to dry out bread
Cooking Time: 1 ½ hours for garlic, 25-45 minutes for croutons
Servings: 20

1 loaf of bread, cubed and placed in a bowl to dry for 1-3 days
12-14 heads of garlic, tops cut off exposing garlic with excess paper removed
2 ½ cups vegetable broth

Preheat oven to 375 degrees. Place the heads of garlic in a large Pyrex baking dish with the exposed garlic facing down. Add the vegetable broth and soak for 5-10 minutes. Turn over the garlic and cover with aluminum foil, placing parchment paper in between the garlic and foil. Cook the garlic for 1 ½ hours, or until the garlic has become golden brown. Remove from oven and allow the garlic to cool before handling, about 10-20 minutes. At this point, you may invert the whole heads over a bowl and squeeze hard with your hands to remove as much of the roasted garlic from the cloves. Either remove as much as you need for this recipe, and reserve the remaining heads whole, covered, in the refrigerator. Or squeeze all of it into a covered bowl, use what you need for this recipe and save the rest in the bowl in the refrigerator for other uses.

Take the bowl of cubed bread and add the squeezed out (as above) insides of 3 to 6 heads of roasted garlic. Mix the bread and garlic with your hands. You want to make sure the bread has been coated with the garlic. Place the bread on a baking sheet lined with parchment paper and spread it evenly. Bake the bread, checking it every 10 minutes. Once the bread has started to turn golden brown (about 20-25 minutes), turn off the oven. Taste is the best way to see if it's done. Bread may not be extremely hard at first, but will continue to harden as it cools.

For croutons: Place in a container and use when needed.
For breadcrumbs: Place in a sealed zip lock bag, and place that in another sealed zip lock bag. Pound it until you have breadcrumbs.

Note: One thing I did not expect from making this was how much this mimics the flavor of parmesan cheese. This has less fat than my nutty parmesan cheese recipe (walnuts vs. bread) and I tend not to need to use much of the croutons or breadcrumbs in recipes.

Easy Croutons/Bread Crumbs

Preparation Time: 25 minutes, plus 1-3 days to dry out bread
Cooking Time: 20-30 minutes
Servings: 20

1 loaf of bread, cubed and placed in a bowl to dry for 1-3 days
¼ - ½ cup vegetable broth

Preheat oven to 375 degrees. Add ¼ cup vegetable broth to the bread, making sure you coat the bread. You do not want to turn your bread into mush; you just want to coat it. Using your hands, mix well. If needed, slowly add more vegetable broth a little at a time. Mix well. Place the bread on a baking sheet lined with parchment paper and spread evenly. Bake the bread, checking it every 10 minutes. When the bread has started to turn golden brown (about 20 minutes), turn off the oven. Taste is the best way to see if it's done. Bread should be crispy, but not rock hard.

For croutons: Place in a container and use when needed.
For breadcrumbs: Place in a sealed zip lock bag, and place that in another sealed zip lock bag. Pound it until you have breadcrumbs.

Beans and Braised Kale

My new favorite dish! Not only is it easy to prepare, you can refrigerate the leftovers and it still tastes great!

Preparation Time: 10-15 minutes
Cooking Time: 10-15 minutes
Servings: 4-6

1 cup vegetable broth
1 tablespoon garlic, minced
1 tablespoon red pepper flakes
1 15 ounce can cannellini or butter beans, drained and rinsed
3 bunches lacinato kale, stripped from its vein and chopped
¼ cup Roasted Garlic Breadcrumbs (optional)
Salt to taste

Place vegetable broth, garlic and red pepper flakes in a non-stick pan over medium high heat. Sauté, stirring occasionally, for about 5 minutes. When the broth begins to boil, add beans and stir. Cook for 3-5 minutes, until the broth starts to boil again. Reduce to medium heat and add kale. Continuously stir the kale. The kale will cook down and the liquid will almost completely evaporate. Remove from heat. Serve with a few tablespoons of Roasted Garlic Breadcrumbs and salt to taste, if desired.

Note: This recipe does not need the Roasted Garlic Breadcrumbs. I've added this option in here because it adds a different texture to the cooked ingredients with a bit of parmesan cheese flavor.

Absolutely Fabulous No-Butter Sauce

Preparation Time: 5-10 minutes
Cooking Time: None
Servings: About 2 cups

½ cup cashews
1 cup vegetable broth
½ cup water

Place the ingredients in a blender. If you have a Vitamix: turn it on to the highest speed possible and allow it to blend for 5 minutes. If you have a blender: puree the ingredients at a high speed for about 7-10 minutes. You want to make sure the mixture is not grainy. Strain the sauce to make sure all chunks of cashews are removed. Transfer sauce to a bowl.

Note: To cut down on the fat content of this recipe, try adding another ¼-½ cup of water and vegetable broth. The sauce with be a bit thinner, but still very tasty.

Linguine with English Peas

Growing up there were only 3 things my mother ever cooked. One of them was pasta with a cube of butter (no joke) and parmesan cheese. I have always wondered if there was a way to turn that into a McDougall recipe. Hope you enjoy!

Preparation Time: 20 minutes
Cooking Time: 20 minutes
Servings: 6-8

12 ounces linguine
3 cups of shelled English peas, rinsed
1 15 ounce can butter beans, drained and rinsed
2 cups Absolutely Fabulous No Butter Sauce
2 tablespoons bouquet garni
2-4 cups Roasted Garlic Croutons
3 bunches frisee salad, cleaned and chopped
Salt and pepper to taste

Bring a pot of water to boil. Add linguine and cook until the pasta becomes al dente, approximately 6-10 minutes. Transfer to a strainer and rinse linguine with cold water to stop it from cooking. Place the pasta back in the pot, adding ½ cup of the No Butter Sauce and toss to keep the noodles from sticking together.

Over medium high heat, place the remaining 1 ½ cups of No Butter Sauce, English peas and butter beans in a non-stick pan. Stir-occasionally, allow the sauce to come to a boil. Add bouquet garni and mix well. After about 7-10 minutes, the peas should be cooked but not mushy. Remove from heat. Add the bean and pea mixture to the pasta and toss. Serve with Roasted Garlic Croutons and some fresh frisee salad on top. If desired, salt and pepper to taste.

Note: Bouquet garni is an herb mixture that can be purchased in most markets. It is usually a mixture of dried parsley, thyme, bay leaves and rosemary. Or use your own favorite herb/spice mixture in this recipe instead.

Roasted Red Bell Peppers

Fresh roasted red bell peppers are a treat, but take a bit of work. You may opt to buy them already prepared at your local store.

Preparation Time: 10 minutes
Cooking Time: 5-10 minutes per pepper or 30-40 minutes in oven
Servings: 6

6 whole red bell peppers, washed

There are two ways you may cook these:

If you have a gas range, turn your stove on to medium heat. Holding the bell pepper with tongs, roast the bell pepper over the open fla ing only when the side becomes black. Continue doing this until you have roasted all sides of the pepper.

Preheat oven to 400 degrees. Place bell peppers on a baking sheet lined with parchment paper. Cook for 30-40 minutes, turning the pe

Place the roasted peppers in a brown paper bag for 10-15 minutes. This will allow them to cool quickly. Remove the skin and seeds with your hands (they will easily come off). Cut these into lengthwise strips and store them in your refrigerator until needed.

Breaded Oyster Mushrooms with Roasted Red Bell Pepper and Roma Tomatoes

Preparation Time: 20-25 minutes
Cooking Time: 20 minutes

Servings: 4-8

3-6 cups Easy Bread Crumbs
1-2 cups Absolutely Fabulous No Butter Sauce
3-4 bunches Oyster mushrooms, cleaned
1 roasted red bell pepper, diced
1 roma tomato, diced
1-2 teaspoons lemon juice
Salt and pepper to taste

Preheat oven to 350 degrees. Oyster mushrooms are very delicate, and you do not want them to get water logged. To clean: cut them from their stalks and use a wet paper towel to clean off any dirt. You may also use a paring knife to help clean off any debris that is hard to get in the gills.

Place 1 cup of No Butter Sauce in a bowl. Place the breadcrumbs in a shallow pan. Dip each individual oyster mushroom in the sauce, then transfer it to the shallow pan and coat completely with breadcrumbs. Depending on how many oyster mushrooms you are making, you may need to add more No Butter Sauce to the bowl. Place the mushrooms on a baking sheet lined with parchment paper. Bake for 20 minutes.

In a separate bowl, add the bell pepper, tomato and 1 teaspoon of lemon juice. Mix well. The lemon juice should not over-power the other flavors. Depending on the flavor of your bell pepper, you might need to add a bit more of the lemon juice.

Serve the roasted red bell pepper and roma tomato mixture with the oyster mushrooms. I do not feel you need it, but you may salt and pepper to taste if desired.

I Cannot Believe this is NOT Clam Chowder

What to do with the remaining Absolutely Fabulous No Butter Sauce and breadcrumbs? I'm glad you asked…

This is not a low fat meal. However, if you really miss the days of eating clam chowder and it happens to be a **special occasion** in your life…why not! I repeat: **This is not low fat and should not be apart of your everyday, or every week, menu plan.**

Preparation Time: 3 minutes
Cooking Time: None
Servings: 4-6

Remaining Absolutely Fabulous No Butter Sauce
Remaining Breadcrumbs (if you have croutons on hand, add them as well)
Salt and pepper to taste

Place the breadcrumbs/croutons in a bowl. **Slowly** add the No Butter Sauce to the bread. You do **NOT** want to drown the bread in sauce; you want the bread to soak it up. The consistency should not be soupy, rather like a hearty wet bread look. The flavor of dipping the oyster mushrooms in the sauce gives this recipe its clam chowder taste. If desired, salt and pepper to taste.

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