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FIGHTING THE GOOD FIGHT: THE DIET WARS

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EDITORIAL

"The key to successful management of type 2 diabetes is diet and exercise." That statement was practically a mantra to those of us who trained in diabetes management 20 years ago. To we naïve students of nutrition, people with diabetes simply had to lose weight and their disease would be controlled. At that time, we believed, fat was the perpetrator of all things bad, including weight gain. Thus, we reviewed peoples' diets to identify and remove sources of fat; when obvious sources of sugar were identified, we banned those too.

To what advantage, though? Today, people continue to gain weight, obesity rates are at an all-time high and the epidemic of diabetes continues apace.

What was once considered a simple concept (eat less = lose weight) is, in reality, very complex. In the last 20 years, we've gone from high fat to low fat; now we're being directed to go from high carbohydrate to low carbohydrate. The debate rages on.

Today, an endless parade of 'miracle' diet books, popular consumer magazines and even measured commentary in respected publications tell healthcare practitioners and laymen alike that we've gotten it all wrong. Many of these books and articles claim that lowering fat intake isn't the answer to weight loss; rather, it's reducing the carbohydrates we love to eat. Currently, the 2 factions—low-fat vs. low-carbohydrates—are lined up on opposite sides of the battlefield. So, what are the implications of these 'diet wars' for our patients caught in the middle?

The diet wars first began with the appearance in the 1970s of Dr. Robert Atkins' revolutionary diet book (1), but have erupted more recently in the popular press. Earlier this year, *The New York Times Magazine* published an article on diet and weight loss by respected science reporter Gary Taubes (2), who wrote that members of the American medical establishment, after ridiculing Dr. Atkins' diet for years, "find that their own dietary recommendations—eat less fat and more carbohydrates—are the cause of the rampaging epidemic of obesity in America," and that Dr. Atkins "was right all along."

As well as setting the establishment's teeth on edge, Taubes offered insight into peoples' views about food and dieting in general. People often categorize foods as 'bad' or 'good,' he noted; accordingly, bad food (fat), should be completely avoided, while good food (carbohydrates), can be eaten freely. There may be some truth to his argument, as there has been a shift in people's eating habits; however, there has been no major weight loss trend but, rather, a startling increase in obesity.

Taubes discusses numerous theories of weight gain vs. weight loss, from the thrifty gene hypothesis to the reduction of regular physical activity in our society. However, he keeps returning to the argument that carbohydrates, not fats, are causing people to gain weight. His evidence rests in what he describes as an "Endocrinology 101" lesson: carbohydrates beget insulin, which begets weight gain and appetite, which beget carbohydrates, which start the cycle again. Unfortunately, his science is too simplistic. People will gain weight if they eat too much fat and/or too many carbohydrates, i.e. if they eat too many calories for their level of physical exertion.

However, what drives hunger and what drives eating are 2 very different and very complex issues. There are physiological, psychological, cultural, financial and societal factors involved.

In September 2002, *Time* magazine published an article about the diet wars that presented a more balanced view (3). Dr. Dean Ornish, President, Preventive Medicine Research Institute, Sausalito, California, supported the very-low-fat diet, based upon his belief that it improved cardiovascular (CVD) outcomes. He also supported the theory of ingesting fewer calories overall and choosing complex vs. simple carbohydrates. Dr. Atkins supported carbohydrate intake only with the addition of what he described as "healthy carbohydrates" once maintenance weight is reached. Is it possible that the commanders of the diet wars' opposing forces can be in agreement?

Nutritionist Marion Franz gave the diet wars a balanced perspective in a recent *Clinical Diabetes* article (4), in which she promoted the concept of balance in fat and

In This Issue

TYPE 2 DIABETES AND THE DIETITIAN

Page 3

carbohydrate consumption, along with physical activity, and advised: "The first message to give individuals with weight problems should be to eat healthfully."

Simple logic dictates that weight loss or weight gain isn't simply a matter of fat vs. carbohydrate intake. There must be multifactorial causes that involve a range of issues, including the quality and quantity of our diets. Follow-up commentary to *The New York Times Magazine* article identified other cultural, financial and societal factors that promote obesity. For example, physical activity is an endangered species, and we mark our increasing achievements in sedentary practices as benchmarks of advancement in a labour-saving civilization.

Numerous societal dynamics also encourage obesity. What are the forces driving the fast-food industry to "supersize" everything? Why are restaurant portion sizes increasing? Cookbooks undergoing revision now describe recipe portions that used to feed 6 as enough to feed only 4. And why is it that selections from the new Lighter Choices™ Menu in a ubiquitous, golden-arched, fast-food chain cost considerably more than the supersized burger and fries choice? Why is it extremely difficult, not to mention inordinately expensive, to give access to and extend the shelf-life of a variety of healthier choice foods in remote areas of Canada, but the supply of potato chips and soft drinks continues unabated?

The old weight-loss mantra of diet and exercise is clearly an overly simplistic panacea for a very complex issue. There is no simple answer to be found in a book or newspaper article. Perhaps it's time to promote a new mantra: "balance," i.e. balance in food intake and physical activity, and in our mental approach to them. It's time to end the diet wars and build a nutritional peace so that we can get on with the daunting epidemic of obesity and diabetes that we already face. In following the new mantra, when faced with the porterhouse steak vs. the baked potato, the balanced advice would be this: eat them both, in half the portion size offered, and then take a walk and smell the roses.

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TYPE 2 DIABETES AND THE DIETITIAN

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The diagnosis of diabetes is often overwhelming, and can be accompanied by uncertainty and confusion for people struggling to cope with the seriousness and complexities of their disease and its treatment. Above all, lifestyle changes are required to reduce the risk of complications, which may differ from habits that are often deeply entrenched at the time of diagnosis. These broad, sweeping changes may be difficult for people to undertake.

Family physicians often make the initial diagnosis of diabetes, and may be faced with the daunting task of answering a wide range of questions about eating habits and exercise; they may also be expected to provide basic information and incentives for patients to adopt potentially life-saving lifestyle changes.

While the patient/physician relationship is of primary importance, physicians may not have the time to instruct newly diagnosed patients, or those with longstanding diabetes, about broad strategies necessary to maintain good health, let alone provide individualized information on how food consumption and physical activity will affect blood glucose (BG) and lipid levels. Other specialized healthcare professionals can be an invaluable resource to complement the role of the physician by providing in-depth counselling, either individually or as part of a healthcare team based in a Diabetes Education Centre (DEC).

CONSULTATION WITH A DIETITIAN

While the professional diabetes team can set a treatment plan and provide ongoing support and monitoring, the reinforcement and general coordinating function of family physicians is essential to the successful overall care of the patient.

Dietary intervention is a key component of diabetes management, in conjunction with regular exercise, oral medications and insulin. One educational resource, "Just the Basics: Healthy Eating for Diabetes Management and Prevention" (1), was developed by the Implementation Subcommittee of the Canadian Diabetes Association's National Nutrition Committee to assist physicians, diabetes educators and those affected by or at risk of developing diabetes in making dietary and lifestyle changes. Simple and practical, it is especially useful for those who are newly diagnosed with diabetes, to help them cope between the initial diagnosis and the time they meet with a registered dietitian and the diabetes education team.

There is no ideal diet to suit every person with diabetes. Dietitian and patient should work together to formulate a specific, individualized meal plan. Dietary goals are to provide 50 to 60% of total calories from carbohydrate, 30% or fewer from total fat and the remainder from protein. Consideration must be given to the person's age, concurrent medical conditions, medications and food preferences, as well as cultural and social factors. Essentially, all meal plans aim to normalize BG and lipid levels, while ensuring adequate nutritional intake (2).

Nutritional prescriptions are most likely to be effective and sustainable when they are practical, take individual eating habits into consideration and cause limited disruption to lifestyle. Devising a suitable meal plan is a dynamic process requiring continual refinement to meet the changing medical and social needs of the person with diabetes. Severe restrictions are not necessary or reasonable, prove difficult to sustain over the long term and are likely to result in limited success (3). It is generally more effective to set realistic, achievable goals that focus on the dietary issues considered most important to the patient, even if these differ from those of the healthcare professionals. People should be encouraged to choose 1 or 2 issues to focus upon at a time, particularly when multiple health problems exist.

Once an individual meal plan has been devised and goals set, regular follow-up visits to the physician or DEC are necessary for ongoing support and encouragement. Positive reinforcement of all achievements, however small, helps motivate those with diabetes to continue managing the disease to the best of their ability, and is an approach that cannot be overemphasized.

Structured meal plans are not suitable for all patients. Some may view them as too rigid, difficult to follow or even redundant if moderate, well-balanced meals are already in place. For those who prefer a less structured approach, self-monitoring of BG before and 2 hours after meals can provide a wealth of information about appropriate foods and portion sizes. This approach can also be encouraged as an initial step for people who have difficulty accepting their diagnosis. Adults are experiential learners, so adjusting their intake by trial and error, in conjunction with BG monitoring, can be a very effective teaching tool.

USING THE GLYCEMIC INDEX

Some people may want to include foods that raise their BG more slowly, depending on the glycemic index (GI). The GI was established to rank foods according to their glycemic response, using a scale of 0 to 100. Carbohydrates that break down quickly during digestion are assigned a higher GI than those that are digested more slowly. Results are not always the same for a single food, depending on its physical state, degree of gelatinization and particle size (4). In general, foods that are cooked, more processed and of smaller particle size have the highest

glycemic response. Including a moderate portion of foods with a low GI ranking at each meal (whole grains, beans, lentils, pasta), may help control BG levels. Table 1 shows the GI of selected foods. A GI teaching tool, developed recently by the Canadian Diabetes Association, is now available (5).

TEACHING PATIENTS HOW TO COPE

Dealing with the vast array of nutritional information on food products and adjusting to changes in diet when travelling or eating out can prove complicated for people with diabetes.

Food labels

The first step in many diabetes education programs is to teach people how to interpret food labels accurately, so they can make informed, nutritionally sound choices regarding which products are best for their meal plans. Food labels provide detailed nutrition facts about a product, including its total carbohydrate and fat content per serving. Ingredients are listed in descending order by weight, not volume (eg. if oatmeal is the first ingredient, then it is present in the largest amount).

Many people with diabetes are under the false impression that sugar, even in small quantities, should be avoided at all costs. However, research has shown that sugar in moderate amounts causes no greater rise in BG than many starchy foods, and can be incorporated into a meal plan in moderation (6).

Eating out

Basic eating-out knowledge should include a familiarity with portion sizes from a variety of foods eaten at home that can easily be transferred to the restaurant setting. All-you-can-eat and buffet-style restaurants offer an irresistible invitation to overindulge and inevitably sabotage the good intentions of even the most health conscious. Choosing individual dishes from a menu is a less dangerous option.

Eating food away from home could also mean losing control of the quantity and type of fat used, but careful menu reading and ordering can prove useful in avoiding some common pitfalls:

- Menu items described as 'broiled,' 'poached' and 'steamed' are generally lower in fat than those described as 'fried,' 'crispy' or 'breaded.'
- Clear or vegetable soups contain less fat than cream soups.
- Certain substitutions can be helpful, i.e. salsa in place of sour cream, cheese or guacamole; pasta with tomato sauce rather than cream sauce.
- If menu items are unfamiliar, ask what they contain and how they are cooked.
- Request low-fat alternatives, such as rice in place of French fries.
- Ask that meat or fish dishes be prepared without butter or mayonnaise.
- Order salad with dressing on the side, and fresh fruit after a meal instead of rich desserts.

Take-away and fast-food restaurants offer convenient but less nutritionally sound options. Many fast-food restaurants provide pamphlets containing complete nutritional breakdowns of all items sold, thereby taking the guesswork out of carbohydrate and fat content (7-9). Table 2 shows the nutritional analysis of some fast-food items.

Value marketing, or supersizing, is a technique used frequently by fast-food restaurants to encourage consumers to buy the larger size of 1 or 2 items at a small price increase. The temptation for customers to supersize can have serious nutritional consequences: a small-size item on a fast-food menu can be incorporated into a balanced meal plan; however, it is difficult to justify the incorporation of the supersized version, with its drastically higher amounts of fat, carbohydrates and calories, into any healthy meal plan. The financial cost to increase the portion may be low, but the cost to postprandial BG and weight is much higher. Table 3 depicts the costs of supersizing McDonald's French fries.

FACTORS INFLUENCING ACCEPTANCE

Apart from constant encouragement and reinforcement from the professional healthcare team, numerous other factors may affect one's ability to adhere to a dietary plan. The temptation for family, friends and healthcare professionals to threaten and nag the person with diabetes about dietary requirements usually does little to improve outcomes. Support for and acceptance of any dietary adjustments can provide motivation for further improvement and avoid unnecessary conflict.

We live in an age in which there are numerous resources for people to access, each of which contains widely discrepant quality and content. The sheer volume of data on diabetes available in books, journals

Continued on page 6

Table 1: Glycemic index (GI) of selected foods (adapted from reference 4)

Food	GI
Apple	38
Beans, red, boiled	27
Bread, white	70
Corn flakes	84
Fructose	23
Glucose	100
Potatoes, white, mashed	70
Skim milk	32
Spaghetti	40

Table 2: Nutritional analysis of selected fast-food items

Restaurant	Menu item	Calories (kcal)	Fat (g)	Carbohydrates (g)	Dietary fibre (g)
Tim Hortons (7)	Honey-dip donut	231	10	31	0
	Whole-wheat carrot muffin	408	20	51	4
Swiss Chalet (8)	Grilled chicken Caesar salad	832	53	41	
	Grilled chicken breast with rice	627	9	91	
McDonald's (9)	Mandarin California green salad with raspberry vinaigrette	113	0.4	28	2.6
	Mandarin California green salad with raspberry vinaigrette and trail mix	425	19	55	4.6

What To Do Until the Dietitian Comes! A Resource for Family Practitioners

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Maintaining healthy habits for people with type 2 diabetes means (1):

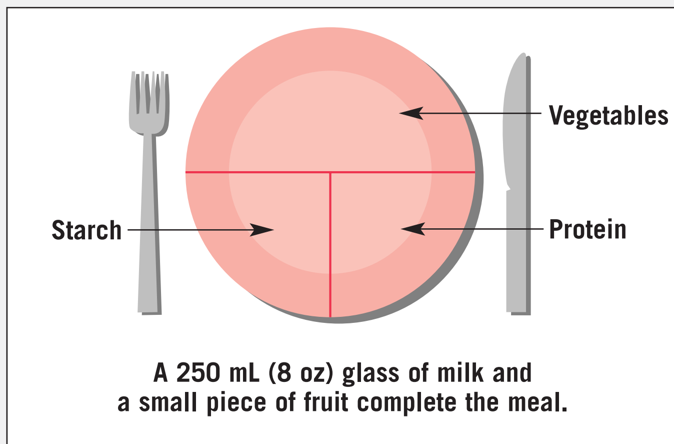
- Eating 3 regular meals spaced throughout the day.
- Limiting sweet foods (sugar, regular pop, desserts, candies, jam, honey).
- Limiting high-fat foods (fried foods, snack foods, pastries).
- Eating high-fibre foods (whole-grain breads and cereals, lentils, dried beans and peas, brown rice, fresh fruits and vegetables).
- Drinking water when thirsty.
- Enjoying physical activity every day.

Two simple and straightforward tools can be used to teach people with type 2 diabetes how to enjoy proper nutrition:

PLATE METHOD (1)

Divide your plate into quarters:

- ½ should be composed of vegetables (preferably 2 kinds).
- ¼ should be composed of starch (potatoes, rice, pasta).
- ¼ should be composed of protein (fish, lean meat, chicken, beans, lentils).



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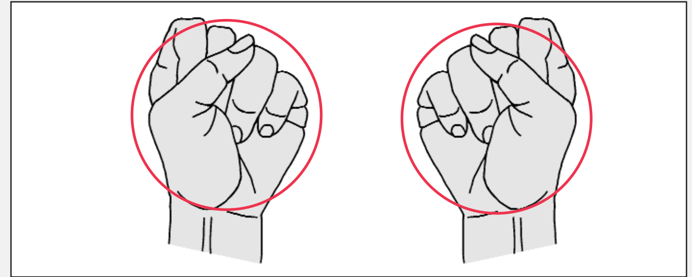
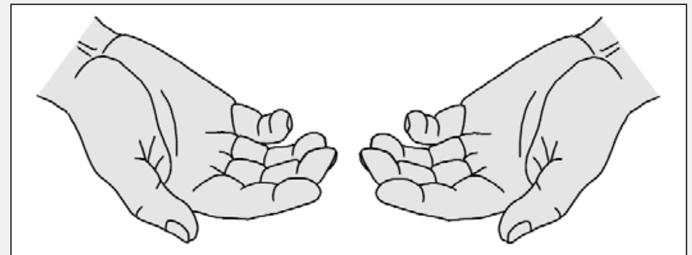
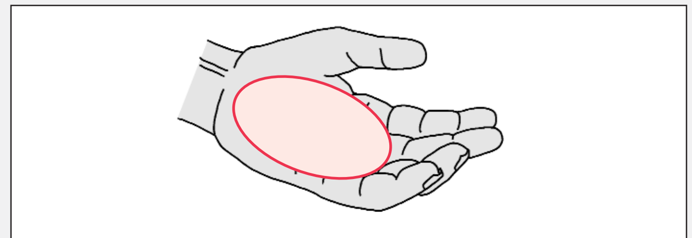
When planning a meal, use these portion sizes as a guide:



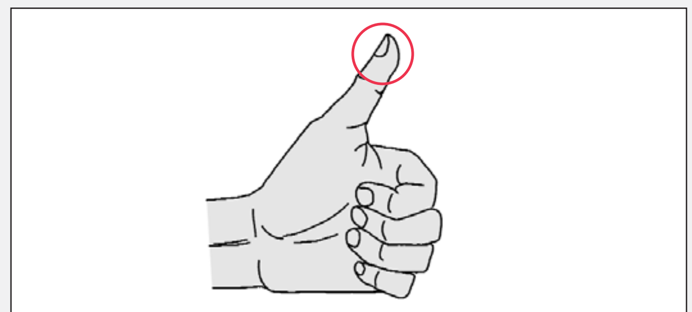
Carbohydrates (starch and fruit): Choose an amount the size of your 2 fists.



Vegetables: Choose as much as you can hold in both hands. Choose low-carbohydrate vegetables (e.g. green or yellow beans, broccoli, lettuce).



Protein: Choose an amount the size of the palm of your hand and the thickness of your little finger.



Fat: Limit fat to an amount the size of the tip of your thumb.

Drink no more than 250 mL (8 oz) of low-fat milk with a meal.

Remember, your hands can be very useful in estimating appropriate portions. They're always with you, and they're always the same size!

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Type 2 Diabetes…continued from page 4
and on the internet can be overwhelming as, all too often, the information is conflicting and leads to confusion.

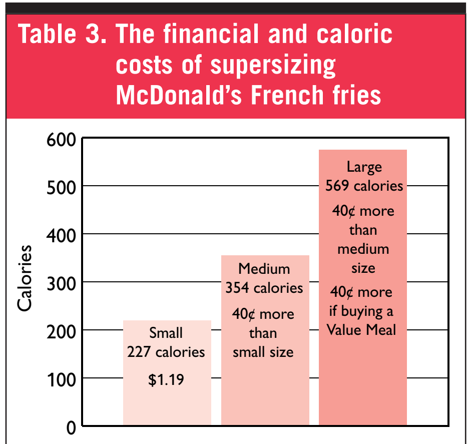
The recent proliferation of diet fad books can't help but add to the confusion and also reduce the public's willingness to accept conventional teaching methods about healthy eating, moderation and balance. People are increasingly seeking alternative solutions to their health problems, and food fads offer them this opportunity. It is not surprising, therefore, that some will elect to follow a fad diet that recommends extreme changes in food intake in the belief that it will assist them in shedding unwanted pounds with ease. Some of the most popular are Sugar Busters®, the Atkins Diet, Protein Power and The Zone (10).

These high-protein, high-fat, low-carbohydrate diets promise rapid weight loss and improved BG and insulin levels. Many of the diets also promote the all-you-can-eat approach, encouraging dieters to eat as much high-fat, high-protein food as they wish, as long as they consume only minimal amounts of carbohydrate. There is little mention of the importance of including vegetables, fruit, whole grains and dairy products.

People with diabetes should be advised that any diet that completely eliminates or significantly reduces the intake of entire food groups does not promote healthy eating habits or help to establish realistic and positive long-term lifestyle changes. In addition, these diets are extremely prescriptive, virtually impossible to maintain, and do not promote positive and sustainable dietary changes.

It is the healthcare professional's responsibility to inform patients of the potential risks of rapid weight loss and of diets that fail to provide all the essential nutrients required for healthy living.

Table 3. The financial and caloric costs of supersizing McDonald's French fries



Diabetes is a chronic disease that requires patients to play a central role in its overall management. A nutritional prescription, an essential component of all healthcare plans, should be based on sound nutritional principles, and all recommendations regarding food and lifestyle should be geared to the individual's needs. The healthcare team is an invaluable, ongoing resource for all patients trying to attain optimal metabolic outcomes.

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WHERE TO GET MORE INFORMATION

- Refer your patients to a registered dietitian or diabetes education centre.
- Provide your patients with 'survival' education material:
  - *Just the Basics* is available at the Canadian Diabetes Association's website (http://www.diabetes.ca/Files/justthebasics-eng.pdf) or by calling toll-free (800) BANTING.
  - *The Glycemic Index* is available at the Canadian Diabetes Association's website (www.diabetes.ca/Files/glycemicindex_Eng.pdf) or by calling toll-free (800) BANTING.
  - *Canada's Physical Activity Guide to Healthy Active Living* is available at Health Canada's website (http://www.hc-sc.gc.ca/hppb/paguide/pdf/guideEng.pdf) or by calling toll-free (888) 334-9769.
  - *Canada's Food Guide to Healthy Eating* is available at Health Canada's website (http://www.hc-sc.gc.ca/hppb/nutrition/pube/foodguid/index.html) or by calling (613) 954-5995.
- Surf the internet. The following websites are useful for healthcare practitioners are patients alike:
  - Canadian Diabetes Association (www.diabetes.ca)
  - Dietitians of Canada (www.dietitians.ca)
  - Health Canada (www.hc-sc.gc.ca)
  - Canadian Health Network (www.canadian-health-network.ca)
  - Heart and Stroke Foundation of Canada (www.heartandstroke.ca)

Suite de la page 8

n'est pas la solution pour perdre du poids. Il faudrait plutôt réduire notre consommation des glucides que nous aimons tant. Actuellement, les deux groupes – partisans des régimes pauvres en lipides et partisans des régimes pauvres en glucides – sont prêts à défendre leur position. Quelles sont donc les implications de cette «guerre des diètes» pour nos patients qui sont pris entre deux feux?

La guerre des diètes a commencé dans les années 70, au moment de la publication du livre sur la diète révolutionnaire du Dr Robert Atkins (1), mais elle a repris récemment dans la presse populaire. Un article sur la diète et la perte de poids, rédigé par le respecté rédacteur scientifique Gary Taubes (2), a paru cette année dans *The New York Times*. Selon Taubes, les médecins américains, après avoir ridiculisé la diète du Dr Atkins pendant de nombreuses années, trouvent que leurs propres recommandations – mangez moins de gras et plus de glucides – sont la cause d'une véritable épidémie d'obésité aux États-Unis, et que le Dr Atkins avait raison après tout.

En plus d'horripiler les pouvoirs établis, Taubes a donné un aperçu de ce que pensaient les gens de l'alimentation et des diètes en général. Les gens croient souvent que les aliments sont «mauvais» ou «bons», a-t-il souligné. Ainsi, il faut complètement éviter les mauvais aliments (le gras), mais on peut manger sans restriction les bons aliments (glucides). Cette opinion peut comporter un élément de vérité, car les gens ont changé leurs habitudes alimentaires; on n'a cependant pas observé de tendance importante à la perte de poids, mais plutôt une hausse de la fréquence de l'obésité.

Taubes traite de nombreuses théories sur le gain et la perte de poids, passant de la théorie du génotype vigoureux à la baisse de l'activité physique régulière dans notre société. Cependant, il invoque sans cesse l'argument selon lequel ce ne sont pas les glucides qui font prendre du poids, mais plutôt les gras. Pour le prouver, il se sert de ce qu'il appelle le «cours d'endocrinologie 101» : les glucides déclenchent la production d'insuline, l'insuline fait prendre du poids et augmente l'appétit, le gain de poids et l'augmentation de l'appétit produisent des glucides, et le cycle reprend. Malheureusement, ses arguments scientifiques sont simplistes. En fait, les gens prennent du poids s'ils consomment trop de gras et/ou trop de glucides, c'est-à-dire s'ils consomment trop de calories par rapport à leurs activités physiques.

Par ailleurs, les facteurs qui influent sur la faim et ceux qui influent sur le fait de manger sont bien différents. En effet, des facteurs physiologiques, psychologiques, culturels, financiers et sociaux entrent en jeu.

En septembre 2002, la revue *Time* publiait un article au sujet de la guerre des diètes qui contenait une opinion plus équilibrée (3). Le Dr Dean Ornish, président, Preventive Medicine Research Institute, Sausalito (Californie), s'est prononcé en faveur des diètes très faibles en gras, car il croit que ces diètes sont associées à une amélioration de la santé cardio-vasculaire. Il souscrit également à la théorie voulant que l'ingestion d'une quantité moindre de calories et le choix de glucides complexes plutôt que de glucides simples soient favorables. Le Dr Atkins, par contre, avait déclaré qu'il ne préconisait en réalité la consommation de glucides qu'après l'ajout de ce qu'il appelle des «glucides sains» une fois le poids visé atteint. Est-il possible que les commandants des forces d'opposition de la guerre des diètes soient d'accord?

Marion Franz, nutritionniste, a exprimé un point de vue équilibré au sujet de la guerre des diètes dans un récent numéro de *Clinical Diabetes* (4). En effet, elle préconise une consommation équilibrée de gras et de glucides ainsi que l'activité physique, et ajoute : «Le premier message à communiquer aux gens qui ont des problèmes de poids est qu'ils doivent manger sainement.»

La simple logique veut que la perte et le gain de poids ne soient pas simplement une question de consommation de gras et de glucides. Il doit y avoir des causes multifactorielles qui comportent divers éléments, y compris la qualité et la quantité de ce que nous consommons. Le commentaire qui suit l'article paru dans *The New York Times* fait mention d'autres facteurs culturels, financiers et sociaux pouvant favoriser l'obésité. Par exemple, nous faisons de moins en moins d'activités physiques et nous considérons l'accroissement de nos réalisations sédentaires comme des exemples de progrès dans une civilisation qui cherche à s'épargner du travail.

De nombreuses dynamiques sociales favorisent aussi l'obésité. Qu'est-ce qui pousse l'industrie alimentaire à tout offrir en «format géant»? Pourquoi les portions augmentent-elles dans les restaurants? Selon la version révisée de livres de recettes traditionnels, un plat qui servait 6 personnes n'en sert maintenant plus que 4. Pourquoi les choix des menus allégés des rapido-restaurants aux arches dorés, qui sont partout, sont-ils beaucoup plus coûteux que les hamburgers et frites de format géant? Pourquoi est-il très difficile, et excessivement coûteux, de distribuer une variété d'aliments santé dans les régions éloignées du Canada et d'en allonger la durée de conservation, tandis que l'approvisionnement en croustilles et en boissons gazeuses se fait sans peine?

Le vieux précepte voulant que la diète et l'exercice suffisent pour perdre du poids est nettement une solution trop simpliste à un problème très complexe. Nous ne trouverons pas de réponse facile dans un livre ou dans une revue. Il serait peut-être temps d'adopter un nouveau précepte : «équilibre», c'est-à-dire équilibre entre la consommation de nourriture et l'activité physique, et de notre attitude à l'égard de la nourriture et de l'activité physique. Il est temps de mettre fin à la guerre des diètes et de choisir la paix sur le plan de la nutrition afin de contrer l'épidémie déconcertante actuelle d'obésité et de diabète. Selon le nouveau précepte, lorsque nous devrons faire un choix entre un gros filet de bœuf et une pomme de terre au four, nous choisirons l'équilibre, c'est-à-dire que nous prendrons les deux, mais en demi-portions, puis nous ferons une marche et profiterons de la vie.

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LE DIABÈTE AU CANADA

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LIVRER LE BON COMBAT : LA GUERRE DES DIÈTES

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RÉSUMÉ

«La clé de la réussite du traitement du diabète de type 2 est la diète et l'exercice.» Il y a 20 ans, cette affirmation était pratiquement un précepte pour ceux et celles d'entre nous qui apprenaient à équilibrer le diabète. Pour nous, étudiants en nutrition naïfs, les personnes atteintes de diabète n'avaient qu'à perdre du poids et la maladie serait équilibrée. À cette époque, nous croyions que le gras était responsable de tous les maux, y compris le gain de poids. Nous faisions donc l'inventaire du régime alimentaire des gens et retranchions toutes les sources de gras. Lorsque nous y trouvions des sources évidentes de sucre, nous les supprimions également.

Mais quel en était donc l'avantage? Aujourd'hui, les gens continuent de prendre du poids, les taux d'obésité ont atteint un niveau record et les cas de diabète se multiplient rapidement.

Ce qui était autrefois considéré comme un concept simple (manger moins = perdre du poids) est, en réalité, très complexe. Au cours des vingt dernières années, nous sommes passés de régimes riches en lipides à des régimes pauvres en lipides et de régimes faibles en glucides à des régimes riches en glucides. Maintenant, nous sommes quelque part entre les deux, mais le débat se poursuit.

Aujourd'hui, une panoplie de livres sur des diètes miracles, des revues d'intérêt général populaires et même des commentaires modérés dans des publications respectées disent aux médecins comme aux non-initiés que nous sommes tout à fait dans l'erreur. Selon plusieurs de ces livres et articles, la baisse de la consommation de gras

Suite à la page 7