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The Big Lie

SPRING SUMMER

ISSUE 2016

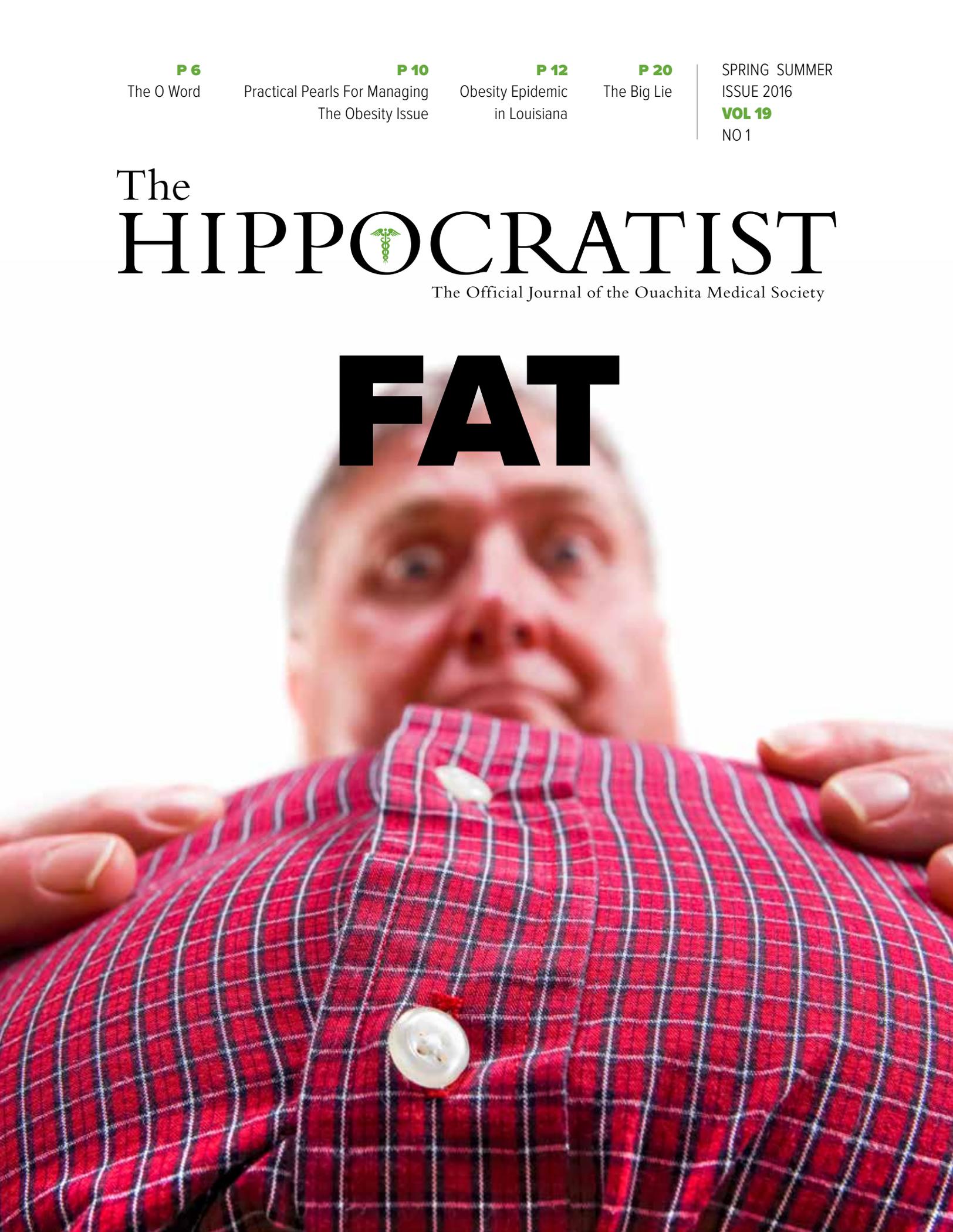
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Editor / Executive Director
Krystle Medford

Research Student Aide
Sameer Wadhwa

Design / Layout
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Too Fat to Fight

With this issue of the Hippocratist We explore obesity. From 1960 to 1980 obesity rates in the U.S. were fairly stable at 12% to 14%. By 2004 one in three Americans could be considered to be obese. We have continued to get fatter to the point that an estimated two thirds of Americans now are considered overweight or obese. What happened? Why did it happen? Some ideas suggested by nutrition researchers, physicians, and science writers include the introduction of high fructose corn syrup as a food additive in 1975, the belief that high cholesterol diet was a major cause of atherosclerotic cardiac disease in the post WWII 1940's, Ancel Keys' "Seven Countries" dietary study in 1961 with the hypothesis that dietary fat caused heart disease, publication of "Dietary Goals for the United States" urging reduction of dietary fat in 1977, and the National Cholesterol Education Program recommendations to reduce dietary fat in 1986. These are all referenced in a book by Gary Taubes, science writer, "Good Calories, Bad Calories" released in 2007. A popular YouTube video, "Sugar - the bitter truth" by University of California San Francisco pediatric endocrinologist, Dr. Robert Lustiq reiterates some of these points in a convincing presentation. As nutritional deficiencies and infectious disease were greatly reduced by the 1950's, more of us could live longer to die of cancer, heart disease, and chronic diseases. The electrocardiograph machine invented in 1918 helped launch cardiology as a medical specialty. Cholesterol could be measured as a blood test by the mid 1930's. Ancel Keys of the Laboratory of Physiological Hygiene at the University of Minnesota hypothesized that dietary fat was a cause of atherosclerotic heart disease. "Dietary Goals for the United States" in 1977 was the first comprehensive report



on risk factors in our diet by a branch of our government. This report was from a Senate select committee on nutrition. This committee was first formed in 1968 with a goal to end malnutrition. NCEP recommended a low fat diet for those with a serum cholesterol above 200 mg/do. We embarked on a low fat diet and ended up greatly increasing our ingestion sugar and refined carbohydrates. Our total caloric intake increased as well. Donuts just don't fill the way steak does. We missed the point of adopting a low or lower fat diet by replacing the fat with sugar and refined carbohydrates. The recommendations for low fat diet were made with the expected results of reducing heart disease. Our maladjustment to a lower fat diet by adding sugar and refined carbohydrates seems to have resulted in our increased obesity rates. The health consequences of obesity include increased risk of breast and colorectal cancer, sleep apnea, orthopedic impairments, increased surgical risks, infertility from secondary anovulation, non-alcoholic fatty liver disease, and many others. A report by Mission Readiness, a group of retired generals, admirals, and civilian military leaders, called "Too Fat to Fight - Retired Military Leaders Want Junk Food Out of America's Schools" states that being overweight or obese is the leading medical reason why applicants to the Armed Services fail to qualify. Too many of us have become too fat to fight. What to do about it? Current dietary prescriptions to reverse obesity reflect those from the recent and not so recent past i.e. eliminate sugar and excess starch (refined carbohydrates) from the diet.

You cannot out-exercise a bad diet.

Easy right?

Adrienne Williams, MD

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THE **O** WORD

OBESITY, THE O WORD HAS BECOME THE RAGING HOT TOPIC OF THE DECADE.

By: Uma Rangaraj, MD

Physicians & scientists are chewing their nails, fretting over solutions to treat and stop the obesity trend.

Our first lady has made it a priority issue to tackle the problem at a root level – our school children – by creating awareness at a tender age, so the trend may be reversed for the next generation.

The many medical associations of America are churning out stats and theories and treatments ad nauseum, & have in fact managed to get restaurants and fast food chains across the nation to publish the caloric values of their menu items, so consumers may make informed choices.

Weight-loss programs, supplements, diet plans and drinks by the hundreds are flooding the market, spouting promises of easy and dazzling results (incidentally raking in millions in profits, from hopeful and gullible customers)

How did Americans, the children and grand children of the Greatest Generation, become so fat and so out of condition? There are many reasons for this collective weight gain....

As this is an opinion article, I may opine, without having to spew boring stats and studies for scholarly (yawn!) consumption (Dr. Google can do that very well, thank you very much), & offer my perspective, looking through the window of decades in medical practice & also the experience of two cultures, old & new.

I notice, as I coax and counsel my overweight patients towards a healthier state of fitness, that most of my sturdiest patients are elderly farming folk – their breakfast alone is a heart attack waiting to happen - but here they are, in their 70's and 80's, still baling hay & mowing acres of grass, maintaining clean coronaries and healthy lungs.

Which fact blows to bits, our modern, well studied Theories of low-fat, low carb, Mediterranean, vegan, this, that & whatever other, fad diet.

So here are my observations in Q & A format:

How did Americans, the children and grand children of the Greatest Generation, become so fat and so out of condition?

I notice, as I coax and counsel my overweight patients towards a healthier state of fitness, that **most of my sturdiest patients are elderly farming folk**

Q What do these healthy farm folk do that's different? They...

- A**
 - Eat plenty... (lots of nutrition)
 - Work plenty... (lots of toning)
 - Breathe in fresh air and soak in sunshine... (lots of vitamin D)
 - Eat fresh foods... (peak nutritive value, no preservatives, non-processed)
 - Rise early & sleep early... (work with the biological rhythms of the endocrine system)
 - Live lives of simple straightforward values: Faith, family and community, content with fulfilling the basic needs of life... (peace of mind and spirit, less stress hormones, zen state)
 - Do not go racing for deadlines, slaving for raises and recognition, and cramming family life into a few hours at the tail end of a tiring day; all of which add stress (generating cortisol & adrenaline) & take away joy in life (resulting in a nervous break down, or life on the verge of one)
- There is something to be said for the old rhythms of life. I am reminded of a beautiful book by Gary Paulsen, "Clabbered Dirt, Sweet Grass", which is a poetic biographical account of his childhood days growing up on a farm. Well worth reading.

Q So how should we avail of these observations?

A No single answer is perfect for all of us, but, if we give it concerted thought and effort, we can begin to simplify life and our goals in small ways, learning methods to de-stress, making changes by degrees. Put a picture of a farm next to your work desk...

Q Ok, got that. But I am overweight now! – what advice do you have for me?

A Here are some facts to guide you:

DIET:

- No single diet is better than the other (proven by studies); whatever works for you is best, provided it is balanced, moderate and practical
- Very low-calorie diets (<1000 kcal a/day) are dangerous and could be detrimental to health in the long run, implementation must be supervised by a physician
- Carbs (yikes! The C word!!) & fats (eeeww!) are actually good for you, and necessary – in the right amount (Remember those sturdy farmers?)
- Fasting one day a week has benefits at many levels besides the obvious reduction in weekly calorie consumption: there are proven long term metabolic benefits aiding health at multiple levels
- 1200 kcals/ day for women and 1800 kcals/day for men are safe goals for weight-loss along with exercise

EXERCISE:

- Leave fiendish workouts to G.I. Joe's and Navy SEALs! A normal human schedule does not permit time for this in the long run.
- Exercise bingeing is dangerous (coach potato on weekdays & killer workouts on weekends). The sudden extreme demands on the cardiovascular system can result in stress on the heart
- Vigorous yard work and gardening = gym workouts (with the added benefit of sunshine and fresh air and getting chores done)
- Continual sitting (watching TV from 6 PM to 11 PM daily after work and then all weekend) leads to weight gain (zero Cals burned). Even standing burns 1 cal/ minute. There is actually a study that found that these people die sooner.
- Late nights = weight gain (keeps cortisol up and encourages bedtime snacking)
- Remember, obesity is a consequence of the automobile culture – in America and the world over. If Europeans are skinnier despite their mouth watering pastries and rich foods, it is because they have embraced biking and walking as their

major mode of transportation, implementing this into their city planning. If only somehow, we could make this happen in America! Meantime, we could try to walk & climb stairs as often as possible

Q What about weight-loss drugs?

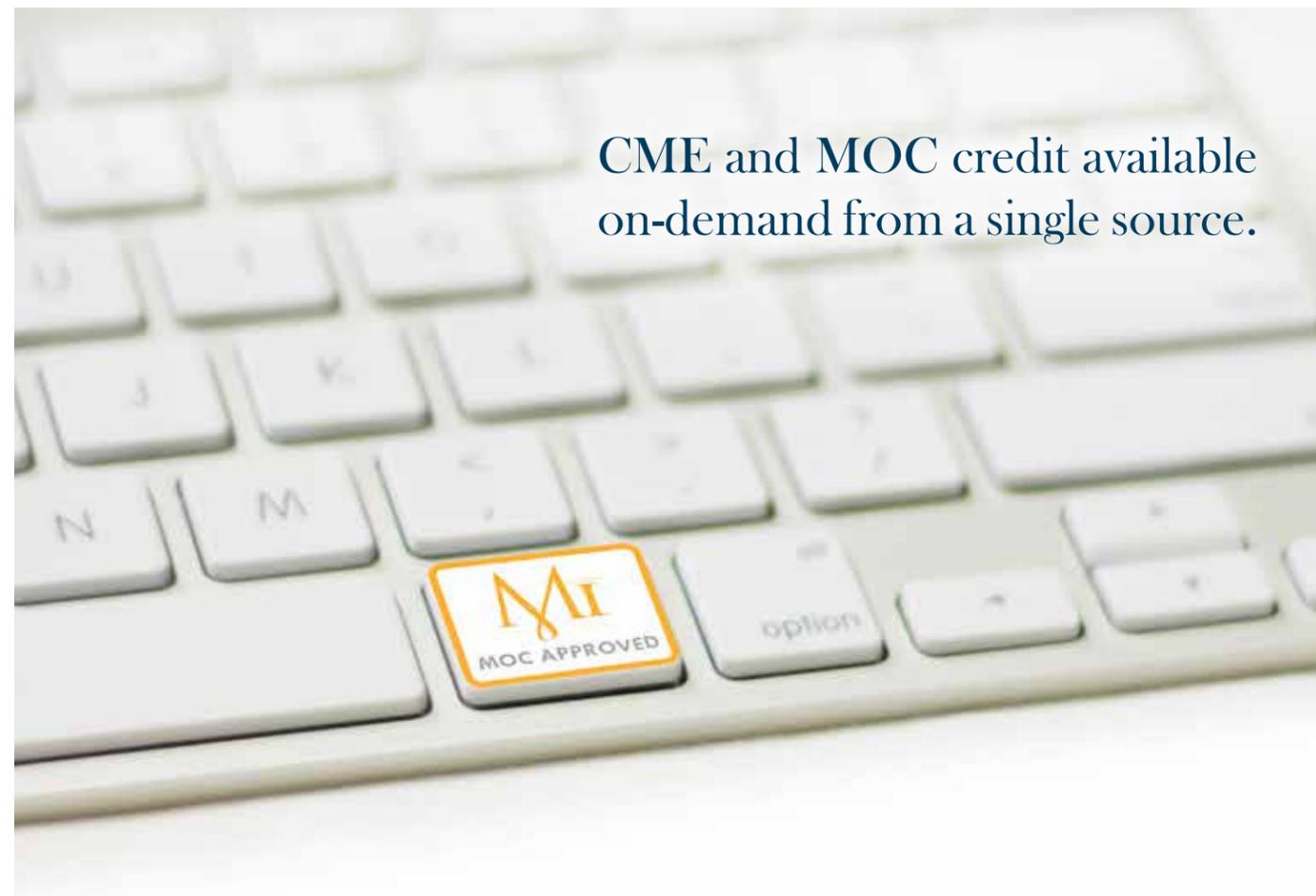
A They are definitely helpful, can be very expensive, do not effect dramatic weight loss, are most effective only with a diet and exercise program, and only work as long as one takes them. Helpful to start with, all the same.

Q And weight-loss surgery?

A proven to be beneficial for the morbidly obese (BMI>40) with serious health problems like diabetes, hypertension and high cholesterol which can be reversed by the weight-loss effected by the procedure. Gastric bypass is the most effective but also the most invasive procedure. The immediate weight-loss is often not sustained if the patient reverts to the former lifestyle. Surgery should be considered only after a serious trial of diet, exercise and lifestyle modifications for 6 to 12 months.

If all of this sounds oversimplified, that's because it is that simple for most of us! Walking the middle path, practicing moderation in all things, is the only way & the best way to keep body and mind in good health. Pathological & hereditary forms of obesity do exist, but these are not the cases that are tipping the national scale. It is all the rest of us, trapped in a 9-5 world in which we are struggling to balance work, family and faith.....

If all of this sounds oversimplified, **that's because it is that simple for most of us!** 



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PRACTICAL PEARLS FOR MANAGING THE OBESITY ISSUE

By: **Steve McMahan, MD**



I've probably **lost over a thousand pounds** in my lifetime, **only to gain it back**

Before I get started in this article, I need to disclose a few things about this topic of obesity. The first thing is that this issue is very personal to me. I have struggled personally (as most of you can SEE) over my lifetime to maintain a healthy weight. I've probably lost over a thousand pounds in my lifetime, only to gain it back. I calculated my BMI recently, and I'm at 33 (after being around 40 or more for many years). It's been a grind keeping it off, and patients have noticed my efforts through the years, offering a unique bond with a lot of them also struggling with obesity. Enough said.

Secondly, as I've done some research on this topic, I've been amazed at the vast amount of information available regarding obesity. It is mind boggling; just google obesity and start reading.

obesity facts

With that said, I want to share some facts regarding obesity, then share some practical advice in dealing with the obese, besides the typical "You need to lose some weight" we've all told patients at times.

- 1.** 35% of US adults are classified as obese (BMI>30) and our state falls in line with this figure (I thought we'd have a higher rate).
- 2.** Blacks have the highest rate of obesity (47.8%) followed by Hispanics (42.5%) in the US, and 17% of our children & adolescents are now classified as obese. Interestingly, obesity rates in children are worse in low income families.
- 3.** The following parishes in northeast Louisiana have obesity rates over 40%: Morehouse, Madison, Winn & Tensas.
- 4.** Fast food comprises 11% of today's typical American diet, and the average calorie intake increased by 300 kilocalories per day between 1985-2000 when the number of fast food restaurants grew by over 200%.
- 5.** The estimated annual cost of obesity in the US is over \$150 billion, with the average cost of care for the obese being \$1500 more per year than those with normal weights.



practical suggestions

So what do we make of this information & what do we tell our patients? I offer some practical suggestions that are grounded in the science, research & professional experience of obesity management.

- 1. Cut out fast food.** I have a saying I like to share with patients: If you have to roll down your window to eat it, it's probably not good for you! Fast food is bad for pretty much every nutritional marker measured (fats, carbs, nutrient content).
- 2. Cut out simple carbs & sweets,** instead eat more complex carbs like whole grains, fresh fruits & veggies.
- 3. Limit red meats & fatty foods** because of their higher fat contents. Grilled fish & chicken are a good alternative for our protein needs.
- 4. Exercise.** It doesn't really matter what type of exercise, as long as it involves aerobic activity that gets our heart rates up. The magic number in the latest research suggests 150 minutes per week is optimal.
- 5. Longevity should be the mindset.** I often tell patients, "It's a marathon, not a sprint" when trying to lose weight. There are usually no quick fixes or shortcuts, no matter if a patient chooses a medical program or surgery to treat their obesity. And remind them that reaching their weight goal isn't the finish line; they've just crossed the starting line in their race. To keep that weight off, they must maintain the healthy lifestyle changes that helped them lose the weight.
- 6.** Lastly, as a treating physician, make sure to avoid common medicines (antidepressants, hormones, etc.) that can cause unwanted weight gain in your patients. It's already tough enough to lose weight, so let's not add to the problem by what we prescribe to the obese people we treat.



My last comment for all of us is this-- **be an encourager to these patients.**

A lot of them are struggling emotionally as well as physically, and your genuine kindness can help foster a positive attitude in an otherwise discouraging situation.

OBESITY EPIDEMIC In Louisiana

By: **Walter Sartor, MD, FACS**

There are enough obese adults in Louisiana to fill the Superdome **16 TIMES**



Obesity has become a significant and worsening public health challenge in both economically developed and developing regions of the world, increasing at an alarming amount. In 2008, worldwide estimates demonstrated that 1.4 billion were overweight and of these, more than 200 million men and 300 million women were considered obese. This figure has doubled since the 1980's. It is currently estimated that a third of the world's population of 7.08 billion people are now overweight or obese. That totals up to 2.36 billion people. In the United States, the incidence of obesity is 35.7%.

Since obesity is associated with significantly reduced life expectancy, it has now become the leading cause of preventable death in the U.S., with an estimated cost per year that ranges from 147 billion to 210 billion dollars. Systemic diseases such as hypertension, high cholesterol, diabetes, sleep

apnea, degenerative arthritis, and even certain types of cancer are all obesity related. Metabolic disease, which occurs with a combination of diabetes, hypertension, and elevated cholesterol, is highly associated with obesity as well, and affects all organ systems.

Louisiana ranks fourth in the nation in obesity

According to stateofobesity.org Louisiana ranks fourth in the nation in obesity according to 2014 statistics. It is estimated that 34.9% of adults in the state are obese, an increase from 22.6% in 2000. In 1990, the prevalence of obesity in the state of Louisiana was 12.3%. To put this into

perspective, there are enough obese adults in Louisiana to fill the Superdome 16 times. This presents a significant challenge to the healthcare industry, and for physicians and practitioners across a wide range of specialties. In 2010, we ranked 12th in the nation for obesity related diabetes, and 4th for hypertension. As a state, we saw over 274,000 cases of heart disease, 877,000 cases of arthritis, and over 69,000 cases of obesity related cancer. We can only expect these life threatening diseases to dramatically increase over time with the near exponential increase in the incidence of obesity. The cost of this epidemic is staggering. Of the 4.5 million people in our state, the number of obese people is estimated at 1.5 million. The annual cost of obesity in Louisiana is \$2,906,143,070. Higher poverty rates, especially in Northeast Louisiana, along with poor diets and lower physical activity all play a role.

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Unfortunately, the worst foods are the cheapest and most accessible for those less fortunate with fresh produce and unprocessed foods being more expensive.

Louisiana's poverty rate was 18.3% in 2014, ranking 3rd in the nation in poverty. This correlates with obesity for several reasons. Unfortunately, the worst foods are the cheapest and most accessible for those less fortunate with fresh produce and unprocessed foods being more expensive. In the urban setting, the lack of safe places to exercise and play can be scarce, limiting the amount someone can exercise. Racial disparity plays a role, as well. African Americans

surgery in 2003, beginning with Laparoscopic Roux en Y Gastric Bypass. We gradually built a multidisciplinary program centered around the weight loss surgery patient, and in 2007 we established the Louisiana Center for Weight Loss Surgery, with dedicated personnel to cover nearly all aspects of care for the weight loss surgery patient. Thanks to a group effort on the part of P&S Hospital and St. Francis Medical Center, we received our designation

of both obesity and the procedures that treat it, better instrumentation, surgical technique and anesthesia management, both gastric bypass and sleeve gastrectomy carry no higher mortality than any other major general surgical procedure such as a colon resection or removal of a cancerous organ. The mortality risk following weight loss surgery in a bariatric center of excellence is .13%. In comparison, patients with obesity that are

Even to be able to fit in a seat on an airplane or in a theater or shop in a regular clothes shop and not the big and tall section is **LIFE CHANGING. We can see the excitement on the patients face as they tell us these stories.**

have a 41.9% incidence of obesity as compared to 30.4% for the Caucasian population, and are twice as likely to develop diabetes than whites.

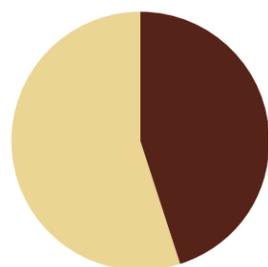
Weight loss surgery can help where diet and exercise have failed. Studies have shown that the average weight loss following sleeve gastrectomy or gastric bypass is 70% of excess weight. We have also seen an 85% resolution or improvement in diabetes, 71% in obstructive sleep apnea, as well as significant improvements in hypertension and hyperlipidemia. I started performing weight loss

of Bariatric Surgery Center of Excellence by the Surgical Review Corporation in 2010, based on our results, patient safety, and case volume, as well as our facilities. I started performing Laparoscopic Sleeve Gastrectomy in 2008, and to date we have over 1100 patients who have had weight loss surgery. Our experience mirrors that of the rest of the country with comparable results. Many feel that the surgery is risky or dangerous, however the risk of being 100 pounds overweight increases mortality by 12 fold. Due to a better understanding

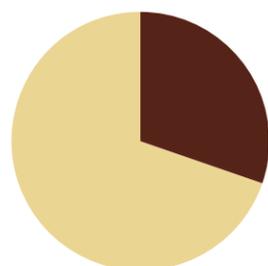
left untreated have a 50-100% risk of premature death mostly from diabetes, sleep apnea and cancer. The risk of a weight loss surgery patient having a serious complication requiring readmit or reoperation within 30 days of surgery is less than 1%.

K.R. has lost 136 pounds since undergoing sleeve gastrectomy in August 2014. She credits the surgery with "saving her life." "Five months after my gastric sleeve surgery, I was diagnosed with pseudotumor cerebri, which means I have too much cerebral spinal fluid

incidence of obesity

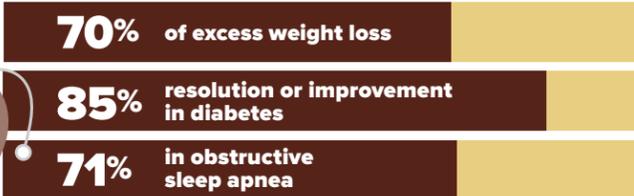


African American



Caucasian

following sleeve gastrectomy or gastric bypass



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around my brain; all of my symptoms mimic a tumor. Although there is no known cause, my neurology team said it is more common in obese people. They are confident that the more weight I lose, the better my diagnosis will be. I knew in that moment that I made the right decision to have the gastric sleeve surgery!” Her post-surgery life has changed dramatically. She no longer suffers from high blood pressure or polycystic ovary syndrome. She is a teacher, so her weight loss has transformed the way she interacts with her students.

In my 13 years of practice as a weight loss surgeon I have seen patients not only improve or resolve their medical problems, but also improve their quality of life. Not only do they no longer need diabetic or blood pressure medication, they are able to play with their children or grandchildren. Even to be able to fit in a seat on an airplane or in a theater or shop in a regular clothes shop and not the big and tall section is life changing. We can see the excitement on the patients face as they tell us these stories.

Even though Louisiana is one of the most obese states in the country, insurance coverage for obesity surgery is limited or not available for many, significantly limiting access to care, from both a surgical and nonsurgical standpoint. Even though studies show that weight loss surgery decreases or resolves many comorbid conditions and results in improved quality of life, some patients are left without treatment. Hopefully in the future, we can improve access to care in our state to make weight loss surgery and obesity management more accessible to our patients.

Dr. Walter Sartor is a board-certified general surgeon here in Monroe. He has over 19 years of experience in general surgery. In 2003, he began performing weight loss surgery and since that time has treated more than 1,100 bariatric patients. Most people think they need to be at least 100 pounds overweight. While being 100 pounds overweight does qualify one for the surgery, there are other health conditions that can qualify a patient for the procedure, such as diabetes, high blood pressure, or sleep apnea.

OMS MEETING WITH THE NEW SECRETARY OF DHH REBEKAH GEE, MD



On May 25, 2016 Representatives of the Ouachita Medical Society met with the new Secretary of the Department of Health and Hospitals to discuss the impending Medicaid expansion across the state.

UPCOMING EVENTS

LAMMICO - CME Lecture Series:

Changing Medical Practice: The Internet & Social Media

Wednesday, August 3, 2016 | 6:00-7:00 pm
St. Francis Conference Center (Main Auditorium)
Register: www.lammico.com/lectures

OMS General Meeting: “Meet and Greet” with the Senate Candidates

Thursday, September 8, 2016 | 6:30 pm
Bayou Desiard Country Club, Monroe

Beers with Peers

Flying Tiger Brewery, Monroe
October 13, 2016 | 6:00 pm

OMS Christmas Party

December 2016-TBA

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HISTORY OF THE OUACHITA PARISH MEDICAL SOCIETY

By: Robert Hendrick, MD and Sameer Wadhwa

In this issue we have an article on the history of the Ouachita Parish Medical Society. It is good to look back at times to learn about where we came from and how we got here.

In the late nineteenth century, communication transportation was not what it is today. Physicians were isolated and very busy with their practices. They needed a forum where they could share ideas and experiences treating patients. As time went by the societies also became advocates for changes that would improve medical care. They became leaders in public health issues and actually, in conjunction with the American Medical Association, were a driving force behind the creation of the Blue Cross systems in the 1940's to provide more opportunities for patients to obtain health insurance. In the past few decades, the societies evolved to additionally serve as physician advocates in the legislative process as the government has become more involved in the health care arena. They provide an avenue for physicians to speak as one voice for their patients and their practices benefits. Finally, the medical auxiliaries associated with the societies provided an opportunity for physician spouses to participate in activities that could improve their communities.

It wasn't until 1884 when Ouachita organized the first district medical society—the Fifth.

With the assistance of Dr. A.W. Jones, vice president of the State Society for the Fifth District organized Ouachita Parish Medical Society in 1894. Ouachita Medical Society continued to be active thereafter except for a short interval in the early twentieth century.

The society met monthly. The State Society affiliated with Ouachita in 1896. For a brief period from 1900–1903, Ouachita was inactive until it reorganized under the new constitution of the State Society and it became chartered on Nov. 24, 1903. In those days, dues were a whopping \$1.00 a year and the society met the second Friday of each month.

Interestingly enough, physicians from surrounding parishes were also active members in Ouachita. In 1915, Ouachita took the lead in organizing a district society with other parishes of the district.

The twenties were busy years for Ouachita Parish Medical Society. Several of its members made a special study of the intravenous administration of quinine in the treatment of certain types of malaria. As a result of their studies, quinine in ampoule form was put on the market by pharmaceutical companies.

During WWII, while most parish societies were inactive, Ouachita still held its meeting and tried to recruit physicians from those inactive districts to the meetings. This plan turned out to be a success because in 1955, eight parishes did not have medical societies and six unorganized parishes had physicians enrolled in OPMS from: Caldwell, Concordia, East Carroll, Madison, Richland, and Tensas. The meetings typically consisted of a scientific program with case presentations and speakers as well as a yearly banquet and an election for the new officers.

Like Medicine, the Ouachita Medical Society continues to evolve and advance. We have a strong history and an even brighter future. 



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Ouachita organized the first district medical society – The Fifth

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1955
eight parishes did not have medical societies and six unorganized parishes had physicians enrolled in OPMS

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THE BIG FAT LIE

It's **sugar** that makes you fat (and sick), **not fat**

By: Timothy J. Mickel, MD

And certainly, eating fat would make you fat
Professor Yudkin was unconvinced

John Yudkin was a professor of nutritional science at Queen Elizabeth College in London. The son of Jewish parents who fled Russia for England in 1905, he excelled at academics, eventually studying biochemistry and physiology at Cambridge before pursuing medicine. In 1953, he established a department of nutritional science, one of the first of its kind, at Queen Elizabeth and it rapidly became internationally renowned.

In the 1950's most researchers were gravitating toward the intuitive notion that since fat clogged arteries,

eating fat had to be bad for you. And certainly, eating fat would make you fat. Professor Yudkin was unconvinced. When he looked at data on heart disease, he found a direct correlation with sugar consumption, not fat intake and he conducted a series of laboratory experiments on animals and humans to support his observation. Dr. Yudkin felt that sugar, not only played a role in heart disease, but was the major cause of obesity. He wrote a popular diet book, *This Slimming Business*, in 1958, in which he argued that since starches and sugars added nothing to the diet except calories, they were the

obvious nutrients to remove in order to lose weight.

Yudkin was one of the first to note that humans had incorporated carbohydrates into their diet only about 10,000 years ago, having been primarily carnivorous for a couple million years before that. Moreover, he recognized, as had others before him, the particular evils of sugar, a pure carbohydrate devoid of any nutritional value. Compared to fat, protein and unrefined grains, sugar had been part of our diet for only the past three or four hundred years – a mere millisecond on the human timeline – and Professor Yudkin felt that “if only a small fraction of

what we know about the effects of sugar were to be revealed in relation to any other material used as a food additive, that material would promptly be banned.”

Unfortunately, before Yudkin could adequately sound the alarm on sugar, he collided head-on with Ancel Keys – a brilliant, outspoken, charismatic professor of biology and physiology at the University of Minnesota. By sheer force of personality Keys demonized saturated fat and cholesterol and convinced not only fellow scientists but also the public that diets low in animal fats and cholesterol were the key to cardiovascular and overall health. Keys not only called Yudkin's work “a mountain of nonsense”, he accused him of being a propagandist for the meat and dairy industry. Keys excoriated Yudkin – a gentleman and a scholar, who was mild-mannered and never responded in kind – whenever he published a paper or presented at a meeting. The British Sugar Bureau joined the attack, dismissing Yudkin's claims as “emotional assertions.” Keys was certain that eggs, red meat, cheese and cream were the enemy and he remained true to this idea through the years, even when the data began to prove him wrong.

Professor Yudkin eventually retired from his post at Queen Elizabeth College in 1971 to write *Pure, White and Deadly*, a summary of decades of

research on the physiologic evils of sugar. He paid a high price. Nutritionists and the food industry joined forces to ruin his reputation. The World Sugar Research Organization called his book “science fiction.” He and his theory were marginalized to the point that his career never recovered. Queen Elizabeth College took away his research lab and he died in 1995, a disappointed, largely forgotten man, his life's work discredited. Good luck trying to find a copy of his book.

Interestingly, in 1905, the year Dr. Yudkin was born, Secretary of War, William H. Taft, who tipped the scales at 305 lbs. began a low-calorie/low-fat diet not unlike a standard “heart healthy” weight loss diet that would be advocated by Keys and that would be prescribed today. He soon reported feeling “continuously hungry,” and at his inauguration three years later he weighed 354 lbs.

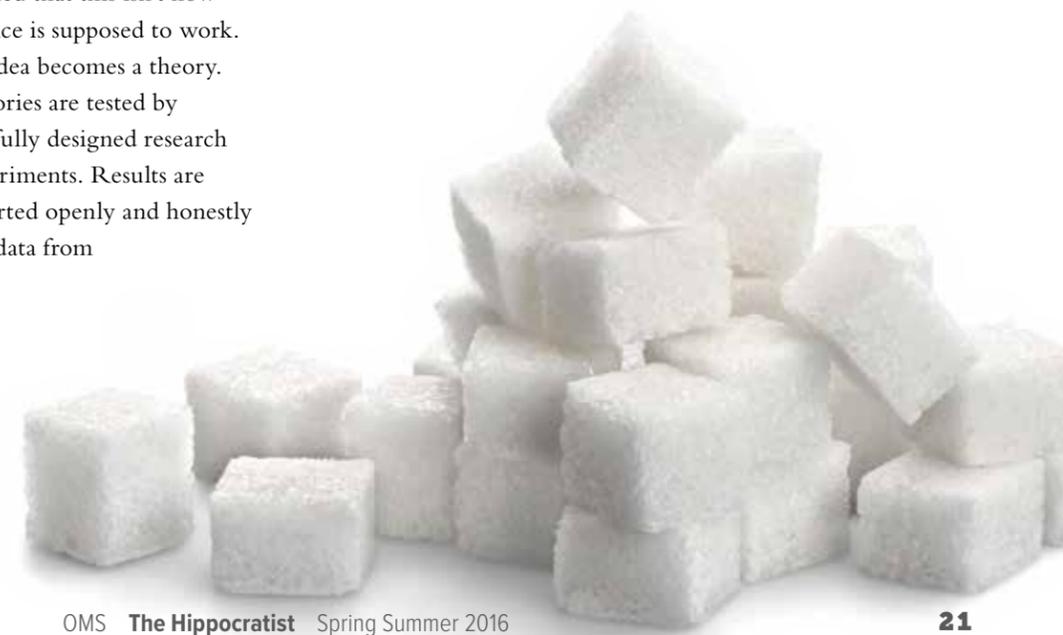
In medical school, we learned that this isn't how science is supposed to work. An idea becomes a theory. Theories are tested by carefully designed research experiments. Results are reported openly and honestly and data from

experiments on competing theories are compared. Papers are reviewed among professional peers at meetings and in journals where civil discussion fine-tunes the process, eventually revealing basic and essential truths that advance the field and ultimately better mankind.

Instead, the sugar vs. fat story is a fascinating account of how decades of bad science was used to support a flawed and simplistic theory – that fat makes you fat and clogs your arteries and that a low-fat, high carbohydrate diet is healthy. Anyone who dared to challenge the orthodoxy was ridiculed, ignored or simply dismissed as irrelevant and eccentric. Fortunately, the detrimental effects of sugar and refined carbohydrates are finally being acknowledged, but forty years of bad nutritional advice has led to an epidemic of heart disease, obesity and type II diabetes that threatens to implode our health care system.

“if only a small fraction of what we know about the effects of sugar were to be revealed in relation to any other material used as a food additive, **that material would promptly be banned.**”

- Professor Yudkin



Calorie counting assumes all calories whether from a donut, a tablespoon of lard or a filet mignon are handled the same way by our bodies. They are not.

THE PROBLEM

So what is so bad about sugar?

After all, a gram of sugar has four calories, and a gram of fat has nine. So if you limit your fat intake, you will inevitably consume fewer calories. Everyone knows that the only way to lose weight is to take in fewer calories than you burn off. So if you want to lose weight, exercise more and eat less. And since you're exercising more you need carbs for energy, so eat more carbohydrates than fat, but keep them relatively healthy: whole grain crackers and bread instead of their white counterparts, brown rice instead of white and a lot of fruits and vegetables. And since fat is more calorie dense, cut the fat – at least the saturated fat and cholesterol.

I have recited a version of the above paragraph to hundreds of patients over the past 25 years because they are too fat to be good candidates for body contouring surgery, and all it has done is make them hungry, tired, frustrated and mad at me. They may lose a little weight at first, but they inevitably gain it back, and then return to the office to plead their case for surgery. So why does this conventional dietary advice – eat less and exercise more – espoused by well-meaning, skinny doctors, parroted back by every dietician and considered gospel truth since the 1970's, inevitably fail in the long run?

First, calorie counting to lose weight never works. It sounds good, and maybe if we were bomb calorimeters on a lab countertop instead of complex organisms it would be a reasonable strategy. Calorie counting assumes all calories – whether from a donut, a tablespoon of lard or a filet mignon – are handled the same way by our bodies. They are not. It is not as simple as throwing logs on a fire. Calorie counting ignores the effects of insulin, the major stumbling block to weight loss.

As we all learned in our first year of medical school, when we eat a typical carbohydrate heavy meal, the rice, potatoes, corn, carrots, bread and fat-free salad dressing gets broken down to glucose molecules that spike blood sugar and stimulate the pancreas to come to the rescue by squirting out a bolus of insulin. Insulin sweeps glucose into cells throughout the body to be used as energy and to replenish backup fuel supplies. Muscle cells replete their glycogen and liver cells will store some glucose as glycogen and convert some to fat. Fat cells, under the influence of insulin, will convert the excess sugar to triglycerides and store it as fat – on your belly, hips, buttocks or wherever you deposit fat.

Insulin also up-regulates lipoprotein lipase (LPL), an enzyme that sticks out from the surface of various cells, snags triglycerides from the bloodstream, breaks them

down into their component fatty acids, then transports them into cells. LPL on the surface of a muscle cell directs triglycerides into the muscle to be used as fuel. If it's on a fat cell, it packs in fat for storage. Conversely, insulin down-regulates the enzyme hormone-sensitive lipase (HSL), which works inside the fat cell to break triglycerides down into fatty acids so they can be liberated back into the circulation and used for fuel. Just a little bit of insulin shuts down HSL, holding fat hostage in our fat cells where we can't burn it.

So eating carbohydrates, especially refined carbohydrates, spikes blood sugar, which raises insulin levels, which increases fat storage and makes it difficult if not impossible for us to mobilize and burn fat for fuel. Instead we burn sugar, and as blood glucose decreases we get irritable, lack energy and get hungry for more carbs. It's a vicious cycle that makes us fat and ultimately, not very healthy.

Second, calorie counting is doomed to fail because basic homeostasis will prevent us from existing in negative caloric balance for too long without righting the balance sheet by eating ravenously or by reducing total energy expenditure to compensate – especially if we have conditioned our systems to burn sugar. Consider, for example, that there are 3500 calories in a pound of fat and

that strenuous exercise (like jogging or riding a bike) burns about 700 calories an hour. So you would have to bike like you were in the Tour de France for five hours to lose a pound of fat.

Let's make it a little more realistic. Say you usually consumed a reasonable 2800 calories a day and by compulsive calorie counting you cut back to 2200 calories a day. Assume you are a 70kg man and your BMR is 1500 cal/day. This leaves you with 700 extra calories. If you buy into the concept that the only way to lose weight is to burn more calories than you take in, you would have to strenuously exercise for two hours a day, without consuming any additional calories, to lose a pound of fat every five days ($700 - 1400 = -700\text{cal/day} \times 5 \text{ days} = -3500 \text{ cal deficit}$).

It is a well-known fact that if you exercise like an Olympian for two hours, you will be starving when you get finished. Eat a Cliff Bar and knock back a PowerAde and you just negated one of your hours. Reward yourself with some ice cream, a six pack of beer or a couple of donuts over the weekend and you negated a couple of days. If you are thirty pounds overweight you would have to exercise hard for two hours a day, five days a week for thirty weeks, and never reward yourself with any treats or alcohol, to reach your goal weight. Even if you are a self-flagellator who likes to suffer, you will end up hungry, exhausted, miserable and frustrated, and after a few weeks you will give up. Homeostasis demands that input and output balance out. Eventually, you will either eat back those lost calories or exercise less so you don't burn as many. Calorie counting never works. The concept of losing weight long term by burning more calories than you eat is a myth.

The problem isn't calories; it's insulin. Carbohydrates increase insulin. Protein has minimal effect on insulin

secretion; fat intake has none. A calorie is not a calorie, is not a calorie. The only way to lose weight for good is to drastically cut carbs to decrease insulin.

This was a difficult paradigm shift for me, because I was one who would swear I lost my excess weight by taking up regular exercise. But like everyone else who takes up running or swimming or biking several times a week to slim down, I made significant changes in what I ate and drank. After all, who starts an aggressive workout regimen to shape up, without cutting down (or cutting out) cookies, cake, candy, sugary sodas and beer – and even trying to eat more green, leafy stuff and less starch? Carb restriction is the real reason exercise works, not semi-starvation. Physicist Gary Taubes succinctly summarizes this in his book *Why We Get Fat*:



When calorie restricted diets fail, as they typically do (and the same can be said of exercise programs), the reason is that they restrict something other than the foods that make us fat. They restrict fat and protein, which have no long-term effect on insulin and fat deposition but are required for energy and for the rebuilding of cells and tissues... Any weight that might be lost can be maintained only as long as the dieter can withstand the semi-starvation, and even then the fat cells will be working to recoup the fat they're losing, just as the muscle cells are trying to obtain protein to rebuild and maintain their function, and the total amount of energy the dieter expends will be reduced to compensate... Weight loss regimens succeed when they get rid of the fattening carbohydrates in the diet; they fail when they don't. What the regimen must do, in essence, is reregulate fat tissue so that it releases the calories it has accumulated to excess. Any changes the dieter makes that don't work toward that goal (reducing the fat and protein consumed in particular) will starve the body in other ways (of energy, and of protein needed to rebuild muscle), and the resultant hunger will lead to failure.



The idea that carbohydrates make us fat and lead to a host of chronic problems isn't new information. It was certainly well known in 1992 when the U.S. Department of Agriculture published its famous Food Guide Pyramid and gave credence to another myth: that fat makes us fat and carbohydrates are healthy.

THE UPSIDE DOWN FOOD PYRAMID

How did we become a nation of overweight carboholics in the first place? And how did the government get the food pyramid so upside down?

...not only that there is no correlation between saturated fat intake and heart disease, but that there is a positive correlation between sugar consumption and heart disease

To understand these two related questions, we have to appreciate that the prevailing mood among researchers in the 50's and 60's was that saturated fat and cholesterol were bad for your heart and therefore evil, and that diets that were low in fat and replaced fat calories with heart-friendly carbohydrates were good. Never mind that decades of population research would fail to support this diet-heart hypothesis; the resulting vilification of fat lead to carb-heavy dietary recommendations that created an epidemic of obesity and related problems that haunt us to this day. So to understand the sugar-obesity connection, we have to start with heart disease.

Most of the blame for this rests on Ancel Keys, the forceful and charismatic biochemist and physiologist from the University of Minnesota who ruined the career of John Yudkin. Keys had become famous in the 1940s for developing "K-Rations" for the military (the "K" was for Keys). He was a friend of Paul Dudley White, a cardiologist who was one of the original six

founders of the American Heart Association and personal cardiologist to president Eisenhower. Dr. White authored a classic 1931 textbook on heart disease, helped set up the National Heart Institute as part of the NIH in 1938, and was a renowned Harvard professor. In September 1955, when Ike suffered a heart attack after playing golf in Denver, White was flown out to manage his care.

Keys was convinced that cholesterol and saturated fats were public enemy number one and undoubtedly influenced his friend Dr. White, who put Eisenhower on a strict diet containing little fat and less cholesterol. His meals were cooked in either soybean oil or the newly invented substitute for butter and lard, "polyunsaturated margarine." Ike ate oatmeal and skimmed milk or Melba toast and fruit for breakfast, ate very little red meat and gave up butter, lard, cream, eggs, cheese and eventually margarine – replacing them with corn oil – to control his weight and lower his cholesterol. The president weighed 172 and his cholesterol was 165mg/dl at the time of his first heart attack. In spite of following a bland, low-fat diet his weight slowly increased and his cholesterol had risen to over 250, fourteen years and six MI's later when he died of a heart attack in 1969.

While Ike was cutting most

of the cholesterol and saturated fat from his diet and losing the battle with cholesterol, Keys was busy promoting his "diet-heart theory" which touted a low-fat, low-cholesterol diet as a means to prevent heart disease. Time magazine featured him on the cover in January 1961, calling him "Mr. Cholesterol", quoting his advice to cut dietary fat from its then current average of 40 percent of total calories to a measly 15 percent, and saturated fat from 17 percent down to 4 percent. Said Keys, "people should know the facts, then, if they want to eat themselves to death, let them." The media, the American Heart Association and mainstream medicine jumped on the low-fat bandwagon, despite the lack of scientific evidence to support it – at least, not good evidence.

Keys was one of the lead investigators of a large epidemiological study of the relationship between diet and heart disease in five European countries, Japan and the United States. This "Seven Countries Study" initially suggested that there was indeed a higher incidence of heart disease in populations with a high intake of saturated fat. Keys considered this proof that his diet-heart theory was correct and soon most nutritional researchers were firmly onboard with the concept of low-fat diets as "heart healthy."

Over the past ten years, scrutiny of the Seven

Countries Study has revealed serious methodological flaws and poor overall design. The results are inconclusive at best and mostly suggest not only that there is no correlation between saturated fat intake and heart disease, but that there is a positive correlation between *sugar* consumption and heart disease. But back then, the die was cast.

The *New York Times* quoted

prompted Mayer to make the mass murder accusation. On January 27, 1977, the government joined the low-fat movement when Senator George McGovern announced the publication of *Dietary Goals for the United States*. This was the first time any government institution had told Americans they could improve their health by eating less fat. This document,

height of fashion", crowed nutrition journalist Jane Brody, "it can help you lose weight." Even the American Heart Association followed suit, publishing a pamphlet in 1995 suggesting you could eat almost anything as long as it was low in fat: "To control the amount of saturated fatty acids and dietary cholesterol you eat, choose snacks from other food groups such as

with the bassackwards Food Guide Pyramid that most nutritionists and dieticians still consider the Holy Grail?

The Food Guide Pyramid (fig. 1) puts fats and oils at the top, to be "used sparingly." Dairy products should be limited to 2 – 3 servings per day, as should meat, fish, eggs and nuts because of their high saturated fat content. You are allowed a

fats and oils
used sparingly

dairy, meat, fish, eggs & nuts
2 – 3 servings per day

fruits and vegetables
a lot of carb-heavy fruits and vegetables

grains, breads, cereals and pasta
unlimited

fig. 1



Harvard nutritionist Jean Mayer, a Keys disciple, as claiming that to prescribe carbohydrate restricted diets to the public was "the equivalent of mass murder." He claimed that because these diets restrict carbohydrates, they compensate by allowing more fat; and it's the high fat nature of the diets, the *Times* explained, that

the product of McGovern's Select Senate Committee on Nutrition and Human needs, became gospel and would serve to return starches and grains to their rightful place in the American diet.

By the 1980's, health and nutrition columnists for the *Times* were advocating starches and bread as diet food! "Not only is eating pasta at the

...low-fat cookies, low-fat crackers ...unsalted pretzels, hard candy, gum drops, sugar, syrup, honey, jam, jelly and marmalade (as spreads)." Given the broad academic, political and popular support for the idea that fat is evil and carbs are good for you, is it any wonder that in 1992, the U.S. Department of Agriculture came up

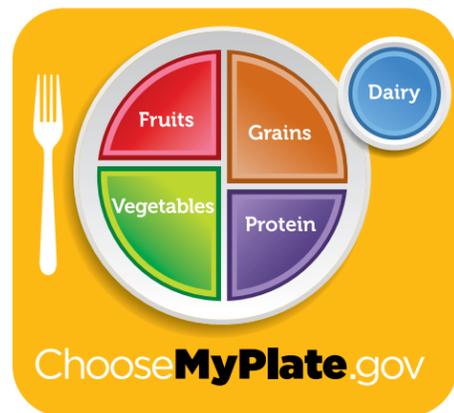
lot of carb-heavy fruits and vegetables and an almost unlimited amount of heart-healthy, fat-free, carbohydrate dense grains, breads, cereals and pasta. With all this high-powered consensus, certainly one would think that incorporating the *Dietary Goals* and the *Food Pyramid* (low-fat, high carb diet) into our collective eating habits would

“food is a political issue,

and politicians hoping for a long career in politics aren't going to endorse an agenda that makes it hard to sell wheat, corn or potatoes.”

- Grant Petersen

fig. 2



make us a slimmer, fitter, healthier nation. Think again.

According to the CDC, in the 1960s, only about 13% of the adult population was considered obese (BMI >30). Today the prevalence is 36% – nearly triple. Since 1980, the prevalence of obesity in children aged 6 –11 years has tripled as well, from 6.5% to 19.6%. Obesity contributes to somewhere between 100,000 and 400,000 deaths in the U.S. per year and costs society an estimated \$117 billion in direct costs for preventive programs, diagnostic and treatment expenses, etc; and indirect costs from time off work, loss of future earnings from premature death, unemployment, etc. This is higher than the health care costs associated with smoking and accounts for almost 10% of health care expenditures in the U.S. That's just the tip of the iceberg.

A direct off shoot of the obesity epidemic is the explosion in type II diabetes. When I was in medical school in the late 70's and early 80's this was still called adult onset diabetes. But according to the American Diabetes Association, almost 30% of diabetics under age 20 are type 2 diabetics. If there was ever an indictment of sugary breakfast cereal, juice

drinks, chips, french fries and other fast food, this is it.

Metabolic syndrome is another direct result of the sugar and carb fueled obesity epidemic. We have created scores of fat-around-the-middle, insulin resistant, glucose intolerant prediabetics with high blood pressure, high triglyceride levels, low HDL, high LDL (the small, dense kind that sticks to vessel walls) who are manufacturing advanced glycation end products (AGEs) that wreck havoc throughout the body. We have only just begun to appreciate the potential implications of AGEs and metabolic syndrome for heart disease, stroke and a host of other conditions including Alzheimer's and cancer.

To be fair, in 2011 the USDA replaced the food pyramid with MyPlate (fig 2) which is still carb-heavy, has only a relatively small portion of meat and makes no mention of fat – the only thing on the plate that doesn't jack up your insulin. We had it wrong before, and we still have it wrong. But then, the USDA is a government organization subject to political influence, and as Grant Petersen said in *Eat Bacon, Don't Jog*, “food is a political issue, and politicians hoping for a long career in politics aren't going to endorse an agenda that makes it hard to sell wheat, corn or potatoes.” If you could ask the late George McGovern, he would agree.

THE SOLUTION

So what should our diet look like?

One strategy is the idea that we should eat what we evolved to eat. This is nothing new. It has been around for over a century, and is the basis for the “Paleo Diet” made popular by thousands of twenty and thirty something muscle heads at fitness facilities around the country. The concept is that the longer a particular type of food has been part of the human diet, the better adapted we will be to that food and the more beneficial and less harmful it will be. As Gary Taubes says in *Why We Get Fat*, “our genes were effectively shaped by the two and a half million years during which our ancestors lived as hunters and gatherers prior to the introduction of agriculture twelve thousand years ago ... [this period] constitutes more than 99.5 percent of human history – more than a hundred thousand generations of humanity living as hunter-gatherers, compared with the six hundred succeeding generations of farmers or the ten generations that have lived in the industrial age.” Considering this timeline, it is not a stretch to assume that the last 0.5% of the history of our species – the agricultural period – has had only a minor effect on our genetic makeup.

The challenge is to figure out what we ate during the two and a half million years before that – the Paleolithic

era – since we don't have any surviving cave men to interview. The best we can do is look at anthropological data on hunter-gather populations that survived deep enough into the twentieth century to have their diets assessed. Taubes' book reviews an analysis of 229 such hunter-gatherer populations. Of their many conclusions, four are relevant to the fat vs. carbohydrate issue.

First, not a single one of these populations was exclusively vegetarian. When averaged together, they consumed about two-thirds of their calories from animal foods and one-third from plants. Many got as high as 85% of their calories from meat or fish. Second, their diets were high to very high in fat – 28 to 58 percent of their calories, some even higher. They preferred the fattest parts of the animal (organs, tongue, bone marrow), and would eat essentially *all of the fat* on the animal. Third, their diets were low in carbohydrates, at least by western standards, averaging 22 to 40 percent. And these weren't sugary, floury foods and starches, they were low glycemic index items like roots, tubers, seeds, nuts, bulbs, random plant parts and the occasional seasonal fruit. Not only did they eat relatively few carbs, but the carbs they did eat were bound up tightly with indigestible fiber making them difficult and slow to digest. These carbohydrates would be very

slow to raise blood sugar and therefore elicit a very slow and measured insulin response.

In contrast, the recommended diet according to the Food Pyramid or MyPlate is at least 50% carbohydrates, most of which are easily digestible starches and grains such as corn, potatoes, rice, wheat and beans. Most of these foods have been available in their modern, hybrid, super carb-laden form for only the past 50 to 75 years. Refined flour and sugar date back only to the 1800s when we ate less than a fifth of the sugar we eat today and high fructose corn syrup didn't exist. Even fruit is dramatically different today than it was for our Paleolithic ancestors, and for that matter for humans in the 17th and 18th centuries. Back then it was a rare seasonal treat; you couldn't get watermelons in November or nectarines from Argentina in January. Moreover, the fruit we eat today is bred to be juicier and sweeter than wild fruit – and with a much higher fructose content. So it has only been for the last one thousandth of one percent of our two and a half million years on the planet that we have been exposed to an excessive



dietary load of refined carbohydrates that spike blood sugar and demand an extreme insulin response from the pancreas.

The point of this evolutionary argument is that more than 60 percent of the calories in the typical American diet – dairy products, cereal grains, beverages, vegetable oils and dressings, sugar, candy and hybrid fruit – would have contributed none of the calories in the diet of our prehistoric ancestors. Taube concludes, “If we believe that our genetic makeup has a say in what constitutes a healthy diet, then the likely reason that easily digestible starches, refined carbohydrates and sugars are fattening is that we didn't evolve to eat them and certainly not in the quantities in which we eat them today.” It is no wonder that obesity,

“our genes were effectively shaped by the two and a half million years

during which our ancestors lived as hunters and gatherers...

- Gary Taubes

metabolic syndrome and diabetes are the scourge of modern society.

It is enlightening to look at what happens to these isolated primitive populations when they transition from their traditional diets to our modern western diet. The Pima Indians of Arizona are a tragic example. In 1846, U.S. Army battalion surgeon John Griffin described the Pima as “sprightly” and in “fine health.” But by the mid-1890’s, Anglo-American and Mexican settlers had hunted their game almost to extinction and upstream settlements had diverted most of the Gila River so they could no longer depend on it for fishing and irrigation. They relied on government rations of flour, sugar, coffee and occasional canned goods for sustenance. By the 1950’s, in addition to large quantities of refined flour, sugar and sweetened canned fruits, trading posts began to carry soda pop, candy, potato chips and cakes. According to a University of Arizona anthropologist working with the Bureau of Indian affairs, 50% of Pima children were considered obese, and in 1973, an NIH epidemiologist testifying before McGovern’s Senate Select Committee on Nutrition stated that half of all Pima adults were diabetic. That’s right – half.

A similar fate befell other Native American tribes of the Great Plains as well as the Inuit, the Masai and the Australian Aborigines. The addition of sugar, white flour, white rice and other Western staples led to obesity, diabetes, heart disease, dental caries and periodontal disease. Again, the problem is a high carbohydrate diet, which spikes blood sugar, raises insulin levels and results in a host of chronic health issues.

CONCLUSION

In the epilogue of his book, *Good Calories, Bad Calories*, Gary Taube summarizes the primary problems resulting from a sugar-laden, high carbohydrate diet.



By stimulating insulin secretion, carbohydrates make us fat and ultimately cause obesity. The fewer carbohydrates we consume, the leaner we will be.



Insulin is the primary regulator of fat storage. When insulin levels are elevated – either chronically or after a meal – we accumulate fat in our fat tissue. When insulin levels fall, we release fat from our fat tissue and use it for fuel (ketones and glycerol)



By driving fat accumulation, carbohydrates also increase hunger and decrease the amount of energy we expend in metabolism and physical activity.

Try as I might, I can’t find anything that suggests a long-term health benefit from a low-fat, high carb diet. And since fat makes food taste good and feel satisfying, who wants to suffer through the culinary hell of bland, low-fat meals? Over the years, multiple studies – Seven Countries, Multiple Risk Factor Intervention Trial (MRFIT), Women’s Health Initiative, even Framingham – to name just a few, have shown that a low-fat, carb-rich diet doesn’t prevent anything except your ability to squeeze into the same size pants year after year.

Dietary fat, whether saturated or not, is not a cause of obesity, heart disease or any other disease of civilization. But blindly following a high fat diet isn’t the answer either because it’s not total fat but

the type of fat that matters. We all know that hydrogenated (trans) fat is bad, but saturated fat isn’t – though some are not as good as others. The omega-6 to omega-3 ratio is key (20:1 or lower). Don’t take my word for it, be good doctors and read more about it. (See reference list)

Finally, consider all the obese patients we see in our practices and have seen over the years. If we are honest with ourselves, we have to admit that we subconsciously see them as lazy and glutinous, and that’s why they are fat. We probably tell them to eat less – particularly to decrease their fat intake – eat more fruits and vegetables, substitute whole grain products for white flour products and exercise more so they can burn off more calories than they take in.

We do this with the best of intentions, because we believe the conventional wisdom that fat makes you fat and carbs are healthy. But now we know this is just a big fat lie. We know that carbs spike blood sugar that drives up insulin that deposits fat and traps it in the fat cells, that counting calories to lose weight is futile, that you can’t exercise yourself thin without being miserable, and that people are fat, not because they are sedentary and overeat, but because they really do have an imbalance in the insulin mediated regulation of adipose tissue and fat metabolism so that fat synthesis and storage exceeds fat mobilization and oxidation, and the reason for this is sugar.

For this undercurrent of misdirected blame, we owe them an apology.

REFERENCES

Petersen, Grant. *Eat Bacon, Don’t Jog*. New York: Workman Publishing, 2014.

Read this one first. Witty, concise, basic intro to ketogenic concepts. If you are a layperson, this may be all you need, but doctors will want more science to justify the claims.

Taubes, Gary. *Good Calories, Bad Calories*. New York: Alfred A. Knopf, 2007.

Comprehensive, intelligent and interesting guide to the association of carbohydrates, sugar and insulin to a host of health problems. Taubes isn’t a rocket scientist, but he’s almost one. He’s a physicist.

Taubes, Gary. *Why We Get Fat*. New York: Anchor Books, 2012.

After *Eat Bacon*, read this one. Shorter and less weighty than his other book.

Teicholz, Nina. *The Big Fat Surprise*. New York: Simon and Schuster, 2014.

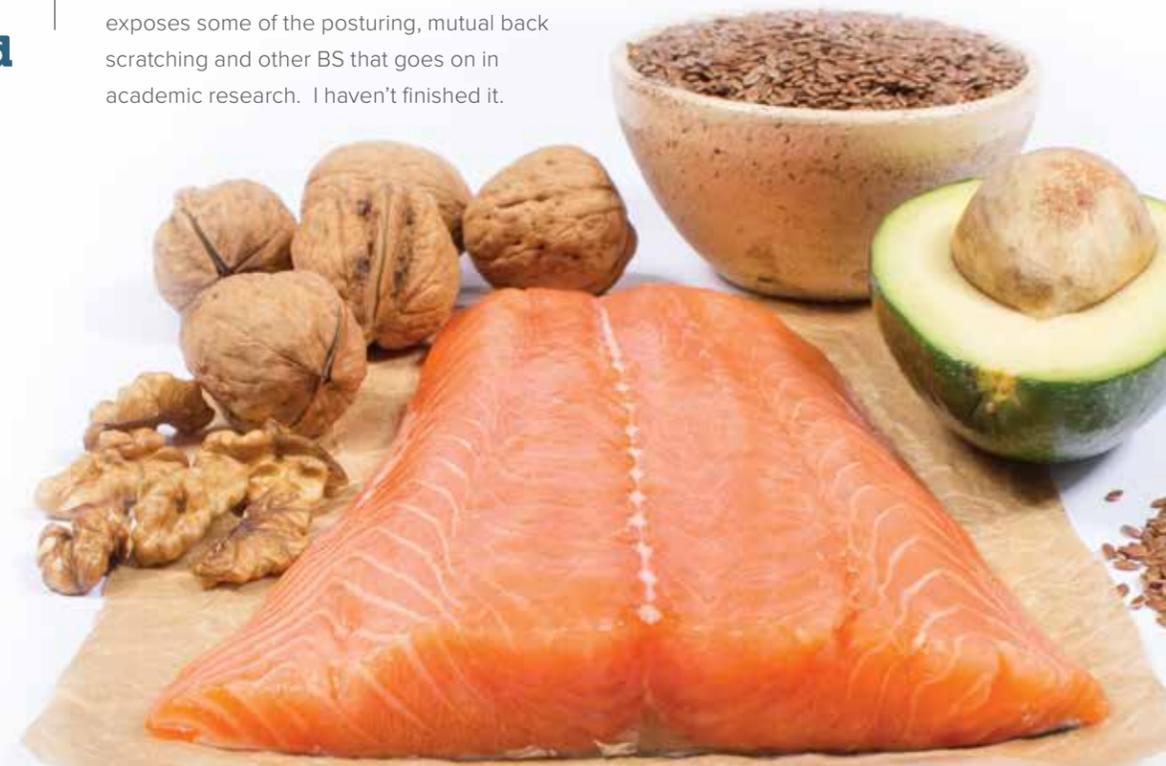
Long, dense, extensively researched book that will challenge everything you thought you knew about food and nutrition. It also exposes some of the posturing, mutual back scratching and other BS that goes on in academic research. I haven’t finished it.

Ludwig, David S., MD, PhD. *Always Hungry?* New York: Grand Central Publishing, 2016.

Dr. Ludwig is an endocrinologist and professor of pediatrics at Harvard Medical School and a professor of nutrition at Harvard School of Public Health. He lends some scientific credibility to the low carb, ketogenic diet concepts. Everything good is in the first 100 pages.

Steward, Leighton H., Morrison G. Bethea, MD, Samuel S. Andrews, MD, Luis A. Balart, MD. *Sugar Busters!* New York: Ballantine Books, 1995.

Written by three doctors from New Orleans, it is twenty years old but still a good primer on the physiology of cutting out sugar to lose fat. All the meat is in the first half of the book.



National

Research by: Sameer Wadhwa

Local



Percent Of Obesity

MORE THAN
35% U.S. ADULTS
ARE OBESE



\$147 BILLION²
Estimated annual cost
of health services



No state in the U.S. had
a prevalence of obesity
less than **20%**



From
AGES 2-19
prevalence of obesity
is about **17%**

2 in 3 adults are overweight
or **OBESE**

34%
LOUISIANA'S
PREVALENCE OF
OBESE



OBESE ADULTS
34.9%

OVERWEIGHT ADULTS
34.1%



OBESE ADOLESCENTS
13.5%

OVERWEIGHT ADOLESCENTS
16.4%

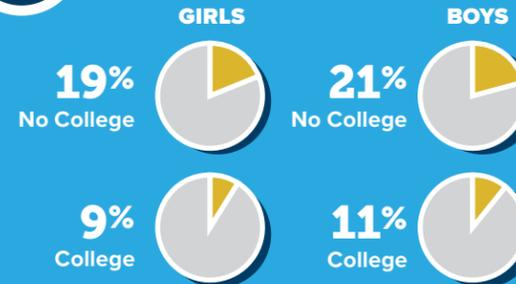


2-4 YRS. OLD OBESE
13.8%

2-4 YRS. OLD OVERWEIGHT
15.2%



Status



Obesity prevalence among children whose head of household completed college versus who did not complete college was half from 1999-2010 (9% vs. 19% among girls, 11% vs 21% among boys)



HIGHER INCOME



PRIVATE HEALTH INSURANCE



Louisiana has the highest overweight/obese prevalence in the country for children in higher-income families (36.6%) and children with private health insurance (33.9%)³



Diet

Adults who consume less than 1 fruit daily



Adults who consume less than 1 vegetable daily



Activity

Adults who engage in no leisure time physical activity



Obesity Facts

As a person's BMI increases, so do the number of sick days, medical claims, and healthcare costs associated with that person.⁴
Obesity can lead to high cholesterol, diabetes, high blood pressure, different types of cancer, heart disease, and stroke.

¹ most data from - <http://www.cdc.gov/obesity/data/>
² <http://stateofobesity.org/healthcare-costs-obesity/>
³ https://www.childhealthdata.org/docs/nsch-docs/louisiana04_23_508.pdf?sfvrsn=2
⁴ <http://stateofobesity.org/healthcare-costs-obesity/>

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MICROAGGRESSION

By: Timothy Mickel, MD

An attractive forty five year old woman sat across from me in the exam room. She was about 5'2" and tipped the scales at 185 lbs.

"I was a cheerleader in high school and weighed about 105 lbs," she said. "I looked really good until about a year ago."

"What happened," I said, trying hard to hide my disbelief.

"I don't know," she replied. "All of the sudden I started getting fat. It happened almost overnight."

"HmMMM."

"I mean; I hardly eat anything. Cereal, juice and a banana for breakfast; a bagel with cream cheese for a snack, a sandwich with skim milk for lunch, or maybe a baked potato with low-fat margarine and some non-fat sour cream, and salad with some crackers for supper – hardly any fat."

"Well, you've had two kids. I think you look really good for your age..."

"...And I'm starving all the time," she interrupted. "My dietician put me on this bland, low-fat, low calorie diet and all it's done is make me fatter."

"I think you're being too hard on yourself. You have a really pretty face."

"You're sweet. But can't you just suck some of this fat off so I can get a jumpstart on losing weight?" she asked, grabbing up the roll of skin and fat on her lower abdomen.

"Well, that's a lot of fat," I said. "And if we suck out the fat you're going to have a flap of skin left behind that will need to be cut

off. You're going to have a long scar across your lower abdomen."

"I don't care about scars."

"Yeah. I guess it will be hidden. Do you wear a one-piece or a tankini?"

"Neither one," she said.

"I bet you have some really cute cover-ups," I said.

She looked away. "So you'll operate on me?"

"The problem you have is not just the fat on the outside of your abdomen, but also the fat on the inside. We can't suck that out."

"So how do I get rid of the inside fat?"

"Well, you'll have to keep dieting and start exercising. If you can get closer to your ideal weight – which is probably around 120 lbs – you will get a much better result from surgery."

"I exercise all the time," she said, her eyes getting a little watery. "So you won't help me."

"I'm not saying that at all. It's just that liposuction is not a weight-loss procedure, and you will be much better off in the long run if you follow a reasonable program of exercise and dietary restraint, so you not only get a better surgical result but you can maintain..."

She interrupted again, "I've tried every diet, and I exercise." She reached for a Kleenex to wipe her eyes.

"I know," I said, as I patted the top of her knee. "Tell you what. I'm going to give you this great book on the low-carb lifestyle and another book that has 100 simple ketogenic recipes that will make it easy for you to eat all you want and still lose weight. Then let's see you back in three months to assess your progress."



THE OUACHITA MEDICAL SOCIETY UNIVERSITY HEALTH-CONWAY SCHOLARSHIP

The Ouachita Medical Society will be awarding two PGY2 University Health-Conway Residents with monetary scholarships. The monetary prizes may be used completely at the discretion of the winners. The winners will be announced and awarded at the September OMS General Meeting.

In order to qualify, residents must:

- be entering the PGY 2 phase of their residency at University Health-Conway (Monroe, LA)
- submit in-service exam scores
- complete the scholarship application
- complete the essay questionnaire
- submit a staff recommendation letter
- appear for a final interview before the OMS Executive Committee



1st Prize
\$1000



2nd Prize
\$500

SO YOU'RE SAYING I'M IN "THE GROUP"
UM... IS THAT WHAT I SAID?



But we should at least be given the benefit of the doubt **that our well-intended advice was borne of a spirit of compassion and goodwill**

On the way out of the office she said to my office manger, "I can't believe this cost me money!"

"Why is that?"

"Because all he did was tell me he wouldn't operate on me because I'm fat and lazy."

I was baffled that my honest, ethical and well-meaning advice to this overweight patient was totally misunderstood. But at the time, I didn't understand the concept of "microaggression".

Microaggression is a term coined by psychiatrist and Harvard professor Chester M. Pierce in 1970 and further developed by Columbia University Psychologist Derald Sue. These hypersensitive Ivy Leaguers define microaggressions as "brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership." The perpetrators are generally well-intentioned members of the dominant, majority group and are unaware they are causing irreparable psychological harm. Obviously, I had made her a member of the fat group.

Apparently, I was guilty of five or six examples of subtle "fat shaming", and in spite of the fact that I had the patient's best interest at heart, I was somehow affirming a negative stereotype of "people of size." I didn't mean to express disapproval of her lack of discipline or subtly demean her lame excuse making; I just wanted her

to be happy. I sincerely wanted her to have a better long-term result; I certainly wasn't trying to put myself in a dominant position or exert "slim privilege", but frankly, she let go of the rope at age forty and the tide was sweeping her out. Am I being insensitive, or was she just being too thin skinned? Oops, is that a microaggression against sensitive people?

Is it just me, or have we taken this PC stuff too far? If I say to someone with an accent, "where are you from?" is that microaggression against foreigners? When a waiter says, "you guys don't look like you need dessert" is that another example of subtle fat shaming? Liposuction by its very nature is inherently microaggressive. After all, you have to have excess fat to even be a candidate. Should we just abandon it and embrace the beauty of the "riding britches" deformity? How about when you try to get amorous with your wife and she rolls away; is that testosterone shaming or feminine privilege? And where do you cross the line between micro and macro? If my dog marks on my couch but doesn't entirely empty his bladder, is that micro or macroaggression?

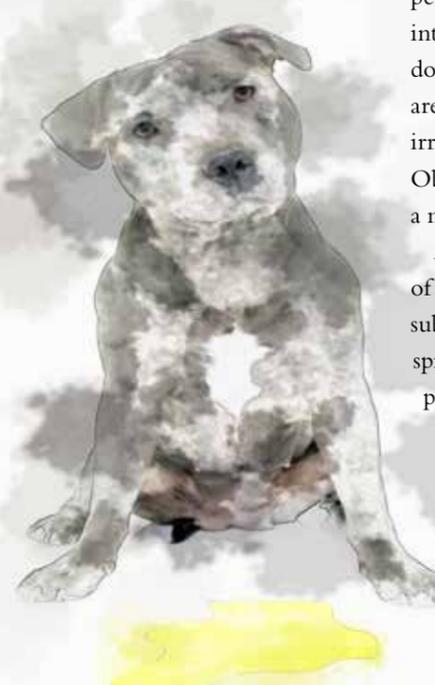
Not long ago, if I said something truly innocuous and you found it offensive, people would say, "you're too sensitive" or "don't be so easily offended." Nowadays, I would get accused of a hate crime and you would get government funded group therapy for being psychologically traumatized.

Not only does every kid get a trophy for damn near anything, but if he doesn't it's a microaggression. We've replaced "The Greatest Generation" with a culture of whinny victims.

Isn't it high time we should be able to call a spade a spade? Okay, maybe not that. But we should at least be given the benefit of the doubt that our well-intended advice was borne of a spirit of compassion and goodwill, and that our everyday exchanges aren't laced with subtle aggression, but with civility, honesty and humor. Otherwise, we are the victims of an imagined injury to someone with hurt feelings telling us how they feel we feel – reverse microaggression, I guess.

Gotta go. I'm watching a re-run of Brett Favre fake clapping for Caitlin Jenner at the ESPY awards then heading to that sandwich place with the poster child fat guy who turned into a child molester.

After that, gonna catch up on the last season of *Downton Abbey* - **where microaggression is an art form!** 🩺



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