

Dietary Approaches, Therapeutic Diets & Evidence Based Diet Selection Course

6 Month Comprehensive Professional Course

COURSE POSITIONING

A comparative professional course designed to help nutrition and dietetics learners understand major dietary approaches through a consistent clinical framework. Participants study what each diet includes, its physiological rationale, potential advantages, disadvantages, nutrient concerns, evidence quality, appropriate applications, contraindications, sustainability, cultural fit, monitoring needs and professional boundaries. The goal is not to promote one diet as universally superior, but to develop objective diet selection and modification skills.

The Course Moves Participants Away From

Common Approach

Professional Direction

Which diet is the healthiest?

Compare adequacy, evidence, clinical context, patient preference and sustainability.

A diet worked for someone, so it works.

Separate testimonials from controlled evidence and actual clinical outcomes.

More restriction means better results.

Assess whether exclusions create benefit, burden or nutritional risk.

Every disease has one fixed diet.

Individualize therapeutic nutrition according to diagnosis, laboratory findings, symptoms and nutrition diagnosis.

The dietitian should recommend the diet they personally prefer.

Use objective evidence and shared decision making rather than dietary ideology.

Advantages prove that a diet is safe for everyone.

Evaluate advantages and disadvantages together, including contraindications and monitoring needs.

Core Learning Pathway

Understand Diet Categories > Compare Evidence > Assess Nutritional Adequacy > Evaluate Advantages > Identify Disadvantages > Recognize Contraindications > Adapt to Culture and Lifestyle > Protect Psychological Safety > Apply Therapeutic Diets > Monitor Outcomes > Document Through ADIME > Defend Diet Selection

Standard Diet Evaluation Framework

Evaluation Area

Professional Question

Definition

What does this diet actually mean?

Food Pattern

Which foods are included, limited or excluded?

Physiological Rationale

What mechanism is proposed and is it biologically plausible?

Evidence

What outcomes are supported, for whom and for how long?

Potential Advantages

What clinical, nutritional or practical benefits may occur?

Potential Disadvantages

What nutritional, behavioral, financial or social burdens may occur?

Nutritional Adequacy

Which macro and micronutrients require attention?

Clinical Application

Where may this approach have a legitimate therapeutic role?

Contraindications

Who may require avoidance, medical review or closer monitoring?

Sustainability

Can the person maintain the pattern without nutritional deterioration?

Cultural Adaptation

Can the approach fit familiar foods and religious requirements?

Cost and Access

Are appropriate foods, products or supplements realistically accessible?

Eating Behavior

Could restriction worsen food fear, binge restrict cycles or eating

disorder risk?

Monitoring

Which symptoms, intake variables, anthropometry or laboratory markers should be reassessed?

Professional Decision

Recommend, modify, monitor, discontinue or refer?

Course Roadmap

Month

Main Focus

Month 1

Foundations of Dietary Patterns, Evidence & Diet Comparison

Month 2

Plant Based, Vegetarian, Vegan, Mediterranean & DASH Approaches

Month 3

Low Carbohydrate, Ketogenic, High Protein, Paleo, Animal Based & Carnivore Diets

Month 4

Weight Loss, Fasting, Meal Replacement & Popular Commercial Diets

Month 5

Therapeutic, Elimination, GI & Disease Specific Diets

Month 6

Cultural, Religious, Lifestyle Diets, ADIME & Advanced Diet

Selection

MONTH 1 | Foundations of Dietary Patterns, Evidence & Diet Comparison

Before comparing diets, understand what makes a dietary approach nutritionally and clinically appropriate.

Week

Focus

Learning Content

Practical Application

Week 1

What Is a Diet?

Dietary pattern. Therapeutic diet. Medical nutrition therapy. Elimination diet. Religious dietary framework. Ethical dietary pattern. Weight loss diet. Commercial diet. Fad diet. Short term therapeutic protocol. Distinguish a Mediterranean pattern, low FODMAP protocol, vegan pattern, halal framework and ketogenic therapy rather than treating every diet as the same type of intervention.

Classify twenty named diets into dietary pattern, therapeutic protocol, religious framework, ethical pattern, commercial plan or fad diet.

Week 2

How to Compare Diets Scientifically

Randomized controlled trials. Observational studies. Systematic reviews. Meta analyses. Short and long term outcomes. Adherence. Dropout. Confounding. Weight loss independent effects. Mechanistic claims. Testimonials. Social media evidence. Surrogate

outcomes versus patient important outcomes.

Take a claim such as Diet X reverses insulin resistance and determine what the evidence actually supports.

Week 3

Nutritional Adequacy & Diet Quality

Energy. Protein. Carbohydrate. Fat. Fiber. Iron. Calcium. Vitamin B12. Vitamin D. Folate. Zinc. Iodine. Omega 3. Potassium. Sodium. Food variety. Food processing. Fortification. Supplementation. Bioavailability.

Score different diets for adequacy without using the diet label as a shortcut.

Week 4

How Dietitians Select a Dietary Approach

Medical condition. Nutritional status. Age. Pregnancy. Medication. Weight goal. Body composition. GI function. Food preference. Culture. Religion. Budget. Cooking ability. Lifestyle. Eating disorder history. Sustainability. Clinical monitoring.

Choose between several possible dietary approaches for the same diagnosis and justify the decision.

Month 1 Development Outcome

Move from asking which diet works best toward asking which dietary strategy fits this specific patient, clinical goal and risk profile.

MONTH 2 | Plant Based, Vegetarian, Vegan, Mediterranean & DASH Approaches

Plant predominant diets can be nutritionally strong, but the label alone does not guarantee adequacy.

Week

Focus

Learning Content

Practical Application

Week 5

Mediterranean & DASH Diets

Mediterranean principles: vegetables, fruit, whole grains, legumes, nuts, olive oil, fish, moderate animal foods and low reliance on processed meat. DASH principles: fruit, vegetables, whole grains, legumes, nuts, low fat dairy and sodium control. Compare cardiometabolic evidence, flexibility and cultural adaptation.

Translate Mediterranean and DASH principles into South Asian and Middle Eastern food patterns without replacing the cuisine.

Week 6

Vegetarian, Flexitarian & Pescatarian Diets

Lacto vegetarian. Ovo vegetarian. Lacto ovo vegetarian. Flexitarian. Pescatarian. Protein quality. Iron. Vitamin B12. Calcium. Iodine. Omega 3. Food variety. Ethical and environmental motivations.

Design several vegetarian variants of the same prescription and compare nutrient concerns.

Week 7

Vegan & Whole Food Plant Based Diets

Vegan versus whole food plant based. Protein. Vitamin B12. Iron. Calcium. Vitamin D. Iodine. Zinc. Selenium. Omega 3. Choline. Fortified foods. Plant milks. Soy foods. Supplementation.

Build a nutritionally complete vegan day and identify which nutrients require reliable fortified foods or supplementation.

Week 8

Raw Vegan, Macrobiotic & Plant Based Myths

Raw vegan and macrobiotic restriction. Energy density. Protein. Micronutrient risk. Food safety. Plant protein myths. Soy claims. Antinutrients. Lectins. Oxalates. Seed oil claims. Plant based automatically equals healthy.

Compare a well planned vegan diet with a highly restrictive raw vegan diet and explain why greater restriction does not equal greater benefit.

Month 2 Development Outcome

Move from vegan is deficient or vegan is automatically healthy toward precise nutrient assessment, evidence appraisal and individualized planning.

MONTH 3 | Low Carbohydrate, Ketogenic, High Protein, Paleo, Animal Based & Carnivore Diets

Understanding a restrictive diet does not mean endorsing it.

Week

Focus

Learning Content

Practical Application

Week 9

Low Carbohydrate & Very Low Carbohydrate Diets

Definitions vary. Moderate carbohydrate reduction. Low carbohydrate. Very low carbohydrate. Glycemic control. Appetite. Weight loss. Triglycerides. Fiber. Whole grains. Fruit. Fat quality.

Diabetes medication context.

Compare a high quality low carbohydrate diet with one based mainly on processed meat, butter and cheese.

Week 10

Ketogenic Diets

Nutritional ketosis. Very low carbohydrate intake. Popular weight loss keto versus therapeutic ketogenic diet for selected neurological conditions. Electrolytes. Fiber. Micronutrients. GI effects. Lipid response. Diabetes medication risk.

Differentiate medical ketogenic therapy from commercial keto and identify when specialist supervision is required.

Week 11

High Protein & Paleo Diets

Protein and satiety. Muscle preservation. Sports and weight management. Risk of displacing fiber rich foods. Renal context. Paleo emphasis on meat, fish, eggs, vegetables, fruit and nuts with exclusion of grains, legumes and often dairy.

Evaluate whether the exclusions in a paleo plan provide actual benefit or unnecessary nutritional burden.

Week 12

Animal Based & Carnivore Diets

Animal based patterns are poorly standardized. Strict carnivore. Meat and eggs. Meat and dairy. Lion diet. High protein. Fiber absence. Food variety. Potential micronutrient gaps. GI symptoms. LDL response. Eating rigidity. Limited long term evidence.

Assess a real world carnivore food recall objectively and identify risks, monitoring priorities and possible safer modifications.

Month 3 Development Outcome

Move from carnivore is amazing or carnivore is dangerous toward objective evaluation of evidence, nutritional risk, patient motivation and professional scope.

MONTH 4 | Weight Loss, Fasting, Meal Replacement & Popular Commercial Diets

A diet can create short term weight loss without its proposed mechanism being correct.

Week

Focus

Learning Content

Practical Application

Week 13

Intermittent Fasting & Time Restricted Eating

12:12. 14:10. 16:8. 18:6. 5:2. Alternate day fasting. Energy intake. Hunger. Adherence. Protein distribution. Training. Medication. Eating disorder risk. Distinguish meal timing from calorie reduction.

Compare fasting and non fasting strategies that create a similar energy deficit and identify who may prefer each.

Week 14

OMAD & Prolonged Fasting

One meal a day. Nutrient adequacy. Large meal burden. Protein distribution. GI tolerance. 24 hour, 36 hour, 48 hour and multiple day fasting. Dehydration, electrolyte and refeeding concerns.

Evaluate why a fasting protocol may appear effective while still

being clinically inappropriate.

Week 15

Meal Replacement & Very Low Energy Approaches

Partial meal replacement. Total diet replacement. Very low energy diets. Commercial shakes. Structured clinical programs. Nutritional completeness. Lean mass. Transition back to food. Weight recurrence. Medical monitoring.

Compare nutritionally complete clinical meal replacement with an unregulated commercial shake plan.

Week 16

Commercial, Social Media & Fad Diets

Military diet. GM diet. Cabbage soup diet. Egg diet. Fruitarian diets. Juice cleanses. Detox diets. Alkaline diet. Blood type diet. Food combining. Clean eating. Viral elimination challenges.

Explain why a fad diet may produce weight loss while its advertised mechanism remains unsupported.

Month 4 Development Outcome

Move from it caused weight loss so the diet must be scientifically correct toward separating energy balance, adherence, water change and evidence from marketing claims.

MONTH 5 | Therapeutic, Elimination, GI & Disease Specific Diets

A therapeutic diet requires an indication, structured implementation and reassessment plan.

Week

Focus

Learning Content

Practical Application

Week 17

Gluten Free Diet

Celiac disease. Wheat allergy. Nonceliac gluten related symptoms. Voluntary gluten avoidance. Cross contact. Label reading. Fiber. B vitamins. Iron. Cost. Food variety.

Differentiate medically required gluten avoidance from unnecessary gluten restriction.

Week 18

Low FODMAP Diet

Assessment. Restriction. Reintroduction. Personalization. IBS symptom management. Fiber and calcium concerns. Microbiome considerations. Food fear. Long term liberalization.

Build the complete restriction to reintroduction pathway rather than leaving a patient permanently restricted.

Week 19

Elimination, Allergy & Dairy Free Diets

Cow milk elimination. Egg allergy. Nut allergy. Soy elimination. Wheat elimination. Multiple food allergy. Eosinophilic GI disease concepts. Replacement of removed nutrients. Growth and caregiver burden.

Remove an allergen while deliberately replacing the protein, calcium, vitamin or energy contribution that food previously provided.

Week 20

Disease Specific Dietary Approaches

Renal nutrition. Cardiac diets. Diabetes meal patterns. Low sodium. Fluid restriction. Potassium and phosphorus modification. Texture modified diets. Low residue concepts. Pancreatic and fat modified approaches. No universal renal, diabetic or liver diet.

Compare two patients with the same diagnosis but different laboratory findings and show why their diets should differ.

Month 5 Development Outcome

Move from every disease has a diet sheet toward individualized therapeutic nutrition based on actual clinical and nutrition assessment.

MONTH 6 | Cultural, Religious, Lifestyle Diets, ADIME & Advanced Diet Selection

The correct dietary approach must fit nutritional needs, medical safety, culture, values and real life.

Week

Focus

Learning Content

Practical Application

Week 21

Halal, Kosher, Hindu & Jain Dietary Practices

Halal and haram concepts. Kosher principles. Hindu and Jain dietary variation. Religious vegetarianism. Religious fasting. Ingredient verification. Gelatin. Enzymes. Supplements. Clinical formulas. Respect patient interpretation and refer theological questions where appropriate.

Review a hospital nutrition prescription for religious compatibility

without confusing religious permissibility with nutritional quality.

Week 22

Cultural Dietary Patterns

South Asian. Middle Eastern. Mediterranean. East Asian. African. Western. Latin American food patterns. Traditional staples, cooking methods, food availability and culturally familiar substitutions.

Modify roti, rice, daal, curries, biryani, kebabs and regional staples for a clinical goal rather than replacing them with unfamiliar diet foods.

Week 23

Sustainable Diets, Processing & Dietary Identity

Local foods. Seasonality. Food waste. Plant diversity. Environmental concerns. Whole foods. Processed and ultra processed foods. Ethical veganism. Dietary identity. Restrictive eating. Orthorexic behavior. ARFID and eating disorder screening.

Distinguish ethical, religious and medical food restriction from fear based or psychopathology driven restriction.

Week 24

ADIME, Advanced Diet Comparison & Case Defense

Integrate diet type, reason for choice, foods included and excluded, energy, protein, fiber, fat quality, micronutrients, supplements, medical condition, medications, culture, religion, budget, food skills, eating disorder risk, nutrition diagnosis, intervention and monitoring.

Defend four contrasting cases and justify why the selected dietary approach is appropriate, what its disadvantages are and what alternatives were considered.

Month 6 Development Outcome

Move from recommending the diet you prefer toward defending an individualized diet choice through evidence, nutrition assessment, patient values and monitoring.

Core Diet Comparison Portfolio I

Dietary Approach

Potential Advantages

Potential Disadvantages or Limitations

Professional Note

Mediterranean

Strong cardiometabolic evidence. High plant diversity. Flexible.

May require cultural adaptation. Energy intake and portions still matter.

Translate principles rather than copying a Mediterranean menu.

DASH

Strong blood pressure evidence. Nutrient dense.

Lower sodium pattern may be difficult for some. Potassium may need adjustment in selected renal cases.

Adapt to renal status and cultural food pattern.

Omnivorous

Broad food choice and easy access to many nutrients.

Quality varies greatly. Can be low fiber and high in sodium, saturated fat or processed meat.

Do not assume adequacy simply because all food groups are allowed.

Flexitarian

Flexible. Can increase plant diversity while retaining animal nutrient sources.

Definition is inconsistent and quality depends on replacements.

Assess what actually replaced meat.

Pescatarian

Plant predominant with fish derived protein and omega 3 opportunities.

Seafood cost, availability and mercury selection may matter.

Assess total plant quality and seafood choice.

Vegetarian

Can support plant diversity and fiber while allowing eggs or dairy depending on subtype.

Iron, B12, omega 3 or protein may need attention depending on subtype.

Classify the vegetarian pattern first.

Vegan

Can be high in fiber and plant diversity and align with ethical values.

Reliable B12 provision is essential. Calcium, vitamin D, iodine, iron, zinc and omega 3 require planning.

Assess fortification and supplementation, not just food variety.

Whole Food Plant Based

High fiber and minimally processed plant foods.

Can become excessively restrictive if interpreted rigidly.

Whole food plant based and vegan are not identical labels.

Raw Vegan

High fruit and vegetable exposure.

Very restrictive. Energy, protein and micronutrient adequacy can be difficult. Food safety concerns may arise.

Extra caution in children, pregnancy, older adults and underweight.

Low Carbohydrate

May help selected people with glycemic control, appetite and triglycerides.

Fiber and food diversity may fall. Quality of fat and protein sources varies.

Define the actual carbohydrate level and food pattern.

Ketogenic

Established therapeutic role in selected epilepsy. May help selected adults with weight or glycemic goals.

Restrictive. GI effects, nutrient concerns, lipid changes and medication issues require monitoring.

Medical ketogenic therapy is not the same as commercial keto.

High Protein

Can support satiety and lean mass preservation.

May displace fiber rich foods and requires renal context.

More protein does not automatically create more muscle.

Core Diet Comparison Portfolio II

Dietary Approach

Potential Advantages

Potential Disadvantages or Limitations

Professional Note

Paleo

May reduce ultra processed food intake and emphasize whole foods.

Excludes grains, legumes and often dairy without universal medical indication.

Evaluate whether exclusions produce real benefit.

Animal Based

Can provide protein, B12, iron and zinc.

Poorly standardized. Often low in plant diversity and may be high in saturated fat.

Clarify what animal based means for that patient.

Carnivore

Simple food rules and high protein intake.

Very restrictive, little or no fiber, potential nutrient gaps, GI concerns and limited long term evidence.

Understand and risk assess without presenting it as standard therapy.

Intermittent Fasting

Simple timing structure and may reduce energy intake.

Hunger, inadequate intake, binge restrict cycles and medication concerns in some people.

Not automatically superior to other sustainable energy reduction.

OMAD

Simple schedule.

Difficult nutrient adequacy, poor protein distribution and large meal burden.

Assess whether requirements can realistically be met.

Meal Replacement

Structured energy control and convenience.

Cost, monotony, lean mass concerns and transition back to food.

Differentiate nutritionally complete programs from ordinary shakes.

Gluten Free

Essential treatment for celiac disease and appropriate in selected conditions.

Higher cost, lower fiber or micronutrient intake if poorly planned.

No automatic health advantage without indication.

Low FODMAP

Useful symptom strategy for selected IBS patients.

Restrictive and not intended as permanent elimination.

Teach reintroduction and personalization.

Elimination Diet

Can identify or manage medically relevant food triggers.

Risk of deficiencies, food fear and unnecessary long term restriction.

Every removed food requires a replacement strategy and

reassessment.

Dairy Free

Necessary in selected allergies or preferences.

Calcium, iodine, protein, B12 and vitamin D may require alternatives.

Differentiate milk allergy, lactose intolerance and preference.

Halal

Supports religious compatibility and patient trust.

Does not by itself define nutritional quality. Product verification may be needed.

Ask about individual interpretation rather than assume.

Kosher

Supports religious compatibility.

Ingredient and food preparation requirements may affect options.

Clinical products may require verification.

Detox or Cleanse Diet

May temporarily reduce some processed food or alcohol intake.

Detox claims are unsupported. Restriction, low protein and inadequate energy may occur.

Address the desired health goal with evidence based nutrition instead.

Alkaline or Blood Type Diet

May encourage attention to food choice.

Proposed mechanisms are unsupported or misleading.

Separate any useful food changes from unsupported theory.

Clean Eating

Can encourage home cooking and minimally processed foods.

May become rigid, moralized and psychologically unsafe.

Screen for food fear and orthorexic patterns.

Professional Competency Portfolio

Competency

Expected Skill

Diet Classification

Distinguish dietary patterns, therapeutic protocols, religious frameworks, ethical patterns, commercial programs and fad diets.

Evidence Appraisal

Judge the strength, duration and applicability of evidence rather than relying on mechanisms or testimonials.

Advantages

Describe realistic potential benefits without overselling them.

Disadvantages

Identify nutrient, behavioral, financial, social and clinical limitations.

Nutrient Adequacy

Assess energy, protein, fiber, fat quality and micronutrients according to the actual food pattern.

Contraindications

Recognize when a diet is inappropriate, needs medical review or requires specialist supervision.

Supplementation

Use supplements and fortified foods according to actual need and professional scope.

Cultural Adaptation

Translate dietary principles into familiar foods rather than imposing a foreign menu.

Religious Adaptation

Respect halal, kosher and other dietary practices while maintaining clinical care.

Eating Disorder Safety

Recognize when therapeutic or ethical restriction overlaps with pathological restriction.

Clinical Adaptation

Modify a preferred dietary pattern around disease rather than automatically abandoning it.

Monitoring

Define what symptoms, intake, anthropometry and laboratory markers need reassessment.

ADIME

Document dietary approach selection through professional nutrition care process reasoning.

Case Defense

Defend why a specific diet was selected, modified, discouraged or discontinued.

Advanced Case Portfolio

Case

Required Decision

Obesity

Compare Mediterranean, lower carbohydrate, fasting and structured energy reduction options.

Type 2 Diabetes

Assess carbohydrate modification, Mediterranean pattern, medication context and sustainability.

Hypertension

Compare DASH, Mediterranean and culturally adapted sodium reduction.

IBS

Determine whether low FODMAP is indicated and build reintroduction.

Celiac Disease

Create a nutritionally complete gluten free pattern.

CKD

Adapt the chosen food pattern according to actual potassium, phosphorus, protein and fluid needs.

Vegan Pregnancy

Protect B12, iron, calcium, vitamin D, iodine, omega 3, protein and energy.

Athlete

Compare high protein, plant based, mixed and lower carbohydrate approaches around performance needs.

Carnivore Patient

Identify evidence limitations, nutrient risks, biomarkers, GI concerns and readiness for change.

Halal Clinical Patient

Adapt disease specific nutrition to religious and cultural needs.

Eating Disorder Risk

Recognize when diet selection is being used to justify severe restriction.

Keto Request

Determine whether benefit, risk, medication and sustainability justify use.

Intermittent Fasting Request

Assess nutrition adequacy, eating behavior, medications and schedule.

Multiple Restrictions

Prevent cumulative deficiency when medical, ethical and religious restrictions overlap.

Final Case Defense

Compare at least three plausible approaches and defend the final selection.

Professional Scope Integration

Situation

Dietitian Responsibility

Therapeutic Diet

Use an evidence based indication, individualized prescription and reassessment plan.

Popular Diet

Understand the pattern and claims before recommending or discouraging it.

Medication Interaction

Recognize when diet changes require medical or prescribing review.

Diabetes Medication

Do not independently alter medication doses outside authorized scope.

Kidney Disease

Base restrictions on stage, laboratory findings, dialysis status and clinical context rather than generic renal lists.

Ketogenic Therapy for Epilepsy

Use specialist protocols and multidisciplinary monitoring.

Food Allergy

Work from established diagnosis and replace excluded nutrients.

Religious Diet

Respect patient interpretation and refer theological questions when needed.

Eating Disorder

Avoid reinforcing unnecessary restriction and refer within appropriate specialist pathways.

Fad Diet Claims

Correct misinformation without shaming the patient.

Supplements

Assess evidence, dose, need and safety within professional scope.

Complex Disease

Collaborate with the relevant medical team when risk extends beyond dietetic management.

Expected Professional Transformation

At Entry

At Completion

Which diet is healthiest?

I compare adequacy, evidence, risk, sustainability and individual context.

Keto is good for diabetes.

I assess potential benefit, medication, nutrition risk and sustainability before considering carbohydrate restriction.

Vegan is healthier.

I assess the actual foods, fortification, supplements and nutrient adequacy rather than the label.

Carnivore is unhealthy.

I can explain specific evidence limitations, nutrient concerns and monitoring priorities professionally.

Intermittent fasting boosts metabolism.

I distinguish meal timing from energy restriction, adherence and actual outcomes.

Mediterranean is the best diet.

I understand its evidence and can translate its principles into different cultures.

Gluten free is healthier.

I know when gluten avoidance has a clinical indication and when it adds unnecessary restriction.

Low FODMAP treats IBS.

I understand structured restriction, reintroduction and personalization.

Halal is a healthy diet.

I distinguish religious permissibility from nutritional quality.

Every disease has one diet.

I individualize therapeutic nutrition according to assessment and nutrition diagnosis.

If a diet causes weight loss, its theory is correct.

I separate energy balance and adherence from unsupported mechanisms.

I recommend the diet I prefer.

I defend diet selection through evidence, patient goals, nutritional adequacy and monitoring.

Final Learning Pathway

Learning Step

Learning Step

Classify Dietary Approaches

Understand Evidence Hierarchy

Assess Diet Quality

Assess Nutritional Adequacy

Identify Potential Advantages

Identify Potential Disadvantages

Recognize Contraindications

Evaluate Sustainability

Adapt to Culture

Respect Religious Requirements

Assess Cost and Access

Screen Eating Behavior

Compare Plant Based Patterns

Compare Mediterranean and DASH

Compare Low Carbohydrate and Keto

Evaluate High Protein and Paleo

Evaluate Animal Based and Carnivore

Compare Fasting Approaches

Understand Meal Replacement

Critically Appraise Fad Diets

Apply Gluten Free Nutrition

Apply Low FODMAP Correctly

Manage Elimination Diets

Individualize Disease Specific Diets

Monitor Outcomes

Develop Nutrition Diagnosis

Apply ADIME

Defend Advanced Diet Selection

In One Line

This course develops nutrition professionals who can objectively compare major dietary approaches, understand their potential advantages and disadvantages, evaluate evidence and nutrient adequacy, recognize clinical risks and contraindications, and select or modify dietary strategies according to the individual rather than promoting one diet as universally superior.

Final Course Standard

Every diet recommendation should answer five questions: Why this approach? What potential advantage is expected? What disadvantage or risk must be managed? How will adequacy and safety be monitored? What alternative approach could also meet the same clinical goal?