Fixing Up
The Atkins Diet

Why Dr. Atkins Is Dead, You're Still Overweight, And the Debate Rages On

HOW TO DO ATKINS WITHOUT FAILURES AND SIDE EFFECTS

Konstantin Monastyrsky

www.FixingUpAkins.com

Chapter III.

WHY ARE YOU STILL OVERWEIGHT?

This question—part rhetorical, part speculative, part provocative—is presented in this context: *why are you still overweight after trying the Atkins diet*? Why would you be reading this book otherwise, right?

I can take this question even further by asking *Why was Dr. Atkins himself overweight after introducing his namesake diet?*, but since he's no longer available for retort, I'll be analyzing and answering both questions at once—about you and about him.

This is, by far, the most important section of this book. Don't dismiss it as fluff, speculation about your misery, or a ruthless attack on the late, defenseless Dr. Atkins. Blaming the messenger (the author) for bad news (the performance of the Atkins diet) will not make you any happier or any lighter.

Since it's so easy to mix up Dr. Atkins' failures with the benefits of low-carb nutrition, his detractors mercilessly blame Dr. Atkins' shortcomings on the tool. Don't get confused. A low-carb diet is just that—a great tool. And just like any other tool, it's only as good as the skills of its user, be it a Stradivarius violin or a Formula One racer.

That's what this book is all about—getting the tools, gaining the skills. And to fix anything, you first ought to learn what actually needs fixing. Learning from mistakes is a time-honored tradition, chiseled into war-strategy books, market analysis, autopsies of expired patients, the investigation of black boxes, and so many other goings-on that often end up tragic failures. Even medical students begin learning their trade not from interviewing healthy people, but by dissecting

cadavers. And even before that, they slice and dice ham to acquire scalpel skills, although it could be argued that the corpses won't care whether they've practiced or not.

It's my turn to autopsy the Atkins diet. In the process, you'll learn a lot of essential details, obscured by popular medical myth and Dr. Atkins' mostly fictional prose. Postmortems are a bloody business, but a necessary evil. Fortunately, a cadaver wouldn't care about the indignities any more than it would care about scars from a blunt scalpel.

Beware when M.D. stands for "Mining Dough"

Let's begin with his books. *Robert C. Atkins, M.D.* is printed on their covers in bold, prominent letters. It isn't there for nothing: the well-respected, coveted 'medical doctor' prefix implies a certain seal of approval, and sets up a level of almost unconditional trust and confidence. When you buy and read an M.D.-authored book about weight loss, you rightfully expect a rock-solid, non-fiction treatise, where each and every fact was doubly, or even triply verified, all statements have scientific bearing, all recommendations have been researched and confirmed beyond a reasonable doubt, and all known contingencies have been given a thorough review. Right?

Wrong! This isn't even remotely close in Dr. Atkins' case. Since publishing his first book in 1972, Dr. Atkins wrote about human physiology in general, and metabolism in particular, without once, as it appears from my examination of his books, consulting the professional literature about those well-studied subjects. Not surprisingly, he made numerous errors and omissions, all of which will be analyzed on these pages.

What's even more striking is that each of Dr. Atkins' three "Diet Revolution" editions—the original from 1972, "New" from 1992, and "Completely Updated" from 2002—are as different as the 'Best of Show' finalists in the Westminster Kennel Club dog show. Yes, the bark, the common theme, the attention-grabbers, the gimmicks are all there, but the texts and structure are as different as night and day, each edition adapted anew to Dr. Atkins' evolving view of the weight loss quandary. As you will learn from this book, many of those views had not been completely correct. And that's perhaps an understatement.

Here's just one example. The topic is *alcohol metabolism* and its impact on

weight loss—a simple, extensively researched subject, taught from high school to med school:

- *1st Edition (1972)*: "But this is one diet where alcohol acts just like a carbohydrate. It makes the body discharge insulin and stops you from putting out FMH [Fat Metabolizing Hormone – ed.]" (p. 147)
- *2nd edition (1992)*: Amazingly, there are no index entries at all for *alcohol, wine,* or *liquor*. As if they don't exist. FMH is renamed FMS— the *S* stands for *substance*.
- *3rd edition (2002)*: "The body burns alcohol for fuel when alcohol is available. So when it is burning alcohol, your body will not burn fat. This does not stop weight loss; it simply postpones it. Since the alcohol does not get stored as glycogen, you immediately get back into lipolysis after the alcohol is used up." (p. 157).

The "artistic license" here is taken way, way too far:

- "*…alcohol acts just like a carbohydrate"*—Not true. Alcohol doesn't act like carbohydrates. In fact, it inhibits carbohydrate metabolism and metabolizes into triglycerides (which becomes body fat) and glycerol.
- "*It makes body discharge insulin…"*—Not true. Alcohol doesn't stimulate a discharge of insulin. The carbohydrates in drinks and the elevated level of endogenous glucose may do so, but not alcohol.
- "*…stops you from putting out FMH*"—Not true. There are no such medical or biological terms as *fat metabolizing hormone* or *fat metabolizing substance*. Pure fiction. Just as with carbohydrate metabolism (glycolisis), the metabolism of fats (lipogenesis) is an innate body process governed by enzymes, and it's not regulated by any "hormones" or "substances." The body functions which control metabolism are certainly regulated by various hormones, but not lipogenesis. The archaic term FMH came from research done in the mid-fifties (see below) and it is incorrect.
- "*So when it is burning alcohol, your body will not burn fat. This does not stop weight loss; it simply postpones it*"—Not true. Alcohol not only doesn't postpone weight loss, it also leads to weight gain, because it's metabolized into fatty acids that are eventually stored as body fat. Beer belly, anyone? Was Atkins blind?
- "*…you immediately get back into lipolysis after the alcohol is used up*." Not only untrue, but plain stupid: lipolysis IS the metabolic pathway for alcohol. Any medical resident knows this from emergency room duties: when uncon-

scious alcoholics are admitted to the ER, they all have a sky-high level of ketones—the natural byproduct of lipolysis. Excessive ketones may lead to lethal metabolic ketoacidosis.

What's truly amazing is that the final 2002 edition of *Dr. Atkins' New Diet Revolution* was completely rewritten by a team of writers, doctors, nurses, registered dietitians, researchers and editors (all in all twenty different people), each one acknowledged by name and title in the front credits. And this is before the editorial team of the publisher *Avon Books/HarperCollins* had their turn. The ignorance Dr. Atkins and his teammates displayed to the basic fundamentals of science, as demonstrated above, is startling. And what's more, this misinformation will encourage you to gain even more weight. Some diet!

From inception to deception

So let's begin with two of Dr. Atkins' boldest, most prominent claims: that the Atkins diet is *"*new*"* and that it's "revolutionary." Actually, the Atkins diet isn't new. At the end of nineteenth century, low-carb dieting was called *banting*, and *to diet* was *to bant*. This came about after the obese English undertaker William Banting[1] successfully lost weight on a low-carb diet, and published his *Letter on Corpulence*[2] in May of 1863. It was the first low-carb diet primer, and it was all the rage until the mid-twentieth century. So much for "new," considering that the noun *banting* made it into the English language. Here's the definition from a mainstream dictionary:[3]

> bant·ing [bánting], noun, dieting method: dieting by cutting fat [*incorrect – ed.*], starch, and sugar out of the diet (archaic)

It's ironic that before the overweight Dr. Atkins came along, the most famous low-carb "how-to" diet guide was penned by an obese undertaker. Doubly ironic that insulin, one of obesity's main culprits, was co-discovered by a Canadian scientist named Frederic Banting, who wasn't related to William Banting, one of the insulin's most perceptive victims.

In all probability, Dr. Atkins' "revolutionary" epiphany came not from Banting, whom he once briefly acknowledged, but from reading a scandalously titled and provocative book, *Eat Fat & Grow Slim*[4], which was written by Dr. Richard Mackarnass. It was first published in the United States in 1962, one hundred

years after Banting's *Letter on Corpulence* appeared.

Dr. Atkins wrote the following sentence in his first book: "It wasn't until 1963, after another ten years of gaining, that I suddenly realized, seeing myself in a photograph, that I had three chins.[5]" A page and a half later, he continues, in capital letters, "I was looking for 'THE HUNGRY MAN'S DIET' "[6]—exactly the diet prominently offered on the cover of *Eat Fat & Grow Slim*:

NO MORE HUNGER PAINS

And this is what the *NO MORE HUNGER PAINS* diet was all about:

> "The ideal high-fat, high-protein, low-carbohydrate diet restricts carbohydrates (starch and sugar) to a minimum and combines unrestricted quantities of fat and protein…[7]"

Sound familiar? Well, not just familiar, but identical. Nevertheless, while discovering his "revolutionary" diet in the same year—1963—Dr. Atkins never credited Dr. Mackarnass for his inspiration. If you doubt this conjecture, there's more to it. Wrote Dr. Atkins:

> "As I searched, I found more pieces of the puzzle. I read the work of those brilliant English researchers, Professor Kekwick and Dr. Pawan, who had shown that a fat mobilizing hormone was present in the urine when that diet had been free of carbohydrates for forty-eight hours.[8]"

Interesting coincidence! *Eat Fat* was first published in England in 1958, and Dr. Mackarnass also credited exactly the same work of the same two compatriots—Professor Kekwick and Dr. Pawan. But in the mid-fifties, when their research was published in England, Dr. Atkins was just a student. In that era, decades before the Internet, a study of English medical journals, even mainstream ones, by an ordinary medical student in the United States was as likely as you today reading daily briefings prepared by the CIA for the President of the United States. Very, very, *very* unlikely.

It took Dr. Atkins another ten years to publish his first *Diet Revolution: The High Calories Ways To Stay Thin Forever*. Evidently, he borrowed key concepts from Dr. Mackarnass' book, which he applied to himself and to his flourishing

weight loss practice, and which he'd published earlier as the "Vogue Superdiet" in *Vogue* magazine. The book itself was written on Dr. Atkins' behalf by Ruth West Herwood, a ghost writer.

So much for "new" and so much for "revolutionary." What used to be the "Banting diet" and could have easily become the "Mackarnass' Diet," had briefly been known as the "Vogue Superdiet," and was reincarnated as *Dr. Atkins' Diet Revolution*. Finders keepers.

Not surprisingly, the index entries for *Banting, William*—the father of the low-carb diet—had been altogether eradicated from the second (1992) and third editions of the *New Diet Revolution* series. As the old diet was getting newer and newer, the past was slipping away without a trace. Ironically, ever since the rebellion that established the short-lived Paris commune in March of 1871, revolutionaries of this world have marched to the accompaniment of *L'internationale*[9], singing these prophetic verses: "*We'll change henceforth the old tradition, and spurn the dust to win the prize*."

Indeed. The times may have changed, but the modus operandi of diet "revolutionaries" remained true to form: *low-fat* into the dustbin, *low-carb* in—to grab the prize. Not surprisingly, the revolutionist dedicated his first book essentially to himself:

> This book is dedicated to all the diet revolutionaries who are not content merely to follow their own diet, but who are dedicated to carrying the message of the diet revolution to the world which needs it[10].

At this point we'll never know the full truth, except this one: If Dr. Atkins indeed believed that his diet had been honest-to-goodness "Atkins," "new," and "revolutionary," then he'd either been blissfully ignorant, or intentionally deceitful, or both. Does it matter?

Of course it matters. Because darn it, it says right there on the book covers: "Robert C. Atkins*, M.D.*", and the unspoken standards for disclosure and research for medical doctors are ten-times more stringent than for average Joes. Why? Because if that M.D. isn't thorough and trustworthy with his readers, who's to say he's thorough and trustworthy with his patients? (By the way, this "average Joe" meticulously researches his references, statements and claims. The disparaging adjective "average" by no means implies that I allow myself the indulgence of inventing weight loss science as I see fit.)

The more I think about it, the more plausible it becomes: medical doctors trained in the United States, as their diplomas indicate, are taught not medical "science" but "medical arts." Once licensed, they have a great deal of latitude to practice their art as they see fit, as long as they have their patient's best interests in mind. Alas, there's a big difference between "best interests" and "best results," even when a fictional book gets the artistic "treatment."

Separating facts from fiction

Back to fiction. When one approaches a non-fiction subject as complex as human physiology from a purely observational vantage point, or by borrowing ideas from paperbacks, as was evident from an examination of his literary legacy Dr. Atkins did, mistakes are bound to be made, lots of mistakes. What do I mean by this?

There are several key premises to the Atkins diet, all prominently listed on the covers of his books and elaborated within ad nauseam:

- Obesity and weight gain are a "metabolic disorder and not an eating disorder[11]";
- The Atkins diet is *The High Calorie Way To Stay Thin Forever*;
- The Atkins diet is *The Most Effective And Luxurious Weight-Loss Diet of The Twentieth Century*.

Unfortunately, none of these claims are even remotely true. Pure fictional nonsense. A pseudoscience made credible by an M.D. title. Let's investigate why.

Obesity and weight gain are a "Metabolic Disorder And Not An Eating Disorder"

Beginning with the front cover[12], and continuing on throughout his books, Dr. Atkins repeats the "metabolic disorder" mantra over and over and over again. So it must be correct, right?

No, it's absolutely not correct; it's an absurd claim, a quack theory. Weight gain and obesity are not metabolic disorders, never have been metabolic disorders, and will never become metabolic disorders. In fact, to make this claim indicates incredulous naiveté, mind-blowing ignorance, or both. Why?

Well, because we human beings are wired for weight gain by nature, are pro-

grammed to gain weight from birth to the grave, and our ancestors passed evolutionary muster primarily on their ability to fatten up. Even the words "heavy" and "heaven" are of the same origin.

In fact, *not* gaining and/or losing weight is a symptom of a true-to-God "metabolic disorder," which is called *juvenile diabetes,* a.k.a. *diabetes mellitus type I*. But gaining weight isn't a disorder—it's nature's foremost order, and a metabolic advantage. Yes, yes, yes: a metabolic A-D-V-A-N-T-A-G-E, not disadvantage. An asset, not a disease[13].

What we do with that asset and to what extent we fatten up by gobbling down more food than our bodies require, well, that's a whole different story. But I repeat, weight gain, and even obesity, are not metabolic disorders, as Dr. Atkins claimed, but the opposite: a metabolic advantage as innate as pain, hunger or appetite. None too desirable in some respects, but nonetheless essential for survival.

This isn't just my opinion. It's also the opinion of mainstream medical science, which classifies disorders. *The Merck Manual of Diagnostic and Therapy*, in section 2, *Endocrine and Metabolic disorders*, for example, doesn't list either weight gain or obesity as metabolic disorders. Yes, *Merck* indicates that weight gain and obesity may be symptoms of several metabolic and endocrine disorders (including "Disorders of Carbohydrate Metabolism" in chapter 13, "Thyroid disorders" in chapter 8, "Hyperlipidemia" in chapter 15, and a few esoteric diseases) but it doesn't classify them as "metabolic disorders." Never!

Rest assured, I'm not in cahoots with *Merck* to discredit Dr. Atkins. Outside of Merck, you still won't find a single mainstream medical reference or textbook that classifies weight gain and obesity as a *metabolic disorder* either.

And consider this:

- Weight gain (accumulation of fat) is one of the most essential parts of a healthy pregnancy. Breast milk still doesn't come in a bottle, but is made from fat deposits under the bubs, buns and bellies of moms-to-be. Breastfeeding is not only the best diet for a baby, but also the most efficient way to lose weight after a pregnancy.
- A child's health at birth is judged by weight—the more weight, the merrier. Chubby ducklings are more likely to evolve into beautiful swans than a skinny or underweight brood.
- The whole purpose of breast-feeding is to fatten up a child for the first two years of the child's life. That 's why breast milk is so exceptionally high in lactose (~6.9%), a.k.a. milk sugar—baby's first carbohydrate—and fat (~4.4%).

Proteins come in last at a mere 1%. And as any pediatrician will tell you, babies properly breast-fed by a healthy mother are the easiest to spot: unlike their formula-fed brethrens, they are most often flabby, happy and quiet.

- American men are obsessed with breasts; big, perky female breasts, that is. What's under the bra? A pure sack of fat. Evolutionary instincts attract prospective mates to well-endowed women as certainly as honey to flies. Not necessarily because these women may be great lovers, but because they're most likely to survive a famine and nurse the healthiest offspring. (Obviously, neither of these things is likely to happen with an "appliance" in place of the fat.)
- Anorexic-looking, flat-chested models, draped in design attire, may appear groovy on catwalks, but most of them suffer from amenorrhea (absence of period), lack sex drive, and often cannot conceive. And that moody, bitchy, *don't-bother-me* look on their faces, popularized by high couture ads, may not, actually, be a put on, but a genuine exhibit of the emaciated models' depressed minds and fatigued bodies.
- If not for the human body's ability to gain weight (i.e. its ability to quickly and efficiently metabolize excess blood glucose and dietary fats), we'd all be dead from diabetes long before we got a little bit fat, moderately fat, or even obscenely fat. This is why, incidentally, after a certain point as many as 90% of patients diagnosed with non-insulin (type II) dependent diabetes are either overweight or obese[14].
- Any doctor will tell you that a moderately overweight patient has a much higher chance of recovery from a major trauma or surgery, and that a precipitous loss of body fat, not gain, is one of the primary "symptoms" of death. Please note that for accuracy's sake I wrote "fat loss" instead of "weight loss," because a number of terminal diseases such as cancer, kidney failure, liver cirrhosis, congestive heart failure and others are often accompanied by fluid retention and a corresponding weight gain.
- And finally, a precipitous weight loss (not gain) is the surest symptom of encroaching and deadly insulin-dependent (type I) diabetes or liver failure. The true diabetics—those unable to produce insulin and metabolize excess carbohydrates into fat—struggle not with weight gain, but weight loss. And when the liver goes down, the patient goes under.

I hope you now understand why Dr. Atkins' claim that weight gain is a "metabolic disorder" is so preposterous, so clearly wrong, and so irresponsible. I repeat again: *the ability to gain weight is a metabolic advantage, an intrinsic body func-*

tion, and a sign of superior genetics. It is not by any stretch of the imagination a "disorder."

If you care to know why Dr. Atkins erred so crudely in naming this innate property of the human body a "metabolic disorder," here's my take on it: When a patient comes to a doctor, the doctor needs a "disorder" in order to bill the insurance company, prescribe lab tests, and, finally, treat the patient. Until this day, very few, if any, insurance companies reimburse weight loss treatment. So, unless the doctor finds an underlying disorder, there's little or no money in treating obesity. A little slight of hand with terminology goes a long way towards practice prosperity.

This is why dieticians are paid $30 to $40 per hour for counseling obese and overweight patients, while doctors can charge whatever they can get away with, as long as they can "diagnose" a disorder. Since diabetes, cardiovascular diseases, hypertension, and many other conditions are obesity's most frequent companions, overweight patients are a treasure-trove of income opportunities for any enterprising physician. And that's exactly what Dr. Atkins had been involved in all along in his overflowing, six-story clinic in the middle of Manhattan—diagnosing and treating the droves of overweight patients who had, among other things, "metabolic disorders."

Incidentally, the Oral Glucose Tolerance (OGT) test that Dr. Atkins administered with a vengeance to all his patients, and urged all readers to have done, is almost certain to "uncover" problems among many obese patients. Why? Because if they didn't have impaired glucose metabolism, they wouldn't be obese or overweight in the first place. So if you are about to drop carbs from your diet, don't waste any time and money determining what is already so patently obvious from looking at yourself in the mirror.

Keep this in mind: Atkins' apologists may do some fancy footwork here pointing out what I just explained: that hypertension, atherosclerosis, heart and kidney disease, cancers, and other similarly destructive conditions go hand-and-hand with being overweight. And that therefore he was doing the "right thing." All well and true perhaps, but that's putting the carriage way ahead of the horse. All of those conditions are indeed disorders related to long-term carbohydrate overindulgence, but the weight gain is not a medical disorder, not a metabolic disorder, but a natural, physiological outcome of excessive carbohydrates consumption, and it manifests itself decades and decades before the onset of those diseases. Yes, it is definitely dis-figuring, but, nevertheless, not a dis-order.

Please note that I'm not saying here that obesity is "normal," only that it's "natural" It is, indeed, abnormal to be obese by current societal standards, but it's definitely not unnatural. In fact, with over 65% of adult Americans being overweight, a statistician might point out that nowadays not being fat is abnormal.

I have to give Dr. Atkins due credit here: he correctly and forcefully pointed out that as you get thinner, you get healthier. But again, you do not get healthier because you lose weight, you get healthier because you're no longer consuming prodigious amounts of carbohydrates, which are what caused the weight gain and the diseases in the first place. The weight loss here is purely coincidental; a nice side effect of a low-carb diet.

So if obesity and weight gain are not metabolic disorders, what are they, then? Eating disorders?

Of course not. Anorexia, bulimia, binge eating—these are indeed eating disorders, but obesity and weight gain aren't, because, as I said before, we're programmed for these things by nature. Weight gain and obesity are intrinsic to our heavenly—pardon—heavy bodies. Incidentally, "eating disorders" are classified by The Merck as a Psychiatric Disorder (chapter 15, section 196). Not only that—dramatic weight loss is one of the most striking and tragic outcomes of those eating disorders.

Are obesity and weight gain an overeating disorder? Again, no. They're the end result of eating too much of a certain type of food, principally carbohydrates, but, again, the process of gaining weight, even too much weight, is inherent, and not acquired, the way that "disorders" are.

As far as mainstream medical science goes, The Merck classifies "obesity" as a "nutritional disorder" in Section 1, chapter 5. The definition is concise and simple: "Obesity: The excessive accumulation of body fat.[15]" The fun part comes further down:

"In one sense, the cause of obesity is simple—expending less energy than is consumed. But in another sense, it is elusive, involving the regulation of body weight, primarily body fat. How this regulation is achieved is not yet fully understood.[16]"

Oh, come on, guys. You're the only ones left who don't understand this yet. Even a five-year-old knows how people get fat: through eating more than they need. No wonder we have an obesity epidemic in the United States—the world's leading medical reference authors do "not yet fully" understand how people get fat. The description of obesity in the current 17th edition of The Merck Manual

finally mentions eating as one of the factors of obesity. Just recently, in the 16th edition, food hadn't even been mentioned as a causative factor of obesity.

The Atkins diet is "The High Calorie Way To Stay Thin Forever"

This is only true if you've never been overweight or obese. Even then, fate may eventually catch up with you. Otherwise, this claim is pure nonsense. It's courtesy of this lunacy that you're still overweight. And what never worked for Dr. Atkins himself, hasn't been working for me, and wouldn't work "forever" for you, either. Why?

Because, as we just discussed above, Dr. Atkins possessed, and you and I possess, a certain "metabolic advantage" that makes us efficiently *store* energy as soon as we consume *more* energy: more food than we can expend as energy. It's the same process that happens to be known as gaining weight, or, if you wish, *getting fat*.

Relative to our projected lifespan (the "forever" claim), the period of rapid weight loss experienced during the exceptionally permissive *eat-as-much-as-you-wish* induction stage (the "high calorie way" claim) is relatively short, usually less than a month. Dr. Atkins didn't cut the length of induction to fourteen days for nothing, because after that brief period, the weight-loss bonanza was pretty much over for most of the dieters that he had observed. But why?

Well, because that's about how long it takes for our marvelous bodies to adjust to a new dietary pattern, and to start utilizing its innate "metabolic advantage": to fill your fat cells back up with whatever "fuel" you've just digested, but didn't casually "burn" up, be it from excess carbohydrates, or from excess proteins, or from excess fats.

Let's restate these important points again:

- If you have ever been overweight, you can quickly and easily lose weight by eliminating or substantially reducing any one food component from your diet. Carbohydrates happen to be the food component that is primarily eliminated on the Atkins diet.
- You lose weight on the Atkins diet not because you suddenly began eating meats and fats, but because you no longer eat prodigious amounts of carbohydrates. For the average dieter the net daily reduction of carbohydrates during the induction stage is between 300 to 450 grams, or the equivalent of 20 to 30 tablespoons of refined sugar. It ain't rocket science to figure out that you'll lose

weight by eliminating so much food from your plate.

- As soon as your body adjusts to a new dietary pattern, in our case low- or zero carbs, it will resume preserving excess nutrients for rebuilding, and for energy causes: dietary proteins as muscle tissue, and dietary fats as triglycerides (adipose tissue fats). Under certain circumstances the body may metabolize dietary proteins into glucose as well. Excess glucose from glyconeogenesis may also be stored as fat.

What are the solutions to this dilemma? Well, the same as always: either eat less, or work out more, or do both.

Now, let me ask you a few simple questions:

– *What is going to happen if you follow Dr. Atkins' advice, and increase the amount of carbohydrates after the induction period?*

You are, of course, going to gain weight back again, but this time with a vengeance, as it happens with all other diets. This is for several reasons:

- First, after removing carbohydrates from your diet, you've alarmed your body into "starvation" mode. This duress inevitably leads to a metabolic slow-down. The less energy you expend, the more weight you accrue, even on the same amount of food, and much more so with resumed carbohydrates.
- Secondly, the moment you return to carbohydrates, you instantly terminate the process of converting body fat into energy. More about this in later chapters.
- Finally, along with carbohydrate consumption, your insulin level immediately rises, and your appetite returns full-strength to mitigate low blood sugar.

As you can see, returning to carbohydrates following the induction period wasn't very wise advice. Next question:

– *What's going to happen if you follow Dr. Atkins' advice, and gorge on meats and fats without restraint, even without a trace of carbohydrates?*

Eventually, you're going to gain weight back again, just not as rapidly. Here are the reasons why:

- 100 grams (3.5 oz) of cooked porterhouse steak contains 22 grams of protein and 28 grams of fat[17]. Another half of its weight is water. Of course, there are no carbs in meat.
- Your energy expenditures to salivate, bite, chew, ingest, digest, assimilate and eliminate this porterhouse are close to its energy content, and a good share of proteins and some fats are required for the body's maintenance (plastic) needs. It is, essentially, a zero-energy, zero-body-fat food. This math is quite obvious when the Atkins diet is practiced in moderation—it rocks.

- If you follow Dr. Atkins's loony advice and eat a 12 oz porterhouse—454 grams or more—then we're talking excess, maybe 100-150 grams more fats and proteins than your body may need for energy and reconstruction. There isn't a significant difference in energy requirement to assimilate 100 g vs. 454 g of meat, short of energy for chewing. Once the digestive process has started, with whatever amount of food, it's pretty much a wash. And that excess, just like with carbs, will either go to fat stores, or will preclude their "meltdown." Not exactly a working strategy for weight loss and maintenance.

Interestingly, as I am writing this (January 19, 2004), the New York *Times* reported[18] that the Atkins organization is backpedaling on the original "all you can eat" claim, suggesting that dieters limit their consumption of saturated fat to 20%. Since most of the fat comes from meat, it is also a covert attempt to reduce meat consumption without "embarrassing" 30 million readers, who had been taught otherwise over the past three decades.

As you can see, Dr. Atkins' claim that you can eat any amount of proteins and fats, along with another 100 or so grams of "maintenance" carbohydrates, and "stay thin forever" is preposterous at the very least, and destructive to your efforts to lose weight at the most. Do that, and eventually you'll get right back to where you started from. Well, you already probably did.

In fact, this is why you're reading this book, right? You, too, couldn't "stay thin forever" following Atkins' recommendations.

Just for your information, the same 3.5 oz of not particularly sugar-laden, "innocent" cereals, such Kellogg's Raisin Bran, contain 76 grams of carbohydrates, 8.5 grams of protein, 2.5 grams of fat and only 8.3 grams of water. The insoluble part—ash and fiber—about 16 grams. It takes much less time and energy to digest a bowl of cereal than it does meat. Eighty-eight percent of carbohydrates (minus 12% fiber) will enter your bloodstream as pure glucose within a few hours, with almost no energy going toward its digestion. That's close to 70 grams of glucose, or almost your entire daily need in terms of energy, if you're a typical desk-bound worker.

So the equation is very simple. 100 g of meat goes to work for you and leaves almost nothing behind, and out of 100 g of cereal, 70 grams goes toward energy or body fat, and sixteen grams of undigested, intestine-clogging debris is left behind. But nothing goes to waste from meat, not even water, because meat digests almost completely. The so-called "ash content" of 3.5 oz of meat—what finally makes its way into the toilet—is about one gram (1.11); literally nothing. Maybe

another 3%-5% of fat will also go down the drain. This is why, no matter how much porterhouse you eat, constipation might set in. But this is a subject for later chapters: you definitely don't want to unplug the plug with a fiber plunger.

Finally, a rhetorical question:

– *Why did Dr. Atkins err so dramatically with this claim, when even he himself couldn't "stay thin forever"?*

My wildest guess is probably the most accurate: to lure patients and to sell books. Evidently, Dr. Atkins wasn't the first, and wasn't the last, to successfully sell the Brooklyn Bridge; in his case more than 30 millions times over[19].

Let's give Dr. Atkins due credit: We, the human species, are omnivores for one and only one reason: to assure our survival. Because of this unique ability, we can, for a limited time, subsist on any one type of food, and we can subsist indefinitely with little or zero carbohydrates, as the Eskimos do, for example. And that's why the health benefits of a low- or zero-carbs diet are so superior to other diets, which promote useless carbohydrates (biologically speaking) at the expense of essential and irreplaceable dietary proteins and fats. But obviously we're not talking of an "*anything you can eat*" smorgasbord-style here!

The Atkins' diet is the "The Most Effective And Luxurious Weight-Loss Diet of The Twentieth Century"

I'm not going to argue the "luxurious" aspect of the Atkins' diet— as far as I'm concerned, a rich chocolate-raspberry mousse, accompanied by a glass of aged port, a cup of espresso, a few fresh raspberries and a dollop of whipped cream, are infinitely more luxurious than any piece of meat or fish, no matter how well-cooked. I will tackle, though, "*The Most Effective*" claim.

So is it really true that the Atkins diet is the most effective weight-loss diet of the twentieth, or, for that matter, the twenty-first century? Of course it's not. When it comes to weight loss, it's no more effective than any other diet based on a net reduction of all food, or any individual food group. In some respects, it's even worse.

According to Dr. Michael Dansinger, M.D., assistant professor of medicine at Tufts University in Boston, MA, who compared the performance of the Atkins, Weight Watchers, Ornish, and Zone diets with randomly-selected overweight people, all four diets demonstrated close results for patients who were able to stay on course during this one year study[20]. "Instead of saying there is one clear

winner here, we are saying they are all winners," said Dr. Dansinger, according to a Reuters[21] news agency report. But the same report noted another interesting outcome:

- 22% quit the experiment after two months.
- 35% abandoned Weight Watchers and the Zone diets after one year.
- 50% got off the Atkins' and Ornish' plans after one year.

So much for the "most luxurious" and "most effective" claim. Plainly, we're not talking about a gastronomic tour through the south of France. Unmistakably, it is a restrictive DIET for overweight people to lose fat, not to enjoy food. This is why the Atkins diet becomes either too boring, too problematic, or both, for half of the dieters within a year.

In fact, even making these kinds of claims for any diet is irresponsible. Overweight people want to lose weight, not feast in the lap of luxury. Creating over expectations for a diet usually causes more damage than it does good, because it breaks the essential will and motivation necessary to make compromises, stay on course, and tolerate limited food choices.

The slightly better success rate of the Weight Watchers and Zone diets are easily explained: notwithstanding their other shortcomings, both diets include normal food in balanced proportions, just not as much. But let's not get charmed by their 15% advantage. The objective of this book is not discovering what's best from the worst, but fixing what I consider the best.

Why, then, did the Atkins diet end up as half-a-lemon in Dr. Dansinger's trial? Why was it not as effective as Dr. Atkins had claimed? Why did 22% quit it within two months and 50% after one year?

The 22% failure rate is obviously related to the problems already listed in the Introduction—constipation, fatigue, dehydration, bad mouth odor, and others. There are also personal, subjective causes, unrelated to the diet itself: over expectations, fat-phobia, lack of motivation, emotional issues surrounding food, dislike for meats, poor cooking skills, financial considerations, etc. As Dr. Dansinger astutely pointed out, the diet style must match the participant. In other words, if you hate meat or can't cook, steer clear of Atkins.

But why did 50% quit after one year? Apparently, for two key reasons, which may amplify each other: cessation of weight loss, and health-related problems (such as constipation, hair loss, muscle cramps, depression, and others, which I'll discuss in later chapters). Calling this kind of performance of a namesake diet *The Most Effective And Luxurious Weight-Loss Diet of The Twentieth Century*

takes either a lot of nerve or an abundance of arrogance.

Another due credit: The low- or zero carb diet is an exceptionally efficient diet, because it quickly stabilizes blood glucose levels and banishes excess insulin from the bloodstream. You cannot accomplish anything like this with high-carb diets, unless you run several miles after every meal to work out all the excess insulin and sugar in your bloodstream.

That wasn't really Dr. Atkins' discovery, but a simple fact of human physiology described in great depth in Dr. Mackarnass's *Eat Fat & Grow Slim* book, and also implied in William Banting's *Letter on Corpulence*. Of course, it's also stated in any medical reference.

Nevertheless, despite his rather slapdash errors, Dr. Atkins made a very forceful point about carbs and the blood sugar connection (either too low or too high), and for that we are grateful.

I hope by now you're beginning to understand why you couldn't lose weight following Dr. Atkins diet from soup to nuts. His approach to the theory and practice of weight loss can best be characterized as inspired *nutology*. No, not science about nuts, but science created by a nutty professor[22]. I've been beating up on the late rooster because one must be absolutely nuts to reinvent basic human physiology.

Failure to deliver beyond the sales pitch

The claims on the cover represent a strategy, a lure, a big picture. The Atkins diet strategy is expressed in just two words—"low carbs." The rest is just window dressing. Of course, Atkins' loony claims yielded a lousy strategy, but even this bad strategy worked well for many, whom I identified in the Introduction as: *relatively young, healthy, active, affluent, and lucky*. Certainly a distinct minority group among overweight people.

What "most effective" weight loss diet was Dr. Atkins talking about, if not one contingent upon one's youth, wealth, health and luck? This isn't a particularly effective weight loss diet. And the results have to do with tactics. In other words, strategy may win the war on fat, but tactics are critical to win the small and big battles along the way to complete victory. The "occupation"—meaning staying slim for good afterwards—isn't a piece of cake either, and it's every bit as challenging as losing weight. The reverse is just as true: wars are lost because of inef-

fective strategy; battles are lost because of bad tactics.

Since we're already in agreement on strategy (low-carb, definitely), let's review the tactics that imperiled your battle with fat, as per Dr. Atkins. Key among them: Atkin's complete ignorance of your *health, age, gender, lifestyle, financial resources, ethnicity, religion, physiology of digestion*, and other factors. Come to think of it, the omission of these topics from Dr. Atkins' books is stunning, because some of them are the very first things a doctor asks all patients. Let's do a little post-mortem….

Health: Worth its weight in medical bills

If anything is worth its weight in gold to a doctor, it's an overweight patient. The heavier, the merrier. It's just one income opportunity after another: diabetes, hypertension, heart disease, kidney and liver problems, digestive disorders, you name it—the overweight have it all. That much Dr. Atkins did acknowledge, and he correctly pointed that as the weight goes away, so do the health problems. But he didn't bother telling you that in real life the same conditions may sink the Atkins diet as certainly as a torpedo may sink a slow-moving cruise liner. Here are some of the reasons:

- *General medication*. Many prescription drugs, especially for people with chronic pain, hypertension, and heart disease, indicate weight gain and digestive disorders among their most prominent side effects, and they aren't "compatible" with the Atkins diet.
- *Oral contraceptives*. The good news is that if you're taking these, you're more than likely relatively young and active, and you enjoy sex often. All of this helps you to stay slim. The bad news it that contraceptives alter a woman's hormonal balance, and these changes may stimulate appetite and result in weight gain, especially in women over thirty. This consideration isn't mentioned in any of Dr. Atkins' books. If you are taking the pill, and are unable to lose weight on the Atkins diet, consider other means of pregnancy protection.
- *Cholesterol-lowering medication (statins):* Among other things, cholesterol is essential for normal reproductive function and proper weight maintenance. In this regard, cholesterol-lowering medication is a triple-whammy: it compromises liver metabolism reduces the available pool of cholesterol for hormonal synthesis, and it lowers the rate of metabolism in muscles on a body-wide scale. All of these factors lead to weight gain and can interfere with your ef-

forts to lose weight.

- *Sugar Diabetes*. Diabetes medication stimulates appetite by lowering blood "sugar" levels, stimulates the conversion of excess glucose into body fat, and often increases the level of insulin, which impedes weight loss. Quitting all carbs while takings these drugs is a sure way to wind up in an emergency room, after passing out because of extremely low-blood sugar.
- *Endocrine disorders:* The endocrine system, among its other functions, regulates hormonal balances and metabolism. Two individuals of identical weight, age, gender and diet will lose or gain weight differently, depending on their endocrine health and hormonal balance. A restrictive diet, including Atkins', may be inappropriate and ineffective with endocrine disorders, such as Cushing's Syndrome (hyper secretion of adrenocortical hormones), a dysfunction of the pituitary gland (hypopituitarism), thyroid hormone deficiency *(*hypothyroidism), an estrogen deficiency in women and testosterone deficiency in men.
- *Dental health.* Healthy teeth or functional, well-fitted dentures are essential for proper digestion. Inadequate or slow digestion (gastroparesis, or delayed stomach emptying) which can occur because of poor chewing, prevents many people from enjoying the benefits of low-carb nutrition. These problems, however, are easily overcome with proper preparation techniques and supplements that aid digestion.
- *Digestive disorders (upper GI tract).* The gastroparesis mentioned above is a common (up to 50%) complication of diabetes and obesity. The toxic[23] rotting of undigested meat proteins is one of the most prominent side effects related to gastroparesis. It may also lead to the rapid development of gastritis, peptic ulcers, enteritis, and colitis, when a high-carb diet is suddenly replaced with Atkins' protein-rich fare. This is because the stomach begins producing lots of hydrochloric acid and proteolytic enzymes, which can literally "eat alive" the unprotected intestines. Trying to lose weight on the Atkins diet with gastroparesis in your stomach is like trying to put out a grill flare-up with a bucket of oil. And this example is just the tip of the iceberg. None of this is mentioned by Dr. Atkins.
- *Heartburn medication:* Heartburn is mistakenly treated as an "excess acidity" disorder with a variety of prescription and over-the-counter drugs that range from hydrochloric acid (HCl) neutralizers to inhibitors. The heartburn sensation is localized in the esophagus, and not in the stomach, which is well protected from its own acidity. The esophagus is just a short chute from the mouth

to the stomach; it's not a digestive organ per se, so its mucous membrane isn't protected against acidity. When HCl acid contacts mucousa, you feel heartburn. When the acidity is partially or completely neutralized and/or blocked, the burning sensation is not as sharp. But here come two perplexing questions:

– *What the hell are gastric juices doing in your esophagus?*
– *What the hell happens with digestion when there is no acidity in the stomach?*

The answer to the first question is rather simple—insufficient digestion, poor chewing, the wrong food, too much food, too much liquid, etc., can cause the contents of the stomach to travel up into the esophagus. We'll deal with this in a later chapter.

The answer to the second question is more straightforward: hell happens, and here's why: Meats get digested only partially, or not at all, and it rots in the intestines. The by-products of this rotting then poison you. Flatulence, cramps, and pain set in, and your attempt at the Atkins diet is stopped dead in its tracks. You go back to the foods that require no digestion in the stomach. These foods happen to be carbohydrates, which caused you to become overweight in the first place. It's instructive to see how Dr. Atkins handles the question of heartburn in his books:

- *1st edition (1972)*: "Q. I get heartburn on diets. What do I do? A. Go on this diet immediately. Nothing clears up on this diet more predictably then does heartburn.[24]"
- *2nd edition (1992)*: no mention of "heartburn" in the index.
- *3rd edition (2002)*: no mention of "heartburn" in the index. I wonder why? So as not to spoil the appetite?

Incidentally, if you do go "on this diet immediately," and start consuming prodigious amounts of meats and fats as suggested by Dr. Atkins, your heartburn may get worse, because it takes considerable time and effort to restore an adequate digestion of proteins in the stomach, especially in older adults. If you're relatively young and healthy, and have had only occasional bouts with heartburn, this diet may indeed clear up your heartburn, because carbohydrates are no longer interfering with the digestion of proteins and won't overload your stomach with insoluble, indigestible fiber and gases from fermentation, both of which serve to push the stomach's excess contents up into the esophagus.

- *Digestive disorders (lower GI tract).* Unpleasant, chronic conditions such as ulcerative colitis, Crohn's Disease and Irritable Bowel Syndrome are usually

accompanied, in doctor's speak, by gastroenterocolitis—an unspecific inflammation and hypersensitivity of the entire GI tract. Throwing gobs of meat and fat into the irritated stomach and intestines isn't much different than drinking undiluted hydrochloric acid along with extra-strength digestive aids. Imagine pouring HCl onto an open wound: this is approximately what's happening when, combined with these conditions, one attempts the Atkins diet.

- *Constipation and hemorrhoids.* These two related conditions are so prevalent among contemporary Americans that they are no longer even considered a disease. Nonetheless, two thirds of dieters complain about constipation. And all those with hemorrhoids will experience flare-ups or will soon get hemorrhoids when they attempt the Atkins diet. Dr. Atkins solution? A few lines here and there. Just eat more fiber, he advised. What he wasn't telling readers is that dietary fiber, a bulk laxative, makes hemorrhoids even worse, interferes with digestion, stimulates appetite, scoops out vitamins and minerals from the body, clogs the intestines, causes cramps and bloating, hernia and diverticulosis, and on, and on, and on, until constipation becomes a chronic condition. Bon appetite!

This list is far from complete, just a sampler. Remarkably, these and other health-related issues, so critical for effective weight-loss, and so prevalent among Dr. Atkins' captive audience (overweight, middle-aged people, often with undiagnosed diabetes[25]) were not discussed with any appreciable depth, or at all, in any of his books. No wonder so many readers hadn't been able to lose weight, regardless of how diligently they tried to follow the Atkins' diet. One may only guess how many of them got hurt.

Gender: What's good for the rooster may not work for the hen

Sexes might enjoy equality in the workplace, but when it comes to weight loss, the discrimination is as blatant as it gets: always against women. When is comes to weight gain, it's the reverse; all systems are *pro* women, but this is a dubious benefit. Unfortunately, this is one tough rap that's hard to beat. And all of it has to do with gender-defining hormones—women's estrogen and progesterone, and men's testosterone.

Amazingly, there isn't a single index entry for, or reference to, these hormones in any of the "Diet Revolution's" three editions. There's no discussion of gender's impact on weight loss and gain. It's an embarrassing oversight, because

gender impacts weight loss and gain in so many profound ways. So much so that I believe diet books should be written separately for men and women. Here are several key differences:

- *Body fat ratio.* Women have a higher ratio of body fat to total body weight and less bone and muscle mass than do men. Body fat is essential for reproductive functions, a healthy pregnancy, and nursing. As body fat falls below a certain ratio (10%-15%), infertility and amenorrhea (absence of period) sets in.
- *Rate of metabolism.* Because body fat plays such an essential role in female health, women retain fat better and gain weight more rapidly than men do, on similar or lesser amounts of food—the body compensates its fat needs by slowing or speeding up metabolism.
- *Estrogen balance.* Hormonal fluctuations, primarily estrogen deficiencies related to age, pregnancy, reproductive health, and medications (especially contraceptives and cholesterol-lowering drugs) can all lead to the gradual weight gain typical for middle-aged women.
- *Aging.* As women age, they generally experience a faster reduction of their metabolic rate, and a decrease in muscle mass and physical activity, as compared to men, and they experience a corresponding weight gain.
- *Ovulation.* Ovulation raises body temperature, which is a well-known fact used for millennia to determine a natural algorithm of birth control (also known as the "Natural Family Planning" or "Periodic abstinence" technique). The hormonal activity and physiological metamorphosis during ovulation stimulates metabolism, hence the temperature rise and the appetite that goes along with it to "keep the burner" going. Instead of using these natural phenomena to burn fat by excluding carbohydrates, overweight women—especially those prone to low blood sugar (hypoglycemia)—feed "the burner" with loads of carbohydrates, and gain weight.
- *Menstruation.* The period represents a particular challenge for weight loss, because, as during ovulation, the body goes into overdrive, and requires more energy and nutrients for rebuilding and restoration (plastic needs), including micronutrients, such as vitamins, minerals and microelements. During a woman's period (as well as during ovulation), the body specifically demands additional proteins and essential fatty acids to synthesize hormones. All of these factors and corresponding mood swings stimulate a voracious appetite that's often not satisfied with essential macro- and micronutrients, but with useless (nutritionally speaking) carbohydrates that inevitably get converted into body fat.

- *Pregnancy.* Women are programmed by nature to accumulate body fat and muscle tissue during pregnancy. These extra stores are essential for the dramatic plastic and energy needs related to pregnancy, and for breastfeeding. Pregnancies terminated by abortion or miscarriage may also lead to a precipitous weight gain.
- *Breastfeeding.* Failure to breastfeed is a primary cause of postpartum weight retention, i.e. getting fatter and fatter after each baby. Long-term milk production "burns" fats deposits better and faster than any form of exercise. Besides, breast milk fertilizes the healthiest, happiest, and chubbiest babies. In fact, using formula rather than breastfeeding may be a cause of weight gain and obesity among young women in the United States.
- *Chronic dieter syndrome*. Women have a propensity for recurrent dieting. Each consecutive diet, especially one low in fat and protein, compromises the body's essential endocrine function, slows the rates of metabolism, and, often, increases the consumption of carbohydrates, which leads to the accumulation of fat and to reductions of muscle and bone mass. Each consecutive cycle results in more and more fat stores, and a corresponding decline in overall health. This results in even more weight gain.
- *Muscle mass.* Men have a much greater muscle mass than women. Muscles are primary "consumers" of energy, equally adept to anabolic (glucose-driven) and catabolic (fat-driven) metabolism. That is why men on a low-carb diet (insufficient glucose) lose weight much more rapidly than women, and don't gain weight as quickly as women on a mixed diet.
- *Water metabolism*. Women more than men are susceptible to water retention (edema), and often confuse excess water with extra weight. Incidentally, protein deficiency, along with mineral deficiency and an excessive consumption of water, are the primary causes of idiopathic (cause "unknown") edema in otherwise healthy women.
- *Anthropology*. Ancestry plays a significant role in weight gain and resistance to weight loss, particularly for women whose roots are in countries with warm climates and a predominance of seasonal, carbohydrate-rich grains, fruits and vegetables. Because of a cyclical, climate-dependent food supply pattern, they're genetically predisposed for rapid weight gain in order to accommodate less plentiful seasons or even frequent periods of starvation. This is apparent from the rates of obesity among, for example, African-Americans, Hispanics, Indians, American Indians, and persons of South-Pacific ancestry.

- *Lifestyle*. Because of family and societal obligations and expectations, women are generally less active than men from the same age group and socioeconomic bracket. A lack of activity or participation in sports may precipitate weight gain on a diet similar to that of men's.
- *Occupation*. Traditionally, a male's blue-collar occupation—policeman, fireman, laborer, construction worker—kept many men in better shape longer than women of the same age, whose jobs weren't as physically demanding.
- *Husband's occupation*. Women should be particularly mindful of differences in food content vis-à-vis their husbands. Being a policeman's wife is a definite hazard, not because of the guns around the house, but because of a husband's ravenous appetite after a long day of fighting crime. It isn't easy to resist hearty and plentiful food at the family dinner table.
- *Eating out*. Short of Nieman Marcus' café-cum-bistro spa-like menu intended for well-healed, predominantly slim patronesses, I've yet to see a restaurant that provides a gender-specific menu. Hence, same-sized steaks are smacked in front of a petite woman and an oversized body-builder-type man as a matter of course. Women, who dine out often, must be mindful of this paradox, and demand half-portions or split main courses with their companions.

These are just some random considerations off the top of my balding-from-years-of-abuse-and-worry head. It's a far from comprehensive list of gender-specific differences that plague women when it comes to weight loss, most of which were not accounted for or acknowledged in Dr. Atkins' books, and ignored altogether in his diet. The result: you're still overweight, and reasons similar to why you wouldn't pick up an evening gown from a "one-size-fits-all" rack. One diet can't fit both genders, either.

All things considered, men don't know how lucky they are when it comes to weight loss and maintenance. Neither did Dr. Atkins, to the great detriment of millions of women who struggle with their weight all their life, regardless of the over-hyped Atkins' diet.

Age: Coming of age has its negatives

As with gender, age represents a particular challenge for weight loss and maintenance, no matter what the diet. Even worse, the challenges intensify geometrically rather than linearly as we get older and older. Yet another paradox: as we get older, we need more nutrients to get by, while our propensity for weight gain

goes up, not down.

Dr. Atkins' ungraceful aging and his premature death, related in large part to his excess weight, and despite his devotion to his "Age-Defying" diet, illustrated this age-and-weight connection. You won't find much discussion on this subject in Dr. Atkins' "Diet Revolution" books, even though he had a lot of time to observe the ravages of age on himself and on his graying patients. Let's review key factors:

- *Hormonal changes.* The decline of hormonal activity, primarily "anabolic" sex hormones and Human Growth hormone (HGh) lead to the decline of metabolism and to a corresponding weight gain and/or retention. Contrary to once great expectations, hormone replacement therapy increases the risk of cancers and heart disease, hardly a gamble worth taking to shed a few extra pounds.
- *Reduced lung capacity.* Deep breathing alone is an effective weight loss method, because it speeds up the metabolism, which is easily observed in the rise of body temperature. Without exercise or because of external factors, such as smoking and air pollution, the lung's capacity decreases with age, as does the capacity to lose weight.
- *Reduction in physical activity.* Age-related diseases, infirmities, mental outlook, and similar factors bring along a gradual decline in physical activity and lessen the ability to metabolize excess fat and/or maintain weight loss.
- *Reduced intellectual load.* The central nervous system (CNS) is a primary consumer of blood glucose and/or energy dense fat metabolites (ketones). Intensive intellectual pursuits are as effective for weight loss as moderate exercise because of the brain's high demand for "fuel." It's quite typical even for young adults to rapidly gain weight after graduation without an appreciable lifestyle change—a similar amount of food, a lesser demand for energy. It's instructive to watch an episode of Jeopardy: based on obesity statistics, two-thirds of the participants should be overweight, but in reality you rarely see an overweight contestant. So keep the CNS going with intellectual pursuits, play Jeopardy. This also explains why many people find watching Jeopardy-like shows a calming and addictive experience. Since they usually "play" along with the participants, their level of blood glucose drops down, and this has a relaxing effect.
- *Compromised digestion.* The digestion of nutrients decreases inversely to age, and the demand for food increases directly proportionate to age. I already mentioned the health and gender-related reasons behind this trend in the paragraphs

above. Interestingly, this reduction in digestion applies to proteins and fats, but not to carbohydrates, especially water-soluble sugars and starches, which quickly and easily assimilate into the bloodstream as glucose, fructose and galactose. These are the primary progenies of body fat when digested in excess of body requirements, which obviously becomes reduced with age.

- *Medication.* Discussed above. Fortunately, low-carb nutrition, when done correctly, rapidly reduces the need for most, if not all, lifestyle drugs, prescribed to counteract not the ravages of age, but the ravages of excess carbohydrates: sugar diabetes, hypertension, depression, cardio-vascular disorders, heartburn, chronic pain, and many others. There are "happy" exceptions, like Viagra, Levitra or Cialis, but I am not advising that they be used for weight loss, just for jovial sex.

  An interesting aside: low-carb nutrition in general, red meat in particular, is as good an aphrodisiac as any, because it accomplishes the same trick that Viagra does—it raises the level of nitrogen (by-product of amino acids metabolism) in the bloodstream that relaxes the peripheral blood vessels and improves penal and vaginal circulation, which is essential for viable intercourse. And I'm not even mentioning the intangible benefits such as endurance, agility, and the essential absence of flatulence, bloating, and belching from carbohydrates and fiber: all ingredients for great sex. Don't worry about the "bad mouth odor" innuendo that's associated with high-protein diets. It's easily fixable and isn't particular to any specific diet.
- *Declining health.* Discussed above. Fortunately, as with medication, low-carb nutrition is the best remedy for declining health. Health comes first, weight loss second. Alas, this point escaped Dr. Atkins and he paid a hefty price with both his excess weight and his own life. Please, don't repeat his feat.
- *Incorrect dietetic advice.* As you get older, the advice to eat more fruits, vegetables and whole grains is getting louder and louder. An aging body is made of water, proteins, fats, and minerals. Fruits, vegetables, and grains deliver lots of water, nutritionally-useless carbohydrates, minor amounts of secondary proteins, mostly oxidized, rancid, toxic trans fats, lots of intestine-clogging fiber, meager amounts of minerals from depleted soil, and vitamins deteriorated from storage. This is exactly what the aging body doesn't need, if it wishes to avoid rapid decline and weight gain. Unfortunately, many older, well-meaning adults, unable to resist their doctors and dietitians, combine the Atkins-style diet with fresh fruits, vegetables, and nuts, which completely nullify its ef-

fectiveness, and they gain even more weight.

- *Broad deficiency of macro- and micronutrients*. Just as an example, consider chronic anemia—a deficit of oxygen-carrying hemoglobin in red blood cells. Anemia may be related to the deficiency of dietary iron, vitamin B-12, folic acid, and certain essential proteins and fatty acids. It's prevalent among American adults because of an inadequate diet, history of bleeding, and age-related digestive disorders: indigestion, atrophic gastritis, celiac disease (intestinal disorders that block absorption), and also as a side effect of certain prescription and over-the-counter drugs.

  Anemia, of course, deprives the body of oxygen, a key metabolic agent and participant in all of the energy-related body functions, including the "burning" of glucose and fats. Inevitably, fatigue, dizziness, irritability, depression and shortness of breath set in—not exactly conditions conducive to weight loss. Unfortunately, most physicians have a rather simplistic attitude towards anemia, and so it goes under-treated and under-diagnosed in most adults. As a result, chronic anemia not only impedes weight loss, but also stimulates weight gain, because its fatigued sufferers are naturally starved for energy-dense and rapidly digestible carbohydrates (primarily sugars and starches).

  I will discuss this subject in later chapters, because, among other things, anemia leads to hair loss—a side effect frequently reported by Atkins' dieters that wasn't addressed in any of Dr. Atkins' books. It may happen rather precipitously in many cases, because the Atkins diet excludes bread, rice, pasta and cereals fortified with dietary iron, folic acid and some other supplements.

  Theoretically, red meat should provide dietary iron and vitamin B-12, but because of digestive problems, cooking techniques, cut choices, and koshering (complete blood-letting required by Jewish and Muslim dietary traditions to, in fact, prevent iron overload), most people do not get enough of these essential nutrients, which is especially noticeable among children and older adults.

  Please note that I just touched on but a small aspect of nutrient deficiencies and the impact they have on all diets, including low-carb diets. Please also note that Dr. Atkins briefly touched on supplement-related topics and made a brisk business in Atkins' line of supplements, but not with the depth and breadth the subject requires. I suspect this is because he was always fighting the accusation that the Atkins diet is "unbalanced" and lacks many micronutrients. Of course it is. It's just as "unbalanced" as any "balanced" diet, but this is a topic I'll address in later chapters.

It all adds up. The older you are, the longer it will take you to attain your desired weight loss, and the more effort you'll have to put into it: an unpleasantness Dr. Atkins "forgot" to mention in his books. Why bother, when young folks represent the most desirable buying "demographics?" It's hard to believe Atkins didn't know about these issues, because, although he wasn't a brilliant man, he was a far from stupid one.

Individuality: Different strokes for different folks

Both the Old and New Diet Revolution made it look simple and easy: just drop the carbs, chew the fat, and soon you'll enter a weightless nirvana, no matter what your age, gender, ethnic background, religion, family, financial circumstances, and so on and so forth—the endless array of those little, often imperceptible things that distinguish one person from another. The things that create individuality.

Overall, in the large scheme of things, it's true that we really aren't that much different from one another. The generic difference between the Australian aborigine, Claudia Schiffer and you is less than 0.1%, but within this tiny fraction of genetic code lie evolutionary programs that make you flinch with disgust upon seeing a cricket, while the aborigine will salivate with delight. And these variations—some dramatic, some minute—make a big difference when it comes to successful weight loss. Had they been anticipated by Dr. Atkins? Nope, not at all. And this is too bad, because all of them play a role, and you're better off knowing your "software" before turning on the program:

- *Occupation*. This is, by far, one of the most important factors. You'd be hard pressed to find a single overweight mounted (on the horse) police officer, while his twin brother in the air-conditioned cruiser may carry a few extra pounds. As little as that makes a big difference. So when you cannot figure out why your mother, sister or girlfriend is doing better or worse on low-carbs, this is the first place to look.
- *Personality*. Expansive, outgoing, hyperactive *over*achievers will always lose more weight, and lose it faster, than measured, introspective, low-key *super* achievers. It's not the end result that matters, but how much energy you're going to expend getting there, which is wired into your character. Keep this in mind when the go is slow.
- *Lifestyle*. Habitual party-goers dance hard, eat even harder, and can still stay

slim. That is one aspect of your life that you should consider changing along with your diet. Low-carb is great for a party animal, because your energy is even, palms and underarms stay dry, legs don't hurt as much, and drinks don't hit as hard.

- *Smoking*. Overall, smokers are slimmer than non-smokers, even though smoking stimulates appetite. It happens because smoking, just like the infamous ephedra in diet pills, stimulates metabolism. In that sense, a pack of cigarettes each day may be as "effective" as a few hours in the gym. But with that said, I strongly suggest you do the latter.
- *Drinking*. Alcohol, even in small amounts, has a profound effect on weight loss. First, wine, beer, liquors, and specialty drinks contain carbohydrates, often a lot of them. Secondly, alcohol inhibits the utilization of glucose by the CNS that is already in the bloodstream. Third, the liver metabolizes alcohol into fatty acids, which are then stored as body fat, and finally, alcohol slows the body down, so that even more excess glucose and triglycerides are dispatched into the fat stores. At this point, just note that non-drinkers lose weight much faster than drinkers. I'll discuss this subject in greater depth in later chapters.
- *Climate*. In general, people in warmer regions tend to be "lighter." A cold climate encourages the accumulation of body fat to keep internal organs well protected, and in anticipation of food shortages during the winter-spring season. People who are moving from a warm to cold climate are at the highest risk for weight gain. Also, the absence of sun exposure impairs the production of insulin and the metabolism of glucose (key obesity factors) because the body isn't producing vitamin D, an essential regulator of these two functions. For this reason, late spring, summer and autumn are the best time of the year to commence a low-carb diet. One great benefit of a low-carb diet, along with quality supplements, is that they reduce perspiration and increase one's tolerance for cold. If you don't feel the cold as acutely, your body's genetic memory isn't as "scared" into the "get fat" mode. There are lots of other psychosomatic and societal factors that influence the weather-weight connection, but none as significant as our genetic memory. After reading this book, moving to a warmer climate may be the next best thing for effective weight loss.
- *Financial resources*. Body fat follows a thin wallet. Poor communities in the United States have the highest number of overweight and obese people. Obesity and diabetes rates among African-Americans, Hispanics and American Indians are a great many times higher than in wealthier white communities

within close proximity. Poor whites aren't the exception, either. As always, there are several reasons at play: first, a genetic predisposition to rapid weight gain from the millennia of famine-abundance seasonal cycles. Second, economic factors come into play: unlike meats and fish, processed carbohydrates (bread, pizza, cereal, pasta) and natural ones (fruits, vegetables, grains) are cheap and plentiful year round, and represent the bulk of a poor person's diet. These are challenging problems, especially for large families. Unfortunately, this sad set of circumstances requires a more progressive and complex solution than can be found in books.

As you can see, it's not just *ham vs. jam or fish vs. knish.* These factors are real, important and must be considered, no matter what the diet, no matter what the lifestyle, no matter what the means. Fortunately, if a low-carb diet is done right it is neither bland nor expensive, works in any climate, matches any personality, goes well with a glass of wine, and is great for your career, because among two equally well-qualified candidates, employers almost always subconsciously pick trim, fit and healthy-looking individuals.

The diet-breakers

Then, there are the diet-breakers. Some are significant, some less so, but they add to the challenge of staying on the Atkins diet, losing weight or just keeping it off. Some of these are based on ignorance, some are profit-driven. In fact, this entire book is about the diet-breakers, and here are just a few:

- *Unrestricted consumption of proteins and fats*. I already discussed Dr. Atkins' advice to consume meats and fats in an anything-you-can-eat style, including vegetable fats in dressings, mayonnaise, sauces, etc. This no-limit strategy works during the brief induction stage because of the huge net reduction of carbohydrates and the adaptation of the metabolism. This is an absolute weight-loss dead end: just three tablespoons of mayo (or about 45 grams of pure vegetable fat) on top of all other food consumed that day, is enough to "fuel" your body for half a day. The unused fats and excess proteins will be stored as fat. At best, you are going to stay where you are, at worst you are going to gradually gain weight.
- *Dietary fiber.* Dr. Atkins suggests liberal consumption of dietary fiber in salads, in Atkins' low-carb bars, and in the form of bulking laxatives. Dietary fiber stimulates appetite, because of the increased stomach bulk, fermentation,

and intestinal obstruction. Seasoned low-carb dieters know this phenomena well from "the morning after" effect of cheating with fiber-rich food: you get up feeling hungry, very hungry. Also, keep this in mind—the stomach stretches as food comes in. Fiber-rich food accounts for the most volume and the most stretching. As you get off carbs, your stomach begins to gradually shrink, and as it shrinks, your feeling of satiety (a complex physiological and physiological phenomena) arrives much more quickly. There probably isn't an American who doesn't believe that natural appetite control (not suppression) is one of the most challenging aspects of any diet.

- *Artificial sweeteners.* Dr. Atkins recommends unrestrained consumptions of artificial sweeteners, including some that are processed carbohydrates, such as maltitol—a sugar alcohol with a slow rate of digestion. When you start a low-carb diet, a sensation of sweetness in your mouth will cause a release of insulin (unconditional reflex) and there will be a corresponding drop in blood "sugar." This much has been known since the existence of Pavlov's dogs. Guess what follows a drop in blood "sugar"? Not only irritability, but hunger, appetite, and even more appetite. This should create a brisk demand for Atkins Nutritionals' candies, bars and ice creams, all of them rich in fats, and, to a lesser extent, proteins and carbohydrates.
- *Frequency of eating.* Dr. Atkins recommended eating at least four meals a day. Snacking with Atkins low-carb bars in between is fine, too. This means that for at least sixteen to eighteen hours (12 + 4-6 for final digestion: all of your waking hours) your body doesn't stop digesting and assimilating food. It means increased opportunities to eat more, and more darn hunger and appetite. It means wear-and-tear on your digestive organs, and a drag and drain on your energy and time, with fifteen to twenty minutes spent per meal (an hour or more just for chewing). It's bad news for your purse, especially if you have to eat out. Most importantly, all this eating is bad for your weight loss, and a great opportunity for you to gain weight, because to curb your appetite, you must first satisfy—meaning fill to capacity—your stomach. When a low-carb diet is done correctly, most people are satisfied with just one major meal a day, or one or two minor meals, and no snacks. Not because "this must be so," but because they're not hungry, they're satisfied and they're full of energy. Of course, more about this—much more—will be discussed in the following chapters.
- *Supplementation*. Dr. Atkins doesn't emphasize strongly enough the critical importance of supplements, especially those that are added to major carbohy-

drate food sources (products from fortified wheat flour, such as bread, pasta, cereals, and rice). An extended absence of these products in daily diet can quickly lead to iron, niacin and folate deficiencies, unless you take quality supplements.

- *Stress* stimulates appetite and cravings for carbohydrates. This is a no-brainer. Stress hormones stimulate an aggressive response that, in turn, stimulates metabolism and a demand for energy. As the blood sugar drops, a craving for carbs (especially sweet ones) sets in. Unfortunately, as you supply carbs to feed the raging inferno, rather than calming stress, you are stimulating it. The vicious cycle sets in – stress stimulates appetite, satiety stimulates even more stress, so you crave carbs more and more. Interestingly, the combination of stress and a low-carb diet are more effective for weight loss than are diet and physical exercise. So, if you have plenty of stress in your life, take advantage of its serendipitous side effect, and enjoy rapid weight loss in combination with a low carb diet.
- *Side effects.* This book is dedicated to dozens of diet-breakers spelled out in the first chapter. Study each one of them, because even a single one is one too many.

Undoubtedly, there are other diet-breakers, especially behavioral, that may be described in numerous books on this subject, because they compromise any diet. Keep them all in mind.

Chapter summary

Weight loss isn't just a matter of dropping the carbs. Unlike naturally occurring *weight gain* from numerous causes enumerated above, *weight loss* in the absence of food deprivation, great physical strain, inordinate stress, or famine is a challenging, unnatural objective. To accomplish effective weight loss, you must create artificial conditions that mimic its natural causes. This isn't easy, because discomfort goes against human nature. And that, among all of the other things listed above, is what Dr. Atkins ignored, while giving you false hopes about a *quick, easy* and *luxurious* weight loss diet. No wonder you're still overweight. Furthermore:

- *Weight gain is not a disease*, but a normal physiological occurrence. Obesity, along with diabetes, heart disease and other related conditions, is just another

symptom of over consumption of carbohydrates, and not the primary cause of those deadly diseases.

- *A low-carb diet is just a tool*. It is as effective as the skills and expertise of its user. In fact, any weight reduction diet done right is effective no matter which foods are low and restricted or high and eaten often. A low carb diet is the most optimal diet, because it provides the protein and fat essential for proper body function, and inhibits the production of insulin.
- *Avoid excess*. A low-carb diet works well only when it is combined with sensible (within the body-needs range) consumption of protein and fat. Forget about "luxurious" feasting.
- *You are what you are*. Besides diet composition, many other factors impact diet performance. Consider all of them before you begin blaming yourself and your body.

Above all, be patient, diligent, and knowledgeable. Most people fail Atkins because they expect too much, in too little time, with making minimal effort, and without changing their eating habits very much. It didn't work for Dr. Atkins, it once didn't work for you, and it won't work for you again.

***

Normalcy of weight isn't a question of diet, but a question of a lifelong style of eating, that, among other things, removes the primary causes of weight gain and obesity without affecting any essential body functions. The merits of the best weight loss diet and eating styles are still hotly debated. Let's find out why in the next chapter.

Footnotes

[1] "William Banting, The Father of the Low-Carbohydrate diet". http://www.westonaprice.org/know_your_fats/banting.html

[2] Full text is available at http://www.lowcarbing.com/downloads/banting.pdf

[3] Encarta complete listing makes four mistakes: Banting wasn't suggesting cutting fat; he was a making coffins, not cabinets; he wasn't a dietician, but mortician; and he published "Letter on Corpulence" in 1863, not 1864. (http://encarta.msn.com/dictionary_561538314/banting.html.)

[4] Eat Fat & Grow Slim, Dr. Richard Mackarness, A pocket book edition published in the U.S. January 1963, 1st printing – November 1962, Paper Books, Inc. (first printing in England – 1958)

[5] Above, p. 21

[6] Above, p. 23

[7] Above, p. 120

[8] Above, p. 23

[9] L'INTERNATIONALE, Original French Lyrics by Eugéne Pottier (1871). Music by Pierre Degeyter (1888)

[10] Dr. Atkins' Diet Revolution, Robert C. Atkins and Ruth West Herwood, 1972

[11] Dr. Atkins' New Diet Revolution, Robert C. Atkins, M.D., excerpted from front cover, 1992, hard cover 2nd edition

[12] "The author of the most successful weight loss book ever offers proof that 95% of overweight is a metabolic and not an eating disorder." – front cover, *Dr. Atkins' New Diet Revolution*, Robert C. Aktins, M.D., 1992, hard cover 2nd edition

[13] Obesity and weight gain are frequent, primary symptoms of Diabetes mellitus type 2 (non-insulin dependent), which, according to correct medical classification, is a *disorder of carbohydrate metabolism*.

[14] American Obesity Association, Health Effects of Obesity, http://www.obesity.org/subs/fastfacts/Health_Effects.shtml

[15] http://www.merck.com/mrkshared/mmanual/section1/chapter5/5a.jsp

[16] The Merck… http://www.merck.com/mrkshared/mmanual/section1/chapter5/5a.jsp

[17] USDA National Nutrient Database for Standard Reference, NDB No: 13230, 08060; http://www.nal.usda.gov/fnic/cgi-bin/list_nut.pl

[18] *Make That Steak a Bit Smaller, Atkins Advises Today's Dieters*, Marian Burros, The New York *Times*, January 18, 2004, http://www.nytimes.com/2004/01/18/nyregion/18DIET.html

[19] About Dr. Atkins, From Past to Present. http://atkins.com/about/dratkins/timeline.html

[20] American Heart Association Scientific Sessions 2003, "One Year Effectiveness of Atkins, Ornish, Weight Watchers and Zone Diets in Decreasing Body Weight and Heart Disease Risk." Michael Dansinger, MD, Tufts;

[21] Four Popular Diets All Work Well, U.S. Study Shows, Maggie Fox, Reuters, Sun Nov 9, 4:48 PM ET

[22] Eddie Murphy's overweight character in the movie "Nutty Professor"

[23] Cadaverine ($C_5H_{14}N_2$), from Latin *cadaver, dead body.* Formed by the carboxylation of amino acid lysine by bacteria (rotting). Extremely toxic.

[24] *Dr. Atkins' Diet Revolution*, Robert C. Aktins, M.D., p. 284, 1972

[25] By various accounts, the rate of undiagnosed sugar diabetes among overweight individuals ranges from 15% to 30%, particularly over the age of 40. If you regularly experience dry mouth, frequent night-time urination, excessive thirst or hunger, sudden weakness or fatigue, numbness of extremities, frequent irritation, insomnia—request that your doctor perform an Oral Glucose Tolerance test to screen out diabetes or pre-diabetes, following the protocol recommended by the American Diabetic Association. (http://www.diabetes.org/info/pre-diabetes.jsp). Simpler, less expensive and more effective blood tests are also available: HbA1c (glycosylated hemoglobin) and C-Reactive Protein (CRP). Consult your physician for details.