A Brave New World for Nutrition and Diabetes

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We are living in a brave new world of rapidly evolving health care systems. Corresponding to this is a parallel evolution in the strategies we use for providing guidance to people with diabetes, exemplified by the Clinical Practice Recommendations published yearly as a supplement to the January issue of *Diabetes Care*. These carry the status of position statements of the American Diabetes Association and are based on a combination of scientific evidence, expert consensus, and professional judgment. They serve as a guide for us in this brave new world by providing the rationale and scientific basis for clinical practice and clinical care decisions (or changes in such) not only for ourselves but also for non–diabetes focused colleagues, other health professionals, and administrators.

Nutrition continues to be one of the traditional cornerstones of treatment and self-management training for people with diabetes and serves as a prime example of this evolution. It wasn't so long ago that

- Patients with diabetes were admitted to the hospital for "diabetes regulation and education."
- Anyone with diabetes admitted to acute/long-term care facilities was assigned a "diabetic" diet (defined calorie level; set percentages of carbohydrate, fat, and protein; and no "simple sugars" or sweet desserts).
- "Sugar-free" candy bars and other foods without sucrose were specifically targeted to people with diabetes by a label statement: "Diabetics, this food may be useful in your diet on the advice of a physician . . ."

Now, because stays in acute-care facilities are as short as possible, almost all nutrition education and counseling (self-management training) for people with diabetes is done on an outpatient basis. We also now assure everyone that there is no "ADA diet" or "diabetic diet" as such, because the American Diabetes Association position statement *Nutrition Recommendations and Principles for People with Diabetes Mellitus* (1) provides us with the basis for individualization. That is, an individual nutrition assessment dictates a particular meal-planning macronutrient focus based on treatment goals related to blood glucose and lipid values, renal status, endogenous insulin production, and medications affecting carbohydrate metabolism. These recommendations also provide us with the justification for *not* excluding sucrose and other sweeteners in diabetic meal planning.

Each set of current Clinical Practice Recommendations is reviewed yearly by the American Diabetes Association's Professional Practice Committee, and minor revisions are made and published in the January supplement. An example of an update is the position statement on food labeling (2). The American Diabetes Association has long maintained that the statement on some food labels

> Diabetics: this product may be useful in your diet on the advice of a physician. This food is not a reduced calorie food.

is in direct opposition to its position that although specific nutrients may be recommended in greater or lesser amounts for all people (including those with diabetes), no specific food is inherently good or bad. The U.S. Food and Drug Administration agreed with the American Diabetes Association position and, as of 3 July 1996, revoked the authority to include the statement on food labels. The direct result of this change is that food manufacturers cannot use niche marketing to play off or build on the impressions of people with diabetes that they need special foods or that they cannot eat regular sweetened foods.

When a position is new or significantly revised, both the position and the technical review upon which it is based appear in *Diabetes Care*. In this issue, there is a new position statement and a technical review on translation of the diabetes nutrition recommendations for health care institutions (3,4). They have the potential to affect not only readers of this journal and members of the Association, but also every hospital and long-term care facility in the U.S. The position statement offers a number of suggestions for applying the current nutrition recommendations in a different setting: health care facilities providing group feeding programs (hospitals, residential care for younger adults or the elderly, rehabilitation facilities).

Why is this new position needed? The current nutrition recommendations are specifically meant for individuals in home environments who are, in conjunction with a team of health professionals, self-managing their diabetes. When people with diabetes are admitted to an institutional setting, it is usually not because of diabetes, but because of other conditions or complications related or unrelated to diabetes. In these situations, they delegate much or all of this self-management responsibility to health professionals and other members of the staff. In terms of food, this means being provided some kind of designated set of meals at set times during the day.

Since there is now no such thing as a "diabetic diet," what are group feeding facilities to do? One option that makes intuitive sense is an old concept in a new guise: consistent carbohydrate. Here, the major focus is on the *amount* of carbohydrate, which is predetermined for each meal and then kept consistent for that meal from day to day. While there are no designated calorie levels with specific percentages of carbohydrate, protein, and fat in this system, it does not mean a free-for-all, anything-goes tray of foods served to the

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Received and accepted for publication 8 October 1996.

person with diabetes, nor does it mean a "no concentrated sweets diet." It still means that meals offered should be based on the "healthy diet" principle: dietary fats, especially saturated fats, should be limited, and protein should not be excessive. It also reinforces the scientific evidence that the amount of carbohydrate deserves the most attention in diabetic meal planning while the *source* of carbohydrate (sugar packets, juice, potatoes, bread, beans, desserts) can vary and has little priority. More specific information about the consistent carbohydrate concept can be found in the new American Diabetes Association and The American Dietetic Association publication *Diabetes Medical Nutrition Therapy: A Guide to Management and Nutrition Education Resources* (5).

Providing meals this way relieves the burden on the health care team of trying to individualize, especially in terms of calories, when it is not practical (e.g., during a short stay). It is easy to adjust meals for individuals with type I diabetes by providing extra (or fewer) carbohydrate servings and snacks as needed. It also makes sense in terms of cost efficiency for food preparation and food service and may enhance patient satisfaction.

After reading the position statement and technical report, think about the institution(s) you are affiliated with and what/how meals are served to patients with diabetes. Are changes needed? Each health care facility needs to consider its unique situation based on local factors, including patient satisfaction, budgetary costs, and food service worker time, before determining the best method of implementing the current diabetes nutrition recommendations. Share this information with colleagues who may not receive this journal, because it takes a team effort to implement changes (if needed) and change outdated policies and procedures.

References

1. American Diabetes Association: Nutrition recommendations and principles for people with diabetes mellitus (Position Statement). *Diabetes Care* 20 (Suppl. 1):S14–S17, 1997
2. American Diabetes Association: Food labeling (Position Statement). *Diabetes Care* 20 (Suppl. 1):S33–S34, 1997
3. American Diabetes Association: Translation of the diabetes nutrition recommendations for health care institutions (Position Statement). *Diabetes Care* 20:106–108, 1997
4. American Diabetes Association: Translation of the diabetes nutrition recommendations for health care institutions (Technical Review). *Diabetes Care* 20:96–105, 1997
5. Pastors G, Holler H (Eds.): *Diabetes Medical Nutrition Therapy: A Guide to Management and Nutrition Education Resources*. Chicago, The American Dietetic Association, 1997