UNITED STATES
DEPARTMENT OF AGRICULTURE

IN RE:)
)
DIETARY GUIDELINES ADVISORY)
COMMITTEE MEETING)

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DIETARY GUIDELINES ADVISORY)
COMMITTEE MEETING)

Waugh Auditorium
1800 M Street, N.W.
Washington, D.C.

Tuesday,
September 7, 1999

The meeting in the above-entitled matter commenced,

pursuant to notice, at 8:55 a.m.

APPEARANCES:

Advisory Committee Members:
CUTBERTO GARZA, CHAIRMAN
RICHARD J. DECKELBAUM
JOHANNA T. DWYER
SCOTT M. GRUNDY
RACHEL K. JOHNSON
SHIRIKI K. KUMANYIKA
ALICE H. LICHTENSTEIN

SUZANNE P. MURPHY
MEIR J. STAMPFER
LESLEY FELS TINKER
ROLAND L. WEINSIER

Advisory Committee Staff:
SHANTHY BOWMAN
CAROLE DAVIS
ALYSON ESCOBAR
JOAN LYON
KATHRYN MCMURRY
CAROL SUITOR

Also Present:
EILEEN KENNEDY
SHIRLEY WATKINS

PROCEEDINGS

DR. GARZA: We are going to start. We expect Dr. Grundy to come in, but given the time schedule I am concerned about trying to start on time.

I do not have very many introductory remarks other than to refer the committee to my letter to you in the handout, which outlines at least the work that is before us today. As everyone knows, we planned for this to be our final committee meeting, although certainly we will continue trying to work either in subgroups or whatever as we bring this to conclusion.

We are going to move then to what has been called either the adequacy or the variety or the pyramid guideline. This has certainly turned out to be not as straightforward as I think many of us originally thought. We said well, the first one is going to be the most direct and straightforward one.

As usual, I do not know whether it was W.C. Fields or who was the journalist in Baltimore, the one that used to write for the Sun?

DR. KUMANYIKA: Menkin.

DR. GARZA: Menkin. Thank you. Who used to say that confidence was the feeling before you understood the problem. Perhaps that is what we all had was a little bit of confidence before we understood the problem.

Somebody who I am confident understands the problem is Suzanne. Suzanne?

(Pause.)

DR. MURPHY: Thank you and good morning. I am afraid I was not any wiser than the rest of the group because I thought when I volunteered to take the "variety" guideline I had chosen by far the easiest, least controversial guideline, so this was a wake up call for me, as well as everybody, I guess.

We do have some issues to resolve this morning on this particular guideline. As you may have been able to tell, at least the committee members, we could not even decide what to call it in the agenda. We go around from variety to adequacy to pyramid, and I am hoping that in the next hour we will at least decide what we want to call this guideline.

Dr. Garza has asked us to focus on a couple or actually three specific topics, and I guess in

focus it would be even better. The first was to think a little bit about where there is substantive agreement. Now, when I did this overhead I did not have everybody's comments. Some have come in since I did this.

You may wish to correct me on what I felt we had substantive agreement on, but I had summarized three points. First of all, the focus of the guidelines should shift away from variety, and I think there is pretty unanimous agreement at least within the committee that this is so. I am going to take a minute in a minute to review why we felt this was the correct direction to shift away from variety.

There is probably less agreement on what we should shift to, but by the end of the last meeting at least we had come to some consensus on shifting towards something that focused more on the food guide pyramid.

There was again several steps in the logic of what we should shift to. They centered on ways to help consumers better understand nutritional adequacy and also some concerns about over consumption that went with the concept of variety.

The second thing that I felt we had agreed on was to increase the emphasis on plant foods; not to the exclusion of animal products, but to focus more than had been done in 1995 on plant food, and the third thing was to have an increased emphasis on ways to adapt the recommendations of the pyramid, if you will, to different cultural preferences, including preferences for people who did not consume either dairy products or meat products.

The important thing to remember is that the text of this particular guideline is essentially very similar to the 1995 text. The controversy is over the wording of the guideline itself. I think we are all agreed that the content we were fairly comfortable with from 1995, but how did the guideline itself get worded?

I want to just quickly review for you the three lines of evidence that supported the change in the wording of the guideline that we proposed at the last meeting. We all agreed that we wanted this guideline to help consumers insure that they chose diets that were nutritionally adequate, and our concern about variety was that clearly variety across the food groups, if you will across the pyramid food groups, is associated with better nutritional adequacy.

That does not seem to be a controversy at all. You can show that people whose diets conform to the recommendations of the food guide pyramid tend to have more nutritionally adequate diets. There are papers that support that, and you may recall we did some of own analyses. Although we cannot cite those because they are unpublished, they at least

reassured us that things had not changed, that indeed nutritional adequacy is increased if people have variety across the major food groups.

However, again looking at the literature and looking at our own analyses, we found that variety within food groups, with the exception of the fruit and vegetable group, the variety otherwise within food groups did not appear to increase nutritional adequacy.

Finally, we considered that the food guide pyramid by its very design and by all the work and all the science that has gone into it and all the publications that support it, it is designed to insure nutritional adequacy, so there were several lines of reasoning that took us away from variety and towards the food guide pyramid.

Now, I wanted to briefly address a concern that several of the people who sent us comments had and that is that the dietary guidelines are supposed to drive the food guide pyramid. This is something we have discussed before, you know, the chicken and the egg sort of thing. If the pyramid is based on the guidelines, how can we incorporate the pyramid into the guidelines?

Again to remind everyone, we have talked to the people at USDA. It does not look like anything we are saying in this revision of the guideline would have an impact on the current food guide pyramid. What it does look like to me might happen is in the next five years if the DRIs change, if there is some major change in a DRI that we do not at this time know about, that indeed might change the structure of the food guide pyramid.

Whether that could possibly happen on a time line that includes from now until the next committee meets is a question, but I think it is very unlikely, and the people I have talked to also think it is very unlikely, so for the purposes of this round of the guidelines I do not feel that that is of concern that the pyramid is going to change right away and, therefore, somehow we cannot incorporate it into the guideline. Indeed, the 1995 committee incorporated it into the guideline, and I would like to feel comfortable and I would like to have the committee feel comfortable with the same concept here.

Nutritional adequacy was our first line of evidence for the shift. The second line of evidence was our concern that variety was associated with an increased energy intake, and this again is variety as a total concept overall without any further definition.

Although we have not talked about it very much because we do not really go back in history a great deal, it has been known for a long time that if you do laboratory experiments with a meal and you give people a variety of foods on a plate or you give people their favorite food on a plate, equal caloric amounts or equal opportunities to eat, people will eat more of a

variety of foods. This goes back to some of Barbara Rolls' work and well-accepted, laboratory based work.

On the other hand, there has also been lines of evidence published that show variety in a cross sectional examination of intakes is also associated with increased energy intake. There have been a series of papers showing that, and again our own analyses showed a strong correlation of this concept of broad variety with energy intake.

And then finally, a third piece of evidence, but by no means the only piece of evidence, is a recent paper by McCurry and her co-authors that showed for some food groups variety is indeed associated with increased body fatness. To put it in perspective, remember that this paper came out after we had abandoned the concept of variety. This was not the paper that drove our thinking. This was, if you will, another piece of evidence that was added to the base that we already felt was very convincing.

I have serious concern that the concept of variety may indeed be contributing to over consumption by Americans, and when I come back down to the one thing that worries me the most, it is this concern that we are somehow causing harm by encouraging variety.

The final line of evidence that we considered was the focus group results. Of course, we only had the results of the first or the earlier focus groups until this meeting. Now we have another set of focus group findings, and I am going to talk about those in a little more detail, but you remember the reaction from the original focus group, the focus groups we considered at our first meeting, was that although a few respondents perceived this guideline as less important than the others, most had no objection. In other words, it did not offend anybody.

On the other hand, many people felt the guideline allows people to eat foods that may not be considered healthy choices. There were several comments that said well, now I have my cookies, and now I need my cake and my pie and things like that. There was again a lot of concern by all of us that we were not communicating well to consumers when we said eat a variety of foods.

Now we have indeed more consumer reaction, and in general people thought our new wording was too long and too confusing, but they did say that the pyramid was the most useful part of the guideline, so people seemed to like the pyramid, but they did not like our guideline.

Now, here is the guideline as it currently stands. At the end of our last meeting we agreed to say "Adapt the pyramid to plan your healthful eating pattern." I summarized some of

the consumer reaction to that. It was not very good. They liked "Eat a variety of foods" better. They thought it was clearer. The new guideline is too long and too confusing. They prefer "Use the pyramid" to "Adapt the pyramid." Again, people did not understand what we meant by adapt.

There was a mixed reaction to the word plan, and also the word shape was tested. "Adapt the pyramid to shape your healthful eating pattern." Some people liked those words, and some people did not. A generally negative reaction to the word healthful, but again at the very end many said the pyramid was the most useful part of all the guidelines.

So, I would like to stop here a minute. I will address the other two issues that Dr. Garza asked us to address, but I think we should talk about the wording of the pyramid itself before we get into fine tuning or doing anything else to the wording of the text. Is that acceptable?

DR. GARZA: Sure. Any questions or comments perhaps?

DR. DWYER: Suzanne, can you tell us where you come out after all of the careful study you have done? What would you suggest as the guideline?

DR. MURPHY: Well, I guess milk I would go back a step to something simpler. As you know, I agree that the pyramid is probably the most useful part of the guideline. In spite of the fact that others do not like the pyramid, I still think it is something consumers can understand.

I would generally favor I guess going back to something that just says "Follow the food guide pyramid," or at one point we talked about "Let the pyramid be your food guide." Those things to me still have the concept. It says guide, so it says to me it can still be adapted, but apparently the wording here did not appeal to people.

DR. GARZA: Any comments? Meir?

DR. STAMPFER: It is nice to have a message that is simple and understandable, but our main charge is to come up with scientifically sound recommendations, and then it is logical that the simplicity in the way the message can be received should follow from that. It should not be the driving force.

In terms of the pyramid, it is very recognizable. People understand it, but we do not have any data at all to show that people who follow the recommendations based on the food guide pyramid have a better health experience than people who do not. We have looked at this in

our studies, and we do not see any reduced risks of heart disease or cancer among those people.

It is not based on the best scientifically sound advice, so I think we are putting the cart before the horse here. Just because it is well recognized by the consumer does not mean it is the best scientifically based advice that our committee can come up with.

DR. GARZA: What would be your alternative suggestion to that?

DR. STAMPFER: I think there are some reasonable elements to the pyramid with the emphasis on fruits and vegetables and whole grains, but I think to make the pyramid be your guide is basically advocating our role here entirely.

DR. GARZA: Should we say "Let the trapezoid be your guide?"

DR. MURPHY: What about the need to insure nutritional adequacy? I mean, is that not a worthy goal?

DR. STAMPFER: Yes, I think it is, and that should be the emphasis and I think it is the emphasis in the text, but I think to shift it around to make the pyramid be the central icon that people follow is not taking into account what we know to be the most scientifically based nutritional advice that we can give. I think the adequacy part is very important, and I think that should be the emphasis.

DR. MURPHY: Is there another way to help consumers insure nutritional adequacy?

DR. STAMPFER: Besides to follow the pyramid? Sure.

DR. MURPHY: Okay. Well, maybe we need to explore that. What other ways are there?

DR. GARZA: Let's explore that just a bit because I certainly understand our failure to be able to demonstrate something in terms of the databases that we now have, but if we take the data that are available to us and assume, for example, that someone by not following the pyramid guidelines is consuming maybe, to make the point, 30 percent of their calories are saturated fat, i.e., they are not following the pyramid, versus someone who is it is very difficult if you had a sizeable group to demonstrate that in fact one would not see a linkage between health and the guideline.

Given the difficulty that we have in following patterns, the semi-quantitative nature of the pyramid, is it in fact reasonable for us to expect that given all of that and all of the

attendant noise that in fact we would succeed in finding the sorts of correlations that you are seeking when you look at your own data, or should we use a broader set of information, a broader information base of is it reasonable and in fact could you expect healthful outcomes from individuals who do and individuals who do not?

The major concern I have heard expressed has to do with the depiction in the pyramid of the dairy group and the meat group. I mean, that seems to be what at least some committee members and as we have had people write to us be the principal concern; that in fact by having milk and having meat on that pyramid that in fact we are recommending their consumption. On the other hand, if you do not have them you are recommending that they not consume them.

That is what I meant by the trapezoid. You know, should we let the trapezoid be your guide if in fact can we come up with some wording that would get the idea across that in fact if you choose either pattern you can do it in a healthful way without trying to get ourselves into a polarizing situation.

DR. DECKELBAUM: I think, Meir, you will agree that your group has also published some studies showing that parts of the trapezoid are in fact quite valid and helpful and do help reduce risk.

I think that when we look at this first guideline, it is really the general guideline, and then there is going to be a whole set of other guidelines which are going to refine each of these different little boxes and different nutrients so that I do not think we can look at this guideline in isolation, you know, given the different messages that we can convey.

You know, if the trapezoid is still okay, that is still, you know, almost two-thirds of the calories that people are supposed to be taking in so that I think it is a good start.

DR. GARZA: Meir, a chance to respond?

DR. DWYER: What is the trapezoid?

DR. DECKELBAUM: Take off the top. Fruits and vegetables, grains.

DR. GARZA: Plane geometry or something.

DR. STAMPFER: Well, that was the reason that I sort of was able to live with "Adapt the pyramid" because I think that that sends a message that there are a variety of healthy patterns for eating and that that is the message that we can convey.

But, I think once we alter the wording to things like "Follow the pyramid" or "Use the pyramid," then I think we are getting locked into a particular number of servings and a particular proportionality of meat, of dairy, of fat that I do not think is well supported, so I think adapt provides the message of flexibility and that there are actually lots of healthful eating patterns that are possible.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I am trying to remember our previous conversations about wording for the guideline and how we came up with the word adapt. That did seem to sort of fit the intent and address a lot of the concerns.

I think the other issue to be considered is actually the reality of it, although from a technical point of view arguing all these different words, adapt seemed to be what fit looking at what some of the focus groups said.

Also just sort of re-thinking it and re-looking at it after a month or two, I think the fine distinction that we thought it would convey actually gets lost a little bit, and one has to come up with a balance between what we really want to convey and how it is going to be interpreted, so I think that is difficult because unless we give very specific guidance probably which would exceed the length of the document, it still does not help because how do you adapt.

I think the basic, fundamental thing is either we are going to accept the pyramid as sort of a basic eating plan indicating it can be modified or not. If we are going to accept it as a basic eating plan, then we might as well recommend it.

DR. GARZA: Shiriki?

DR. KUMANYIKA: This one decision that we are discussing is whether the wording of the guideline will have reference to the food pyramid in it, and we might be able to separate that decision from the use/adapt scenario.

I hope this is not going backwards, but I was wondering if we could consider guidelines that do not include reference to the pyramid. I mean, the pyramid will be in there. I was thinking about something like a general case of the other guidelines like "Choose foods that support your health."

We seem to want something that is non-judgmental and that does not use the terms adequacy and balance because perhaps they are old fashioned or not interpretable, but we

are saying that people should have some basis for choosing foods. They should not just choose them willy-nilly.

If we do not mention the pyramid, I think we should go for something that just says to people you need to have a point of view when you are choosing your overall food pattern.

DR. GARZA: The caution is that there have been several allusions to choosing healthful food. Throughout the committee's deliberation, both this committee and in previous committees, there has been a ready acceptance of a healthful diet, but a great reluctance into categorizing specific food as being healthful or not with the total diet.

We may be shifting away from that in this discussion, and I raise it only because it will be important here if we say choose healthful foods. Well, that means categorizing them in some way, so keep that in mind as we move into this discussion.

DR. KUMANYIKA: I do want to make a point. I deliberately separated health from foods because I said choose foods that support your health, which I would actually like to include your quality of life in a more general sense, but I could not figure out how to get there.

If you choose foods that make you happy, that does not sound really like it is worth bringing us here to Washington, but that is really what I mean, and healthy.

DR. GARZA: Okay. This ought to be very helpful to you, Suzanne.

DR. MURPHY: Oh, yes. Right. We need a way to come to some sort of consensus. I mean, I see several alternatives. I believe we had all agreed we were comfortable with the wording, the "Adapt the pyramid." All right. We could stay with that and say well, consumers will just have to learn what we meant. They may not like it, but maybe they can understand it eventually.

Meir is right. It becomes a compromise between keeping it scientifically accurate and keeping it consumer friendly. Those two are sometimes not possible. We are the scientists, and we are not necessarily consumer communications experts. I do not know how to resolve that. Here is our first example of it.

DR. GARZA: Should we consider an alternative? The other message that we seem to be wanting to convey is that in fact you do not get to pick and choose among the guidelines. In other words, you cannot say well, you are going to follow three, but not seven, or six, but not eight.

Should we have something that in fact alludes to that more directly that says, you know, you do not get to choose; you must follow all the guidelines, or something to that effect? Would that also achieve the adequacy criterion that I think we also are concerned about, achieve a variety issue that we are talking about, not variety within food groups, but variety across them?

Would bringing that to the very forefront as the first guideline with wording that I do not want to pretend that I now have be an alternative way of thinking about these issues that gets us away from variety and gets us away from the specific icon in the guideline?

DR. MURPHY: You have to give us wording. We cannot go forward without wording.

DR. GARZA: Well, first of all, is the concept something that people buy into? Then I think we can try to sit and work something out because that gets into wordsmithing because I think the issue that I am hearing is we would like to be able to convey the issue of adequacy, of nutrient adequacy, that we will be able to achieve that through variety, but not variety within, but variety across, and yet give people something that is actionable where the sense of the committee was that by telling people eat a variety of foods that that is not very helpful and that, you know, following the guidelines obviously provides an actionable concept.

Is that something that people buy into that would get us away from the two words of concern as to pyramid and what it conveys and variety? Do you want to think about it, and we will have Suzanne go through the second and third parts of this and then come back?

Scott?

DR. GRUNDY: I have a question for Meir. Is it your feeling that the guide over emphasizes saturated fat if you follow the guideline? If you look at the pyramid, there is milk, yogurt, cheese, eggs and so forth. Is that a concern of yours that it goes away from what we are recommending?

DR. STAMPFER: Well, I think yes, generally it over emphasizes animal foods in general, and I think there is a bit of a mismatch between our emphasis against eating too much saturated fat and in a sense at least from the way it is portrayed in the pyramid that it could be promoting it as well, so I think there is a potential for a miscommunication.

DR. GARZA: I would remind you both throughout the guidelines and the pyramid we alluded to lowfat, fat free and lean so that it is unfair for us to characterize those two food groups as always being of the full fat variety.

DR. GRUNDY: I agree with that. I mean, I have some concern about a changing emphasis to plant foods. I mean, I think most of our calories come from plant foods anyway. There is no doubt about that, so what is it we are changing in terms of our emphasis unless it is to these components in the animal fat areas. They are lowfat.

I think they are all right, are they not? Is there a problem with that, Suzanne, if they are lowfat like lowfat or fat free milk? You do not have any problem with that, do you?

DR. MURPHY: No. We looked at how much saturated fat was in the pyramid, and it is actually quite low if you do make lowfat choices within those food groups. Six grams.

DR. GRUNDY: Right.

DR. GARZA: The other major concern that has been expressed at least in written material that we have received is that by depicting the dairy group as prominently as it does and given the lactose content of dairy foods, at least some dairy foods, that in fact that fails to recognize lactose intolerance among a significant proportion of the U.S. population.

Now, again that can be construed in that way, or you can read the text and realize that there are yogurts and other low lactose choices. In fact, intolerance does not mean intolerance at any level, but there are those sorts of issues that also concern us, and they have that same quality of saying well, when you see a depiction of either meat or dairy products it means saturated fat. Well, not really. In the same sense, it does not mean necessarily a lactose low either, but it can in circumstances mean both.

Johanna?

DR. MURPHY: Rachel.

DR. GARZA: I am sorry. Somebody had their hand up.

DR. MURPHY: I thought it was Rachel.

DR. JOHNSON: I just wanted to go back to what Bert was saying about the adequacy issue. I think it is going to be very difficult to get across all the adequacy issues when the pyramid, as we know from Carole Davis' presentation at our least meeting, was very carefully crafted to think about the RDAs or the DRIs.

You know, we have problem nutrients. We have problems with calcium, with folate, with Vitamin A. I think unless we are really going to get very specific about adequacy and have

some specific messages for each micro nutrient that is considered a scarcity nutrient or a problem nutrient when you look at consumptions patterns of Americans, I think it is going to be very complex and difficult to get adequacy across without the pyramid.

DR. GARZA: That is good. I am told the Federal Government tries to do the difficult. The impossible they contract out to groups like us.

DR. DWYER: I think the concerns that have been raised are worthy of thought, but I think a guideline like "Adapt the food guide pyramid" or "Use the food guide pyramid," we should leave it. We should clearly have something like that.

DR. GARZA: What about the concern, though, that in the food groups that in fact, I mean, as I understand Meir's concern that if we say use that is restrictive. It says this is the pattern, one that depicts animal products very prominently.

By saying adapt that in fact we become more scientifically correct. Then we have a consumer issue that they are not quite sure what that means and how to deal with it. In your own mind, how do you feel we ought to resolve that? I mean, could we educate and just tell the USDA educate people on what we meant by adapt; that is your job, or do we --

DR. DWYER: Fine, if we have to have a compromise. The other thing to do is to vote and see how many votes there are and go that way.

DR. GARZA: It could come down to that.

DR. DWYER: My computer is broken and so I cannot look up -- Dr. Deckelbaum suggested I get a thesaurus out and find out what is the synonym for adapt that is more consumer friendly than the Harvard word, but my problem with not having a focus on the pyramid is that if you look around the world at all of the other pyramids that there are, they are all pyramids at least in this country. Therefore, there is something useful about having this sort of guidance. The consumers tell us there is something useful. A lot of research tells us that it is useful.

It is not definitive, and it does not show up in surveys of health professionals who probably know to begin with not to eat a diet that is totally popcorn, so it seems to me that we do need to have something about the pyramid. If it says adapt that is fine, but basically I would find this far more useful in my eating than some vague things about adequacy.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I am wondering if maybe we could go back to one of the early suggestions, something like "Let the pyramid be your guide," because the use would not be there, which could be construed as very restrictive. Adapt would not be there, which is going to be problematic, although we certainly could undertake the task of educating people as to exactly what that means.

Guide just means you sort of should use it in general terms, and then the other guidelines start getting more specific about how it can be used and how it can be adapted, since I think there is a fair amount of text dealing with the issue if you do not use dairy products.

DR. GARZA: Scott?

DR. GRUNDY: The way I am going to say this is not exactly right, but I wonder if we could say adapt it to fit the current guidelines? That is what we want to do is to not just use it, but to adapt it to fit our current thinking about the guidelines. Could that word be in there in some way?

DR. GARZA: We are getting to the adapting.

DR. GRUNDY: Yes.

DR. GARZA: That is what I meant by follow all the seven --

DR. GRUNDY: Right.

DR. GARZA: -- or all the guidelines.

DR. GRUNDY: But somehow make those linked together.

DR. GARZA: How do you feel about that, Alice? Are there any comments, either pro or --

DR. LICHTENSTEIN: I am in favor of it.

DR. GARZA: Meir, how do you feel about it? I will put you on the spot.

DR. STAMPFER: I oppose it. Follow the pyramid ties us specifically to this particular food guide pyramid, which is flawed, so I would much prefer Shiriki's wording.

DR. GARZA: Which was?

DR. STAMPFER: Choose -- what was it?

DR. KUMANYIKA: Choose foods that support your health or something like that.

DR. STAMPFER: Something like that and then directly get at the adequacy issue as we have, as Suzanne has, in a nice way talking about our calcium and iron and perhaps some of the other nutrients that seem to pose a problem instead of making it encompass the whole dietary guidelines.

DR. GARZA: Alice and Johanna, can you react to "Choose foods to support your health" as a first guideline?

DR. LICHTENSTEIN: I could certainly find that as an acceptable compromise with reference to Benjamin Franklin, but, quite frankly, I do not think that gives me much help or guidance at all.

DR. GARZA: That is fair.

Johanna?

DR. DWYER: No, I do not think it does either. I think it is not actionable. It is a nice platitude, but it is not useful.

DR. GARZA: Suzanne?

DR. MURPHY: If you look at the consumer comments from the focus group, I was actually quite surprised at how insistent people were that they wanted concrete advice. I have been worried about being too directive in some of our guidelines -- you know, do this -- but the consumers seem to like that. I mean, they can ignore us, but they would like to know what our thinking is.

What is the best thinking? I mean, all the guidelines are to choose foods that are good for your health. I do not see that we have added anything by saying that in a guideline.

DR. GARZA: In terms of the focus group, I was struck by that as well. They kept telling us please do not ask us to read your mind.

DR. MURPHY: Yes.

DR. GARZA: Be concrete with it.

DR. KUMANYIKA: I agree that we need to be concrete, and I think that saying to choose foods to support your health is kind of like saying nothing and then you read the rest of it, but I guess the issue for me is whether we are going to refer to the pyramid. While I do not think that it is as flawed as Meir perhaps, I do worry about the circularity of our needing to endorse something that we do not have any direct influence on in this guideline.

It seems to me a dilemma of the process because the pyramid is developed with different issues in mind, and we are supposed to be doing this data based recommendations. We did not go after the data to see if there were a test of the dietary pattern that is described in the pyramid, so when we put it in the lead especially as the pyramid, it says something that we have not done. To that extent, I agree that we need to -- and adapt is too vague. I was worried when we came up with that that it would not fly. It is too abstract.

I am not adverse to mentioning the pyramid and showing it in the guideline, but I do not want it to look as if we evaluated the evidence for the pyramid as an eating plan as a group and found evidence to support that because we did not do that.

DR. GARZA: Remember that in fact we are not asked to justify everything that is in the past guidelines. If we did that, that would be very difficult. We just are not staffed to do that, so unless we see something that is inconsistent with the current guidelines and we say well, as we look at the present pyramid it is inconsistent with what we are recommending, if that is the case then I think that those sorts of concerns are justified, but then I think we need to be explicit about what those inconsistencies are, and at least from my perspective I have not heard any.

Now, perhaps some of you have, and that does not mean they have not been said. I just have not heard what is inconsistent as a general guideline of the present pyramid if in fact one uses instructive sense in the sense that yes, if you choose all your calories from high fat products at the top of that trapezoid and make it a pyramid you are going to run into trouble, but that is not what the guidelines say, I mean, if you take the fat guideline at any rate.

DR. WEINSIER: I think a clear inconsistency is that the other guidelines spend a lot of verbiage, you know, alluding to things such as whole grain, lowfat, and it comes out very clearly. Here I think a picture is telling a thousand words.

We do not have a thousand words to offset the impact of the picture, which is largely milk, yogurt and cheese, meat, poultry, fish, eggs, so my recommendation is that if we continue to use the pyramid that with as few words as possible, such as in Box 1 we emphasize what is going to show up in these other guidelines.

For example, the first paragraph in Box 1, emphasize the starting point is servings, number of servings, number of daily servings, and then we put these five bullets, you know, the bread, cereal, rice. The first one does say including whole grains often.

Why not do the same thing with the last two bullets, the milk, yogurt and cheese group, preferably lowfat options?

DR. GARZA: That is what it says. I mean, there are asterisks. Remember, we went through that, and the consensus was well, let's put them down as asterisks because it would make the table too complicated.

DR. WEINSIER: Well, I am re-thinking this --

DR. GARZA: Okay.

DR. WEINSIER: -- because I think Meir's point is well taken.

DR. GARZA: You would like to see those up at the top?

DR. WEINSIER: Well, I am thinking just with those few words, and we do have including whole grains often.

I mean, what is wrong with saying milk, yogurt and cheese group, preferably lowfat? Under meat, poultry, fish, etcetera, preferably lowfat, non-meat options, and still consider putting an asterisk by those two final food groups, the milk/yogurt and the meat/poultry, and say if you choose not to eat dairy products or not to eat meat, you need to plan to find other sources of calcium, Vitamin D, B_{12} and zinc, but I do think in retrospect that taking out these points gives too much emphasis left to the visual image, which is not as clear and directive.

Finally, in terms of the title, an option to consider, getting away from the word adapt, might be, "The pyramid can guide your food choices." In other words, it is not necessarily it is the guide, must be the guide, but the pyramid can guide your food choices, or the pyramid is a guide to your food choices. Would that be helpful?

DR. GARZA: Let me go one step further. What if we were to adapt the same sort of thing to the figure itself and to under milk put in preferably lowfat because in fact when we did the calculation the only way you can achieve consistency with the guidelines is not to always have lowfat, but preferably most of your servings should be in that category, and to add that to the --

DR. WEINSIER: That would be wonderful. That was my first option. I did not realize we had the choice of authoring a --

DR. GARZA: Well, it is our booklet. We can recommend anything. You do not have to follow what we say. We can recommend it.

DR. WEINSIER: Oh, I would go wholeheartedly with that; to add those caveats to each of the groups in milk and cheese, lowfat, and to the meat one say preferably lowfat, non-meat options, and under the bread/cereal/grain to say preferably whole grain.

DR. GARZA: Okay.

DR. MURPHY: We were going to go through the text in a few moments.

Roland, are you saying if we made those changes you would be then okay with the pyramid wording --

DR. GARZA: Let the pyramid be your guide.

DR. MURPHY: -- in the guideline?

DR. WEINSIER: Those changes in the text part

like --

DR. MURPHY: Right. I mean, does that influence how you --

DR. WEINSIER: You know, you and I have gone back and forth on this --

DR. MURPHY: Yes.

DR. WEINSIER: -- repeatedly. I was, you know, strong in not supporting the pyramid for those reasons.

I and Meir, you know, I think are compromising on the basis that, you know, we have to come up with something that is useful. You convinced me that I still feel that the picture now is overbearing compared to the text. I think we have backed off too much.

DR. MURPHY: I would like to have a whole discussion of how to modify the text, which is coming up any moment now, so the question I have right now is does modifying the text

influence how you feel about the wording of the guideline itself?

DR. WEINSIER: Modifying the text would help.

DR. MURPHY: Okay.

DR. WEINSIER: If Bert is right that we can modify the picture, that is what I would do.

DR. MURPHY: Okay.

DR. GARZA: The text and the picture. What I am suggesting is that under milk/yogurt not only do you have a copy of it. We have servings. Two to three servings. It is just adding two words or three words, preferably lowfat, which is consistent with the calculations that we did at our last meeting because in fact if all the choices were full fat then we cannot stay under the ten percent of calories being from saturated fat, so then it becomes consistent and less open to misinterpretation.

I thought if we made that change the people would then be more comfortable with, "Let the pyramid be your guide," or staying with adapt the pyramid, but keeping the pyramid in the guideline since in fact we would have altered that to be more consistent with our recommendation.

DR. GARZA: Meir, and then Alice? I do not know. Was there somebody else?

DR. STAMPFER: Just looking at the picture of the pyramid and looking at our guidelines, I mean, basically we have whole guidelines that are devoted to most of the major elements of the pyramid already, the grains, fruits, vegetables, fat and sugar.

They get their own whole guideline, so I think we should just have the title and the main message of this one reflect what the goal is, which is basically to go across guidelines and to pick up what is not there, such as sources of calcium, sources of iron.

It is really not the whole over arching picture of all of our guidelines because we have already got that. Instead it should focus on what its unique contribution is, which is these extra pieces that do not fit in any place else.

DR. GARZA: My sense is now that you are in the distinct minority now of almost one, so you need to come up with wording that would achieve that because the sense I am getting from the group is that with those changes that they are going to be comfortable with that.

I did not see anybody rise to the suggestion I made earlier, which is very similar to the one that you just made and somewhat similar to the one Scott made and also to Shiriki, but each of it made it in different wording without finding much resonance with the committee.

Scott?

DR. GRUNDY: One thing. If we do not make those changes in the pyramid, then the pyramid is out there, and people will -- that is still the thing that people will look to. Whatever we say in the fine text is not going to be read.

The general public still sees the pyramid as the product of this process. If we do make those changes that are alluded to, I think it would have a big impact and would be better than just letting it float out there disembodied from this committee.

DR. GARZA: Richard, Alice and then --

DR. DECKELBAUM: Following on what Shiriki said that, you know, if we include it in the guidelines does that mean we endorse it, and I think we discussed that. What the rest of the guidelines are really doing is qualifying how to use the pyramid as your guide.

Even though the DGAC is separate from the pyramid group, we do know that they sort of listen to each other. Part of this discussion is related to that interchange between the two groups. Carole is sitting here and other representatives.

The interchange between this committee and the people that are involved in the pyramid, and changing nutrition is not an instant process. It is going to take a number of years, and I feel fairly confident that the pyramid group is going to be taking quite a number of suggestions that come out of our deliberations into account when they come up with some new version of the pyramid. I think we must recognize what the public wants in terms of a teaching aide.

I guess the one question I have to USDA regarding the pyramid in terms of what we are talking about is the picture I had imagined could not be changed, and the question is whether the wording around the triangle or whatever shape, whether these wordings, for example, milk, yogurt and cheese group, two to three servings, are those part of the inviolate pyramid? Can those be changed in this document?

DR. GARZA: Are you asking can we add under two to three servings --

DR. DECKELBAUM: Yes.

DR. GARZA: -- preferably lowfat --

DR. DECKELBAUM: Right.

DR. GARZA: -- or fat free?

DR. DECKELBAUM: Is that allowable?

DR. GARZA: All right, Carole. You are on the spot.

MS. DAVIS: My Under Secretary is over there,

so --

DR. GARZA: All right.

DR. DECKELBAUM: Do not show any facial expressions.

DR. GARZA: Shirley, would you like us to keep the spotlight on Carole here?

MS. DAVIS: Should we have talked again? No.

I --

DR. GARZA: Your job depends on this, Carole. Otherwise I would not worry about it.

MS. DAVIS: She can override actually what I say, but I feel that if you want to make a descriptive thing like that that would be possible. Now, that is the only one you have asked me. I am not clear what you are saying on the meat side. I heard you say something about --

DR. GARZA: Having lean --

MS. DAVIS: Just lean?

DR. WEINSIER: No, no. I said --

MS. DAVIS: Did you say non-meat?

DR. WEINSIER: No. I made four recommendations, and one related to the dairy products

group, and I said preferably lowfat options. The second related to the meat and poultry group, and I said preferably lowfat, non-meat options.

The third recommendation was under the grains saying preferably whole grains, and the fourth was a footnote to say if you choose not to eat dairy products or not to eat meat, you need to plan to choose carefully other foods that contain calcium, Vitamin D --

DR. GARZA: Roland, let me ask you. Why would you say preferably non-meat? When we did the calculations, if you picked lean meats then you were fine. What would be the scientific justification of saying non-meat?

DR. WEINSIER: Well, not having gone through the calculations in terms of I do not know what the calculations told us. Is that going to --

DR. GARZA: Well, within the ten percent of saturated fat, which is the reason --

DR. WEINSIER: When I say non-meat, I am not saying not poultry or not fish. Maybe there is a better word. Is that what I am violating here is because you have to have meat?

DR. GARZA: No. I am not thinking you have to have anything, at least from my perspective. You do not have to have it. It is saying that we have a scientific justification for saying not meat, which for me means poultry, fish. Well, not fish, but poultry and --

DR. WEINSIER: Well, then I will yield to the wording, but that is what I am trying to say is that we have listed first the first word is meat, and it is also, you know, a part of the picture and so I am trying to and my second recommendation is to indicate verbally that it does not have to be meat. Maybe changing the order would be another way to do it.

DR. GARZA: Poultry, fish, meat, dry beans?

DR. WEINSIER: Yes, and put the --

DR. GARZA: Something like that?

DR. WEINSIER: Put the least preferred, you know, farthest down.

DR. GARZA: Does everybody have those four? Those are all changes for the text in Box 1. Let's hold them until we come back to the text discussion.

DR. WEINSIER: The top one or the figure. Preferably the figure.

DR. GARZA: Johanna?

DR. DWYER: Roland, I agree with most of yours. They sound like reasonable things. I do not agree with the lowfat, non-meat one. I think that needs to be re-thought on the science.

DR. GARZA: Alice, we had skipped you, but I wanted to get to him.

DR. LICHTENSTEIN: I generally support those changes, especially because with respect to fat it is going to take the emphasis off the top of the pyramid and to where it should be, which is the meat and dairy group where most of the saturated fat is coming from, so I think that that is a step in the right direction.

I think including the caveats would also be very helpful, and then I think it would be helpful for me if we go back to the title because I find discussing the text without having finalized the title at this point, it becomes abstract.

We constantly go back and forth so, you know, I am again going back to proposing "Let the pyramid be your guide" or "Let the pyramid guide your food choices." I think we should come to some resolution, a straw vote or something.

DR. GARZA: Okay. Shiriki?

DR. KUMANYIKA: Listening to this discussion, I wonder if we could say something like "Learn how to use the pyramid." It was something that Richard said that actually made me think of that because that is essentially what we are trying to do.

I do not think it is feasible to modify something that is on as many food labels and so forth until the USDA decides whether they want to modify it. Nobody has seen this booklet. The focus groups made it clear that even most health professionals had never seen the booklet.

DR. GARZA: I saw that. Most health professionals have not seen the book.

DR. KUMANYIKA: Right, so what is in the booklet is going to be advisory to policy makers perhaps, but what the public sees is going to be the pyramid as it now stands, so if we have a guideline that says learn how to use the pyramid that can mean many things to many people, and it could mean learn how to use it to fit your ethnic diet or learn how to use it to follow the rest of the guidelines, but maybe learn is the word that people understand better than adapt. At least does that get us closer to the compromise?

DR. GARZA: That was a good suggestion.

Scott?

DR. GRUNDY: Following up on what Roland said, I guess the way you see this is on the left is the dairy products, which could be lowfat, which you thought was a good idea, and on the right are mainly protein sources.

When you say non-meat alternatives or something, maybe if you could just list what those are? In other words, if they are protein sources, what did you have in mind there?

DR. WEINSIER: Well, they are already in there, i.e., beans, nuts. I mean, examples are already given, but I think the suggestion to change the order would get around this for me.

We could still say preferably lowfat, you know, options, but just change the order so meat is not the first word. That should be, in my opinion, at the end to conclude it.

DR. GRUNDY: Right. You would keep the same words, and you would just change the order?

DR. WEINSIER: I really had not thought about even putting in different foods. That may be a problem for USDA, I think. I would be very, very happy if we could even change the order.

DR. GARZA: Okay. I promise we will take a straw vote before this is over, but I am persuaded by Alice's suggestion that until we go to the text it is a bit abstract to take that straw vote on the guidelines.

Why do we not begin the discussion of the text unless, Rachel, there is one more comment to make?

DR. JOHNSON: I just wanted to reemphasize that point again that the consumers say they know the pyramid. Clearly it sounds like that is the only thing they are using.

If we completely remove the pyramid from the guidelines, I think we are just making that separation all the worse. The pyramid will continue to be the primary nutrition education tool, and we will have lost any sense of the connection between the pyramid and the guidelines.

I think we can work with the guidelines and hopefully work with USDA to try and resolve some of these issues with the pyramid, but to completely remove it I think we are just going to put the guidelines all the further away from the consumer.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I may not have expressed myself adequately, but I really find it abstract to talk about the text without finalizing the guideline.

DR. GARZA: You want to finalize the guideline and then --

DR. LICHTENSTEIN: Yes. Yes.

DR. GARZA: I thought you wanted to go through, change --

DR. LICHTENSTEIN: No. No.

DR. GARZA: -- the text, and then we could decide whether people could live with the pyramid or not. All right. Let me ask for discussion then on learning how to use the pyramid before we take that up. We are going to come back.

I think you were nodding, Johanna. You said no, let's finish up the discussion on the guideline. Then we will go to the text. That would seem fine. Let's finish up our discussion if that is the predominant opinion.

DR. KUMANYIKA: At the risk of increasing the length, what about something like "Learn how to use the pyramid to guide your food choices," because that is what we really -- we do not want people to use the pyramid to learn how to exercise, but really it is to guide their food choices.

DR. WEINSIER: I am afraid of the word learn. I am trying to play the consumer here, and it would scare me away. It sounds like the first chapter in this whole thing after the introduction I have to start learning. I think I would stop reading at that point, even though I understand what Shiriki is trying to get at.

I feel more comfortable with if we are going to use the pyramid, if we are advised and are comfortable with it, then come out and say the pyramid can guide your food choices. Be actionable.

DR. GARZA: So let the pyramid be your guide? Is that what you are --

DR. WEINSIER: No.

DR. GARZA: -- speaking in favor of?

DR. WEINSIER: The pyramid can guide your food choices.

DR. GARZA: The pyramid can?

DR. WEINSIER: Can guide your food choices. That is an option to learn.

DR. GARZA: That is a statement rather than --

DR. WEINSIER: Yes.

DR. GARZA: -- an imperative, so that would be inconsistent with all the others that are written in the imperative, if I remember my English correctly. English grammar and plane geometry.

DR. KUMANYIKA: Being the chair has many responsibilities.

DR. GARZA: All right. The options we have before us are "Learn how to use the pyramid" or "Learn how to use the pyramid to guide your food choices," "Let the pyramid be your guide," "Adapt the pyramid to plan your eating pattern or to plan your healthful eating pattern."

Let me just start with Johanna and go around to say can you tell us what your favorite one is, and then we will ask perhaps Kathryn and Shanthy to keep tallies of which they are because we have so many before us that trying to present them all it may be easiest just to say well, which one are more folks comfortable with.

DR. DWYER: "Let the pyramid be your guide," because it gives permission without acting like American consumers are three-year-olds and telling them to learn.

DR. GARZA: Okay. Rachel?

DR. JOHNSON: I would go with "Let the pyramid be your guide," but I can live with adapt.

DR. GARZA: Okay. Meir?

DR. STAMPFER: I like adapt, but also you asked if there was any contradiction between the pyramid and the guidelines as we are proposing them, and in fact they are contradictory because at least this little representation of the pyramid does not distinguish between types of fat, which is one of the main points that we have been making.

It starts off by saying such foods as salad dressings, cream, butter, margarine. These are all different kinds of fats that are all lumped together without any distinction, so I think there is a contradiction between the pyramid and the way our thinking is evolving.

DR. WEINSIER: Where are you in the picture?

DR. GARZA: The picture is what is in our --

DR. MURPHY: On the back.

DR. GARZA: You are talking about the back part?

DR. MURPHY: The back will not be in the booklet.

DR. LICHTENSTEIN: It is not in the booklet.

DR. GARZA: That is educational material that we can recommend be altered. I mean, if you look at the icon in the guideline, I am assuming that what we are doing is recommending two things, both the addition of wording that says, you know, preferably lowfat choices, and then we are going to be suggesting altering the order to give preference to leaner products. Are those the --

DR. STAMPFER: No. My point is that it does not distinguish between polyunsaturates, monosaturated and trans in the food guide pyramid, whereas we do in our guidelines.

DR. GARZA: Okay. So your choice then would be?

DR. STAMPFER: Adapt.

DR. GARZA: Adapt what?

DR. STAMPFER: The pyramid.

DR. GARZA: So you would keep the pyramid in the title, but use adopt the pyramid?

DR. STAMPFER: Well, I would rather not have the pyramid in the title at all, but given the --

DR. GARZA: Well, what would be your --

DR. STAMPFER: Given those three choices, I would rather have adapt.

DR. GARZA: With adapt. You would stay with this one? With the present one? Okay.

DR. LICHTENSTEIN: My first choice would be "Let the pyramid be your guide," but I could live with adapt.

DR. GARZA: Richard?

DR. DECKELBAUM: I am 50/50.

DR. GARZA: No, no. You get to choose. You can be 49/51 if you want.

DR. DECKELBAUM: Adapt the pyramid.

DR. GARZA: You are not persuaded by the consumer guides or the consumer --

DR. DECKELBAUM: Not yet.

DR. GARZA: Okay. So adapt the pyramid.

Shiriki?

DR. KUMANYIKA: Well, I will stick with learn for the moment because I think that this concept of how you use the pyramid should be considered.

I hear something different in let than Johanna hears, and she hears something different in learn than I hear. I do not know how consumers hear it.

DR. GARZA: What do you hear that let means?

DR. KUMANYIKA: I hear something judgmental in this. It means that okay, give up. Go ahead and accept the pyramid. That is the way I hear it, you know. I hear an accept or assimilate with the let.

What matters is how consumers will hear it, and you hear sort of a patronizing thing in the learn, but maybe if we keep these different concepts on the table we will eventually come to the right thing, so I will go with learn at the moment.

DR. GARZA: Okay. Scott?

DR. GRUNDY: I think what Shiriki just said. I think let is a little too dogmatic. I like adapt better. If we can modify the wording, I would like that more because I think that is going in the same direction as adapt. It means that we are adapting the pyramid that is presently existing in the direction, so I like that sequence.

I am a little concerned about the lack of distinction between different kinds of oils and fats. You know, maybe there might be some wording at the top, too, about the different kinds of fats. You know, choose unsaturated fats. I do not know whether that is possible to change the wording here. We could maybe add that in terms of instead of just fats.

DR. GARZA: Okay. Now, remember, we also have the problem that consumers had absolutely no clue as to what saturated, cholesterol, trans and unsaturated and monosaturated meant.

DR. GRUNDY: Okay. I would answer that as we have to educate them, and that is part of this process. Even though they do not have a clue, we have to go out there and lead on that.

DR. GARZA: Yes. All right.

DR. TINKER: "Let the pyramid guide your food choices," the first one.

DR. GARZA: What about the issue that --

DR. TINKER: The let? Yes. I did not read --

DR. GARZA: Let versus learn.

DR. TINKER: I reacted more like Roland. I reacted to the learn negatively and felt like wait a minute. I have enough to do. I do not want to have to learn. If you allow me not in the judgmental sense, but if you are like getting oh, this is not good, but it is my choice, let the food guide --

DR. GARZA: So you find let being not as imperative, but --

DR. TINKER: Right.

MS. MCMURRY: And now here we are with these different opinions.

DR. WEINSIER: If the wording in the pyramid is revised as I have suggested, then I think "Let the pyramid be your guide" or "Let the pyramid guide your food choices" would be the

best wording.

DR. DWYER: Does the chair vote?

DR. GARZA: Yes. Of all the choices --

DR. MURPHY: And I vote.

DR. GARZA: Suzanne, that is right. You are over there.

DR: KUMANYIKA: You are too far away.

DR. GARZA: How do you feel since you are on the committee?

DR. MURPHY: Well, I like "Let the pyramid be your guide."

DR. GARZA: How do you react to Shiriki's learn versus let?

DR. MURPHY: Learn versus let? Yes. I come across just initially negative about learn, but I would be willing to hear what consumers say. My experience is that if you tell people ahead of time they are going to learn, they tune you out.

DR. GARZA: We have three adapt? No. Two adapt?

DR. WEINSIER: We have three adapt, --

DR. GARZA: Three adapt.

DR. WEINSIER: -- one learn and six let.

DR. GARZA: I would go with let, so that is seven lets.

DR. WEINSIER: What is the wording. I get the let, but what comes after "Let the pyramid..."?

DR. GARZA: "Let the pyramid be your guide" or "Let the pyramid guide your food choices." We are going to come back to the refinements in just a bit. Okay.

DR. DECKELBAUM: How about "Let the pyramid help guide your food choices?"

DR. GARZA: It is getting too wordy. Let the pyramid help you if you really feel like it.

Okay. Now, since we had three adapt and one learn, how uncomfortable are the adapts? Not that we do not have any concerns about the learn group, but the adapt group? Shiriki?

DR. KUMANYIKA: My biggest concern with adapt is based on my exposure to specialists in adult education that the term will not work for consumers. That means that if we voted, it will not hold up. It will not end up in the booklet because it will not prove out from a consumer point of view. That is my biggest concern about it.

DR. GARZA: So those of you that elected adapt, are you irrevocably opposed to let, given the wording changes that have been suggested, around the icon and recommending that in fact we indicate lowfat both in the dairy and meat/poultry/bean group and reorder the choices that are in the icon in terms of the wording?

It does not change? You are not persuaded that you would follow the --

DR. GRUNDY: I mean, I would be much more comfortable with that let if those changes are added. You know, I can accept that. I think adapt implies a little more flexibility to people.

DR. DECKELBAUM: That is the question I asked earlier. These little words, phrases that go around the icon, are they part of the icon? Are they changeable?

DR. GARZA: They are part of what we can recommend because we are saying the pyramid now. I cannot guarantee to the committee that. All we are doing is advising the Secretary. They may not choose this guideline either. They may say forget it. We do not agree with you. We are going to go with variety, and they may choose not to take our recommendations for changing the pyramid.

Given the analysis that we went through, though, I do not see that making the changes we are suggesting would in any way violate any of the basic data that went into this because all we are doing is making it more consistent with our present recommendations. It is not going to influence micro nutrient intake. All it is going to do is lower saturated fats.

I do not want to put Carole or anyone in the Government on the spot right now, but if that is your recommendation, that is what we can recommend and justify it as to why we are doing it.

DR. DECKELBAUM: Except that we do not want to make a recommendation that is going

to be dropped and then ignored because that will have taken a lot of work.

DR. GARZA: But I heard Carole say that it is possible.

DR. DECKELBAUM: I did not get an answer yet.

MS. **MS. DAVIS**: Well, it is possible, but I personally had been a little concerned about all the footnotes hanging on the graphic that we have of the pyramid. I mean, so far as the table I knew that we were going to have footnotes there, and there might be more possibility, but I heard four different footnotes.

DR. GARZA: But those are not to the pyramid. Those are to the box. The two changes in the pyramid

icon --

MS. DAVIS: Was it on the graphic that you --

DR. WEINSIER: Preferably in the graphic.

DR. GARZA: But I thought the four changes, though, were lowfat in both.

MS. DAVIS: There was something about whole grain.

DR. WEINSIER: Well, these are the four recommendations that I made, and remember that Meir made a fifth. One was in the graphic where it says milk, yogurt and cheese group, preferably lowfat.

DR. GARZA: That is right. That is one.

DR. WEINSIER: Number two was under the meat/ poultry/fish. Change the order to move meat toward the end and say preferably lowfat.

DR. GARZA: So that is just adding words. I mean, the preferably lowfat, the same words. It does not hang any footnotes or anything. It just reorders it.

DR. WEINSIER: Third was under the bread, cereal, rice and pasta group, preferably whole grain.

DR. GARZA: How strongly do you feel? I think that is getting more difficult. Now we are

talking about three to five changes around there.

DR. WEINSIER: Well, these are the changes that I recommended.

DR. GARZA: Okay.

DR. WEINSIER: I mean, it is very, very strong in that guideline. If this, in my view, is reinforcing and preparing you for the guidelines to follow, that is a major point. In fact, it is in the title of the grains guideline.

DR. GARZA: So you would add that to the bread/ cereal/rice/pasta group, preferably whole grains?

DR. WEINSIER: Yes.

DR. GARZA: Okay.

DR. WEINSIER: And the fourth recommendation was an asterisk by the milk group and the so-called meat group with a footnote to indicate that if you choose not to eat dairy products or not to eat meat, you need to plan carefully to insure your diet has adequate calcium, Vitamin D, B_{12} and zinc or words to that effect.

DR. GARZA: You would not put that in the icon.

DR. DWYER: What about iron?

DR. LICHTENSTEIN: That is a footnote, right?

DR. WEINSIER: That would be a footnote with an asterisk to those.

MS. SUITOR: A footnote to the picture?

DR. GARZA: To the picture? I mean, let's be serious. You know, trying to get consumers to focus on all those micro nutrients on a picture, even I would not ask the government to do that. I think that would be difficult.

DR. WEINSIER: Well, then an option might be to put that under, you know, Box 1.

DR. GARZA: Yes. We could put it in Box 1. I think that is fine in our text.

DR. WEINSIER: Okay. Those were my four recommendations, but I understand your point.

DR. GARZA: And then Meir wanted to --

DR. WEINSIER: And then Meir had a fifth.

DR. GARZA: Yes, for the fat.

DR. WEINSIER: Which I think is well taken.

DR. GARZA: I think Scott had that one as well in terms of differentiating fats somehow in the box. I am trying to think how we would do that, given the complexity of cholesterol, saturated fat, monosaturated fat.

DR. LICHTENSTEIN: I think it may be possible since right now the text is really distinguishing between saturated and trans and unsaturated that we do not have to go into monos and polys.

DR. GARZA: So you would say that in that gray box what would be your recommendation then, Alice?

DR. LICHTENSTEIN: I have to -- give me a minute to think.

DR. GARZA: While Alice is thinking, since it came from you originally, how would you alter the gray box in the icon?

DR. STAMPFER: I think it needs more than just little tinkerings here because the main sources of saturated fat are from the meat and the milk group. There are other reasons not to eat meat or not to recommend too much meat besides saturated fat like colon cancer. The added fats that are at the top of the pyramid are only part of the thing, so I would --

DR. GARZA: So you would argue that we ought to say less than two to three servings of meat, beans, eggs? What would be the basis for saying two to three is too much of lowfat --

DR. STAMPFER: Of red meat?

DR. GARZA: No, no. It is a mixture. I am not --

DR. STAMPFER: Well, yes. That is the --

DR. GARZA: Are you saying there ought to be variety across the group?

DR. STAMPFER: Well, that is the point. I mean, I do not think this mix of meat, poultry, fish, dried beans, eggs and nuts is a natural group except as sources of protein, and I do not think it makes sense to make recommendations of a group like that, so my bottom line is that I do not think that any little tinkering with the pyramid can cure it.

DR. GARZA: That is why I am confused by your supporting "Adapt the pyramid" if you feel it is that flawed.

DR. STAMPFER: Well, that is in the spirit of compromise. It is a place to start from. It is a point of departure.

DR. GARZA: Now, how many of those changes -- Johanna?

DR. DWYER: Just a point of clarification of the science. That group is also rich in a number of things other than protein, is it not, such as B_6, zinc, --

DR. GARZA: Iron.

DR. DWYER: -- iron and so forth, so I am not sure I agree with your science.

DR. GARZA: To make sure as we go through the text we get some agreement over those changes, let's begin with the fat one.

Alice?

DR. LICHTENSTEIN: Perhaps the word saturated could be inserted in front of fat so saturated fat and in parentheses naturally occurring and end it and leave it at that.

DR: GARZA: Where are you?

DR. LICHTENSTEIN: I was supposed to be working on the gray box.

DR. GARZA: And you think that that type of change -- I mean, I do not want to --

DR. LICHTENSTEIN: That is adequate from my perspective.

DR. GARZA: Richard?

DR. DECKELBAUM: I just spoke to Carole. Carole said that the gray box is part of the icon and would not be able to be changed.

MS. DAVIS: We will need to consider it.

DR. DECKELBAUM: So we could change text underneath. We could change Box 1 of our thing, but to clarify --

MS. DAVIS: That is just to give you an idea of the shape of the pyramid. The booklet may even be -- I do not think it would be this small, but the icon is going to be pretty small when we get through. We may have 6x9 inch page.

DR. GARZA: The concern, Carole, is that if the committee is going to say "Let the pyramid be your guide" that in fact we should be able to tell the Government how we think the present icon needs the explanatory text -- not the pictures, but the text ought to be changed within the icon itself to be consistent with our guidelines.

What I am hearing is that those are at least with the fat one if we go to the blue box then in the picture that we ought to say saturated fat or something that helps the consumer deal with that guideline. We can deal with that a little bit later. With the milk, we need to emphasize lowfat or fat free.

With the meat group, we ought to emphasize again lowfat or lean products and reorder them so that we can begin with those that have the least amount of fat or the leanest in there, and then with the grain that we ought to say especially whole grains because that follows the guideline.

Now, that is what I heard, which I think is reasonable if we are going to say "Let the pyramid be your guide;" that we make those recommendations, realizing that you will take those under advisement.

You look puzzled, Johanna.

DR. DWYER: Yes, because I am not sure I agree with ordering the adequacy guideline on the basis of content of fat. I think one has to look across the spectrum of all the nutrients and order them and also consumption, current consumption, not of the Dietary Guidelines Committee, but of the American public, and try to come up with something that is reasonable.

DR. GARZA: So do you think in reordering them what would be the scientific issue that

would concern you? I mean, it is fair that you would be closer to the fat recommendation in the reordering.

DR. DWYER: Probably micro nutrient density as well.

DR. GARZA: So zinc and --

DR. DWYER: Iron, B_6.

DR. GARZA: Okay. Richard? Alice? So there is obviously a lot of wobble around that, but I think we all have some picture of how we would like the icon to be modified.

Now, with those changes in mind or those recommendations in mind we have two choices. "Let the pyramid be your guide," "Let the pyramid guide your food choices," and then a minority, seven people, going for one or the other variety of that and then three people going for adapt and one for learn.

The four of you that are not in sync with one or two of the "Let the pyramid be your guide," do you have a preference for either one? "Let the pyramid guide your food choices" or "Let the pyramid be your guide" period, or can you live with neither?

We will begin with Richard, and then we will go to Meir, who I think I know what he is going to say. Maybe not.

DR. DECKELBAUM: I can live with let the pyramid, one of the two, yes. My preference would be "Let the pyramid guide your food choices."

DR. GARZA: Meir?

DR. STAMPFER: I can live better without the pyramid.

DR. GARZA: Okay.

DR. GRUNDY: I do not have any choice between the two lets. Either one is okay with me. I think the critical point is that the pyramid somehow has to be modified, the wording, to fit with our guidelines. Otherwise there is some disconnect there.

DR. GARZA: That is why I say it was important that we --

DR. GRUNDY: Yes. Right.

DR. GARZA: -- talk about the sorts of changes --

DR. GRUNDY: Yes.

DR. GARZA: -- we would like.

DR. GRUNDY: Yes.

DR. GARZA: Shiriki?

DR. KUMANYIKA: Well, after consulting Scott's thesaurus and finding that tailor and adjust were the only two even reasonable words that are probably not more clear than adapt, I think I could probably go with "Let the pyramid guide your food choices," although I mention that the discussion here sounds like it should say something like let the pyramid guide something for adequacy because it is not really guiding food choices in terms of the other guidelines. If so, why have the other guidelines? We could just have a short booklet.

I am not sure if we are thinking the pyramid should guide all the food choices or should primarily guide the considerations of adequacy, after which the other guidelines are helping with the fine tuning. That is something that we might not have resolved yet, but I could probably live with the let, hoping that people do not take it the wrong way.

DR. GARZA: Fine. Suzanne, how do you feel about all these, having thought about this probably more than anyone else?

DR. MURPHY: Well, I still favor a short guideline. I think that message came through very clearly from the consumers, and so I am as always torn between being accurate, because I do like the concept of adapt and being clear, but I think consumers say be clear, please, and so I like the shortest version, which is "Let the pyramid be your guide." I had said be your food guide because I think it is food oriented.

DR. GARZA: Carole, are the focus groups out of commission? Can we see how the consumers do with let?

MS. DAVIS: We can. I mean, we are into the last phase.

DR. GARZA: Okay. The consensus I hear then is, and in fact what Suzanne has just given us is a compromise. "Let the pyramid be your food guide."

DR. KUMANYIKA: I do not like that.

DR. GARZA: You do not like that?

DR. KUMANYIKA: I have trouble with that.

DR. GARZA: All right. So you would prefer "Let the pyramid be your guide" for shortness?

DR. KUMANYIKA: No.

DR. GARZA: You are not persuaded by the shortness argument?

DR. KUMANYIKA: You do not have to personify it if you just guide your food choices. I feel much better with that.

DR. GARZA: So "Let the pyramid guide your food choices?"

DR. KUMANYIKA: Guide your food choices, not to be your guide.

DR. GARZA: All right. We have those two. There will be an abstention possibility. All those in favor of "Let the pyramid be your guide" or be your food guide?

DR. KUMANYIKA: Guide your food choices.

DR. GARZA: No, no. We are going to have two.

DR. KUMANYIKA: Oh. You are voting? Okay.

DR. GARZA: We are voting. Raise your right hand. "Let the pyramid be your guide."

DR. MURPHY: "Let the pyramid guide your food choices." I am sorry. I am sorry. Now I am getting confused. "Let the pyramid be your food guide."

DR. GARZA: "Let the pyramid be your food guide." All those in favor, raise your hand.

(A show of hands.)

DR. MURPHY: That is not a big crowd.

DR. GARZA: "Let the pyramid guide your food choices."

(A show of hands.)

DR. GARZA: One, two, three, four, five, six, seven. Okay. I will go with that one. Eight. Yes. Eight.

All those opposed or who do not want to vote on either one?

DR. WEINSIER: Well, I did not vote on one because we dropped that option, "Let the pyramid be your guide."

DR. GARZA: Well, we are going to go to that one. "Let the pyramid be your guide" then is one.

DR. WEINSIER: That is what I would have voted for. That is why I did not vote for the others.

DR. GARZA: Yes. We said food guide. Suzanne and Roland are applied by food.

DR. MURPHY: Well, that is not a point I would debate.

DR. GARZA: So we have two for "Let the pyramid be your guide," eight for "Let the pyramid guide your food choices," and one abstention. Is that right? Okay.

Let's see if we can get some consumer input. If not, we will go with that if it plays as well as we hope it will in terms of adequacy, getting all the messages we want to get across.

Let's go to the text.

DR. DWYER: So are two things being tested in focus groups, "Let the pyramid be your guide" and "Let the pyramid guide your food choices?"

DR. GARZA: I mean, Carole will take those, and we probably may even if we have time do learn and see how learn does. I do not know if we will have enough time.

Okay. Now let's go on to the text.

DR. MURPHY: You have --

DR. GARZA: We only have about five minutes.

DR. MURPHY: -- technically five or six minutes to do the other two points. Should I --

DR. GARZA: We will take some time.

DR. MURPHY: Okay. All right. The second thing we were asked to look at was "remaining issues," and in my opinion these are --

DR. GARZA: This is what we agreed on, folks.

DR. KUMANYIKA: That is what we agreed on?

DR. MURPHY: I think these are fairly minor, and actually I think we have already discussed some of them. One thing we do have control over is what is in the boxes, as opposed to what is in the icons, and I think we have already discussed a couple of these things.

For example, in our first box, which is "Choose a variety of foods and beverages from each of the five major food groups." It is on page 5 of our briefing book. Actually, a couple of people have recommended we get rid of the word major, but that is not -- I think we will never get finished if we get down to individual words.

The issue that Roland has brought up today, but also in our working group, was whether we needed to insert some text at the bottom of Box 1, and the actual text he recommended is on page 14, but I will read it to you. "If you choose not to eat dairy products or not to eat meat, you will need to plan carefully to get enough calcium, Vitamin D, Vitamin B_{12}, iron and zinc," and the question was would we like that to be a footnote on Box 1.

The other members of the working group did not vote to put that in, so we are bringing it to the full committee for your opinion.

DR. GARZA: Rachel?

DR. JOHNSON: My concern, and I think we do this a lot throughout the document. We are offering options for people who choose not to eat dairy products or not to eat meat, and I think if we look at the percentage of people that fit into those groups it is quite small.

I think about one to three percent of the American public say they are vegetarian, but then when we look at consumption data they actually eat meat, so we are not even really sure. It is probably lower than that.

I guess my concern is if we consistently do that with those food groups, I ask the question why are we not doing it with any other food group? I mean, there are a lot of children in

this country who refuse vegetables regularly, and in working with the pediatric population that is a major question that parents ask me. What should I do if my child will not eat vegetables. We do not address that at all.

We are making the assumption that everyone eats fruits and vegetables and grains, so I have concerns about consistently singling out those two food groups as food groups that we need to offer options for and then ignoring other food groups that there certainly are portions of the population who either refuse to eat it or for some reason do not eat it, and we do not offer alternatives for those.

DR. GARZA: Given the state of our knowledge, Rachel, are there alternatives to not including vegetables in your diet?

DR. JOHNSON: There are. You can create an adequate diet for a child that does not include vegetables if they are going through a period of time when they are refusing it, whether it is by using fruits or encouraging, you know, some form of supplementation until they work through that period of time. I would say yes, but I guess I am just concerned.

Throughout the document I think we consistently single out those food groups as food groups that we should provide options for, and I am not totally clear what the consistent basis for that is, given consumption patterns.

DR. GARZA: Okay. Comments? Responses?

DR. WEINSIER: I do not have the figures at hand, but I am not comfortable with the figure that less than one percent of the population does not use dairy products, or less than one percent does not use meat.

I think until we have a figure, I would be reluctant to have that in the record unless you are sure that is the case because I am saying one or the other, the dairy products or choose not to eat meat. I am not referring to vegans.

DR. JOHNSON: We have it from nationwide food consumption survey data, do we not? I have seen that. I have seen the figure of two to three percent.

DR. DWYER: There is some data in the latest supplement to the American Journal of Clinical Nutrition which reports the Third International Congress on Vegetarians.

The problem that you bring up is a good one, and that is that there are no good data that I know of on these statistics. The national surveys are probably the best in terms of

population based. Vegetarian Times does a survey, and I think there is a paper on that in the document, but getting at this group of people who are no meat or no poultry or some of the other groups is pretty tough, and I do not know of any good data on it.

DR. WEINSIER: Yes. I was trying to stay away from and in fact we have stayed away from the word vegetarian, and what I was trying to get at is flexibility to major groups, i.e., those people who choose not to use dairy products, for example, for whatever reason and to give the option to people who choose not to eat meat, but they may be very different groups.

There may be people who use certain animal products, including meat, poultry, fish, but choose not to use dairy, either voluntarily choose not to or cannot tolerate it.

DR. GARZA: The point I think, though, is if you look at the numbers, as I recall, the percentage of people who will not drink milk is substantially greater than the number of people who do not consume any dairy products whatsoever. Most people who stay away from milk will have ice cream, so it depends on how you define dairy --

DR. WEINSIER: Well, it may not be an all or none.

DR. GARZA: -- and milk products. The numbers shift a lot, so I think the two to three percent that you are hearing are individuals that stay away from all dairy foods, but that is much lower than individuals who do not drink liquid milk, for example.

DR. WEINSIER: Well, I think one thing we have to keep in mind is that I am not sure how prescriptive we want to be in this document. A major concern has been expressed that people do want to have certain choices and still have a nutritious diet.

We have recognized that that can be done, particularly without requirement that people have dairy products. It is not just a matter of whether you do or do not. It is a matter of if you do, we are suggesting two to three servings a day.

DR. GARZA: No. The issue is not that, Roland. As I understand Rachel, it is that we are going out of our way to meet the needs of one to three percent of the population if we define it as rigidly as some of our surveys do.

Are we being fair then by not dealing with other potential problems that are much more prevalent, i.e., children with eating habits that we would like to discourage, but, nonetheless, are very prevalent. An issue of attention time I think was what Rachel was asking us to deal with.

Suzanne?

DR. MURPHY: I wonder, Roland, if we could put that same text a different place under There Are Many Healthful Eating Patterns. Actually, that is my fourth point up here. If we look on page 9 -- actually the heading is at the very bottom of page 8, but the text is on page 9 where we talk about different eating patterns.

We now have a fairly new paragraph that talks about cultural preferences, but the second paragraph you and I have played with a bit, Roland, and it now says something about if you choose not to eat dairy products, choose other foods that are good sources of calcium and be sure to get enough Vitamin D.

Could we modify that to somehow read like this other sentence and put it there instead of putting it -- I think my concern is about featuring it too prominently on the very first box in the whole booklet, but if it was in the text under Many Healthful Eating Patterns then I would feel it was appropriate.

DR. GARZA: Shiriki, then Richard?

DR. KUMANYIKA: I think it belongs actually in the text under There Are Many Healthful Eating Patterns. I might have some edits to suggest on that section, but I think that would be a good place to put it.

On the prevalence issue, if we think about people who follow vegetarian or even vegan eating patterns for a period of time, especially a lot of adolescents going through a phase, I mean anecdotally the surveys cannot pick up these transitions, but there might be a critical developmental period or pre-conceptually, and then there are a lot of immigrant populations who would be vegetarians if they could find the foods when they got here.

We certainly need to mention patterns that do not include all of the groups on the pyramid and talk about that in a way that is non-judgmental.

DR. GARZA: Richard?

DR. DECKELBAUM: I would agree. I think that this section could be expanded a bit to include what we are hearing, and I would just like to comment on your second point up there, which is there has been quite a bit of feedback we got during the deliberations of our group about lactose free or lactase deficiency being a major problem.

I would like to point out that actually Allen Hoffman's group many years ago did a study in

the Pima Indians, which was published in Gastroenterology in I think it was the 1960s or the 1970s. Pima Indians are severely lactase deficient at a fairly young age.

He showed that the Pima Indians can drink a glass a milk or two glasses a day without any symptoms of lactose intolerance, so certainly one glass, and many populations can drink milk, at least one glass a day, with no adverse symptoms even if they have a high prevalence of lactase deficiency.

I think it would be worth it. Because it is a major issue, I think it is worth including in the text that lactose intolerance does not absolutely preclude taking in any lactose containing products. I can provide references for that, studies that have been done on that side.

Certainly a high amount of lactose containing products will cause symptoms, but there are alternatives to lactose containing products, so I think that Point 2 should be in the text, but it should be that it is not an all or none phenomenon. I will give you the literature for that, along with the papers.

DR. GARZA: All right. So we have, sticking with the first box, that in fact there are some suggestions for putting it in the text versus the box and reasons for that. Can I have a show of hands, those that prefer it in the box?

DR. DWYER: Prefer what?

DR. GARZA: The text that Roland suggested that is on page 14.

DR. DWYER: Yes.

DR. GARZA: Having that in the box as your first choice or in the text under There Are A Variety of Healthful Eating Patterns. I do not know what the exact heading is.

DR. DWYER: The work group chairman's preference is in the text?

DR. GARZA: In the text, yes. All those in favor of the box, please raise your right hand or your hand.

(A show of hands.)

DR. GARZA: Two. All those in the text?

(A show of hands.)

DR. GARZA: Okay. We have nine. No. Eight. Eight and two. All right.

I do think, though, that before we do it Rachel raised an important point. Does the group feel that in fact we are being responsive to minority vocal groups and not paying attention to major issues? The one that she pointed to was vegetarian versus children.

Keep that in mind as we go through that because obviously children cannot write us letters, and adults can mobilize themselves in very effective ways. Given, I suppose, my prejudicial option for children, I would ask you to please keep that in mind as we go through this.

DR. JOHNSON: I would like to raise the issue that I would like to if we are going to include the pyramid in the booklet, I would like to consider also including the new food guide pyramid for young children. I think of it as the kids' food guide pyramid.

We have had testimony that has requested that, that we include it, and I think that some of the rationale for that is throughout the document there is a number of times -- I know it is in the weight guideline, it is in the fat guideline, I think there may be something in the sugar guideline -- that gives some options about how to feed children, and I actually think we could save space by including the kids' food guide pyramid, referring to that whenever we talk about how to feed children, so I would like to offer that as an option.

DR. GARZA: Are you sure?

DR. JOHNSON: It is the ages two to six.

DR. GARZA: Given the discussion we have had over the other pyramid, I am a bit reluctant to look at a second one. If we have time before the end of the three days, if perhaps staff could get us a picture of that, circulate it, and we will come back to Rachel's suggestion.

All right. Point No. 2 then. I understood Richard's suggestion to add text rather than just a footnote for the reasons that he gave. Those are the two options.

DR. DECKELBAUM: I would add it as text under There Are Many Healthful Eating Patterns.

DR. GARZA: That is what I am saying.

DR. LICHTENSTEIN: As a follow up, in addition to that I would suggest if we can get some data on the availability of lactose free milk? You know, at least on the east coast it is

commonly available in supermarkets.

We are going to indicate that there is a range of levels of tolerance and also indicate that this is now, it seems to me, over the past five years far more available, easily available. If it is that way across the country, then perhaps that could also be included.

DR. GARZA: The text would have to suggest that you can choose not to do it, and if you do not experience discomfort you may still elect not to have milk. You can stay away from lactose because you are not quite sure. I know some people are quite sensitive to it and will swear to you that in fact one glass will produce symptoms.

I think Allen's papers are correct in terms of the majority, but that there are still some that appear to be at least on the face of it lactose, whether that has to do with flora or whatever, so we need to look carefully at the text. It is not either/or as Richard is saying.

I am just worried about the length. I mean, do we really want to discuss lactose intolerance? In terms of how we can do it reasonably, it is not clear to me.

DR. DECKELBAUM: Probably two sentences.

DR. GARZA: Can you work on those two sentences?

DR. DECKELBAUM: Yes.

DR. GARZA: All right.

DR. MURPHY: Box 3 has a footnote that says, "This includes lactose free and lactose reduced dairy products." My question was do we want that same footnote in Box 2?

DR. GARZA: Yes, I would think so.

DR. MURPHY: Yes.

DR. GARZA: Can we go to Box 3?

DR. MURPHY: Point No. 3. Is that what you meant? Not Box 3.

DR. GARZA: Yes.

DR. MURPHY: Point No. 3 actually has to do with Boxes 3 and 4. I have worked with

Carole Davis and her staff to try to double check, I guess, that these are indeed in order by calcium or iron content per serving, and we have tried to respond to Johanna's concerns that we are not actually putting levels on there, but I do not think we have done it very well, and that is why I wanted the group to discuss it.

The options I looked at to try to put these into tiers or to put asterisks after which was the highest and which was the lowest is that there is a range in each of these categories. For example, if you look at lean meats, liver and other organ meats it is two to three full levels of iron, so depending on which one you pick out of there it is not sure what level you would put that broad group into.

I did not really want to make the list any longer. I think they are already kind of long for such a brief document, so I did not come up with any good way to put these into tiers. The compromise was to put them in order by the average content.

Then two other related points. When you are talking about iron, you have to think about bio availability, and that is one reason that the foods at the top tend to be meat products, and the foods at the bottom tend to be the vegetable products because almost anything you read on bio availability suggests that meat products have at least double, maybe triple, the availability of vegetable products, so they are ordered partly on bio availability and partly on actual content.

The final point that is mentioned up here is the bread. Enriched and whole grain breads was added to Box 4, but these foods do not provide five percent of the daily value. I mean do not provide ten percent. They only provide five percent. Nonetheless, they are a major source of iron in the U.S. diet, so that was the argument toward putting them in there, but we could easily argue to take them out.

DR. GARZA: Alice?

DR. LICHTENSTEIN: Given the number of servings that is recommended probably on that basis it could be justified to include them, but I also think just pertaining to your comment about being concerned about the length, I think these boxes really provide what it appears that the consumer is looking for very specific items.

DR. GARZA: Shiriki?

DR. KUMANYIKA: I wonder if anyone has ever tested this box format as a way of conveying the information because even though the footnote says that it is in descending order, I could imagine some graphics that would make it easier for people to figure out kind

of a lot, you know, medium and good, some good, better, best, you know, one plus, two pluses, three pluses or something like that, because this list by itself just seems like a list that is alphabetical or something.

I mean, it is not alphabetical, but, I mean, it just seems like a list, and it does not convey what you just said about the difference in bio availability or amount for a typical serving. That is just advice perhaps for somebody to consider.

DR. GARZA: Is there a natural break point in either point, Suzanne, that one could --

DR. MURPHY: No.

DR. GARZA: -- shade it in?

DR. MURPHY: Not that I could readily identify. I mean, there are some animal products that actually are not very high in iron. I mean, you cannot readily do it that way, so when I put them down there I did not see any point where you could say these are all good sources.

We took out the word good from the title because of concerns that it would be misused. We can talk about those some more if you want, but these are now sources of iron and calcium.

DR. GARZA: Rachel, Alice and then Johanna?

DR. JOHNSON: My concern with Box 3 is that without putting amounts -- I mean, typically the way I see it is you might use a cup of milk as a standard, and I guess it is what, like 280 milligrams of calcium. Then you give amounts that you need in order to achieve that. There have been some really good tables done, some good work done with tracers that, you know, compare absorption with the amount in the food and what you actually end up with.

For example, for most leafy, green vegetables, and we do not list broccoli here, but I think you need about four and a half cups to be equivalent to the calcium that is available in a cup of milk. I think without having that, you know, when you look at this you sort of make the assumption that if you have a serving, which we define earlier as a half a cup, of a dark green, leafy vegetable it would be an equivalent calcium source of some of the other things on this list, and it is not at all.

DR. MURPHY: Actually, those leafy greens, if I could just quickly address that. Collards and turnip greens are very high in calcium, much higher than broccoli.

DR. JOHNSON: Uh-huh.

DR. MURPHY: I think a serving of those is, if not equivalent to milk, it is in the ball park. You do not need four cups.

DR. JOHNSON: Does that account for absorption, too? Do you know?

DR. MURPHY: Absorption is pretty good for most products, actually.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I would be concerned about going with the high/medium/low. I certainly think the logic for ordering them is good, but again because we are also recommending ranges of servings for various food groups, you might have one that is very concentrated in a specific nutrient, but we are recommending fewer total servings so it I think could get very complicated. This is a reasonable approach.

DR. GARZA: Johanna?

DR. DWYER: Suzanne and I had some E-mail correspondence about this because I felt strongly on the same point that Rachel mentioned about amount. I realize now that it is a very complex problem to present this in a little box and do it in a meaningful way.

The one suggestion I would have, and I think you did a good job, Suzanne, is to say, to try to meet some of Rachel's concerns, the amount of these foods you eat is also important, and that would be under asterisk that now says the foods at the top of this list are highest in X, calcium or iron, and then after that put the amount of the foods you eat is also important or something that conveys the issue of frequency of consumption.

To get at Rachel's final issue, I do not have a good way to get at that.

DR. MURPHY: What was Rachel's final issue?

DR. DWYER: That without quantities, it is still a little misleading.

DR. GARZA: Lesley?

DR. TINKER: If we put the amount or a comment about the amount lower in the box but without reference to what the amount was, the consumer, I would think, would be puzzled. Well, what does that mean?

It gets back to well, how much should I be consuming to have it be considered a source? I am not sure it really gets around needing the amounts. It feels like it opens up a Pandora's box to have that comment in there.

DR. GARZA: As we go through this, try to keep in mind that these are just guides for people as a general teaching tool. I do not think we are going to be able to have people plan a menu.

Try to leave your professional lives at a distance. While we would like to have that type of detailed guidance, we are not going to be able to get it into a box.

DR. KUMANYIKA: I just wanted to comment on this issue of quantities because I do sense that there is such a huge cultural bias towards dairy calcium that people ignore the fact that no one who eats collard greens ever eats a half a cup. I mean, the serving sizes for things like greens are much larger, you know, so it gets very complicated.

DR. GARZA: Especially if you measure them before they are cooked. They are enormous. They are always enormous in our kitchen.

All right. I do not think that we have come to -- you know, we can ask the USDA to think when they sit down and send this to production of either using shading in a way that helps the consumer understand that this is a gradual decrease or increase, but trying to get to specifics because of the complexity that we have heard I think will be difficult.

I am not sure that we gave Suzanne much guidance other than to say that we think the listing is fine. We would like for the graphic designers to think about this and maybe with color or whatever, yes, try and achieve the reinforcing concept that these are going from light blue to dark blue as things increase in content.

DR. MURPHY: What if we put the footnote up at the top so it says some sources of calcium in descending order or something that at least you do not have to get down to the footnote before --

DR. GARZA: Let's not try and design it --

DR. MURPHY: Okay.

DR. GARZA: -- because if we do that we will never get through the ten guidelines. I think people have enough guidance.

DR. MURPHY: Okay.

DR. LICHTENSTEIN: But there has to be some specificity that is per serving, you know, and then refer to where the servings are defined or something or per 100 grams or per average intake. It cannot just be richest to poorest.

DR. GARZA: Well, in terms of a guideline, Alice, I am not persuaded that we can provide that much detail, I mean.

DR. LICHTENSTEIN: But if it is based per serving, now it sounds like that was formulated on the basis of per serving.

DR. GARZA: But it is for the whole group, though. If we just go to broccoli and collards -- I mean, you cannot say per serving. You have them in the same group. There is a three or fourfold difference.

DR. MURPHY: These are per serving.

DR. GARZA: But it is the average for the group, right?

DR. MURPHY: That is right.

DR. GARZA: That is what I understood you to say.

DR. MURPHY: Well, we could say --

DR. GARZA: Basically there is great variability.

DR. MURPHY: -- are highest in calcium per serving.

DR. GARZA: Then there is a problem that I think Shiriki pointed out that it is very accurate. I mean, a serving. If we take collards, which I had not thought about, it is a great example. It is, as Johanna said, much more complicated when you try to actually do it.

Beyond providing the general guidance, it is going to be hard to do. I do not want to increase your expectations beyond what I think is deliverable.

DR. LICHTENSTEIN: Well, then perhaps we should not go with dark blue to light blue or red to yellow or something like that.

DR. GARZA: Just leave it the way it is?

DR. LICHTENSTEIN: Yes.

DR. GARZA: All right. The last point?

DR. MURPHY: I think we may have gone beyond needing to assess that because if we insert the sentence Roland is recommending, we will have already talked about B_{12}, and I do not think we need to say it again under the paragraph on supplements unless someone would like to argue to the contrary.

On page 13, which is the page with the supplements, we have two paragraphs on that page. The second paragraph talks about dietary supplements in a somewhat negative tone, I think. Johanna made a comment. She said so after I read this paragraph, what am I supposed to do? As I keep reading it, I wonder if we need that paragraph.

I guess, Alice, I might come back to you because I believe your original group wrote this paragraph. Looking at it now sort of hanging there by itself, do you still think it adds to our guidance?

DR. LICHTENSTEIN: There really was not a group that wanted to get involved with this, quite frankly. This is an adaption of text that was in the original booklet trying to update it and acknowledge that botanicals were becoming more available and used.

I think the issue of supplements has been extremely difficult. There really has not been anyone on the committee that I have identified who, you know, feels they can adequately address it. I say it is up to the committee.

DR. MURPHY: You do not have a strong feeling about it?

DR. LICHTENSTEIN: No.

DR. GARZA: My sense, though, I mean, as the chair is that if we do not mention supplements, we are going to fail to recognize that they play a highly important and visible role in most Americans' food choices.

DR. MURPHY: Now, you understand this is just the second paragraph or just the botanicals.

DR. GARZA: Okay. I misunderstood. I thought you wanted to get rid of the whole section.

DR. MURPHY: No. I am talking about only the paragraph that starts, "Dietary supplements include..."

DR. GARZA: Let's deal with the first paragraph. I had one suggestion there, and that is we say, "People who seldom eat dairy products or other rich sources of calcium may need..." I do not think that "may" is -- I mean, if people are really avoiding all sources of calcium, we ought to give them stronger advice. They need to take a calcium supplement.

DR. LICHTENSTEIN: But what about calcium fortified orange juice? What about collards and --

DR. GARZA: That is a source of calcium. What it says here is "or other rich sources of calcium."

DR. LICHTENSTEIN: Maybe that is where the problem is. I mean, are there groups --

DR. GARZA: Fortified orange juice with calcium is a rich source of calcium.

DR. LICHTENSTEIN: And collard greens.

DR. GARZA: And collard greens. If you are avoiding all of that --

DR. LICHTENSTEIN: But do we have any indication is there any segment of the population that is avoiding all sources of calcium. We certainly know that there are certain individuals that specifically avoid dairy products.

DR. GARZA: Well, given the calcium intakes in this country are so low, I suspect that is probably true.

DR. LICHTENSTEIN: Actively avoiding or not consuming?

DR. GARZA: Well, it does not say. It says who seldom eat. It does not say actively avoid.

DR. STAMPFER: I think we should leave it, the wording, because we have been reluctant to be very directive where there is no clinical trial data for health effects, so I do not think we should go forward than "may need," although for the folic acid in pregnancy I think that "or" should not be there. Women who may become pregnant are advised to take a folate supplement.

DR. GARZA: Individuals who do not consume calcium are also advised to take a

supplement if we look at the OIM report.

DR. STAMPFER: Right, but we have usually shied away from directive language where there is no clinical trial data. Folate we have clinical trial data. Calcium we do not.

DR. GARZA: Meir, if you are not meeting your dietary needs --

DR. GRUNDY: I have one question here about this Vitamin B_{12}. You say, "Older adults may need to take a B_{12} supplement." Where did that come from?

DR. GARZA: See, that was from older language. That came because of the concern that achlorhydria and other issues of B_{12} absorption in the elderly population were significantly prevalent; that individuals should be aware that when you are enter the over 65 age group that in fact you may have a need for other sources of B_{12}. Whether that is true or not, I do not know whether it is still true.

DR. GRUNDY: I do not know. I think we ought to find out whether that is really true or not and, if so, you know, be a little more specific about that. That is very vague.

DR. GARZA: But I think that is where that came from, --

DR. GRUNDY: Yes.

DR. GARZA: -- if I recall correctly.

DR. LICHTENSTEIN: I think it is also in the current RDA document that just came out.

DR. GRUNDY: Should I take a B_{12} supplement or not?

DR. GARZA: You are not old enough.

DR. GRUNDY: Well, some day I will be. Should I start taking it when I get to be -- I should? How much?

DR. LICHTENSTEIN: Well, maybe you should find out whether you have megaloblastic anemia --

DR. GRUNDY: Well, yes. That is right.

DR. LICHTENSTEIN: -- or some indication of lack of B_{12} adequacy. I think we should look

at what the current RDA says and see because they go through extensive justification for all their recommendations.

DR. GARZA: Johanna?

DR. DWYER: Yes. I think it is in the DRIs. The new DRIs for B_{12} do in fact document the prevalence of atrophic gastritis increasing over 60, and it reaches I think about a quarter or a third of the population over 80 and recommends B_{12}, supplementary B_{12}, in the DRI for people over 50.

DR. GRUNDY: I guess my question is is that a clinical judgement that you have to get that checked, or do you just do it automatically if you get over a certain age? That is what is not clear from here.

DR. GARZA: I think that --

DR. DWYER: Carole probably memorized the DRIs.

DR. GARZA: I think the issue was that the risk of B_{12} supplementation was so low in terms of any toxicity, while the risk of not having it was so high, given the effects of B_{12} deficiency, that for a population wide recommendation the option would have been taken, given the prevalence of all of this, that a supplement was probably going to be done.

DR. DWYER: But there is another issue, too, as I understand it, and that is the food bound source in people who have atrophic gastritis is not available. In other words, you cannot cleave the protein together.

DR. GARZA: Even if you did not have it in your diet, I mean if you did not need it because you did not have atrophic gastritis and achlorhydria, that in fact taking it was not going to put you at any risk and trying to get everybody to go get checked for it was very unlikely and so that given the consensus of all of that, if I recall the report correctly or the discussions at any rate, having a supplement was going to be recommended, but we ought to go back and check to make sure that our memories are serving.

DR. GRUNDY: I asked a gastroenterologist recently about that, and he said not to do it unless you found out you were low, so that is what made me think of it.

DR. GARZA: We will have to go back and check.

DR. GRUNDY: Yes.

DR. WEINSIER: Is it appropriate to say that pregnant women are advised to take an iron supplement before the second trimester? My recollection is that there are risks associated with taking it during the first trimester.

Am I wrong, or is there updated information on that? I realize the last guideline made the same statement, but I am not sure.

DR. GARZA: The recommendations still are that you start iron as soon as you find out that you are pregnant. If you go through the calculations on it, one might argue whether the calculations are correct or not, but it is very difficult to meet your iron needs during pregnancy. In fact, I think it is almost impossible not to come out of pregnancy totally depleted of iron stored.

DR. WEINSIER: Before the second trimester?

DR. GARZA: No. For everyone. If you do not start iron then as soon as you are pregnant, and most people will find out they are pregnant --

DR. WEINSIER: The National Research Council, if I remember correctly, and I am pretty sure. It says start the second trimester. That is what the recommendations, as I recall, have always been. I have never seen otherwise. In fact, it is my recollection that to start before the second trimester may be a risk --

DR. GARZA: We can go back and check.

DR. WEINSIER: -- unless there is new information.

DR. GARZA: The sense of mine is that the recommendation is you start whenever you find out you are pregnant. Are there risks that you are concerned about?

DR. WEINSIER: Well, yes, but I do not have the facts at my fingertips. I just have a recollection that the reason it is recommended to start after the first trimester is because of the risk of the effects of iron supplementation in the first trimester.

DR. GARZA: You are really taxing my physiology now, but lead volume expansion starts very early in pregnancy, way before weight gain, so that the expansion of RDCs is more or less complete by the end of the second trimester.

DR. WEINSIER: Lead volume does, but the hemoglobin content --

DR. GARZA: No.

DR. WEINSIER: -- relatively reduced may not --

DR. GARZA: The body. I mean, the iron carrying capacity of hemoglobin expands. Not plasma volume, but RDC volume expands I think way -- I mean, it starts expanding before the second trimester.

DR. WEINSIER: Without going through the

physiology --

DR. MURPHY: We can check.

DR. WEINSIER: -- we ought to check.

DR. MURPHY: We need to move on here.

DR. GARZA: That is my recollection.

DR. MURPHY: We are bogging down on details.

DR. GARZA: Yes. I agree.

DR. JOHNSON: You had asked about the last paragraph, and I guess I would argue to keep it because in fact there are concerns about the lack of standards for purity and potency, and there have been some deaths attributed with use of botanicals, so I think if we feel that we need to give advice short of telling them to lobby their Congress people for increased regulation on these issues, I think we would say to talk to your health professional, which we have done in some other areas, if you are considering using one of these products.

DR. GARZA: Johanna, you had expressed what do we do with the second paragraph, so perhaps you should respond.

DR. DWYER: What I suggest is crossing out the first sentence and then editing down the rest of it, but leave it.

DR. GARZA: Edit it down with what object in mind? I mean, just to send the message of --

DR. DWYER: Well, basically the wording I would suggest is, "Botanical products usually provide very small amounts of essential nutrients. The value of most botanicals for health has not been established. At this time, there are few standards for purity or potency."

The reason for keeping that is that the President's Commission on Dietary Supplements felt that that was one of the key things that needed to be done, and this reaffirms and supports another expert committee.

DR. GARZA: All right. The summary of all of this, and we can move on unless you have something.

DR. KUMANYIKA: Since I was on that commission, I think I can comment on the supplements anyway.

I had a question about folic acid actually, but I am not sure that it should be reduced. I thought that someone had done a nice job of at least getting something on the table.

The point that I think the first sentence makes is that the term dietary supplements now, and I would insert the word now, includes all these things because we are in a transition, so I was going to modify it to, "The term dietary supplements now includes these things," so that educational statement is there and then more or less leave the rest of it there.

It might be considered a little prejudicial against supplements, but the lobby is in the other. You would not want -- the lobby is in the other direction. The strong lobby would be for decreasing the regulation because there is a lot of consumer interest, so I think this is an important paragraph.

DR. JOHNSON: What advice would you give?

DR. KUMANYIKA: I think this is a good paragraph except that I would say now. I would point out to people that it has been redefined to these things that were not in nutrition before, but now they are.

DR. GARZA: Hold on. Let's let Johanna respond.

DR. DWYER: I just wanted to suggest that the fourth point be taken and that we add vegans.

DR. GARZA: To that last paragraph? We are still on the paragraph that you edited, and Shiriki was commenting that she was not in agreement with you. I thought you were going

to address that.

If not, Roland?

DR. WEINSIER: Yes. Just real quick, I am not sure how the word botanicals is used by or understood by consumers. This may be something that should be brought up with the focus group or maybe a comment, botanical products, i.e., herbs, or e.g., herbs, something like that.

DR. GARZA: So do you have it then? I mean, I think the working group needs to go back and make sure that the recommendations on that first paragraph are consistent with current recommendations for pregnant and elderly individuals, and then on the second we have two views expressed; Johanna that says we need to take that second paragraph and re-edit it down, Shiriki that said no, you know, it is pretty good. All we need to do is add dietary supplements now include to make sure that we signal, in either case defining botanicals or saying botanicals and herbals.

Is there a strong view to the suggestion made by Johanna or Shiriki on the committee, or can we leave that to Suzanne and her group to iron out?

DR. KUMANYIKA: Maybe she changed her mind and agreed with me.

DR. GARZA: No. She said she did not want to comment on it.

DR. LICHTENSTEIN: That means she agrees with me.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I agree with Shiriki. I think we have to acknowledge that there has been an expansion in what we think of as nutrient supplements or dietary supplements.

DR. GARZA: Scott?

DR. GRUNDY: I would urge that we follow up on what Roland said about defining these. I do not think most people know what that word means. It may be good to have several examples.

DR. JOHNSON: I guess I still go back to the original question of sort of so what at the end of this paragraph. I mean, we say that the value for health has not been established, and

there are few standards. So what? So do we want to say, you know, talk to your health care provider --

DR. KUMANYIKA: No.

DR. JOHNSON: -- or do we want to say nothing?

DR. KUMANYIKA: There is no more to say.

DR. JOHNSON: This is how it is.

DR. KUMANYIKA: We do not know any more.

DR. JOHNSON: It is up to you.

DR. KUMANYIKA: It is up to them.

DR. GARZA: Johanna?

DR. DWYER: Just back to the Point 4 there.

DR. GARZA: Before we go to Box 4, Shiriki wants to know if you agree with her suggestion or not.

DR. DWYER: I think it is useful to define dietary supplements. I had not thought about that. Just shorten the verbiage.

DR. GARZA: All right. We will leave that up to Suzanne and her group then, given the input that they have just heard.

You are on. Point No. 4.

DR. DWYER: The number of vegans is probably less than .1 of one percent in the United States, but some of them are children. Some of them are older people who are at special risk for other reasons. Therefore, I think it is very important to suggest that in the statement where it talks about B_{12} that vegans are mentioned as it says.

DR. GARZA: Suzanne had said that we have changed text to the preceding paragraph, or was that --

DR. MURPHY: Well, the text back on page 9 is now going to say something about if you do not eat animal products you need to worry about a series of nutrients, including B_{12}. The question was did we need to repeat that again on page 13.

DR. DWYER: My own preference is to repeat it because it is a good example. The point about vitamin/ mineral supplements is there are some specific uses that are very, very important, and it seems to me that is one. It is for people who have these various problems associated with aging, and a second one is people who are vegan vegetarians. They just are not going to get enough.

DR. GARZA: So you would say to repeat it in that paragraph?

DR. DWYER: Yes.

DR. GARZA: In terms of the health consequences, they are very serious.

DR. DWYER: Well, irreversible neurologic damage.

DR. GARZA: That is right.

DR. DWYER: Yes.

DR. GARZA: That would be an argument for repeating B_{12}. Any other comments? On Point No. 4.

Okay. Do you have another slide on remaining issues?

DR. MURPHY: I do.

DR. GARZA: Then let's go to the other slide because she may be raising it, Roland.

DR. WEINSIER: Yes. I will wait.

DR. MURPHY: Probably not. We are running out of time.

The only other thing is I just want to draw your attention to the fact that we do have now this graphic on how to read the food label. I do not think we have time to talk about it.

Kathryn wrote a paragraph to put in under it, and we are also going to put in an ingredient list. I do not know if we have time to come back and talk about that at some point, Bert,

but --

DR. GARZA: An ingredient list and what?

DR. MURPHY: Well, we wanted to have an example of an ingredient list somewhere --

DR. GARZA: Yes.

DR. MURPHY: -- in the text for this first guideline, and so the list that she gave me was for macaroni and cheese, which is what the label is for. It is kind of nice because it has a lot of --

DR. GARZA: It is in your folders, and it is in the second --

DR. MURPHY: Right.

DR. GARZA: If you take the colored graphic, it is the second page, the one that is stapled.

DR. MURPHY: Right. Thank you. It does have partially hydrogenated soybean oil, which maybe when we get to the discussion of the fat guideline you could refer back to this instead of having yet another one. It is possible.

Okay. Given the time --

DR. GARZA: Do you want to ask other questions with the food label paragraph?

DR. MURPHY: Well, I guess at some point we need feedback from the committee on that paragraph and on the inclusion. We have never really talked about -- we have never had a specific example of a food label until this meeting, so --

DR. GARZA: Okay. Rachel?

DR. JOHNSON: I would just like when we talk about the ingredient label I would like everybody to keep the sugar guideline in mind because that is one area where we do refer the consumer to the ingredient list because the food label gives total sugar, and this macaroni and cheese example will not facilitate them learning that because there is no sugar.

DR. GARZA: You would like one that includes both sugar and hydrogenated fat?

DR. JOHNSON: Yes. I think we might consider it. Kathryn has given me some examples here of comparing a plain yogurt with a sweetened fruit yogurt, for example, where you need to look at the ingredient list, but just to consider that as an example.

DR. GARZA: Kathryn?

MS. MCMURRY: The macaroni and cheese example was chosen by FDA because it illustrates the different points of how to choose certain amounts of different nutrients, so it was felt to be representative of a broad range of nutrient values, but we can choose virtually any food to represent --

DR. GARZA: Well, let's come back. After we go through the guidelines, we may want to come back and revisit this I think is what Rachel is saying.

DR. JOHNSON: Yes. I could have --

DR. GARZA: I do not hear any objection to having an ingredient list or to the graphic on a food label you would like to see included, right?

DR. JOHNSON: Right, and I could have this example you shared with me, Kathryn, copied for everyone --

MS. MCMURRY: Okay.

DR. JOHNSON: -- if that is all right.

DR. GARZA: Alice?

DR. LICHTENSTEIN: In the current booklet there is an ingredient list listed with three food labels on page 12, 13 and 28. You said the issue is giving more specific guidance on how to use that information?

DR. GARZA: Yes.

Richard, did you have your hand up or not? No?

Roland?

DR. WEINSIER: Just another consumer advocacy point is when we use the statement Nutrition Facts Label capitalized, I am not sure the consumer is going to know what we are

referring to. It may be better to use nutrition facts food label.

DR. GARZA: That is --

DR. WEINSIER: I am not talking to this guideline in specific. This was throughout. When I was reading the text, many times we are saying capitalized words Nutrition Facts Label, and we assume that everyone knows what a nutrition facts label is.

DR. GARZA: So you want to change the --

DR. WEINSIER: No.

DR. GARZA: -- title on the label?

DR. WEINSIER: I just think the wording --

DR. GARZA: It would take an act of Congress.

DR. WEINSIER: No. Just nutrition facts food label not capitalized or somewhere make it clear that it is a food label.

DR. GARZA: Okay. Any other comments about this then? Good.

DR. MURPHY: All right. I had two recommendations for further work, and these have not been passed by my working group yet so these have to be labeled Suzanne's personnel recommendations, but at least they are a place to start the discussion.

My first one is to try to better unravel the whole concept of variety because we were not able to do that as well as we might have wished to for this particular session of the Dietary Guidelines Committee, but I think we need to look at variety because even if we do not have it in our guideline, it is a concept that underpins much of nutrition advice today, so I would like to see a more comprehensive effort at looking at what promotes over consumption, what does not and how can that inform guidelines in the future.

The second thing I recommended was to somehow in the next few years look more carefully at the interrelationship between the food guide pyramid and the dietary guidelines. That has been a real stumbling block for this committee, and yet the food guide pyramid is such a valuable consumer tool that I do not see the two processes can really be undertaken in isolation.

My personal belief is that the food guide pyramid is much more a tool for insuring nutrient adequacy than it is a tool for interpreting the dietary guidelines, and I would like to see more discussion of this point, but at a minimum is there something we can do in the next few years to make future committees more comfortable about incorporating the food guide pyramid into the dietary guidelines.

DR. GARZA: Any other recommendations or suggestions? Roland, and then Johanna?

DR. WEINSIER: Yes. I think the review of literature that I did convinced me, and I think the comments of the three outside reviewers that critiqued this review of the literature lend support to the need for further research on the role of dairy foods versus alternative dietary sources of calcium in the prevention and treatment of osteoporosis particularly in the black population. I mean, we are really lacking in solid data there.

DR. GARZA: So that would relate to the adequacy issue, the nutrient adequacy nature of the guideline in the pyramid?

DR. WEINSIER: I guess.

DR. GARZA: I am just wondering if we are going to make a recommendation of this guideline how we hook it in, I mean.

DR. WEINSIER: Well, but I thought when we were trying to substantiate positions and changes that we have to indicate where the data exists and where the data do not exist, and this is an example of where the data do not exist. Therefore, we did not make the change in this guideline because we felt the data are not strong enough.

I am saying the data are lacking. We need the data, so now you can tell me where it is in under Adequacy or whatever. I am not sure. What am I not being clear on?

DR. GARZA: Well, let's hear the other comments. We will come back. Scott, and then --

DR. GRUNDY: I think Suzanne has a very good point about making the pyramid in sync with the guidelines. I do not know. I know that there are certain rigid ways that all this is handled, but could this process now open that up a little bit more and make it possible that if the two are linked in the minds of the public that somehow we could make them more connected to one another? Maybe we could raise that issue. I think it is an extremely important points.

DR. GARZA: I know you had your hand up. Let me finish here. I will not forget people.

Shiriki?

DR. KUMANYIKA: I wanted to add in the study of the pyramid the concept of how the serving sizes are conveyed because I still believe that putting the range of servings on the graphic is misleading to individual consumers and so in terms of what drives over consumption it may be variety, but it may also inadvertently be placing the population range on the pyramid and how that is interpreted by individuals.

DR. GARZA: Alice?

DR. LICHTENSTEIN: This is a general point, but I am bringing it up now because this is the most general guideline.

I think we need a lot more work on exactly how these guidelines are being used. Who is actually using them and for what? We hear a lot about how the public is interpreting them, and we are concerned about verbiage with respect to that. We have consumer group data, but then also we got a history of the guidelines and the point on the year 2000. It said this publication will continue to serve as the federal nutrition policy and provide advice to consumers about choices.

You know, I have not seen anything on really not how they are intended to be used, how we would like them to be used, but how actually they are used and by whom.

DR. GARZA: Rachel?

DR. JOHNSON: I would like to support what Shiriki said, and I think we have to get very clear in this booklet what we mean by a serving, what we mean by a portion, and I think this is the guideline where we need to do that.

I have a number of comments later on where we make vague statements like "Keep your portions moderate to low" or "Keep your serving moderate to low." I think if we are clear what we mean by a serving, then this what is a moderate, what is a low, what is a high, I mean, I think we need to be clear in this particular guideline what we mean by a serving and what we mean by a portion.

DR. GARZA: Johanna?

DR. DWYER: Well, the third member of the holy trinity of nutrition is the nutrition facts label. Perhaps if we can focus on harmonizing between the three, the pyramid, the guide to healthy diet, the dietary guidelines and then the nutrition facts label. Several of the public

comments speak to that, the confusion between the different portions and the three different things.

The other thing is I really applaud your list, Suzanne, and agree with the comments of others. The one thing I would add in terms of studies of variety, though, that I think is critical and we have not done a very good job of addressing is that enjoyment is part of nutrition, too. The contribution of variety to enjoyment, both within food groups and across food groups, is really critical.

Maybe we can come back to that later, but we really do need more studies that focus on those hedonic variables, as well as the nutrition science nutrient approach.

DR. GARZA: See what happens when the Irish invade New England? The Puritanical issues go out the window. Enjoyment. I do not know whether we can -- fun and frivolity are probably going to show up in Boston any day now.

DR. STAMPFER: In terms of research recommendations, I think these are good suggestions, but I would also just add that the whole point of the guidelines is to promote health. We need to have research that actually links these recommendations with real, live human health outcomes and not just theoretical constructs.

DR. GARZA: Other points? Roland, you had I thought some comments to make?

DR. WEINSIER: Mine would fall under Meir's then. In other words, he is looking at it more globally, which is appropriate. In other words, how do these foods and these guidelines reflect outcomes in terms of health? I am saying one specific aspect is just to look at the dairy group.

DR. GARZA: Yes.

DR. WEINSIER: This is a major issue that we spent a lot of time discussing on the basis of --

DR. GARZA: Especially among the black population, as you pointed out. That would be a very specific example of that.

Are there any other points that have to do with either recommendations or any other part of the text that you want to raise? If not, then --

DR. WEINSIER: Sorry. One paragraph --

DR. GARZA: That is all right. That is why we are here. We may be here until midnight.

DR. WEINSIER: One paragraph I am really struggling with is on the top of page 7. It is actually under the section called Keep An Eye On Servings. I had not seen a draft of this before. If I did, I failed to comment.

It starts out reading on page 7, "If you do not need many calories, choose nutrient rich foods from the five major food groups with special care." I was not sure what that meant. It went on, "Try to get most of your calories from foods that are a rich source of essential nutrients." I was not sure which.

The more I thought about this paragraph, I was not sure how it fit into the context of keep an eye on servings, and I thought it left open so many questions in terms of which, what kind, how much. You know, it says be mindful of or give special care, but I am not sure without giving specific information. It would be better just deleting this paragraph.

DR. GARZA: Again, what page was that on?

DR. WEINSIER: The top of page 7.

DR. MURPHY: It is the only thing on page 7.

DR. WEINSIER: Yes. It is the only paragraph on page 7, but it follows from page 6 under the category Keep An Eye On Servings. I really do not see how it relates to servings. Even if it did, it left me very uneasy as a closing paragraph in this section in terms of what specifically do you want me to do.

DR. GARZA: So you would suggest just eliminating it totally?

DR. WEINSIER: My suggestion -- I wrote off to the side question mark, omit the whole paragraph.

DR. DWYER: Amen.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I agree because the first thing that came to my mind, which I wrote, is how can I do this? It just did not give me any guidance at all, so either we go into a more narrative or eliminate it.

DR. GARZA: Okay. Shiriki?

DR. KUMANYIKA: Well, I was going to make a suggestion that might help to save space here, too, because I think that the chart -- I think I have seen this in other former booklets, the chart that shows how the serving range on the pyramid relates to calorie levels. It should be in chart form because that is a lot of what this is trying to say.

Under the first box is this little chart that goes 1,600, 2,000, 2,500 and then tells you how the serving levels do that. Maybe it is in the pyramid. It is in the pyramid for sure, not the dietary guidelines for sure. Yes. Yes.

DR. GARZA: How do use the daily food guide?

DR. KUMANYIKA: Yes, this chart. I think that this needs to be in there. The text is not that effective in explaining what this range of servings means, and it would save that paragraph.

DR. GARZA: So you are arguing for the addition of another box?

DR. KUMANYIKA: Well, a replacement of the text on page 5 that tries to explain the footnote to Box 1 there and the first paragraph could be replaced by a very teeny, little chart.

DR. GARZA: I mean, you are suggesting that we replace Box 1 then with something that is more similar to the --

DR. KUMANYIKA: Yes.

DR. GARZA: -- table that is in the food guide that provides both --

DR. KUMANYIKA: Is it on the back of that.

DR. GARZA: -- serving sizes and for different levels of calories?

DR. KUMANYIKA: Yes. It is on the back, yes. I like it better here.

DR. GARZA: So it is taking Box 1 then and replacing it with that? That may have some merit. At least we do not add a box.

MS. MCMURRY: Can we get copies of that?

DR. GARZA: Yes, and we will distribute them.

Alice?

DR. LICHTENSTEIN: I have a small comment about page 9 under Growing Children, Teenagers and Women that suddenly right in the middle we come up with the term animal fat, and that is not consistent with the way we are talking about fat in the fat guideline.

We talk about foods that are high in saturated fat or more specific, but nowhere else does the term animal fat come up, so either it should be further defined, or we should just rethink about that.

DR. GARZA: That is on page 9 --

DR. LICHTENSTEIN: It is on page --

DR. GARZA: -- under Growing Children?

DR. LICHTENSTEIN: Right. Right smack in the middle of the paragraph, the last two words in one of the sentences.

DR. GARZA: So you are saying we ought to have saturated fat instead of animal fat?

DR. KUMANYIKA: From foods high in saturated fat or just revisit that because it is standing out alone.

DR. GARZA: Any other comments? Roland?

DR. WEINSIER: The same section under Growing Children, the very first half of the first sentence did not help me at all. It starts out, "Adolescents, young adults and adults...", so that includes everyone except for, you know, young children. Why do we not just start with the third line and start out by saying, "Most people need a good source of calcium?"

DR. GARZA: That probably relates to everyone, would you not say?

DR. LICHTENSTEIN: Yes.

DR. WEINSIER: Yes.

DR. LICHTENSTEIN: But as far as maintaining calcium mass, bone mass, it is probably

appropriate to say everybody.

DR. GARZA: I think the group was trying to point out those that have the greatest calcium need in terms of actual quantity. That is what the adolescents, young adults and adults over the age of 50 have in common.

DR. MURPHY: I am not actually sure why young adults is in there. That may be a holdover from when the high requirements went up to 24, but they --

DR. GARZA: That is right.

DR. MURPHY: -- end now at 19, so I think we could cross out young adults.

DR. GARZA: So if one had adolescents and adults over the age of 50, Roland, would you be more inclined to keep it in?

DR. WEINSIER: Leave it in because now you are talking about specific groups.

DR. GARZA: Yes.

DR. WEINSIER: Otherwise you had essentially everybody.

DR. GARZA: I think we will check the DRIs and see if that point --

DR. MURPHY: I know them by heart. They end at 18 or 19.

DR. GARZA: Yes. Any other comments or concerns?

What I would like to propose to the whole committee then is that we refer the remainder of the editing and tweaking of this to that working group. If I see that there are in fact issues that, you know, do not fall under tweaking we will come back to you. Other than that, we have this one pretty much closed.

On Wednesday what we will do -- I am sorry. Thursday. If Kathryn will get us the food label -- I am sorry. The table from the food guide. We will look at that so we can see whether it would better replace Box 1, but that is the only left over charge, I think, when we come back to this on the last day.

Are there other points that you want the working group to come back to you with? There was wording that somebody was going to work out, one or two sentences on lactose

intolerance. That is the second thing we will look at on Wednesday. I am sorry. On Thursday.

DR. KUMANYIKA: I have some wording I want to suggest for that same section.

DR. GARZA: For the lactose section?

DR. KUMANYIKA: For the healthful eating pattern section.

DR. GARZA: Okay. We will take a look at that.

Are there other items, though, so we can be quite specific about what we want the group to come back to us with?

DR. DWYER: Of the four items Roland suggested, I think some of us agreed with three and not with one other, so we need to revisit that.

DR. GARZA: Do you mean on the guide? In fact, what I was going to suggest is if you could make the changes, if somebody could give Roland a xerox copy of that, of the icon, have him pencil in the changes he would like to see, together with Meir and Alice that wanted to do the fat, and bring back that to the committee on Wednesday? I am sorry. I keep saying Wednesday. It is probably Freudian each time. On Thursday. That will be another item for us to look at.

DR. JOHNSON: And we are going to look at the kids' food guide pyramid?

DR. GARZA: Thank you. That was the fifth one. Kathryn or Shanthy, will one of you remind us of those five items? We will need to get the kids' pyramid, the pyramid to Roland and Alice and Meir, and the box for the food guide. That is material that should be passed out.

We had a break, but we used it up. We are going to have to go to lunch at 12:00 p.m., so what I would like to do is to have Scott get started with the fat, and then we will break at 12:00 p.m. and just go without the break. I mean, we have to go to lunch at 12:00 p.m.

We have to try to stay on schedule because the agenda has been published, so we will be expected to start at 1:00 p.m., so I do not want to break early and then start early because we will create some problems, I think, for individuals that plan to join us at 1:00 p.m. perhaps.

Why do you not all just stand up at random and stretch while Scott is getting ready?

(Pause.)

DR. GARZA: Let's go.

DR. GRUNDY: I think there are two areas of importance here. One has to do with --

DR. GARZA: I do not know whether you can adjust the mike.

DR. MURPHY: I think I turned it off. Turning it on would probably help.

DR. GRUNDY: Now it is on. Now it is on. Okay. As I was saying, there seems to be two important areas here that we need to cover. One is the rationale for this guideline because it is a somewhat controversial guideline, and the second is the exact wording.

Now, a lot of the issues do relate to the title for the guideline, and I think this is going to have to have a lot of discussion, although I do believe that in the past sessions we have come a long way in reaching a certain level of agreement about the title and the structure of this guideline.

For the rationale part, I took it upon myself to try to do a careful review of the literature and try to update it to see where we stand and see if there is new information that would bolster or modify our thinking about this based on many years of evidence that has been growing in terms of the fact component related to health.

I am not sure that there has been any major breakthroughs in the past five years in this area. Nevertheless, there continues to be quite a large amount of research going on and many papers published that you can see I have tried to delineate here in this rationale part.

Now, one of the most important components was changing the order of the recommendations so that saturated fat was put at the head of the list and then cholesterol and then finally saying something about total fat.

So the recommendation about saturated fat I believe is based on the most solid scientific evidence, which I have tried to outline in the rationale, which comes from a variety of sources, laboratory animals, epidemiology, to some extent clinical trials, more information in clinical trials than you might expect, and then also there is the concept that we do have one solid thing in the cardiovascular field at least, and that is that there has been a tremendous amount of evidence in the last five years that LDL cholesterol is the major

atherogenic lipoprotein and that lowering LDL especially with drug treatment will dramatically reduce the risk.

Since saturated fats primarily raise LDL cholesterol, this puts it in line with the new information coming about the importance of lowering LDL, and I think this gives it extra support, these additional clinical trials that have been carried out, so I think we are on more solid ground now about saturated fat than we have ever been in the past, and it certainly deserves primary attention with regard to a fat recommendation.

Now the cholesterol component of that. The dietary cholesterol does have an effect on LDL cholesterol. There has been ongoing controversy about the extent of the effect. Nevertheless, it does have a finite effect on LDL cholesterol and deserves to be included in the recommendation.

Now the third component, keeping dietary fat intake at a moderate level, has been perhaps the most controversial part of this guideline. I think that this is an interesting discrepancy between what we say should be the recommended intake and what the wording should be. I think there is pretty much agreement that an intake of around 30 percent total fat is acceptable for the general population, and this has been a long-term recommendation.

Now, there are arguments to be made on both sides of that that a lower intake may be beneficial for reducing risk for cancer and for obesity. On the other hand, as I pointed out in this rationale, there is quite a bit of information going in the other direction in terms of scientific evidence.

If anything, I think in the last five years there has been a shift in the direction of weakening the link between the percentage of intake of dietary fat and the rest of these other diseases or obesity and cancer.

Nevertheless, I do not think that that is enough to warrant us making a radical change and taking all or totally eliminating a comment about the rest of the fat from the guidelines and to probably stay with the ongoing recommendation that we have had for many years about the level of intake provided the saturated fat is low.

On the other hand, the term moderate has been open to some question because some people feel that that sort of opens the door to allow people to increase their fat intake, and if we would stick with the original lowfat recommendation perhaps that would lead to a more moderate intake.

On the other hand, to eliminate the term altogether, the total fat term altogether, might

work in the other direction to allow people to eat as much fat as they want to, or at least that is a fear, so I think our subcommittee and I believe now the majority of the people on this committee feel that the term moderate applied to total fat is a reasonable way to go.

I think maybe sticking with the title, and before we get into some of the details of the wording of the guideline maybe I should open the floor for some discussion at this point about those general comments.

DR. GARZA: I would just add one to that. It would be useful to have the group discuss any input that we have gotten, and I forget where it came from, in terms of written comment. The concern was that by focusing on foods again in terms of the total diet or meals that we are making a distinction between good foods and bad foods.

I think the comment was that in asking people to choose foods that are low in saturated fat then we are advising that you cannot eat foods in any quantity that in fact may include saturated fats, so you may want to address that as well in our deliberations.

Johanna?

DR. DWYER: Scott, my first question was exactly the same. It was why would a better guideline not be "Choose a diet low in saturated fat, cholesterol and moderate in total fat?"

DR. GRUNDY: All right. I think that is a very good question, and my inclination would go along the same lines. It was my understanding that choose foods was more in sync of where we were trying to go in our guidelines right now.

DR. GARZA: The other issue is of consumer input; that they felt that diet was sort of a medical plan and that it was just not consumer friendly. I think that was a part of the reason to go to foods as well. I hope I am not having a revisionist construction, but that was the other. Consumers just found diet to be a difficult term to deal with.

DR. DWYER: But it is in the guideline so that you have confused them and also included the word, so I have trouble with it.

DR. LICHTENSTEIN: I am sympathetic to that argument, but, you know, every time it is referred to in the text that Carole has written the reference is still blank. Being sympathetic to those concerns, I think perhaps we are introducing too much of an ambiguity and this issue of good fat/bad fat or good food/bad food that we are really talking about a whole dietary pattern over a day or a couple of days and not specifically singling out one food or one even meal.

That would also be consistent with the idea of there are a lot of alternate eating plans, and some people can still remain under ten percent of calories as saturated fat and get most of them from dairy products, where someone else may choose to use lowfat dairy products and get most of their fat from meat, poultry or whatever, so although I went with the food issue because of the argument that you articulated, I really question whether it is wise. What we really do mean is a dietary pattern, and maybe we should go back to it.

DR. GARZA: Okay. Roland?

DR. WEINSIER: Yes. We have struggled for a long time with the title and the focus of this guideline, and it is, in my opinion, the most energy dense or fact dense section of all. I was particularly struck by the consumer focus groups' comments about three words; one diet, the other moderate, and the third cholesterol. All three of those are in the title.

I wonder. By the way, this is the only section, I think, that includes a word like cholesterol or a nutrient such as cholesterol that is not a food. All the others deal with food, something you can get your hand around and put in your mouth.

DR. LICHTENSTEIN: Sodium?

DR. WEINSIER: No. Salt. It says salt in the guideline, but whether it is alcohol or salt or grains or fruits or vegetables, these are things that conceptually, as well as physically, people can feel.

Anyway, my thought is, Scott, would we be making a major point, if we can only make one, to come across in the title and the major emphasis something along the lines of "Use high fat animal foods sparingly?" Would that get at the saturated fat and the cholesterol? It does not hit the total fat, but, you know, we struggle with that anyway.

Is that really a key message to try to eat less of or use high fat animal foods sparingly and not have to use cholesterol in the title?

DR. GRUNDY: I guess my comment on that is I would be quite sympathetic with that. However, I do not know whether that is going to be acceptable to, you know, like all the different constituencies of the general public in terms of focusing on animal products.

Now, I think you are right. If you did focus on animal fats, you would cover almost everything in the guideline, and that is where we need to pay more attention in reducing animal fats, but I had some concern of whether that is an acceptable term of not. I would be interested in other people's view on that.

DR. GARZA: Let's make sure that we understand. Roland said to use high fat animal foods sparingly, so the operational words are high, animal and sparingly, I suppose.

DR. WEINSIER: One of the comments the consumer focus groups made was that they are not familiar with the words saturated and cholesterol, but they know bad and good cholesterol. Here we have in the title the word cholesterol. We never say anything about good and bad.

Are there good and bad dietary cholesterols? Is that what they are going to be conjuring up in their minds?

DR. GARZA: They are relating it to LDL and HDL.

DR. WEINSIER: Of course, but I am just wondering. We are starting off with the word cholesterol, and we never address what the consumers are looking for, good and bad cholesterol. These are some household words, but these are circulating, you know.

I wonder if maybe dealing with the animal fats and bringing the text particularly which you have done I think very well in Box 13, the different types. Now, here I think it is addressed very well, but the title and the first paragraph are so, you know, dense in bringing out technical terms that I think, you know, my feeling was change the title and also make that first paragraph much less dense and more consumer friendly and then use Box 13 to get into the technicalities.

DR. GARZA: We have a very pertinent suggestion on the floor. Meir, and then Johanna?

DR. STAMPFER: Yes. I think that is a good idea. I like it. Obviously the guideline cannot give all the details that we want to have. For example, it does not say anything about trans, but that stuff could go in the text.

I think that really gets the message across, the main message that we want people to do to change their diet, so I support it.

DR. DECKELBAUM: Use animal fats?

DR. STAMPFER: I support Roland's wording.

DR. DECKELBAUM: Use animal fats?

DR. WEINSIER: Well, something along the lines "Use high fat animal foods sparingly."

DR. DWYER: I do not think that is very useful in that something like what Scott's committee has done,

Choose a diet...", and if diet is a term that is a no-no then how about an eating pattern, "...low in saturated fat, cholesterol and moderate in total fat."

My concern about the total animal fat business is are salmon animals, or are they vegetables? If you ate a diet that was high in salmon, you would be perfectly fine, would you not, even though it is an animal fat?

DR. DECKELBAUM: Or palm oil.

DR. DWYER: Palm oil is --

DR. GRUNDY: There is the tropical oils issue. Now, that is not as big as it used to be. Worldwide it is a huge problem.

DR. GARZA: I think that is where we get into the problem of having foods as well. Again, we are targeting. If you can think of something that conveys dietary patterns but stays away from some of the words consumers are having difficulty with, perhaps we could have our cake and eat it too. I will save that one for the last guideline.

DR. MURPHY: A minor point. I did not see in the consumer comments that anybody reacted negatively to diet.

DR. WEINSIER: That stuff I mentioned, but it may not have been in the --

DR. MURPHY: It was not in the fat one.

DR. WEINSIER: It may not have been in the fat one, but --

DR. KUMANYIKA: It is at the end, at the end under Other.

DR. WEINSIER: It is seen as negative.

DR. MURPHY: Okay. Sorry. I missed that.

DR. DWYER: How do they feel about eating pattern?

DR. GARZA: Carole, do you have anything on eating pattern?

MS. DAVIS: I do not think we tested eating pattern.

DR. GARZA: They are looking at their notes. We will let them --

DR. JOHNSON: They said they liked the phrase food choices.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I think there is fairly good evidence that this consumption is associated with a decreased risk of cardiovascular disease, and it has impacts on platelet aggregation and blood pressure and triglyceride levels and HDL cholesterol, and I would hate to see something that discouraged the consumption of fish. By saying animal fat, it sounds like it is discouraging the consumption of fish.

DR. GRUNDY: If we could choose the word -- I agree with what you just said. If we could choose the word diet or use the word diet up front, it would simplify this a lot.

If you could just accept "Choose a diet low in saturated fat and cholesterol and moderate in total fat," that would cut down a lot of words on it so maybe in spite of what the public said overall, in favor of brevity it might be worthwhile to do that here.

DR. GARZA: How do we deal with the cholesterol issue, Scott, because that I think also is -- I can understand where the public could be confused by good versus bad. There may be a good and bad dietary cholesterol as well.

DR. GRUNDY: Well, you mean just leave the word cholesterol out altogether?

DR. GARZA: Yes, and just deal with cholesterol in the text, but focus on saturated fat and moderate in total fat. They also complained about the length of the message and the many items it seemed to be trying to cover.

DR. WEINSIER: It was not just cholesterol.

DR. DWYER: Yes, but to communicate. Just because. I mean, that is not a reason for throwing out cholesterol.

DR. GARZA: Well, I am not arguing to throw it out. I am saying gee, you can keep it in the text, but if you have a diet low in saturated fat and moderate in fat you almost achieve your low cholesterol diet. You would be hard pressed to plan a diet. With eggs would be the --

DR. GRUNDY: Organ meats and other things. There are sources out there.

DR. GARZA: Organ meats are not consumed that commonly, I would not imagine.

DR. GRUNDY: Yes.

DR. GARZA: Well, I know there are segments of it that do.

DR. KUMANYIKA: Do not let up on the organ meats.

DR. LICHTENSTEIN: I am concerned about putting too much weight on the consumer comments because what we are also hearing is the consumers are not aware of the dietary guidelines. They do not use the dietary guidelines, so we really -- this is where I think the discrepancy comes from where we are working from, who we are aiming towards and then how they are actually being used.

I think health care providers can probably deal with a slightly longer guideline perhaps than consumers, but from what we understand, and these guidelines have been around for a long time. If consumers are not aware of them, they are not aware of them.

We might choose to do something about it, but then to craft the guidelines on the basis of the consumers that tell us they are not aware of them, there is just something inherently flawed there.

DR. GRUNDY: One thing I would say about the cholesterol is that there has been a gradual decline in cholesterol levels in the population, and people look at that in terms of the mechanism for that.

There has also been a parallel decline in cholesterol intake in the population. It has gotten down quite low compared to what it was like 30 years ago. It appears as though a lot of the decline in the plasma cholesterol is related more to the falling cholesterol intake than it is to saturated fat.

DR. GARZA: So am I hearing let's keep all three words that Roland objected to?

DR. GRUNDY: Well, I am sort of in favor of that, but I would be inclined to the diet to simplify this, use the word diet if that would be acceptable.

DR. GARZA: We would add a fourth that the consumer would have difficulty with.

DR. GRUNDY: Yes.

DR. GARZA: I am not arguing either way, but now we would have diet, saturated, cholesterol and moderate. We would have been as inclusive as possible choosing all the words that consumers had difficulty with.

DR. KUMANYIKA: At the risk of making things worse, in the 1995 guidelines we ended up using parallel wording for a couple of these lower things.

Since the consumers seem to understand the concept of less as it related to salt, one possibility is something, "Choose and prepare foods with less saturated fat, cholesterol and total fat," which is not the same as choose lowfat foods. It is choose foods with less, introducing yet another possibility.

DR. GARZA: Okay.

DR. GRUNDY: I think we want to actually emphasize low. I mean, we have specific numbers. We are trying to make the words correspond as much as possible to the numbers that we have, and I think low conveys that. You know, I do not know. We could talk about that, but that would be my impression.

DR. KUMANYIKA: Well, I tried to read as much of the focus group stuff as I could, and I was a little worried that consumers think that low means no and what we are doing with this word low, how it is perceived in a guideline.

DR. GRUNDY: Okay. I guess I would respond that for saturated fat and cholesterol if that is the way they interpret it that would be okay because they are not going to achieve that.

Now, for the moderate I am a little bit more concerned about, you know, total fat saying no to that because I do think that is what low means. For saturated fat I am not so much worried about the implications of that for eating habits.

DR. LICHTENSTEIN: The other point is I agree with Scott. The other point is that if people go to no saturated fat, which we know they are not going to go to, but if they go to no saturated fat or no cholesterol, there are no adverse health outcomes that we are aware of because the essentially fatty acids are unsaturated.

With respect to fat, if they go very, very low there is a significant proportion of the population that are going to spike the triglycerides. Their HDL levels are going to go down, and probably that is not -- that would lead to an adverse health outcome, so I think those

points have to be factored in.

DR. GARZA: All right. It is noon. Let me give all of us a challenge. Come back with the ideal guideline that will answer not only all of the consumer concerns, but all of our scientific issues.

While the gentlemen were out of the room, one of the ladies suggested we ought to start because all the brainpower was in the room anyway, so maybe we ought to challenge the men to come up with something and prove that in fact that was not accurate or something. I do not know.

We will reconvene at 1:00 p.m. and pick up with the guideline.

(Whereupon, at 12:00 p.m. the meeting was recessed, to reconvene at 1:00 p.m. this same day, Tuesday, September 8, 1999.)

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AFTERNOON SESSION

1:05 p.m.

DR. GARZA: Having absolute confidence in my Texas colleague, I am sure that Scott has solved all the problems we discussed and now has some solutions.

To recapitulate very, very briefly, the major challenge before us is how do we transmit a message that updates the science in terms of saturated fat and cholesterol, updates the science in terms of moderate versus lowfat, avoids the word diet because consumers find it complex and also avoids presenting a good food/bad food dichotomy and all in three words or less?

It is not very easy, but I am confident that Scott will come up with a Solomonic solution since the chair is obviously not able to.

DR. GRUNDY: Even if I did, I do not think it would be accepted here by this group. It would not even be recognized.

Well, even since we broke up I have heard several different views on this, so maybe we could continue to discuss this issue until we get just the phrase that we wanted.

I think that what I heard was that we ought to continue putting priority on saturated fats, keep cholesterol in and probably not drop the reference to total fat, but have it third and, if possible, introduce a little more of an idea of moderation on that in total fat with more emphasis on lowfat, low saturated fat.

Now, if we are in agreement on that are we just struggling with the wording to achieve that? Is that the way you see it, Bert?

DR. GARZA: I think so. I believe the issue is whether we just go with low and deal with low in the text in terms of total fat or whether you want to keep moderation in. I mean, it is just a matter of wordsmithing.

DR. GRUNDY: Actually, I am not -- I was sort of in favor of using the word guide all the way through because that would make it a lot shorter if you just said a diet low in saturated fat and cholesterol and moderate in total fat. That would be a simple title. Let me throw that out and then let that get criticized.

DR. TINKER: Can we add one more? Roland and Richard and I had lunch together, and --

DR: WEINSIER: A lowfat lunch.

DR. TINKER: A lowfat lunch.

DR: WEINSIER: Particularly low in saturated fat.

DR. TINKER: Actually, I do not think my lunch was low in fat when I think about it, but it was low in saturated fat maybe.

What we came up with to try to simplify the message that was leaning more on the consumer issue and also put in all the components we were talking about was to say something like "Choose foods lower in fat, especially saturated fat and cholesterol," and agreeing that the moderate fat is within the concept of eat lower, but it was instead of having the specific eat low or moderate, everything was placed in a relative sense.

DR. GRUNDY: That sounds like you are putting fat first.

DR. TINKER: Fat is first, but it puts more of the context and also some of the issues about perhaps nutrient density.

DR. GRUNDY: What is that issue?

DR. TINKER: Nutrient density in the fat being the most calorically dense nutrient and potentially contributing, you know, in a plate of food to a higher caloric intake.

DR. GARZA: The suggestion is "Choose foods..." --

DR. TINKER: "Choose foods lower in fat, especially saturated fat and cholesterol."

DR. GRUNDY: Well, that is similar to the current guideline. I mean, it is just a slight modification.

DR. TINKER: Yes.

DR. GRUNDY: It takes the priority away from the saturated fat?

DR. TINKER: Do you think so when it puts in there especially saturated fat and cholesterol?

DR. GRUNDY: I do not know why you would want to choose foods lower in fat. I mean,

that part I am not sure I understand if it is unsaturated fat why you would want to do that.

I mean, what the rationale is if you read this, that concept seems to have been brought into a lot of question. In other words, the scientific basis for that recommendation is not terribly strong if you look at the emerging data in the field the way I read the literature.

DR. TINKER: Yes. I think we are talking about lower fat. It was really a different way and maybe not the right way, but a different way of thinking about moderate fat, so it is not trying to get people to eat lowfat, but just relative to where they are, particularly on the average with the average diet being higher than the moderate realm.

DR. GRUNDY: A lot of people are eating lowfat already, so --

DR. TINKER: Some are.

DR. GRUNDY: Yes. A lot are.

DR. TINKER: Okay.

DR. GRUNDY: Yes.

DR. TINKER: Well, let's, you know --

DR. GRUNDY: I mean, I could draw you a distribution. I have a distribution curve of the fat intake in this country, and there is a tremendous number of people, like half the population almost, is below 30 percent fat already.

DR. GARZA: Johanna?

DR. DWYER: I was very much impressed with your review, Scott, and for that reason while I hear what you are saying mostly, I still like putting the priority on saturated fat and cholesterol and hope you consider something like choose an eating pattern or a diet low in saturated fat, cholesterol and moderate in total fat or lower in total fat.

DR. GARZA: Scott, let me make a suggestion. If we look at last year's, I mean, at the last guideline that looked at diet, we are not changing the quantitative aspects of it in terms of we are still going to be recommending no more than 30 percent of fat in the diet so that in fact that definition of low is not being changed.

What about going with "Choose a diet low in saturated fats, cholesterol and total fat?" That

gets the emphasis on saturated. It avoids the good food/bad food because we use diet. The only thing it does not do is try to distinguish between moderate and low, but given the fact that we define low or low was defined in the last guideline as 30 percent, continue to go with that and moderate the text in terms of what our expectations are for how to meet that 30 percent rather than trying to get all the concepts in one quicky phrase. Would that offer as a good alternative?

DR. GRUNDY: I have said from the very beginning that that would be one thing that I could accept if we followed that approach.

I do think the term moderate, introducing moderate, is -- there is a message that may be better suited for the 30 percent level for the reasons that we went through. I think that is worthy of debate, but I think really our other choice --

DR. GARZA: My only reason for suggesting it is that in fact we define low, or 30 percent is defined as low in the document --

DR. GRUNDY: Uh-huh.

DR. GARZA: -- and so we are faced with confusion because by saying moderate then I think we are going to have to be very specific that we did not change the number. We are just changing the wording as to the educational paths that we have given ourselves. Perhaps not. I mean, that is an alternative to what less is.

Let me go with Alice -- I am sorry -- and then Meir.

DR. LICHTENSTEIN: Well, I am a proponent of the moderate fat. The reason for that is I think currently the 30 percent number, 30 percent or less, is certainly out there. I think the general perception, though, is that 30 percent is not a lowfat diet. It really is a moderate diet or very close to there. A lowfat diet is really the 15, ten percent fat that certain individuals are advocating, and I think we really need to distinguish between those two.

I think that although there is going to be -- there may need to be a fair amount of education put into it. I think we have to realize that perceptions have changed. Eating patterns have changed. Fat consumption in the U.S. has changed, number one.

Number two, I think that there have been some unanticipated consequences of saying a lowfat diet, and that has been that a lot of the fat that has come out of the diet has come out from unsaturated fatty acids and not saturated fatty acids. We can see that the decline

in saturated fat has really been paralleled with the decline in total fat where it would have been nice to see the saturated fat decline in a more precipitous fashion.

I think what has also happened is that we ended up with a lot of foods that are non-fat, lowfat or being perceived as being beneficial or having certain advantages and that to a certain extent it can be over consumed because they are good for you because they have no fat in them. That has not resulted in an advantage, and we are seeing that caloric intake has stayed the same or gone up, even though fat has gone done.

DR. GARZA: But there are regulatory definitions, I thought, associated with low. I mean, we are taking on a burden that goes beyond the present burden that you have just described. If we are going to do it, we better be very strong as to why we are doing it.

Although moderate to this committee may be very clear, in a legal sense it is not, and in the way we defined it in the past it is not. If we are going to change it, we are going to need some science rather than it is our perception that.

Meir, and then Johanna?

DR. STAMPFER: Just to echo that, I think it is essential that we highlight the distinction between types of fat. I mean, here the evidence is just so overwhelming. We are not talking about just what we feel are historical recommendations in the past. This is randomized trial data.

Just a few weeks ago there was a new randomized trial that came out on Omega 3 fatty acids. We do not have this strength of evidence for other guidelines that we are perfectly happy to make strong statements about.

In contrast, the 30 percent calories that keeps getting repeated like some holy phrase, it was just picked arbitrarily. There is no scientific data. I think part of the problem that we have when you say our extra burden is that we are burdened with historical recommendations in the past that were not scientifically based.

DR. GARZA: Meir, I thought that Scott reviewed data that showed that in fact 30 percent may be a very adequate number.

DR. STAMPFER: It is adequate. So is 25. So is 40.

DR. GARZA: No, no. That is not what he says in his data review. Thirty percent seems to be right where we want to be. Not 20, not 25, but 30.

DR. STAMPFER: Not 35?

DR. GARZA: Not 35.

DR. GRUNDY: Well, that was my interpretation of the data that that is a fairly good number. Now, I think it was more that we do not want to be on the 20 percent range. That is not a good idea. Thirty-five? I do not have too much trouble with that, but I think that 30 is about the right number. I think Meir would like 35, but --

DR. STAMPFER: I do not want any particular number, but the point is that --

DR. GRUNDY: Yes. Right. Well, that is why I think the moderate might fit better with the database.

DR. GARZA: Could somebody help us? What is the definition of a low, a product to be lowfat? What percent calories have to come from it?

DR. KUMANYIKA: It is less than 20 grams. Is it 20 grams?

DR. SUITOR: Three grams or less per serving. We did not figure it out on the percentage.

DR. GARZA: A percent. It is not going to help us then.

MS. MCMURRY: For a meal product would it still be three grams?

DR. SUITOR:A meal is three grams or less per 100 grams of product.

DR. GARZA: So if fat is the only source of calories in that product and it has three grams, it could be 100 percent fat, and it would still be labeled a lowfat product. No?

DR. SUITOR: Three grams or less per 100 grams.

DR. GARZA: So if you had water --

DR. SUITOR: No. There may be a percent of calories and fat.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I would question not to focus on individual foods. We are really talking about a diet and a dietary plan, so I do not think that we should go in that

direction.

DR. GARZA: Johanna?

DR. DWYER: I was not clear from your discussion. Scott, would you be willing to accept "Choose a diet low in saturated fat, cholesterol and total fat?" Is that what you said?

DR. GRUNDY: I said that if it was in that order, and that is a definite change, I would be willing to accept that. I do not think it is quite as good as the moderate, but it is a departure.

We are using the same numbers, but we are adding a different word because we think that perception in the world has changed about what lowfat means, and maybe changing the word may be more in line with what we are recommending. That is what I think we are saying here.

I guess, Bert, your feeling about moderate, it is confusing or it changes the --

DR. GARZA: From my perspective, if we look at we said low in --

DR. GRUNDY: Right.

DR. GARZA: Not we, but at least the guidelines said low in the past. It was defined as 30 percent. I can certainly appreciate that the sense on some of the committee members at least is that we can be more liberal, but there is a major clinical trial in effect in this country that is testing to see whether or not the total fat in the diet has remained in health outcomes.

I think for us to pre-judge that at this time sends a very -- has the potential of sending a very confusing message to the American public unless we think that trial ought to be stopped, so there are other issues that I think we need to be very cognizant of as we move this forward.

Now, if, however, we were going to say no, we are going to change the definition of what low and moderate mean in terms of quantitatively, then perhaps I would not be as concerned about it, but if we are still going to stick to 30 percent but we are going to change low to moderate, then we are just I think creating the potential for confusion beyond that which we might reasonably want to go. That is my read of it, and I have an open mind still, I hope.

DR. DECKELBAUM: I hope we are not getting back to the perception of something like let, but, you know, the word low, you know, we have heard does have regulatory meaning, and it also has perceptive meanings. My perception of low might be different from Alice's.

The American Heart Association I believe has the Step 1 American Heart Association cholesterol lowering diet, which would be a total fat of 30, so that there is a lot of room for mis-interpretation over the word low, and it is all going to be -- a lot of it will be subjective going from low to moderate.

That is why when we discussed this at lunch we thought that the word lower -- it is wordsmithing, but the word lower does not, I believe, carry regulatory meaning to it, but it gives the message, I think, between low and moderate. You can use it for both the moderate camp and the low camp, and I do not see people being unhappy.

DR. GARZA: Suzanne?

DR. MURPHY: Well, I think it is another choice between doing the science exactly right and conveying a message to consumers that is understandable.

To add to the list of reasons Bert likes "Choose a diet low in saturated fat, cholesterol and total fat," if I read the focus group results as consumers saying they do not know the difference between those two words, and I think we give very good guidelines on how to operationalize it in the text of the guideline. We give exact cut points for both saturated fat and total fat, and I do not know that it matters so much the exact wording of the guideline itself as long as the concept of lowering gets across. I like Bert's wording.

DR. GARZA: Shiriki, and then Alice? No?

DR. KUMANYIKA: No.

DR. GARZA: I am sorry. Alice?

DR. LICHTENSTEIN: Right now we only give a number for the 30 percent. We do not give a lower limit, so we do not really give guidance.

DR. MURPHY: For saturated.

DR. LICHTENSTEIN: Right, but I am talking total fat now. We just have 30 percent or less with the implication that the lower the better because there is no bottom. I think there is good evidence that very low is not advantageous except under certain circumstances.

Now, do we want to undertake putting a lower limit and coming up with a number for a lower limit? I mean, that would be another option. It would be a big undertaking.

DR. GARZA: Roland?

DR. GRUNDY: Yes. In the rationale section, I think the point is pretty clearly made that, if I could state it, as intake of foods high in saturated fats is reduced, there likely will be a reduction in saturated fat intake. Excuse me. A reduction in intake of total fat. As foods high in saturated fat is reduced, there likely will be a reduction in intake of total fat.

If in fact that rationale is correct, then I would feel very comfortable, and I think the consumer comments would be dealt with considerably, in going back to what I think was the original proposal, "Choose foods that are low in saturated fat and cholesterol" period.

We are getting into so much trouble trying to deal with the word moderate and total fat and diet. If in fact by emphasizing low saturated fat we are going to in effect take care of the total fat, then why not just stop there?

DR. GARZA: Johanna?

DR. DWYER: Maybe we should just get a straw vote and --

DR. GARZA: Before we do that, and I think we are going to come to that. Alice, if I go through the text I do not think the text now is recommending. I think the previous text did, recommending the lower you go the better. I mean, I --

DR. GRUNDY: Can we follow up on what Roland said? I think that rather than just letting that lie, why do we not discuss that?

I think that is a good point that he made. That kind of follows up on what he said about the animal fat food. If you leave it there and let the text deal with the rest of it, it might be a way out of that dilemma.

DR. GARZA: I think we could have that discussion again. We have had it I think two or three times in terms of --

DR. GRUNDY: Well, we have, but we have --

DR. GARZA: Okay. All right. Johanna? Let's have the discussion.

DR. DWYER: Well, let's talk about deja vu all over again. If there is a national -- the largest national clinical trial that has ever been attempted in the United States, which is the Women's Health Initiative, in the field sponsored by the Department of Health and Human Services to ask that question and test it, it strikes me as unwise to not include total fat.

DR. GRUNDY: Because we do not know the answer yet? Why would you have to have it in if the question is not answered?

DR. DWYER: Well, I read your rationale, and I thought it was a very good rationale except you did not mention that particular trial and that it was going on right now.

I think we do need some guidelines on total fat, and I am willing to compromise on the word, but I am not willing to compromise on whether total fat is mentioned in the guideline or not. I do not think it is true scientifically that if you decrease saturated fat that necessarily total fat will go down. I do not think that is true, and I think I can show you that it is not true, working out some diets.

DR. WEINSIER: So you are saying the rationale is incorrect, and we need to change the rationale, not only the title? I was just reading from the rationale.

DR. DWYER: Whereabouts in the rationale?

DR. WEINSIER: Page 29, the bottom paragraph. Page 29. There is a Section E, Tab E. If you look at the bottom large paragraph, it starts with the words, "A previous reason..." Then go down six lines to the word, "Nonetheless..."

DR. DWYER: Well, there is a word in there called likely. It says, "Nonetheless, as intake of foods high in saturated fat is reduced, there likely will be some reduction in total fat." It depends on what the fat is that is in the diet.

For example, Carmelite nuns living in the Philippines who eat no animal foods at all have very high intakes of coconut oil, and they have very high saturated fat.

DR. WEINSIER: Oh, there have got to be exceptions. I do not think that is the issue. I am just trying to think of a title as a compromise between what the consumers understand and interpret and the scientific message that we want to be sure to convey.

DR. GRUNDY: If there is a clinical trial going on, that would not necessarily -- if that is discussed and all the rationale are in the text, it would not preclude leaving out the total fat

from the guideline, would it?

DR. GARZA: No. As I have interpreted at least Johanna's and others' misgivings is that by omitting it then we send the message in fact that we are no longer concerned about total fat. I do not know whether we have built a sufficient rationale for saying that total fat does not matter.

DR. MURPHY: My concern all along, of course, has been the contribution of fat to over consumption of calories. I do not see any evidence that contradicts what I am pretty sure is true that high fat diets tend to be high calorie diets.

DR. GRUNDY: Well, I mean, what you are saying is literally true that the more calories you consume in the form of any nutrient are going to have more calories in them, but that does not necessarily hold that the percentage of fat is going to make the total calories higher. You could have -- I mean, there are millions of people around the world who eat a higher than 40 percent fat diet and are very thin people.

You can go to Europe and look. They eat higher fat than we do, and they are as thin as we are so I do not think that it necessarily follows the percentage of fat, but you are absolutely right that the total number of calories

-- fat contributes to the total calories. If you eat a lot of fat, that is going to add to the total caloric intake.

I tried to get at that by modifying the text to the rationale to distinguish between those two concerns.

DR. GARZA: Is it Roland's rationale or in yours, Scott -- I do not remember -- that goes to the literature in terms of the role of energy density of foods and the quantities of foods not obviously being the regulatory factor, so if they eat the same quantity food if one of them -- let me see if I can pose this correctly.

Individuals who are offered similar quantities of food, one that was more calorically dense than another, they consume exactly the same quantity rather than adjusting for the caloric content of the diet --

DR. GRUNDY: The problem, and I would note that there have been a lot of short-term studies that are suggesting one direction or another, but the problem is there is no long-term studies that show that, so we do not have two year data showing that you have those alternatives as any difference in the final ways that you choose those different groups.

DR. GARZA: No. I am not arguing. I am saying however we resolve this has implications for other parts of the text.

DR. WEINSIER: That is under the rationale section for the weight guideline based upon data indicating exactly what you are saying that the energy density of the diet is contributed to a large extent by fat, but the ultimate determinant of energy intake at meals and over short periods of time, two weeks, is determined by the total energy density of food, i.e., your eating to weight, not to calories or to specific nutrients.

DR. GRUNDY: That is true for those studies, but whether that is going to translate over a long period of time in modifying someone's weight, we do not know that.

DR. WEINSIER: Yes, and there are some studies of weight control, too, that I know of, but I think there are more that indicate that weight loss will occur simply by reducing the fat content of the diet and recommending adding an intake of lowfat foods. It does not get specifically to the energy density, but it does address the lowfat.

DR. GRUNDY: If what you say is true, then we should recommend a lower fat intake, but I do not think that is true, what you just said.

DR. WEINSIER: Well, I do not know how you would find proof. I am just saying --

DR. GRUNDY: Yes.

DR. WEINSIER: -- that we have included in our rationale section reference to two articles. I am saying I think there might be others, but two that I am definitely able to put in here that show that weight loss, but this is not over years. Not many weight loss studies go for

years, --

DR. GRUNDY: That is what I am saying.

DR. WEINSIER: -- so I do not think we are going to have those data, but in terms of, you know, months and looking at body weight as the end point, then lowfat diets appear to be one tool for helping people lose weight.

DR. GARZA: Do you feel that there are data that would support the notion that in fact the percent fat in the diet does not matter over the long term? I mean, can we not make the same argument that in the same way we do not know whether or not a lower fat diet is conducive to good health that we know that a higher fat diet may also not be conducive to

good health over the long term?

DR. GRUNDY: If we knew the answer to that question, then there would not be any discussion here today. The data are not there. We are picking around the edges of small studies done here and there, but if you look at large population trends like I just said, if you take Europe versus the United States, that does not hold up in large population studies.

DR. GARZA: We could take the position that in fact previous committees may have made errors in recommending a lowfat diet, but unless we have the data now to change that recommendation we are going out into a revisiting of every decision that has been taken over the last 20 years in consideration of these guidelines.

Shiriki?

DR. KUMANYIKA: I think that the rationale states clearly that the reason, the direct reason, for including total fat had to do with wanting to include cancer, even though the heart disease literature was pointing more to saturated fat.

Tim Byer spoke to us early on and said that that has not panned out, the total fat, but the Women's Health Initiative is still in the field so I think it is because there are so many ways that fat could be a health problem that we have to include it until it is shown that it does not cause problems for any of these things that we are concerned about, not just the heart disease.

DR. GARZA: Alice?

DR. LICHTENSTEIN: First of all, I would hate to see total fat not included in the guideline because I think we do not want to give the impression that we are not concerned about total fat intake at all. Regardless of what we say of this text, the guideline is going to be used out of context.

If we went from moderate fat to lowfat for the total, then we would have to rewrite. Certainly we could, but then what are we going to end up saying actually in the text itself because right now it says keep the fat intake moderate, about 30 percent. I would actually prefer to see 30 percent or less and then we give specific guidance. We would be going back to what we have been doing all along, which is to say keep fat content low because that is what we would end up saying in the guideline.

Now, one thing that I find interesting is it looks like the percent of calories in the U.S. diet from fat has decreased. It was at 38 percent. Now we are at 34, 32 percent. We do not see

body weight going down. Total calories, caloric intake, is not going down. I mean, that is one bit of data.

Short-term studies I have done and other people have done show that if you drastically reduce the fat content of the diet in the short term in a metabolic study situation, yes, people eat less and they lose weight. If they eat less calories they lose weight, but there also is a very contrived situation.

It is not free choice. They get a lowfat diet. Usually it is very repetitive. They have the same thing every three days. They do not get to go out and buy unlimited quantities of lowfat cookies, lowfat cakes, lowfat ice cream, the whole thing with fat free, so I think that if we are looking for data from an experimental perspective it is not there right now for the long term, and I am not sure it is going to be there for the long term because to do those kinds of studies is next to impossible in a free living situation.

Then you have to sort of look at what kind of data is out there. I think the data in the U.S. population is very interesting.

DR. GARZA: Does the whole situation as far as metabolic data trump epidemiological data because of all the errors in terms of proving causality with those types of data?

DR. KUMANYIKA: No.

DR. GARZA: No? I mean, because at least in DRI discussions that is the general rule. I mean, if you have epidemiological data and metabolic data that in fact you end up the metabolic data ends up trumping the epidemiological data. Now, we may agree or disagree, but precisely because it is more controlled that in fact it offers you less ambiguous information.

DR. LICHTENSTEIN: Certainly, but I think you -- you know, I think but you also, I think, have to take each situation independently.

I am the last one to knock my data. I published one of those studies, and I think it was a darn good, well controlled study where I had people on 30 percent fat diets, 20 percent fat diets and a 15 percent diet at, you know, the same caloric level as the 30 percent and then where they could choose, and they actually reduced over the short term.

That data is confounded and so then I think although, yes, most of the time we would rather see intervention data as opposed to observational data, you have to look at each study in the way it is done and the confounding factors.

Confounding means that if you are not giving people free choice in one situation you know there is a lot of free choice, and we have heard a lot of variety and discussed a lot of it and how it is going to impact on things, so I think you really have to take things case by case.

DR. GARZA: Lesley, and then Shiriki?

DR. TINKER: About the free living studies and the lowfat diet. In the early 1980s when the original Women's Health trial was conducted it was not a weight loss study particularly, but it was 20 percent energy from fat compared to a usual diet among post menopausal women. Those that were in the lowfat, which was defined as 20 percent, they did lose weight up to 18 months.

DR. LICHTENSTEIN: Right, and the weight loss was what, 2.3 kilos over two years?

DR. TINKER: Something like that, yes.

DR. LICHTENSTEIN: That is 2.2 kilos over two years. Would they have lost it by four years? There is some long-term studies like that that have shown that the two groups have ended up converging after a year or two.

There is some data showing compensation, that at first you just sort of wait, and then eventually there is a compensation. If you are on a lower fat diet, the total volume of food increases so you start approaching --

DR. TINKER: Even beyond 18 months. That study went 18 months.

DR. LICHTENSTEIN: Right. You also, you know, need to look at the pattern. Was the weight loss precipitous at the beginning and then it sort of held constant or it did not?

I think you can make more of an argument that the fat intake can impact on weight maintenance, as opposed to weight loss. As far as weight loss, I think it has almost been disappointing because it would have been terrific if all we had to do was drop, you know, everybody's diet from 38 to 32 percent of calories as fat, and everybody would lose weight. It would have been wonderful.

DR. GRUNDY: Bert, it seems to me like let me just say I think, you know, we cannot resolve this complicated question about the body weight and percent fat. We do not have the data to do that, but we have two choices it seems like.

Moderate is a better term to describe what we want to say, but low is a term for total fat

that we have used in the past and has historical connections, and it did relate to basically a 30 percent intake so I guess we have to say are we going to introduce a new term that will catch everybody's eye and start making people think a little differently, or are we going to stick with the old term of lowfat, stick with the same percent and just change the emphasis to saturated fat? That seems to me to be the choice.

DR. GARZA: That is well put. Let me just ask for a few more comments, and then we will take the straw vote.

Shiriki?

DR. KUMANYIKA: I wanted to mention on the issue of whether reducing fat by itself reduces weight. When the NHLBI review for developing clinical guidelines was done, and Scott was on that too, with the criteria that we used we could not find any studies that were actually designed to answer that question that showed a beneficial effect of reducing fat calories over other calories.

The whole question of which evidence, as I think Alice pointed out, it depends on the purpose for setting some RDAs or RDIs that might be relevant to use a metabolic study because what you are asking about is metabolism, but for what happens in the population, a population based on invention would be superior because how it is going to play out when people do it, you know, we did know people were going to increase their fat intake when they were trying to lower fat because they could not recognize which foods were high in fat, so I think we need to use the population based evidence if we are actually trying to advise on population behavior, as opposed to metabolic needs.

DR. GARZA: Okay. Any other comments?

All right. We have two choices. One is "Choose a diet..." Is that right, Scott?

DR. GRUNDY: I think so

DR. GARZA: "...that is low in saturated fat and cholesterol and moderate in total fat." Have I captured that correctly? The other one is "Choose a diet that is low in saturated fat, cholesterol and total fat."

DR. LICHTENSTEIN: There was also a suggestion to just say "Choose a diet low in saturated..." --

DR. GARZA: I am sorry. You are absolutely right. "Choose a diet that is low in saturated

fat and cholesterol."

DR. LICHTENSTEIN: What was the second one again?

DR. GARZA: "Choose a diet that is low in saturated fat and cholesterol."

DR. WEINSIER: And what was the third?

DR. GARZA: That was the third one.

DR. WEINSIER: Okay. What was the --

DR. LICHTENSTEIN: The second was a diet low in saturated fat.

DR. GARZA: The first one is "Choose a diet that is low in saturated fat and cholesterol and moderate in total fat." The second one that I mentioned originally was then "Choose a diet that is low in saturated fat, cholesterol and total fat." The third is "Choose a diet that is low in saturated fat and cholesterol."

DR. DECKELBAUM: Clearly if you go over the focus groups there was much confusion with low and moderate, but I actually like Scott's point of if you put the word moderate in there that may tweak a lot of people to ask the question what do you mean, and that will actually give a form of really getting this out in an educational way both for the health professionals and to the public who, according to the focus group also, were really not too well educated in this, and there is a need for further education, so whatever word you want to use, tweaking or stimulation, may actually be a good aim even if at the present time it is somewhat confusing.

DR. GARZA: Was it Truman who said if you cannot convince them, confuse them?

Let's take the same type of poll as we did with the last one. This time we will start at the other end of the table.

Roland, those are the three choices. Which do you favor?

DR. WEINSIER: We are not allowed to say choose meals rather than choose a diet?

DR. GARZA: Oh, yes. All right. If you want to use a fourth, that is all right.

DR. WEINSIER: No, not foods because it does not work with the total percentage. I think

I really have to go with "Choose a diet or choose meals low in saturated fat and cholesterol."

DR. GARZA: Full stop?

DR. WEINSIER: Full stop.

DR. GARZA: You would prefer meals as to diet, though?

DR. WEINSIER: Oh, yes.

DR. GARZA: Okay. Lesley?

DR. TINKER: "Choose a diet low in saturated fat and cholesterol and moderate in total fat."

DR. KUMANYIKA: Same for me, although I would like to see if meals would work for consumers. I had not thought about it. I do not know what it implies, but --

DR. GARZA: Meals with which of the three?

DR. KUMANYIKA: With the one that Lesley --

DR. GARZA: Lesley?

DR. KUMANYIKA: Yes. I think the low and moderate is useful, but I also know that we need to one day find a substitute for the word diet. We do not have one now.

DR. GARZA: You would go to meals?

DR. KUMANYIKA: To a diet low in saturated fat and cholesterol --

DR. GARZA: And moderate in total fat?

DR. KUMANYIKA: -- and moderate with the request to look into the word meals as a substitute for diet.

DR. MURPHY: I would like it to be low.

DR. GARZA: "Choose a diet..." --

DR. MURPHY: Your second choice.

DR. DECKELBAUM: I would go for "Choose a diet or choose to prepare foods or choose foods..." -- not meals, because meals does not include snacks, so I have a concern about that -- "...low in saturated fat and cholesterol and moderate in total fat."

DR. GARZA: So pretty much what we have now other than --

DR. DECKELBAUM: Yes.

DR. GARZA: Instead of foods, you would go with diet?

DR. DECKELBAUM: Yes.

DR. LICHTENSTEIN: I would like to see "Choose a diet, meal, foods, food consumption pattern, eating pattern that is low in saturated fat and cholesterol and moderate in total fat," but with the caveat that I would like to see a 30 percent cap on the total fat at this point.

DR. GARZA: Meir?

DR. STAMPFER: Like Roland, end after cholesterol. Low in saturated fat and cholesterol.

DR. GARZA: Diet? Meals? Foods?

DR. STAMPFER: Whatever. Any of the above.

DR. GARZA: All right.

DR. JOHNSON: I would go for "Choose an eating pattern that is low in saturated fat and cholesterol and moderate in total fat."

DR. GARZA: Johanna?

DR. DWYER: Low in saturated fat, cholesterol and total fat.

DR. GARZA: Scott?

DR. GRUNDY: I would say a diet low in saturated fat, cholesterol and moderate in total fat.

DR. GARZA: Okay, and I would go with the low across the spectrum, so we have an evenly split group, three, three and four.

MS. MCMURRY: No, you do not.

DR. GARZA: Six for the first one?

MS. MCMURRY: Low and moderate.

DR. GARZA: Six, three and two then.

MS. MCMURRY: That makes 11.

DR. GARZA: Six, three and four.

MS. MCMURRY: Six, three and two.

DR. GARZA: Will the five of us then be willing to accept the moderate, or do you feel that gee, that is going to be too confusing and you want more discussion?

Johanna, why do we not start with that?

DR. DWYER: I think it is confusing, and I think the focus group said it was confusing.

DR. WEINSIER: Johanna, which one did you go for?

DR. DWYER: The low across the board.

DR. WEINSIER: Low all the way across?

DR. GARZA: Suzanne?

DR. MURPHY: Yes. I can live with the low/ moderate combination. I cannot live with omitting total fat entirely.

DR. GARZA: I would go with Suzanne. I would prefer one, but I think omitting the total fat would be a mistake.

I think we need to look at the text very carefully to make sure that we do not confuse people by what we mean by moderate because given the fact that we have defined it in the past,

we have defined low as 30 percent, that in fact moderate may be interpreted to say that gee, we are saying go above that when you look at the text.

DR. GRUNDY: What about another possibility, moderately low?

(Laughter.)

DR. GARZA: We appreciate the effort. Somewhat low. Kind of low.

What about those of you that wanted to go full stop and not mention total fat?

DR. WEINSIER: If I had to go with one, I would go with "Choose a diet low in saturated fat and cholesterol and moderate in total fat."

DR. GARZA: Meir?

DR. STAMPFER: It is hard to argue against moderation.

DR. GARZA: All right. Why do we not go on to the next? We have "Choose a diet that is low in saturated fat and cholesterol and moderate in total fat."

DR. LICHTENSTEIN: Could we address this issue of diet? Are we going to go with diet? Are we going to go with food? Eating patterns?

DR. GARZA: Well, let's go with I think meals we have heard one objection. I think we have to take seriously that it eliminates snacks. Foods. We have to consider the issue. Then you have good foods and bad foods. Diet confuses the public because it is seen as something medical.

DR. LICHTENSTEIN: Food pattern? Eating pattern?

DR. GARZA: Food pattern, eating pattern, or do we go with diet? How do people feel about that?

DR. DECKELBAUM: I vote for eating pattern.

DR. DWYER: Can it be tested in a focus group to see if eating pattern is more meaningful?

MS. DAVIS: We are getting really late on the focus groups. In fact, the next time we are going to have a report will be and that focus groups are going to be held is the beginning of

November, so it is not going to help you too much. It might help us. They did not see diet as medical, so that --

DR. GARZA: What was the concern about diet then, for those of you who have not had a chance to go through this? I had the sense that they did not like diet. If they do not, then we perhaps are going to have to deal with the question that Alice raised.

DR. STAMPFER: What does it mean when the consumers say they do not like diet? Does that mean they do not understand what we are getting at, or they do not like the concept of restraining foods?

DR. GARZA: Actually, they do not understand the message.

MS. DAVIS: The word out of context, you know, sounds like it is something restrictive, but when it was in concert with the whole title, you know, it was not as bad.

DR. STAMPFER: It is meant to be restrictive. That is the whole point. We are trying to say do not eat too much saturated fat. Restrict. That is the concept. I mean, I can see how people might not like it, but if it is clear and that is our goal, why not just say it?

DR. GARZA: We are back to the Puritanical side. We will get some Irish influence on it.

DR. WEINSIER: The way it is stated here is that, "Most consumers thought negatively of the word 'diet' and felt that the phrase food choices was a more positive way to express the concept of diet as used in the guidelines." This is under Other Topics.

DR. GARZA: Shall we go then with diet for the meanwhile?

All right, Scott. You are on then for the remainder of the --

DR. GRUNDY: Okay. Well, I think another major issue is how we are going to present the saturated with a change in emphasis. We have added some boxes to choose from and some descriptions of alternatives, and also we have given definitions in there. I think we ought to look at some of these boxes to see whether they are what we want.

One thought, which is not a box, and maybe I could show that, is something that Kathryn put together for us to consider --

MS. MCMURRY: It is a slide.

DR. GRUNDY: -- which actually shows some examples of how much saturated fat are in different foods to illustrate how easy it is to exceed the amount that we are recommending. This would be another potential way to do that.

DR. JOHNSON: I like this a lot. Thank you, Kathryn. I think it gives really clear, specific food based advice.

DR. DWYER: I am sorry, Scott. Will this be inserted in the text?

DR. GRUNDY: This would be I guess a box or a table that would illustrate in quantitative terms what we are talking about. It is trying to get people away a little bit from thinking only in qualitative terms.

We do have a box in there that shows how many grams of saturated fat you should take for so many calories, Box 14, which gives you some idea of where your limit on saturated fat is, and then this I guess would back up that box to give some examples of how you might reach that limit.

DR. JOHNSON: I think I might add something that says, you know, use the food label when making food choices or compare or something just to make it clear that we are not saying these are the only choices, but, you know, when you compare the two different foods you can see the difference in the saturated fat.

Somehow tying this in with the food label to help consumers make that comparison would be helpful. I do not think we want to come across like one, two, three, these are the five items; that this is where you make your choices. It is sort of a continuum of choices, and these are some examples.

DR. STAMPFER: Is this an additional box?

DR. GRUNDY: That would be the idea that we would add another box. I mean, this could be modified, but what about the concept of it?

Some of the things that we have listed in terms of choosing different food groups and all this, they do not give you any feeling for how much saturated fat is actually in a hamburger or a donut.

DR. GARZA: Yes?

DR. MURPHY: I like this particularly better than the text at the bottom of page 44, so

would it perhaps replace that? Page 44.

DR. GRUNDY: "Keep saturated fat intake low?"

DR. MURPHY: Uh-huh.

DR. GRUNDY: Yes.

DR. STAMPFER: That is a different concept. That text at the bottom of page 14 is more replacing the different kinds of foods. These are the same food items. I think both are valuable.

DR. MURPHY: Well, that I could certainly go along with, but it does seem we say the same things many times about saturated fat.

We have Box 15 that are food choices low in saturated fat. Then we have this thing at the bottom of 44. We have a new one, and we have Box 13 that has a section on saturated fat, and then on page 43 we have a paragraph on saturated fat. I question whether we need to say that five different ways.

DR. GRUNDY: You are a teacher. You tell us.

DR. MURPHY: I accept that when you are lecturing you may need to say it five times, but I think it makes the section awfully long, and it jumbled it up a lot, too.

DR. GARZA: I found the section that looked at choose foods in saturated fat to be confusing. That paragraph mixed a lot of different concepts in one. Various pieces were dealt with in different boxes.

DR. MURPHY: Which page?

DR. GARZA: On page 43. All that information was important, but I found it repeated in several different places.

DR. GRUNDY: Right.

DR. GARZA: It is sort of all coming together, but in a non-random or almost in a random --

DR. GRUNDY: Which one? What would you replace?

DR. GARZA: I mean, I think the table that you have --

DR. GRUNDY: Yes.

DR. GARZA: -- pretty much says what you might want to print in another section, but it was more the concern we have heard expressed that it is repetitive when you go back and perhaps repeat things two or three times, three being the maximum number.

DR. GRUNDY: One thing that you may be saying is that the boxes and the text contain the same information. Maybe we could look at that.

DR. GARZA: I think at times they should. I mean, I am not arguing that we do not, but it was too many times.

DR. GRUNDY: There is no reason why they have to say the same things exactly. We could eliminate one or the other, preferably leave it in the box and take it out of the text and just refer in general terms to the text. Do you think that would solve --

DR. GARZA: I think so.

DR. GRUNDY: Suzanne, would that do the trick?

DR. MURPHY: Yes, that would certainly help.

DR. GRUNDY: Yes.

DR. LICHTENSTEIN: Yes. I agree it would help, and I think that it is clearer in this table than it is actually in the text, so substitute.

DR. GRUNDY: Okay. What do you think about Box 14? Which of those do you like best? Would that do the job for us?

DR. GARZA: On page 44?

DR. GRUNDY: Page 44, Box 14.

DR. GARZA: Richard?

DR. DECKELBAUM: Scott, you know I E-mailed you on this, and I thought that putting in the different levels of numbers that would be useful. We do not need people going

around with a calculator to keep track of how many grams they are ingesting per day so that it adds a whole other layer of numbers.

In terms of practicality, what is your upper limit of fat or suggested maximum? If people are going to be able to use this, they are going to need to add up all their food labels. Unless you mean, you know, they are going to choose one sort of food with a lot of fat, is this going to make a difference to their total saturated fat for that day, but I just find it hard.

You know, we have three levels, depending on your caloric intake. Most people do not even know what their caloric intake is. Then built on top of that is sort of the upper limit of saturated fat. It would be sort of tricky, I think, in terms of limitation.

DR. GRUNDY: One thing is that adding this helps with that problem, I think, because you can see then if you have a hamburger and you have 24 grams, you have used up half of it just for that hamburger so maybe that would amplify on Box 14 and make it a little -- I mean, I agree with what you are saying. It is hard for people to put what they are eating into quantitative terms. This might help a little bit.

DR. GARZA: Alice, Lesley and then Rachel?

DR. LICHTENSTEIN: I think that this information is a repeat of what is in the nutrition facts figure, so perhaps in this section it could just be back referenced.

That is going to end up being under the first guideline, I believe, so perhaps just back referencing, as opposed to making a separate table would work. Right now it is on page 12 and 13.

DR. GARZA: Lesley?

DR. TINKER: I agree with the back referencing, but I would like to see it stay in there. If we talk about a percent, ten percent saturated fat or even 30 percent total fat, that seems to be meaningless to consumers. We need to give them some target that they could measure.

DR. GARZA: Rachel, and then Shiriki?

DR. JOHNSON: I agree with Lesley. I think the reason we initially included this was that very argument that this is really a teaching tool to help consumers get at least some idea of how many grams of fat they should be eating because to tell them ten percent of total calories is not something very workable.

At least we have the food labels, you know, if they have some kind of a target to work with. I agree with Lesley.

DR. GARZA: Shiriki?

DR. KUMANYIKA: That is actually a perfect segue. Has anybody used this booklet for teaching because I was looking back at the old booklet. I am getting very nervous about presenting information on saturated fat without any information on total fat or all fats or whatever you would want to call it because there are probably many consumers who will not notice the modifier and will just see fat.

I mean, people are not clear on it, so I am really worried about doing an inadequate job of nutrition education in this booklet by showing even also on the other chart --

DR. GARZA: Total fat is in Box 16.

DR. LICHTENSTEIN: But the error is even there on the second version of Box 14.

DR. KUMANYIKA: No, but in the box with the saturated fat.

DR. GARZA: So you are putting it all in one box?

DR. KUMANYIKA: Yes, because I do not know. If people just see fat, they are going to be totally confused. I felt the same way. You know, I like this chart, but if you do not help consumers contrast that there is more than one type of fat it might be a total loss.

DR. GARZA: So you are suggesting somehow merging Box 16 and 14?

DR. KUMANYIKA: Not showing the information separately if you are trying to teach consumers to differentiate.

DR. GARZA: Hold on.

DR. LICHTENSTEIN: There is an error in the second version of Box 14 if there is no saturated in there, so it is easy to get it confused.

DR. GRUNDY: Would you combine Box 14 and 16? Would that satisfy your concern?

DR. KUMANYIKA: Yes. Yes.

DR. GRUNDY: That is not a bad idea.

DR. WEINSIER: I totally agree.

MS. MCMURRY: They were originally together, but they were separated here because one was a maximum and one was a target.

DR. GRUNDY: You can make one "or less" than the other one. You could even have "or less" on both of them. I think that would be okay like that. That is not a bad idea.

DR. MURPHY: Yes. I am getting a little worried about the fact that the DV is for a 2,000 calorie diet, and we are not showing that as any level in our little boxes, so this very nice summary is talking about a caloric base that we do not talk about.

DR. GRUNDY: That is a very good point. So you mean the labels are for 2,000 calories? Is that right? The food labels?

DR. MURPHY: Yes.

DR. GRUNDY: Then we ought to have one for that, I guess.

DR. MURPHY: And 2,500. They are indeed both on this sample label that we have.

DR. GRUNDY: So maybe we ought to have that 1,600, 2,000, 2,500, have those three.

DR. MURPHY: I know it is the pyramid levels that are the three. That is where the 1,600 came from, but they just are not the same as on the label.

DR. GRUNDY: Yes.

DR. MURPHY: It is one of those needs that we have to make these things a little more parallel in our education.

DR. GRUNDY: So what should we do?

DR. MURPHY: I think if we have to put -- if we are going to use daily values, we are going to have to somehow explain why it is not 2,200.

DR. GARZA: Well, given the fact that we are using the pyramid on the first guideline to educate, is there an overwhelming reason for using the daily values because what people

will do is to add up the grams of fat in the food labels out there, but keeping track of their daily values may not be as important, so can we drop the daily value?

DR. DWYER: Why do we not add 2,000 and 2,500 to the little thing that Scott has already prepared?

DR. MURPHY: So you would have five levels?

DR. DWYER: Yes.

DR. GARZA: Five levels?

DR. DWYER: Because that way it is transparent.

DR. GARZA: Arguing for simplicity, what would be the reason for the percent DVs, I mean, that people see? What practical --

DR. DWYER: The practical thing is that is what they see on the label, right?

DR. GARZA: But they also see grams, right?

DR. DWYER: Yes, but they cannot use that.

DR. GARZA: But they can use a percent DV. They can use the grams since we are giving them, you know, do not eat more than this number of grams. We are not saying keep track of your percent DV.

I mean, as an educational tool I am persuaded by if you are going to use this for teaching purposes, given what we have done with the rest of the task to continue focusing on amounts, on a percent DV, because we have not explained how to use percent DV.

DR. KUMANYIKA: That is not what we have in the first section.

DR. GARZA: Percent DV?

DR. MURPHY: We talked about low and high.

DR. KUMANYIKA: Right. Five percent and 20 percent.

DR. GARZA: You are right. The suggestion then is because we do that, we ought to do

both?

DR. DWYER: Maybe this is post-prandial torture, but the problem is that we are talking about something nobody knows about, which is calories.

You never know your energy level unless you use those equations of James and whoever to get your resting metabolism. Then you make sort of a fudge factor and make it into what, you know, you pretend you really eat, which is 500 calories lower than it really is probably, but maybe we need to put in the equation like that if it is all going to be based on calories, right?

DR. MURPHY: Well, I think one of the suggestions is if we took the little box off of the back of the pyramid it did have verbal descriptors of those calorie levels --

DR. DWYER: Okay.

DR. MURPHY: -- like inactive women, so maybe if we use those it would give people --

DR. DWYER: That is a much better suggestion than an equation.

DR. MURPHY: But again, that is for 1,600, 2,200 and 2,800. It is not for 2,000 and 2,500.

DR. DWYER: But it could be made into that, could it not?

DR. MURPHY: Perhaps by someone.

DR. DWYER: Federal civil servants.

DR. GARZA: I am one of the pot pourris. Are you suggesting then that we add the five calorie and we include all five calorie levels, or are you arguing only in favor of the pyramid level or --

DR. MURPHY: I am suggesting adding all five --

DR. GARZA: Okay.

DR. MURPHY: -- until FDA and USDA come together across them all.

DR. GARZA: Well, that will be forever.

MS. DAVIS: Bert, are you suggesting now that in the first guideline we are going to have this table that tells the fruits and the vegetables and all the servings for the three calorie levels, and now you would be proposing that we add two more?

DR. GARZA: Well, I am not.

MS. DAVIS: Or somebody is.

DR. GARZA: I am trying to get the group to choose one or the other, but I am not doing that too successfully.

DR. GRUNDY: I think we ought to stick with the three levels according to the pyramid. That would be my pick. I realize the problem that it creates, but it is consistent throughout the whole document, is it not, to do that?

DR. GARZA: Well, except for the one place that we talked about the percentage with the food label.

DR. GRUNDY: I mean, these could be checked.

DR. WEINSIER: I am thinking about Richard's comment earlier, you know, about, you know, carrying a cash register in your mind or a cash register throughout the day. I do not do that, but I have a pretty darn good feeling that my diet is low in fat.

I wonder if for the point we are trying to make in this booklet the feeling I get is it tells me a lot when I talk about an individual food, cheddar cheese versus reduced fat cheddar cheese. It is a sixfold difference. When I go through the buffet line, I can keep that in mind. I have trouble dealing with how many grams that adds up if I add this meal to the next meal to my snacks at the end of the day.

My recommendation is to stick with some comparisons of qualitative, semi-quantitative comparisons of types of foods in terms of high/low fat, stay away from the calories, stay away from the percent DV.

DR. GARZA: What if we were to do the following? Instead of having the calorie numbers is to have sedentary, active and very active. You can categorize yourself wherever one wishes and then have suggested levels of fat and saturated fat rather than getting people to worry too much about gee, am I 1,200 calories or 1,600?

Have them categorize themselves into these broad bands and then having them aim at a

certain amount of fat based on that broad band because of their label. They can say gee, I am sedentary. I should be consuming no more than 18 grams. We can minimize the calculator at best.

DR. WEINSIER: I am suggesting we keep it at the individual food level rather than the total day.

DR. GARZA: Yes, I know. I understand.

DR. WEINSIER: I know. I am just responding to your --

DR. GARZA: Carole, you are suggesting one step further, I guess, in terms of --

DR. WEINSIER: Yes, and I am trying to keep it one step lower.

DR. GARZA: Yes, but in terms of how an individual aimed at a level, and I do not know whether --

DR. WEINSIER: But I am just not sure individuals carry around total grams of fat in their mind and keep adding up through the course of the day until they hit that 53 if sedentary or 73 if --

DR. GARZA: That is not the point. I did not express it very well. If I know that I am inactive and my limit is 18, I may want to recognize that a hamburger pretty much gets me there.

DR. WEINSIER: But the point is if I am very active then I am going to eat more hamburgers in the course of the day to meet my calorie requirements, but if I am eating more hamburgers that are high fat I am going to end up with still an excess of fat.

DR. GARZA: But you still have how many? If you are very active, you have 31. You may choose to have -- I mean, we do not want to be food police, Roland. I mean, if somebody wants a hamburger it is perfectly all right, right?

DR. WEINSIER: I know, but the point we are trying to make is that we are not excluding any food from any of these guidelines. What we are suggesting is that when you choose foods, try to choose those that are relatively low in saturated fat. I think at that level -- I am suggesting we stop at that level. I am not saying you can never have a hamburger.

DR. GARZA: I do not think I would find enough guidance with just that. I think that I

would find that confusing, but let me hear from the others.

DR. JOHNSON: I would agree with Bert. I think we should leave the calorie levels, but sedentary, moderately active and active under the 1,600, 2,200 and 2,800 or whatever works. I do not think we should under estimate what consumers do.

The Atkins book is number two on the best seller list right now. The whole concept of that is to count your carbohydrate grams. There are Americans all over the place that are counting the number of grams of carbohydrates they eat on a regular, daily basis, so there are people that count their grams. We can give them a limit or a target.

DR. DWYER: I am sorry. Did you say put both the calories and the descriptors?

DR. GARZA: No. I would just eliminate the calories. I do not know whether any of us know our own caloric intake, so I do not know how useful that information may be.

I am not quite as far along as Roland suggested. The reason I want to have the numbers there is so that people can add up throughout the day to give them a general sense of what their limit for fat intake should be, and then they can judge what their diets are like, not necessarily trying to adhere to it on a daily basis or carry a calculator around with you, but if I know that I have 24 grams of saturated fat as I look at labels I can sort of make judgements that are approximate.

DR. DWYER: I think that is a great suggestion to put the adjectives in, but I think it is important to also put the caloric levels in.

The problem -- you know, our committee would have no problems if it were not for these adjectives. The problem I see with the descriptors alone and the reason for putting in the calories is that people tend to over estimate their activity in terms of assuming that you are active, not sedentary, whereas at least a quarter of us are extremely sedentary.

DR. GRUNDY: I think also a lot of difference in body size say between men and women. A lot of women know they take about 1,600, even though they are pretty active. They could not take 2,500 or 2,600 calories in active women, so maybe I kind of agree with Johanna on that.

DR. GARZA: So the suggestion is that for

non-gender specific, just general?

DR. GRUNDY: Right. Okay. So I gather what we agreed, we will have a box something like this to combine it with Box 14, which will include total fat, as well as saturated fat.

DR. GARZA: That is right.

DR. GRUNDY: Okay. There is one thing in here that I am not quite sure how it got in there, but I wanted to talk about it. On the very first page when we talk about unsaturated fat it says underlined with two question marks, "Unsaturated fat, just like saturated fat, lowers the risk of heart disease."

How did that get there exactly? I am not quite sure, and why the question marks? That is an important statement.

DR. GRUNDY: Page 41.

DR. GARZA: Carole?

DR. SUITOR: One of the committee members had suggested it, and I was asking if the rest of the group wanted to include it.

DR. GARZA: It must have been in a telephone call, and I do not recall who suggested it either, but what we asked Carole to do was to underline suggested text where in fact the chair had not been involved in the discussion but others had made it so that we could assess its validity.

DR. GRUNDY: Okay. It raises a point that I wanted to make in general which I saw throughout this whole document, and that is the idea that certain foods actually protect you against disease in a positive sense almost like a drug would protect you.

It seems to me that on the basis of epidemiologic data we can say that certain foods are safe, but to take the next step and say that they actually have protective effects against a disease in an active way, I am not sure we have the database to say that.

I think unsaturated fats are safe in terms of risk, especially the monounsaturates. Polyunsaturates may be a little -- we have to discuss a little bit, but I am just a bit concerned about saying that you can reduce your risk if you eat more of this food or that food. That is kind of a general comment, and it relates in part to this one. I would like to have some reaction to that.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I ended up flagging that all the way through my whole thing. I had written in both places really it is associated with an increased risk with the saturated fat and associated with a reduced risk with the unsaturated fat, but then all through the commentary for the green book it is the exact same thing. These are associations, and there is no evidence that they actually decrease this or change that.

DR. GARZA: I think we ought to be very careful and make sure that that gets edited out, I mean, wherever we have causation of the type that you analysts described.

Meir?

DR. STAMPFER: I think it is important to distinguish where we have strong data from where we have relatively weak data. I think here we do have relatively strong data, randomized trial data.

A number of trials have been conducted to look at this very question, and that is what they came up with using clinical end points. The most recent one -- well, it was not the replacement of unsaturated fat with saturated fat, but the addition of Omega 3s just a few weeks ago, but there are a whole slew of trials that have been done over the years looking at these randomized trials with real clinical end points.

To me, that constitutes strong evidence compared to say the evidence we are relying on some of the other guidelines to make our --

DR. GRUNDY: Okay. Let me comment on that. I think we ought to distinguish between Omega 3 fatty acids and Omega 6 fatty acids and Omega 9 because the Omega 3 are kind of in a special category.

There is an emerging body of data that suggests that they may have almost like pharmacological effects. They are very bioactive compounds or molecules that might in fact protect you against heart disease in a couple grams a day or something like that. I mean, that is what the clinical trials suggest.

I think for the regular unsaturated fats, Omega 9 and Omega 6, the clinical trials that have been done have only compared those against saturated fats, and we are making the statement that saturated fat raises the risk, but to turn the coin over to the other side and say that the unsaturated fat actually affords a protection if you eat more of those, I am not sure we are at that level yet.

DR. STAMPFER: Yes, but we are not saying that. The current text, the underlined text,

says using unsaturated fat in place of saturated. I think we are on safe ground there. I do not think anywhere it says you should eat more unsaturated fat. I would agree with you that that has not been addressed in a randomized trial way, but here it is explicitly replacement.

DR. GRUNDY: I think that is ambiguous. That could be taken to mean -- it is true that literally it says in place of saturated fat, but it implies a causality that might lead people to think that if you should eat more of the unsaturated fat that you will get some protective effect.

I mean, that has a long tradition going back for many years where people recommended very high intakes of unsaturated fat beyond what you would get if you replaced the saturated fat that afforded potential protection against heart attack. I do not think that we really can say that, so I guess we have to be careful in how we word this.

DR. GARZA: Richard?

DR. DECKELBAUM: Could you say instead of lowers risk of heart disease that it lowers blood and LDL cholesterol levels? That would be true. Is that needed?

DR. GARZA: I think, Richard, the point that Scott is making is one that we need to consider carefully.

I am going to give you a totally different situation. There are individuals, for example, who would take a diet drink with the idea that there is something active in the drink that helps them reduce.

I mean, I know I had one aunt who would have a coke float with diet coke because, after all, there was an active ingredient that would help her lose weight in the coke. You had to explain that no, you know. What helped you lose weight was that the calories were not there, not that they were going to be actively promoting weight loss.

When you read this sentence, you do get the sense. I mean, if you read it carefully, as Meir said, it is replacement, but a consumer would see this and say gee, what I need to do now is instead of taking three tablespoons of saturated fat, I will just replace it with six tablespoons of polyunsaturated fat, and my risk is going to go down.

Well, that may be true because of a saturated fat that he was taking in before, but it is not anything inherent in the fat itself that is going to lower that risk.

DR. STAMPFER: The trials that looked at just lowering saturated fat did not see that benefit.

DR. GARZA: Is there any response to that point that in fact just lowering saturated fat did not see any benefit at all without increasing your intake of polys? Is that what you are saying, Meir?

DR. STAMPFER: Most of the trials -- there are not that many fat lowering trials, and there are not a whole lot, but the preponderance of the randomized trial data is in fact replacement. There is a reduction in clinical end points.

Maybe there is a better way to phrase this in a way that would be completely unambiguous, but I think it is a well substantiated --

DR. GARZA: You would argue that polyunsaturated fats actively protect you? The Omega 6s and 9s actively protect you against heart disease?

DR. STAMPFER: You always have to replace something. I mean, we are talking about macro nutrients here, so you cannot raise or lower a macro nutrient without something else.

DR. GARZA: Let's say that you had them as whole grains.

DR. STAMPFER: Well, we do not have the data. All we have is the data that we have before us and the data that -- the randomized trial data where saturated fat is replaced by unsaturated fat. You see a reduction in the risk end points. Where the attempt was just to lower saturated fat, you did not see that where it was not an explicit exchange.

DR. GRUNDY: Meir, I agree completely with what you say. I am sure you have had the same experience that I have in dealing with a lot of people who believe that if you take unsaturated oils and add them to your diet regardless of what you do with the rest of the diet, you are protecting yourself against heart disease.

Now, that might be true. I mean, I kind of think there may be an element of protection, but I do not think they have the data yet to come out and say that yet so I think we have to be careful how we say it. That is all I am saying.

DR. GARZA: Alice?

DR. LICHTENSTEIN: There is metabolic data to indicate that if you keep the total fat

constant and you drop the saturated fat that at least cholesterol levels will go down.

DR. GRUNDY: No doubt about that.

DR. LICHTENSTEIN: But which studies are you talking about where intervention with saturated fat has been dropped, and there has been no effect on clinical end points?

DR. STAMPFER: Well, there is a couple.

DR. GARZA: Okay. We will look at rephrasing that in some way.

DR. STAMPFER: Okay. Fine.

DR. GARZA: Are there other points that individuals would like to make in terms of either the text or the rationale that develops this?

DR. JOHNSON: I would like to make a point under Advice For Today. The first bullet is, "Use animal fats, hard margarines and partially hydrogenated shortening sparingly." This is page 49.

I think the single biggest question that I always get about fats is what spread should I use? We tell them what not to use, but we do not give any positive advice about what you should use, so do we want to say soft tub margarines or dipping your bread in olive oil? What kind of suggestion do we make because I think that is actually a question that a lot of consumers have. Well, if I cannot use margarine and I cannot use butter or should not, what should I do? Should I use nothing?

DR. GRUNDY: I guess my view on that, and others may differ, is if it is hard margarine or hard shortening it contains a high trans content. If it is a soft margarine or liquid margarine, then it probably does not contain enough trans to be worried about it.

Maybe we ought to make that explicit, although not everyone here, like Meir, might agree with that. I do not know. Could it be more explicit?

DR. LICHTENSTEIN: It sounds reasonable.

DR. JOHNSON: I think that would be good even if we could add that the soft tub margarines may be preferable.

DR. LICHTENSTEIN: Or trans free margarines.

DR. JOHNSON: Trans free. Something to help people sort out that case that, you know, spreads are now getting --

DR. GRUNDY: Are soft margarines -- how much trans do they have in them? I know that varies quite a bit,

but --

DR. LICHTENSTEIN: Reasonable low at this point.

DR. GRUNDY: -- can we make just a general statement that it is okay to eat soft margarine?

DR. LICHTENSTEIN: In moderation, but, yes. I think that is a reasonable statement. There is also I know the AHA has some guidelines on the maximum number of grams of saturated fat per serving of soft margarine.

If it is soft, from what I am aware, all the current ones on the market are relatively low in trans or trans free, so I think it is actually a good point that we should give advice on what people should consume.

DR. GRUNDY: Right.

DR. LICHTENSTEIN: We could probably get those definitions.

DR. GRUNDY: That is a good point, Rachel.

Suzanne?

DR. MURPHY: On another topic? I do not want to change topics.

DR. GRUNDY: Yes. Sure.

DR. MURPHY: All right. On your two choices for Box 15, I liked the one that had prepared foods separated out on page 47. I assumed you were looking for feedback on those two alternatives.

DR. GRUNDY: Sure. Right.

DR. MURPHY: I sort of liked having prepared foods and the nutrition facts label separate,

but on the same box why is there the second bullet under Dairy Products? What does that have to do with saturated fat and total fat?

DR. GRUNDY: What is your question again? I am not sure.

DR. MURPHY: I do not understand why there is a statement under Dairy Products, "If you do not eat dairy products, eat other calcium rich foods." We have said that repeatedly in the first guideline.

DR. GRUNDY: Oh. Oh, I see.

DR. MURPHY: I do not understand why it is here.

DR. STAMPFER: You are questioning just the second bullet?

DR. MURPHY: Yes. Yes. The first one is fine.

DR. GARZA: Lesley, and then Alice?

DR. TINKER: I am going to comment on the rationale.

DR. GRUNDY: Did we answer that question? Let's try to answer.

DR. MURPHY: We are doing that right now.

DR. GRUNDY: I mean, I think it could be taken --

DR. MURPHY: Okay.

DR. GRUNDY: I think it can be taken out. I do not think it relates to saturated fat, if everyone agrees.

You would like the one on Box 15 on page 47 best. Does anyone disagree with that?

DR. LICHTENSTEIN: I have a comment on both of them. Why are we recommending lean fish? You know, that is what we are saying. I mean, you know, fish is rich. You know, especially fatty fish is rich in Omega 3 fatty acids. We are actually recommending it, and I just think lean poultry, meat, beans --

DR. GRUNDY: Where is that?

DR. LICHTENSTEIN: The very top of page 46.

DR. GRUNDY: We are doing 47.

DR. LICHTENSTEIN: Okay. Well, the same thing. It is in both places, I think. It is in both places. "Choose two to three servings of..." Okay. I see. In this case it is fish.

DR. GRUNDY: Fish.

DR. LICHTENSTEIN: Okay. All right.

DR. TINKER: One says fish and then lean, and the other says lean fish.

DR. LICHTENSTEIN: Right.

DR. TINKER: I think if you put the lean after the word fish you are okay.

DR. GRUNDY: Yes.

DR. LICHTENSTEIN: But to the issue of are we going to drop that bullet on the calcium because I was also sort of questioning that. We do not put, "If you do not eat meat..." --

DR. GRUNDY: Yes. We are going to drop that. We are going to drop that and then just three servings of fish and then lean poultry of meat, lean beans and lean nuts.

DR. DWYER: How do we get across the issue of fried fish and trout, which is very high in saturated fat? The word is not lean fish, but what do you mean by that?

DR. LICHTENSTEIN: Trout?

DR. DWYER: Is trout not high in saturated fat?

DR. LICHTENSTEIN: No.

DR. DWYER: I thought it was freshwater trout was.

DR. LICHTENSTEIN: No, I do not think so.

DR. GRUNDY: Fried fish. That is a good point, I think.

DR. DWYER: Yes. The fried fish are a big issue.

DR. LICHTENSTEIN: It depends on what they are fried in. If they are fried in butter, you know, we are not recommending it. If it is fried in olive oil --

DR. MURPHY: It is covered a little bit under Fats and Oils.

DR. DWYER: Okay.

DR. MURPHY: Your calories decrease depending on the fat used in cooking.

DR. GARZA: Shiriki?

DR. KUMANYIKA: Let me stress the importance of that for people who are not yuppies or whatever. I mean, I just came through the Philadelphia train station. That is what fish means to people, either tunafish or fried fish, to a lot of people. People, you know, if they can afford it because they are getting it, you know, that looks like kind of a buffet. They have four different kinds of fried fish.

Another place that that comes out is that some of the scales for rating the heart healthiness of your diet give credits for fish, and it just did not work in an African American study because people were eating fried fish, so I think we need to pay more attention to the fact that the type of fish people can afford may not be the type we are thinking of and give more emphasis to how fish is prepared.

It may not be in an oil. It may be butter in the pan, especially with people who are used to eating the really bad tasting cuts or types of fish that they had to fry in order to get rid of the taste, you know, the cheap stuff you could get a whole barrel of. That is why people think they have to drown the flavor of the fish out by frying it in butter.

DR. GARZA: Roland?

DR. WEINSIER: Yes. Just to try to tone down some of the technicalities of the report, which if others disagree that is fine, but I find it a little distracting from the key messages.

I wonder if on the top of page 43, it is under the section labeled at the bottom of the previous page Unsaturated Fats. The first part of the paragraph is very clear. It says, you know, focus on unsaturated fats which occur in vegetable oils, most nuts, olives, avocados and fish, so we have sort of lumped the polyunsaturates and monounsaturates, which I was fine with, but then when we got to the top of page 43 it started to go into details separating

further the monounsaturates and polyunsaturates and Omega 3s, and I felt that the major point was lost.

My recommendation is to consider just stopping at the top of page 43 right after the second line where it says, "...excess calories." and consider even leaving out all the rest of that or condensing it to one or two sentences, but I am not sure that when your point seems too clear with the unsaturated fats that it helps to go into the highly specific different types.

The second point was continuing in the next paragraph under Choose Foods Low In Saturated Fat. I think this has been discussed before where we get into percent of calories, and it says ten percent of calories. I would tend to avoid that. At the bottom of the paragraph it goes into 15 percent, and then on page 48 it goes into 30 percent.

I think we are already being very heavy from a numerical standpoint by putting in calories and grams, and I think by putting these percentages in it is just going to make it a little more difficult.

DR. GRUNDY: I think we decided to take some of this out in favor of the boxes already, but you do raise an interesting question which I think needs to be discussed a little bit about the mono and the poly.

I think you are right that the thrust was to not distinguish between those, and if we want to continue not doing that then it would be reasonable to take those out. I do not know how others -- Alice, Richard, Meir -- feel about it, whether we need those in or can we take it out.

DR. STAMPFER: I do not feel strongly one way or another, but I think it is sort of I think getting to be in parlance. I think we should have it in because people now have heard about it a little bit, if we can do it in a way that does not dilute the message.

People have heard about Omega 3s and polys. Maybe part of our role is to continue to educate, so I guess I would slightly lean to keeping the distinctions in.

DR. GRUNDY: Alice?

DR. LICHTENSTEIN: I could go either way. As far as the monos and polys, I do not particularly think that is necessary because we are not giving any guidance on it or distinguishing it in any way.

I would argue strongly to keep the text in on the Omega 3 fatty acids because I think that is a different category, and we are giving specific guidance, or we are indicating that it may be

beneficial, but we are not saying one way or another as far as the monos and polys.

DR. DECKELBAUM: I would leave it as is.

DR. GRUNDY: You would leave it as it is for the same reason that Meir says, that people really are beginning to --

DR. DECKELBAUM: Yes.

DR. GRUNDY: -- distinguish between those two and talk about them?

DR. DECKELBAUM: I think we see from the focus group that people are having big trouble between total and saturated. I think if we want to use this as part of an educational document and hopefully increase its dissemination, this says what it is.

DR. GARZA: Maybe playing the devil's advocate, but other than Omega 3 through fish, are most consumers really going to be increasing in the fine distinction that we make among the 3s, 6s and 9s and polys and monos?

I am concerned that as we have all become more and more expert on fat we are becoming a bit like Eskimos with praying for it to snow. It is very important if you live in Alaska or in universities; possibly not so much if you are at the grocery store.

If you want to make it consumer friendly, these are highly technical terms. I mean, I doubt if most people even know what Omega is and 3 and how we count from the ends of molecules.

DR. DECKELBAUM: But a lot of people know what olive oil is and canola oil.

DR. GARZA: Yes. We want to use olive oils. Just say polys. We get discussions of this type that take on a life of their own that are independent of their intended use.

If you are sure that it is important to educate consumers as to the virtues of these different fats then perhaps we should educate them, but it is from a practical perspective not going to be as important as long as they are in fish, perhaps in non-frying and limiting their saturated fat intake if that is what we really care to do and so we do not delete that message. There is a lot of technical jargon.

DR. WEINSIER: One of the reasons I am suggesting this is that after having read about the monounsaturates and polyunsaturates, the next sentence left me with the feeling of

why did you take my time to learn this when it says, "All forms of unsaturated fats have the advantage that they do not raise blood cholesterol."

You know, I struggled with this, and I finally got to the point that it does not matter anyway as long as I am eating olives and avocados and fish. If it is education for the sake of education that is one thing, but I am not sure that is going to be advantageous here.

DR. GRUNDY: There is no message is what you are saying.

DR. WEINSIER: Yes. The bottom line is still all forms of unsaturated fats have the advantage they do not raise blood cholesterol, and I think that is fine and should be kept. I am just raising the question how much technical information do you want to include? I am uncomfortable that we are including too much.

DR. GARZA: Shiriki?

DR. KUMANYIKA: I think that maybe someone who is used to writing more in consumer language for that purpose, I mean, as opposed to for a technical report needs to take a good look at this and be given license to change it because it just seems really dense from a consumer point of view. I mean, there are no pictures of these things. There is no -- I mean, if you do not know what they are, how could you ever figure it out?

When you think about it, you know, the unsaturated, it does not really use a lot of the language of, you know, liquid at room temperature. I mean, there have been ways that people have used to explain these things, but they are not reflected in the bulletin so it might be nice to come back to that after we have decided what the concepts are because I do not think people will get it at all.

DR. GARZA: And we already ask people to understand trans fatty acids and partially hydrogenated fat. There is a message there because I think it is applicable, and it has an end point. With these I am more concerned.

If we can follow the advice that Shiriki has given us and say let's give license to this group and Carole to try to tone this down a bit and make it more friendly that the group would find that acceptable. Depending on if you felt very strongly, we could go either way.

DR. LICHTENSTEIN: I do feel strongly about the fish and associating Omega 3 fatty acids with fish because that may be independent of plasma cholesterol levels. As far as the monos and polys, I perfectly agree.

DR. GRUNDY: I guess they agree with what you are saying. I am not quite sure what the message is here. Are we encouraging people to eat more Omega 3 --

DR. LICHTENSTEIN: Yes.

DR. GRUNDY: -- in a kind of a subtle way? Is that what you are --

DR. LICHTENSTEIN: Yes.

DR. GRUNDY: I am not sure of the language.

DR. LICHTENSTEIN: Yes, and I think the most recent interventions --

DR. GRUNDY: Yes.

DR. LICHTENSTEIN: -- are supporting it even more. I think there was a lot of data that has been generated over the past five years, and the study that came out last month further supported it so I think we should encourage this consumption. Also, if people are eating fish they may not be eating as many hamburgers, but, you know, time will tell.

DR. GARZA: I guess we could say something to the effect that because fat in fish helps lower cholesterol, you know, eat more, but we do not have to --

DR. LICHTENSTEIN: That sounds good.

DR. GARZA: -- tell them it is Omega 3.

DR. LICHTENSTEIN: Right. That is fine.

DR. WEINSIER: But, Alice, it says it right here. "Ocean fish may reduce the risk for heart disease in other ways." Just leave out all the intervening words?

DR. LICHTENSTEIN: Yes. Yes. That is fine.

DR. GARZA: Okay. Richard?

DR. DECKELBAUM: I think when coming out with a recommendation for different types of fat in a 30 percent diet, the American Heart Association, as I recall, wrote for polys no more than ten percent polys. There are reasons for that, so polys are different than folic acid or monounsaturated acid in that there have been some concerns that they may

adversely effect the immune response, and there has even been some literature relating to increased cancer risk with high intakes of poly, not monounsaturated, fatty acids.

I agree that we must emphasize Omega or keep in Omega 3, but I disagree about leaving out mono versus poly because there are risk factors that may be present if it is all polyunsaturated Omega 6 fatty acids.

DR. GARZA: Richard, can you give us a suggestion for how we are going to help consumers make food choices so they will arrive not only at ten percent, keep their fat at about 30, saturated fat at ten and then worry about their poly and mono ratio?

DR. DECKELBAUM: So the message should be to encourage intake of olive and canola oils.

DR. LICHTENSTEIN: I disagree with that. I think there was a very good meta-analysis published last summer indicating that yes, with the animal studies there is evidence that polys do increase tumor development, but in humans there is absolutely no data at all.

I think it was Dr. Cayton who went through the entire literature in humans, and I think this whole issue of distinguishing between monos and polys has actually weakened with respect to Omega 3 fatty acids and immune responses. That was some of the data that, you know, it had altered immune response.

The differences are small, and clinically it is unclear as to whether it is advantageous or disadvantageous, depending on how you feel the progression of arteriosclerosis goes.

DR. GRUNDY: I guess the way I feel about it is I think I would agree with what Richard said. However, I think when implemented it is not going to change the ratio too much from polys to monos.

I do not think as a result of this guideline the amount of polys in the U.S. is going to increase. If it was, I think we would have to take a hard look at that, but I think that is very unlikely because it is kind of controlled by other factors, and it is sort of at a maximum in the last couple of decades or maybe even the last decade, so I guess I am not too worried about the point Richard raises, although I agree with what he said.

DR. GARZA: Is the sense of the group then that we will try to decrease the technical aspects of this section, that we will lump polys and monos together despite some of Richard's concerns, that we may want to put this as a recommendation for future work to see whether or not the types of meta-analysis that Alice referred to apply to humans, as

well as they do to animals?

DR. LICHTENSTEIN: The meta-analysis was just for humans, not animals.

DR. DECKELBAUM: And just for cancer and not for immune response.

DR. LICHTENSTEIN: Right. No. Immune response was tested.

DR. GARZA: There is room to better understand this, and perhaps in the future we may need to refine the fat recommendation, but at present the major advance will be trying to emphasize saturated fat with a greater degree than in the past.

DR. GRUNDY: I have one other issue I wanted to raise. Maybe Nancy Ernst could help on this.

It is my understanding that people who know where saturated fat comes from have pretty well defined it in terms of certain categories of foods where we get the vast majority of it. I do not know. Is that true, Nancy?

DR. ERNST: (Inaudible).

DR. GRUNDY: So maybe a very significant portion of the saturated fat in the American diet is coming from these things listed here.

DR. ERNST: (Inaudible).

MS. MCMURRY: These foods were taken from two articles by Amy Suvar, et al., that were published in JADA and Pediatrics in 1998. For children and adults, they are roughly the top five sources of saturated fat.

DR. GARZA: So mozzarella did not make it first, given the amount of pizza consumption?

MS. MCMURRY: No. Well, I think it was cheese generically, but I chose cheddar arbitrarily so it shows cheddar.

DR. GARZA: But it would --

DR. GRUNDY: That is very good. I know that is what we had discussed, but I did not realize that that is actually what you did here. I think we ought to state that somewhere that these are very major sources of saturated fat in the diet.

DR. GARZA: Would it be --

MS. MCMURRY: There is a statement in --

DR. GARZA: Would it be incorrect then, Kathryn, to just say cheese so that people could understand that there are other cheese? Most of us do not think of having cheddar in our pizzas, but given the amount of consumption of mozzarella, because I think it is probably --

MS. MCMURRY: Maybe some kind of a composite.

DR. GARZA: Yes. I was talking to Suzanne. It is probably lower, but not that much lower. I would assume maybe it is about 20 percent lower.

Are there other questions?

DR. LICHTENSTEIN: I am just wondering if on page 44 where we give advice to keep saturated fat intake low if we could add a bullet saying something like "Minimize addition of saturated fat to foods you eat" because we are saying choose this, choose that, keep your food choices, but we do not -- this is at the bottom of page 44. If we just say do not --

DR. GARZA: What I thought we were going to try to do is combine the bottom of 44 --

DR. LICHTENSTEIN: That one, too?

DR. GARZA: -- with Box 15. Did we not --

DR. LICHTENSTEIN: Okay. I thought it was actually the --

DR. GRUNDY: I thought it was that.

DR. LICHTENSTEIN: Okay. I misunderstood.

DR. GRUNDY: Right.

DR. LICHTENSTEIN: I thought it was the numbers part. Okay. That is fine.

DR. GRUNDY: Yes.

DR. LICHTENSTEIN: Then on page 48, are we going to address the issue of "Keep fat intake moderate?" Are we going to say about 30 percent, or are we going to say 30 percent

or less?

DR. GARZA: I thought we had agreed at about 30 percent due to the concerns of by going or less, that was the whole reason for not going with low because we did not want people to get much lower than 30.

DR. LICHTENSTEIN: That is going to be a major departure from all recommendations.

DR. GARZA: Well, that is why it says about 30 now because --

DR. LICHTENSTEIN: Yes. I still think moderate can -- it is appropriate to say 30 percent or less. I think this would be a major change in policy because it would be different than NCEP. It would be different than the AHA.

DR. GARZA: I thought that was your whole point of moderate.

DR. LICHTENSTEIN: No. No. Moderate was I just felt that 30 percent is no longer considered lowfat. It is considered moderate fat, and you needed to distinguish between lowfat and moderate fat so it was more in what is currently being consumed in the definition. Now we are at around 32, and I do not think most people would say we are all consuming lowfat diets.

DR. GARZA: What is the basis for the data that says that we consider moderate 30 percent? I do not have any data that says that.

DR. LICHTENSTEIN: No. I do not have any data either.

DR. GARZA: I mean, I am sorry. I thought the reason why the group was voting moderate was because you wanted to send a strong message that you did not want people to lower their fat intake too much because you were concerned about carbohydrates and the whole business of low calorie strategies people have used to get to a lower fat where it was prejudicial to their health, but if it is based on moderate is no longer 30, then --

DR. LICHTENSTEIN: Well, I am the exception. Maybe you should find out how other people interpreted that.

DR. GARZA: That is why I thought about 30 was what the group wanted to do.

DR. LICHTENSTEIN: I was just concerned that there was no --

DR. GARZA: Now you are raising it.

DR. DWYER: I was not part of the group, so I do not think that we should -- we should say or less because --

DR. GARZA: You think we should say or less or not?

DR. DWYER: Yes, I think we should, and that is why I voted against the moderate because clearly in what is it, Stage 2 I guess, Step 2, is 27.

DR. LICHTENSTEIN: No. It is 30 percent.

DR. GARZA: The saturated fat.

DR. LICHTENSTEIN: Thirty.

DR. GRUNDY: It is the saturated fat that is different, not the total.

DR. DWYER: Okay. Between that and the --

DR. GARZA: So we have keeping the wording of about 30 percent or saying aim for a total intake of 30 percent or less without offering a lower limit.

Scott, do you have any views on those choices?

DR. GRUNDY: Well, I admit that it is somewhat of a departure of what other groups are out there saying when they say 30 percent or less. This has been a continuous debate on how to say that. Some say up to 30 percent. Some say 30 percent or less.

I guess we just have to decide what we think is the right thing to do and not in fact what others are doing or saying.

DR. GARZA: What do you think the scientific data support? In going to moderate --

DR. GRUNDY: I think moderate and 30 percent go together. I mean, that has been the whole idea we have had.

I am not quite sure I understand Alice's point of 30 percent or less, what that means. I guess I have to ask you what do you mean by that? I can understand about 30 percent.

DR. LICHTENSTEIN: Well, does about 30 percent mean 40 to 20 percent, or does about 30 percent mean 25 to 30 percent? Maybe we should define it. I guess I thought well, close to 30 percent is moderate. When you start deviating from that it is low.

DR. GARZA: You saw that as a ceiling to aim at?

DR. GRUNDY: My point on that is if you say 30 percent or less then that would mean that if people adopt this guideline there would be nobody in the United States with more than 30 percent, so the group mean intake for the country would be 20 percent fat in order to get that. I do not think that is what we are shooting for is the group mean intake for the country to be 20 percent.

DR. DWYER: I do not think that is true, is it?

DR. GRUNDY: It would have to be true.

DR. DWYER: Oh, I see.

DR. GRUNDY: If 30 percent was the maximum that anybody could take, then the population distribution would be shifted over to 20 percent as a mean intake.

DR. DWYER: Would it be 20?

DR. GRUNDY: Yes.

DR. DWYER: Have you done those calculations?

DR. GRUNDY: It would have to be, yes.

DR. MURPHY: Well, unless people narrowed -- unless you narrowed the deviation.

DR. GRUNDY: You can try that, but at least the group mean intake would be well below 30 percent. It would have to be. That is why I thought 30 percent would be a better number.

DR. GARZA: I mean, my interpretation of going to moderate was that we would be accepting 25 to 35 percent. We were willing to inch above 30. That was the whole idea of calling attention to moderate.

DR. DWYER: How do you define moderate? Is it 25 to 35, Scott? Is that what you are

saying?

DR. GRUNDY: Do you mean the group distribution or the average for the individual?

DR. DWYER: When you say moderate, what are you really saying to a patient, someplace between 25 and 35? Twenty-five and 50?

DR. GRUNDY: If you are talking about the individual patient, if you are guiding him you should say you should be about 30 percent so you can shoot to be as close to that as you can. You know, you could accept a little bit on each side. You would not accept extremes on each side, but it would be somewhere in that range.

DR. DWYER: Twenty-five to 35?

DR. GRUNDY: Yes, you could say that for individuals it would be something like that.

DR. GARZA: So the major change that I saw with saying about 30 was that in fact we were shifting that ceiling to 35, where it had traditionally been at 30 or less. Well, 30 was the ceiling. I mean, we did not want people to go above 30.

DR. DWYER: So we are going back?

DR. GARZA: Well, that is the message I think we are sending. I want to make sure that in fact everyone is comfortable with that, and we have the data to back that up unless I am misinterpreting the intent of those that champion moderate.

DR. GRUNDY: I guess the other thing I think is whenever you set a ceiling on something and it is a group recommendation, and I think these are recommendations for individuals so we have to be more precise about that and not make a recommendation to the whole population.

DR. GARZA: So do we want to say that for individuals that they should aim at 30 percent or less?

DR. GRUNDY: Well, then I think you would have a good recommendation. If you made that recommendation for all individuals that it be 30 percent or less, then the average for the country would be a lot less than that.

DR. GARZA: Yes, but given that these are aimed at the individuals -- I mean, you want individuals to do this as a guide for their diets. We do not take guidelines and say people in

Washington, you know, this is what --

DR. GRUNDY: I think about 30 percent implies that that would be a reasonable number. I think we made an argument that that is about the ultimate level for individuals in the population.

DR. GARZA: Suzanne?

DR. MURPHY: I read this as saying under 30 percent is undesirable. Is that your message?

DR. GRUNDY: Well, too much under 30 percent is undesirable. If it is 29 percent or 28 percent, that is not undesirable, but if it was 15 percent I think we would have some concern about recommending that the whole U.S. population suddenly modify their diet dramatically and go to 15 percent without fully understanding the consequences. It is a radical change, so I think that 30 percent on average would be about the right amount for individuals to take.

Now, if you want to have a range, that would be okay with me, but most people are not willing to accept a range, you know, between 25 and 35 percent.

DR. GARZA: Scott, if we were to say 30 percent or less is there a real danger that in fact we are going to be down to those levels, or are we likely to hit the ranges that the group feels are going to be most inducive to health?

DR. GRUNDY: I think a lot of people will go below -- way below -- 30 percent. I am not saying the average in this country will, but there are already a lot of people who are at 20 percent. I think that is an encouragement to go to levels around 20 percent.

DR. GARZA: So that is why you are saying about 30 would be the right one?

DR. GRUNDY: That is what I thought.

DR. KUMANYIKA: I was thinking that the goal for Women's Health Initiative is 20 percent. Since that trial has not yielded any answers, it might be appropriate to say about 30 percent until there is evidence that we could really use to say you should definitely go lower than that.

I mean, I think that is appropriate if that is going to be the population level. If it shows that that is not the desirable level, we will not have been advising people. We will not be in

a position of telling people to bring their fat intake back up.

I feel comfortable with "about" right now because it is far from an exact science. I mean, this in a way is a wild discussion because it is like we know that 30 percent is the right number. We do not know that. We just ball park.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I think my original intent was just to distinguish limiting saturated fat and total fat and that the emphasis should be on saturated fat and total fat. With respect to the wording of the guideline, that is how I interpreted the wording.

DR. GARZA: Are you happy with the wording now?

DR. LICHTENSTEIN: I am not happy with it.

DR. DECKELBAUM: The current wording is "Choose a diet that provides no more than 30 percent..."

DR. GARZA: Right. That was a ceiling. That discussion took almost as long as this one.

DR. DECKELBAUM: Right. I have been in other committees where this exact discussion has taken place, so it is a major point.

One of the things that we have to consider in deciding this, because the ADA and other organizations also have sort of fallen behind this kind of recommendation. American Heart I think is 30 percent. Is it 30 percent or less?

I think that is what it is. It really is a major change. I am actually happy with no more than 30 percent and moderate.

DR. GARZA: We have three wordings. No more than 30, 30 percent or less or about 30.

DR. DECKELBAUM: Or close to 30.

DR. GARZA: All right. Let's take a poll so we can move on. Otherwise we will -- we have gotten through two of the five guidelines we are supposed to deal with today, folks.

All right. Johanna, we will start with you this time. We have about 30, 30 percent or less, or no more than 30.

DR. DWYER: Thirty percent or less.

DR. GARZA: Okay. Rachel?

DR. JOHNSON: I guess 30 percent or less, but I can live with about 30. What was the third option?

ALL: No more than 30.

DR. JOHNSON: No. That one --

DR. KUMANYIKA: It is the same as 30 percent.

DR. JOHNSON: Yes.

DR. GARZA: It is exactly the same. I am trying to be as fair a chair as I possibly can, but it is taxing at times.

DR. STAMPFER: About 30 is better than the other two.

DR. LICHTENSTEIN: I will go for the other two.

DR. GARZA: What other two?

DR. LICHTENSTEIN: Less than 30 percent or 30 percent or less.

DR. GARZA: Less than 30 or no more than 30.

DR. DECKELBAUM: I would be most pleased with no more than 30 percent, so 30 percent or less.

DR. GARZA: Okay.

DR. DECKELBAUM: And will not be a dissenter if it is about 30 percent.

DR. MURPHY: Yes. Well, I am still no more or less than. I find them interchangeable.

DR. GARZA: So then you would like the wording to about? You do not want about?

DR. MURPHY: Correct. Correct.

DR. GARZA: Shiriki?

DR. WEINSIER: What did you choose?

DR. MURPHY: I chose either no more than or less than. I do not care which.

DR. KUMANYIKA: I think I prefer about, but I do not feel strongly about it. I think we are being calculated anyway.

DR. TINKER: Right. I prefer about, meaning that it is on average. It does not have to be 30 percent every single day, but not to say that the average for a person over time would be 35 percent.

DR. WEINSIER: No more than 30 percent. Option, 30 percent or less.

DR. GARZA: What is the tally, Kathryn?

MS. MCMURRY: You missed Scott.

DR. GARZA: I am sorry, Scott. I keep forgetting the speakers.

DR. GRUNDY: I like about best; next, no more than; third, 30 percent of less.

MS. MCMURRY: Which one?

DR. GARZA: About. About.

MS. MCMURRY: About. I had four, five and one, so four and six.

DR. GARZA: So evenly divided.

MS. MCMURRY: Four for about, five plus one for or less.

DR. GARZA: And I would go with sticking with the old wording because I do not think we have definitive data to change it.

DR. DECKELBAUM: What was the old wording?

DR. STAMPFER: No more than.

DR. GARZA: Since I do not feel that people are willing to go down to the mats on whether we say about or no more than, I am sticking with the old wording. Rather than burden ourselves with having to marshal arguments that say we think that we can go substantially above 30 and we have the data to support it, is that wording reasonable?

DR. GRUNDY: Yes. I think another thing is that I am not sure this rises to the level of a specific guideline either. I think that there could be some language around this because this is not like an American Heart guideline where it is highly specific, so we can talk about some reasoning related to this.

Does that make sense? It is not written down anywhere else beyond this. It is just in the text, is it not?

DR. GARZA: That is right. So we will stick with the wording that we had in the previous guideline.

Let's try to finish fast before we take our break. We will have several other points.

DR. DECKELBAUM: Just one quickly. At the start of the green book section --

DR. GARZA: We are going to go to the rationale in just a bit. Let me make sure that no one has any other issues to do with the text.

DR. LICHTENSTEIN: On page 49 it says, "Eat plenty of grain products." I know we are stressing plant based foods, but are we saying plenty? I thought we were getting away from that to avoid suggesting over consumption.

DR. GARZA: We have plenty in several places.

DR. LICHTENSTEIN: Okay. All right.

DR. GARZA: You are right. I mean, we do.

Carole, am I remembering that correctly that plenty appears in other places? I mean, it is not just here.

DR. KUMANYIKA: There is something in the focus groups about not using it.

DR. LICHTENSTEIN: Maybe we should just consider that in light of the discussion on the first guideline.

DR. GARZA: So you would suggest eliminating the plenty.

DR. LICHTENSTEIN: Yes. If we are really going to get at the issue of over consumption, I think it is appropriate to recommend that people consume, you know, a diet that is relative.

DR. GARZA: Should we then say, "Make grain products, vegetables and fruits the mainstay of your daily diet?"

DR. LICHTENSTEIN: Yes, and be consistent throughout the text.

DR. STAMPFER: Just a little point in Advice For Today. I think the order of the second bullet should reflect the order that --

DR. GARZA: I noted that, too. Saturated fats.

Okay. Why do we not move on to the other issues that you might have, Scott, or the rationale if you are ready to move on to the rationale?

DR. GRUNDY: Okay. For the rationale, I think we tried to develop that in line with what we talked about, this issue about how we are going to define the optimal amount of intake, which we tried to make a point that about 30 percent is an optimum level.

We may have to change the wording of that a bit if there is not total agreement on that point, so it could require some modification of language there.

DR. GARZA: I think we could deal with that if we said that there is increasing evidence that in fact 30 may not be a ceiling or something and that it might vary with closer attention in the future, so if we want to change the ceiling that may be the most direct way to deal with that. Do you think that would be accurate?

DR. GRUNDY: Yes, I think so.

DR. GARZA: The rationale focused almost exclusively on cardiovascular disease and did not deal with cancer at all, so we may want to -- I do not think it would take a very long paragraph, but a paragraph that summarizes some of the recent data.

DR. GRUNDY: Well, I had all the references in there. Maybe I --

DR. GARZA: Did I just miss it?

DR. GRUNDY: Yes, like on the first page there it says -- you know, on the one hand there it says similar claims have been made for a high percentage of total fat in some forms of cancer, cancer of the breast, colon and prostate.

I looked at the more recent records that I could find on that. On the other hand, there is another set of references that have called that into question, which are the last references.

DR. GARZA: Now, I took that to be the introductory material which had been introduced, discuss it in more specifics as you had --

DR. GRUNDY: Okay.

DR. GARZA: -- with the other material that is introduced in that paragraph.

DR. GRUNDY: Maybe that could be repeated or gone into more detail under the Total Fat.

DR. GARZA: Unless, I mean, if I was the only one with that concern and you feel it was adequately covered in the introduction, I would not press it.

DR. GRUNDY: One thing Johanna said about the clinical trials that are being done. That should be mentioned.

DR. DWYER: Yes. I would suggest that you mention Ross Prentiss. I think he did a review within the past five years similar claims had been made about some forms of cancer, and then I do not know who the first author is for the baseline paper for the Women's Health Initiative trial, but you might want to cite that --

DR. GRUNDY: Okay.

DR. DWYER: -- since it describes the design and the rationale for the trial.

I do not have much to do with that trial. Meir does and others. Do you not have a clinical center?

DR. STAMPFER: Yes, we do.

DR. DWYER: Yes. There are people around the table who have clinical centers. I do not, but they may be able to tell you.

DR. GRUNDY: What about that, Meir? I think last time you said something that the

rationale for that trial was open to some question.

DR. STAMPFER: I think it is open to question, yes.

DR. TINKER: It is open to question, but there is a paper on the baseline rationales.

DR. GRUNDY: Yes. Fair enough. Yes.

DR. TINKER: You could include it. Also, I think in that section that listed the counter evidence to the cancer, one of the arguments about the cancer is back to the same thing of how do you measure what people are eating.

Some of the ups and downs, the pros and cons, have been in the measurement error. There is another article that Ross Prinz did that commented on that measurement error, and I think that would be useful to have in here.

DR. GRUNDY: What I am hearing is that we need to expand under the total fat more on cancer, a specific paragraph that goes back and looks at all the data and mentions the clinical trials. That is fair enough.

DR. GARZA: I think the obesity connection if you are able to cover it in the weight maintenance. I would not worry about that other one.

DR. DECKELBAUM: Scott, again in the rationale you mention that, you know, lower intakes of fat are associated with adverse effects on triglyceride, HDL and insulin. You quote a good number of papers, including one that we published about a year ago which showed that at least in hypercholesterolemic kids, but I would expect in other populations, that these effects on triglyceride and HDL were not seen if the lower fat was accompanied by complex carbohydrate substitution as compared to simple.

I am wondering if in these other papers, which actually I guess I have reviewed some of them, but is there literature that addresses this, looking at simple versus complex in different populations that might be cited here? In other words, this would be another advantage for substituting complex versus simple when you go with the lower fat.

DR. GRUNDY: That certainly has been a view that the more complex carbohydrates are not associated with the lipoprotein changes that are seen with simple carbohydrates. Whether that is substantiated with a whole database I am not sure.

That is controversial, and it is hard to really make a final decision about that, but at least

perhaps it could be mentioned, and the papers that are out there should be quoted.

DR. GARZA: Rachel, and then Roland, and then Johanna?

DR. JOHNSON: The sugar subcommittee did review several of those papers and in fact had something about that in I think the very first rationale that we drafted, and then based on subcommittee discussions, and I think, Alice, it was largely your viewpoint that it was preliminary and not to include it as a basis for the rationale for the sugar guideline, but we certainly might want to include -- I had pointed out in my comments that there is some inconsistency between what we are saying in the fat guideline and then what we are not saying or leaving out in the sugar guideline.

If we are going to make the assumption that there is metabolic consequences of high carbohydrate diets and there may be a link with complex carbohydrates versus simple sugars, to not say anything in the sugar rationale I think is a disconnect.

DR. GARZA: Do you mean as a research item?

DR. JOHNSON: Well, it is stated here in the fat rationale as if it is part of the rationale for why we are saying moderate total fat intake, but then the sugar subcommittee had felt that the data was not conclusive.

DR. LICHTENSTEIN: On total fat or type of carbohydrate?

DR. JOHNSON: On type of carbohydrate.

DR. GRUNDY: On type of carbohydrate, yes. No. I agree. It is worth noting that.

DR. WEINSIER: Has the issue been resolved about the temporal transient effect of switching from a relatively high fat to a relatively lowfat but high carbohydrate diet on triglyceride levels? It seems to me this --

DR. GRUNDY: There are population studies that show that populations that consume high carbohydrate diets have higher triglycerides on the average and lower HDLs than populations that consume higher fat diets, so on a long-term basis at least in population studies there is a difference.

I do not think that the old idea that, you know, it affects or has an effect for a couple months in some indicated way, that does not look like that is true from the population study.

DR. WEINSIER: So populations which subsist traditionally on lowfat, relatively high carbohydrate diets have higher triglycerides and lower HDLs. Do they have higher risk of heart disease? That is counterintuitive. In fact, I was not sure the population data showed that, at least the populations that are not obese.

DR. GRUNDY: I think the problem is that there is some populations now that people are getting fatter where they are getting a lot of heart disease let's say like in India or other places where there is population susceptibility.

Now, in some populations like in Japan and China and rural areas where people are very thin and work all the time and eat a lowfat diet, they have very little heart disease. That is one argument in favor of a very lowfat diet is because there is little heart disease, but we do not know that as they become more industrialized and begin to get fatter and more sedentary whether that same diet is going to be protective.

I think that is one of the concerns about making a recommendation to go to that kind of diet for the American public is that we just do not know whether that would be --

DR. WEINSIER: I think we need to reconcile some of this because on page 32 we are saying this modification talking about this 30 percent calories from fat is based on growing evidence that about 30 percent of total fat is an optimal intake.

DR. GARZA: You should be on Tab K.

DR. GRUNDY: Yes.

DR. WEINSIER: Was that sentence already changed?

DR. GARZA: I do not know whether that was changed. That should have been changed. That is the latest revision we have of the rationale.

DR. WEINSIER: Yes. Yes. Okay.

DR. GRUNDY: I guess what I would say to that is that about 30 percent being optimum, at least from the point of view of the plasma lipids it appears to be the case.

DR. WEINSIER: It is pretty much the same statement, 30 percent appears to be optimum, which does not seem to match with what we just went around the table saying.

DR. GRUNDY: You know, that is why I would not want to eat a 20 percent fat diet. My

HDL would go down, and my triglycerides would go up.

DR. WEINSIER: I just think the rationale has to agree with -- you know, it has to be the rationale for our statement.

DR. GARZA: That is why I thought that we might want to say this is something if we feel there is sufficient data now we can defend that 30 percent as a mean, as opposed to a ceiling we should do that. If we have only one or two papers and there is a need for additional research in this area so we can become more explicit, then we need to make that a research recommendation.

Given the nature of the evidence that we have, I do not feel that it is sufficiently overwhelming, at least from the data that Scott has summarized, that we can make national policy on it or change policy that it is no longer the ceiling. Maybe I am mis-interpreting the depth of the data.

Hold on. I think it was Johanna who wanted to go after Roland, and then --

DR. DWYER: Yes. It is just that if statements are made about carbohydrates, I think we should update the terminology and talk about mono and disaccharides and polysaccharides and starches and resistant starches and

non-starch polysaccharides. We should not be talking about terms that were used ten or 15 years ago.

DR. GARZA: Okay. Meir or Alice? I am not sure who was first.

DR. STAMPFER: Well, I agree with Roland. If we are -- you know, if the consensus around this table is that 30 percent is the maximum, then we cannot talk about optimal in the rationale. Maybe my colleagues who think that 30 percent is the maximum could give a sense of is there an optimal level, or is it the lower the fat the better?

DR. GARZA: My position is not based on what is optimal; that they know that we have sufficient scientific data to change the guideline from last year.

If we have sufficient data, I think we ought to go ahead and move and change it, but the number of references and the references that we have in fact do not argue strongly that we know what the optimal level is. We suspect it may be 30, but it seems to be an area for future work rather than something that we think may necessarily be ready for prime time in terms of all right, Americans, the population mean should be 30. Therefore, we ought to

go from 35 to 25. I just do not know whether we are there yet, and I am phrasing that as a question.

Scott?

DR. GRUNDY: What is the question?

DR. GARZA: Do you feel that we have enough data to say that the 30 percent is an optimal level and, therefore, it is no longer a ceiling, but in fact a mean that we ought to be either above or below a substantial change from past policy?

DR. GRUNDY: I think that from the point of view it depends on -- you know, we are all coming from a different point of view here. That is the problem. Those of us that work in the cardiovascular field and see coronary heart disease as the biggest killer of people think that that is a level that is most optimum from the point of view of risk factors for cardiovascular disease.

There is some concern of a little higher fat intake that might be related to cancer, which is in clinical trial. There is certainly not a rationale going in that direction, so we do not have an answer on that, but there are some people who believe that.

Then there are other people that believe that a higher fat intake may be associated with more obesity. Again, from my reading of the literature that is a pretty weak hypothesis, but the hypothesis is out there so the 30 percent represents some kind of a compromise between those different trends, between cardiovascular, cancer and obesity. When I say it is optimum, it is a number that seems to be a compromise between those different directions.

DR. GARZA: But do you feel that if somebody were to consume let's say a 27 or 25 percent fat diet and was following the guidelines in terms of making fruits, vegetables, grains, whole grains the base of that, choosing lowfat products, using the top of the pyramid sparingly or rather limiting their sugar intake and alcohol consumption, etcetera, if we take all the guidelines that those individuals would be at a significant risk because their fat intake was below 30 percent? That is different from saying gee, they took only a simple carbohydrate, which nobody is recommending.

DR. GRUNDY: Do you mean if you took a million people and had them eat 27 percent, another million and had them eat 30 percent, would there be any difference in their outcome? I do not know the answer to that. Probably there would not be any difference because it is not very much difference. It is only three percent of your calories.

DR. GARZA: Well, or 25. That is why I went to 25.

DR. GRUNDY: Yes.

DR. GARZA: I mean, it was more substantive.

DR. GRUNDY: But I do believe that the lower you go in the percentage of fat, the more the lipoprotein abnormalities begin to appear.

DR. GARZA: Even if you were consuming not simple? I do not know whether it was Alice or Rachel that brought that up, but taking them as complex carbohydrates from fruits, vegetables and grains as we now recommend?

DR. GRUNDY: Even 30 percent fat you begin to see trends in that direction compared to a higher percentage of fats, 38 percent compared to 30 percent. There are trends that the further you lower your fat intake, the more you begin to find abnormalities in your triglyceride and HDL and LDL, so that is the increasing concern. That is why I would not recommend going to very low fat intakes.

DR. DWYER: Does it vary at all with the type of starch or resistant starch or fiber?

DR. GRUNDY: Well, that is what we were debating. you know, the evidence might be suggestive that there is a difference, but I do not think there has been enough research. That is clearly where we need more research in that area.

DR. DWYER: How about the effects of physical activity and exercise?

DR. GRUNDY: Yes. Physical activity reverses those trends.

DR. DWYER: And weight?

DR. GRUNDY: And weight both, so if you have thin people exercise and working in the fields all day in China they can overcome the detrimental effects of a very lowfat diet by keeping their weight down.

DR. GARZA: Okay. Do we want to revisit the wording, or can we say no, we will make a strong statement in terms of the need to look at this issue in terms of the type of carbohydrate and bring it to the attention of the next committee that this is something that we struggled with?

DR. LICHTENSTEIN: And also what needs to be considered is the level of fat with respect to different subgroups within the population because as Scott just said, if you have a skinny person doing a lot of activity there is probably going to be a different effect as a moderately overweight, middle aged person that has abnormal glucose tolerance.

DR. GARZA: Could you put together, Scott, a paragraph that addresses this, I mean, so that in fact we can call it to people's attention in terms of the research recommendation?

DR. GRUNDY: Sure.

DR. GARZA: Meir, did you have your hand up?

Are there other issues on the rationale? The group looks exhausted. Maybe we are going to get work done now.

DR. MURPHY: Too tired to argue.

DR. GARZA: That is right. Too tired to argue. All right then. Thank you very much.

What we will do then is take a break and come back with the next guideline in 15 minutes, 3:45 p.m.

(Whereupon, a short recess was taken.)

DR. GARZA: We are moving on to our 1:00 p.m. item.

DR. WEINSIER: We are on time somewhere, but not in Washington, D.C. Okay. Regarding the weight section, let me just mention that in terms of background the changes we have made are based upon some new research data, as well as some new consensus data that have helped our subgroup considerably.

I think I have identified about six areas in which I would say there has been significant new research data available and/or a significantly greater consensus, and those include definition of healthy weight and overweight categories. Second is the role of body fat distribution patterns and appropriate and convenient ways of assessing body fat distribution patterns.

A third area is a clearer understanding or at least a greater discussion of the contribution or one of the contributions of genetic versus environmental versus behavioral factors related to obesity. A fourth relates to treatment guidelines.

A fifth relates to weight cycling, i.e., repeated attempts at weight loss and its impact on psychological and physiologic parameters, and the sixth is one relating to the impact of energy density on energy intake, so those are areas that our subgroups feels that we have significant new data.

Since I am talking about it, let me just jump to the third area, which is are there areas in which we need further research? Are there areas in which there needs to be further work? Since I am talking about new research, let me just jump to that even though that is really the last thing I am supposed to address. Let me just address it here, and we do not need to come back to it unless you want to.

That is, I have identified four areas in which we really do need considerably more work. One is the impact of preventive measures in childhood on development of obesity in adulthood. We have certainly a lot more information there, but we have a lot more that we need to accrue.

A second area is the impact of portion size versus energy density on long-term weight control, and this issue has been discussed repeatedly. I think there is a lot of bias around the table in terms of how important portion size is and energy density of foods, but we are basically working with limited data when it comes to portion size.

We are working with very solid data when we talk about energy density on food intake, but more scarce data when it comes to the effect of portion size and energy density in long-term weight control.

The third area in which we need more work is the health benefits of long-term, sustained weight reduction, and you would think that we would have had that answer a long time ago. In fact, that is probably going to be the hardest data to get. The NIH now is prepared to and has committed significant funds to address the health benefits of long-term, sustained weight loss.

Finally, the role of different types of exercise on weight control, which perhaps could be addressed in the rationale section of the exercise, but particularly comparing aerobic versus strength exercise and relative intensities on weight control, so those areas in which there is a paucity of data makes it very difficult for us to reach firm conclusions.

Can I have the first overhead? In terms of proposed changes in the overall section, just as a quick overview similar to what I did last time, and then we will come through it for a little bit more detail going through each section.

These are the recommendations for the 2000 version. We have a change in title. I will come back to that. We have subsections that either combine or reorganize some of the older sections, some that pretty much, you know, go directly across, and then we have some boxes and figures in which we have added a box and we have deleted a box, so there are some revisions in each of these.

Let me just go step-wise and give you the rationale for our changes and what data I think from a scientific basis we have to support each of those.

In the next overhead, first starting with the title. As you recall, in the previous version it was Balance the Food You Eat With Physical Activity to Maintain or Improve Your Weight. We struggled with the title. Remember, last time we met we had a title that was called Achieve and Maintain a Healthy Body Weight or Achieve and Maintain a Healthy Weight.

There has been a lot of discussion and at least one conference call since then dealing with this issue because it really overstepped the bounds of what we know. We really cannot say on the basis of available scientific data that if you achieve a healthy weight that is ideal from a health standpoint.

Intuitively it sounds good, but we honestly do not have the data, nor does it really match well with what is a practical goal in terms of what we can expect people who are in an overweight or obese category to do in terms of can they really practically achieve a healthy or normal body weight, so in that context we have tentatively recommended the title Aim For a Healthy Weight.

Justification for the changes. I have gone over these two before. I do not think I need to reiterate, but there was concern about the word balance in the old title and the word improve. There was a problem with the old title, and the proposed title -- I do not know if we can raise that a little bit, Joan -- is less than ideal, but it is a compromise of the following two messages of the guideline.

I am trying to hammer or we are trying to hammer these two recommendations in terms of weight control home. One is if you are at a healthy weight, aim to avoid weight gain. Two, if you are already overweight, initially aim to prevent further weight gain and then to lose about ten percent.

Now, there are more specifics in the guideline, but these are the, you know, messages we are trying to, you know, convey. If you are lean, stay lean. If you are overweight or obese, at least do not gain more weight, and try to lose at least five, ten or 15 percent to improve your health status.

The title is a compromise to try to get at these two points. If you feel uncomfortable with that, we are open to your suggestions when we come back to that.

Interestingly, in past guidelines here are some of the titles for what they are worth. 1980, Maintain an Ideal Weight; 1985, Maintain a Desirable Weight; 1990, Maintain a Healthy Weight; 1995, Balance the Food You Eat With Physical Activity. Maintain or Improve Your Weight. At least between 1980 and 1990 they were maintain an ideal weight, maintain a desirable weight, maintain a healthy weight.

In the next overhead, the first section of the text relates to Evaluate Your Body Weight, and it is pulling together information from two previous sections, How To Evaluate Your Weight and Location of Body Fat, so we are discussion the relevant importance of degree and distribution of fatness in the same section because of the complementary contributions to health.

The new section recommends the use of waist circumference versus the waist/hip ratio because of new data showing that this is an appropriate, as well as a practical, measure for assessing indirectly interabdominal fat, which is a significant and independent health concern independent of total body fat.

Finally, this section introduces the concept of BMI in concert with the new international and federal guidelines that have come out in the past couple of years.

There is a box that deals with Evaluate Your Body Weight and complements this section, but let me come back to that when we get back to the figures in the boxes toward the end.

In the next overhead, the next section is called Control Your Weight, and it is actually we try to condense three of the previous sections, How To Maintain Your Weight, Problems With Excessive Thinness, and If You Need To Lose Weight, into the one section called Control Your Weight.

The justification is that since issues of excessive thinness often arise in the context of and as a result of desire to control the weight that we probably ought to discuss them together.

There is a new concept -- if you can raise this a little bit -- that has been introduced, and that is a concept of relative contribution of modifiable attributes, i.e., lifestyle, relative to unmodifiable attributes, i.e., our genetic, you know, makeup.

To say that this is based upon new, hard data, the answer is yes and no. There are definitely a lot of new data since 1995 in terms of the role of genetics in obesity certainly in

animal models and growing in humans, but in terms of dealing with the relative contribution the data are not as clear so the committee has acknowledged that there are three major factors that modulate body weight within an individual -- our metabolic rate, i.e., our energy requirements, our physical activity and our dietary pattern, and these are all influenced by our genetic makeup.

The recent increase in obesity prevalence cannot be explained by genetic mutations in the general population, but, despite obstacles, personal lifestyle choices can impact on one's weight, so what we are trying to do is acknowledge that there are data addressing metabolism, activity and diet, but that the individual should not be left with the feeling that yes, the new data and the OBOB mouse and the DBDB mouse does not indicate that genetics necessarily in the population at large is a major determinant of overweight and obesity in the population wide group so that we still have to come back and say that genetics do not override for most of us our environment and our personal choices, so that is why this was brought in.

The wording is roughly to this effect. Our genes affect our tendency to gain weight, especially in an environment like ours, and it goes on, where there is high energy dense foods throughout the year and little physical activity being required. These factors can make it very difficult, but you can still have an effect on whether you stay lean or gain excess weight through your food and physical activity choices.

This may not be ideal wording, but we are trying to get at this issue, which has received a lot of attention. There is a lot of misperception in the public, as well as among health professionals, about the theoretical overriding effect of genes on our behaviors and the environment.

In the next slide, we are still continuing with the weight control section. In the 1995 version, there was emphasis on eat less fat as a means to decrease energy intake. The new section clarifies that lowfat foods are not necessarily low in energy density. We discussed this last time.

As in the 1995 version, there is emphasis on

long-term changes in diet pattern, but the new version specifically promotes fruits, vegetables and grains as an approach to decrease the energy density of meals.

Suzanne and I were talking just a few minutes ago. Is it really true that food groups really do give you lower energy density? Well, these three food groups in general. You can take any one food group and find some variation such that one type of grain or cereal may be

somewhat more or less energy dense than another, but as groups the fruits, the vegetables and the grains are relatively low, energy dense foods in comparison to foods, for example, like cheeses, the meats, the beans, the nuts, etcetera, so it is food groups, and it sort of fits with the rest of the guidelines in terms of what we are emphasizing, i.e., the base of the pyramid.

Justification. Accumulating data indicate the role of energy density and regulation of appetite and food intake. I feel very comfortable with standing behind this; in fact, even more so than in our last meeting because Meir brought to my attention a number of new articles which I had not seen by the Prentis Group at the Dunn Institute that complement the studies that have been done at Penn State looking at energy density and regulation of appetite and food intake, and they are all saying the same thing.

The studies go from a few days up to a few weeks. They are solid, but they do not get at long-term weight control. The data are more indirect in that regard.

Some of the wording we have included is to this effect. Eating a plant rich diet, mainly vegetables, fruits and grains, allows you to eat more, feel full and achieve good health while helping you control your weight, so we are just trying to tie in the other guidelines with this one so that you do not get the feeling you do something if you are overweight than what you would do if you had hypercholesterolemia, for example.

The next section, as you know, defers discussion of physical activity to a separate guideline.

In the next overhead, the next section is If You Need To Lose Weight, Do So Gradually. It is pretty much along the lines of what was in the 1995 version in which we, as they, emphasize the importance of even a five to 15 percent weight loss in terms of improving or having a health benefit.

The new section introduces a concept of weight cycling, however, which was not in the previous report because there have been a number of studies and consensus reports that have come out on weight cycling, i.e., repeated attempts at weight loss in terms of is it inappropriate to try to lose weight if you have already failed in the past is that going to have greater health risk than benefit.

We have included to the effect -- this is not the exact wording because it was changed, but to the effect trying to make the point that past failures at maintaining weight loss should not be a deterrent to try again. There is no compelling evidence that past attempts at weight loss affect the body's metabolism such that you will be less successful at future attempts. This is true for the psychological impact, as well as the psychologic impact.

If you want we can go over the exact wording, but it is to the effect that failures are not condoned. I mean, we are definitely recommending as the ideal approach to lose and maintain if a person is overweight or obese, but if there have been past episodes of weight regain it does not preclude you from a health standpoint of trying again.

In the next overhead, the next section is Encourage Healthy Weight In Children, and it builds on the section that was in the 1995 version of a similar title. It is basically unchanged in terms of emphasizing the need for adequate food for growth and the fact that excessive energy intake and sedentary activity lead to obesity.

The new section adds a statement regarding the severity of the problem because over the last decade or at least the decade of time in terms of looking at changes in prevalence rates, the number of U.S. children who are overweight has more than doubled.

Also, Rachel has brought in some important data based upon some new studies showing that parents can have a major impact on a child's eating and activity patterns, so the new section emphasizes the role of parents in setting an example and sharing the child's diet and physical activity patterns as an attempt to modify their behaviors so I think the section is not dramatically changed, but is strengthened.

The last section is called Advice For Today, and it is really not very different from the 1995 version, but basically what we have tried to do is to reinforce the justification for the title and give us an opportunity to come back and restate that if you are at a healthy weight to avoid weight gain. If you are already overweight initially to prevent further weight gain and then lose about ten percent over about six months.

There are other statements in the Advice For Today, but those are not very different from what was in the 1995 version. This one is a little bit different and is more congruent with what is in the WHO and the NHLBI reports.

The next section deals with the figure. You may recall in the 1995 version it was Figure 3 at that time. Yes. This is what was in the 1995 version. You cannot read it, but this says Healthy Weight, Moderate Overweight, Severe Overweight based upon your height and weight. It just gives you a guideline to, you know, look up the chart, down the chart and find what category you fall into.

They tried with a color scheme to give the feeling that it is a blended type thing without clear distinction, even though there were lines that were drawn here that you cannot see in this overhead.

What we have done is tried to pick up on the NHLBI and WHO reports and other documents emphasizing that the BMI is perhaps a more useful cutoff than just weight per height, and yet we do not want to lose sight of the fact that this is a graded type effect.

In other words, people who are even within the same category, let's say a healthy weight category, that if you happen to fall here at the leaner part does not mean you can still be healthy. Heck, I am just going to eat a little bit more, exercise a little bit less, and I will push it right up to this limit and have fun for the next, you know, six months or a year just as long as I stay below that line.

So, we tried to deal with that in two ways. One, in the figure by showing the graded, you know, darkness to show that it is a continuum in terms of health risk and in the caption, if you can see that from here back there. You can raise it up a little bit, Joan.

The caption might read to the effect the BMI or weight for height ranges are not intended to indicate distinct categories of healthy and unhealthy weights. They are intended to show that health risk increases at high levels of overweight and obesity. Weight gains, even within the healthy weight range, may carry health risk.

This is major concern that is not new. I mean, they addressed it in the 1995 version, but we are just trying to be particularly careful when we are dealing with categories by either title or BMI cutoffs that we are not misleading the public to believe that you are either at a healthy weight or you are sick at an unhealthy weight; that it is a graded effect.

In the next overhead there are several boxes in this guideline. Excuse me. This still deals with the figure. Yes. This is just the justification that we are adding the three categories of BMIs to match with the WHO and the NHLBI reports and that we are emphasizing spectrum of health risk with increasing weight versus distinct health categories. At least that is what we are trying to do. Whether we have done it effectively or not you will have to guide us.

Then the next one deals with the box, the first box, which was not -- we did not have a counterpart in the 1995 version, and this one deals with Evaluate Your Weight. This is based upon again the new federal guidelines. This box is intended to help consumers follow currently recommended steps for assessing your weight status in relation to health risk, and it was a box that probably left some of us uncomfortable. I will not go through it now, but it is currently Box No. 7, and it is too long and it is too convoluted.

DR. GARZA: It is No. 6 now.

DR. WEINSIER: It is now No. 6? Yes, it is No. 6. I am sorry.

Even since the version you have there, several people, including Kathryn, Joan and Trish, have worked on this and made a recommendation that I think is outstanding and ways to break it up and to make it even a fun type box where you can actually check off the number of risk factors you have, add up your total, write in your own BMI, write in your own waist circumference, and then you come up with a bottom line. Am I in good health, not so good health or bad health?

It becomes more of a game type thing, but still within a box rather than just a bunch of words that you are struggling to read through. Anyway, I like their suggestions, but we will have to get that printed out for you later.

The next overhead is another box. This is the counterpart to Decrease Your Calorie Intake. In the 1995 version there were seven specific bullets in terms of how to reduce your calorie intake. We are using a slightly revised title and trying to be more positive or put a more positive spin on these.

Without going through the individual ones, I will just say that the 1995 version of the seven, seven were negative type statements in terms of eat less, eat without, reduce and that sort of thing, so we tried to be more positive in terms of eat more of these types of foods, be a little more generous with this type of pattern, that sort of thing, so it is in terms of such as get most of your calories from high fiber plant foods like vegetables, fruits, potatoes, corn, beans, pasta, etcetera. Go easy on foods high in added fat. If you drink alcoholic beverages, do so in moderation. We are still saying essentially the same thing, just trying to twist it a little bit so it is not quite as negative.

Then the next overhead deals with the box that was removed because remember in the 1995 version there was one dealing with energy expenditure and types of physical activities, which are now moving to a different section.

Those are pretty much the issues that we have grappled with and reiterating briefly that we do not feel that we have all the answers because we are still shy from our research standpoint on a lot of data that would help us move this out, but let me just stop there and see if there are any questions or comments.

DR. GARZA: Questions? Comments?

DR. WEINSIER: Particularly regarding the title. I am not thrilled with the title, but, you know, we are compromising it seems like every other month.

DR. MURPHY: I like the title. That was not the title. That was not what I was going to first comment on, but maybe we should talk about the title before we go to the text. I like a short title.

DR. GARZA: Are there any comments about the title? I mean, I do not --

DR. TINKER: I like the title.

DR. GARZA: I think people are happy with the title, Roland. I do not think there is -- at least I am not aware of any major concerns.

Scott?

DR. GRUNDY: Yes. When I went over this I made a few comments here for consideration.

DR. WEINSIER: Oh, yes. I wanted to respond to your --

DR. GRUNDY: Yes. Fine. There was one thing the more I thought about this the more I wondered if we were a little bit on the wrong track in that maybe we could tie this in to the guidelines and address the guidelines a little more by emphasizing the caloric excess associated with overweight and make the recommendation more to adjust your calories to achieve a healthy weight rather than aim.

I know exercise is involved in that, but the more I thought about this the more I wondered if the emphasis should be on weight, or should it be on excess calories that lead to weight? If we concentrated on the caloric excess then maybe that would tie it in with everything else that we are doing with energy density and portion size.

Anyway, that was one thought that I had that maybe we could discuss and see what you think about that idea.

DR. WEINSIER: Well, how do others feel? This is a marked swing away from other guidelines and approaches.

DR. GRUNDY: It is. I mean, that is what --

DR. WEINSIER: That does not make it wrong.

DR. GRUNDY: No.

DR. GRUNDY: It is just very different.

DR. GRUNDY: It is, and that is why as I read through this I thought that maybe if we are going to tie it to the dietary guidelines and foods then maybe the emphasis ought to be on amount of food.

You know, when you calculate the excess calories required to make a person overweight it is only like 300 calories a day more. You know, we are not talking about major changes to be at say a BMI of 27 versus 23. I think that is like 300 calories a day more, and a BMI of 30 is 500 calories a day.

So maybe concentrating on the excess calories, where they are coming from, and if we adjust caloric intake just to be at a healthy weight then your fat will melt away, and you will be at that healthy weight so everyone should eat the right number of calories rather than trying to adjust your diet to get rid of your body weight. That was what I wanted to throw out for some discussion.

DR. GARZA: I am trying to think of how one could phrase it in a positive sense. Certainly with fat, alcohol, sugar, salt, you know, we get into the thou shalt not.

DR. GRUNDY: I think that is why I say if you just eat the number of -- if you follow the pyramid guide exactly, you would not be fat, right? The problem is you are eating more than what is in here.

If you adjust yourself to eat what is in the recommended number of calories, then you are not going to be overweight so you do not have to change anything. Just eat what you are supposed to eat, and then your weight will take care of itself.

DR. WEINSIER: Scott, what is the recommended number of calories?

DR. GRUNDY: Pardon?

DR. WEINSIER: What is the recommended number of calories that you suggest we put in?

DR. GRUNDY: Well, that is why I had something there about excess calories. You can estimate how many calories you need to remove from what you are eating to get your weight to where it ought to be.

You know, if you should be eating 2,300 and you are eating 2,700, you are going to weigh something like 20 pounds more than you ought to weigh, so just eat 2,300 calories.

DR. WEINSIER: So you are suggesting we have a formula based upon gender, age, some estimate of physical activity, perhaps body composition, to derive calorie requirements and then I guess a reference point for what is an --

DR. GRUNDY: I think you are making it too difficult. In a way, that is kind of what you are doing, but I think the point that most people do not realize is that they are not consuming a lot more calories than someone who is thin. They are just consuming a little more than they should, maybe ten percent of their calories more than they should, so all it will require is some adjustment in their daily caloric intake, and they will become at a desirable weight.

Anyway, the idea was link it with the rest of the guidelines by focusing on total calories as part of the recommendation.

DR. GARZA: Richard?

DR. DECKELBAUM: Just to link it with what we are eating, you might consider something like "Choose the right eating pattern for a healthy weight."

DR. GRUNDY: Something like -- I guess that is what I am saying, too.

DR. DECKELBAUM: This is the nutrition part of these two guidelines, so this is the part that we can specify what you are eating. If you say eating pattern, I guess, rather than diet it is what they want to hear.

DR. GARZA: Shiriki?

DR. KUMANYIKA: I think I agree with the need to make it more prominent. The information is here.

I have one question for Roland because it says manage your weight on page 24, and your slide said control. I like manage better. I do not know if that is a change to put it differently, but I think one could by formatting and maybe some additional subheads under the Manage Your Weight do exactly what Scott recommended because all the dietary advice is here and the idea.

Everything you said is right in this paragraph, but it needs to be -- this is the main advice for how to do it. I think it is kind of buried there under the little paragraph about genes and stuff.

DR. GARZA: Shiriki, what Scott is also suggesting is in fact being tied to the guideline itself more explicitly to diet rather than aim for a healthy weight, which is obviously an isometric focus, and have a dietary focus.

DR. KUMANYIKA: Well, I did not mention that I am against --

DR. GARZA: Is that what --

DR. GRUNDY: That is what -- yes, I guess that is what I am saying.

DR. KUMANYIKA: We did it the last time, and nobody understood it.

DR. GRUNDY: Well, anyway, I think that the focus instead of looking at how much they will weigh on the scales is how much am I eating. I think that is some shift that is worthy of some consideration.

DR. KUMANYIKA: I mean, I agree that it should be tied into food, but I think at this point if the public consumes anything it is weight issues, and they know it has something to do with eating.

They may not know it has to do with physical activity, but that balance the foods you eat with physical activity seems to have so totally backfired that I thought the short and sweet guideline without mentioning food would work.

DR. GARZA: Any other feeling from the rest of the group? I mean, should we try and strike at a dietary focus, as opposed to an isometric one?

DR. DWYER: I like it the way it is. I like the aim for a healthy weight, and I think we can cope with those other concerns in the text. They are legitimate, but it just clutters up the document.

DR. GARZA: Any others? Has Johanna summed up the sense of the group? You would like to deal with the concerns primarily in the text, as opposed to the title?

DR. GRUNDY: As long as I am in the minority, I would like to throw out one other thing is that I am not too happy --

DR. GARZA: You just do not totally agree.

DR. GRUNDY: Right. Right. I am not totally happy with recommending that overweight

people eat a different diet composition than people who are at normal weight. I think that implies that, you know, if you are normal weight you can eat everything on that pyramid, but if you are overweight you have to restrict your diet and only eat part of the pyramid.

Again it comes down to what my thought is that eat the amounts of everything and then you will assume a normal weight and not say you are overweight so I can only eat certain things. That seemed to come across to me in this recommendation.

DR. GARZA: Putting the emphasis so much on the quality of the diet, as opposed to the quantity?

DR. GRUNDY: Yes.

DR. GARZA: Let's look at the text. Suzanne?

DR. MURPHY: Yes. To build on that, maybe you are not really in the minority here. The pyramid is only 1,250 calories. There are very few adults that would not lose weight if they just chose the lowest number of servings from each food group in the pyramid.

I think that is an important point to make. A lot of people, consumers that I talked to, say I cannot follow the pyramid because I would gain weight. That is really not true.

DR. GARZA: Maybe the explicit advice ought to be there that if you select from the lowest range from all the groups that in fact one should be able to achieve the type of weight loss that is recommended here, the gradual weight loss.

DR. MURPHY: I think that is the place to start, and then if you can afford the calories you can start adding them.

DR. LICHTENSTEIN: I agree that there is a misconception about that, but I think it goes back to what a defined serving size is versus what the perceived serving size is and that if someone is consuming a regular bagel that you get out on the street now it may be two or three servings so that maybe a little more emphasis on serving size and back referencing to the definitions would help clarify.

DR. GARZA: We have two major sections on serving size, one on the first guideline and another one here, that talk about exactly those issues somewhere I thought in terms of portion sizes.

DR. WEINSIER: Well, we talk about portion size, but qualitatively we do not -- I do not

think we redefine them.

DR. LICHTENSTEIN: Do you mean in Box 7?

DR. GARZA: Somewhere we talk about a bagel being equivalent to two or three serving sizes. Where was that?

DR. KUMANYIKA: Page 26.

DR. MURPHY: The top. The top of 26.

DR. GARZA: That is right. Control Portion Size.

DR. LICHTENSTEIN: Right. That is embedded in a box.

DR. GARZA: So you think that ought to be highlighted more prominently?

DR. LICHTENSTEIN: I think so because I think it is a recurring sentiment that we heard that I cannot possibly eat all the recommended servings in the pyramid. Is that for a week or a day we have heard, so, you know, I do not think it is unreasonable to --

DR. GARZA: We need to tie it into the pyramid more closely in making specific recommendations about sticking to the lower portion sizes and giving examples --

DR. LICHTENSTEIN: Right.

DR. GARZA: -- so making the control portion size, expanding that to be more inclusive of quantity and trying to get across the pyramid.

DR. KUMANYIKA: I have a question. Does anybody know how many calories the pyramid minimum servings would have if you used nutrition facts label servings?

DR. GARZA: I do not know. Suzanne just said that it was 1,250 if you use the minimum serving numbers.

DR. MURPHY: 1,215.

DR. GARZA: 1,215, which is --

DR. MURPHY: But that is if you do not eat anything else. That is right.

DR. GARZA: Those are the recommended --

DR. MURPHY: But I do not know how that would compare to the minimum servings.

DR. GARZA: A 1,200 calorie diet is pretty stringent.

DR. MURPHY: It would be pretty hard not to lose weight.

DR. KUMANYIKA: But I am going back to the point that Johanna made earlier, which is probably one of the most important things said today, which is that the fact that the pyramid servings are not the same as the servings people have on the labels is festering under there as a big source of confusion that I had not identified that clearly, so we should know.

Let's say people never look at the page that says what this mysterious thing called a pyramid serving is. How else would they know what a pyramid is because it is not written anywhere except, you know, in the booklets. What if they were to calculate their pyramid diet from the food label? It would be nice to know whether they get too many calories or too few or whatever.

DR. GARZA: Carole, does that exist, that calculation?

MS. DAVIS: No, it does not.

DR. GARZA: Does it exist within the FDA or anybody? Would it be possible for the staff -- I think it is an important point. I mean, we ought to give advice. I mean, if those are the two major tools for education are the pyramid and the nutrition fact label, then not assuring ourselves that they are approximately at least interchangeable is serious.

MS. DAVIS: They really are not.

DR. GARZA: Well, I know, but that is what I mean about this. We have got ourselves in a real pickle within the guidelines because we keep going back and forth between the pyramid and the label.

AUDIENCE MEMBER: The label is based on 139 references, and the pyramid is 50. It is giving you optimal or recommended amounts within a group.

DR. GARZA: I think the concern is that we all may recognize that, but it is not as clear to the consumer that it is not a recommended serving, and so we have a recommended serving

in the pyramid, another one on the label.

I think Shiriki's point is well taken. We should at least be aware of what those differences are so we can either incorporate them in the text that we provide or say do not use the other. Use only -- while we all recognize the differences, I think to a consumer whether they see a serving on the pyramid or a serving on the label I think it would be reasonable for them to assume that they mean the same.

MS. DAVIS: There are so many products. I know offhand it is different.

DR. GARZA: Do we have the same problem that we dealt with in the first guideline, that in fact trying to find this level of homogeneity is just going to be impossible because of the complexity of groupings the way they are in the pyramid versus a case by case basis for a food product, and we are sort of to a broccoli versus collard green analogy?

MS. DAVIS: I mean, you have many processed foods that have a label to them. I am just trying to think of the great number of products.

MS. MCMURRY: There are some basics that are pretty easy to compare like pasta. I think the serving size is one cup on the food label and half a cup on the pyramid. Raspberries, depending on the size of the load.

Alyson, do you have comments?

MS. ESCOBAR: I was thinking that the biggest difference would probably be the grain products serving because the composite are put together based on consumption. Bread is only going to have the impact that bread consumption has contributing to that group and the mixed dishes because of the way the label defines some of those prepared mix foods as being a set quantity, but not really relative to how much of any of the individual ingredients is in the food.

DR. GARZA: This is sounding more like a research issue and a recommendation that in fact we ought to go back to the Federal Government and say look, we are going to be using the pyramid for reasons that we developed today in making these recommendations, but we feel that there is a potential source of confusion to the public as we go to one source saying that a serving is a cup, another source saying that a serving is a half cup for a food product that we should be able to standardize in terms of a serving.

I mean, there is no apparent reason why it could not be the same, or am I just missing the reason why it cannot be the same? That may not be true everywhere, but to make the

recommendation that in fact we look at this so the next group will not be struggling quite as much with this issue as we are. Would that be satisfactory?

DR. KUMANYIKA: Well, this relates directly to the issue of the kind of advice we give people about portions for weight control because if in fact, as Scott is saying, if you ate the pyramid servings you would be fine, but you would eat double the calories from grains, cereal and pasta if you use the food label servings, as opposed to the actual pyramid serving which is there.

I think, you know, after Johanna pointed it out this morning, I think this is really serious because it is one thing to point to consumers that the size they buy is different from the serving, but if we are actually giving them guidance based on a difference in the serving sizes someone needs to sit up all night and figure out how to do this. I mean, it really has been worrying me even since this morning. It is very confusing.

DR. GARZA: Well, the alternative is just not to talk about them the way that we just did, but to say if you want to lose weight then stick to the type of advice that is given here and punt on this whole issue.

DR. WEINSIER: How far off -- from a practical standpoint, I mean, the pyramid is talking about for the grains group a slice of bread, a half cup of, you know, cooked rice or pasta, cereal, and for vegetables a half cup of, you know, chopped, raw fruits one piece, etcetera. How different are they likely than the label? Is it that significant?

DR. GARZA: Well, we just heard that for pasta it is one-half cup versus one cup, so that is twice the number of calories.

DR. GRUNDY: That is the difference between being fat and thin. Really. I am not kidding you. I am not kidding you. That is the difference.

DR. GARZA: No. We are agreeing with the concern that Shiriki expressed. Now, for others they may be minor, but at least for the base of the pyramid what I am hearing is that there may be significant differences in serving size between the two.

DR. WEINSIER: Well, recognizing our time frame and whether we will have this information or not before we conclude on this, what is the recommendation to our subgroup?

DR. GARZA: Well, the subgroup is -- in the pyramid we have that calculation that if you follow the serving size of the pyramid it is 1,215.

DR. WEINSIER: So as long as we are internally consistent we can stick with that, and maybe in Box 7 where we are talking about the control calorie intake we can make reference to the pyramid and the number of servings and roughly the calorie intake, which suggests --

DR. GARZA: And maybe all we need is a cautionary note that the servings in the food label can be substantially different or something, so exercise caution or something. That is too strong a word maybe, but --

DR. KUMANYIKA: I mean, at minimum there is one place on page 26 where we could add a reference to the food label serving size where we could talk about the units of purchase where it says, "Many items sold as single portions actually provide two to three servings."

Well, something could be added there, you know. Of course, they will not know the pyramid servings. Will they know it from another box?

DR. WEINSIER: Well, you have to go back to the --

DR. GARZA: See Box 2. You would need another bullet then to say at point of purchase the serving sizes may differ or something.

I do not think we can fix it. I think it is just giving the consumer enough guidance and sticking with the pyramid because trying to estimate the caloric intake if one bases it on serving size we are going to get into a calculation we may not have time to go through the permutations that are possible.

Richard?

DR. DECKELBAUM: I was just talking with Alice. If there are as many items as we heard, just make it a separate bullet to stand out so that people are aware.

Just to switch to another topic, since you acknowledge and the working group acknowledges the great increase in obesity in children and overweightness in children, and there is a section on that, at our previous large group meeting we discussed including the figures that the USDA has on estimated and appropriate weight in children.

I would encourage that those be included because that to me is a problem for the major part of the population and if not addressed will be part of the adult obesity epidemic as well. There is no tool in here for helping to determine children who are overweight, you know, looking at --

DR. WEINSIER: Rachel, do you want to address that or do you want me to?

DR. JOHNSON: We had a long talk about that on the last conference call, Richard, and basically opted to exclude it for a number of reasons. One is they are not ready. The BMI charts are not ready for children. Help me out if I forget all the points.

Two was that there was a lot of concern that a very small difference in height or weight in children which may not be accurately measured by a parent can put a child into a different BMI category and could raise undue concerns.

I think the conclusion of the committee, after a long discussion, was that the best advice was to refer children to their health care provider if the parent felt that there were issues that they needed to proceed further, but we did decide not to include the BMI charts.

Did I get all of the --

DR. WEINSIER: Yes. The only thing was a variation on one of the points, and that is that just by getting the height off a little bit and categorizing or miscategorizing a child's weight status, parents may then overreact by using interventions that are inappropriate for children.

Therefore, in all accounts it is probably best if you are concerned about the weight of your child then go to a health care provider, get the estimate, as well as the recommendation for treating it.

DR. GARZA: Let me add to that. We had some input from various groups about recommending the stamp of the committee on its own because they reiterated many of those same concerns.

In terms of space, if we were trying to give sufficient guidance to a parent we would end up making it quite a lengthy document because even the strategies for appropriate response would be difficult because I do not think there is any consensus around the community of what to do in terms of a child with a weight problem.

DR. JOHNSON: I do think in the rationale when this is ready if they are available, since the rationale is more for the scientific community, it would be great if we could include them in the rationale.

My understanding is the charts themselves will be available on a website, so we could even include that for professional use.

DR. GARZA: Do you mean in the rationale?

DR. JOHNSON: Uh-huh.

DR. DECKELBAUM: I think I referred to the previous drafter, Christine Williams, and she got back to me, and I got back to you. I think I sent you a copy or sent Roland a copy of her recommendations.

You know, it might be worth maybe not the BMI charts if they are not ready or too precise, but, you know, at least reference to weight per height percentile and then at what level the health provider should be concerned because I would bet that the majority of health providers for children do not pay much attention to a mild to moderate overweightness towards obesity so that it is probably an ignored problem, and I think we should address it.

DR. WEINSIER: Well, two things. One, as Rachel is saying, the new guidelines should be available fairly soon for health professionals, i.e., pediatricians, and they are -- even though they are BMIs, they are based upon, as I understand, the 85th percentile cutoff.

Secondly, if in the rationale section if a person is interested, particularly health care providers, then they would have access to that if we can refer, you know, to them without giving the public the information to go on.

In other words, we will make sure that people know because I think that we have made a statement in here that guidelines are available or see your health care provider to assess --

DR. GARZA: It is 26 and 27 of the guideline.

DR. WEINSIER: So we try to make the point in the text, as well as in the rationale, that guidelines will be available.

As Rachel said, as soon as they come out then we will actually include the reference there, but we are trying to keep the onus on the health care provider to do the right thing rather than just a little bit of information that may be dangerous to parents.

DR. DECKELBAUM: How is it going to be dangerous?

DR. WEINSIER: Well, just for the reasons that Rachel went over that it is going to take a lot of text and description to make sure that people are using the male/ female separation, the right age group and that when they measure the height they are doing it properly, how do you measure height in a growing child, and that it is a distinct cutoff when you go from

overweight to, you know, obese, etcetera, and --

DR. GARZA: To give you an example, take a three year old and try to measure his height. The parent may make a miscalculation. If they are trying to manipulate the weight of the three-year-old it might be problematic.

Now, if the kid is 16 I do not worry as much because the danger can be minimized, but the younger the child is the greater the risk for miscalculations and the greater the risk for any intervention the parent might choose.

DR. DECKELBAUM: What I am concerned about is the major part of this epidemic is in the pediatric population, and the health professionals are not handling it. This has happened under the eyes of the health professionals so that I am not sure that you can --

DR. GARZA: We agree with you on that point. If there is any disagreement on that it is all right, what would you suggest we do is the next point? What advice can we give parents when even health professionals do not agree?

Johanna?

DR. DWYER: I thought the first advice was to grow the child into their fatness. In other words, you do not put children on reducing diets. You grow them into their fatness.

DR. GARZA: So what do you tell a parent, to restrict their food intake?

DR. DWYER: Moderately, yes, or increase physical activity and restrict, but you never have a child to lose weight, do you?

DR. GARZA: No. No. That is the concern.

DR. DWYER: So let's put it specifically down there that without the medical guidance you do not have children losing weight. This is for consumers.

DR. JOHNSON: Well, page 27, the last paragraph or the last sentence before Advice For Today. "If you need to make major changes in a child's eating pattern, ask for guidance from a health professional."

I do think this section on children, and I had a lot of input into it, but I think it needs some work. I think it is very wordy listing all these food groups. I am the one that asked for the option of just referring to the food guide pyramid.

I am a little uncomfortable in the second paragraph saying, you know, make only modest reductions in dietary fat; for example, opt for lowfat milk rather than whole milk. I mean, you know, the data are not really conclusive on children and how you successfully have children reach an appropriate body size. We are making the implication that modest reductions in dietary fat will do that, and I do not think that is based on data.

DR. GARZA: I think it would be helpful if Richard shared with us how he felt and what sort of recommendation strategies we could recommend and base them on science.

DR. JOHNSON: For children.

DR. GARZA: For children.

DR. DECKELBAUM: Well, what I would like to do is check and get back to you. This is a difficult subject.

DR. GARZA: And I think that this may be a very good example of a major issue that we need help on to say this is something that we need to pay attention to. There are a lot of research questions that are left unanswered. There are questions for the professional community that need to be addressed and make this a major plea.

I think to some degree the committee has already done that with the list that Roland gave us, for example, of prevention strategies and research on how you prevent the problem from occurring, but then I do not think you address treatment strategies. I do not remember what you did for children.

DR. WEINSIER: No. I did not mention it.

DR. GARZA: And the health implications of how rapidly you slow down or rest their weight, as Johanna has suggested, or do you just slow down their weight gain so eventually they catch up or catch down rather with the weight they are supposed to be at?

There are significant issues, and I am not clear as to what advice I would give that would be science based rather than when you are a health care professional you are watching the child. You know their health history, and you can interact with the parent and perhaps figure out a strategy that might work for them.

Suzanne, and then Johanna?

DR. MURPHY: I get very nervous because the possibilities for abuse I feel are enormous.

Again, we want to be very careful to not have failure to thrive children because parents go overboard on some of these recommendations. I think seeing a health care professional is really the right advice here.

DR. GARZA: Johanna, and then Scott?

DR. DWYER: I would urge if you can, Roland, to incorporate the following sentence. "Weight loss is never recommended for children without the guidance of a health care professional." In other words, it should never be attempted by parents on their own. I think that is absolutely --

DR. GARZA: No. I would agree with you.

DR. DECKELBAUM: As a doctor in pediatrics (Inaudible). I agree about this failure to thrive (Inaudible) articles. They mainly relate not to fear of cardiovascular, but fear of obesity, but that is still another reason to throw it entirely back to the health professionals (Inaudible) adequate job to control this

problem.

There are some strategies that may be out there and further research or that may exist in some areas, and I will try to get back to you on that.

DR. GARZA: Okay. Scott?

DR. GRUNDY: Two things I want to say. One is we know what a healthy diet is for children, I think, and you can recommend that. Whether they are obese or not, that ought to take care of the problem. You are not telling them to lose weight. You are trying to tell them what they should eat.

The other thing that we have gotten into, but it relates to all of the obesity issues, is that bad eating habits that we have not addressed, but maybe, you know, we could have a list or a box showing things that people do to lead to excess caloric intake like, you know, eating out too often or eating when you are watching TV or things that are bad eating habits that contribute to obesity in adults and children. Maybe some of the worst offenders could be identified in people, and we could alert that and bring it to their attention. Is that out of bounds for us?

DR. GARZA: As I read the literature, there is not even good unanimity among the researchers as to what those are. I mean, people will suggest, for example, that it is

television watching, lack of activity, and it is hard to argue against that in a public health sense, but when you get to the individual child without doing an interview with them and talking to the parent and trying to understand what their activity patterns are like, whether it is snacking or being sedentary and meeting their nutrient needs, it requires at least a one to one exchange, in my experience. Perhaps others would have a different experience.

DR. KUMANYIKA: Well, I was trying to recall the data from the NHLBI growth and health study, which I am not sure they have done the prospective look yet on weight gain following black and white girls from preadolescence because in one of the papers -- I think McNutt is the first author

-- they show a set of behaviors that are related to high calorie intake in the girls.

It is exactly what Scott said; eating while watching TV, eating a certain number of snacks a day and so forth, so it might be possible to make statements like we have in some other guidelines, things like behaviors that have been associated with excessive weight gain in preadolescent girls include these things and give some information about what some of the associations are, which I think could be data based.

DR. LICHTENSTEIN: I think something that was alluded to but perhaps could be strengthened is that setting examples of eating patterns in children are often --

DR. GARZA: Some of these suggestions are taken up under the physical activity guideline. You will find that adults setting examples and some of those behaviors targeted there because they relate to physical activity, but they do not relate necessarily to snacking.

DR. KUMANYIKA: Well, this particular one study relates, but I do not know if they have related it prospectively to weight gain. They relate it to black/white differences, but I am not sure if they have actually looked to see if those were the girls who gained weight.

DR. GARZA: Well, are you familiar with that literature and could we include some of that if in fact we do put a box in it that says here are behaviors that put children at risk that relate to eating patterns?

DR. JOHNSON: I am not familiar with that paper.

DR. KUMANYIKA: I can get the reference. Sue Kim is one of the main authors on those papers. You can ask her.

DR. WEINSIER: Yes, if it is in the reference.

DR. KUMANYIKA: It is an NHLBI study, so we could find out.

DR. GARZA: Other suggestions or comments on the rationale, the text or the recommendations? I think we are doing all three simultaneously.

DR. LICHTENSTEIN: I just have one last comment on portion size. I am wondering if perhaps it could actually be included as a small, separate paragraph in Advice For Today, just be aware that there is a discordance between the portion sizes on the food label versus the pyramid so if you are trying to plan your diet around number of portions, which is a lot easier than total calories, or something like that you need to be careful. Maybe that would allow it to be differentiated a little bit more.

DR. GARZA: Okay.

DR. WEINSIER: Yes. I have a note to that effect.

DR. LICHTENSTEIN: Then there is a minor point on the paragraph right above it where it says deal with overweight child. The example is offering lowfat milk rather than whole milk. That is sort of a little discrepancy with the fat guideline because we are recommending everybody drink lowfat milk, so perhaps a different example could be used.

Just one other point, and it goes to the other spectrum of older individuals. On page 25 there is reference to changes in body composition in older individuals and that perhaps they should consider, you know, adding physical activity that is going to maintain muscle mass, but perhaps that could just slightly be reworded to indicate that that is sort of something that should be incorporated earlier.

You should not wait until you are an older individual and you have already lost muscle mass before you should start weight bearing activity, but it is something that should be a lifelong activity.

DR. GARZA: Okay. There are several hands that went up. Meir, and then we will go around the room.

DR. STAMPFER: Yes. I had three points. First, just getting back to Scott's suggestion and thoughts, I think that really would be a good thing to add because, I mean, as our discussion on portions, number of portions and portion sizes reflects, that is going to be extremely difficult.

Total calories is even harder than that, but I think to give people an idea since whatever pattern they are that how many calories they would need to decrease rather than the total calories that they need to count up, but if they take the total pattern, whatever it is, even though they cannot estimate what it is, but thinking in terms of well, I do need to cut out a couple hundred calories, and if I do that over a long term then I will get down to where I should be, so I think some way of incorporating Scott's idea in there would be good.

The second point relates to the children, the problem of obesity in children in the sense that a lot of the thrust of the guidelines sort of says well, you know, monitor your weight and make sure that you do not gain weight, but a lot of the people have already gained a lot of weight. I think the guidelines are too gentle.

For example, in Box 5, Point 5. Consider. Just consider. It does not say lose weight. It just says consider if you have a BMI of 25 to 30 and two or more of the risk factors, or even if you have a BMI of 30 you still have to have a large waist circumference to even get into the consider trying to lose weight.

I think anybody with a BMI over 25 should consider losing weight, and I think anybody who has gained substantial weight since they were in their early 20s is probably overweight.

DR. GARZA: Do you mean Box 6? I am lost.

DR. STAMPFER: I am sorry. Box 6, Point 5. It is too lenient.

DR. GARZA: All right.

DR. DECKELBAUM: I felt rather pleased personally when I classified myself, Meir.

DR. GARZA: Roland, do you think you can get more directive than consider?

DR. WEINSIER: Let me go back and check the NHLBI because I was trying to keep those, you know, in parallel here. Let me see if that was wording they used or for some reason our subgroups twisted that.

DR. GARZA: I am going to try to go around. Johanna, I think you were next.

DR. DWYER: Three points. Agree with Alice.

DR. GARZA: Agree with Alice on?

DR. DWYER: Almost everything.

DR. GARZA: That may come back to haunt you.

DR. DWYER: On page 24 --

DR. LICHTENSTEIN: That felt good for 20 seconds.

DR. DWYER: -- something additional. As a person who is hovering perhaps above, such as I, I would suggest that we start with the material that is about gaining and putting that first. In other words --

DR. WEINSIER: Under Manage Your Weight on page 24?

DR. DWYER: Yes. Starting out with a section -- well, no. Even earlier than that, Roland.

In the very first part of the guideline in the first paragraph, at the end of the first paragraph I would suggest moving what is on page 22 that starts "As a minimum, try to avoid..." and put that right at first. In other words, the first thing that every American --

DR. GARZA: I am sorry. You are on page 22?

DR. LICHTENSTEIN: Page 22, the top.

DR. GARZA: That is still part of the box.

DR. WEINSIER: So we are lifting --

DR. DWYER: No.

DR. WEINSIER: Well, actually it says No. 6. It is in a box.

DR. DWYER: Yes, it is. It is in a box.

DR. WEINSIER: Okay. So we are lifting out, "As a minimum, try to avoid further weight gain?"

DR. DWYER: No.

DR. WEINSIER: No?

DR. DWYER: Cross out "As a minimum" and just say, "Try to avoid further weight gain," and put that right at the beginning because that is the first thing all of us can do who are above 25.

Then beyond that there are many other things they can do, but it is the same as the Golden Rule and the Ten Commandments. You know, first get the simple stuff and then go after perfection, so just helping people get started.

The other thing with Scott is your ideas of maybe stating some equivalents of 500 calories, some commonly eaten items that are about 500 calories or about 1,000 -- maybe 500 would be better -- seems like a good idea, too, because no matter what you eat if you subtract 500 calories probably you are going to lose weight.

DR. GRUNDY: A lot of weight. A huge amount of weight.

DR. DWYER: The final thing is I wish we could have a specific, explicit statement that body mass indices for adults are not appropriate for children. In other words, and this comes from a terrible experience years ago where a resident at a very famous Boston teaching hospital located on Longwood Avenue placed a baby on a diet that was for an adult. You do not do that. The baby was gaining weight. He thought there was a problem, but the basic point is that BMIs for adults and kids are different.

Finally, I am mystified why it takes the combined researchers with the Federal Government three years to come up with the 85th percentile for body mass index. Could you explain why that is?

DR. GARZA: The person who is working on that, and I notice that is an isometric reference. We could go on for a long time. I will talk to you about that afterwards.

DR. WEINSIER: Can I ask a question, though, for clarification on your first point? You are trying to say start out the first paragraph instead of dealing with the lifestyle issues of eating and physical activity, you want us to put more emphasis on avoiding further weight gain if your BMI is greater than 25?

DR. DWYER: No. Right before Evaluate Your Body Weight, or you could put it right after that, but basically have a section. You do not even have to -- well, let's see. You would have to.

DR. WEINSIER: Because we have it in the introductory paragraph. The third sentence says, "Most adults need to avoid gaining weight." I am afraid to say anything about BMI

greater than 25 at that point because we have not even --

DR. DWYER: I understand.

DR. WEINSIER: -- gotten into the normal ranges.

DR. DWYER: I think I made a mistake on where I suggested, but the point is that it is buried in a paragraph, and you go right on to the exultation to do more.

The first thing is, it seems to me, to have something singled out just like Evaluate Your Body Weight. If you are above, do not gain. I can mark it up and give it to you after the meeting, but it seems to me that that is the beginning of weight control, not gaining more if you are over a BMI of 25 or if you are drifting upward. It is to stop the upward drift, and then we can worry about people getting to decrease from BMIs that are too high.

That is all. It is just starting a little less efficaciously perhaps.

DR. GARZA: Okay. You will have to wait, Richard. We went past you.

Suzanne, and then Scott?

DR. MURPHY: I would like to come back a minute to the nutrient density and the energy density, Roland. You did explain that to me well, but I notice in Advice For Today are a kind of summary of the whole section. There seem to be two things people can do, choose plant foods most often and get moving.

Is that really our summary of the two best things you can do to lose weight? I am not sure I think plant foods should have that kind of prominence in a weight loss diet compared to just following the pyramid. I guess I am mystified about that.

DR. WEINSIER: Well, this is sort of a summary of, you know, what are the key messages. It seems to me the key message is throughout the whole -- not just the weight document, but the whole guidelines is to build on the pyramid, which is basically the bottom three are the base of the pyramid.

If you are starting in a weight control program, that is essential. I mean, almost any health care provider is going to do that.

DR. MURPHY: But it all --

DR. WEINSIER: That is not to say there should not be -- in fact, we discuss in the text using lowfat dairy products, lowfat meat. It is all discussed, but in terms of what you start with you start with building on the base of the pyramid and get moving.

DR. MURPHY: Well, I would not mind if you said, you know, eat the minimum servings from the pyramid with little added fat or sugar. That would be fine, but it gets back to what I heard as one of Scott's concerns.

We seem to be saying a different pattern is appropriate for people who want to aim at a healthy weight. In other words, you only use plant based foods if you want a healthy weight.

DR. WEINSIER: Well, no. It does not say eat only. It says eat the most often. You feel that that is incongruous with the other guideline?

DR. MURPHY: Uh-huh. Well --

DR. WEINSIER: Eat most often fruits, vegetables and grains?

DR. MURPHY: As the single best food guide guidance for a healthy weight, yes. I think it is part of it. It seems incomplete.

DR. GARZA: You would suggest?

DR. MURPHY: I think it is perfectly fine to say choose foods with little added fat or sugar. I mean, I think that is the nutrient dense energy/low energy density concept that we really want to get across, not that there are good foods and bad; plant foods and animals foods are good foods and bad foods.

DR. WEINSIER: Well, I guess the other strategy is trying to be more positive. You know, traditionally if you are on a weight loss diet that means you have to restrict. You have to stop eating. Everything is down, but there is a whole other approach that behavioralists tend to use, and that is, you know, the positive aspects. You do not have to starve yourself. In fact, quite the opposite.

You should be eating a sound -- you know, the basics of a sound diet, which are pretty much throughout this whole guideline that you build on the pyramid, so if we can say that in a positive fashion and still get the point across you are trying to make, but I do not think technically we would be saying what -- we should be saying eat whatever you want just as long as there is little fat and sugar. I am not sure dry Ritz crackers is going to do it.

DR. MURPHY: Well, I would just like all the food groups there, not just --

DR. GARZA: So you would recommend saying, "Take the minimum number of servings from across the pyramid?"

DR. MURPHY: "With little added fat or sugar." That would be fine.

DR. GARZA: That is already there. I mean, the added fat or sugar is the second sentence that follows.

DR. MURPHY: Okay.

DR. GARZA: Would that, Roland, present any problems from your perspective?

DR. WEINSIER: Well, I just want to be careful that we do not just keep referring to the pyramid, but if people have not memorized the pyramid they do not get anything out of it. That is why I am trying to reinforce the foods. I do not know.

Rachel? Shiriki? You are on the subgroup.

DR. JOHNSON: Well, if you want to reinforce all the food groups we could add lowfat dairy and lean meat, poultry, fish and lots of grains, but it does make it rather long.

DR. WEINSIER: Yes. I mean, it is basically the second bullet under Box 7.

DR. JOHNSON: I mean, I agree with Suzanne. If you are talking about nutrient and energy density, if you take a glass of skim milk or a lean chicken breast I think in terms of energy and nutrient density we would be very close to a serving a pasta or grain product in terms of the energy.

DR. STAMPFER: The best way to improve your energy density is to add water.

DR. JOHNSON: And breathe.

DR. GARZA: On that wise note --

DR. LICHTENSTEIN: Well, as a continuation I think what we know is it is very difficult for people to change their eating patterns. I think there are a lot of different approaches to weight loss with limited success of each one, but obviously some work with some people and some work for other people.

For some people I think eating a plant based diet and making a radical switch perhaps from what they were consuming is going to work. I think for some people it makes sense to eat the minimum number of servings from the pyramid, and for some people it just means, as I think Scott was alluding to, eating a little bit less of what you are eating. For some people, that is going to be what works so that maybe it is an acknowledgement that there are a variety of different ways of decreasing caloric intake.

The bottom line is, though, for this guideline you have to decrease caloric intake, and then for the next one you can also help it out by increasing activity patterns, so maybe expressing it that way.

Also, I really like the idea of giving some examples of how if you cut a certain amount of food, number of calories, you know, instead of linking those two things. I am actually thinking of units even smaller than what you suggested, which was I think the 500, but even 100 or 200 calorie units that if you just drop a little bit of this or a little bit of that over the long term it can have a significant effect. That would be a very actionable thing for people to do if I just ate one of those cookies instead of two.

We might like to say well, do not eat any of those cookies and you will solve your problem, but we know that in reality that is not going to happen. You know, stop tasting the food while you are preparing it. Do not lick the peanut butter off the spoon when you are making your kids' lunch.

You know, those are the kinds of things that are really actionable and for some people will have less of an impact and easier to do in the long term than switching the dietary patterns, even though it might be optimal, so just acknowledge those options.

DR. GARZA: Okay. Any others?

DR. TINKER: One thing that we do not have in the Advice For Today is anything about portion sizes, so some kind of reinforcement going back to portion sizes ties in with the pattern.

DR. GARZA: I thought Richard had made that suggestion -- I think it was Richard -- of coming back or somebody said in the Advice For Today. Maybe it was Alice. Go back to warn people about the differences in portion sizes.

DR. GRUNDY: Okay. Well, a couple things. What concerns me about the way it is written is that it is going back to promoting a high carbohydrate diet for weight reduction. You know, I guess I feel that unless a person eats a balanced diet for weight reduction, you

know, you run the risk of the metabolic problems that we have talked about before, so I think that though this pyramid the way it is designed is supposedly the best metabolic combination that we have put together, and that is what people ought to eat so if you change that and just eat out of the bottom half of it you are eating a high carbohydrate diet.

We know the population is getting more obese. They are eating less calories as fat. You know, I am wondering if they have not been following our advice and it is causing problems for us, so I think that we have to be careful about that recommendation, and I still go back to saying we should recommend the whole pyramid and reduce calories.

DR. GARZA: With the minimum serving sizes?

DR. GRUNDY: Right. Exactly.

Now, the other point I wanted to make was about just a small point about the NHLBI, NIDDK, OBI guidelines and risk factors. I am not sure they are germane to this document. Those are clinical guidelines. You know, if you have risk factors that is for physicians to decide how best to treat those patients, but I do not think individuals ought to say well, I have two risk factors. Therefore, I need to lose weight.

I think it is more general guidelines for individuals no matter what their risk category is. They are still going to have risk factors, even though they are not measured clinically. They are going to have higher blood pressure. They are going to have lower HDL, higher triglycerides, higher cholesterol, even though they do not reach a categorical level, so I think we ought to not try to tie these guidelines in to clinical guidelines.

I do not know what you think about that, Shiriki, but I am concerned about that a little bit.

DR. GARZA: So your suggestion would be to cut that box out entirely?

DR. GRUNDY: I do not think that ought to be part of it for the general public.

DR. GARZA: But could we give individuals then -- how do we provide the guidance to say you have to worry about weight loss more than perhaps you were worrying about weight loss two years ago or four years ago?

DR. GRUNDY: I guess that as individuals, every individual ought to be worried about weight loss. I think that as you take the guidelines of the NHLBI, overall cholesterol guidelines, blood pressure guidelines beyond just the weight guidelines, everyone who is overweight, that is a target for modification for the general public.

Now, if you have in addition to that risk factors and you are overweight, then, you know, maybe put more emphasis on getting someone to lose weight in a clinical setting to control the risk factors, but I am just not sure we ought to be linked too closely to the risk factor paradigm here.

DR. GARZA: So then if you are outside of this 19 to 25 range, you ought to do something about that is your recommendation?

DR. GRUNDY: Right. I think you should be concerned about it.

DR. GARZA: Regardless of the --

DR. GRUNDY: Also, it has nothing to do with diabetes. You cannot predict who is going to get diabetes if you are overweight. That is really the major concern about being overweight anyway.

We can control risk factors with medications pretty easily, but not diabetes. The long-term concerns of overweight still are there plus multiple marginal risk factors.

DR. GARZA: Before we --

DR. WEINSIER: I am not sure I know where to go from your recommendation. You are suggesting we delete completely Box 6?

DR. GRUNDY: Yes.

DR. WEINSIER: So when should you try to intervene?

DR. GRUNDY: Yes, I think so. I guess I am not -- I do not think we should tell the people when they should intervene for weight reduction based on their risk factors. I think that is a clinical decision, and they should be concerned about their weight because it carries risk beyond what is on that risk factor list.

DR. GARZA: What I meant is eliminate 3 through 5 on Box 6, but 1, 2 and 6 are fine?

DR. STAMPFER: It is really just 4 and part of 5.

DR. GARZA: So you are thinking 4 and part of 5. You would go with 1, 2, 3 and 6? That is on page 21.

DR. KUMANYIKA: I tend to agree with Scott. I mean, these guidelines are much more clinical than they were before, but the clinical guidance is taken out of the context in which it was developed because there was a health professional in the equation when these guidelines were developed, so maybe what would need to be added is something that says to people many people need assistance with losing weight or consult a health professional about your weight related risk, but not give the algorithm that is intended to be used by a clinician to help evaluate weight related risk more specifically.

DR. GARZA: Richard?

DR. DECKELBAUM: I do not see a major disadvantage of having the public be aware of that they are in a risky situation and so, you know, a compromise might -- so I am actually -- I think I would consider leaving these in, but you might have to define it a little more for the public. For example, personal or family history of heart disease. What age? At 90 years or 40 years? That type of thing.

But, you might say that if you have this, if you are in this category and you do have these risk factors, you should lose weight under the management or the care of your health professional so that you would refer them to their health professional because a number of individuals are going to have some of these risk factors.

They may not even have a health professional. They know that they have these risk factors. If they do not have a health professional, nothing is going to be done about it so why not let them know that these are added risk factors but that they should be in the care of someone if they have this set up?

DR. GRUNDY: That is what I am saying. It looks to me like on page 21, No. 5 there, it lets you off the hook if you have a BMI between 25 and 30 and you do not have high blood pressure or high lipids. You know, you do not have to worry about your weight. You are okay, you know. I am just fat, but healthy, you know.

What I am saying is that may not be true; that there is a health price to pay for that for many people ultimately.

DR. DECKELBAUM: So perhaps then add a clause in 5 referring them to the health professionals rather than just omit that Section 4 and 5.

DR. GARZA: Okay.

DR. LICHTENSTEIN: If they do not have a health care professional, it is unlikely they

are going to know that they have hypertension or hypercholesterolemia, so I think that is going to complicate things.

DR. GARZA: Would a compromise position be discuss the following risk factors with your health professional?

DR. GRUNDY: We certainly want people to get checked for their risk factors. That is for sure. I am just -- are we willing to let people not to consider losing weight if they do not have categorical risk factors?

You know, we did not define what they are here. You know, what is high blood pressure? What is low cholesterol? You know, are we willing to let people say -- you know, I do not think we are. That is not the point.

DR. WEINSIER: I would not feel comfortable saying that if you have a BMI between 25 and 30 and no risk factors that are identifiable that you need to lose weight, but that does not mean you may be healthier if you do, but I do not think that we have the data to indicate that you need to lose weight and that I could make such a categorical statement. Is that what you are suggesting?

DR. GRUNDY: Yes. Well, I am thinking we do have the evidence that there is increased risk of people in that category because I do not think the risk factors are that easy to determine.

You know, you get your blood pressure measured once or your triglycerides or LDL measured once, you know. That does not determine your levels for life. You are at higher risk for developing those. Also, how does that -- are you not at increased risk for diabetes if you are in that range?

DR. WEINSIER: Well, the guidelines, the NHLBI guidelines, do not go that far. They are not saying that you should not lose weight. It becomes an option. You know, it is a graded sort of thing. If you look at diabetes, yes, you are going up, you know, a relatively slow slope, and then you go up a steep slope. You get about fourfold the normal referenced BMI.

Theoretically at any point you could benefit from some weight loss, but that is based on the BMI being, you know, absolutely over and obese, a relatively obese state. We do not know. See, BMIs are based upon, you know, body build, bone mass. It is just not that accurate, so I think we have to be careful that we do not start preaching to everyone with a BMI, you know, above 25 that they have to lose weight. I do not think we have the data that can say that.

DR. GRUNDY: Well, how does the waist circumference fit into all this? How does that relate down there to No. 5? If your waist circumference is high, how does that link to your risk factors? Do you have to measure those, too?

I mean, I would be willing to say to use your waist circumference as the guide that is okay, but I am not sure that I -- I mean, I recognize the problem with the BMI as a predictor.

DR. WEINSIER: No. Waist circumference independently of BMI, when associated with risk factors, you know, weight loss is indicated.

DR. GRUNDY: What about above 30 if you do not have any risk factors? Is that a problem?

DR. WEINSIER: A BMI of 30?

DR. GRUNDY: Yes.

DR. WEINSIER: A BMI of 30 by itself is an indication for weight loss.

DR. GRUNDY: I mean, what is the difference? Does it carry independent risk beyond the risk factors? Is that what you are saying?

DR. WEINSIER: Well, yes. They are both independent risk factors, BMI as well as waist circumference. They are independent.

Would another way to deal with this -- I was just looking back in the 1995 guidelines. They have dealt with it in one sentence. "If you are overweight and have excess abdominal fat, a weight related medical problem or family history of such problems, you need to lose weight." I mean, they have not gone through these algorithms. Maybe we have gotten too specific here, and maybe that is the concern. We are trying to be too prescriptive.

Would that be a better approach just to take out maybe Items 4 and 5 and just deal with it in a more qualitative, you know, fashion, add something to the effect to discuss risk factors with your health professional as Bert suggested?

DR. GARZA: What I find persuasive about Scott's concerns are that we do not offer specificity in terms of what is high blood pressure or what is an abnormal blood lipid pattern or, you know, when do you know whether you have diabetes.

I mean, some people may be told that they have borderline diabetes and may feel that gee,

being a borderline diabetic is it a risk factor? Well, in fact, you know, that may be a person who wants to lose weight so somehow -- I mean, I am struggling with how do we get the idea of perhaps a uniform recommendation of everyone losing weight is not accurate, but this is providing unguided specificity, which will be difficult to implement without a health professional being actively involved.

You know, we may want to modify 4 to say see your health professional to see if any of these risk factors apply to you, and then go to 5 and perhaps adjust it, as Scott has said. You may want to lose weight regardless if that is a personal choice, but you are even more motivated to lose weight if you have a less of an option, I suppose. Would that be accomplishing both with that?

DR. WEINSIER: I think that would take it out of the hands of just the individual to make the decisions about the need to lose weight based on their own perception of their risk factors, which are not defined here, as you point out.

People with impaired glucose tolerance, they have high risk, but that is not listed here, so I am uncomfortable with just giving people in that range carte blanche to not be concerned after that point about their weight.

DR. GARZA: Rachel?

DR. JOHNSON: I think we can work this out. I just want to make sure that we do not come across as saying that anyone with a BMI over 25 needs to lose weight because when the NHLBI guidelines came out --

DR. GARZA: I agree with that.

DR. JOHNSON -- there was a lot of criticism about that, and most of it was because they were not read carefully, and they clearly say that, you know, the people between 25 and 30 who have these additional risk factors, so I just want to make sure that we stay consistent.

DR. GRUNDY: But in your diagram you call that overweight, right?

DR. JOHNSON: Right.

DR. GRUNDY: So, you know, you call it abnormal or overweight is a condition.

DR. GARZA: See, I think that is the point that persuades me that if we have additional language, for example, that says look, you have not gained any weight, is it after

adolescence? I forget what the age is that NHLBI and WHO recommend that if you reach a certain age and then you gain weight after that age that it does not really matter whether you are even within below 25, but in fact that presents an additional risk. The very fact that you have gained weight in young adulthood puts you at risk.

It is not just a matter of whether you have a BMI of below or above 25. It is the dynamics we went on beforehand. It is more complicated once you start getting to this level of specificity.

Shiriki?

DR. KUMANYIKA: Yes. The NHLBI guidelines were an attempt to discuss how obesity could be viewed as a clinical problem. It does not really apply to how people in the general population might evaluate their weight because I think the guidance there is conservative because it is saying just because you have a BMI over 25 it does not mean you should get medication right away or the doctor should do -- you know, you should have a major health intervention, but I do not think it was intended to say that that is not an area of concern. It is just that the guidelines were for screening and meant to guide an interaction with a health professional, so let's decide what to do.

I think we can step aside from that a little bit and talk about that the healthiest weight is below 25 and some kind of guidance about what one should -- you know, what should I do if my BMI is over 25 and just decide what is the right way to say that, you know, to the lay public with one option being consult a health professional to see if you are really at high risk.

DR. JOHNSON: I think, you know, if we have the data to support that, that a weight between 25 and 30 with or without additional risk factors has poor health outcomes because if in some way this is perceived as saying that anyone with a BMI over 25 needs to lose weight, we need to be able to defend it because that will be perceived as even more rigid than the NHLBI guidelines whether --

DR. KUMANYIKA: That is what this says, right?

DR. JOHNSON: I understand --

DR. KUMANYIKA: This already --

DR. WEINSIER: No. That is not the way I read it. It says, "If you are overweight and have excess abdominal fat, a weight related medical problem or a family history of such

problems, you need to lose weight."

DR. KUMANYIKA: Do you mean in the older one?

DR. WEINSIER: It is very similar.

DR. KUMANYIKA: What page is it on?

DR. WEINSIER: Nineteen.

DR. KUMANYIKA: Nineteen.

DR. WEINSIER: I agree with Rachel. You know, I am very sensitive to this because I tend to, you know, lean towards Scott's side and think if you are overweight, yes. When dealing with an individual person, you know, I do come across that way, but here, you know, we are dealing with a population at large.

I do not think we can overstep our bounds. I mean, maybe we can reword this, but we say in Box 6 under No. 2, you know, find your BMI category. The higher your BMI category, the greater the risk for health problems. I mean, that is implying to me as you go up it is worse. Not only do not go up, but if you are up there think about slipping back down. Then we specifically say if you have already got this, then you really ought to start slipping back down, so we are not trying to hide the information, but I just want to be careful that we do not overstep.

DR. GARZA: Johanna, did you have your hand up?

DR. DWYER: Yes. I just wanted to be reassured that we do this. I think it would be a mistake to go against the weight guidelines committee that Dr. Kumanyika and Dr. Pi-Suyen recently mentioned, and I think it was also be a mistake to go against the World Health Organization report.

I do not believe what Rachel has said is contradictory to that. Both of those reports, if carefully read, do say that.

DR. JOHNSON: The additional research.

DR. WEINSIER: Right.

DR. DWYER: So is this as written in line with those two reports?

DR. WEINSIER: Yes. That is the way it was designed to be in line.

DR. DWYER: Let me just add one thing. If you are going to put 4 and 5 in the box on page 21 in the text, if you want to make it consumer useful and sort of downplay it, but at least give people a hint of what might be necessary, maybe use the wording of the item in some of the national surveys where they ask has your doctor ever told you that you have high blood pressure, high blood sugar, all these other things.

There is standard wording there, and at least that gives another level of risk. There is cigarette smoking obviously and men over 45 and so forth that you can tell yourself, but with the others at least it gives something.

DR. GARZA: Scott, would that take care of some of your concerns if the wording was changed to has your doctor told you?

DR. GRUNDY: I do not know. I think we are on the borderline between the patients making the decision about whether to lose weight and if the physician does.

Now, I think that we defined a healthy weight, and we say aim for a healthy weight. Unless you have risk factors, you do not have to. I do not think that is a very good idea. I think even for the healthy weight it ought to be the major thrust across the whole population.

Now, if they have clinical problems they should go and get checked out and see if they have high blood pressure and lipids and get them treated, but the physicians would help them control their risk factors by losing weight or whatever they need.

I am concerned that we are allowing individuals to make medical decisions about the treatment of these problems based on their risk factor status and whether they lose weight or not.

DR. GARZA: What would be your advice then?

DR. GRUNDY: I guess I would point out the dangers of being overweight, and then I would stick with aim for the healthy weight.

DR. GARZA: So you would recommend that anybody over a BMI of 25 that is then categorized as moderately overweight in this chart then would be advised to lose weight?

DR. GRUNDY: Aim for a healthy weight.

DR. GARZA: Well, so then if they were in the moderate overweight category you would say aim for a healthy weight. The only way you could do that is to lose weight.

DR. GRUNDY: Well, we define what a healthy weight is. They have to make that choice.

DR. GARZA: Yes, we have. I mean, if you look at the chart we have defined what a healthy weight is.

DR. GRUNDY: We will have to change that and not call that an unhealthy weight if it is -- you know, it is called overweight.

DR. GARZA: Well, that --

DR. GRUNDY: Yes. Right.

DR. GARZA: The reason I am asking is if you look at our guideline and look at the label we have --

DR. GRUNDY: Yes. Right.

DR. GARZA: -- they match.

DR. GRUNDY: Okay. So are we saying that the only reason that we call that overweight is because they cause the risk factors listed here? That is the only dangers that are associated with the overweight. I do not buy that.

DR. GARZA: No, and I am not disagreeing with you. I just wanted to make sure that everyone is clear that by saying aim for a healthy weight we are asking people then to fit within this pink range.

Now, we have caveats in there to say, you know, just because you are within that range does not mean you are fine. If you are gaining weight, then try to --

DR. GRUNDY: Yes. Well, the other thing I said is I think people ought to eat the number of calories that you would weigh if you weighed in that range. Then if you drift down to that range then so much the better.

DR. GARZA: Okay. Meir?

DR. STAMPFER: These risk factors that are listed are strictly coronary risk factors. That

is not our only concern for overweight. For example, adult weight gain increases risk of breast cancer and other cancers, so I do not think that is the only consideration.

Here we have an abundance of evidence for weights between 25 and 30 being associated with greater risk for disease. What we do not have is an abundance of evidence that if you lose weight you will lower your risk because we do not have an abundance of people who proceeded to do that, but we do have the association between BMI in that category and risk of serious, chronic disease so I do not think we are going out on any kind of limb to say if your BMI is over 25 consider losing weight. You do not have to wait until you are 30, a BMI of 30, before you can consider losing weight. That is pretty mild.

DR. GARZA: But we were getting our wrist slapped for being too mild. That is how we got into this discussion. After that --

DR. STAMPFER: This is mild.

DR. LICHTENSTEIN: We also have not said anything about this should be a wake up, that you should stem the tide and really start paying attention to your weight. One issue is losing weight, and that is what we have been discussing, but there is another issue of just noticing that you are starting to creep up and make some kind of adjustment.

DR. GARZA: That is No. 6.

DR. LICHTENSTEIN: Well, actually, yes. In fact, the issue I have been waiting to talk about, No. 6, because, you know, it is one thing to keep track of your weight if you have a scale or to measure your waist circumference if you have a tape measure, but what about things like watching how your clothes fit, seeing whether you have to go up a notch on your belt? Are those things that simple that we should not be mentioning something like that?

DR. KUMANYIKA: Do not press the clothes.

DR. GARZA: People who buy them tight can get away with it.

DR. LICHTENSTEIN: Okay. So that is not --

DR. KUMANYIKA: I think that has been considered. That might actually be bad advice because you could gain maybe ten or 15 pounds, and certain clothes would still fit you depending on --

DR. LICHTENSTEIN: So then it is probably not a good idea to go that low tech and to

really --

DR. GARZA: Men just generally lower their waistlines, so you can get around that.

DR. KUMANYIKA: Right.

DR. LICHTENSTEIN: Now I know the tricks.

DR. KUMANYIKA: This discussion makes me think that we should pay more attention to why these levels are associated or are called healthy or unhealthy.

We have the sentence in the beginning of the guideline that says being overweight or obese increases your risk for blah, blah, blah, and that may be the only place that appears, so some more rationale for like a separate bullet that talks about, you know, how is weight associated with health and give a little more detail about the graded risk, the graded increase in blood pressure, some of the things that are very well documented, so that people can see that being at one weight is better than being at a higher weight, and then we can be clear about what the options are.

You know, what do I do if my BMI is already over 25? Well, you know, your chances of gaining more weight and having problems are very good, so you should try to hold the line or whatever, but listening to this I think this is very taken for granted that the person actually understands the health risks associated with weight, and we should raise it up a little bit.

DR. GARZA: Do you think there is a need to motivate people even further than that first paragraph?

DR. KUMANYIKA: With the health because we have tried to turn weight into a health issue more than a social or cosmetic issue, but when I look at it we do not spend even as much time doing that as we do in some of the other guidelines.

We are saying, you know, what this link is, and we could probably strengthen that not with a lot of text, but by bulleting out separately and saying studies have shown that the chances of getting X increase tenfold in people who have a BMI of this versus that or something like that.

DR. GARZA: Johanna?

DR. DWYER: Well, given the state of our treatments for obesity, we need to be careful not

to run the risk of nutritional Calvinism or predestination because back to what Rachel said. We do not have very good treatments. Once people get too heavy, it is hard to get them back down.

We can change the definition and say only -- well, as long as you lose five to ten percent that is good enough and so that is a healthier weight range than the ideal weight, but even then the treatments are not very good. Long-term outcomes are not that good, so I do not want to get too much into trying to get everybody to go on diets and go on diet pills, and I think maybe we should edit out some of this stuff.

DR. GARZA: I want to come back to Scott now because he is the one that got us on this. After hearing this discussion, what would be your advice, Scott?

DR. GRUNDY: Well, I think we are going in two directions at once. One is saying what a desirable weight is and the guideline aim for a healthy weight.

Then on the other hand we are saying that if you are in the range of the overweight category unless you have risk factors then you do not have to consider losing weight. I think those are inconsistent with one another, and somehow we have to bring those together.

My inclination is to take the clinical part out of it, put it somewhere else, say you need to have a physician. If you are in that range, you may have these other risk factors that need to be treated, and you should go and have those checked -- you should have those checked anyway, but that would be a double reason for having them checked -- and these are some of the potential problems.

At the same time, if you are in that range I think you have to take stock of your body fat and should consider achieving a more desirable body weight. Also, especially if you have a high waist circumference that is even more reason to do it, so I would be inclined to recommend that people give serious thought to reducing weight if they are in the overweight category.

DR. WEINSIER: I am not sure how to deal with it because, you know, I am trying to keep in mind that just because the word is overweight that does not necessarily mean that you have ill health. It is overweight meaning that your weight for your height is higher than a referenced standard.

This might be a body builder, and it might be a person who, you know, get normal height, you know, measurement. All of a sudden now they are reducing their already 20 percent

body fat, and they are down to ten or 15 because we are saying hey, they need to lower their BMI. I think these are the issues that are addressed.

I mean, the NHLBI guidelines, you say they are clinical guidelines. We can change the way we present it, but I think we still have to be able to stand behind -- from a health standpoint stand behind any recommendation, and the NHLBI guidelines make it pretty clear that if the BMI is 30 or above and/or between 25 and 30 and you have risk factors, then you need to lose weight.

Perhaps, you know, Meir is right that we ought to change the wording here. I have already made a note to do that. Perhaps we can make it clearer that if you are in the overweight category your risk is likely to increase. Certainly do not gain any more weight, and perhaps we can say consider losing weight or at least having a health professional assess the presence of morbidities.

DR. GARZA: Let me try and summarize it a little bit different. What I am hearing is that there are different levels of how prescriptive we can be, and what Scott is saying is that if in fact one has a certain BMI and we have sent them to their health professional then based on that assessment they may get very prescriptive.

On the other hand, if all they are is above, I mean a BMI above 25, that perhaps we should ask people to consider losing weight, but not be as prescriptive because of the issue that Alice and others are raising that not everyone over a BMI of 25 may necessarily have to lose weight as an imperative, but that they should at least consider losing weight because of the risk of gaining more weight and eventually developing these health risks, so it is the level of prescriptiveness that are modulated by the presence of risk factors that are best determined by interactions of the health care profession. Is that --

DR. GRUNDY: It sounds good to me.

DR. GARZA: Let's do the following. If we can take Box 6 and say gee, if you have one, two and then go to three and say you may want to consider losing weight because you have all these other problems that you might be facing in the future and then have perhaps a different box that says, you know, check with your health professional to see if in fact you are at risk to any of these problems, and then down there if you are then have a more prescriptive statement about the need to lose weight.

DR. DWYER: And include 6, right?

DR. GARZA: And include 6.

DR. DWYER: Yes. Good.

DR. WEINSIER: So No. 4 --

DR. GARZA: Include 6 as part of Box 6, so that would be 1, 2, and 6.

DR. WEINSIER: So No. 4 and 5 basically come out and are replaced with if you have an increased waist circumference or BMI, check with your health professional to see if you have risk factors and whether it is appropriate for you to lose weight.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I just have a minor --

DR. GARZA: Be careful. Minor issues have gotten us into hours of discussions here.

DR. LICHTENSTEIN: Okay.

DR. GARZA: We have to do that guideline so we can wake up for the night.

DR. LICHTENSTEIN: All right. You know, I see becoming overweight or obese in the first paragraph. However, in this chart here nobody is obese because there is no category for obese. Can we standardize the terminology in some way?

DR. WEINSIER: What are you looking at, that figure?

DR. LICHTENSTEIN: Well, the first paragraph, yes. The first paragraph. It says becoming overweight or obese increases your risk for high blood pressure and all these other things.

DR. GARZA: So just change if you are overweight to obese on the chart?

DR. LICHTENSTEIN: Or vice versa.

DR. WEINSIER: Are you talking about the figure?

DR. LICHTENSTEIN: Yes. I am sorry. The figure.

DR. WEINSIER: We have already changed that. I do not know where this one actually came from. Remember the one I showed up here? It has as categories Healthy Weight,

Overweight and Obese.

DR. LICHTENSTEIN: Actually, it looks so much like this. Okay. Got it. Great. Thank you.

DR. GARZA: All right. Rachel?

DR. JOHNSON: This is another hopefully simple thing. On page 25, the first full paragraph where we are talking about pre-occupational body weight and we say, you know, they should seek help if these apply to you or a family member.

I think the highest risk group is female adolescents and college age women. I do not think that that advice -- often times parents are not even aware that their child is perceiving it.

DR. GARZA: Where are you? I am sorry.

DR. JOHNSON: The last page, 25.

DR. GARZA: Yes. Okay.

DR. JOHNSON: The last sentence says, "Seek help from a health care professional if any of these apply to you or a family member." I think it is often times friends that are more aware of these problems existing among their friends than it is necessarily a parent or a family member, and often times the most difficult thing at least with people with anorexia is that they deny it, and they are not apt to seek health professionals so often times it often becomes a confrontation with a friend who is willing to say you have to get help.

DR. GARZA: What is your advice?

DR. JOHNSON: So my advice is that we need at least add friends in that sentence.

DR. GARZA: Seek help from friends?

DR. JOHNSON: No. Seek -- I will work on it.

DR. GARZA: No. We are getting too serious. Go on. This is directed at the person, and you are saying gee, you know, if you notice that your friends are not --

DR. JOHNSON: Yes.

DR. LICHTENSTEIN: If any of these apply to you --

DR. GARZA: Or your friends.

DR. LICHTENSTEIN: -- or friend or family member.

DR. WEINSIER: A friend or a family member or anybody else you see walking down the street.

DR. JOHNSON: Urge them to seek help from a health care professional.

DR. GARZA: Urge them, yes. Okay. Good.

DR. LICHTENSTEIN: Just add or friends.

DR. GARZA: Or friends.

DR. WEINSIER: I wrote it in. I have it.

DR. JOHNSON: Good. Thank you.

DR. GARZA: Good. All right. At least we got a chuckle out of that.

Now, are there any other points?

DR. DWYER: Can we just give him --

DR. GARZA: Yes. You can give him an editorial.

All right. Now, my suggestion is take a ten minute break, and we will do physical activity because we cannot leave two guidelines for tomorrow. We can leave one, so we will not have to go through salt and be here until 9:00 p.m., but we do need to get at least through physical activity. Otherwise we will be here through Wednesday and not break at 4:00 p.m., which I do not think you want us to do.

DR. MURPHY: You mean through Thursday.

DR. GARZA: I mean Thursday. I keep telling you. It is that Freudian slip of mine.

All right. Ten minutes. That means 5:50 p.m.

(Whereupon, a short recess was taken.)

DR. GARZA: All right. I want to congratulate you, Lesley. You look very much awake.

I have one message from the control tower at the back to please speak into the mike because they have noticed that as you become more experienced throughout the day you have tended to get further and further from the mike. People do read your transcripts. I am amazed, so please speak into the mike so that you are not misquoted.

DR. TINKER: Okay. We are going to finish the day with the physical activity guideline. You know, what Joan suggested is everybody stand up instead of sitting down for the discussion. It does a couple of things. It keeps us a little bit more physically active maybe, and it also what Joan said is that she read somewhere that if you stand up the meetings go more quickly, so the discussions go more quickly.

DR. GARZA: Tomorrow we will all stand.

DR. TINKER: I would like to thank all of the working group because this group really pulled together from an outline that was developed early in June and through some work in the spring mainly through Roland and his group's efforts and Johanna and Rachel, Shiriki, Joan, Kathryn, Peter, and without Carol Suitor's expert help on rewriting and revising some of the wording, we would not be where we are today.

I am going to start out by just reviewing what our progress has been from June to September, and what we did is we agreed to proceed with a physical activity guideline because this does make a new guideline, a tenth guideline. We agreed upon the different messages, which I will review briefly, the types of activities to talk about and the populations to address.

Since then we have also refined the messages and added a couple of new messages. We dropped the text in the rationale, and then what I call identified the unresolved issues, which is really what we are talking about, either unresolved issues and also ideas for the future research.

Because this is a new guideline, I think we need to spend a little more time on the rationale for why we even have the guideline to make sure we are comfortable with it. I would love to have some advice from the various offices perhaps on what would really sway this to become a guideline, a stand alone guideline. Do we have that covered?

The main points that we were going on had to do with a variety of about eight consensus

papers and review articles in the course of the last five years that promoted physical activity and particularly that the extensive health benefits were well beyond the energy balance and weight. It was that argument, among a few others, that encouraged us to separate the physical activity guideline from the balance your weight and physical activity.

Included in that was lower chronic risk disease and all cause mortality and increased well being, so it was a combination. Some of the examples from the consensus documents we worked with were the Surgeon General's Report on Physical Activity, the CDC Guidelines for School and Community Programs, Health Education Authority, which Dr. Russell Pate provided regarding pediatric guidelines, Exercise and Physical Activity for Older Adults, which was a review paper.

There is an NIH consensus paper on physical activity and cardiovascular health. There was CDC and the American College of Sports Medicine recommendations about physical activity and public health, which were about

1995-1996. There was a resistance training article and then another article on recommended quantity and quality of exercise for developing cardiovascular and muscular fitness.

Most recently, in the American Journal of the Dietetic Association there was an article that described some survey or focus group work between the Dietetic Association, the American College of Sports Medicine and the International Food Information Council promoting the coordinated efforts among health professionals to promote physical activity. I think one of our big questions was what would a physical activity guideline be doing in dietary guidelines.

Also, because there is a lower than desired physical activity in the United States and the need to improve physical activity, we were really structuring this to promote and further put the consumer message out there to increase physical activity, so it is back to the coordinated messaging and to help support that message.

In the last conference call we had for the dietary guidelines, we talked about needing to increase the rationale for the relationship between physical activity and nutrition, and what I did in that short period of time was at least start a paragraph or two that described those relationships. This is based on a few articles that I had received from the committee, so I have not done a literature search and could use if people have additional ideas here, this would be a great time to discuss those.

The pieces that we were approaching on that was the synergistic effect of reducing chronic

disease risk between nutrition and physical activity, and this came mainly from a review paper that Steve Blair did and is referenced in the rationale.

Then with a question mark there was another paper I had by Symoes and a group that talked about the lower fat intake and inverse relationship of fat intake and physical activity, so people that were more physically active had a lower fat intake.

I put it in there, but as I reviewed the rationale it really seemed out of place with what we were talking about with the fat guideline of talking moderate fat. I think the conclusions of that Symoes paper were really a matter of just keep it in mind. It was not an idea to say let's promote physical activity because it reduces fat intake, but that is the only paper that I had that pursued anything within a relationship of how with macro nutrients physical activity may affect those. It is my suggestion that that is really not useful in the rationale.

Another piece that we added in there was by increasing physical activity, even at the moderate level of 30 minutes or so a day of a brisk pace, some type of brisk activity, you could increase your calorie balance by 150 calories to 200 calories, and over the course of time that would allow a compensatory not increase, but balance with calorie intake that would provide more calorie avenue for nutrients.

There are some literature in the older populations that suggests that if one is more physically active that some of the micro nutrients -- particularly the papers that I had looked at riboflavin. That riboflavin intake was increased when people were a little bit more active, so that is how we tried to accommodate that.

I think the strength of all of this is still with the energy balance and the weight management. That was the approach that we took for it. It was mainly with a new guideline the approach was really, and we talked about this on the conference call that it is primarily consensus based so the consensus articles, the Surgeon General report and promoting this idea that the more times we can get the message out about physical activity the better was what prompted us to include a special or a unique guideline on physical activity, so it seems to me that there is strength.

Looking at the focus group reports and even some of the public comments, even though there is the request to not have so many guidelines or to not increase the number of guidelines, the focus groups and some of the public comments still supported adding the physical activity guideline, having a separate physical activity guideline. What I do not know is whether we have got strong enough evidence to indeed have that and wanted to make sure that everybody on the committee had a chance to speak to that.

With that, I will kind of take a pause and invite a couple of comments about where you think the strengths and weaknesses may be over the rationale section for even having a guideline on physical activity.

DR. GARZA: Okay. Any comments on that? Shall we scrap the guideline then?

DR. STAMPFER: Silence is assention.

DR. TINKER: So we are still agreed that at this point from all that we know about the documents that talk about physical activity, we feel that the rationale to support a separate guideline is as good as it gets right now.

DR. GARZA: I think that you did a good job of putting that in the bullet forms in the rationale as to the four general ones. I think there were four --

DR. TINKER: Uh-huh.

DR. GARZA: -- that you listed, and then you went on to develop each one, and I found that it was done in a convincing way. I do not think that we have to worry about --

DR. TINKER: Okay.

DR. GARZA: -- at least from my perspective convincing people that there is a strong rationale for one. That was my view.

I suspect, given the assent of the committee, that that reflects everybody's view, or are there ways you think that rationale could be strengthened, even though you may agree with it, that there are ways we could make it stronger?

DR. TINKER: Without trying to make this longer, let me just ask because, Scott, you had given me some written comments that were questioning the argument really about the nutrient balance.

DR. GRUNDY: Yes. I had a question about that.

DR. GARZA: You need to get closer to the mike.

DR. GRUNDY: Okay. I thought it was pushing the envelope maybe a little too far to claim that physical activity was necessary in order to basically meet the nutrient requirements.

In other words, you had to take in more calories than were generally recommended than someone who is say not physically active to meet the nutrient requirement. I do not think that we are right on the edge or on the margin of nutrient inadequacy so that you have to be physically active in order to get enough nutrients so I did not buy that as a valid argument, and I would put more emphasis on the energy balance than on that.

DR. GARZA: Rachel?

DR. JOHNSON: I would like to argue a bit for the other point of view in the sense that I think activity levels are becoming increasingly lower and lower in the American population, and I think my understanding at least, and somebody who is on the committee may be better able to help me with this, is that with the DRI for energy they are really starting to think about what is an appropriate expenditure level that we need to reach in order to have an intake that can meet our nutrient needs.

As expenditure levels get lower and lower it will become difficult to meet nutrient needs on the level of intake that you need to stay in balance, so I think that the argument of increasing your energy expenditure allows you to have a higher energy intake, which can help to improve the nutrient density of the diet.

DR. GARZA: My understanding is that if we take caloric needs of 1,600 to 1,800 for somebody who is sedentary that in order to meet micro nutrient needs you really have to pay much more close attention to the diet. Otherwise it is more difficult to meet those needs.

You can do it, but it requires a greater level of care and less leeway than if you were at about 2,200 calories or above so that there is some merit to that argument; not that you cannot do it, but that the level of care and the flexibility that you have are heightened or lessened. I mean, the level of care is heightened, and the flexibility is less.

DR. GRUNDY: Well, I could understand that you may have to be more careful if you have a low caloric intake to meet the needs. I am not totally convinced that the only way to do that is by exercising, and I think that this is a necessary part of nutrient adequacy to have physical activity.

I think we need to debate that a little bit more and whether that -- you know, if it is true that you do need to I guess it would have to be an absolute requirement that we have this guideline, right?

DR. GARZA: Well, that is why one of the issues, and --

DR. GRUNDY: Yes.

DR. GARZA: -- Rachel is right. At least I thought within the DRI committee as we move into the macro nutrient is that in fact there is serious consideration within the FMB to look at an energy expenditure level because there is growing concern that meeting nutrient needs will be increasingly more difficult as activity levels fall. That was my understanding, so you are right.

I do not know whether -- that group is supposed to start working I hope in the next two months. Whether it will come out that way I do not know, but that has been one of the things that has motivated the review has been the need to look at expenditure.

DR. DWYER: It is already in the 1989 RDAs though, is it not? I mean, the recommendations refer to 200 calories.

DR. GARZA: Well, I do not know whether it is quite phrased that way, I mean.

DR. KUMANYIKA: It is higher than people

usually --

DR. GARZA: That is right.

DR. KUMANYIKA: -- take in, and that is what -- the rationale I thought was because they try to push people's calorie balance up to that level to get the nutrients in.

DR. GARZA: I think there is a rationale, Scott, that says we ought to think about it. Whether this is the best way, I think we need to come to a conclusion at this meeting.

DR. LICHTENSTEIN: Yes. I think it is also particularly a concern as individuals get older and their caloric needs go down that they need to be more careful by maintaining physical activity besides their other important benefits that older individuals can get. One of them also is making it easier to attain nutrient adequacy. As the demographics of the whole population shift, more and more --

DR. GRUNDY: Okay.

DR. LICHTENSTEIN: -- people are going to be influenced to do this.

DR. GRUNDY: You know, I tried to figure out the mathematics of this. How many calories

a day are we talking about exercising?

DR. TINKER: 150 to 200 on this guideline.

DR. GRUNDY: Okay. I found that hard to believe that that would make much difference in nutrient intake if it is 100 calories or 150 calories. I just thought that was so marginal.

DR. GARZA: Meir, and then --

DR. STAMPFER: Yes. I think Scott makes a good point, but I really think it is just a matter of emphasis. On the bottom of page 30 and 31, maybe we should just reverse those points. The first point under that heading is that if you --

DR. GARZA: The rationale?

DR. STAMPFER: No, just in the text. If you are more active, you can eat more food. That makes it easier. It does not say it is required, but it makes it easier to get the nutrients you need, and then the second point is the weight. I think those should be reversed.

I think maybe it would be nice, as Scott had suggested, with the weight guideline to actually give an example and say, you know, if you switch from half an hour a day of sitting to half an hour a day of brisk walking, over a year's time, you know, you will have this kind of impact on your body weight. I think that would add some encouragement. I do not know what it would be, but I guess 150 calories a day would probably be --

DR. GRUNDY: That is ten pounds a year.

DR. STAMPFER: A year?

DR. GRUNDY: Yes.

DR. WEINSIER: No, no, no, no.

DR. GRUNDY: One hundred and fifty calories is ten pounds.

DR. WEINSIER: Yes, but you cannot do it that way. You can only go for a certain segment of time. Then your body weight and body mass changes and you have to

re-equilibrate, so you cannot project infinitely.

DR. STAMPFER: Oh, not infinitely.

DR. GRUNDY: Yes, you can.

DR. STAMPFER: But to the next plateau.

DR. WEINSIER: How would you do that?

DR. GRUNDY: What?

DR. WEINSIER: Yes, to the next plateau. Sure.

DR. GRUNDY: Sure.

DR. STAMPFER: But that would be a substantial --

DR. GRUNDY: It is about 150 calories sustains about ten pounds of weight. I mean, you would lose ten pounds if you ate 150 calories less.

DR. WEINSIER: Ultimately. Ultimately you will reach a plateau.

DR. GRUNDY: Yes.

DR. GARZA: Yes. You do not lose weight forever.

DR. WEINSIER: Right.

DR. GARZA: Rachel?

DR. JOHNSON: Yes. I do not think it has to be a major point. I would just like to make it because I think it is a good point for consumers.

I would argue that 150 to 200 calories a day is a lot. That can make the difference of having dessert at night. If somebody exercises regularly and chooses to have --

DR. GRUNDY: Well, I admit we have to have dessert at night. That is important.

DR. JOHNSON: Yes.

DR. GRUNDY: That is a different issue.

DR. GARZA: It is hard to say whether that contributes to your nutrient intake.

DR. LICHTENSTEIN: Just as long as it is nice with fruit that is deeply orange in color.

DR. GARZA: Johanna, do you have a comment or not? I thought I saw your hand up.

DR. DWYER: No. I am asleep.

DR. GARZA: You are asleep.

Suzanne?

DR. MURPHY: Just a technical question. Why is it 45 minutes to maintain a healthy weight, but 30 minutes to get health benefits? That seems a little contradictory.

DR. TINKER: It can seem contradictory. This has to do back again with the presentations that we had in June when we asked that question of is 30 minutes adequate for weight maintenance, and I can't remember who it was, but they said no, it really needs to be 45 minutes for weight maintenance.

It was Blair. Then we got some articles to support that. It seems a fine line, but that is what the data supports.

DR. MURPHY: I think we have to say why.

DR. DWYER: I think the reason is lean body mass, is it not, because lean body mass goes down if you lose weight and so two thing go down, the resting metabolism --

DR. MURPHY: It does not say to lose weight. It says to maintain my weight.

DR. DWYER: Yes. Once you have lost, Suzanne, your lean body mass is lower, and then the amount for moving your body is less too because you have lost weight, so you have two elements that are both affected where you have to increase your -- you cannot go back to the energy that maintained you at the higher rate.

DR. MURPHY: So this is only for people who have lost weight?

DR. TINKER: Now I understand your question. Yes, I think for people who have lost weight and are trying to maintain that weight loss, but then we need to put that.

DR. MURPHY: That probably needs to be said.

DR. GARZA: Yes. Maintaining weight loss. That is a very important point.

Other issues? I am assuming then that the rationale for the new section then is accepted with the caveat we are going to try to re-order them to reflect the discussion.

Okay. Why do we not move on then to the actual text, which we have already begun to discuss, which is fine. You moved us along. That is all right.

DR. TINKER: Just to get us back to what we agreed on last time for the messages for the physical activity guideline, we agreed that we were going to include increasing total physical activity to more than or equal to 30 minutes most days of the week.

We shortened that in the guideline title just to be physically active. Increasing physical activity for its own sake. Then if inactive, become active. If active, become more so and include strength and endurance activities, so those formed the basis.

For the activities that we talked about, we wanted to emphasize moderate daily intensity, so the emphasis on moderate. We had an interesting discussion at lunch about what moderate might be; another one of these trying to understand what moderate is. Aerobic and resistance training included three short, ten minute bouts are okay. Lifestyle activities are encouraged.

The populations that we agreed to discuss, really all persons over the age of two benefit from physical activity. This was the overriding message for the populations, but we have sections that were more general for adults, but definitely have something for children and comment on older adults, which is consistent with what we have done with the rest of the guideline to address population age issues, but we did agree to not highlight race, ethnicity, income or gender issues with regard to physical activity.

With some of the refinements, what we did in adding to the core messages because of the presentation that Russell Pate gave us last time and the references that support that, we have a specific recommendation for children to have at least 60 or more minutes of physical activity a day, and then here is this healthy weight that we already talked about a little bit, but it is really a matter of maintaining weight loss, not just healthy weight. We added the box about ways to increase physical activity that is in Box 10.

Maybe what might help is I wrote down a few of the headers or all of the headers for the physical activity guideline, and we can go through it that way and see it

point by point.

The title of the guideline, Be Physically Active. The subheadings within the guideline that we have are Physical Activity and Nutrition, Make Physical Activity a Regular Part of Your Lifestyle, Help Children be Physically Active, Older People Need To Be Physically Active Too, and then summarized in Advice for Today.

Those are the subheads, and we can go through each one of those as the messages --

DR. GARZA: I will begin with the first paragraph, the one right under Be Physically Active.

DR. TINKER: Uh-huh.

DR. GARZA: As you begin, it sounds as if we have to wait until we are grown men and women to have the benefit, so you may just want to say, "Everyone from children through the elderly can improve their health" or something to that effect. It is the very first sentence. It says, "All men and women from childhood through..."

DR. KUMANYIKA: We thought that is what it said.

DR. GARZA: I know, but it sounds almost as if it is yes, you will benefit, but you have to start when you are a child, but you do not get to benefit until you are an adult.

DR. LICHTENSTEIN: I see what you mean. Yes.

DR. GARZA: It is just wordsmithing.

DR. KUMANYIKA: So it is all people.

DR. GARZA: It is everyone.

DR. KUMANYIKA: Men and women and children.

DR. GARZA: We should just say everyone.

DR. TINKER: Everyone can improve their health and well-being.

DR. GARZA: Yes. You can list what we mean by everyone, but that might be a simpler construction.

DR. TINKER: Well, we are trying to shorten it.

DR. GARZA: I know.

DR. TINKER: So that works.

DR. GARZA: That is right. All right.

DR. WEINSIER: Are you sure that connotes really what we want to say because I think Lesley is trying to point out, you know, that it is never too late to start, and just saying everyone --

DR. GARZA: Well, no. I said --

DR. DECKELBAUM: No, no. It is everyone from children to the elderly.

DR. GARZA: Through the elderly.

DR. WEINSIER: Okay.

DR. GARZA: Meir?

DR. STAMPFER: Two very small points. One is I think it would be better to have the vigorous activity mentioned up earlier. It is in there later, but just to make the point that -- to stress the point that it is not just moderate. It is at least moderate.

DR. GARZA: You want that in the first paragraph then?

DR. STAMPFER: Something. Some mention of that at least or get the idea that this is a minimum.

The second point is for the activities maybe they could be ordered somehow in frequency because I think like for most adults basketball would not be the first moderate activity. Probably walking would be. Maybe it should be just like we did for the calcium and so on.

DR. TINKER: In fact, we are even trying to think of ways to if we need to shorten this box. That is one of the unresolved issues for shortening.

DR. GARZA: Okay. Shiriki?

DR. KUMANYIKA: I am just back from a discussion about this issue in Australia, and it seems clearer and clearer that more emphasis should be put on things people could do during their work. I mean not during leisure time.

I wonder. Even though the guidelines have not -- you know, this lifestyle and leisure time, for most people that is a short part of the day. Even if they kill themselves being active, they have not necessarily, you know, improved their overall activity level because they cannot do it every day, so I wonder if there are some ways to be active at work and at school that we can find in the list and add to this so it does not sound like we are only concerned about what people do on the weekend or after work?

DR. GARZA: Like taking the stairs --

DR. TINKER: Yes.

DR. GARZA: -- instead of the elevator or something like that.

DR. TINKER: Some of those are in the ways to increase physical activity, which, you know, we do not want to have them repeated twice. What are suggestions for where they best belong?

DR. KUMANYIKA: Well, I was going to also suggest that we might change the bullet Include In Your Lifestyle to Daily Routine, so maybe if we could do that and then emphasize the daily routine perhaps first and then the additional ways so that it does not sound like it is only a lifestyle issue. It might be more practicable for --

DR. GARZA: You are saying in Box 6 replace Box 6 with a daily routine?

DR. KUMANYIKA: Yes. It is the subhead that we have not come to yet, but --

DR. GARZA: Yes.

DR. KUMANYIKA: But I am thinking that after we discuss it we might want to rearrange it to focus more on active being something you do all day and then some moderate activity in the leisure time or extra time might help even more.

DR. GARZA: Alice?

DR. LICHTENSTEIN: With respect to Box 9, I think I am feeling a little uncomfortable with the specificity of some of these issues. I suspect most people do not need to be

convinced that there are benefits from regular physical activity. Perhaps breaking out with a subheading the first paragraph on page 29 and just sort of summarizing it might be a better approach and then using the extra spaces freed up to expand on some of these other points.

I mean, we cannot guarantee that adults are going to reduce their risk of dying sort of prematurely and then go through all these individual ones. It would be nice if we could.

DR. GARZA: Johanna?

DR. DWYER: Shiriki, you may know the name of this gentleman who works with Jim Salas in Australia. He just published a book.

DR. KUMANYIKA: Neville Owen.

DR. DWYER: Neville Owen.

DR. KUMANYIKA: I just talked to him.

DR. DWYER: Dr. Owen has maintained that for physical activity you need just as much guidance as you do for the food pyramids or whatever, so maybe that would be a good idea if we could shorten the benefits and have more actionable ideas then for each area.

DR. GARZA: So on the benefits, will you reduce that box in half? Is that your recommendation?

DR. DWYER: Yes. Cut it in half, and then we can use the space for more actionable things.

DR. GARZA: Okay.

DR. LICHTENSTEIN: In fact, I think we should really discuss whether we need the box and whether it can just be discussed with the subheading and the paragraph.

DR. GARZA: All right. We are going to eliminate Box 9.

DR. GRUNDY: I support that. I think that ought to go in both the obesity and this one, more practical things which people can do. I think that is a great idea.

DR. GARZA: Okay. Roland?

DR. WEINSIER: Yes. I agree. Lesley and I had already talked about eliminating Box 9 and moving the first like six or seven benefits into the text on page 29.

DR. GARZA: Okay. Meir?

DR. STAMPFER: I do not object. I do not object to removing Box 9, but I think it is nice to have some specific health benefits listed apart from just, you know, generally it is good for you.

This provides something that is basic evidence that it is not just general good health, but specifics, so I think if we eliminate the box we should have at least some of the specifics mentioned someplace.

DR. GARZA: The recommendation was to move that to page 29 so that the box would be eliminated and some of them moved over. Not all of them.

DR. TINKER: When you talk about moving some of the specifics, which ones are you thinking of as being specific just in general because there is the children and adult section?

DR. GARZA: Well, for example, for children you could say help build and maintain healthy bones because in fact that is -- I mean, choose the ones that are most prominent among each of the groups and for which we have the best data. Obviously for osteoporosis that would be important.

DR. LICHTENSTEIN: Yes. You may not always have to make that distinction because maintaining bone mass is going to go across.

DR. GARZA: Right. That would be for everybody.

DR. LICHTENSTEIN: Yes, and I think for a lot of them it would be similar.

DR. GARZA: Yes, but I think you have the flexibility --

DR. TINKER: Okay.

DR. GARZA: -- rather than us getting too detailed.

DR. LICHTENSTEIN: I would also suggest, and this is on the top of page 33, again in reference to older people that one of the advantages is to forestall the loss of lean muscle mass, so it is nice to think about strengthening, but when you get to older individuals the

real emphasis is on just maintaining what is there and then relating that even a little bit more to ability to live independently. They even say things like opening jars, buying groceries, preparing meals, things like that.

DR. GARZA: Okay. All right. So then are we then through that first section and ready to go to Physical Activity and Nutrition?

DR. LICHTENSTEIN: Can I make one more?

DR. GARZA: Sure.

DR. LICHTENSTEIN: Just one more suggestion with help children be physically active. One of the other points that could be listed is enable children to participate in school and/or community based sports programs because --

DR. GARZA: No. We are not there yet. We are just on page --

DR. LICHTENSTEIN: Oh. This is 30.

DR. TINKER: Well, we have been all over.

DR. GARZA: No. Lesley wanted to -- we are on page 29 or page 30 under Physical Activity and Nutrition. She wants to take this in order, which I think would really help, rather than flipping back and forth.

Do you have anything above that section that starts Physical Activity and Nutrition? Going, going, gone.

All right. Physical Activity and Nutrition. You had an overhead I think on that one, did you not?

DR. TINKER: Yes. These are the main points that we got in the section on Physical Activity and Nutrition. That physical activity increases the calories used and, therefore, the ability to get nutrients. We talked about reversing the order and emphasizing the energy balance and weight on that. We have the point about weight management if one is trying to maintain a weight loss and improving bone health.

DR. GARZA: So we are going to change some of that text to deal with the weight loss?

DR. TINKER: Yes.

DR. GARZA: And changing the order, which you said.

Any other changes then? Suzanne?

DR. MURPHY: The middle point is entirely on weight loss. Is that physical activity and nutrition? I do not know that I would put weight loss. Why not a separate bullet on the role of physical activity in maintaining weight loss? It does not seem to me to fit under that part.

DR. TINKER: Well, the reason we really even have this section is to help people bridge between the physical activity guideline and the dietary guidelines, so we are really trying to boost all of those pieces. That is the only reason that the weight management is in there.

DR. MURPHY: I do not mind it being in there. I just --

DR. TINKER: Yes.

DR. MURPHY: -- wondered whether it fell under physical activity and nutrition.

DR. GARZA: You would recommend a separate heading?

DR. MURPHY: Yes, because I missed the point entirely obviously that that is what that was about, and it seems like some of the things that you talk about there, are those not just general things?

Spend more time walking to the store. Use stairs. I do not know. I am a little confused by the point here because these are some of the same things that you have in Box 10.

DR. TINKER: Yes, they are.

DR. MURPHY: It is a little confusing the way it is. I would put it somewhere else. If there is no other logical place, because I do not see any place else you talk about the role of physical activity and weight loss. If that is a major point --

DR. TINKER: Yes.

DR. MURPHY: -- then I think it deserves a heading.

DR. WEINSIER: Could it be Physical Activity, Weight and Nutrition and just leave it the way it is because, I mean, she is discussing -- she opens it with talking about the role of

physical activity in nutrition and weight maintenance and then gives examples of how it can help with weight control and ends in that last paragraph about its role in health, so what about just changing the title of it, the topic?

DR. TINKER: I need a clarification real quickly, Suzanne, with what is confusing. Is it that the whole weight piece is under this Physical Activity and Nutrition?

I also think I heard, but it may not be what you meant, that the comments about, you know, spending more time in activities like walking to the store, there may be confusion because they are there, and they are also in Box 10.

DR. MURPHY: Right.

DR. TINKER: So there are two aspects.

DR. MURPHY: Yes. I cannot tell whether this is a major message. It just sounds like a throwaway sort of here, and I think most people think it is a major part of weight loss so either it should be addressed, or it should be dropped.

DR. GARZA: Shiriki?

DR. KUMANYIKA: Maybe the thing to do is to make a clearer statement and cross reference to the weight guideline.

You know, physical activity has an important role in weight loss and maintenance and somehow cross reference to the other guideline to make that statement clear rather than mention it in passing here because it seems under play, but we do not want to go into the gory details here because we have already gone into it and then talk about other aspects of nutrition or general physical activity and nutrition.

DR. MURPHY: If the 45 minutes is a well accepted necessity for weight maintenance, maybe that needs to be highlighted in the other guideline as well. I mean, is that Steve Blair's opinion, or is there real evidence to that?

DR. GRUNDY: I wanted to comment on that, too. I am a little concerned about having two different messages, one at least 45 minutes, one at least 30 minutes. I think we ought to have some consistency.

I think if we got people exercising 30 minutes extra, you know, we ought to do all these other things, climbing stairs, walking as much as possible. That can add in, but to add on

an extra 15 minutes to somebody's busy life I think is asking a lot, and it is inconsistent.

I am not sure whether I should measure 30 minutes, walk 30 minutes, or exercise for 45 minutes, you know. I do not know whether I have lost weight. I always try to lose a little weight, so it is confusing to me. I think it ought to be consistent throughout and have one number.

DR. GARZA: Scott, the issue that we seem to be facing is that the data suggests that if you have lost weight and you want to keep it off that the best data we have is that you need to have 45 minutes of activity to maintain your weight loss.

DR. GRUNDY: The data on that are not ironclad, I can assure you. I mean, between 30 and 45 minutes, you know, that is not --

DR. GARZA: So would you --

DR. GRUNDY: That is way beyond our reservations.

DR. GARZA: No. I agree, but if the data say 45, I mean, what do we pin the 30 on, consistency alone, to say that gee, we recognize that it is 45, but we thought it would be confusing to the consumer so that we are going to go for 30 as the minimum?

DR. GRUNDY: Well, you know, earlier this year I was on a panel that reviewed the role of exercise in weight reduction. They had all the experts in the world there, and I was chairman of the panel to look at that.

When you began to write up the whole thing, it is not proven. I mean, there is no proof that exercise contributes to weight reduction in controlled clinical trials. I mean, we believe it and all that, but it is not proven. Certainly 45 minutes versus 30 minutes is certainly not proven in my view.

DR. GARZA: Shiriki?

DR. KUMANYIKA: I was wondering if it was, I mean, because I have heard Clark Burshad (phonetic) talk about those data to us.

DR. GRUNDY: Yes.

DR. KUMANYIKA: It is depressing. I think the 30 minutes is just saying there are general health benefits.

I agree with Suzanne that the statements about the role of physical activity and weight management should be separated so that they do not confuse the issue. They should be highlighted as such.

Now we are talking about the special case when you are using physical activity as a part of a weight management program, and then let the rest of it be clear that we are saying it is good for your health and in general whether you are overweight or not, you know, these are the recommendations.

DR. GARZA: Can you address Scott's point that given the imprecision in the data that going with 30 minutes across the board would be better than trying to make the distinction between 45 and 30?

DR. KUMANYIKA: I think that in this section on how physical activity helps with weight reduction something has to be said about 30 minutes may not be adequate to help lose or maintain weight loss for people. In total, it might be nice to work more in if you are actually trying to create a deficit, but, I mean, you know how to say that.

If we are talking about weight, we know how to say that may only be enough to improve your physical fitness, but weight reduction requires a caloric deficit and so forth.

DR. GRUNDY: Certainly the more you exercise, the more caloric deficit you would have, but I do not think there is anything magic about those numbers. If you want to bring it in to a weight reduction program, you know, that would be fine. I mean, I do not have a problem with that, but I think that has to be very clear.

DR. GARZA: Lesley, you followed that exchange and do not need any clarification?

DR. TINKER: Well, what I heard out of it in summary is that it is too confusing to have both 30 minutes and the 45 minutes, and maybe one comment would be to include 30 minutes may not be adequate to lose or maintain weight loss, take away the recommendation for 45 minutes and refer readers to the weight management guideline.

DR. GARZA: Yes. Good. Scott, is that --

DR. GRUNDY: Yes, I think so. At least 30 minutes. That is what you said down there, and then maybe more if you are trying to --

DR. TINKER: And maybe more.

DR. GRUNDY: -- maintain weight.

DR. TINKER: Okay.

DR. GRUNDY: You know, that is qualitative.

DR. GARZA: Okay.

DR. TINKER: Yes. Without quantitating it.

DR. GRUNDY: Yes.

DR. GARZA: Roland?

DR. WEINSIER: Yes. I agree with Scott. I think his point is well taken. There is no magic number that I have ever seen related to exercise.

I mean, Scott knows the panel well because he was directing it, but the paper that is in the press I am sure you are referring to by Rena Wayne, I mean, basically it is showing that there is, first of all, no clear amount of exercise needed for weight loss, no less weight loss maintenance, but it does not make sense that you should have one figure for weight loss maintenance and another figure for weight gain prevention. Theoretically it should be one and the same.

DR. GARZA: Well, but this not -- I mean, 30 minutes is not necessarily weight gain prevention.

DR. WEINSIER: No, no. The 45 minutes.

DR. GARZA: Oh, yes.

DR. WEINSIER: So I agree with Scott. There is no magic 45 minutes. At least 30 makes sense, and I will go back and check the weight guideline and make sure it matches.

DR. GARZA: All right. Any other comments for that section? Richard?

DR. DECKELBAUM: I think that in justifying the physical activity and nutrition this ties into the weight guideline as well. There is no other guideline that crosses so many chronic condition categories where the evidence is so strong. I think you could emphasize that in the text just after that first sentence at the bottom of page 30 in that section.

DR. GARZA: The only other thing that I heard, Lesley, was that somehow because the examples you have of increasing activity get us to the point that Shiriki was making earlier whether we want to move that up to the text up front to say gee, if you want to be physically active try to make it part of your daily routine and make that the emphasis of the first paragraph rather than referring the reader only to activities that you have to plan for and make special time for rather than incorporate into your daily life.

I mean, is that what you were getting to earlier, and should we move that section then forward?

DR. KUMANYIKA: Yes. Yes, I think so.

DR. TINKER: The section making exercise a part of your daily routine, moving that forward.

DR. GARZA: Yes, because the emphasis being that if people do that they are likely to sustain that, where if you have to make room or time to play basketball and go dancing, I mean, it is not that --

Okay. Richard?

DR. DECKELBAUM: Just going back to Box 8, and we discussed some of this earlier today and some of the specificities of what moderate exercise 30 minutes a day represents. You know, some of these guidelines that we discussed, two miles in 30 minutes or five miles, those are very definite set points maybe set by only one organization, so I think one is you could make this a little more general without those specificities. You know, walk vigorously.

The other thing that I just happened to note is it is hard to see for me how you are going to do a golf game at 30 minutes a day.

DR. TINKER: You just sneak on and sneak off.

DR. GARZA: Okay. Then let's move on to Make Physical Activity a Regular Part of Your Lifestyle. Obviously that --

DR. GRUNDY: I think you have to pull somebody else's cart.

DR. GARZA: That overlaps a bit with the discussion we just had.

DR. TINKER: Which we have already talked about calling it daily routine.

DR. GARZA: Yes.

DR. TINKER: These are the key points that are in that section. If inactive, become active and start slowly. See a health care professional if you have a health problem or you are a man over 40, a woman over 50 and that you want to start a vigorous activity plan.

It repeats the message about at least 30 minutes of physical activity daily. It comments that three bouts of ten minutes each are okay. It does not have to be all in one 30 minutes block, and it can be lifestyle or structured, which gets into the daily routine as well as leisure activity. Anything is fine.

Then it has this is where the Box 10, Ways to Increase Physical Activity, shows up. Those are actually -- some of those are repeated in the text earlier in the Nutrition and Physical Activity section.

DR. GARZA: Shiriki, and then Alice?

DR. KUMANYIKA: I actually think that there is a mixed message here of having an activity program and increasing it in your routine, so the advice to see your health professional and so forth probably does not apply to deciding to take the bus.

DR. TINKER: Right.

DR. KUMANYIKA: You know, it really applies more to an activity program, and it might be nice to try to separate those concepts in here so that the routine, daily life stuff is noted, and then we find a way of describing this thing where they are actually going to start with more sustained, moderate activity.

I mean, I do not know what terms they use for it, but if you change that bullet that I suggested the rest of it kind of does not match because it starts off more like talking about a program until you get to Box 10.

DR. TINKER: Uh-huh.

DR. KUMANYIKA: Then it comes back to a daily routine.

DR. GARZA: Are you still suggesting that we ought to move the daily routine up forward, have a heading that says gee, if you want to do something extra then put that here?

DR. KUMANYIKA: I think we should separate the daily routine and then talk about a program of moderate activity in spare time or something like that and separate those so that people can see the difference and which precautions are needed for which.

DR. TINKER: So particularly with regard to the precautions of when you would see a health care provider.

DR. KUMANYIKA: Right. Right.

DR. GARZA: Suzanne, and then Alice?

DR. MURPHY: Yes. I have a question on that. I had always understood that the things in Box 10 could be the components of a moderate exercise program. I mean, do exercises or pedal a stationary bike while watching television, play actively with children. Are those not all moderate exercises that I can count?

I think it is a little artificial to say these are things that count toward moderate exercise, and these are not.

DR. KUMANYIKA: But you do not need to necessarily see your health professional to decide to --

DR. MURPHY: I agree.

DR. KUMANYIKA: -- take a flight of stairs. That is what I am saying.

I agree that they could come together, but now when you mix them there are some things that trigger the mentality of an exercise program, and there are others ones that do not. They are blended together in a way that I think is confusing.

DR. GARZA: The other point that I thought you were making was that there are certain items that in fact one could incorporate into your daily life for which you do not have to make special time.

DR. KUMANYIKA: Right.

DR. GARZA: It is just how you use that time.

DR. MURPHY: Right.

DR. KUMANYIKA: Right.

DR. GARZA: And we are mixing all three.

DR. MURPHY: It is a difficult line. Maybe a man over 50 should see his physician before he starts using a manual lawnmower. There are men that drop dead.

DR. TINKER: This is for vigorous. If you have been inactive and you are starting a vigorous, and vigorous really is --

DR. GARZA: Shoveling snow.

DR. TINKER: -- shoveling snow and has a definition within exercise physiology.

DR. MURPHY: Yes.

DR. TINKER: That is why it is there.

DR. GRUNDY: You know, I am a physician, and when someone comes to me I would not know what to tell them if they are over 40. What would I do, do an EKG stress test and then just let them get an angioplasty and go down that route? That is what we do not want to happen.

DR. GARZA: Only when they want to use a manual lawnmower. If they want to have their lawn mowed by somebody else, they may not have to worry about their angioplasty.

DR. TINKER: Do we need that precaution in there at all?

DR. GRUNDY: Well, I do not know. I think not

for --

DR. DWYER: Yes, you do.

DR. GRUNDY: For your protection, I guess, but you are opening a lot of Pandora's boxes.

DR. GARZA: The operative word is vigorous. Yes. Okay.

DR. LICHTENSTEIN: At the risk of getting heckled, I am going to suggest an extra section, and it has to do with why should I pay attention to my physical activity or why

should I become more physically active and just point out that modern life is really conspired to decrease our physical activity because now we have remote controls for the TV. We do not have to get up when we answer the phone because we have cellular phones and modular phones and all those kinds of things.

We are spending more time in front of the television. We are spending more time in front of the computer, but just sort of remind people that where they may not have had to be concerned with this ten or 20 years ago life has changed, and that in itself is justification for paying more attention to their activity pattern.

No heckles?

DR. TINKER: It is intuitive, and we all know it happens. I do not know what data there are other than some of the television watching data for the children.

DR. LICHTENSTEIN: Okay.

DR. GARZA: There should be some time use. I do not know the literature that well, but there is a whole branch of economics that looks at time use in daily life.

There may be somebody in the Economic Research Service that does that type of thing. Down at ERS they used to keep track of things like that.

DR. KUMANYIKA: It may be in Neville Owen and Solis' book, Solis and Owen, A Behavioral Exercise, which I ordered, but I do not have yet. I mean, I think that argument is made a lot, but it is often made on a cultural descriptive basis and not from data.

DR. LICHTENSTEIN: Yes, like what I am doing now.

DR. KUMANYIKA: Right. I think the only possible problem with that, because it is in the WHO report on combating the epidemic of obesity, is that the way we eat has changed too, and so if you make that argument without talking about the way we eat -- I mean, Philip James' estimate is that there is only a 50 calorie a day difference, so we have lost 800 calories in activity, but we have only dropped our dietary intake by 750, which may or may not be true.

Some people hate that estimate, but the question is if we say that do we also have to say that we are going to go out and kill and lion and then eat that for dinner?

DR. LICHTENSTEIN: It is probably that we should not sit down with our family and have

a meal, but we should eat on the run. Okay. I withdraw my suggestion.

DR. KUMANYIKA: No. I think that the theme is good, but you have to be careful with it.

DR. GARZA: All right. Can we move to Helping Children Be Physically Active? Is that the next section?

DR. TINKER: It is. The main point in there is to have children be physically active at least 60 minutes daily, and then we go on to state ways parents can help, such as encouraging them to be outside playing, jumping rope, limiting the television watching, joining the children in setting a good example, which we have done the setting a good example in the weight guideline as well.

DR. GARZA: Okay. Richard, and then Alice?

DR. DECKELBAUM: I think one of the concerns relating to physical activity in children is that a number of schools, a large number of schools, no longer provide gym, as it is called, as part of the regular school routine. I do not know because I guess that is Department of Education, which is separate from the USDA. Does the USDA handle school gym?

DR. GARZA: No.

DR. DECKELBAUM: But in any case, I think it would be worthwhile putting it in a Government document the need for --

DR. GARZA: Why do we not put that in our recommendation because I think that putting it here would be difficult.

DR. TINKER: I believe it is one of the recommendations not to have a gym, but to have kids participate more in physical activity in school is one of the healthy or the year 2010 goals, so there is support for it to be added.

DR. DECKELBAUM: I think we have to think of some kind of wording where it is not just in the green book, but in this text so that people can act on it, sort of encourage your child to participate.

DR. GARZA: Physical activity in school.

DR. DECKELBAUM: Besides the extra-curricular, but during school.

DR. TINKER: Yes.

DR. KUMANYIKA: It is in Box 8, but it gets lost.

DR. DECKELBAUM: Yes.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I would like to see something put in about encourage and enable your child to participate in community and/or school extra-curricular activities because frequently that necessitates a parent or some caregiver getting the child to wherever they need to be and getting them back and also just generally encouraging.

DR. TINKER: Encouraging them to be active and enabling them to be active in extra-curricular activities, school activities.

DR. GARZA: So it is both intra and extra.

DR. TINKER: Right.

DR. GARZA: Okay. Shiriki?

DR. KUMANYIKA: I wonder if the word alternate -- I am in that section of Box 10. If we could advise parents to alternate TV watching, etcetera, with active forms because this computer -- it is not just computer games. Parents perceive that their children are learning important skills, which they might be, at the computer, so would it be more effective to tell parents if you let them sit in front of the TV, then they have to get up for awhile before you can let them go back? Would that be more effective advice, child experts?

DR. GARZA: That is not Box 10. That is in the section itself, right?

DR. KUMANYIKA: Well, this is actually in the box that says -- I cannot tell if it is in the box. It is below the box. Okay.

DR. GARZA: It is below the box.

DR. KUMANYIKA: Limit television watching.

DR. GARZA: We are on the same --

DR. KUMANYIKA: Right. Some parents have such a hard time thinking of it as limiting it, but if they think of it as alternating it, it is actually suggesting that you replace it with something periodically.

DR. GARZA: Okay. Rachel, you are frowning.

DR. JOHNSON: No. I am just not sure. Alternate. So what are we going to say there? Alternate television watching with computer use?

DR. KUMANYIKA: Well, you have to revise it. You would have to say alternate inactive. Alternate things that your kids do that are inactive with the more active things.

I mean, it has to be wordsmithed, but that is the idea rather than just say encourage it and limit. You could tie the two together in a way that might be more practical, more operational for the parent.

DR. WEINSIER: That is an example of a way to limit television.

DR. KUMANYIKA: It is a way to limit it, but it incorporates the positive so you are not just saying, you know, lock them in the closet and do not let them watch TV.

DR. JOHNSON: Well, one thing. I was at this conference in Ireland, and a physical activity expert from the UK was speaking. I thought he made a very good point that when we were kids we had three television channels, you know, no computer, no Play Stations or whatever, and so we went outside and played because we were bored. We would seek out our friends and we would do active things just because it was something to do.

Kids today never get bored because they have 60 television channels, and then they can go to the computer, and then they can go to the Play Station, so they never reach the point that they are bored and they are seeking out something to do which involves physical activity, so I do think that there is a point at which parents just need to say you have to get outside. You have to limit this, and you have to do that.

DR. KUMANYIKA: But you still have to tell them what to do when they are limiting it. That is what I am saying.

DR. JOHNSON: Right.

DR. KUMANYIKA: I think Epstein uses that approach. Do not just say -- tell them not to do it.

DR. JOHNSON: Right.

DR. KUMANYIKA: Tell them what to do.

DR. JOHNSON: Well, he has them ride a bicycle, which is connected with the television, which the only way the television will go on is if they are riding a stationary bike. He does.

DR. GARZA: Yes, but it is not a very practical suggestion. You are an American parent.

Suzanne?

DR. MURPHY: Could you get by with saying something like replace television watching and computer games with more active forms of play?

DR. KUMANYIKA: I personally think that alternate might be good advice for parents, but my son is 26 now so he does not listen to me anyway.

DR. GRUNDY: I like your idea.

DR. LICHTENSTEIN: I still would like to see limit there at some point because I think that is real clear advice. It is consistent advice, and at some point parents just have to put their foot down and limit, and they should be encouraged to do so and then, you know, follow it up with alternate physical activity. You know, encourage alternate physical activity or activities that involve motion or whatever, but at some point there has to be just a cut.

DR. GARZA: All right. Hopefully, Lesley, you have some help. Since both of these are opinions, I am not sure that if you go either direction they will be able to prove that you are wrong.

Any others under Helping Children? All right. Then under Advice For Today?

DR. TINKER: There is one section, Older People Need To Be Physically Active Too.

DR. GARZA: I am sorry. That is right. I missed that. That was at the bottom.

DR. TINKER: Really the paragraph in there repeats again the message of at least 30 minutes daily and then gives comments about why.

DR. GARZA: Any problems with the -- Johanna?

DR. LICHTENSTEIN: I still think there should be something indicating that it is important for maintenance of muscle mass and that older individuals are at risk for losing lean muscle mass.

DR. TINKER: I have that.

DR. GARZA: All right. Then under Advice For Today?

DR. TINKER: The messages that we repeated out of the text for Advice For Today is the 30 minutes for adults, the 60 minute recommendation for children, choose lifestyle or structured, and I guess we would put in there daily routines, but something to infer that it is not just a structured activity plan.

If you are inactive, become active. If you are already active, become more so. Stay active through life, and then we have repeated the consulting a health care professional if needed.

DR. GARZA: Well, I see a sense. It may be because they are locking the building as we speak. I am going to --

DR. TINKER: There is --

DR. GARZA: I think we are done.

DR. TINKER: Well, there is one question that I think --

DR. GARZA: All right. Go ahead.

DR. TINKER: -- I would suggest. The reason, to cut it short, is the question to include the activity pyramid or not. I think we have pretty well ruled out that we have enough data to support including a physical activity pyramid right now.

DR. GARZA: We have not been able to find one.

DR. TINKER: That is right.

DR. GARZA: We have contacted WHO. There is no such thing at WHO. They are in the process of maybe developing one, so you may be setting some prototypes, but it has not been adopted yet.

In terms of research recommendations, perhaps, Lesley, tomorrow morning we will take

those up.

DR. TINKER: Okay.

DR. GARZA: That ought to be a brief item, okay?

DR. TINKER: Good.

DR. GARZA: For Thursday, I am going to be passing out how we might be able to group some of these guidelines on the cover. The suggestion has been made after looking at focus groups, staff has talked about it, is to have an ABC theme, but the A being Aim, the B being Build, and the C being Choose for Good Health.

I will pass these out. Consider them, and we will take them up I think on Thursday morning if all goes as planned. We have published comment summaries -- that is right -- that you have been given this morning and also the salt rationale. Make sure that you take a look at all of those.

(Whereupon, at 6:53 p.m. the meeting was concluded.)

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Date of Hearing

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