UNITED STATES
DEPARTMENT OF AGRICULTURE

In the Matter of:	)
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DIETARY GUIDELINES ADVISORY	)
COMMITTEE MEETING	)
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DIETARY GUIDELINES ADVISORY)
COMMITTEE MEETING)

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

Thursday,
September 9, 1999

The hearing in the above-entitled matter was convened, pursuant to notice, at 8:50 a.m.

APPEARANCES:

On Behalf of the Dietary Guidelines Advisory Committee:

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Chair
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Cornell University
Associate Director, Food and Nutrition
Programme, United Nations University

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New England Medical Center
Professor of Medicine (Nutrition) and Community Health
Tufts University School of Nutrition

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For the Staff:

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JOAN LYON, M.S., R.D., L.D.
HHS/OPHS

KATHRYN McMURRY, M.S.
HHS/OPHS

CAROL SUITOR, Sc.D., R.D.

Also present:

Eileen T. Kennedy, D.Sc.,R.D.
Deputy Under Secretary
Research, Education, and Economics
U.S. Department of Agriculture

PROCEEDINGS

(8:50 a.m.)

DR. GARZA: All right. We're going to begin today with the — what we have eventually come to call the sugar guidelines.

DR. JOHNSON: All right. Thank you very much. We have saved the best for last.

DR. GARZA: Dessert.

DR. JOHNSON: Dessert. Okay. I also apologize for the quality of my overheads. We — our subcommittee had a number of people traveling, but it wasn't until Tuesday night that we got to get together and come to some conclusions or some consensus as a subcommittee on some issues that had been hanging with sugar. And based on our last conference call, we've come up with some things.

First, I wanted to cover the content which I believe we've agreed upon. If this isn't the case, let me know. I think it's been unanimously agreed upon that sugar is associated with dental caries, and I just added this quotation from a recent paper that the assertion that diet plays a role in the development of dental caries is unquestionable.

Clearly, it's related to the stickiness of the carbohydrate, how fermentable the carbohydrate is, and then the issues related to the carbohydrate or sugar, but I think we have agreed that probably the strongest diet health association that we have been — has been demonstrated in the literature with sugar is one of dental caries.

So we have agreed upon that. I'd like to pass this handout with these figures to the Committee. I think we've also agreed that energy intake of Americans has increased principally since the '89/'91 CFSII survey. And I pass this handout which came out of one of the USDA nutrition insights, the title of it was — I think it's something like "Is fat intake increasing?" or whatever.

And the point of the article was to show that fat intake in fact has remained relatively stable as the absolute amount in terms of grams. The reason why the percentage of fat in the diet has gone down is because energy intake is going up and this intake has largely been in the form of carbohydrates.

So as you can see from that handout, if you look from '91 to '95, most of the increase in energy intake has been in the form of carbohydrates, a little bit in alcohol. But fat and protein have been relatively stable. So it is one macronutrient that is increasing in intake.

Okay. As I say, the energy intake's contributed largely to carbohydrate. We do have some published data in children that has demonstrated using the CFSII surveys that the increase in carbohydrates is largely attributable to added sugars and principally in the form of — of soft drinks. And this was a paper by Morton and Guthrie that demonstrated this.

I believe we've agreed as a committee that there has been an increase in the intake of caloric sweeteners. This has been — this trend has been shown in both displacement data, published displacement data, primarily from FDA publications, as well as consumption data, using USDA/CFSII survey, also published data.

There has been some testimony submitted to the Committee questioning this increase in intake of caloric sweeteners based on different definitions that have been used. But I believe and — and if any of the Committee members want to disagree with me, certainly it's open to that. But I think we have agreed that the data are pretty convincing, that in fact that has been an increase in the commodities.

So the last agreed-upon content that we have — or not the last, the second to last, is that consumption of foods high in added sugars — and particularly the data — the published data have looked at soft drinks — have been negatively associated with intakes of more nutrient-rich foods. And these include things like fruit, grains, and milk.

The published data in children particularly has looked at soft drinks and the negative association between soft drinks and milk and fruit juice intake and there's some published work in adult women that shows that women who meet their calcium intakes have higher intakes of fruit, grains, and dairy products, and lower intakes of soft drinks.

Or vice versa. The women who don't meet their calcium DRI have higher intakes of soft drinks and lower intakes of those other foods. But — and I think this is a big but — that the subcommittee has discussed is that what we don't know or can't really answer is whether or not these decreasing intakes of food — if we were able to limit or decrease the intake of these foods high in added sugar, would that lead to a subsequent increase in intakes of food that are more nutrient-rich.

And we don't have published data that have been able to look at that. We know there's an association between foods high in added sugar, a negative association between intake of foods high in added sugar, and intake of more nutrient-rich foods. These are from cross-sectional data. What we can't answer is what the impact of decreasing the intake of those foods — of those foods high in added sugar would be on the intake of more nutrient-rich foods.

So I do leave us with that question. And then lastly, we did agree upon — during the last conference call — that we would drop the association between diet and cancer that was mentioned in the consumer booklet. This was based on some published work in the — oh, what was the book?

DR. GARZA: You said diet and cancer.

DR. JOHNSON: I'm sorry?

DR. GARZA: You meant sugar and cancer, right?

DR. JOHNSON: I mean — I mean sugar and cancer, yes. I meant what it says up there.

DR. GARZA: It's being recorded.

DR. JOHNSON: Yes, thank you. Sugar and cancer. We had a fairly lengthy discussion about this on the last conference call, and I believe that because it wasn't a lock- tight case at this point, and it did not seem to be central to our rational on sugar, that we would drop mention of that in the guideline itself.

Now, that's what we agreed upon and what I'd like to do is — is raise some of the remaining issues that we have to deal with here today. The subcommittee met and felt that given that this sugar caries — sugar and its relation to dental health is the strongest diet and health association for sugar that we have considered new wording for the guideline that emphasizes all sugars or total sugars, rather than just added sugars.

I think that — and Alice and Richard can help me out here if I'm not representing your views. I think we believe that there is certainly a strong emerging literature looking at added sugars and looking at their impact on consumption of more nutrient-rich foods, but at this time, it may not be a lock-tight case. So I think we can discuss that today.

Some of the suggested new wording that we have is, "choose foods and beverages to keep your diet moderate in sugar" and I looked carefully at some of the USDA focus group work which said things that consumers didn't like to go easy on. Our proposed first guideline was go easy on foods and beverages high in added sugar and consumers didn't seem to like that term, go easy on.

They preferred the word limit. They said that they wanted the word limit. The consumers believed that sugar should be limited in the diet. They were able to name major sources of added sugars in the diet when they were asked if they understood what this meant and if they could name them, and they also said they prefer the mention of food to diet.

We've added beverages in here because we think that the increase in beverages that are high sugar containing beverages has been so dramatic that we'd like to emphasize the importance of beverages in this sugar guideline.

So I came up with a few other alternatives based on some of this consumer work that said that they like the word limit and I came up with limiting — limit sugary foods and beverages or limit foods and beverages which are high in sugar, so I proposed those to the group for your consideration.

Let me just — so should I go through all the remaining issues and then we can come back and revisit and have a group discussion. Some other remaining issues that have been brought up is that this guideline has become overly clouded with this issue of good food, bad food, particularly the relationship between soft drinks and

milk.

And clearly, there's nothing wrong or bad about soft drinks if you meet your nutrient needs and you can afford to have calories left over to meet your energy needs. I think that the wording of the guideline has evolved based on the published literature that has shown these associations with foods. And certainly, well documented in the literature that there is this negative association between soft drinks and milk.

But I do think that the guideline has evolved a bit to really emphasizing this, so I ask the group and the Committee has talked about in box 17 where we list sources of added sugars, we listed major food sources. One alternative to that would be to list the ingredients — the — the ingredients that would be on a food label that would represent sugar content. We do that in the text, but we don't highlight it in the box.

So I think we need to talk more about whether we want to specifically highlight ingredients that a consumer could look for on a label or whether we specifically want to — to mention specific foods. Now, that box 17 was carefully crafted based on analysis of CSFII data, which showed that those foods listed in box 17 do contribute a little over two-thirds of the added sugar in Americans' diets. So that list is carefully crafted, but I think we need to revisit if we want to, to change it in any way.

It's been asked that we include a list of foods high in total sugars, as well, since they do have an impact on dental caries and if so, I ask the Committee how we'd like to see that constructed and how we might approach that. Another suggestion was that we could use a food label example comparing sugar content of foods. This is an example that Kathryn very nicely pulled together for me, which is a comparison of plain yogurt and a sweetened yogurt that contains sugar.

And you can see the difference in sugars and calories on that label. But we might consider something like that, that would help consumers to sort out the sugar issue on a label. Okay.

And I think lastly of the remaining issues are the sugar and non-insulin diabetes — non-insulin dependent diabetes. The etiology — and I have tried to focus on sugar and etiology of diabetes, not treatment of diabetes, because I've been operating under the principle that the dietary guidelines are for generally healthy Americans and I don't think that we want to get into disease treatment.

So the literature that I've tried to look at is more in the area of etiology of diabetes, rather than treatment. And the subcommittee had decided fairly early on that we would — we briefly mentioned glycemic index in the rationale and say essentially that there's a pavcity of data and that more research is needed. Bbut I did note that we did mention this issue in the fat rationale about how changes, you know, we talk about how very low fat diets and high carbohydrate diets may have metabolic implications and what this may mean.

But we mention it only briefly in sugars, so I think we want to have some merging of the guidelines across the document. We may need to think about how we want to approach that, not just with fat, but with sugar as well.

My last is future research, which I think we can

—

DR. GARZA: We can hold off —

DR. JOHNSON: — hold off on that. But how would you like to proceed, Bert? Do you want to go through it general discussion or, you know, section by section?

DR. GARZA: Let's begin as we have with the other guidelines and begin with the suggested guideline and then go paragraph by paragraph, and then go to the boxes, and then advice for the day. And it seems to be working well.

DR. JOHNSON: Can I just ask, is Phil or is somebody taking detailed notes about all the comments? Because I'll try my best, but I'm a little worried that I won't catch every —

DR. LICHTENSTEIN: It's on the tape. It's being recorded.

DR. JOHNSON: Well, that's true. Carol, do you take notes in the text of changes that we're considering so I could get those from you as well? Okay. Thanks.

DR. GARZA: So why don't we go with the suggested guideline and any comments?

DR. DWYER: Can you put that sheet back up?

DR. JOHNSON: The one that had —

DR. DWYER: The name and —

DR. JOHNSON: — the suggested wording and — yeah, it's in the green on this one.

DR. DWYER: Oh, there it is.

DR. GARZA: Shiriki?

DR. KUMANYIKA: Oh, I don't know. I'm a little worried that the word sugary might imply syrupy to people. It might narrow their perception of the foods that we're talking about.

DR. JOHNSON: Um-hmm. I just — I was reading some literature and they were using the term sugary foods to describe sugars — foods high in sugars, and so I thought, oh well, I never thought of that, it kind of shortened it a bit, but yeah. I

had no —

DR. GARZA: So Shiriki, you would — you would fill the top one in green?

DR. KUMANYIKA: Well, I don't know how it's perceived, but it just struck me that sugary is not common enough and people might think it means foods that —

DR. GARZA: No, I mean the very top one, which is not — I'm asking if you would say that one rather than —

DR. KUMANYIKA: Well, I don't — I like the limit sugary foods and beverages if people understand it, because it's — it's short. The other one is a little —

DR. GARZA: Choose foods and beverages you think is too long?

DR. KUMANYIKA: Yeah, the rest of it is — is —

DR. GARZA: Because I'm talking about the very top green line.

(Simultaneous discussion.)

DR. KUMANYIKA: That's the one that the group is recommending.

DR. GARZA: Then we've got some alternatives at the bottom. Okay. Meir and then Johanna.

DR. STAMPFER: So is that issue on the table now or — or what? None of those —

DR. JOHNSON: I think —

DR. STAMPFER: None of those headlines use the term added sugar. All right. Is that — are we not allowed to talk about that now?

(Laughter.)

DR. GARZA: You could easily sit here and talk about it.

DR. STAMPFER: Okay. I'd like to suggest another wording that is limit foods and beverages high in added sugars.

DR. GARZA: Johanna?

DR. DWYER: I think there is sufficient evidence to give the guideline on sugars but not to single out added sugars and the first — the first one is probably the choose foods and beverages to keep your diet moderate in sugars or something like that is an improvement over the last go- round.

DR. GARZA: Would both of you give us reasons for why you're recommending that versus the other one?

DR. DWYER: The sugary — the sugary business I think Shiriki's right. I don't — I don't, you know, what I think of is syrup, maple syrup or something. And —

DR. JOHNSON: Well, okay. I won't be able to go home if that's the perceptions, so scratch that. If it's maple syrup, I can't go home to Vermont.

(Laughter.)

DR. DWYER: And I think that the choose appeals to me.

DR. GARZA: Well, if the major concern is —

DR. DWYER: Because there's like the — if there's going to be — if there's going to be — we talked about the salt one yesterday that talked about choosing and preparing salt. The notion of choosing and I liked that idea for that guideline as well.

DR. GARZA: What about the added versus the

nonadded? Is there a major difference between you and —

DR. DWYER: Well, I think those of you who were on the phone call in August know that I don't think that it's helpful. I'm concerned about the dental caries specifically root caries, in older people and necrotic caries too. But I'm very much — I think that the evidence is compelling in dental caries that we need to focus on cariogenicities — we were talking about boxes-- maybe there are some foods that are retentive and have sugars in them that are — need to be pointed out.

So I don't — I'm concerned that we continue to focus on that even though I realize there have been advances in some respects, sealants, and things like that. There's still a lot of preventable dental caries around, specifically through candies.

DR. GARZA: Well, I know also you had some concerns about the strength of the data as related to added sugars and some of the nutrient relationships. You may want to review those for those that weren't on the phone call.

DR. DWYER: Well, in terms of the dental caries, I don't think I need to go into it, because Rachel has summarized, and in terms of the other issues, my only problem is that we don't know causation here. You know, we know associations, but not causation. That — is that the part you were talking about?

DR. GARZA: Well, you — you had listed a number of them on our phone call. That was one. You were concerned that in fact there were no health problems associated as I recall with added sugars. There was some issue of nutrient density. You didn't know of any nutrient density diseases. I mean, you went into a number of — of

issues as I recall them.

DR. DWYER: Yes, I don't think —

DR. GARZA: I don't want to put words in your mouth. Is that — is that correct?

DR. DWYER: Yes, I don't think — I think that nutrient density is a — nutrient nondensity, high-caloric density is a problem across the board. And that we need to address it. And as I said last night, I'm still concerned about these over-arching issues that affect many nutrients. And certainly, this is one nutrient or group of foods that are associated with high caloric density and relatively low- nutrient density.

The problem is the group is rather heterogeneous in terms of that particular approach. If you look at added sugars, there are some foods high in added sugars that are fine in terms of nutrient density and there are others that are not.

And so I don't think that we should go forward pushing hard on that when this is much more in tune with my reading of the science.

DR. GARZA: Meir?

DR. STAMPFER: We've had a lot of discussion on this in the past and I don't know how far to carry this, but if you — if you talk about sugar, and not make a distinction between added sugar and total sugar, you're talking about limiting fruit and milk, which are major sources of natural sugar and I don't think that — that that's the intent of the Committee.

The major problems with sugar that Rachel has pointed out come from foods with — with added sugar and we've been through this at length. I think we should just maybe take another straw vote because I think the discussion has been aired quite extensively in the last few meetings. I don't — we're just going around in circles at this point and I think we should come to a decision.

DR. GARZA: Suzanne?

DR. MURPHY: Maybe I'll comment as one of the people who was pretty convinced about added sugars being in the guideline all along, but what I've come to be more concerned about I think as I've talked to people on the subcommittee in particular is the lack of evidence I based much of mine on the nutrient displacement issue, much of my concern, because it certainly looks like adolescents at least are displacing milk with sodas.

And certainly, the association data that you look at from the national surveys maybe shows it's not a huge displacement, but any displacement of milk in adolescents is not a good thing. But on the other hand, the evidence is I believe almost totally lacking that if sodas were not available or if these kids were told not to drink sodas that they would suddenly start drinking milk.

And given the bar that we have been asked to be above on our evidence, I didn't feel it existed for this displacement issue. I don't — I personally feel that it's a real issue, but I accept that the evidence is not yet solid enough to justify changing the guideline for 1995.

And that's why I've been willing to go along with the wording that does not have the term added in it.

DR. GARZA: Roland?

DR. WEINSIER: I agree with Meir's suggestion that the title being limit beverages and foods high in added sugar for the following reasons. One in the first part, go easy on versus limit is my comments based upon the consumer's recommendation that go easy on is not firm and they actually recommended limit it. I think it connotes slightly from away the message we're trying to send.

The issue about moderate in the title up here scares me because we've been through moderate many times, and the consumers even in this section about added sugars have had trouble with it, and I think we need to steer clear of that because it's not sending a clear message.

They like it, but they didn't know what it meant, so it's been interpreted wrong. And then finally, the issue about added sugars, I think Meir and Suzanne were on target. We're not trying to limit intake of natural sugars. Certainly, as fruit, fruit juices, and milk. And I don't think we should do anything that potentially could be misinterpreted in that regard.

Even if there are some adverse health effects of all sugars, at least we know in the context of fruit juice and milk that they're going along with other nutrients, whereas once you're adding sugar, you are diluting and displacing. And that's — that's a risk that doesn't meet with the rest of the guidelines we're trying to push these other foods — and I think there's little risk of using the word added sugars here, even though technically Johanna's right. We may not have the full answer.

DR. GARZA: Any other comments?

(Pause.)

DR. GARZA: I — let me ask you all. I mean, there are some issues here that I think we need to look at closely because I — I'm persuaded at least by several of the issues that both Johanna and Suzanne raised. One is that as I read the literature and Meir can — has also looked at it, I mean, there's — there's an issue of nutrient displacement, but only for calcium. And there may be some for riboflavin as I recall that it's not here.

For most nutrients, and most age groups, we've not been able to demonstrate other than for calcium that that's an issue. And the claim that Suzanne made I find convincing that if this is going to become our calcium guideline, and that's the

reason we're doing it, we need to have some — some strong rationale for it.

On the other hand, it is added sugars versus energy intake, and I would expect to see some relationship between added sugar intake and obesity. But it's not there either. And I think that's a problem. On the other hand, the data on dental caries is pretty convincing. And therefore total sugars.

So I think we could take it on to say if we feel the data are that strong, to signal out a portion of the — of the diet and we have the definitions for it, then we can move forward. But it's pretty difficult to do it based on at least — I don't know if you really meant what you said when you said we don't have the evidence, but we should go forward anyway?

Now the other issue is — the other point that Rachel made that is more convincing that the evidence is there and I didn't look at it that clearly is that we have good evidence for displacement of foods. And if in fact the evidence is strong that — that added sugar — foods with added sugar as USDA defines them — is displacing fruits, vegetables, and grain, and in fact, we have a population that in fact is consuming above a certain level, are not meeting or — or selecting. I'm searching —

DR. JOHNSON: Well, that was —

DR. GARZA: Even more limited in their intakes than the general American population is with fruits and vegetables, and that could become a very compelling reason. But that's —

DR. JOHNSON: That was the case in the one paper when they compared women — American women who meet their DRI for calcium versus American women who do not meet it. And the women who meet it have diets that are higher in milk, grains, and fruits in comparison with the women who do not meet it, who have diets that are higher in soft drinks.

So that was the one comparison. Some of the debate in the literature also centers when you look on these nutrient displacement effects — and I'm sure Meir can help us with this — is whether or not it's appropriate to adjust for energy intake. When you don't adjust for energy intake, people who eat more foods have higher sugar intakes and therefore in general have higher micronutrient intakes because it's a linear effect.

As you eat more foods, you're going to have more intake. If you adjust for energy intake, you will see this decline in micronutrient intake as energy — as sugar intake goes up. Or if you divide the group by quartile or quintial of added sugar intake, you will see the decline in micronutrient density.

You see it with added sugars. You don't see it with total sugars because of the inclusion of fruit and dairy products. But Meir — there has been some testimony that the — when you look at displacement and you adjust for energy, that that's not how people eat, so it isn't logical. But —

DR. GARZA: Meir, do you want to —

DR. STAMPFER: I don't think you need studies or fancy statistics. If you're adding sugar, you're either adding the calories or else you're displacing those calories with calories from something else. It's not — it's just simple logic. It's — it cannot be otherwise.

DR. GARZA: The question I think is whether or not individuals who do that — I think Meir's right — whether they fall below a recommended level of nutrient intake. Now, if in fact, if it doesn't — you know, they still are meeting their nutrient requirements, then it certainly meets these — our other guidelines.

If you want to take your extra calories in that form, that's fine because you're not — you're not falling below either your vitamin C or your iron or — and as I understand it, I mean, most individuals, once you go through that mathematics, we don't have good evidence that individuals make this perhaps a larger part of the diet than some of us would like are in fact at any risk from a nutrient deficiency.

Now, if that's not correct, then we — that says — as I read the public comments and the — and the literature, that seemed to be the case.

DR. STAMPFER: Well, that would be true if — if our nation were not obese and were nutritionally replete. But those conditions haven't been met.

DR. GARZA: But then we get back to an association between added sugars and obesity, which are not in the literature. I mean, I —

DR. STAMPFER: I believe that if calories contribute to obesity, then it's unescapable that added sugar —

DR. GARZA: Should we then limit fat and go to low-fat because — we only say moderate, we don't say low.

(Simultaneous discussion.)

DR. STAMPFER: We are limiting everything.

DR. GARZA: That's right. And that's why the total sugar — because it's everything.

DR. KUMANYIKA: I had initially been in favor of added sugars, but listening to the discussion, I would be willing to give that term up for slightly different reasons. One is, I was thinking about the salt guideline. When we're recommending for less salt, we're talking about salt that's been added, but we don't — that's not in the statement of the guideline itself. That's in the implementation of telling consumers which foods are contributing the salt that we feel could be avoided.

And I'm worried about the food labels. I mean, that's sort of the one-note song I

have for this round, because if the food label doesn't help them pick it out, there are so many terms on there, I'm not sure except by talking about food groups, that they would be able to pick out what we're talking about anyway.

So I would be interested in considering other ways to modify this guideline because I don't like the way it's worded, but I don't need to have the term added sugars in it for it to be effective for the purpose, I think. So when you get finished with the added sugars issue, I'll give my other comments.

DR. GARZA: Johanna?

DR. DWYER: Well, I, you know, I can understand this business about the milk and the fruit that — as Roland mentioned. I don't think — and I think there's some data to suggest this, even around the table — that if you ask your husband or wife that they don't think that lactose and milk sugars is the sugar that's the problem. Nor do they think that the sugar in fruit, in whole fruit, is a problem.

So I'm not sure that — I think that's not something that most Americans would consider the same as a pie or something like that. In terms of the milk, milk is an interesting substance. Or milk products, if you will. And there are some interesting things there when it comes to dental caries.

Whether it's low-fat or high-fat, there are buffering systems that my colleagues at Tufts Dental School tell me are — are operating so that the cariogenicity of — of this is different. Again, there's some differences in the types of sugars in cariogenicity in that lactose is lower.

The fruits usually aren't retentive enough and neither are most of — most of those milk products. The one exception, I guess, would be dried fruits that stick to your mouth, particularly if you eat a peanut butter, jelly sandwich with raisins in it. I guess that would be a problem.

But — so I'm not sure that that's a problem. The second thing is I think the focus of what we put up there, however it's worded, but focusing on the rationale that was used in '95, and focusing on total sugars and then elaborating on the specific problems in the text is preferable because it — it's in greater harmony with the FAO/WHO '90 — I think it's '97 or '98 — statement about the evidence of — no evidence of direct involvement of sucrose or other sugars and starch and lifestyle diseases.

It also gets around my concern about a good food/bad food kind of approach. And finally, it doesn't prejudge — it doesn't prejudge this whole thing when we know that the dietary reference intake process for

macronutrients is starting maybe in a few months where they're going to have a panel of many people who are experts only in carbohydrates, which I certainly am not and I don't think some of the people around the table would consider themselves to be, to deliberate and come up with exactly what the DRI should be for this.

So those are my reasons. And for a selfish reason, I guess, Rachel has her maple syrup and I've got my cranberry juice.

(Laughter.)

DR. DWYER: I have a lot of friends who are cranberry farmers and there's no way you can make cranberry juice that doesn't pucker your mouth up without adding something to it. You can't have a pure juice in that particular thing. And that is a personal concern of mine, because I have a lot of friends who are cranberry farmers.

DR. GARZA: Well, I hate — it's — I don't have any good friends who are cranberry farmers and I suppose I could get in trouble in New York for not the same concern that — that Rachel has on maple syrup, but I would like to have our discussion on the evidence.

DR. DWYER: Fair enough.

DR. GARZA: And on the evidence, we've heard discussion on excess caloric intake consumption. We've heard issues of nutrient displacement.

And if we're going to discuss this issue, it's —

DR. DWYER: Well, let me just return to cranberry juice and the evidence because there is some evidence — it's still speculative, but it's been demonstrated in a couple of — I think the gentleman who did the study was at the Beth Israel Hospital in Boston — showing that there's some interesting effects of cranberry juice on urinary tract infection in older people.

So I don't want to disturb — have people not drinking it because it's —

DR. GARZA: I don't know whether I'm convinced by thatone food, Johanna, but it was a good try.

DR. DWYER: Okay.

DR. GRUNDY: Can I say something?

DR. GARZA: Okay. Scott?

DR. GRUNDY: I wanted to say something about evidence and how you judge it. It seems to me that there's a lot of pieces to this puzzle that relate to total — increase in total carbohydrate intake. We have evidence of that. We have evidence for increasing obesity. And we have evidence for several things.

And I think it's the requirement of this Committee to synthesize that evidence and come up with a reasonable recommendation because I think to say there's no evidence, you put out a criteria for the evidence, but you say there's no studies to show it's directly related to obesity —

DR. JOHNSON: Well, that's —

DR. GRUNDY: — that doesn't show there's no evidence. What — what that means is that there's no study that specifically asked that question. But there's a lot of pieces of evidence that we have to synthesize on this. And I think a reasonable case could be made, like Meir said, that you put everything together, it is a — a likely contributing factor to the excess caloric intake that is contributing to obesity.

DR. JOHNSON: It's not that there are no studies. When you look at cross-sectional data and try to associate sugar intake with BMI, you don't find an association. I argue in the rationalethat that's very complicated by the problem of under-reporting because we know overweight people under-report to a greater degree than lean and we know they under-report certain foods to a greater degree.

And one of those foods is sugary foods. So I agree that it doesn't mean that no association exists, but it's not exactly correct that it hasn't been looked at because it has been looked at but no real citations have been found.

DR. GRUNDY: Okay. But other things have been looked at too, so just put that in, add in the under-reporting factor, and add that into the total evidence — body of evidence that exists, and then we have to reach a judgment. My judgment is, it probably contributes to the excess calories that are driving obesity in this country.

DR. JOHNSON: Yeah, I have that —

DR. GARZA: And you mean the added sugar is contributing to them?

DR. GRUNDY: Right. I think that a lot of things are adding to it. I mean, I don't deny that other things are. But I think that we could also judge is that added sugar — it's almost certainly is contributing because it is a source of calories so then what is our judgment about the nutrient value of that?

So I think we might come up with a conclusion that the things that we can reasonably recommend reducing, that might be one component.

DR. GARZA: So I mean, but are you saying then that we have good evidence for added versus total or total carbohydrate —

DR. GRUNDY: I think that total is maybe adding too. I mean, it adds calories as well, but it — what I hear is it's associated with other valuable nutrients, like milk and orange juice and things that have other things in it. So if you have to pick and choose between the things you're going to go after to reduce, then I think a reasonable argument could be made to reduce added sugars, preferentially, to other sugars.

Maybe you could reduce everything, but you could say especially added sugars or something like that.

DR. GARZA: Do we have evidence for other than for women that it displaces other foods? I mean, other than the milk and the —

DR. JOHNSON: We have evidence in U.S. children. We have evidence in —

DR. GARZA: Are there other than milk? I mean, that it displaces their food intake or —

DR. JOHNSON: Yes. Fruit as well. And fruit juice and milk. We have evidence in children. We have evidence in American women. And I cite a number of studies in the rationale. One in Danish children and one in British adults. The weakness there is that I think the use of European studies may be fine, but we've discussed this in terms of metabolic studies, when you're looking at food consumption patterns, it gets a little sticky because food consumption patterns differ across different cultures.

I think those studies demonstrate what Meir is saying, is that, you know, when you add sugar and you adjust for energy, this is what happens. But whether or not we can translate those food consumption patterns to Americans, I think it gets more difficult.

DR. GARZA: Alice? I know you've got your hand up. Alice?

DR. LICHTENSTEIN: I'm a little concerned when I hear that well, you know, we may have a problem with cranberry juice or maple syrup or something like that. I think we have to keep in mind that we're not saying people should exclude all added sugar from the diet. And we know how much people follow the guidelines anyway.

(Laughter.)

DR. LICHTENSTEIN: So I really, you know, I — I can't necessarily accept that as an argument.

DR. GARZA: Well, it is really useful to hear that from you and Richard though in terms of how strong do you think the evidence is, or for singling out added sugars as opposed to total carbohydrate, looking at both nutrient displacement issues, which is one of the primary arguments we made in the rationale, or for over consumption of energy.

Which may be the other way that I think Scott is alluding to, because I think the rational would hang on one or both of those.

The third one counts as being the displacement of foods and that would be the one that possibly we have the best evidence for, but I have to confess I need to go back and — and look at that because I haven't looked at it that closely.

I wouldn't have any reason to doubt those of you that assure me that you have.

DR. LICHTENSTEIN: Do you want me to comment? I would have to go back and look at the studies more carefully. However, from what I've talked to Rachel about and read what Rachel has written and synthesized, I think that there is evidence that it is added sugars. I'm very impressed with the data on milk displacement and yes, if you've — if you've suddenly got kids that are drinking soda and you have to change the guideline, it's unlikely they're going to start drinking milk again.

However, my understanding is that there is evidence that once you lose a milk drinker, you won't get them back. But if there's anything that can be done to forestall losing a milk drinker, I think that is — should be a major consideration.

As far as the body of evidence, we're never going to have all the evidence that we need for each and every guideline and for anything that we do. I think what we have to do is take the body of evidence that's available, try to understand why there isn't more solid evidence. In some cases, it's because they're just real mythological issues.

All — everything seems to be pointing in the same direction from all the different sources. So I felt comfortable with the word "added sugars." I listened to the argument against that. I'm not an expert in the field. So, you know, in a sense I'd have to defer a little bit, but from my assessment of the situation, added sugars is where the problem is.

DR. GARZA: So you feel that the displacement data on milk, and calcium, on a single nutrient, would be enough to justify a —

DR. LICHTENSTEIN: Because it's a problem nutrient. It's not something like protein where we're getting more than the —

DR. GARZA: And the lack of evidence of having a — if in fact if we limited this and that would in fact cure the problem and you'd get increased calcium shouldn't be a major concern because that's a reasonable — a reasonable leap in the — in the evidence that you —

DR. LICHTENSTEIN: That if we can shift a curve a little bit, I think we would have made a major contribution.

DR. GARZA: Okay. What about the — the calorie consumption? Over consumption?

DR. LICHTENSTEIN: I'm not familiar enough with that data to comment on that.

DR. GARZA: Richard?

DR. DECKELBAUM: I think that — and this is not evidence based — but my prejudice would be that the displacement of calcium issue would be namely in the children and adolescent population, which is an important population for laying down calcium and making bone.

And then I'm not sure how strong the evidence would be as to the rest of the population. As everyone knows, we were until this meeting going forward with the concept of including added sugar in the guideline itself. And one of the questions I guess we have to ask is if it were maintained, is there a safety issue?

In other words, is it a dangerous type of guideline? I don't see any danger or adverse effects from including it in the guideline. I agree however that at this point, like some of the other guidelines that science and evidence isn't perfect or broad enough. And that may be one reason for being cautious.

But I'm not concerned about any adverse effects if the word added to be included in the guideline.

DR. GARZA: You don't feel that in fact if the evidence is not strong that individuals who in fact may have strong interests in not seeing a guideline like this would in fact discredit all of the guidelines because in fact we based one of them on less than substantial evidence?

DR. DECKELBAUM: No, I — that is a concern.

DR. GARZA: Is it not — how — how do we deal with this one then?

DR. DECKELBAUM: I think we need to deliberate a little more on it, but I would agree with what you said. We really want to present a body of guidelines which are widely accepted.

DR. GARZA: Rachel?

DR. LICHTENSTEIN: I think that point that you brought up is something which I haven't had experience with as far as, if there's less than solid data or adequate data, whatever, for one guideline, that might discredit all of them. So I'm going to have to defer on that.

There's one thing that I am impressed with and that is this guideline, with various, you know, minor changes in wording has been in place for a while. And we seem to see the consumption of sugar — or the data that I've seen has convinced me that there's been a rise in the consumption of sugar.

So that says to me that something's not working if the intent really is to get people to moderate their sugar intake. So we've got a guideline that we think should be there. We know that it's not working. So we have to think, do we just want to perpetuate it? Do we want to change it in a way that might forestall the change?

I think that's something that we need to at least seriously consider.

DR. GARZA: I mean, I — Roland?

DR. WEINSIER: There was — you said there was confusion on the basis of what

I'm saying. Let me clarify briefly. First of all, if, you know, logically you're taking a glass of juice let's say, and you add sugar to it, and you turn it into some kind of fruit-aid, you're increasing energy density. And we do have evidence that increased energy density is increasing caloric intake.

We can't go so far as to say that it necessarily results in overweight or obesity. So that's an extrapolation. But we do know the effects of the energy density when you're adding sugar or other ways that you can increase energy density. In terms of dilution, if I'm adding that sugar to that fruit juice, I am diluting the nutrient density.

I mean, that's a given. It doesn't take any logic to figure that. And if you have a fixed ceiling on the number of calories you can take in the course of a day to maintain your weight and you do add sugar to foods, then you end up — unless you're taking a vitamin supplement or some sort of nutrient-rich, you know, source to — to complement this — you are going to dilute out other nutrients.

The statement was in the 1995 guidelines that some foods that contain a lot of sugars supply calories with few or no nutrients. So this is not a new concept. I think they already had this, so we're going to have to argue again what was in the 1995 guidelines. You're interpreting it differently?

DR. GARZA: I would disagree with that. I think that statement is correct. I mean, I don't think it necessarily follows from the guideline. I mean, that would be correct.

DR. WEINSIER: Well, doesn't follow from the guideline? This is under the sugar guideline of 1995, that foods that contain a lot of sugars supply calories but few or no nutrients. In other words, the implication is that you're not picking up other nutrients in proportion to the amount of energy you're taking.

But the strongest evidence, I mean, if we're going backwards, is back to dental caries. And my concern before is that yes, I suppose if you're using a lot of fruit and fruit juice, you increase your risk of dental caries. But we're not recommending that people they do not eat at all — eat less fruit or fruit juice.

So I think we need to get a feel around the table. I don't know who else is arguing against the — the added sugars.

DR. GARZA: Sure. And I'm not at this point, to argue either one way or the other. I want to make sure that in fact everyone around the table is comfortable with the evidence, because yesterday we struck two sentences from the grain guideline because we weren't quite sure that in fact energy density would change intake or the amount of food — I forget what we were doing — because it was — there was no relationship between the amount of fiber and whether we would find it very satisfying or filling.

And I referred — I'm trying to reconstruct the discussion. Referred us all back to the — the rationale you had provided and we said, well, gee, we can't extrapolate

because of the way the studies were done by Wooderson and —

DR. DWYER: Well, we've —

DR. GARZA: I would argue that —

DR. DWYER: We've struck using meat thermometers because there isn't a randomized clinical trial. Please.

DR. GARZA: Well, the concern is — I would certainly say that there's no way you can argue that if you add sugar to something, you've diluted it. But then I have to ask, well, do we have any evidence that that's related to any nutrient deficiency.

DR. WEINSIER: What I'm trying to put together is not —

DR. GARZA: And that —

DR. WEINSIER: I'm trying to put the whole together, whether it's appropriate to have the guideline and include the "word added sugar" and I'm just trying to build on the body of evidence saying that we do have deficiencies along the way, but we also have some solid data, certainly with dental caries and a lot of suggestive data in terms of the inverse association with other more nutrient-dense foods and the relationship to energy density and the past reference to the impact of sugars on calories within the nutrients.

What I'm just saying is I think we've got a lot to build on.

DR. GARZA: But Johanna, is saying it's not added sugars, that if you take sticky fruits, you're going to have as many caries as you are from a beverage?

DR. WEINSIER: No, I thought I addressed that.

DR. GARZA: Let me — Johanna, are you convinced?

DR. DWYER: No, you know, I think there's a firm body of evidence for a guideline. But I don't think — I think the guideline needs to focus on first and foremost in terms of a disease relationship on this dental caries issue, and it's not a simple issue of added sugar. It's more complicated than that.

It's part of the problem, but not the whole problem and we should focus on what's the real problem, not simply on added sugars. It makes sense —

DR. GARZA: Let me take these comments and then we'll go to the poll that I think we do need — to begin with Meir and Johanna, and then Shiriki.

DR. STAMPFER: Let me just ask you then, Johanna, how would you recommend that somebody operationally apply the guideline limit of total sugars? Do you think that people should limit their fruit and milk intake? I mean, how would you

actually operationalize this?

DR. DWYER: I think it would make sense in terms of the dental caries not to have snacks that were made up of dried fruits that were very heavy in sugars, but basically, there are a lot of different foods that you can cut back on, including foods that even more caloric, I guess, such as foods high in alcohol and fat.

So I don't want to get into this but those are the facts.

DR. STAMPFER: But those aren't in this guideline. This is for sugars. What — what foods would you recommend people cut back on to limit their sugars?

DR. DWYER: I mentioned a couple.

SPEAKER: Dried fruits.

SPEAKER: Dried fruits.

SPEAKER: People should cut out dried fruit.

DR. DWYER: I have no problem with singling out fruit-aids that are very high in sugar, popsicles, things like that in the guideline itself or in the boxes where we talk about what kinds of foods need to be looked at. And some of them are soft drinks, cakes, cookies, things like that.

But in addition to them, there are some that are not included if you're using added sugars here. That's all I'm saying. They're all —

DR. GARZA: Meir, let me come to Johanna's rescue for just — for the sake of keeping this — making sure that we look at all the scientific evidence. I mean, yesterday we decided we were going to go to moderate fat because we were concerned that in fact that we not raise carbohydrates intake too much.

But in the public comments, there is the idea that, gee, when we take certain foods, the higher the fat content of that food, the more nutrient-diluted it then becomes and then for calories. Whether one is adding olive oil to — or whether one is taking other sources of fat, unsaturated fat in a variety of ways, in frying foods, in polyunsaturated fat, et cetera.

And how do we answer that, that in fact we singled out this class and we've got fats out?

(Simultaneous discussion.)

DR. GARZA: No, because it's a nutrient dilution issue.

DR. DWYER: No, I have no problems with the box that has these things in it. It's simply that it shouldn't be the guideline. It should not be the guideline because it

isn't correct.

DR. GARZA: But I think Meir has a point — and I think I was skipping over it — that in fact that the foods that in fact one would end up trying to limit would be those that had either sugar added to them somewhere in the process primarily. I think that was the point that Meir was trying to make.

DR. STAMPFER: Yes.

DR. GARZA: And if that's the point that Meir's trying to make —

DR. DWYER: Not always —

DR. GARZA: — then the issue that becomes, because it was in the public commentary, what do we do then about fat? And do we make the same argument there to be consistent? Because in fact, we can't argue both sides of the issue, choosing to listen to the one and not the other.

And on nutrient dilution — or is that — is that argument flawed is what I'm asking? That's — let's discuss that because it's in the public comments.

DR. LICHTENSTEIN: We decided to put a limit on fat, and we actually had an extensive discussion as to whether that limit should be liberalized a little bit and we decided — we voted that it should not and that it should remain a 30-percent calories cap so that we set a limit within the guideline.

DR. GARZA: Do you think that we've been fair to that — to that criticism?

DR. DWYER: I do.

DR. GRUNDY: You know, the best lipoprotein profile I've have seen 40-percent fat and we used to take that much fat, but it was the wrong kind. But there are populations around the world that do take higher than forty percent calories of fat. You know, they have the best

lipoprotein profile.

Now, what I tried to argue was that we will reduce fat intake by 10-percent of calories, but if you keep on reducing it, then you begin to get into potential adverse effects as you go lower and lower, so by reducing it 10 percent of calories, we hope to achieve some of the benefits of maybe not having so much caloric intake.

And so I guess I would say that we already have gone in that direction, but I think it's not safe for us to recommend at this time just to keep going lower and lower in fat calories because I mean, that's a lot of calories, ten percent of the calories. I think that we've sort of reached the limit there.

DR. GARZA: Okay.

DR. KUMANYIKA: You forgot me.

DR. GARZA: Yeah, we got sort of sidetracked on dilution.

DR. KUMANYIKA: Right. Okay. I hear a lot of things in this discussion and one is the distinction between what the guideline says and what the text says. And I am — even though I agree that I think there's enough evidence that added sugars are where we want to focus, for behavioral reasons I'm not so clear that we have to put this in the guideline.

For example, I'm trying to think of the worst case scenario. If we say added sugars, will that manage to be interpreted that you can eat an unlimited amount of some other kind of sugar as long as you don't eat added sugar? I mean, there are all kinds of consequences that could come up from trying to be too specific in the guideline itself.

So my argument is not to — not to put it in if it's polarizing or if it might not be effective, but to make it clear that that's where the behavior — we want the behavior to focus. And I'll mention my other suggestion because I think if consumers are interested in the word limit, and there is a sort of Calvinistic theme that goes along with this idea that you have to limit your sugar intake, I would modify it to choose foods and beverages to limit your sugar intake.

And that makes it clear that we want to limit it. And then in the guideline, we tell them the one you want to limit is the one that's not doing any other nutrients along with it.

DR. JOHNSON: Should I write that down?

(Laughter.)

DR. GARZA: We'll call her Mrs. Solomon.

DR. JOHNSON: Yes, say that again. Say that again.

DR. KUMANYIKA: Choose foods and beverages to limit your sugar intake.

DR. LICHTENSTEIN: It's just changing the word from —

DR. JOHNSON: Yes, taking diet out of it. You said —

(Simultaneous discussion.)

DR. KUMANYIKA: Diet is going to sound like — if you want a weight reduction diet, choose sugars, people are going to hear that wrong, I think.

DR. GARZA: And the rationale for that would be the theories and the sort of totality of evidence that leads us to suspect that there may be significant nutrient

dilution issues and overconsumption of energy?

DR. KUMANYIKA: And — right. And the evidence as Scott mentioned that there's clear evidence that if consumers take unlimited amount of calories in the form of sugar, it's related to obesity, that we want to have — that's an important message. So I think we could put the story together for that, including calorie intake and obesity.

DR. GARZA: And Scott, you're not using a different standard of evidence because yesterday when I asked you about, you know, do we have enough evidence to say that the composition of the carbohydrate in the diet affected lipoprotein patterns, you said, well, probably not. That's going too far. We don't have the evidence.

But here, the fact that we cannot relate sugar intake, as I understand it — make sure that I'm correct — to BMI is not as worrisome.

DR. GRUNDY: I think we hear the total carbohydrate intake has gone up and that must be related.

DR. GARZA: But not —

DR. GRUNDY: Yeah, so then we have to go through — we didn't say limit total carbohydrate intake. I mean, that goes against the grain of what we're doing here, right?

(Laughter.)

DR. GRUNDY: I guess something has to give and what is it going to be? Because we do need to limit total carbohydrate intake. And so what's going to give? Is it going to be grains? Is it going to be fruits and vegetables? Or is it going to be sugar? And if it's going to be sugar, it's going to be the last man out, right? Because that's going to have to give.

So which sugars is it? I mean, that's kind of —

DR. GARZA: Well, it is the sprinkle on the top of the pyramid, so —

DR. GRUNDY: Yeah, that's kind of the sequence of events that led me to that position.

DR. GARZA: Okay.

DR. DECKELBAUM: I just wonder and I'll ask this as two questions. One is in terms of the major argument being dental caries, I wonder, with the addition of fluoride to the water supply most everywhere and toothpaste, and the very, very substantial drop in dental caries, how much more added benefit are we going to get over that in terms of limiting sugar more?

DR. KUMANYIKA: Better water, probably.

DR. DECKELBAUM: Hmm?

DR. KUMANYIKA: Better water, probably.

DR. DECKELBAUM: So my — does this allow me to take in more sugar?

(Laughter.)

DR. DECKELBAUM: The other point I need to be reminded of is the overweight problem is particularly acute in the U.S. adolescent populations. So there's been a doubling and tripling from NHANES-I surveys to NHANES-III and in certain populations even tripling in the adolescent groups.

And what percent — I think we probably — what — what's the change in calories in that group of total caloric intake during that period? And what's the percent of beverages with added sugars that contribute to this caloric intake in the adolescent group between NHANES-I and NHANES-III?

DR. JOHNSON: I'm hesitant to respond because I can't give the exact number. If you look in the sugar rationale, I do cite the Harneck paper that gives you the difference in caloric intakes between the high consumers of soft drinks in comparison with the low consumers. And I'll have to look it up.

I think it's around — I don't want to say until I look. But you can — it was 188 calories higher for children who consumed an average of nine ounces of soft drinks a day in comparison with children who were

nonconsumers of nondiet soft drinks and that's from Harneck, et al. That was in JADA of '99.

DR. GARZA: So 188 calories a day.

DR. JOHNSON: To get nationwide data on the change in energy intake and the change in added sugar intake, I'd have to — to get exact answers.

DR. GARZA: And the issue there, Richard, that we'll be asked about is whether in fact one ought to then just recommend a deduction throughout the diet of 188 calories or whether in fact one takes it from a specific sector.

One might be able to, I think, to build an argument that — let's hear what the group thinks on the fact that if you take it across a diet then you lose more nutrients than if you take it from a — a beverage that doesn't include them.

DR. JOHNSON: Well, the other hole in that argument is that you don't know what the energy needs of those children are. We know that adolescent boys, for example, are taking 20 percent of their calories in added sugar on average. But we

also know that their energy needs are very high so that's another, you know, part of the argument is that we can't necessarily make the assumption that people who are high consumers of these things are the ones that are overweight, because that link hasn't been made.

DR. GARZA: Suzanne?

DR. MURPHY: Another concern I had goes back to something I think Shiriki said at our last meeting, which is that some families are overconsuming, particularly children, over consuming juices and that that indeed may be a part for concern in total calorie intake.

And one appeal of not saying just added sugars is that gets to the issue of giving your child orange juice at every meal for whatever reason. And also, Johanna reminded me of the concern certainly that we had in California about baby bottles with juice in them and the kids even two years and older running around the house with apple juice in the bottles.

So those are a couple of concerns I've had in the past that are addressed by not saying added sugar.

DR. JOHNSON: And again, I think if we're going to be evidence-based, there are papers looking at juice intake and BMI. One would show the positive influence. One which was nationwide survey data that showed no association. And I also, you know, have been told that fruit intake is well below what is recommended.

So, you know, if we're trying to up fruit intake, do we want to do it in the form of juice or don't we want to do it in the form of juice? I mean, it's another issue.

DR. GARZA: Maybe we — are we ready for the poll, or do you want to say something now? We've got at least two or three different — I mean, there is Meir's suggestion of limit your intake of foods with added sugar. Is that —

DR. STAMPFER: Something like that.

DR. GARZA: Something to that — all right.

DR. WEINSIER: Limit beverages and foods high in sugar.

DR. GARZA: High in added sugars.

DR. WEINSIER: I think that's what you said. Is that right?

DR. STAMPFER: The main dichotomy is added sugar or limit foods high in sugar.

DR. GARZA: Yeah.

DR. LICHTENSTEIN: Although the one that was up there, which I actually am impressed with, I would just suggest that it just be beverages and foods because I keep

— the recurrent theme and from the data in box 17 appears that that might be more appropriate. Rachel?

DR. JOHNSON: Yep, I got it. I'll switch those.

DR. GARZA: Okay. Are there other — other flavors of this guideline that you want —

DR. JOHNSON: We're saying choose beverages and foods to limit your sugar intake and then I have limit beverages and foods high in added sugars.

DR. GARZA: Richard and then Roland.

DR. WEINSIER: Yes, very quickly. Two points. One is in the text of the current guideline, not counting the title, where added sugars is mentioned 18 times, I mean, it's rich throughout here, so we're going to have to revise the text considerably. Keep that in mind. So there was some point that was trying to be made here about added sugars, so let's —

DR. GARZA: Well —

DR. KUMANYIKA: That's different. I mean, the evidence to use the term added sugars for implementation of this guideline is completely solid. That's different from whether it should be a part of the guideline, I think. I don't — that's implementation and that's separated from — it doesn't mean we can never mention added sugars because it means a lot in terms of behavior and what foods you would choose.

So I just —

DR. WEINSIER: Well, yeah.

DR. JOHNSON: I think there was some editing that will be required, because I will admit that in the writing that Carol and I worked on, we were working with an added sugar guideline and I think I made an attempt anyway to be consistent. And so if we change it, we'll — I mean, it will be within the context of what we're saying, but it may require some editing.

DR. GARZA: Johanna?

DR. DWYER: Yeah, I think I really do feel that if you change it — if you make it into an added sugars, you know, some of you want to do that, then the bar is a new guideline. If it talks about total sugar, it — the bar is continuing what was in the '95 guidelines. And I think there's enough evidence for continuing something on the

line of what we — the Committee concluded in '95.

But to go to something new that makes — talks about added sugars, I don't think is — is appropriate on the basis of the evidence we have now. If you can prove that, you know, this new disease emerges, then fine. But I don't — I don't see it.

DR. GARZA: Alice —

DR. LICHTENSTEIN: I wouldn't be too concerned about added sugar in the text regardless of what's in the guideline because it's a term that's in the pyramid right now. It's quite clear in terms of added sugar.

DR. DWYER: Yes, but in the guideline itself, I'm concerned —

DR. LICHTENSTEIN: Yeah, I —

DR. GARZA: Okay. Why don't we begin by taking that poll? We'll begin —

DR. DAVIS: Sure.

DR. GARZA: They make your intake out of sugars.

DR. DAVIS: Well —

DR. GARZA: All right. Johanna? Which of the — the — if you want to add a third, I mean, if you're not comfortable with either one, then let's take a poll and —

DR. DWYER: Let's see and take it from —

DR. GARZA: All right. Meir? We'll come back to Johanna.

DR. STAMPFER: The second one.

DR. GARZA: Limit beverages first?

DR. STAMPFER: Yeah, limit beverages and foods high in added sugars.

DR. GARZA: Okay. Alice?

DR. LICHTENSTEIN: The first one.

DR. GARZA: Okay. Richard?

DR. DECKELBAUM: Having our cake and eating it too. The first one.

(Laughter.)

DR. GARZA: Okay. Suzanne?

DR. MURPHY: The first one.

DR. KUMANYIKA: The first one.

DR. GARZA: Now I — first, everyone wants beverages and — Scott?

DR. GRUNDY: The question is between these two, right?

DR. GARZA: Or others that you —

DR. GRUNDY: Others —

DR. GARZA: — that you might raise yourself.

DR. GRUNDY: It seems like everybody's been voting for without added sugars. Is that right?

DR. GARZA: Well, we have — we have —

DR. TINKER: The first four.

DR. GARZA: — the first four did. I'm sorry. Four for the first one and one for the second.

DR. GRUNDY: Okay. Well, I'll vote for the second one.

(Laughter.)

DR. GARZA: Okay.

DR. TINKER: The first one.

DR. GARZA: Roland?

DR. WEINSIER: Yeah, Shiriki is great at this, but I don't know what foods and beverages to choose to limit sugar intake, so from a consumer standpoint, I'm not sure that's readily, you know, actionable. So I'm going to go with the second one.

DR. GARZA: Okay.

DR. DWYER: And I'm going to vote for the first one with the modification of "moderate" instead of "limit" and my rationale is that the most persuasive and convincing evidence is for saturated fat and we say choose foods that are low in saturated fat. And here, we're saying limit sugars, which doesn't make sense in terms of the overall guidelines.

So I vote for number one, with "to moderate" instead of "to limit.

DR. GARZA: All right. Then that's a third one. Rachel?

DR. JOHNSON: I'll go for one, with limit.

DR. GARZA: Okay. And I will go for number one. So we have a tally of —

MS. McMURRY: Eight for number one and three for number two.

DR. GARZA: I'm persuaded by the —

MS. McMURRY: I'm sorry. Seven for one and three for two, one for three.

DR. GARZA: Okay. Do any of the three of you that did not go for number one have a — and I say thinking of at least the consumers' request that in fact they found "limit" to be more useful in those focus groups, can you live with number one or would you like to have more discussion or an opportunity to convince your colleagues that in fact the seven are wrong and we can get a — can we get a consensus on number one? Meir?

DR. STAMPFER: I can live with that.

(Laughter.)

DR. GARZA: Well, we —

DR. STAMPFER: No, I think it's a bad guideline because I think the only way to achieve this guideline, unless you're limiting things with added sugar, is to — is to eat less fruit and I —

DR. GARZA: Let me be the advocate of number one with you. Let's assume that what you're doing is in asking people to have a total diet that limits their sugar intake. That permits you that if you want to have a soft drink or you want to have some ice cream or you want to have a cake, you can do that, but in fact in the totality of your diet.

And you're going to be limiting those foods and beverages to limit your sugar intake. Now, that's a — that's how I saw it as actionable, Roland, that it permitted a dietary approach rather than saying you must never eat —

DR. STAMPFER: Well, we don't — I mean, just to clarify it, the suggestion wasn't omit added sugars. It was to limit, that's all. But I don't think there are any further — I don't have any other arguments to make.

DR. GARZA: Okay. Scott?

DR. GRUNDY: I voted against it. I'll give you a couple of reasons. First of all, I think that the way we're going, nothing is coming out of this because this was was going to be the last one. Nothing is standing in the way of a progressive increase of

sugar intake in the country that's contributing to obesity.

So we haven't made any changes in the guidelines that's really going to have an impact on that as I can see.

DR. GARZA: Okay.

DR. GRUNDY: But that was before that — that's there before, okay, so I don't — I think that if you hit — if you focus on or state added sugars, at least that gives a focus to lead to some modification. And I think it would have a lot more impact and create a lot more controversy, but it would also have more impact to really say there is something there in the carbohydrate impact that we need to do something about.

DR. GARZA: Scott, let me ask you, why would you argue that in fact we have better evidence that by moderating — by liberalizing because that's the way the fat guideline is going to be read — by liberalizing our recommendations for fat intake, we're not going to be contributing to obesity, but we are with this other one, with carbohydrate?

DR. GRUNDY: Okay. The argument is that we haven't — first of all, we haven't changed the amount of fat that — and we've changed the word moderate instead of low, that is true. But I think that that comes in more in line with what we really are recommending and have recommended for a while, I think readjusting that.

And I think also in so doing we are attempting to overcome some of the problems with the excess carbohydrate intake. So I think in a way, that's — the purpose of that is to try to bring attention to the drive towards higher and higher carbohydrate intake.

DR. GARZA: But that's —

DR. GRUNDY: And that will help to some extent to do that, but I think that you need also to —

DR. GARZA: That relates to lipid profiles that you're concerned in terms of carbohydrate intake or obesity?

DR. GRUNDY: The metabolic effects are what concern me in high caloric fat intake.

DR. GARZA: Okay. Roland?

DR. WEINSIER: The reason I'm — I think we've watered this down and gone in the wrong direction. Basically the following. First of all, as I read the text and the rationale, I think it's well written and I think it gives a clear image that the issue is the added sugar that we're not trying to get the public to reduce their use of natural sugars as with fruit juices, and dairy products.

And it's useful to have a title that conveys the message that you're trying to convey. The current title — and by the way, the consumers were very comfortable and understood the words "added sugar." They had it and I think this guideline was one of the best in terms of the consumers' comments. They were right on target. They knew exactly what we were trying to say.

The interpretation impact is there. And now we're going to go with something that to me if you choose the wording of the top one, well, you can't see it there, but just change the order of what it's trying to say, to limit sugar — to limit the intake of sugars to choose foods and beverages, that was the problem I was having.

I don't — what does that mean? To — in other words, I know it's written choose beverages and foods, limit intake of sugar, but it doesn't — it's not as actionable in my mind because what we're trying to say is to limit intake of sugars, choose foods and beverages. Well, does that mean that foods and beverages decreases — it's not conveying a solid, actionable terse message that we have here.

DR. GARZA: Do any of the seven want to change their minds? Is — are you still comfortable since obviously the three did not then, before we move on to the text? Alice?

DR. LICHTENSTEIN: Is there any way, Carol, that we could get some feedback on this potential change? And that would be — you know, in a time period that would actually be helpful? Or is that unrealistic at this point?

DR. DAVIS: Certainly, we should try to straighten it out, before it's finalized — I mean before the year —

DR. GARZA: We hope to be finished before then, obviously.

DR. LICHTENSTEIN: Okay. Well, then, it's not —

DR. JOHNSON: And we did ask them to get the focus group information on added sugar, which we have.

DR. GARZA: Yeah. That's right.

DR. JOHNSON: So I'm not sure what additional information you would want.

DR. LICHTENSTEIN: Well, whether this guideline that the majority has voted for is really going to convey what we intended to convey.

DR. DWYER: If you're going to do focus work, then I think the other — the reason I was concerned about the word limit was that in looking at that versus the low saturated fat, I thought it was — it gave more power to the sugars than to the saturated fat.

And that concerns me very much because I think the thrust — the best evidence of

all, of all the things we talked about, is probably saturated fat and abuse of alcohol. So I'm very much concerned that we don't overdo it on this. And that's why I didn't like the word limit.

So if you're going to do focus groups, if you can test — get some idea of how consumers feel about those two and what they feel the message really is, I'd really appreciate that since I lost.

DR. GARZA: Alice?

DR. LICHTENSTEIN: We do have a little bit of information, not specifically addressing that, but the general consumer comments that we got was that most participants were indeed impressioned that sugar should be limited in their diets. And this is specifically addressed in the word moderate.

They were aware — and actually, the word limit was used there in describing what moderate meant in relation to sugars and most responded they felt that it meant balanced or a reasonable amount, so they seemed to interpret moderate not in the way —

DR. DWYER: That is not what I'm talking about. I'm talking about how they feel the wording of that — what we're really telling them in terms of saturated fat versus what we're really telling them in terms of sugars. Now, some of you may feel that the sugars are as bad as the saturated fat. I don't.

DR. GARZA: Shiriki?

DR. KUMANYIKA: I just want to respond to that because I understand the concern, but I see that as more of a concern related to our perception because we have refused to make these guidelines parallel in their wording. If they were completely parallel, where only the word was changed that had to do with the gradation, I could see that.

But I think that there's a more just all around each particular nutrient and that consumers are not going to compare the words specifically to get a — I mean, I think the power of the guideline depends upon how it fits consumer perceptions and some other things, not so much going parallel across the guidelines.

DR. DWYER: Well, I'm not sure I agree with you. It's like the ten commandments.

DR. GARZA: Okay. Well, we've got at least six to four, with the other four — and the other six — not moving, so let's move on. Let's go to the first paragraph then.

DR. DWYER: So what is it going to be again?

DR. JOHNSON: Choose beverages and foods to limit your intake of sugars.

DR. GARZA: Okay. The first paragraph.

(Pause.)

DR. GARZA: It would seem to me, Rachel, that we have to change the emphasis there to looking at all the sources of sugar and introduce added sugars in at that point and the role that added sugars play in the total sugar in the diet.

DR. JOHNSON: Well, I guess my question would be, do you want to start out with dental health?

DR. DWYER: I'm in favor of that.

DR. GARZA: Johanna?

DR. DWYER: I'm in favor of that.

DR. GARZA: Starting with the — with the role of total sugars in dental health.

DR. DECKELBAUM: Johanna, I asked the question earlier about what further benefit do get from fluoride.

DR. DWYER: You are on the Committee and I'm sure you reviewed that data to a greater extent than I have, since it's directly relevant to this guideline. It's my impression that they're — at least consulting with colleagues, I was told that there was still reason for concern with root caries in older people, the caries that are down here in your teeth, and that they were very much concerned about caries in young infants, in children, around the time of what Suzanne described, of kids going around with bottles in their mouths that are filled with cariogenic liquids, including —. So I think there are some reductions.

DR. GARZA: But I would also add the other issues that the committee raised, Rachel, in terms of over consumption issues that Scott feels we can justify, and I think one can certainly look at that data and strengthen that. And the other was nutrient displacement. And to introduce those three issues in the context of total sugars, I don't know whether we can do the same thing for lipid profiles.

DR. DWYER: I provided Dr. Johnson and do not have a copy of a document that's going to Headstart about concerns in infants and children.

DR. GARZA: With caries?

DR. DWYER: Yes.

DR. GARZA: Okay. But as I recall, you don't feel that the document for total carbohydrate or sugars and triglycerides is strong enough to include here?

DR. GRUNDY: Well, I think that on the balance, it is, yeah. Yeah.

DR. GARZA: Then we might want to put that in as well.

DR. DECKELBAUM: I think that Scott's argument — not — Scott's discussion on the tiering of the different carbohydrates that we can take in is always a good, strong, sensible argument. I think that before putting dental caries up there as a major rationale as the or one of the major rationales, we need to really look at the signs to justify that in terms of number, what's the percent. And an answer to the question that I asked directly in terms of numbers.

DR. GARZA: Okay.

DR. JOHNSON: I reviewed dental — I reviewed literature on dental health very early on in the process based on the literature review that USDA did and felt that there was little there that required a change in the '95. I think we pretty much left it the same from '95 with the box on dental health and maybe the information on dental health.

But I must admit that as a subcommittee, I don't think we expansively reviewed the literature on sugars and dental health because we didn't feel there was — at least in the initial run of the literature there wasn't substantial changes from '95.

DR. DECKELBAUM: So we did agree to keep it —

DR. JOHNSON: Um-hmm.

DR. DECKELBAUM: — and I still agree strongly that we should keep it, but I'm questioning whether it should be a rational up front in the first paragraph of the introduction, as the major reason that —

DR. GARZA: I think the —

DR. DWYER: I just argued that there's more consensus on that, at least in the general community, than there is on some of these other things. It's just that I don't hear the consensus on some of the other things. That may be true. I'm not saying these things may not be true. It's just that I don't know where we're going to end up on the metabolic syndrome and then some of those other things.

DR. GARZA: Okay. I mean, I think those are the major changes there. And they fall in I think with the second paragraph as well. We'll see if we can restructure that to broaden it to include these other issues. And we might want to put that in the order after the group has a chance to look at the role of dental caries and the role of the displacement issues and other things that — put them in some context that makes either sense from prevalence or severity or however you think it makes more sense.

And on how do you get added sugars, I would then be motivated by that first paragraph or that introductory paragraph.

DR. JOHNSON: So you're comfortable with leaving the title the same? Just added?

DR. GARZA: Yes, assuming I'm going to be motivated by that first paragraph. Are there any problems with that? Johanna?

DR. DWYER: I'm not concerned about that, but I, you know, said repeatedly that I think the box should show total sugars and —

DR. GARZA: Yeah, we're going to go to boxes in just a little bit. So we can stick to the text. We'll get to the boxes. Are there any issues with what's underneath? How do we get added sugars? Any problems with the text in the first paragraph or the second?

(Pause.)

DR. GARZA: Okay. And sugar substitutes?

DR. DWYER: Well, you're coming back —

DR. GARZA: We're going to do the boxes at the end.

DR. DWYER: I have a question and perhaps this is my ignorance. It says that sugar substitutes such as saccharine, aspartame, ASK, and sucrulose are extremely low in calories. Aren't they all noncaloric, or just super low, so you have a filler in it? Aren't they all noncaloric?

DR. TINKER: I think they have up to one gram of carbohydrate in them.

DR. GARZA: Now, do we want a section on added sugars in health or sugar in health — Johanna?

DR. DWYER: This is just a minor thing, but there are — what about some of these sugar substitutes that are naturally occurring sugars that are not artificial sweeteners? Let me see what one of them would be. Isomotas. I mean, there are a whole bunch that are less cariogenic and they also have less blood glucose responses than sugars. Did you consider them?

DR. JOHNSON: No, I — FDA helped us with this list. These are the approved —

DR. DWYER: Isomotas —

DR. JOHNSON: — sugar substitutes.

DR. GARZA: What is the role of sorbitols and things like that? I mean, the alcohol. Are those the ones you had in mind?

DR. DWYER: Sorbitol is one, but there are some other ones.

DR. GARZA: Alice?

DR. LICHTENSTEIN: What is it — is it aspertame? Yeah, that's used in chewing gum. Now, is that — would that be appropriate to be used under here or somewhere else? I think that's quite prevelant now. Some guidance on it?

DR. JOHNSON: We can find out.

DR. DWYER: It's also — it's got a direct cariostatic effect on —

DR. LICHTENSTEIN: That's my impression. But it's used as opposed to other sweeteners in gum and its preferable.

DR. GARZA: Okay. Yes, go ahead. You're next. I'm just struggling — it's just coming apart.

(Laughter.)

DR. MURPHY: I don't think this list has to be inclusive. This is consumers after all. I actually thought having four sugar substitutes — I thought we could just give one or two. I would sort of resist adding more names to this list for consumers to look at.

DR. GARZA: Unless we — how are we going to use them — just alert them on the market place to avoid them or include in their diet?

DR. JOHNSON: The list was expanded from '95 based on newly approved sugar substitutes that we had testimony about that should be included because they're widely used in the food supply.

DR. GARZA: So it's just an educational tool that these are the ones that are low in calories?

DR. JOHNSON: Um-hmm. And that's why it's — that's why it's expanded from '95.

DR. GARZA: Okay.

DR. LICHTENSTEIN: I would think if they're given prominence, then we should give some guidance.

DR. GARZA: Okay.

DR. JOHNSON: Okay. I'll check on xylitol. Maybe we can figure out from the Hughes Center what the base of it is.

DR. GARZA: Then I would suggest that we expand sugars and health, because certainly if we look at behavior, I mean, if in fact potatoes for example metabolize rapidly, as Dr. Meir has assured us, then the body's not going to be able to tell the difference where the glucose is coming from, from — or the sugar is coming from as

an added sugar as a natural sugar that's equally absorbed and taken up.

So we should probably broaden that to say, you know, behavior isn't influenced by any of those things.

DR. JOHNSON: Right. I need to look at that

meta-analysis. This says intake of added sugars. I'm not sure — I don't know that that's entirely correct. This is based on that meta-analysis on childrens' behavior and sugar. So I'll go back and check it out.

DR. GARZA: All right. Meir, is — I mean, if you compare the uptake of sugar from either bakery products or — or something like a potato, I mean, do you get — are increases in glucose expected to be as high and as rapid? Or should we not worry about that because —

DR. STAMPFER: Well, I don't know — I don't want to tell you what to worry about, but in — because potato is basically just a glucose polymer, it leads to an extremely rapid increase in the blood sugar, faster than table sugar, because table sugars are fructose and glucose.

So the answer is potatoes would give you a sharper rise in glucose than say baked goods with fat in it and sucrose.

DR. GARZA: Please take a look at it and how they analyze the data, Rachel. Richard and then —

DR. DECKELBAUM: I was just going to say, those studies on behavior and sugar in children were on added sugar and I don't think they —

DR. JOHNSON: Was it added? I'll —

DR. GARZA: We have to check on it.

DR. DECKELBAUM: They were on sort of candies and added sugar sources and I don't think potatoes would have been included.

DR. GARZA: We'll —

DR. JOHNSON: I'll check the meta-analysis.

DR. GARZA: Johanna?

DR. DWYER: I don't think that the issue with the whole business with potatoes is as simple as you made it seem, Dr. Stampfer. It's — at least the evidence that I've read suggests the different kinds of potatoes and different kinds of starch that are present, whether it's — it stood out all of these different things, the other foods that are eaten with it, particularly the fat and protein, all affect — and the fiber that are

included — all affect whether glucose rise and not just a simple thing.

A substantive comment under sugars and health is that I think dental caries should be moved up because the evidence is strong for them. It's weaker for weight control, in my judgement. And it's the weakest of all behavioral effects. I feel we should put the strongest evidence of health effects first.

DR. JOHNSON: Okay. I'd like to make a correction in the weight control before we — I think to be totally accurate, it should say between 1989 and '95, Americans or childrens and adults increased the amounts of carbohydrates they consumed — consumed. In children, this has been attributed to increased sugar intake in the form of soft drinks.

And I think that's actually a more accurate reflection of the literature than the way it's stated now.

DR. GARZA: Okay. We are going to Alice and then Roland.

DR. LICHTENSTEIN: Well, I actually question whether we need a paragraph on behavior since we're saying that the evidence indicates that there doesn't seem to be an effect and we don't put — there doesn't seem to be affected learning ability or anything like that. So I think it's something that is no longer an issue.

And then since we decided in the first paragraph to include dental health over consumption over nutrient displacement and whatever order it turns out, if the literature supports it, then I think perhaps that's how it should appear in the — in this set.

DR. JOHNSON: I'd like to argue for keeping the paragraph on behavior. I think it was put to rest, but I think it's still a big issue. There are school systems that will not allow the schools to serve flavored milk because the teachers think it makes the kids hyperactive in the classroom because of sugar.

I really think that we need that paragraph on behavior.

DR. DWYER: Amen.

DR. LICHTENSTEIN: Well, maybe just move it to the end? Hopefully —

DR. JOHNSON: Yeah.

DR. GARZA: Roland?

DR. WEINSIER: Yeah, also under weight control, Rachel, consider not putting the dates in. Whenever you include the date, it dates the document. By the year 2004.

DR. JOHNSON: I thought of saying over the last decade, maybe something —

DR. WEINSIER: Or simply say that —

DR. JOHNSON: Americans have increased —

(Simultaneous discussion.)

DR. WEINSIER: Soft drink may increase —

DR. JOHNSON: Okay.

DR. WEINSIER: — or has been found to increase towards caloric intake.

DR. GARZA: Suzanne?

DR. MURPHY: Yeah, I'd like to see the weight control either modified or slightly expanded. This seems to be a nice opportunity to say some of the things that Committee members have been saying this morning. Foods that are high in sugars are often high in calories as well, or something to that effect.

In the last sentence, I'd modify it to say something about keep an eye on serving size for all foods that are high in calories and low in nutrients. I think that's a theme that has not recurred enough in our guidelines. I can —

DR. DECKELBAUM: Following up on what Suzanne just said, I think this would be a good opportunity in this paragraph to state that again the — in terms of taking in sugar, that it would be best to take in the sugars from fruits and vegetables and from grains because — or other carbohydrates, because they carry added nutrients with them that will help them form up —

(Pause.)

DR. GARZA: Okay. Shall we then go to the boxes? Box 17 —

DR. JOHNSON: Could I just make —

DR. GARZA: Yeah.

DR. JOHNSON: — a few points about — well, okay. Box seventeen. I know that Johanna has requested repeatedly that we include foods that are high in total sugars in this box, and Carol and I have talked about this and, you know, we're just not sure how to compose such a list.

So if that's on the table, we need some help on what we would put in there.

DR. GARZA: Would we — one that in total sugars of foods that are commonly consumed in this — in this country and look at — at content and consumption? Or just content or —

DR. DWYER: Well, it seems to me it should be done in a parallel. You said that the — the major sources of added sugars in the United States were foods that contributed two-thirds of added sugars? Is that what you said?

DR. JOHNSON: We ran an analysis of CSFII data, looked at the food that contributed to added sugar, and this list is about two-thirds, isn't it? I think it was about 66 percent.

DR. DWYER: And can you run the same thing for total sugars, even with the CSFII database? Or if that

database is inappropriate and cannot be used for total sugars, maybe the NCHS or the Minnesota database or some other data base could be used? Is it true that you cannot run total sugars on CSFII database?

DR. BOWMAN: That is correct.

DR. DWYER: Why is that?

DR. BOWMAN: Pennsylvania prescribes it.

DR. DWYER: Is there a way we can get better?

DR. GARZA: Suzanne?

DR. MURPHY: I suppose there is a way. Whether we can do it in the time frame and whether it will add what we ought to add to this document is very questionable. I've heard the figures on the contribution of lactose to sugar intake and it's remarkably high. I mean, I think any list you generate is going to have milk on it and other — I personally am not going to be happy with a table that says limit milk intake.

DR. DWYER: Where — where is the table that says that?

DR. JOHNSON: Well, if we look at total sugar —

DR. DWYER: It says major sources of added sugars in the United States.

DR. MURPHY: But Johanna, if we do total sugars, milk's going to come on that list. It's inevitable. Fruit's going to come on that list as well. I mean, it's the argument that several people have been making, that we don't want people to limit intakes of nutritious foods.

I would argue that we maybe don't need box 17. I was very fond of the box that was in the '95 guidelines, that had the ingredients, because I think that's what we want consumers to do, is look at the label and look at the ingredients. I think we're in trouble if we start doing sources of total sugar intake in the U.S.

DR. DWYER: What page is the —

DR. JOHNSON: Thirty-four. So you're arguing Suzanne to scrap the list of data sources — major food sources of added sugars and replace that with a list of ingredients on the label that would represent sugar in the food. Is that what you're saying?

DR. MURPHY: Correct.

DR. GARZA: Well, there may be a reason for considering both. Let's — let's talk about it a little bit more.

DR. DECKELBAUM: I would agree with you that box 12 on page 34 of the previous guidelines is actually a very good box because it helps the consumer look at the individual contents and pick out on their own sugars. But I would not eliminate box 17 because these are really — these items, when we discussed it, it's as Rachel said, counts for two-thirds of the added sugars and by knowing these food items, people can quickly avoid excessive intake of these types of foods, which are responsible for a major source of sugar intake with empty calories, quite often.

DR. GARZA: Okay. We are going to go down the row now. Alice?

DR. LICHTENSTEIN: In addition to what Richard just said, I think it's more likely people are going to recognize foods. I think it's unrealistic to expect that people are going to start reading labels.

DR. DECKELBAUM: But some do.

DR. GARZA: Alice, are you arguing for including box seventeen and not both?

DR. LICHTENSTEIN: No, I actually —

DR. GARZA: You want both?

DR. LICHTENSTEIN: Yes.

DR. GARZA: Okay.

DR. STAMPFER: I think the tenor of this discussion shows what our problem is, that what we're — what we really want to tell the people is don't eat added sugar. Why don't we just say that?

(Laughter.)

DR. STAMPFER: And if that's not our issue, then we should have a box parallel to box 17 that just gives the total intake and milk will be on there. I mean, you know, we're acting in a schizophrenic way here. We should say what we mean.

DR. GARZA: Well, I don't agree with you, but I'll come back to you.

DR. DWYER: I think that the — box 12 of the dietary guidelines of '95 is fine to add. And all I would ask is that if you want to include the major sources one, that you also include total sugars. And the reason is because I do think there are some foods that are high in sugars that are fine to eat. And it says at the beginning of the guideline as revised something to that effect.

So I don't —

DR. JOHNSON: So you want —

DR. DWYER: I do want that as well, but I think that this is a good place to be —

DR. JOHNSON: Yeah, I'm not sure how to create that list. And what the — you know, if we make that list is the intent that some foods that are high in sugar are okay to eat and some aren't, and that that's —

DR. DWYER: Isn't that true?

DR. JOHNSON: Yeah, but what would the title of the box say? How would you —

DR. DWYER: Major sources of sugars. Added sugars and total — all sugars.

DR. KUMANYIKA: Where are you going —

DR. GARZA: This way, but I think Suzanne's already spoken. I don't want to —

DR. MURPHY: I've given my opinion.

DR. GARZA: Okay.

DR. MURPHY: But I disagree.

DR. GARZA: Suzanne? Shiriki?

DR. KUMANYIKA: I think we should definitely keep box 17 and I'm wondering if something could be added to it. I'm not sure it's feasible but I want to think aloud for a minute. If we could add other nutrients that these foods provide or don't provide, it would show, for example, that a lot of the fruit drinks, because they're fortified, are sources of vitamin C in the diets of some — I mean, they're really an incredibly large source of vitamin C in some calculations.

And the dairy desserts would show what dairy — and it would show that the other foods are not really, you know, 10 percent of the daily value of some of the other things we were targeting. But that's one thing I would like to think about if it's feasible to illustrate the notion of the empty calorie type notion by showing the nutrient content for some other things of these box 17 foods.

DR. JOHNSON: Shiriki, could I just add, I think to follow on that, I was going to suggest maybe the inclusion of a comparison food label that we might be able to pull in something like that for the food label comparison. Just a thought.

DR. KUMANYIKA: Well, I think that the reason that these sources are so interesting to us is because most of them are not major sources of anything other than calories. And we talk about this notion, but we don't illustrate it, except with the sentence that we had, you know, that some foods provide calories, but any of the nutrients.

And this might be a place to illustrate that and drive the point home even clearer that if you use your calories in this way, this is all that you're going to get, is calories. And that that might be your goal, but it might not. So I think we definitely need this box. And I don't think that this is going to become a carbohydrate guideline unless we rewrite it.

So I'm not as concerned about giving a lot of other information about sources of carbohydrate in this particular guideline. It's a limited guideline that has a different purpose I think.

DR. GARZA: Thank you. Johanna?

DR. DWYER: Well, I, you know, that's what I'm trying to get at. And maybe I'm just not phrasing it well. There are some foods that are reverse, so to speak. Most of these are high in calories and little else, and I think the point needs to be made that these are foods that can be — should be moderated or limited.

But then there are other foods that are very high in nutrients, as well as high in sugar. And these are not foods I'm necessarily advocating, but they do exist. Sugared cereals, it turns out that the dried fruits are very high in sugars, have a few nutrients in them, depending on the fruit.

So it seems to me if you make such a thing, maybe put a whole bunch of things down, not just a label with some yogurt on it. But have a couple of foods that illustrate you have to pick and choose.

DR. GARZA: Is there anybody on this side who wants to — because we were going down this way before. Alice? Lesley?

DR. TINKER: I support keeping the box 12 from the previous guidelines and leaving box seventeen as it is and focus on the added sugars to give people the choice of the foods that do have added sugars without the added nutrients.

If we add total sugars, I think it will be really confusing and get into good foods/bad foods without a lot of consumers trying to make a lot of decisions which then dilutes maybe the message of this guideline, which is the dental caries and added sugars.

DR. GARZA: Roland, do you have your hand up or not? No?

DR. DWYER: But doesn't the book — now it's just the bad foods.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I think we have to come back to what the intent of the box is. I think to reassure ourselves, it might be helpful to add additional information to the box. However, I think it's going to be very confusing to consumers.

DR. GARZA: Suzanne?

DR. MURPHY: Well, I think this is getting at my concern as well. We'd like consumers to understand the concept of foods being high in calories and low in nutrients, and vice versa. I like the idea of giving an illustration of the fats specifically.

But I'm not sure giving a list of foods — presumably we're telling people to limit and avoid — doesn't put us right in the good food/bad food situation that we're trying to get out of. Aren't we better off not having box 17 and doing examples of foods that are high in nutrients and low in calories or vice versa?

DR. GARZA: Alice?

DR. LICHTENSTEIN: This is one case where I think box seventeen says what we want people to limit and it's actually quite appropriate.

DR. GARZA: All right. Let's come back to box 17. Box 18 has some related issues, I think, but Suzanne? Is that box all right?

DR. MURPHY: What?

DR. GARZA: Eighteen?

DR. JOHNSON: I — we did have a point, I believe it was yesterday, that we wanted to add something about dried fruit in box 18 because we want — I think we took it out of the fruit and vegetable guideline because we were promoting intake and we said it really belongs in the sugar guideline and I felt it belonged best to put a bullet in line 18 about dried fruit.

What's in your mouth? Shiriki, can you her to rinse out her mouth.

DR. GARZA: Johanna?

DR. DWYER: I think there are some wording changes, like between meals, eat sugary, starchy foods, or sugary foods and beverages. Don't —

DR. GARZA: Is it primarily editing —

DR. JOHNSON: This comes from '95.

DR. DWYER: Yeah.

DR. JOHNSON: This is almost the same —

DR. GARZA: If it's editing, send them in to —

DR. DWYER: Yeah.

DR. GARZA: — but if it's substantive, then we can talk about it. Then let's get back to then box 17. Do you want to look at the yogurt example? Is that what you were going to suggest?

DR. MURPHY: Well, I thought that this was — everybody got a copy of this yogurt label. I appreciate Kathryn putting this together, but I realize she was working under a pretty strict time line. But it's an example of a sweetened yogurt versus a plain yogurt. And it clearly shows there's sugar, 44 grams in the one, and only 10 grams in the other.

And here's an example of a — a very nutritious food, plain yogurt, can be much higher in calories and much higher in sugar, the addition of syrup. I think those are interesting examples we could incorporate, so that's —

DR. JOHNSON: I think my concern with that example is consumption patterns. I'd be surprised that very many people consume plain, unflavored, unsweetened yogurt on a regular basis. So I almost think that puts us into this food police thing. Like who is going to eat that? I know there's usage of it, but I think a lot of people might use it in cooking or in flavoring or some way.

DR. MURPHY: But maybe we could find other —

DR. JOHNSON: Yeah, that's what I was thinking, if we could think of something else.

DR. GARZA: Maybe we could get you and then you work on Suzanne and Carol and we'll see how we're going to solve the box 18 issue and the —

DR. JOHNSON: Well, I would like some guidance on whether it's staying and we're adding a label comparison or we're substituting a label comparison, because I don't —

DR. GARZA: You don't want both choices? I mean —

DR. JOHNSON: Oh, you — we're not in —

DR. GARZA: I agree that we're going to go around the table and —

DR. JOHNSON: Oh, right. Okay. I thought you were closing the discussion, I'm sorry.

DR. GARZA: Would you like both?

DR. JOHNSON: I would like both. I would like box 17 to stay and have a label comparison of similar foods, one of which is higher in sugar and calories to show how you can —

DR. GARZA: Okay. So the word you're asking for some guidance on is whether we eliminate 17 and have 17 or something like 12 —

DR. JOHNSON: In the old 12.

DR. GARZA: — in the old — guidelines and I think those are the two choices. No one is arguing for having only 17 without the other box.

DR. JOHNSON: Okay. So we have adding 12 —

DR. GARZA: Or eliminating 17.

DR. JOHNSON: Or eliminating 17. Can we have both?

DR. GARZA: Or both.

DR. JOHNSON: And the ingredient labels is another issue.

DR. MURPHY: What about Johanna's suggestion?

DR. GARZA: Of adding total sugars. Okay. So we've got three combinations and almost every iteration of the three, it is box 17, box 12, and then an additional box on total sugars. So if you go down and let us know which of the three you want, all three or any combination —

DR. DWYER: I'm sorry. I thought that Suzanne had made another proposal, which was that she would list a whole — you mentioned the yogurt comparison, the sweetened yogurt and the not-sweetened yogurt?

DR. GARZA: That is probably not a good one.

DR. DWYER: You didn't — well, it was two foods that — I like that idea, and it gets across what I was trying to do by adding to this box.

DR. GARZA: Okay.

DR. DWYER: But I just would suggest that there be several foods. I like that idea.

DR. GARZA: So would you do that in place of box 12?

DR. MURPHY: Seventeen.

DR. GARZA: So you would have both the comparison that you had and this one?

DR. MURPHY: And the one from the '95 —

DR. GARZA: So we have four. Okay. Does everyone here on the four — you can — you can let us know on any combination of those four. Johanna?

DR. DWYER: I think that the box twelve —

DR. GARZA: Can somebody keep track of this? Box twelve.

DR. DWYER: And the list of foods, both ways, is good.

DR. GARZA: The list of foods — the label comparisons that —

DR. DWYER: Correct.

DR. GARZA: All right.

DR. DWYER: And box seventeen.

DR. GARZA: And you don't want a total food, a total sugar —

DR. DWYER: I want a total sugar —

DR. GARZA: So you want all four? You want all four boxes?

DR. DWYER: Um hmm. Yeah.

DR. GARZA: Okay. Meir?

DR. STAMPFER: I would go for box 17, box 12. I don't see how anyone who voted for the total sugars can avoid voting for total sugar in the box, but since I didn't, I vote against that.

(Laughter.)

DR. GARZA: Thank you for your comments. Alice?

DR. LICHTENSTEIN: I vote for box 17, box 12, I have no problems being schizophrenic. And I am concerned — if you can come up with two labels that are really reasonable options, I can see doing that. I'm very concerned — I agree with Rachel. I don't think there's really a choice for a person whether to get a plain yogurt or a fruit flavored yogurt, and especially because that's a nutrient with the calcium that we seem to be lacking in. So it has to be I think a really reasonable choice.

DR. GARZA: So you want all three there?

DR. LICHTENSTEIN: I'm not enthusiastic about the label, but I could be convinced if —

DR. GARZA: So two, plus maybe the third? All right.

DR. DECKELBAUM: I'm in favor of box 17, box 12, and the label comparison, but using a different type food than yogurt, because yogurt is such a positive food for calcium and other nutrients.

DR. GARZA: Okay.

DR. MURPHY: Okay. So I'm box 12 from the '95 guidelines and the labels.

DR. GARZA: Okay. Shiriki?

DR. KUMANYIKA: Twelve, 17, and labels.

DR. GARZA: All right.

DR. GRUNDY: Same.

DR. TINKER: Same.

DR. KENNEDY: Same.

DR. WEINSIER: No. I thought you were saying same.

DR. GARZA: I know you want to get out of here.

(Simultaneous discussion.)

DR. DECKELBAUM: Seventeen, 12, I'm not quite uncomfortable with that.

DR. GARZA: Some of us were quite optimistic by bringing in our luggage.

(Laughter.)

DR. DECKELBAUM: Yeah. Seventeen, 12 only. I'm uncomfortable with the label. It takes too much explanantion.

DR. GARZA: And I would tend to be with 12, 17, and I'd like to look at the label comparison.

DR. JOHNSON: And I vote you, Bert. I'm saying that I'm very cautious on the label, when we talk about good food/bad food that we're going to hit similar foods from similar products. So we'll see.

DR. GARZA: Okay. Advice for today.

DR. JOHNSON: I think the first sentence, to be consistent, is going to have — well, we used go easy on from the guideline, they can say limit beverages and foods that are high in sugars.

DR. GARZA: Roland?

DR. WEINSIER: I think that another place instead of using the word milk in the middle of the paragraph we're using dairy now, but —

DR. JOHNSON: Okay.

DR. WEINSIER: — but I believe it's — I believe what we should be doing also, it says the second sentence, get most of your calories and gives the first food breads. I would stick to the categories. Get most of your calories from whole grains, fruits, vegetables, et cetera.

DR. GARZA: So you would — if we're going to stick with it, you'd say grains and whole grains? Or just whole grains?

DR. JOHNSON: Grains, especially whole grains?

DR. WEINSIER: Well, either way. The main thing to me, I just wouldn't isolate the simple source with whole grains.

DR. JOHNSON: Okay.

DR. GARZA: Shiriki?

DR. KUMANYIKA: Is it helpful to add water here? I mean, we're talking beverages and —

DR. GARZA: Try water as a thrist quencher. I like that.

DR. JOHNSON: We do have water earlier, but if you want to emphasize it —

(Simultaneous discussion.)

DR. KUMANYIKA: I mean, I'm not a milk drinker, so it wouldn't have — I would like to see a beverage mentioned that's not milk or not —

DR. GARZA: All right. On research, I'm going to take an unusual step and make a comment before Rachel does. I think this guideline has proven the most difficult and troublesome to both departments for us because in fact the data that we've had to work with has really been appalling in many respects.

And since this was an issue with the last guideline committee, I certainly think that both departments need to provide at least — and hopefully will provide some guidance as well — a much better database than we had available to be able to deal

with this.

I mean, when I read the input from the written comments we've gotten from a wide variety of groups, I'm amazed that everyone is looking at the same data set. And generally when that happens, it's because the data are such poor quality that in fact it generates the data, the kind that we've heard, and because this is such a recurrent issue to our federal policy, then as we start thinking about research recommendations, it's really going to be incumbent upon all of us to help this working group identify those issues that prove to be the most problematic.

Because I think everybody's goals were the same and that is obviously the health of Americans. Many of us were torn because we think we know and yet on the other hand, when we look at the database, it's very difficult to objectively defend.

Others were convinced that the database was quite adequate. And while this was not unusual in nutrition, it seems to be particularly true of this issue. And so that five years from now, we'll try to provide some guidance as to the type of data that we need, but just as two examples, I mean, not being able to calculate total carbohydrates and — and it's extremely frustrating.

DR. DWYER: Total sugars.

DR. GARZA: Total sugars. Yeah. And being able to identify the sorts of relationships and the strengths that we've been struggling with has been very difficult for this group. So on — on that note, Rachel, we'll try to be very helpful and I'll certainly congratulate you for a very difficult job.

DR. WEINSIER: Can I make a comment? The rationale section, I think it's focused largely towards the previous title, now with the title change I think the rationale now needs to perhaps be reviewed —

DR. JOHNSON: Yeah.

DR. WEINSIER: — because it starts out and repeatedly throughout makes a strong case for why the focus has changed from the previous guideline. And the text to a certain degree does that, but the title does not, and I think the rational needs to go back and explain that we are focusing on the title on total sugars.

DR. GARZA: Yeah. I agree. Thank you.

DR. WEINSIER: But it is going to change the text considerably if you do that.

DR. JOHNSON: Well, I think that I'll start out focusing on the major diet-health relationship, which is dental caries and adding some more text about that and moving into the added sugar because I didn't hear today that the, you know, the text in the consumer booklet was changed very little.

DR. GARZA: So the first paragraphs were changed. The first two paragraphs.

DR. JOHNSON: Um-hmm.

DR. GARZA: But I think — and the outline that Scott provided in terms of the various displacement issue and the over consumption issue, they need to be covered in there. Johanna?

DR. DWYER: In the research, perhaps you've already got it, Rachel, but in addition to the need for

databases that appropriately reflect all of the carbohydrate, not just the — not only the saccharides and oligosaccharides, but also the starches, the resistant starches, and nonstarch polysaccharides, the additional problem is that there must be greater attention paid to food composition and analytical work to develop these numbers.

Because the numbers are largely British and Australian, for a lot of those later things.

DR. GARZA: Let me make a suggestion because — Suzanne and I just talked. We're going to work through lunch and so as we get to the research issue, let's take a ten — a short ten-minute break, come back and talk about research and then continue with the rest of the agenda until we adjourn at 2:45. Ten minutes.

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(Wherefore, the meeting was adjourned until 11:25 a.m.)

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AFTERNOON SESSION

DR. GARZA: Will the committee members please take their seats and we'll move on to research?

(Pause.)

DR. GARZA: Okay.

DR. JOHNSON: Go?

DR. GARZA: Yes.

DR. JOHNSON: Okay. Future research. I think we've already talked about this idea that if foods high in added sugar are limited, what effect would this have on the intake of more nutrient-rich foods? We know there's an inverse relationship between these foods. What we don't know is if somehow you could create an environment where there was less access to foods high in added sugar, what would that do to intake of other nutrient-rich foods.

I think there are some issues about sugar and its association with BMI and how — is there a way that we can get at this issue, if it in fact exists? If such an association exists, and how do we adjust for this pervasive problem of under reporting?

I'm very familiar with the dietary intake methodology literature and I know that we're trying to move that field forward in a way that addresses these significant and pervasive problems of under reporting and how we can deal with some of the relationships between diet and disease in context of under-reporting.

I think we need more in the area of sugar and glycemic intake and etiology of non-insulin dependent diabetes. In terms of this guideline, I think much more in the area of etiology, as opposed to treatment.

We've talked briefly about metabolic consequences of high carbohydrate diet, and there is an emerging literature that says that the lipid protein profile is impacted by the type of carbohydrate that is substituted for fat, but I think that literature is yet emerging and we need more work in that area.

There's been — there were questions about how you best analyze databases to look at nutrient density issues. Is it best to just look at absolute intakes? Do we need to adjust for energy? Do we need to look at cortiles as a percent of energy from added sugar? You know, how really do we want to approach these survey databases to best examine them for any types of nutrient displacement issues?

And then I added basically number six which was what Bert and Johanna were talking about, which is some additional variables in the nutrition survey databases would be very useful. Whether it's total sugars or chemicals, or I think we've named

the number here today that certainly the — the database could be even more useful to researchers with some of these additions.

But that's —

DR. GARZA: Lesley?

DR. TINKER: Thanks. That's a great list. I have a suggestion to add to number one, and that would be to — to not only look at the more nutrient rich foods or potential impact on more nutrient rich foods, but just the nutrient profile in general. I'm thinking of what unintended consequences might come out of that.

DR. GARZA: Johanna?

DR. DWYER: I think that these are all interesting topics, but that the fundamental problem that we will contend with increasingly in the next five years is the lack of good food composition data on non-starch poly saccrides, recent starches, the resistant starches, as well as all the other things.

And we need to add to that list analytical work on food composition on the chemistry and also on the effects of these various forms of carbohydrate on absorption and metabolism.

DR. GARZA: Other points?

DR. DWYER: Since Dr. Deckelbaum raised the issue of the effects of the whole issue of carbohydrates and dental care, diet and dental care, it would seem to me it might be appropriate to re-evaluate that and offer studies to re-evaluate the impact of diet on dental caries?

DR. JOHNSON: Yeah, and maybe the impact of bottled — non-fluoridated, bottled water as well I think is a concern.

DR. GARZA: Shiriki, then Roland.

DR. KUMANYIKA: I would like to add research on the industry response or food marketing practices in relation to this guideline, because that's the other piece of the equation on consumer behavior that we don't — we can't anticipate until it happens and see how it all takes off.

DR. GARZA: Roland?

DR. WEINSIER: Yeah, I would expand number six slightly where I think it says definition of sugars and added sugars to include in there a distinction on health outcomes. I mean, we're lumping added sugars and we've listed all these sugars in box twelve in the '95 guideline, and I honestly don't know if I had to make the choice, is honey better than brown sugar? Better than corn syrup, etcetera, on various — so the first step is define it. Second of all is to distinguish the impact and

health outcomes.

DR. GARZA: It may be included in the point that Johanna made in terms of being able to measure this and gain a good estimate. I know there's some controversy over how we estimate added versus non-added sugars and total

sugars — total carbohydrate in our dietary surveys.

But I'm — I mean, obviously, if we're ever going to get a handle on this, we need to be able to measure it, and I would also make a plea that in fact looking at health outcomes is crucial. And if I look at the various guidelines, the sodium guideline, the alcohol guideline, the lipid guideline, when I contrast the amount of data we have to work with in terms of health outcomes, and then look at this, it's dwarfed.

And I mean, it's not because it's not been an area of controversy. And I think as both public comment and our own discussion have amply demonstrated — and not to have as a database that is commensurate with that need in terms of looking at health outcome, really has made I think this committee's job very difficult.

And so I would make a plea that in fact we look at that, the measurement issues, because in fact then we have to look broadly at health outcomes that people suspect may be out there, and be able to deal with this in a much more satisfactory manner than we have been able to do because of the database we worked with.

DR. LICHTENSTEIN: I would expand on what Shiriki said. I think we need more data on exactly how the guideline is perceived, how it's translated into behavior. And if it's not translated into behavior but the intent is perceived why — one way or the other way — especially in light of what we've seen in response to the prior guidelines addressing a similar topic.

DR. GARZA: Johanna?

DR. DWYER: Two other issues. One might be lactase deficiency, lactose intolerance, and the health outcomes associated with that in terms of these particular sugars. The other might be if it's interesting to track things — someone made that suggestion — it might be interesting to see what happens as a result of this is that people start adding fortificants to soft drinks and to some of the foods that are listed in the box seventeen.

DR. GARZA: As we draw this discussion into a close, I'd like each of you to reflect on what made the guideline problematic in terms of the science and does this — I mean, if we had this type of data, would that have informed your discussions or are there other issues that we've not included in that list? Johanna?

DR. DWYER: One other in terms of the food cariogenicity issue is that better methods for evaluating the many factors that influence cariogenicity of diets, especially from dietary data, need to be developed. It's a little tricky to do it because it isn't a food-related thing. It's a whole bunch of things.

DR. GARZA: Roland?

DR. WEINSIER: Yeah, I don't remember — I don't think we had this up there, Rachel, the impact of sugar substitutes on health parameters, particularly body weight and also other health parameters? I mean, the data available, in terms of weight, are dismal in terms of showing any positive impact, and yet we're spending a lot of words discussing, you know, this — we don't make overstatements here or reach conclusions that are inappropriate, but I think we need data if we're going to continue to discuss the role of sugar substitutes.

DR. GARZA: That's a good point.

DR. JOHNSON: Okay.

DR. GARZA: Are there others?

(Pause.)

DR. GARZA: Thank you very much, Rachel.

DR. JOHNSON: Thank you.

DR. GARZA: That concludes the introduction and if all of you could take out the ABC format that we were given on Tuesday, I think it was, at about seven in the evening.

DR. DWYER: Bert, I'm afraid some of us don't know what you're referring to.

DR. GARZA: The ABC format for the guidelines. Aim, build, and choose. It's a sheet, a single sheet.

DR. DWYER: I'm totally lost.

DR. GARZA: It looked like this. And so the cover would read something like "aim, build, and choose for good health with aim for fitness, build a healthy base, and choose sensibly". With "aim for fitness" would be the weight guideline and the physical activity guideline, "build a healthy base" would be the — what we're alluding to in the pyramid as the adequacy guideline, the fruits, vegetables, grains and food safety, and "choose sensibly" would be for fat, sugars, salt, and alcohol.

DR. DWYER: Who thought of it?

DR. GARZA: The staff did. I don't know who on the staff here, but I thought it was Solomonic. Who — does anyone want to take credit for this good idea?

MS. McMURRY: This is a group effort.

DR. GARZA: I probably should have said that a long time ago, right? No, I

thought that it was quite good as well. I was concerned about, you know, we talked about tiering them and while this doesn't exactly do that, even if somebody were to extrapolate to that degree, it's not a back- tiering either, because in fact if we had everyone be of adequate weight and be physically active, then they would probably be implementing the building the healthy base in order to achieve that, and choosing extensively.

And so I thought it was quite a — quite good from every perspective I've tried to evaluate it from, even the ABC one that I discussed with you at the end of the day. Somehow consumers mean A means it must be the most important. B must mean less so and C must mean the — thinking of grades, which many of them might.

As I've tried to put myself in a consumer box and I don't see any — well, a minimum risk for misinterpretation, but let's see if you all agree. Roland?

DR. WEINSIER: First of all, I think it's outstanding. It's a far cry better than what the rest of us have been able to come up with. A consideration under build a healthy base. I'm not sure but what the base is and to try to incorporate the food safety guideline in this. Would it make sense, since it's all under dietary guidelines, to say "build a healthy pattern?"

And then the pattern could be ill-defined in terms of it's sense of the food you eat, but it's also the way you prepare and shop, and then we can keep the food safety guideline in there. So consider "build a healthy pattern."

DR. GARZA: Okay.. Any other suggestions? Modifications? Comments? Concerns? I think we ought to stop while we're ahead.

DR. KUMANYIKA: This is a question of whether the intent of the build a healthy base is to build from a healthy base or from — I mean, I think this concept of a base means that there's something fundamental about what you're starting with and then you do other things to it and it would be nice if we could keep that concept in and thinking more about the wording.

DR. LICHTENSTEIN: I actually interpret it to mean the base of a pyramid.

DR. GARZA: Yeah, that's what —

DR. LICHTENSTEIN: I had actually, you know, the body came into mind also, but, you know, somehow build a healthy body.

DR. DWYER: Sounds like Wonder Bread, doesn't it?

(Laughter.)

DR. LICHTENSTEIN: Twelve instead of — we got ten ways. But I thought it referred to the pyramid. I don't know if that was the intent, the base of the pyramid.

DR. GARZA: Okay. Now, I think we're sort of wordsmithing, but the people are generally pleased. There's one comment in terms of pattern because it might fit better with a food safety guideline. Again, I think since you'll have some time, you might want to put these up to the consumer groups and see how they react to it, because it wouldn't have to be ready until we get ready to print the material.

But it certainly — I think — helps conceptually the consumer. Okay. All right. And if we do that, are there any changes that the people would like to make on the introductory text? Let's go back to the first — pages three and four, thank you.

DR. MURPHY: Presumably, it would be modified to —

DR. GARZA: That's right. And it would be modified then to do this instead of the two bullets. We've probably have A, B, and C.

DR. WEINSIER: Did you want to go paragraph for paragraph or —

DR. GARZA: Yeah, but I — let me — what I'm envisioning this is that somehow we'd have aim, build, and choose in place of those two bullets. And then see if the rest of it would work over the — if it needs wordsmithing, then we can deal with that, but conceptually you feel that what is said here doesn't fit, then I'm — let me begin with Shiriki and we will come this way. Shiriki?

DR. KUMANYIKA: I just —

DR. GARZA: First paragraph.

DR. KUMANYIKA: Yes. I'm just reacting to the two bullets in case they would appear someplace else. I think it's a little bit of wishful thinking as it's written now, because I don't think that the overarching message of the guidelines has the "enjoy" thing. I mean, we went through this in '95 as you will remember.

And it also doesn't have a strong message of exploring new foods and new combinations and so that — those are good messages, but they are not the theme of the guidelines. So I wanted to discuss, if we try to introduce those —

DR. GARZA: We'll eliminate those two bullets — unless you want to keep them —

DR. KUMANYIKA: You may want to — I mean, a lot of national guidelines have messages like this. I don't want to start the enjoy discussion yet, you know, this round, but the question is do we want to give a message like that, at least positive messages about how to eat, because if so, they're added to what's in the guidelines now and not reflective of —

DR. GARZA: Well, think as we go through the paragraphs, some of those themes are repeated in the paragraphs and if we use the three bullets, will those things be adequately covered? Then certainly as we begin to fine-tune the guidelines themselves, we can try to — to incorporate those messages in them. Suzanne?

DR. MURPHY: I'm just still lagging behind perhaps. Take action and be flexible then will be replaced by our new points?

DR. GARZA: Yeah.

DR. MURPHY: And so somehow these paragraphs will be — not necessarily re-ordered, but re-organized —

DR. GARZA: That's right.

DR. MURPHY: — to fit under one of the three topics?

DR. GARZA: That's right. But the message will remain the same. So if you have problems with the substance that let us know — but the copyediting will be reorganized to follow the three themes.

DR. MURPHY: So we won't say "be good to yourself"?

DR. GARZA: No.

DR. MURPHY: As we do in the last sentence?

DR. GARZA: No, we will be puritanical.

(Laughter.)

DR. GARZA: Lest anyone enjoy fun and frivolity.

DR. DWYER: Is it going to say "enjoy" or isn't it?

DR. GARZA: Well, enjoy being —

DR. DWYER: I mean it sounds like a prescription for —

DR. GARZA: We'll try and say — oh, where is it? For instance, the first paragraph on take action will probably stay in there, at least the content, so we'll try and say "A for fitness" and work in the "enjoy" theme. The first two bullets will be worked in.

DR. DWYER: Is it going to say "enjoy your food" someplace in these guidelines?

DR. GARZA: Yes.

DR. DWYER: It would seem to me to be a good idea and then just enjoy —

DR. GARZA: Yes. Richard?

DR. DECKELBAUM: I would just put in the first sentence there that what you

eat and how active you are two major ways of how you could affect your health. The only one missing actually is smoking, but I don't know whether you want to put that in. But it's two major ways of how you could improve your health or promote a better health.

DR. KUMANYIKA: It says diversion, if that's already in there.

DR. DECKELBAUM: But not in the first sentence. That —

DR. KUMANYIKA: But not in the first sentence.

DR. DECKELBAUM: But that's the purpose of this whole committee is to promote health and why not put it right up there in the first sentence and it fits what we're trying to do.

DR. GARZA: Okay. You would add for good health, I mean, because it says the state guideline provides the advice about food choices, physical activity, and keeping food safety —

DR. DECKELBAUM: But we need to add "for good health" — in the title.

DR. LICHTENSTEIN: If some remnant of these bullets is retained, I'm concerned at the beginning of the exploring new foods and new combinations, not that I'm against the concept, but it sounds like eat more —

DR. GARZA: We're going to be eliminating both bullets.

DR. LICHTENSTEIN: I understand that. But in case some of the remnants get retained, I'm just concerned about giving the impression of eat more and we'll just make sure we avoid that.

DR. GARZA: All right. Help me then because if it's — either we tell people to explore new foods or do we want to keep them eating only what they're eating now?

DR. LICHTENSTEIN: I think we're giving them guidance on how to adjust what they're eating if they're not meeting the intent of the guidelines within each guideline. We're giving lists of different kinds of things that could be consumed —

DR. GARZA: You don't think that should be encouraged? Is that what you're saying? You should encourage that by —

DR. LICHTENSTEIN: I'm saying it sounds like eat more to me.

DR. GARZA: Is that the same as it strikes the rest of you? That the concern is Johanna that Alice has — make sure that I'm paraphrasing you correctly —

DR. LICHTENSTEIN: Um-hmm.

DR. GARZA: — that by up front, saying "explore new foods and new food combinations," that we're encouraging overconsumption? That could be a message that could be embedded somewhere else but not at the very front? Right?

DR. LICHTENSTEIN: Right. It's not "don't add," it's "substitute."

DR. GARZA: Right.

DR. LICHTENSTEIN: It's essentially this middle paragraph under "be flexible." It says the same thing, basically.

DR. GARZA: We'll take up the paragraphs one at a time, otherwise we'll —

(Simultaneous discussion.)

DR. GARZA: Oh, I — Suzanne thinks we ought to look at the last paragraph, so let's do that.

(Simultaneous discussion.)

DR. GARZA: Suzanne's on page four. And it's the middle — the second paragraph on page four. And you're asking that we eliminate it there?

DR. MURPHY: No, I'm saying that if Alice thinks that that connotes overconsumption, it worries me whether it's up front or in the middle. I think it's more in context in the middle.

DR. GARZA: So — but I'm hearing that if we use "substitute new foods" — new food combinations and new ways to get moving — well, maybe not new ways to get moving. Meaningful combinations, that that would no longer encourage overconsumption. Let's try with maybe implying add them to your base. That's what I heard.

And you wouldn't worry about — you said "substitute" if it was up front? Or down at the bottom? Meir? Do you have a question?

DR. STAMPFER: Yeah, just in terms of the theme, I agree that we — sort of flexibility in trying new stuff is not a major theme of the guidelines, but I think we should have something in the introduction to emphasize that there's lots of ways of eating that still conform to the recommendations that, you know, maybe just steer the idea of flexibility, new foods, and so on to just — to broaden it to encompass lots of different eating styles that would — there's not just one healthy eating pattern.

DR. GARZA: Is that not in the first paragraph under be flexible or do you think that there are principle messages that are missing from it?

DR. STAMPFER: Yeah, I think it's more in the first paragraph, but it's not so much try all kinds of new stuff, it's just that there's lots of different ways to have

healthy eating — have a healthy diet, as just as a general theme to stress.

DR. LICHTENSTEIN: A lot of ways to meet the guidelines.

DR. GARZA: Okay. Johanna? Rachel, do you want to say something? Johanna?

DR. DWYER: Can we also go to "take action?"

DR. GARZA: Yeah.

DR. DWYER: Paragraph two. The sentence that starts knowing your family history and risk factors and then it lists a whole bunch of values that you'd have to go to your doctor to get. Since 40 million people in the United States don't have any health insurance, maybe that paragraph could be eliminated because it's not directly relevant, is it, to our —

DR. GARZA: That comes from last year's — we can eliminate it, yeah. Is that the sense of everyone? That we shouldn't encourage people knowing their risk factors?

DR. DWYER: That's not what I'm saying. I'm just saying —

DR. GARZA: Well, I'm —

DR. DWYER: — it could be shortened to include risk factors that they can find out themselves.

DR. GARZA: I'll tell you what they've eliminated — the reason I'm asking is there's a national campaign now asking people to know their blood pressure, to know their cholesterol level, and I think that's why it was included five years ago, to be consistent with that — which are the ones I guess you'd have to go — because you know whether you smoke, you know your body weight, and the fat distribution.

DR. LICHTENSTEIN: And some of these you can get done at the supermarket now or at the local drugstore or you can just get a packet and do your blood cholesterol on your own.

DR. GARZA: Oh, but those are not very reliable, I've been told.

DR. LICHTENSTEIN: Oh, but no, I'm not saying the reliability, but —

DR. GARZA: At health fairs?

DR. LICHTENSTEIN: There are a lot of different ways of getting those.

DR. GARZA: Would those allay your concerns, Johanna?

DR. DWYER: Yeah, I think it needs to be put later and maybe made less visible than right at the start. To start out talking about risk factors instead of talking

about enjoyment of food doesn't seem to make sense. It seems, you know, first the —

DR. GARZA: Where would you suggest it be put?

DR. DWYER: At the very end.

DR. GARZA: So you want "be flexible" first and then "take action" at the end? Or the messages that relate to that, I mean, to take action and be flexible.

DR. DWYER: I want "enjoy" first.

DR. GARZA: That's what I'm saying. All right. Well, that's the flexibility —

DR. DWYER: Okay.

DR. WEINSIER: I will follow up on Johanna's recommendation because I think it's a good one. I don't think we need to move it, I'm just trying to make it more actionable because right now it says knowing can help you make more informed decisions, but it doesn't say exactly how.

Is the point or should the point be that the guidelines apply to all of us regardless of whether they have risk factors or not. If they have risk factors, or knowing your risk factors emphasizes even more the importance of the guidelines. Something to that effect?

DR. GARZA: Okay. Lesley?

DR. TINKER: If the factors about the risk factors that are in parentheses are relating to national campaigns, I think there's also one that started recently about diabetes and blood sugar. Do we want to add that in?

DR. DWYER: My problem is this, that these are population-based recommendations and so to put these things first implies that this is sort of secondary prevention. And so I'm just concerned about —

DR. GARZA: We're — they're going to be moved further down was what I heard. The issue seems to be you think they should be eliminated or included. I mean, that's a — we can rearrange it. That's easy. But —

DR. DWYER: I think it's hard to tell without reading it.

DR. GARZA: Well, you'll have a chance to read it, but in terms of getting this revision, it's nice to know if people say, gee, don't — don't even mention it or no, that it's something that we ought to include. So do either of you want to give any advice?

DR. WEINSIER: Yeah, my recommendation was to include it, but not — but make it more actionable in terms of the guidelines apply to everyone, but know your

risk factors, these guidelines become even more important.

DR. GARZA: Is that reasonable, Johanna, from your perspective? Okay. Lesley, do you have other — Scott?

DR. GRUNDY: Well, I think it's very important to keep these in and highlight them, because — I mean, even, you know, the box or something because what we want people to do is not only to have a healthy diet, but also to have knowledge of their risk factors, specifically because this has a lot to do with chronic disease and this is tying together the clinical and the public health. So this is a very important part of it.

DR. GARZA: All right. Let me check with Suzanne. And we're going around the room, and I'm always accused of forgetting — I'm learning at the end of that three days.

(Simultaneous discussion.)

DR. GARZA: The pain tolerance. Yes, Suzanne?

DR. MURPHY: What do I do?

DR. GARZA: You never knew she had that masochistic streak in her, did you?.

DR. MURPHY: I don't have any wordsmithing to do but I do feel I need to see it. There's going to be so much done to it that I'm having a little bit of trouble seeing it, the final product, right now.

DR. GARZA: Okay. Obviously it was because until we knew you liked this, it wasn't redone, right?

DR. DECKELBAUM: I would like to second what Scott said that we retain this, but I would just add knowing about your family history of disease and your diet-responsive risk factors for disease, and then

put smoking at the end because they're all diet-responsible. It may be different wording.

But to emphasize that these risk factors are specifically responsive to dietary change —

DR. GARZA: You're not saying that people should know that they're, for example, there is such a thing as salt-sensitive?

DR. DECKELBAUM: Yeah.

DR. GARZA: They should know they're salt sensitive?

DR. DECKELBAUM: Not necessarily salt-sensitive, but, you know, if you look at the risk factors, body weight, diet responsive, fat distribution —

DR. GARZA: They're all diet responsive. I thought you meant whether the individual —

DR. TINKER: Smokers —

DR. DECKELBAUM: No, it's after smoking.

DR. GARZA: Okay. I see what you mean.

DR. DECKELBAUM: I would put in some indication of that along with the list of risk factors.

DR. TINKER: What about physical activity too if it's tied into the guidelines?

DR. GRUNDY: Could be. Or if it says "risk factor," it ought to be on the list —

DR. GARZA: So then if you're physically inactive or —

DR. DECKELBAUM: I would strengthen that sentence even more.

DR. GARZA: Go ahead, Johanna.

DR. DWYER: Well, maybe my concerns would be allayed if under "food safety" we had something that tells people what to do if they were poisoned. What should people who don't — should we put something in about how to get — how to get your risk factors if you don't have them? Because it does apply to 40 million Americans.

DR. GARZA: So you would say we should say go to your local health fair or see a physician? Something like that, an actionable suggestion of what to do? Is that — okay. Dr. Shiriki?

DR. KUMANYIKA: I have lost track of where we said the objectives for this section — I know we were trying to make it shorter, but the red flag for me was this "try new foods" thing. I can't remember when we decided that that was really important for good nutrition. And I'm not sure that I agree with it.

So I wanted to ask if we could clarify the objectives of this section and the assumptions we were making? That's one part. And then I would like to introduce a message that some people could improve the way they eat and some people are eating a good diet already. So, in other words, why should you read this booklet?

Is it because we think Americans have bad diets? Is it because we think — why is it? Is it because we think people aren't trying out new foods? So I'm unable to react to this without getting a clearer sense of what our main message is and where it came from.

DR. GARZA: The message came from the fact that we had very few — very low consumption of grains, fruits, and vegetables, and so if people are going to add — then is it just that we want them to eat more of the same thing, of the one serving if they're not having, or whether you want them to explore other foods, other vegetables, and other grain products, especially whole grains, to increase their diet.

And so that's where the exploring new foods came in, that it applied to gee, how are we going to get these people to — to begin the —

DR. KUMANYIKA: It doesn't sound — it actually didn't strike me that way and I couldn't have remembered that that was the message from seeing this and so the something — this almost sounds like try new, you know, if you like spinach, try a different vegetable, just for its own sake, try a new product that's on the market.

It doesn't say improve your diet. Because the point of trying new foods —

DR. GARZA: Okay.

DR. KUMANYIKA: — is to do something that's qualitatively different if you need to improve your diet. And I think we need to get that message there.

DR. GARZA: So you think the basic message ought to be "improve your diet" —

DR. KUMANYIKA: Yeah.

DR. GARZA: — "and improve your physical activity?"

DR. KUMANYIKA: I think that's the message if it needs — because this is a little bit of a value judgement that whatever you're eating now, it's not — you should try to eat foods like a kid, try this for mommy.

DR. GARZA: What we'll do then is remember that under the three themes — I'll try to repeat it a third time — we'll try to eliminate the first two bullets. And the themes are going to be for these new guidelines, improve your health and do you know, "aim for health" or "aim for fitness," "build a healthy base," and "choose sensibly" will be those three bullets.

Then we'll try to build in around that an issue that says — and this is where I need your help — "most of us are not eating a very varied diet and therefore if you are one of these who are not, then try exploring new foods so that you can add more variety to your fruits and vegetables".

DR. KUMANYIKA: Yeah.

DR. GARZA: Would variety appear under both or —

DR. KUMANYIKA: We're going to put variety in there, we have to be careful. I

don't think we should try to do the wording now because —

DR. GARZA: What is the message?

DR. KUMANYIKA: I think the message — first of all, I don't know that we — we reviewed the data on some specific guidelines, but we haven't looked — I don't think we have looked at things like healthy eating index table. We haven't talked about the overview. And so I don't want to send a message that's inadvertently negative that says all Americans are not eating well.

I want — if we're not going to be specific about "we need to eat more fruits and vegetables," be very careful about what the message is. Is it how to maximize your diet for health, said in the right words, how to evaluate your diet? We haven't said that people think about what you're eating. If it follows these, you're doing a good job.

DR. GARZA: But what do you think the introduction should be doing then? Maybe we —

DR. KUMANYIKA: That's what I think. I think we should tell people why they should look at dietary guidelines. And it's because the food choices that people make are important to their health, and people need some way of figuring out whether they're eating the right thing. And some obvious —

DR. GARZA: Okay. So taking the information, for example, that's in the first paragraph under "take action" —

DR. KUMANYIKA: Yes.

DR. GARZA: — you think ought to be — well, because that's what says gee, you know, your health — what you eat keeps you healthy, helps prevent disease, just needs to be made less — more transparent? Is that —

DR. KUMANYIKA: I think that's good. And also the sense that people should evaluate somehow — should think about what they're eating but I don't want to assume that everybody who reads these needs to correct something.

DR. GARZA: Okay.

DR. KUMANYIKA: Because I don't think that's the case for at least a small fraction of the American public. And I think we should not give that negative message that — there may be aspects of diet — everybody can probably improve some aspects of their diet for health or some kind of a positive message like that.

DR. GARZA: Okay. So it's the emphasis rather than the content of the first two paragraphs?

DR. LICHTENSTEIN: I think we should consider what was in the last booklet,

the last guideline booklet, because I think some of this information is —

DR. GARZA: Most of that is moved into adequacy.

DR. LICHTENSTEIN: Okay.

DR. GARZA: That's why it's shortened because a lot of this information was taken out and put into the adequacy guideline.

DR. LICHTENSTEIN: Yeah, I certainly know the pyramid and all that stuff, but certainly the latter half of it. But there are some things that sort of very much orients you — I like the question format, I think it very much orients somebody to why they should even care about this pamphlet.

And I also agree with Shiriki and I think that probably of the people who end up reading this, probably a lower — a higher percentage than in the general population are actually eating diets that are consistent —

DR. GARZA: So after the three bullets, you would suggest that if we said, you know, why would you — why should you do this rather than take action because any information — if you compare them, that's in there with what's in the first paragraph, it's very similar. The only thing that's changed is —

DR. LICHTENSTEIN: But I think we should consider going back to the question format.

DR. GARZA: The question format, okay. Do people agree with — before we — should we go back to a question format for the introduction rather than the imperative?

DR. GRUNDY: Well, we can do whatever. I disagree.

DR. GARZA: Roland?

DR. WEINSIER: Yeah, two brief comments. If others agree, I think there are two senses in here that were particularly strong and I would like to see it put in bold, if that's an option. One is under "take action," the second paragraph, the very last sentence at the bottom of the page. It says, in fact, "Take action; enjoy all food but be sensible. Be physically active and handle food safely."

DR. GARZA: And you want that highlighted?

DR. WEINSIER: My recommendation is to — that we consider putting that in bold, highlighting it. And the second sentence that I thought was — with a little bit of rewording — was on the back page, under be flexible, the end of the first paragraph. I'd revise the wording slightly, but still to the same effect, that we might consider putting in bold: "Since there are many nutritious foods and many physical activities, there's lots of room for choice," because I think choice is an important —

DR. GARZA: Okay.

DR. WEINSIER: And the other comment was that we've used the word diets in here, at least several times, and rather than going through each one, I've just written some suggested alternatives, if I can just turn them in.

DR. GARZA: Okay. Give them to Carol. Shiriki?

DR. KUMANYIKA: I want to ask if we've ever considered putting any kind of Racherplate (phonetic)-type checklist in this part? Was that something based on —

DR. GARZA: No, I'm trying to think if we could do it here before we won't go through the guidelines or if it's at the end and you say, gee, read this and take the —

DR. KUMANYIKA: Well, they had — the question was should we go to a question format and one question is how does your eating pattern measure up? In which case, you would have to follow it with some way of figuring that out.

DR. GARZA: But you would put that in —

DR. KUMANYIKA: No, it just occurred to me as a question of how to make this effective in the introduction.

DR. GARZA: Could we — does the healthy eating index lend itself to something like that?

MS. SUITOR: No, If you think about it, it is not particularly quantitative, because it would have to be real straightforward —

DR. LICHTENSTEIN: Just ask people to go through the pyramid. Did you get the number of servings and —

DR. GARZA: And when — how do you tell them when they're good or bad? I mean —

DR. KUMANYIKA: Well, they could be examples. For example, I mean, it could be more of a teaser to read on than anything else. But as a question, it might be effective, you know, a lot of the magazines do that when they want you to think about a particular issue. And so they do have scales, but if then if the staff has already done such a nice job with this A, B, C, I bet they could —

DR. GARZA: No —

(Laughter.)

DR. GARZA: No, we could adopt — no, the reason this is short is because the group said, keep this down to a page or less. Now, we can do this, but what it does

then is add to an already expanded booklet that we're going to try to reduce and that maybe was a good time to raise it. But we're going to — the format from now on is that Carol and I will work with each of the chairs in trying to get this wordsmithed. But it — you know, trying to go through a group process for wordsmithing, you know — will be very difficult.

So if in fact you're still concerned about length, then we need to know that because that will be a criterion as we go through this, this and other sections. If the group is not concerned about length, then we can more easily consider suggestions like checklists and things like that.

So Shiriki, you get the first — you get to give us advice on that first.

DR. KUMANYIKA: Okay.

DR. GARZA: Should we worry about length or —

DR. KUMANYIKA: I think we should, but I would rather worry about length after we're clear on what we're trying to do and then most things can be improved by being shortened, but I'd rather get the degree on what we're doing so that we cut — we know that we're cutting a major concept or just examples. There's a lot of redundancy in this.

DR. GARZA: That's right.

DR. KUMANYIKA: Even within every section, there tends to be redundancy and we could probably get some —

DR. GARZA: And the two aims that I heard you suggesting for the introduction was to motivate individuals and get them to evaluate their base in terms of the dietary intake or plate or whatever. But do you think those are the — as you look at this, that ought to be our principle aim, is a motivational one, but also working in an evaluation?

DR. KUMANYIKA: I think so.

DR. GARZA: Okay. Is that the group consensus?

DR. DECKELBAUM: So then your suggestion would be to have sort of a self-assessment tool in the introduction and —

DR. GARZA: And I'm not promising that because I think that's going to be difficult, but —

DR. DECKELBAUM: But I actually think it would fit better in the first guideline and let the pyramid be your guide. How good is your eating habit?

DR. GARZA: Okay. Suzanne and —

DR. MURPHY: I think that this is a wonderful idea, but folks, it really has to be a research recommendation. Eileen and I looked at each other because she actually once convened a panel to answer this very question and every member of the panel had an entirely different idea of how to go about it. And I don't think consensus was ever reached.

I think it would be worth re-investigating, but we're not going to come up with something —

DR. GARZA: But one thing I think we could do, for example, is to take — maybe not in the first paragraph, because that would be difficult — but coming someway to — by a question that would just be yes or no would address each of the aims of the guideline. And if you have no's, then read the guidelines. "Do you include at least three servings of X in your diet?" "No." "Do you include four X in your diet?" "No."

Well, gee, if you don't, go on and perhaps you should read this booklet. And I think that's what we —

DR. KUMANYIKA: Or do you try to? I mean, it doesn't have to —

DR. GARZA: Of if you're trying to —

DR. KUMANYIKA: No, we don't have to get to the —

DR. GARZA: Okay.

DR. KUMANYIKA: — but to get people to think about —

DR. GARZA: Well — intent you think is enough, huh?

DR. KUMANYIKA: Yeah.

DR. GARZA: The road to good intentions —

(Laughter)

DR. GARZA: Hold on for a minute, I've got to go to Richard.

DR. DECKELBAUM: I think just an editorial comment, Suzanne. I just think this committee has been so good at rapidly reaching consensus that just because it didn't work the first time doesn't mean that we couldn't do it in about ten minutes.

DR. GARZA: Johanna?

DR. DWYER: I'm really concerned about the introduction and I think this is terrific. But I continue to be concerned that there is — this sounds like pleasure prohibition, nutritional nanny-ism, you know, we're having this checklist. You know, it's like lawyers. You go to a lawyer, is anything wrong? Of course it is. You

know, a lawyer can always find something wrong.

(Laughter.)

DR. DWYER: That's how nutritionists are. I think that we need to add to the introduction. This is great, reorganize it, but also say and enjoy what you eat among aiming, building, and choosing for good health doesn't mean that you — that taste needs to take second place, you know, and just say it straight out in a big, bold thing.

DR. GARZA: You know, I agree with you. I —

DR. DWYER: What concerns me enormously is that I've been told that "enjoy" appears twice in these hundreds of thousands of words. So we don't have to worry about it. "Risk factors" probably appears three thousand times.

(Laughter.)

DR. DWYER: And all I'm saying is people don't eat to — for these reasons. They eat because food tastes good. We are trying to get the two concepts to come into alignment together. And I don't think we're going to throw caution to the winds if we put something up front about enjoyment.

DR. GARZA: Well, you'll notice there is — the word was in the first bullet, I mean, enjoy your food. So it's — I —

DR. DWYER: I don't think that's sufficient.

DR. GARZA: It's not enough. I agree. No, and I think we need to go through the whole guideline, Johanna, and I think we would all be —

DR. DWYER: And I strongly suggest a word count on risk factors and on enjoyment.

DR. GARZA: We will count on you under food safety, so you could say that too.

(Laughter.)

DR. KUMANYIKA: Enjoy safely.

DR. GARZA: Enjoy safely, yeah.

(Laughter.)

DR. GARZA: Okay. Are there any other — are there any other comments? Because it's — trying to summarize the various messages and, you know, one is motivate, evaluate, try and make sure that people understand that it's perfectly all right to have, you know, to enjoy your food. Length —

DR. DWYER: No, it's that enjoyment is not precluded by all of these minutiae.

DR. GARZA: The reason why I'm smiling is because that was — remember when we first came to the Committee and said maybe we ought to say that you need to be good to yourself by following these and enjoy it? And people thought that, gee, that was horrible. That asking people to be good to themselves and enjoying their food was going to give people license to do all sorts of bad things.

But I think Carol — so we've been through these discussions and I'm — we will try to find a way to do this without encouraging over consumption and hyperactivity and all sorts of evil —.

I think we're all getting giddy now. All right. Now are there any other substantive issues anybody would want to raise on the introduction? And you all will get to see this. Then let's go to tab J. Before we go to adequacy.

(Pause.)

DR. GARZA: You were passed some material. You know, there are members of my department that I refer to as the tar — the La Brea Tar Pits, because I can extract things from them once I give it to them, but with great difficulty. There are others in my department that I label "black holes" because once you give them something, you will never recover it.

And I'm beginning to suspect we're in the latter category. And you know, it was just two days ago.

DR. LICHTENSTEIN: The heading is 9/3/99.

DR. GARZA: It's — that's right. Draft 9/3/99, appendix two.

DR. LICHTENSTEIN: The title is appendix two, summary of recommendations from public comments.

DR. GARZA: It looks like this.

DR. KUMANYIKA: We've got three of them.

DR. GARZA: You've got three.

MS McMURRY: There should actually be three — yeah, three different format versions. The first one —

DR. GARZA: Hold on. The format — just to make sure everybody's on the same page — is for how we're going to structure public comments because that will be part of our report because we will be asked to see whether or not people want — I think, you know, we obviously have formed our deliberations, so in addition to the references, we need to make sure that the comments are included, in some way

summarized.

DR. LICHTENSTEIN: It's the only handout we got with three holes punched in —

DR. GARZA: That's right. Some of them were not — some of them were punched. Others were not punched.

MS. McMURRY: There's one that is in the paragraph format and in the format of the previous report. There's another — and that's the most complete version right now. There's another option of using similar format using bullets, because it got kind of cumbersome and it listed the comments — there weren't a lot of commonalities. So a long string of one comment or two comments might be a little more readable.

And another option which was seen before in our meeting notebook summaries would be a chart format. Basically, they're — they would all be the same type of descriptive format, just notes, the types of comments that were received and what the comments were. They were not intended to include any direction of how they were addressed and not addressed, just more of an informative description of the public opinion environment in which the committee did its work.

DR. LICHTENSTEIN: What was the format that was used the last time?

DR. GARZA: Paragraphs.

DR. LICHTENSTEIN: And was that felt to be helpful? Do we have any information on how useful, helpful, that was?

DR. GARZA: Not that I'm aware of. I don't think that we've ever — in fact, I'm surprised. I had a request from another country wanting us to send them all the information the government had on evaluating the guidelines and their efficacy. But I wrote saying, "Can you send us all the information you have?" and they said "that would be easy."

There's no individual working groups who have done this, but —

DR. LICHTENSTEIN: Does the staff have any feeling for how — what would be the most reasonable way to proceed? Do you have a preference?

MS. McMURRY: I think most of us would prefer either the bullet format or the chart format as being more readable, easily read.

DR. LICHTENSTEIN: I'd be happy to defer to the —

DR. GARZA: Because once you have to go through the prose, there's a lot more room for interpretation and mis-interpretation. With a bullet, one can extract the comment.

MS. DAVIS: We are unclear in some of the categories there. We need to work on that, so this, as I say, is a draft.

DR. GARZA: So there are two formats, that are bulleted. Which would you find more useful or is there a preference among the staff? From your experience with —

MS. McMURRY: There is really no precedent and it's an appendix to the report and whatever you feel might be most clear.

DR. GARZA: Okay. Alice?

DR. LICHTENSTEIN: If I was going to use this — if I was going to pick up something like this, I would be interested in looking at the comments for a specific guideline. I realize that's organization and then just bulleted would be fine to me. I'm thinking about how I would go through this information and I don't think I —

DR. GARZA: So they are you? You got so there is a general and then —

DR. LICHTENSTEIN: Yeah —

(Simultaneous discussion.)

DR. GARZA: Yeah, I find that this chart helps, you know, is a better guide because you can more easily find comments that relate to a specific interest. And they may help the staff in terms of proofing and — It doesn't seem like a laundry list, but there is some organization to it, and that might be very helpful both to users.

Okay. All right. Then if there are no other comments, then let's go back to the adequacy. Why — don't we have — the sandwiches are here. Let's see if we can finish the adequacy — you want to do the whole — okay, then let's just distribute them and you can eat and — can we do that? Yeah, just have them bring in food.

You can hold on to them and not eat. I mean, whatever is easier.

DR. DWYER: What page are we on?

DR. GARZA: Well, we're on — there are four issues that we were going to — go ahead. Yeah. Suzanne has them on overhead and I've got some things we've got to pass out.

(Pause.)

DR. GARZA: You are getting sandwiches. Drinks are — you're going to have to get your own drinks.

DR. JOHNSON: Where are they?

DR. GARZA: They're by the vending machine. And I would ask you to hold off

getting your drinks until after we go through this part and then we'll take a short five minute break, people can get their drinks, then we'll come back and finish the discussion.

Okay. Suzanne? I'm hoping we've got everybody's attention around the table? Is everyone ready? I'm not getting any nods. Yes? All right. Suzanne?

DR. MURPHY: These are the five issues that Bert and Kathryn and I sort of remembered we needed to come back to, but we're willing to add to or delete from the list. We wanted — and I think we'll just go through them in order and then if people think there's something missing, we'll address that at the end.

One was further we wanted to include the children's pyramid. And I think everybody got a copy of the booklet that has the children's pyramid in it. And I've looked over it again. I like it a lot, but I don't personally think it adds enough new information to put it in the consumer booklet. But we'll certainly open the topic for discussion if people feel strongly otherwise.

Rachel?

DR. JOHNSON: Well, I know I'm the one that requested this, so I'll make my argument for including it. We have had testimony I think primarily from the American Dietetic Association specifically requesting inclusion of the kid's food guide pyramid. I think that we know the pyramid is a key educational tool and something that most consumers recognize and I think that adding it to the booklet would help to give it wide dissemination that we'd like to see.

I think we could shorten — actually shorten the text in a number of places where we list the types of foods that kids should eat by including this and just referring to whatever figure we call it. I think we've done it and I know we've done it extensively in the weight guidelines. I know we've done it in the fat guidelines. We could refer to it in the sugar guideline.

I think the major difference in the kid's pyramid is that it pictures foods that are commonly eaten by children and it does give the appropriate serving sizes for children. So I think it could really help with the obesity or the overweight guideline in terms of stressing appropriate serving sizes for kids.

We don't have a BMI chart in for children. We sort of gave that up, thinking that children needed to be referred to health care professionals and I think this would be a good tool that we could use in terms of some good advice, in terms of balance and moderation for kids.

I think my last point is that the 1995 committee made a very strong point that we needed to consider the needs of children in the guidelines. And this committee decided very early on that we would not pursue separate dietary guidelines for children, that they would be included in these guidelines, and the guidelines are supposed to be for everyone over the age of two.

And I think this would be a big step in recognizing that the guidelines are in fact appropriate for children, that all the guidelines are appropriate for children and — and just by including it. So that's why I'd like to see it.

DR. MURPHY: A point of clarification. You said serving sizes. So you want to add not only the pyramid, but — I didn't think the sizes —

DR. JOHNSON: No, you're absolutely correct. It's the numbers of — these have the numbers of servings, but my understanding — help me if I'm wrong — that the sizes — but for the kids, a serving of milk, for example, is still one cup. It's not half a cup.

DR. MURPHY: Right.

DR. JOHNSON: So I don't need to — it wouldn't be necessary then to repeat the sizes.

DR. MURPHY: Okay. Am I also correct that the number of servings is the same as for the 1600 calorie diet? So it would — if we didn't put this in, could we describe the 1600 calorie pattern as appropriate for children six to eleven years old?

(Simultaneous discussion.)

DR. MURPHY: Oh, I'm sorry. This is for two to six year olds. You're right. Older children I think are at a higher caloric level. But actually, my copy for the 1600 calorie column does not say young children, so we would actually have to add that to the literature, to the current box. It's not up there on that heading. Yeah.

DR. GARZA: Richard and then Alice?

DR. DECKELBAUM: Rachel, would you agree that just by having a sentence saying that, you know, children two to six year old — two to six years old should choose the lower, you know, limit of the servings for each category? Because that's really what it is.

DR. MURPHY: You know, that would —

DR. DECKELBAUM: The pictures are different and that —

DR. MURPHY: I really would like to —

DR. DECKELBAUM: — and that will address specifically that without taking up the space with an extra figure.

DR. JOHNSON: I think really look at the pictures carefully considering the guidelines and I guess, you know, particularly the sugar guideline. I think that these can be very useful.

(Pause.)

DR. LICHTENSTEIN: I'm not sure given the — if this format remains the same and if the reproduction's going to be the same size, I don't think the resolution here would really distinguish between the two pyramids and probably guidance with respect to appropriate number of servings would — even if it was in a box, would probably accomplish the same intent.

DR. GARZA: Okay. So unless people have other questions, we could take a vote? Scott?

DR. DWYER: What was the — I can remember there was something in the newspaper about the process some people affected, the process of developing this? Was it developed the same way that the — I know the other pyramid took like a year and a half or so —

DR. GARZA: Well, we —

DR. DWYER: How was this one done? Was it the same?

DR. GARZA: There were issues related to the depiction of foods. I mean, that — issues concerned about that, the specific foods that were selected —

MS. DAVIS: On the tip.

DR. GARZA: — on the tip of the pyramid. So Scott?

DR. GRUNDY: One thing that's very attractive about this one is it shows active people and that always catches my eyes more than anything else and it — I suppose at some point that the adult one also now that we've added activity in the guideline that if the adults were also —

DR. GARZA: We are getting into the adult one, would that change, yes.

DR. GRUNDY: We are going to do that?

DR. GARZA: Yes.

DR. GRUNDY: Okay.

DR. GARZA: That's the — that is number two on — on Suzanne's list.

DR. GRUNDY: All right.

DR. GARZA: Then if we're ready to take a show of hands, all of those who would like to see the children's pyramid included in the guideline, please raise your hand.

DR. WEINSIER: As a separate pyramid?

DR. GARZA: As a separate pyramid. All those that would not be too disturbed if it were omitted?

DR. KUMANYIKA: I wanted to try the other one, but it wouldn't matter anyway. I really — I like it. I think it should be in there.

DR. GARZA: You think it should be, so there should be two?

DR. KUMANYIKA: There would be two, including the —

DR. GARZA: All right. So there's two. All right. Let's go to the second.

DR. MURPHY: Okay. I don't — it's my understanding that, Roland, you would lead us through the suggestions that you have on the changes you have to the text surrounding the pyramid?

DR. GARZA: We are going to past them out.

DR. MURPHY: Not — yeah.

DR. WEINSIER: All right. What's coming around is a — is just a pyramid with some typed in revisions for consideration. These revisions are based upon the input of about five people around the table, so no one person is agree's with all of them.

And so this is not a consensus of five, it's just recommendations for —

DR. DWYER: Who were the five people?

DR. WEINSIER: Hmm?

DR. DWYER: Who were the five people?

DR. WEINSIER: Meir, Alice, Scott, myself, and one other person. And — oh, and Lesley. Anyway, having said that, it's not that I was trying to do a formal poll, but just taking them one at a time I guess would be the easiest way.

At the top left, it says use sparingly and consider the possibility of putting it as follows. Sweets, oils, fats (preferably unsaturated). Do people see this as a — assuming that the wording can be fit in, do people see this as an added benefit?

DR. GRUNDY: Yes.

DR. GARZA: And it — I mean, that would suggest to me that it's only oils and not fats?

DR. GRUNDY: Unsaturated oils?

DR. GARZA: It is a bit confusing as to where the —

DR. DECKELBAUM: I guess the message here is that it's use fat, preferably unsaturated fat and oils, sparingly.

DR. GARZA: That's right. I think it's confusing because it's —

DR. GRUNDY: There's a little bit of a problem there.

DR. GARZA: Well, not —

DR. WEINSIER: I mean, I guess the wording could be re-worked. It's a message — is this the type of message that we want to convey I guess is —

DR. GARZA: No, it's in doing it here that in fact if we want people to take 30-percent of their diet as fat, but we put preferably unsaturated up here and then it's connected with use sparingly, then they could connect the message — the message of use these unsaturated fats and oils sparingly, which I think could be confusing.

I'm struggling, because I understand what we'd like to say but I'm not certain that this depicts it — that we can deal with a complex issue of fats simply on the — on the icon. I — it's a tough one.

DR. WEINSIER: No, that's a good point. Meir, I think — I don't remember who made the suggestion, so somebody else can respond to it. You're right. It's an incongruity. Theoretically we should say saturated fats and oil. So maybe it's best not to say, just leave it as it is.

DR. JOHNSON: How about especially saturated?

DR. WEINSIER: Well, it just raises the risk that people are going to interpret it wrong either way, because in bold is use sparingly.

DR. GARZA: That's right. We could put use, you know, unsaturated or saturated in bold, as well, but it's — it — it's difficult I think to convey the information you want. But maybe I'm the only one who reacted that way.

DR. WEINSIER: No, I think —

DR. GARZA: Suzanne?

DR. MURPHY: Well, I have a logistics question. The icon is really tiny as was just pointed out. Could these changes — wouldn't these changes be better made to what we have in our boxes than to the icon itself? The icon just has labels on it and to put all this extra text, I think it won't be read.

DR. WEINSIER: You're still talking about the use sparingly or are you trying to do everything now?

DR. MURPHY: Well, all the changes. I'm just wondering if it's worth the effort to

change the icon.

DR. GARZA: We can — we can increase the size of the icon. I mean, if the message is important, and we think that there — that the icon would be most consistent with the guidelines if we make these changes, then I think the sort of issue that Suzanne raised, we should be able to deal with it.

So I would rather that we concentrate on both the signs and whether they convey to send the message we want, and then we can figure out whether to revise and try to mix the two together?

DR. MURPHY: It's just a quality issue. How many messages can we put in this little tiny print?

DR. WEINSIER: Well, we haven't agreed on any messages —

DR. GARZA: Right.

DR. WEINSIER: — so there may be no changes by the time we fix it.

(Laughter.)

DR. MURPHY: It may influence how I felt about the messages.

DR. GARZA: Exactly.

DR. MURPHY: As where they go — as to where they go.

DR. GARZA: Johanna, we're still with the first one on "use sparingly," try to comment on that one. Or back to the other wording. Scott?

DR. GRUNDY: Well, maybe you could just say "use saturated fats and sweets sparingly." And then the oil could just come in other places. I mean, you don't have to specifically —

DR. GARZA: Because the way the calories — these are left over calories after you've met the rest of the — of the pyramid and in fact you can take those extra calories from those three sources. It would be difficult to eliminate oils.

DR. GRUNDY: Well, those are — it should be incorporated into the body of the pyramid. They're part of the base. The unsaturated fats are part of the base guide. The fats — sweets and fats — saturated fats are the ones you want to —

DR. GARZA: Well at the risk of opening up another — these are added fats and added sugar. She walked into that one knowingly, you can report. I —

DR. GRUNDY: Could you elaborate on that just a little bit then?

DR. GARZA: I won't — Shiriki, maybe you could —

DR. KUMANYIKA: Well, I'm going to make it worse. I just wanted to go on the record saying that I'm — I disagree with the entire process of trying to annotate the pyramid. I think it's an unsound process because of what's gone into the pyramid and I don't think it will be effective.

So no matter how good we get the words, I was going to be at least one voice against trying to do it this way.

DR. GARZA: Well, let's hold off that judgement until we look at the few changes, because I don't think we ought to prejudge it. I mean, I think there are problems with the first one, and I'm — and I — of the type that I describe. I don't know whether anyone would come up with solutions for it.

DR. DWYER: I agree with your — I find it confusing.

DR. GARZA: Well, let's go on to the second and —

DR. WEINSIER: Okay. Let's go on down. Under milk, yogurt, and cheese, it was recommended that we put some words in to the effect preferably low fat or fat free.

DR. GARZA: And I know the — I mean, the genesis for this has been — in fact, there are segments — there are individuals who feel we sent a mixed message with the icon and the fact that generally we don't say that these are low fat. And given the new emphasis on saturated fat, whether this adds substantively to the correct interpretation of what you want — the message you want to deliver.

And if it doesn't, because of the point that Shiriki makes, the — that is more or less consistent with our guidelines. Alice?

DR. LICHTENSTEIN: I think that it's consistent and appropriate.

DR. GARZA: Okay.

DR. STAMPFER: Having gone to — first of all, I agree with adding preferably low fat or fat free to dairy, but just on the first one, did we —

DR. GARZA: We have to come back. If we have problems with all of them, I don't think any of them will survive and there's no point in — I think the issues with the first one were raised and unless you have a solution you want to provide that would remove those concerns.

DR. STAMPFER: No, I just wondered if the issue was how to word it or whether it was the concept that was the — that was the problem.

DR. GARZA: It was I think the concept somebody had difficulty with is that given the choice that we had, it was difficult to getting to include it. Johanna, did you

have a point?

DR. DWYER: Yeah, I'm — I have misgivings about this process, as does Shiriki.

DR. GARZA: But what — do you feel that that's just inconsistent with the guidelines? I mean, what's the basis for the concern? If we just say we don't like it, it's not very helpful. I mean, so give us a reason.

DR. DWYER: I'm waiting for number three.

DR. GARZA: Okay.

DR. WEINSIER: So you're not uncomfortable —

DR. GARZA: So you're not uncomfortable with — with this —

DR. DWYER: No, I told you I was uncomfortable with this process. I'm uncomfortable with number one, with number two, and number three. I don't remember the Secretary of Agriculture telling me to revise the pyramid. What I heard them say was to do the dietary guidelines. Maybe I'm way off.

DR. WEINSIER: But we are including the pyramid right now in the guidelines. So it's —

DR. DWYER: That's fine. I think we can do text on the back. I don't think we — I think we should leave the pyramid and then have explanatory text —

DR. WEINSIER: Well, I think our chair needs to tell us whether we should be having this discussion now or —

DR. GARZA: I think we can provide whatever advice we want.

DR. DWYER: Yeah, we can say whatever we want.

DR. GARZA: That's right. And so that if in fact as a committee you would like to advise as to how the pyramid could be made more consistent with the guidelines — remember, we got into this as a very difficult discussion in the chicken or egg issue. And we recognize that this is a very important teaching tool but there are members of the committee that in fact felt that it was not consistent with the messages we were trying to give.

There was a certain amount of flexibility on their part, and I am doing everything I can to meet those concerns and say well, where in those concerns can we make some constructive suggestion for how the icon can be made to conform more easily with the recommendations we've agreed to make?

We went through the calculations of saturated fat and came up with a number that in fact, yeah, if you're going to try to limit it to ten percent, then most of your

choices in the dairy group would either be preferably low fat — not always, but preferably — low fat or fat free. Otherwise, you would exceed the recommended amount of — well, not the recommended amount, but the amount of fat we were cautioning people not to go over.

So that was the rationale for it. Now, you're absolutely right. Johanna's absolutely right. The government can say thank you very much. We've listened, but for these reasons, we can't change it. Now, on the other hand, I would feel very uneasy if you feel the recommendations are inconsistent with the guidelines. Then I think it would be totally inappropriate.

So let's finish the discussion. If we've got — if everybody understands at least the reason why I think we could continue with it. Rachel?

DR. JOHNSON: I have a question for Carole Davis. If we make changes that impact the energy contribution of a particular group, will that change those calorie profiles? For example, if everything in the dairy group was low fat or nonfat, would you then have to revisit those calorie distributions and servings?

MS. DAVIS: No, because the pyramid was constructed with using the lowest fat form.

DR. JOHNSON: Good. That's helpful. Thank you.

DR. GARZA: Suzanne?

DR. MURPHY: I certainly don't object to saying preferably low fat or fat free. That's consistent with everything in the guidelines. But I think our guidance on fat is not just for dairy products and not just for meat products. We don't want people to eat high fat grain products or high fat vegetable products either.

I feel we have a fat guideline and that's the concept of these sprinkles, if you will, and maybe it's not as good as words, but it's there in the pyramid. I think we're gelding a little.

DR. GARZA: Okay.

DR. MURPHY: This has been tested thoroughly and Shiriki said it just right. I'm not sure we should tinker with it.

DR. GARZA: Okay. Alice?

DR. LICHTENSTEIN: I think by highlighting the groups that provide the saturated fat in the diet we're actually helping people follow the guideline and now hearing what Carole just told us, that the calculations were done using the lowest fat, at least for the dairy available, which is consistent with what we're recommending, I think it's long overdue that low fat and non fat be in there and that this will at least — it may not be adopted — but at least it's going to send a

very strong message.

But at least it's consistent with the calculations that were used to generate the pyramid and most — I didn't know that. Most people don't even know that.

DR. DWYER: Could somebody tell us the — there was something between — maybe Nancy could tell us. Wasn't there something about the low fat dairy and some other things that were an issue of contention about the pyramid to begin with?

DR. GARZA: Is Nancy here?

(Simultaneous discussion.)

DR. GARZA: You're not a member of the committee, so you don't have to say anything. And Johanna —

MS. NANCY: It is truly recommend that the dairy groups are non fat or low fat. And that the meat and poultry group — say things meat,poultry, fish and et cetera. That was part of the review process —

DR. DWYER: This was the review process at NHLBI?

MS. NANCY: Yes. But that was a recommendation from some members of —

DR. GARZA: Well, Johanna, do you think there's something again that's inconsistent with that recommendation — with what's being recommended by Roland and the guidelines?

DR. DWYER: I'm concerned about what Suzanne said.

DR. GARZA: Okay. About — even what Carole said —

DR. DWYER: About singling out a specific group in the —

DR. GARZA: Okay.

DR. WEINSIER: Could we go on to the third? Let's go through all of them and then we can decide whether we want to forward these recommendations or not.

DR. WEINSIER: Yeah.

DR. LICHTENSTEIN: You mean we have to go as a group?

DR. GARZA: No, no. No, but I don't want to take five votes. We might just get them all done with one vote, maybe not, but I don't think we — I know. It's the triumph of optimism over experience. That's what keeps it going.

DR. WEINSIER: The other one was a number of recommendations came to me

after some suggested changes I made and that was in some way to note physical activity to get the overall concept of balancing food with physical activity. And I just took the liberty to draw that little figure in there and it is just to remind me and think of some ways perhaps on the back or the side of the pyramid that we can get the feeling of activity or as the kid's chart shows some figures running.

The question is, should we try in some way to convey physical activity? Yes?

DR. GARZA: I don't see any objection. I think recognizing the objections that Suzanne, Johanna, and Shiriki had with the entire process, I don't want to reopen that discussion, but I understand that. Now, is there any concern about trying to depict activity that you think would mess up the dietary messages?

Okay. Let's go on to the —

DR. WEINSIER: And the other was — and this is a little more difficult to explain, but the — it relates to the meat/beans group and what's written there is not intended to be the correct order. I think the issue was really twofold.

One, should the order be changed such that meat does not appear first and/or two, should there be a qualifying term before meat or some of the other products. And Trish, tell me if I'm wrong or perhaps Nancy or others, the order of these — or at least the first word in the group such as milk group, the meat group, the bread/cereals group, is a name recognition issue?

In other words, the first food listed is based upon consumer recognition, not on any prioritization in terms of —

MS. DAVIS: The frequency of use.

DR. WEINSIER: — content?

MS. DAVIS: The frequency of use. It relates to food consumption data.

DR. WEINSIER: That's what I mean.

MS. DAVIS: Yeah.

DR. WEINSIER: Food consumption, in other words, more frequently used not necessarily based on nutritional concept —

MS. DAVIS: Well, it's related to the composition, you know, of the diet. And this is what one of the principles of the food pyramid. We have a lot of shortened versions when we name these food groups in lots of publications where we just refer to it as meat, but it does relate to food consumption data, what people eat.

DR. WEINSIER: Yeah, so more commonly used. So it's not based upon — you're not trying to prioritized to say that bread is more important than cereal or rice

because it has higher zinc, iron content, something like that? Okay. Well, recognizing that, the suggestion was made that we not have meat as the first food listed under this group. The order is up for — for grabs and discussion and —

DR. GARZA: And the reason for meat not being first in —

DR. WEINSIER: And the reason for the suggestion is to try to — to change the — the perception that we are recommending — regardless of what is intended — you're saying it's a more — more commonly used food. The message is that these are the types of foods that can be chosen from within this group.

But we're not trying to make it a meat group, i.e, the key word is probably going to be the first one listed. And that meat is not something that we try to recommend in the guidelines.

DR. GARZA: Something has to be first. What would you — what would you recommend be first and what would be the rationale for it then?

DR. WEINSIER: Well, a reasonable alternative, although there wasn't consensus, offered poultry.

DR. GARZA: And what would be the rationale for the poultry?

DR. WEINSIER: Well, because again, it's according to what I understand from Trish, it's a commonly used food, it's becoming more and more commonly used. Fish is not going to do it. Dry beans is not going to do it. We're not going to probably put nuts or eggs first, so it's a matter of what can I choose?

DR. LICHTENSTEIN: It's also lower in saturated fat, so it'd be more consistent with the guideline.

DR. GARZA: Is that true also for very lean meats? I mean, is that — if you take lean pork and lean beef, is it —

(Simultaneous discussion.)

DR. JOHNSON: Not dark meat with the skin.

DR. LICHTENSTEIN: What about the fatty acid profile.

DR. GARZA: No, that's what I thought. I thought that what the group was going to say was lean, you know, and just have lean meat at the beginning, because we could justify that. I thought if we reordered it, we were going to get into two issues. One is, what's the basis for the reordering and I couldn't come up with one and I don't know whether — that doesn't mean anybody else could not.

The second is that we do have some other micronutrient issues. I'm not sure to what degree those were considered. But, for example, given the degree of anemia in

women in this country, I would be very reluctant not to have an iron source that was highly bio available.

DR. WEINSIER: Well —

DR. GARZA: And that's —

(Simultaneous discussion.)

DR. GARZA: But it highlighted — I could come up with a reason for actually highlighting it, because there's a reason that in fact I could justify publicly in terms of public health issues. And — but saying lean — because then I could deal with the saturated fat issue and then so in essence, I could have my cake and eat it too and not — not give the inadvertent message of increasing saturated fat by not saying lean.

And then also — and meeting an iron problem, maybe, but not solving both. So that's the type of rationale that I would feel comfortable with. That doesn't mean that it's the only one. But if we're going to suggest a reordering, then we're solving the public health issue and that there is a rationale for the reordering.

DR. DWYER: We could call it the baked bean pyramid because baked beans would come first.

(Laughter.)

DR. GARZA: Well, then we would have to —

DR. WEINSIER: Could I ask a question? Are there any health recommending bodies that have addressed this issue in terms of recommending meat as a necessary or key part of the average person's daily intake?

DR. GARZA: In my —

DR. WEINSIER: You know —

DR. GARZA: Yeah, I'm not saying it's the only one —

DR. WEINSIER: No, I'm asking a question. But it raises the —

DR. GARZA: But I know in terms of in children at least, when we think of iron needs, generally we think of two things. Either an iron fortified food that I don't understand the basis for, or meats, because it gives just the best source of iron. So that's the one I'm familiar with.

I don't know if that's true in pregnancy or in other age groups for which you worry about iron metabolism or iron adequacy. Other than recognizing that it's a problem among adolescent females. Now, men don't have that problem, so — but I know that

women do. So Alice?

DR. LICHTENSTEIN: I would actually propose that we just insert the word lean and recognize that there are a lot of — there's a lot of — there's a wide range of choices within the group that should be consistent with most dietary patterns.

DR. GARZA: I think the point that Roland made is a good one. Are there other reasons? I mean, because I was going to, you know, my own thinking about this in terms of how do I write up the recommendation? And so I offered one, but there may be other ways to do it.

DR. LICHTENSTEIN: Well, this is an interesting quandary.

DR. GARZA: Well, and I could say, gee, add lean because of —

DR. LICHTENSTEIN: Saturated fat.

DR. GARZA: — saturated fat, but then if I reordered, then I'd have to deal with those other issues.

DR. WEINSIER: Well, I guess I'm thinking population-wide, if I had to take a risk at trying to make a change that would improve a major disease in this country, cardiovascular disease, and if this would have a significant impact versus the risk that in a sub-population I may increase the risk of increased prevalence of iron deficiency, that's the kind of trade off we might want to consider.

DR. GARZA: And you don't think that by saying lean we solve both problems?

DR. WEINSIER: I don't think it's —

DR. GRUNDY: I did.

DR. LICHTENSTEIN: I do.

DR. WEINSIER: — ideal, but that's up for vote.

DR. GRUNDY: I think it's a very good compromise.

DR. LICHTENSTEIN: Yeah, so do I.

DR. DWYER: Is this the same as the Dash pyramid now?

DR. LICHTENSTEIN: Dash pyramid? Do they have a pyramid now?

DR. DWYER: Dash eating plan.

DR. GARZA: We may come up with that. I don't know. It may be the dash dietary guidelines by the time we're done, but all right.

DR. DWYER: Well, we heard a lot about cardiovascular disease, but I'm not sure that the pyramid is designed for a specific disease.

DR. GARZA: No, but our — would adding lean give you any concerns about adding any problems of disease, Johanna?

DR. DWYER: It's not what's in front of us. What's in front of us is a food group —

DR. WEINSIER: No —

DR. GARZA: No.

(Simultaneous discussion.)

DR. WEINSIER: No, but I said initially — cross that out. Just take the discussion — going on the base of the discussion, do you feel that putting lean in front of the word meat would be an improvement from what message we're trying to convey?

DR. DWYER: I continue to be concerned about the issue of the —

DR. WEINSIER: Okay.

DR. DWYER: — charge to the Committee and secondly trying to get the concept of lower fat throughout this pyramid and not just in two groups. I'm totally —

DR. WEINSIER: Yeah, it's just that foods such as vegetables and fruit and the grain group were not naturally high in fat, with a few exceptions.

DR. DWYER: We've been through a long tirade about french fries.

DR. WEINSIER: Yeah, but that's added.

DR. GARZA: Scott?

DR. GRUNDY: What — I mean, how I wanted to respond to Johanna's point, if, you know, if this pyramid is going to remain — and it sounds like it is — and we're going to link ourselves to this pyramid in some way, then — and yet we have changed the guidelines in a certain direction, it seems reasonable to try to at least modify some of the language around the pyramid without changing the pyramid itself to bring what we're saying more in line with the pyramid.

DR. GARZA: Yes. Sure.

DR. GRUNDY: Well, to bring —

DR. GARZA: The pyramid more in line with what you're saying.

DR. GRUNDY: Well, yeah, that's true. That's right. So, you know, I think we

ought to be — at least make a plea to modify some of the language around it without changing the structure. I think that's very reasonable.

DR. GARZA: Johanna?

DR. DWYER: That's not how this discussion has been structured. Five of you got together and made this new pyramid.

DR. WEINSIER: No. We never got together. There was no meeting.

DR. DWYER: You didn't get together?

(Simultaneous discussion.)

DR. DWYER: Whatever. But the basic point is my problem with this is that verbiage someplace else is fine. And that's — I think we have the prerogative to say how we feel people should choose within a particular category and nothing that's been said is particularly difficult for me to accept on that basis.

What was given to us is a cartoon that has denotations on the side that is not there. What this is is a picture that's different. So if this were all on a separate page, I'd have perhaps different views about —

DR. GARZA: No, Johanna, I think your point has been well taken. We have to recognize the difficulties with the process, so I'd like to get us to limit to the message, whether you think the message is incorrect. Because we'll try in the recommendations to certainly say there were individuals that are concerned about the research, that need to go along with trying to validate these changes, but to make the pyramid more consistent with the guidelines, these are the sorts of things we think you ought to consider.

But that — so right now we could be saying, gee is there — ?

Are you concerned about by saying lean that we're going to be either misrepresenting the guidelines or creating health problems?

DR. DWYER: But you're putting me into — I'm a lawyer's daughter, so I'm not going to — I won't play with you.

(Laughter.)

DR. DWYER: I will not agree because the discussion is in the context of the cartoon that has various labels on it. That is different than putting verbiage into —

DR. GARZA: No.

DR. DWYER: I really believe that —

DR. GARZA: No, I — we heard that.

DR. DWYER: Okay. And then you come back and ask me to comment on the —

DR. GARZA: No, then don't is what I'm saying. Fine, if you don't want to, then you don't — we're not — it's — I'm trying to steer the discussion to content, having already acknowledged your concerns.

DR. DWYER: I agree with the kinds of recommendations that are being considered, except I do feel that it's important to also highlight things in other groups that could be high in —

DR. GARZA: Well, we'll give you a chance to do that.

DR. DWYER: I think it's very — I think we have to start advising Americans where they are now. And there are some groups whose staple is dried beans as the first thing they eat in that particular group. And that's fine. But I think it's better to start advising on the lean choices of the foods that are — that are more commonly eaten within that group so that I don't agree with the order there at all.

DR. GARZA: No, Johanna, let me try to — that order has been thrown out ten minutes ago and the only thing we're discussing now is whether we keep the present order and add the word lean in front of meat. That's the only thing that's up for discussion unless substantive.

And I want to repeat, I fully acknowledge Suzanne's, Shiriki's, and your concerns. That's why it's — let's — let's put those aside now so that the rest of the committee can talk about these other messages and then we'll take a vote and there will be some who on the basis of those concerns say we shouldn't mess with it.

Or some that will say I want other messages. Not just the ones that Roland and others have recommended. Or others that say gee, regardless of process, I'm perfectly happy with what this — the way it's now depicted. And we have all those choices in front of us.

DR. DWYER: If it says preferably lean, it should also say preferably lean and prepared in ways that have little fat.

DR. GARZA: Well — okay.

DR. DWYER: Because a dish can be very high in fat and the kinds of fish a lot of people eat are very high in fat.

DR. GARZA: Okay. Richard?

DR. DECKELBAUM: I would — if this is going to be acceptable by the pyramid committee or USDA to decide on this, I would propose putting low-fat before the word milk and lean before meat. And in the icon that's going to appear in the —

DR. GARZA: So you wouldn't say preferably, you would just say low fat?

DR. DECKELBAUM: Yeah, low fat milk, yogurt, cheese groups, lean meat, poultry, fish, dried beans, eggs, and —

DR. GARZA: I think we have to be careful because —

DR. DECKELBAUM: Sorry, not low fat —

DR. GARZA: — there's no such thing as lean dried beans.

DR. DECKELBAUM: No, I meant lean meat. Lean meat. And then we could also choose lean nuts, if they —

DR. GARZA: All right. Let's go to the last change then. Rachel?

DR. JOHNSON: I don't think I can live with that, because the implication to me then is you cannot include a higher fat dairy product in your diet. So preferably to me means most of your choices should be, but if we put it at the beginning, the implication to me is that there's no room for ice cream in my diet. And I can't —

DR. GARZA: Meir?

DR. STAMPFER: Yeah, I agree with preferably versus all the time low. In terms of the issue raised about other parts of the pyramid where — there's a lot of saturated fat, there aren't other parts of the pyramid where there's a lot of saturated fat. These two are the main sources of saturated fat.

So I don't think we have to worry about preferably whole grain and low in saturated fat when we're talking about the grains. These are the two main sources. Now, another way to order it might be in relation to disease since, you know, it is supposed to be our guide. Meat is not only a main source of saturated fat, regular meat, but it's also a source of cholesterol and it's associated with a higher risk of colon cancer. Fish and nuts are associated with decreased risk.

DR. GARZA: Okay. Do you want to go to the last one? Johanna?

DR. DWYER: We also have to remember that there's some unfortunate Americans who suffer from nut allergies and develop anaphylactic reactions to nuts. And I don't remember anybody developing an anaphylactic reaction to beef.

DR. GARZA: Okay. The last —

DR. WEINSIER: Yes, the last one is on the bottom, right under the bread, cereal, rice, pasta group says preferably whole grain to more nearly match the current guideline, currently revised guideline.

DR. GARZA: Okay. And I will start the discussion. I feel very uncomfortable with

that because we weren't willing to tell people how many. And preferably to me means that you ought to just choose whole grains.

DR. DECKELBAUM: Eleven servings per —

DR. GARZA: And so since the group felt that we couldn't give people any guidance as to number, I would imagine that we should just leave that alone unless we can provide — because preferably to some will mean, gee, I shouldn't have anything else but. Or the majority should be — that might include — no, we're not going to be —

(Simultaneous discussion.)

DR. STAMPFER: The intake of whole grains, as we've seen it, the whole grain products is very, very low, so another word might just be include whole grains in foods that are preferably —

(Simultaneous discussion.)

DR. STAMPFER: — because we don't say — we don't say especially. We're not —

(Simultaneous discussion.)

DR. STAMPFER: The guideline does, that's what I'm saying. We don't have to be wed to the exact wording of the guideline. I think include whole grains just adds a little emphasis.

DR. GARZA: Okay. Any other points of view?

(Pause.)

DR. GARZA: Okay. Then let's — who — who's in favor of forwarding any recommendations, whatever, on the pyramid. Hold on. All right. First is those that will not. Say look, we have no business in this and we should not be forwarding any suggestions for how the pyramid ought to be — the text around the pyramid ought to be modified.

So all those in favor — first of all, of, you know, it's something we ought not do based on the discussion that we had, please raise your hand. I've got one, two, three, four. Seven. Eight?

(Simultaneous discussion.)

DR. GARZA: About the text around the pyramid.

DR. KUMANYIKA: Not necessarily the ones we just talked about?

DR. GARZA: That's right.

DR. KUMANYIKA: Okay. Some recommendations.

DR. GARZA: Some recommendations.

DR. KUMANYIKA: Yes, this is a general.

DR. GARZA: This is just general. And it's yes, we ought to do this or gee, we've got no business messing around with this.

DR. KUMANYIKA: It makes it because — he's — it's a slight of hand.

(Laughter.)

(Simultaneous discussion.)

DR. KUMANYIKA: This is a vote for whether this committee should make some recommendations to the USDA about the pyramid, which I consider to mean the next time they sit down to talk about the pyramid, we would have put some recommendations about how the pyramid is viewed and how it's aligned with things. And that I'm for.

DR. DWYER: Is that what you meant?

DR. GARZA: That's what I meant.

(Laughter.)

DR. GARZA: Okay. Yes, I don't have the power to change the period folks, all we can do is get him to change it and the decision is in another office.

DR. MURPHY: But that's a different concept than saying it needs to be changed in this year 2000 booklet.

DR. GARZA: But we can say if we want, I mean, that we want, you know, for the guidelines that we forward with pictures, can be anything we choose. Now, the USDA can then say, well, we'll take the first one but not the second, and we'll take the third, but not the fourth. The important thing is that you have a strong scientific reason for recommending the change.

They may decide, for example, that because when calculations were made for the pyramid and they used lean or low-fat products for the dairy group, that there's nothing lost by adding those words, preferably low fat or whatever we decide to recommend. On the other hand, that by making the other change, it really distorts how the pyramid was developed.

I mean, I will leave that decision up to them. I think all we can do is to say these are the sorts of changes that we think will be most consistent with our guidelines and figure one.

DR. DWYER: But that's different than what you just said. The first is —

DR. GARZA: Well, we ought to take this in —

DR. DWYER: — is should we have a set of research —

DR. GARZA: And I'm trying to take this in a way that we can deal with it —

DR. DWYER: And I think we can all agree that there are things that need to be worked on in the pyramid.

DR. GARZA: I'm going to — the next question —

DR. DWYER: Okay. And I think we could all vote — or I certainly could vote for that.

DR. GARZA: Okay.

DR. DWYER: But then you're sliding into something else.

DR. GARZA: But it won't —

DR. DWYER: And then this started with something else —

DR. GARZA: The next question is, if you'll give me a chance, I'll — if we are agreed that we can set recommendations, then we can deal with the recommendations that we're going to make in one of two ways. One way — we'll take a vote on it right now — is to actually recommend that in the book, you know, these changes be made. Or the other one saying no, these are just recommended.

But before I do that, I want to agree on what the recommendations are.

DR. KUMANYIKA: I'm not sure we can.

DR. GARZA: No, we can recommend, Shiriki, whatever we wish, okay? Now, so, first of all, let's take them one at a time, because I thought we could do them all together, but I don't know we're going to get everyone necessarily voting the same way.

Does anyone want to change either way — and then we'll determine which — in terms of just making recommendations to USDA or actually saying gee, if you're going to publish this booklet these are the changes we want in the booklet. But I need to know what we're — what we're going to be recommending before I could vote, at least. In either direction.

So how many of you would like to see any changes on the sweets, fats, and oils?

DR. KUMANYIKA: May I ask a question? About this process, because I feel like

this would be equivalent for doing another guideline. For us to actually fine-tune specifics for each category might be more of an elaborate process than — it seems, at lest it would be for me to come to an agreement, because I don't — I can't think through all the considerations that it might take.

So I'm willing to recommend in a more general way that the pyramid be adjusted to make certain things clearer, but I'm not willing — I can't agree on —

DR. GARZA: Let's sift through it that other way, that's a good suggestion. Let's take them — let's take the votes twice. The first one is, we'll talk about each of these changes in the context of just forwarding those recommendations as researched. Okay? And then the second time, asking USDA to consider changing this before they print the next guideline. The text.

There's some members — Shiriki, I'm trying to give USDA the benefit of everybody's input and I know that some of you feel one way and others feel another, and, you know, this is what I meant by "convince individuals". Well, when we're both — when you know, two people are convinced then we ought to hear convictions from both sides.

So as a research recommendation, who would like to see any change to the text on sweets, fats, and oils? Two. Of the type that we discussed. All those opposed?

DR. KUMANYIKA: You mean the text on the picture?

DR. GARZA: Text on the picture, all those opposed? Some of you are not voting. So it doesn't matter to you whether it's there or not? Okay.

MS. McMURRY: I got two yes's and four no's.

DR. GARZA: Okay. So if you're not going to send them as forwarded in the recommendation, then we won't worry about — because I would vote no as well — then we won't go into saying gee, change the text for the next guideline. All right.

DR. GRUNDY: Can we comment on that one before we move on to the next one?

DR. GARZA: Yes.

DR. GRUNDY: It seems to me that that the key to that is over here on one side and it says "use sparingly" and it's not clear, like all the other groups are well demarcated what they are. I think it's very hard to understand what is on that and I think it's all messed up.

Not just making changes that we would make, but I just don't — I just don't think that on top of that is clear what that means and the key is in tiny words, the fat doesn't differentiate between the different saturated fats and you know, I just think it's out of date and hard to understand.

DR. GARZA: Okay. Richard? I'd like to move on because otherwise —

DR. DECKELBAUM: I know, but there's an important point that you brought up. Are we voting now to recommend changing the wording around the picture —

DR. GARZA: As a research.

DR. DECKELBAUM: — in the new book?

DR. GARZA: No, what we did was first as a research, and if it passed — one ascended forward as a research one. Fine. Or, if you want to actually change the — the picture for the new book, we'll take that as a second vote because Shiriki felt it was too difficult to deal with it without taking two separate votes.

And I could understand that. I thought that was good. So, you know, this one didn't pass as a research recommendation, so we don't think that, you know, that it's merited. I don't know whether you want to change the picture now. How many of you would vote to go ahead and change the picture in the next pyramid? I mean, the booklet that is published with "use sparingly". All those that — all those that want figure one that we put in our guidelines, just say "use sparingly".

DR. GARZA: For it to change, rather. Preferably unsaturated. Preferably unsaturated.

DR. STAMPFER: It says "use sparingly".

DR. GARZA: I'm sorry. I misspoke. Preferably unsaturated.

DR. LICHENSTEIN: Preferably saturated.

DR. GARZA: See, it's confusing. That's why —

DR. STAMPFER: This is a little unfair because we didn't have a chance to get the exact wording. And I think part of the problem is that preferably unsaturated versus preferably saturated, I think the aim was to say take or choose unsaturated oils preferably or something like that to get the wording clear so —

DR. GARZA: But that's why I thought it was very confusing.

DR. STAMPFER: Well, I think preferably unsaturated is confusing. I think we can with a little thought and one or two more words come up with something that's less confusing.

DR. GARZA: Well, and that's why on the first time I asked people to vote I said you want to study this and we only got, you know, two people saying yes.

DR. LICHTENSTEIN: I think there may be some misunderstanding. Could we

redo that, please?

DR. GARZA: All right. Let's go back to it. All of those that would like to study how we can refine the message on the use of sweets, fats, and oils sparingly

— not recommend any changes —

DR. KUMANYIKA: I thought it was on the whole pyramid.

DR. GARZA: You know, maybe I'm tired. We said we'd take these one at a time, because the group didn't want to take them altogether.

DR. KUMANYIKA: Okay.

DR. GARZA: All right? So on this one, that in fact we want to study this but not make any recommendations, just study it, as to how it give them a better message. All those in favor, raise your hand. Six. All those that are satisfied with the way it is and therefore don't want to study — don't see any reason for studying this, raise your hand?

I wouldn't vote with the three. Six and four. Six in favor of studying this.

DR. GARZA: I don't see there's much of a problem in voting that as a recommendation in terms of —

DR. JOHNSON: Who did you vote with?

DR. GARZA: I said, I think we're not going to —

(Simultaneous discussion.)

MS. McMURRY: Someone didn't vote.

DR. GARZA: Someone abstained.

DR. TINKER: I did not.

DR. GARZA: Lesley did not vote.

DR. MURPHY: I'm sorry. Won't the whole pyramid go through an evaluation process when we're finished? Why are we doing this?

DR. GARZA: Because there are some members that feel very strongly about this. I know that you don't, but there are who do and I'm trying to be very patient to those who are.

DR. MURPHY: Well, let's let USDA assure us that everything is going to undergo review, that's part —

DR. GARZA: We have done that innumerable times.

DR. MURPHY: And then we can make some recommendations about things we're particularly concerned about.

DR. GARZA: These are issues that people are very concerned about. Trust me.

DR. MURPHY: Making a list of them, you know, I mean, if it concerns at least one member, we can put it on a list. I don't have any problem doing that. It's whether we're going to get in there and not —

DR. GARZA: Let's hold a vote then. Suzanne wants us to drop the entire discussion.

DR. MURPHY: Well, it's a research issue.

DR. GARZA: Yes.

DR. MURPHY: We have research recommendations, let's make them.

DR. GARZA: Okay. I was trying to be responsive to Shiriki.

DR. KUMANYIKA: I didn't want to recommend research.

DR. GARZA: Then, but you said you would vote for it I thought because —

DR. KUMANYIKA: I wanted to make recommendation, well, not researching this. I wanted to recommend that from a policy perspective, the USDA when it looks at the pyramid, consider how it communicates certain things that are in the guidelines. I didn't consider that a research recommendation actually.

DR. GARZA: And I did. It's a choice of words then. So how would you phrase it so we can get it before the group?

DR. KUMANYIKA: I just phrased it.

DR. GARZA: All right. Did everybody understand that now? Johanna did not. Johanna?

DR. DWYER: I didn't.

DR. KUMANYIKA: What I wanted to do was to say to the USDA that we feel that the way the pyramid currently communicates concepts that are in the guidelines is not optimum and to ask them to look at how it — when they revise it can be communicated better. If they do that from research, whatever things — I don't —

DR. GARZA: Just across the board —

DR. KUMANYIKA: — across the board, just to send a message that we have it in there in spite of some of the things it communicates, and to please notice that.

That's —

DR. GARZA: But you would like it as a broad —

DR. KUMANYIKA: A broad — oh, because I have — because there could be other issues too. It doesn't mention salt. Has not been able to fit that in and that's been always since the pyramids, so I didn't want to be narrow and try to start fine tuning things without taking the big picture into consideration. I just felt that was risky.

DR. GARZA: Okay.

DR. MURPHY: I — I 100 percent agree.

DR. GARZA: Okay. So then it's that general recommendation versus individuals that are considerably concerned about specific messages? Now I think we have a general agreement on gee, we're going to say that it ought to be evaluated because when I said that what we've been given that assurance repeatedly, so Shiriki's recommendation in fact, we've already been given that this will be evaluated.

So I'm trying to deal with the specific recommendations that others have because they feel that putting the picture in as it presently is will miscommunicate the guidelines. Now, that doesn't mean that USDA will be able to change them. It just means that we be specific so we don't ask them to read our minds in terms of the types of changes that are being recommended.

I tried various ways to get the consensus of the group or the opinion of the group so that we could then move that forward to the departments, but if it's that complicated, I'm beginning to agree with Suzanne, we should just drop it. Unless there's only two people who don't understand and the other seven do.

Then we'll let Suzanne and Johanna start. Shiriki — don't worry about it too much and the rest of the seven of you could perhaps come to some consensus.

DR. GRUNDY: Well, let me see if I understand this. It seemed to me that there is an inertia in changing the basic diagram and it's components and that's going to take time.

DR. GARZA: That's right.

DR. GRUNDY: But we were — what we were proposing is maybe there is a way to streamline the process to change the things that are attached to it, and that could be done more rapidly, and make it more in sync with what we've recommended. So we could recommend that as a more immediate thing that the USDA could do and that would almost fix the problem in itself.

DR. GARZA: That's very well put. I believe that was my understanding.

DR. DECKELBAUM: So I'm going to ask, are we discussing whether these changes will be in this new booklet only or whether all USDA publications relating to the pyramid will include these changes, because I don't think we can probably relate to all the USDA publications —

DR. GARZA: Richard, the only thing we can recommend is what goes into the dietary guidelines.

DR. DECKELBAUM: All right. So that's —

DR. GARZA: That's all our recommendation can be. We don't have the authority to recommend how they run anything else.

DR. DECKELBAUM: I agree on that, but I wasn't clear whether this was what we were all just sure on, unified on.

DR. GARZA: Now, does that help clarify it for everyone or not? Okay. Now, we can do this one of two ways. Change by change or I can try to summarize what people — I heard and then see if we could just do it in one vote. How would you prefer doing this? Change by change or one vote?

DR. GRUNDY: One vote.

DR. GARZA: All right. Let me try this and I — I will try to do this as objectively as I can. I didn't hear consensus on sweets, fats, and oils. So I'm saying let's just drop that. Any changes to that. For milk, yogurt, and cheese, just say preferably low-fat or fat-free. That we didn't really get to that, but low fat may be sufficient. I don't know we need to say fat-free. Is low fat all right? Okay.

On the meat/bean group, that we just say lean meat and leave everything else the same. That we have some activity somehow depicted in the picture, with somebody climbing the pyramid or do something and there seemed to be consensus on that.

And then that — just leave the whole grains alone and not say nothing. There was some debate about preferential or including or especially. That's right. And so the best thing we can do now is just not say anything. Or you want to say including?

DR. DECKELBAUM: Including whole grains.

DR. GARZA: All right. Including whole grains. Are all of you clear on those changes? All right. All of those in favor, raise your right hand?

DR. DWYER: In favor of —

DR. GARZA: Of recommending that those changes be depicted in the next edition of the dietary guidelines to be in sync with what Scott just said, to move the process

along, because we don't think that any of those are incongruent with our understanding of the way the pyramid was developed.

DR. DWYER: When you say depicted, you mean, did he have a booklet that has this diagram —

DR. GARZA: No. The booklet, we've got figure one, is in that booklet. The whole booklet.

DR. DWYER: And figure one would have these things next to it?

DR. GARZA: We have suggested that in fact figure one — we have a — a figure that is analogous to that in

— in the dietary guideline booklet that we're or the guidelines we're recommending, and that that picture depict the changes in the text that I just summarized.

Now, it's a recommendation. I mean, it's not whether in fact they'd like to move that into all their other, you know, all those in favor — is that — is that clear before I take that off? All those in favor please raise your right hand?

DR. JOHNSON: Can I just clarify one quick thing? Sorry. I'm sorry. We're voting — we're voting to recommend that USDA make these changes in the next booklet? Or we're voting or we're strongly urging USDA to study the feasibility of making these changes in the booklet —

DR. GARZA: No. We're recommending that they make the changes.

DR. JOHNSON: Okay.

DR. GARZA: For the dietary guidelines.

DR. DECKELBAUM: For the blue book.

DR. GARZA: For the blue book.

DR. DECKELBAUM: And the way you're structuring this vote is you want us to vote on these changes or the ones you just read off as being on the pyramid?

DR. GARZA: On the — in the text.

DR. DWYER: I have no problem with the changes, but I'm —

DR. GARZA: No, that — that — it's on the figure. So that in the text that we have in our figure, rather than just saying milk, yogurt, and cheese group, that in the figure we publish, we're going to recommend milk, yogurt, and cheese group, preferably low-fat.

DR. DWYER: Well, perhaps it isn't an important distinction to others. I guess I feel that with the changes you're separating from this that they're appropriate for me to make. If the changes are this, that's a different —

(Simultaneous discussion.)

DR. DWYER: No. What I'm saying is that if we recommend those very same things on the back of this, I'd feel different about it than I do right there.

DR. GARZA: We're only — we're only voting on figure one. We cannot vote on other material. It's only figure one in our text. The text we are forwarding to the Department. So we can — we can fashion that figure as anyway we please. All right. So all those in favor of making those changes in figure one, in the text, raise your right hand. How many? All those opposed? Three.

DR. MURPHY: How did we get seven? Are there eleven members —

(Simultaneous discussion.)

DR. GARZA: I will vote for recommending the changes. Wow, we did that before 2:45.

DR. KUMANYIKA: Can I make a comment?

DR. GARZA: You want to go back and revisit it?

DR. KUMANYIKA: No, no, no. I want to make — I just want to make an observation because for people who routinely use fat-free milk, it could — the way that you've worded your recommendation it could be construed to mean that low-fat is also preferable to fat-free. I just — it's an observation, since it looks like it's going forward, I just wanted to observe that.

DR. GARZA: Well, you want to go by preferably fat free or low-fat? That's a good point. I didn't know it was on the text. I didn't read it correctly. So with that — all those in favor of that modification, raise your right hand? All those opposed? Okay.

DR. DWYER: I would like to just put on the transcript that I agree with the gist of those recommendations. But I do not feel I was invited here to do that particular task and therefore I agree with the changes being included in the booklet, but I believe the pyramid should be put as they have it, and then the changes that are suggested in the appropriate places of the booklet can be included.

DR. GARZA: Suzanne, you want to make a statement?

DR. MURPHY: I guess my primary concern is that this logo and the — including the words around it were extensively tested with consumers, and I feel literally that we are tinkering with a proven product, and I would want to see the same extensive testing done before anything about it was changed.

And I'm sure that will be done, but it can't be done in time for the year 2000 booklet. So I think we may make this recommendation, but how USDA could possibly follow through on it — I think we've given them an impossible task.

DR. GARZA: Okay.

DR. MURPHY: And that's kind of unfair.

DR. GARZA: All right. Any other comments? Meir?

DR. STAMPFER: It's proven to be a good communication tool, but there's no proof that this promotes health.

DR. GARZA: All right. Now, could we go to the third point?

DR. MURPHY: I lost track of the third point. Let's see, the third point was — the third point was which label example. Do you like macaroni and cheese or did you want us to try to find a different one?

DR. GARZA: I think — I think the milk — there were some general concern with macaroni and cheese and we were going to come back and review it but if there were any others that come to mind that would be preferable — I don't think we've identified any others, so we may have to punt and just ask Suzanne and Kathryn to see if there's one that may be more appropriate.

DR. JOHNSON: What guideline was this under?

DR. MURPHY: This is all for the pyramid guideline. So you have the ingredient list and I guess the question was, did that — it didn't have, for example, any added sugar in it. So that was one of the issues that was brought up.

DR. LICHTENSTEIN: I think Bert's suggestion is excellent. I think now for us to think about another food. I think it's going to be difficult to do it in a really systematic way. I suspect that there are better ways of going about this.

DR. GARZA: We thought one would come up in our discussion. I don't recall any coming up.

MS. McMURRY: If you could summarize the types of nutrients you would want represented and whether they should be in high or low amounts, we could try to do some shopping.

DR. GARZA: Do you have any suggestions for what would be better?

DR. JOHNSON: Is that the perfect food? Is that what you're asking?

MS. McMURRY: Well, do you want a good example or a bad example?

DR. GARZA: Be careful.

MS. McMURRY: A high example or a low example for certain nutrients?

DR. GARZA: I would probably — should we ask for one, for example, with iron or calcium or fat, I mean, that — what are the nutrients that you feel are going to be the most —

DR. LICHTENSTEIN: Perhaps breakfast cereal because there's such a broad range and a broad range of nutrients. Some of them include almost all the nutrients and whole grain and some include just almost a single component.

DR. GARZA: I mean, it would be more inclusive of a more — more nutrient groups.

DR. LICHTENSTEIN: I think that's one that would be a consideration.

DR. DECKELBAUM: And then with a breakfast cereal, you could actually have it the way it is, with or without milk, whether you want whole milk or skim milk.

MS. McMURRY: It wouldn't likely include saturated fat or that was something that —

DR. GARZA: Yes, the other characteristics —

DR. DWYER: You could put butter in it. With oatmeal, it's not too bad sometimes.

(Simultaneous discussion.)

DR. GARZA: So would any of you want to offer any other characteristics for that label other than the one that Alice just made? Okay, then, let's go to number four.

DR. MURPHY: Okay. Number four was to revisit the daily values and the pyramid serving sizes. And Kathryn once again to the rescue did a hand out that I think everybody got or is getting that compared some of the typical serving sizes. Now, this is primarily in relationship to box one and let me shuffle pages here a minute, and I'll tell you what page it's on.

But it's our very first box that talks about the number of — no, I'm sorry. It's box two, that talks about the serving sizes. It is on page eight. And the ruler footnote, many — note, many of the serving sizes given above are smaller than those on the nutrition facts label.

And I guess my only question would be, is that enough or do you think we need more? This handout shows that indeed for many of the breads and for some of the fruits and vegetables, indeed the label serving is larger and I guess my belief is we can't go into that in much more detail, but do you have a question or suggestion?

DR. DWYER: Suzanne, do you see a way of highlighting the ones where the — I like this business because I never thought about it until today or last — yesterday that the food labels in the food guide pyramid servings are different. And so I think it's useful for a lot of people to know of the ones that are really different.

For many they're — they'll be the same, so we don't need to clutter the table, but for some, they are different. And would it be too much to ask to have the nutrient — nutrition facts label servings listed as well? Or do you think it would clutter it too much? To me, it gives useful information and it alerts people.

DR. MURPHY: Well, my personal preference if we're going to say something more would be to expand the note to say, for example, and give some of the examples. To expand this table when people can't — I mean, my impression is people have a really hard time remembering what counts as a pyramid serving. And all the rest of our booklet is geared to these serving sizes.

So to give people two different ones I think would be hopelessly confusing.

DR. DWYER: Yes, I understand that. I guess my concern is that we just had two hours or an hour of discussion trying to link two of the tools, the pyramid and the guidelines, and it seems to me this goes in the direction of linking the pyramid to food labels.

DR. GARZA: Would you want, Johanna, another box that would take the same examples, but then give — give the equivalent of a serving for — from the labels that we would have a slice of bread? Is that still one serving or — I mean, have one box based on the pyramid and one box —

DR. DWYER: No, I thought this could be modified to do a —

DR. GARZA: No, I thought your comment was how busy the box would look, so I'm thinking would it work better if we had two separate boxes?

DR. DWYER: I don't think so because I think —

DR. GARZA: Okay.

DR. DWYER: — we could have one box that would just have the ones that were different in italics. It just — the point is to get the message to people that the two are different. That's all. That's the bottom —

DR. GARZA: So you wouldn't put the difference, you would just say highlight it in some way to say look, the ones in bold differ from the DRV's and the ones that are not bolded are the same? What do you think of — of that, Suzanne?

DR. DWYER: And then —

DR. MURPHY: I think we would hopelessly confuse people. That's my personal

opinion.

DR. GARZA: Is there any sense of —

DR. TINKER: I think we would be confusing people too.

DR. GARZA: Shiriki?

DR. KUMANYIKA: I think it would be confusing and I'm really concerned about this since I became aware of it. The — at the very least, these are sort of pyramid servings and the food label servings are food label servings. Some effort — I mean, the — the pyramid servings were useful in developing the pyramid. But they're actually not useful for giving advice to consumers.

So for — could we do something so radical as giving the information about what counts as a serving in food label terms only? Just translating this information — I guess that wouldn't work with the two to three and stuff on the side of the pyramid, but I think it's really, you know, it's one of the biggest problems we have that Johanna stumbled upon the other day, that we're telling people to eat a certain number of servings and some of the servings that they'll see are twice as large —

DR. GARZA: Should we then just — I mean, the sense that I'm getting is perhaps to do it as Suzanne suggested just with a note, and then making a strong research recommendation that the federal government really needs to look at the educational challenge this represents.

Is that — would that be a — Shiriki, is that reasonable or?

DR. KUMANYIKA: I would put serving on the pyramid. I would put something at least to begin to anchor this what counts as a serving with the idea that it's not universally accepted as a serving.

DR. GARZA: So what kinds of — as a pyramid serving?

DR. KUMANYIKA: As a serving on the pyramid or — or something to begin to get that nailed down so that other people will take note of it too.

DR. GARZA: Would that — would that —

DR. DWYER: You know, I think — I think that this is a very fundamental issue and that it's much more important than added sugars or some of these other issues. The serving size is very critical.

DR. GARZA: But, I'm not disagreeing with you. This is federal, I mean, this is FDA's, I mean, we can't go and change the food label. I mean, that's —

DR. DWYER: No, but we can alert people to the fact that —

DR. GARZA: Well, that's what I'm saying. How do we best alert them to change this table to say it's a pyramid serving and then have a footnote that says, you know, these aren't the same as the servings on the label,

or are —

DR. DWYER: That's correct. It is what I think, but I think that the servings that are on the label should also be given.

DR. GARZA: I know, but there's no — no one is agreeing with you. Who else feels that way because it's — oh, but that's satisfying. You're saying no, that you're going to stick to having them both on there?

DR. DWYER: Yes.

DR. GARZA: Yes.

DR. LICHTENSTEIN: I actually think it would be very helpful to have both on there, because I think it would number one really drive home the point, but number two, would alert people that in some cases, there's far more discrepancy than other cases. And it would help them make their own comparisons.

DR. GARZA: So how do you answer Suzanne's and Lesley's concerns this would be confusing? You feel it would be more educational than confusing?

DR. LICHTENSTEIN: The world is confusing. I think this situation is particularly confusing. Initially, I thought well, maybe we should call one a portion, one a serving, but we can't do that because the pyramid goes by servings and the label specifically says serving. I think the — the next best thing is just to say okay, this is what it is. And right — you know, make your own adjustments when appropriate.

DR. GARZA: And so we have to be very careful then if we're going to do something like that throughout the document to repeat that we're talking about pyramid servings?

DR. LICHTENSTEIN: Yes, I think we're going to have to start doing it. I think it's an issue that has been around for a long time and it just seems to get more from, you know, one to the next that no one really is dealing it.

DR. GARZA: Yes, we have two people then suggesting that we have both on the label. Meir?

DR. STAMPFER: I agree with Johanna. This is a really serious problem. The —

DR. GARZA: We agree on that. Now let's —

DR. STAMPFER: Okay. Well, I think what is going to be familiar with consumers

is they buy their foods as what's on the label. The food pyramid I think is very well recognized as a shape and the general form of it, but I doubt that very many — I'd bet anything that only a vanishingly small number of people have any clue what the serving size is of the food pyramid.

So I think we should either have both or what I would really prefer was what Shiriki started to recommend, and then backed down from, was to just do everything in terms of the dietary value label. The food label —

DR. GARZA: But let's — let's explore that. How would you do that given that the food label is food specific and our recommendations are group specific? And the servings differ.

DR. STAMPFER: Well, take a typical, average whatever —

DR. GARZA: Yes, but the typical average would be very — I mean —

DR. STAMPFER: Where they differ —

MS. McMURRY: The food labels — there's — there's — I really summarized these here to try to get them into some — some kind of consistency, but each particular product is — can vary. I mean, they're as consistent as possible across similar foods within packaged foods.

DR. GARZA: From an educational standpoint, I'm having difficulty understanding how we could do it in DRV's. Now, I — as I go to each of the guidelines, I —

DR. DWYER: We can't. You're talking about DB's.

DR. GARZA: Yes. I mean DB's. Thank you. DB's. That's right. Because of the problem that Kathryn just — just described —

DR. DWYER: I don't understand the problem. But I had a, you know, one of those bolts of lightening struck me that I've never seen how big the differences were in some of those groups until yesterday. I've just never seen them and I've seen these things for 100 times. So I think it — it really would help people and I don't know the best way and I'm too tired to think of the best way today, but I wish there were some way of alerting you to this.

DR. GARZA: How do you feel about the recommendation that Meir forwarded that we ought to

do this in DRV —

(Simultaneous discussion.)

DR. DWYER: — United States who are vanishingly small in number who cook, and who don't eat completely the processed foods that have a label on them. And I

think that the USDA servings are probably —

DR. GARZA: You mean the pyramid?

DR. DWYER: Yes.

DR. GARZA: So you would suggest that we continue using the pyramid servings throughout the document —

DR. DWYER: Right.

DR. GARZA: — that have some way of depicting both on this one table, and then throughout the document point out that it's a pyramid serving?

DR. DWYER: Right.

DR. GARZA: I'm sorry, Rachel?

DR. JOHNSON: I'm just wondering in order to ease the confusion, it appears to me that the — that the one group that has the largest disparity is the grain group and I know that — I think that's what a lot of us here, when we say six to eleven servings of grain and then we say, yes, but a serving's half a cup of pasta where really on the label it's a cup; and I wonder if we could highlight that grain group as where the differences occur.

And then say something like, you know, this occurs with, you know, with a variety of foods. Be sure to compare the label with the pyramid servings or something. But it does seem to me that the grains are particularly stand out.

DR. GARZA: So are you arguing for sort of a bolding or the values being side by side?

DR. JOHNSON: The bolding?

DR. GARZA: Well, we suggested that in fact one could bold those where the greatest difference is to alert consumers. These are the types of foods you need to be most worried about and not clutter it with too much — too many numbers. Johanna felt that, no, that we really needed the numbers and —

DR. DWYER: But we need — well, it's the meat, poultry, fish, dried beans, eggs, seafood, nuts, whatever group. And the milk group is different. And then bread, cereals and greens. The others don't matter, do they? Because if we eat more of them, then —

DR. GARZA: Let's, yes, can I suggest that we let Suzanne sort of struggle with this? If there's a way that we can do it, that in fact doesn't clutter the table up too much, we ought to do it that way with the numbers. Consider if it's just impossible, maybe have two — two tables that people can contrast.

Or use some other mechanism for highlighting those groups that are the most different, I mean, and I don't know whether we can do this until we see them formatted in ways that we can judge.

DR. LICHTENSTEIN: But somehow, in any format that that's done, emphasize that in some cases the discrepancies go in different directions because with the milk group, the pyramid servings tend to be somewhat larger than —

DR. GARZA: We may have to deal with that in a what is a serving.

DR. LICHTENSTEIN: Okay, but it's the opposite direction, so just alert the consumer in any way you can.

DR. KUMANYIKA: Are they larger?

MS. McMURRY: Just for cheese, they're larger. One and a half ounces versus one ounce.

DR. GARZA: This is a big mess. And it's a real challenge, even to put it in a paragraph and what is a serving and —

(Simultaneous discussion.)

DR. MURPHY: Okay. I will try it in my preferred format, which is an expanded footnote or possibly even a little new box that talks about discrepancies and then I'll, for comparison, try to do it in this tabular format, but you know where I stand.

On this same topic, we need to — I need to know that it is indeed the consensus of the group that the table on the back of the slick pyramid that follows page six, that we are agreed that that table on the back, on the bottom left, how many servings do you need each day, that this is going to replace our current box one.

DR. JOHNSON: And you're going to add young children under the 1600?

DR. MURPHY: And then if it does, what changes are needed and, for example, the first column, instead of — in addition to saying women and some older adults would need to say children or whatever, six to eleven.

DR. JOHNSON: No, two to six.

DR. MURPHY: I'm sorry. Why do I have it written six to eleven, that's why I keep doing it wrong. Two to six.

DR. DWYER: Would you recommend that we keep it the way it is?

DR. MURPHY: No, I'd like adding children since we —

DR. DWYER: Oh, yes, with that.

DR. MURPHY: With that. The other change that someone needs to think about is are we going to put the footnotes in?

DR. DWYER: Yes.

DR. MURPHY: And then someone — I wouldn't be in favor of the second footnote, because it no longer agrees with the calcium AI's.

DR. WEINSIER: Say that again?

DR. MURPHY: No, I — but there's — I think there's been work done — what would we say about calcium, the second footnote there, that says women who are pregnant or breastfeeding, teenagers, and young adults to age twenty-four need three servings. Those are no longer the right age groups or the right physiological status groups for three servings. It now needs to be all adults over fifty, right?

And the age limit is nineteen, not twenty-four and we're not recommending increases for pregnancy and lactation.

DR. GARZA: That's right.

DR. MURPHY: So all — all those with — I mean, is that okay with everyone? We'll just go ahead and make it agree with the AI's. And is that going to be any problem for USDA?

MS. SUITOR: Just put it down and we'll — take it under advisement, we're not making any committments here today.

(Laughter.)

(Simultaneous discussion.)

DR. MURPHY: All right. The other issue on this — this specific table is whether we add two more columns to agree — here we are back to the label. Do you want a 2000 calorie and a 2500 calorie column because those are the bases for the daily values on the labels? And if you do, what are you going to put into those columns because gee, I don't know how you do servings. They're all going to come out fractional.

DR. GARZA: That would be the nearest whole, I think.

DR. MURPHY: Yes, well —

DR. WEINSIER: And it's going to be the same as 2200.

DR. GARZA: — I mean, I don't know what else you could do. I think if you tell consumers, you know, 3.4 servings, I mean, that's not very practical either.

DR. DWYER: I would like to see it. I realize that it more brings these tools together in a seamless garment of consumer fights, but —

DR. GARZA: It may be useful in doing that —

DR. DWYER: — in terms of the —

DR. MURPHY: Shall we try it and —

(Simultaneous discussion.)

DR. DWYER: As far as the rounding issue, there are some groups that are — like the vegetable group, you'd probably round up and the fruit group, up. And then the others, I'll leave to the group of five to decide what to do.

DR. MURPHY: Okay. But nobody wants to see fractions, I assume. All right.

DR. GARZA: I think it would be confusing if we do it in the same table, is that people will then think that if we tie those calorie levels to the label, but the servings that we give under them are for the pyramid, you know, what do you do?

DR. KUMANYIKA: This was easier before we started doing this.

DR. GARZA: My thoughts are if you put them all in the table and we identify those other calorie levels as relating to the label, but the serving sizes under them are unrelated to the pyramid, not what they're going to say on the label, but how you put that in a box is a struggle for me.

DR. DWYER: But I don't think you need to do that. I think you could put them all in pyramid.

DR. GARZA: But then when they go to the label, because that's what the calorie level is going to be, on the label, the serving sizes are no longer going to correspond.

DR. DWYER: If they can — if they can figure out all the other things we've said in these guidelines, then they can figure that out.

(Laughter.)

DR. GARZA: Well, I didn't even think about it. I think it would be a very confusing table. Is that the sense of the group or —

DR. MURPHY: It would be a what kind — what did you just say? It would be a what kind of table?

DR. GARZA: What I think would be very confusing, Suzanne, if we put the calorie levels in this table, calorie levels that correspond to the food label, but then the food servings are going to be in pyramid. Then it's going to be a disconnect to anybody

who tries to use it because the calorie label will be — will match, but the servings will not match, right?

DR. DWYER: But do you think that anybody would ever try to use it?

DR. GARZA: Well, I — then my point is why put it in?

(Simultaneous discussion.)

DR. DWYER: The didactic point is that the two are different, okay? And that's what I think is my insight, that I never realized that the portions were different.

DR. GARZA: We're acknowledging your insight.

DR. DWYER: But people do not take this little booklet and go to the grocery store so they — the hypothetical you're giving is not the way people use this booklet.

DR. GARZA: Then why put it in?

UNIDENTIFIED : That's right.

DR. DWYER: Because it makes the point that it's different than what they're seeing usually. I mean —

DR. GARZA: They're going to compare them to see they're different —

DR. STAMPFER: If we had — if we had two other columns, we'd have to have a heading, so what would it be? Like moderately active women, some men, but not all? I think I would propose that we leave it that three is enough — three columns and not add those other calorie values.

DR. LICHTENSTEIN: I would agree with that for a different reason. I think by having the discrepancies between the serving size, we could actually risk over consumption if people actually just went to the labels, so we should just stick with the three.

DR. GARZA: Stick with the three?

DR. LICHTENSTEIN: Yes.

DR. GARZA: Okay.

DR. MURPHY: Could I propose a compromise again that maybe in the text where we say consult the food label, point out the discrepancy, the daily values are based on numbers other than the pyramid numbers and consumers should be aware of that.

DR. GARZA: In the text but still have the five levels here, you're saying?

DR. MURPHY: No, I would only put the three levels in the table.

DR. GARZA: And that's put in the text that —

(Simultaneous discussion.)

DR. GARZA: — the serving sizes will differ? Right. But I think that's where we have to put — I'm trying to figure out how we would modify what's a serving to deal with all of these issues, which would be tough.

DR. MURPHY: Well —

DR. GARZA: And to help us understand why the servings are different, Kathryn?

MS. McMURRY: I will try to translate or to explain, the — first of all, the serving sizes for food labels are different because Congress mandated that FDA set serving sizes based on the amount customarily consumed in common household measures. So they're based on consumption survey data.

In terms of the calorie levels for the daily value, FDA originally proposed 2200 calories as the base line, which would be consistent with the food guide pyramid, but in response to public comments that objected to what they felt was a high level of calories, it was lowered to 2000 calories.

DR. GARZA: And —

MS. McMURRY: And then subsequently in 1993, the 2500 calorie level was added as a higher level for people who consumed higher calorie diets. And then it was agreed to by USDA, FDA, the Secretary of HHS, and USDA, and the White House.

DR. GARZA: They didn't ask this committee.

(Laughter.)

DR. DWYER: Could you just review again what the USDA serving —

MS. McMURRY: They started — excuse me?

DR. GARZA: It came before?

MS. McMURRY: The pyramid came first.

DR. GARZA: The pyramid was out there, and then for the reasons that Kathryn —

MS. McMURRY: It started out trying to be consistent with the pyramid, but it was steered in another direction.

DR. GARZA: Okay. So that's how we got into this very difficult circumstance. All

right. Lactose language, can we move on to that?

DR. MURPHY: Okay.

DR. DWYER: Do we want to recommend a harmonization of the two?

DR. GARZA: Well, that's where we — I agree. This is going to be a research issue that will be there.

DR. MURPHY: Okay. I think it's important — I know that both — we're moving on to lactose.

DR. GARZA: Lactose.

DR. MURPHY: Both Richard and Shiriki were going to give us some suggestions, but I'd like to at least take five minutes to talk about specific wording. Do you have specific wording to propose at this point?

DR. MURPHY: He has an overhead.

DR. KUMANYIKA: And I rewrote the paragraph, but I don't have an overhead of it. I just — Richard has it.

DR. MURPHY: Okay. Go for it, Richard.

DR. GARZA: Is that — is that Shiriki's recap? Or just your —

DR. DECKELBAUM: Well, this is separate, but I actually modified it since I showed it to Shiriki.

DR. KUMANYIKA: Okay.

DR. GARZA: Okay. And this would be inserted where?

DR. KUMANYIKA: It's in that there are many helpful paragraph.

DR. DECKELBAUM: It's a separate paragraph.

DR. MURPHY: On page nine, I believe.

DR. GARZA: On page nine?

DR. KUMANYIKA: Under many healthful eating patterns?

DR. MURPHY: Um-hmm.

DR. KUMANYIKA: Okay.

DR. DECKELBAUM: This one that I'm about to show would go under many healthful eating patterns and would be a paragraph, potential paragraph, between the two paragraphs that were on page one, the top of page one.

DR. GARZA: The title for that is on page eight, so those of you who may be confused, that's why.

DR. DECKELBAUM: I think the committee needs to decide whether to address this in detail or not. The reason — the positive aspect of us addressing it is that a large number of the population has physiologic, normally occurring low levels of the intestinal enzyme lactase, so if we take the Europeans who come from northern Europe, generally, they would be largely Caucasians and low lactase beginning in the teenage years and going on to adulthood would occur in about fifteen percent of this population.

But if we look at other populations, African Americans, depending on where they come from, would vary from seventy to eight-five percent low levels of lactase. Asian Americans would be above eighty-five to ninety percent. Ashkenazi Jews would be about sixty percent. Sephardic Jews would be about eighty percent.

So these large segments — Greek Americans would be about sixty or seventy percent. So the large segments of the population have naturally occurring lactase deficiency. And if we look at the public comments we've received during this process, we have a lot of discussion about being insensitive to this physiologic phenomenon.

I would like to report that it does occur and we recognize it, but it — it's handleable as follows. The text doesn't read "a large number of adolescents and adults without specifying populations, have naturally low levels of lactase, the enzyme needed to digest milk sugar, lactose. However, most of these individuals can drink one or more servings of milk daily with no discomfort.

"Still, with those with adverse affects from too much lactose, dairy products low in lactose are readily available, used, for example, in yogurts and certain cheeses."

I leave it for the committee to decide whether this should or should not be — something — unfortunately, this was written without Carole Suitor's input and I'm sure that if the committee decides to go ahead with it, we would have a better version of what appears on this overhead.

DR. MURPHY: Roland? A comment?

DR. WEINSIER: Yeah, a couple of questions. When you say most, I mean, is that established?

DR. DECKELBAUM: In the scientific literature that is available —

DR. WEINSIER: It's clear.

DR. DECKELBAUM: — would say that, yes.

DR. WEINSIER: And that's — let's see. You're saying most of these individuals can drink with no discomfort?

DR. DECKELBAUM: Right.

DR. WEINSIER: So zero.

DR. DECKELBAUM: Zero.

DR. WEINSIER: Okay. And another question is, is all — are all yogurts low in lactose or just those that have been prepared with active lactophysillus or —

DR. DECKELBAUM: Those that are prepared with active cultures.

DR. WEINSIER: So it may not be correct to say —

DR. DECKELBAUM: They don't have to still be active.

DR. WEINSIER: I understand that. But — but they're prepared, are all yogurts — it just says yogurts. Is that correct?

DR. DECKELBAUM: I think — I need help on this. I think all — I don't know — huh?

DR. DWYER: No, he's right. There's some cultures that are not prepared with lactose.

DR. DECKELBAUM: I actually did not put lactose reduced milk there because one, there's a big cost factor there especially; two, I personally don't think that that's what's needed to address those that do have discomfort from lactose. There are other ways around it. So there's three major points that — let's not do wordsmithing yet.

But the three major points are one, that a large population — large segment of the population has a low level of lactase. Two, the — this does not necessarily or most often in fact is not associated with symptomatic problems, and three, if it is, there are products available, dairy products, that can supply, you know, dairy nutrients that are very low in lactose.

Those are the three points that are made here. How the wording would go, certainly we can change it. So I think the committee needs to decide whether we should go ahead to bring this up in the dietary guidelines, remembering that this is a — it's different than vegans or some of the other problems we discussed, food — specific food allergies or that because it does involve a very large portion of the American population.

DR. GARZA: Let me start it — Roland —

DR. MURPHY: Roland already had a turn.

DR. GARZA: Oh, all right. Let's begin with Rachel then.

DR. JOHNSON: I think that certainly support the inclusion of — of something. I think it needs a little work. I'm a little hesitant about a large number. Maybe we can say some people or something. My concern is that I think there's, at least in my experience, a number of young children that may experience some GI symptoms when they drink milk that may be related to a flu of some sort and parents jump to the conclusion that they're lactose intolerant and then they're labeled that way for the rest of their life in terms of dairy product intake.

So I just wanted to, you know, I think I'd be more comfortable with some people rather than a large number. And — and I agree with Johanna and I'd like to see a very inclusive list of the type of products including — I'm — I'm a little reluctant to only recommend yogurt, for example, because yogurt isn't fortified with vitamin D and then if you have somebody who's thinking they're meeting all their nutrient needs that are in the dairy group by eating yogurt, that might not be the case, if they're counting on it for vitamin D, for example. So lactose free milk should be included in that.

DR. GARZA: Suzanne?

DR. MURPHY: I have a much shorter argument and I don't want to get into wordsmithing, which is what we're doing, but I do think it may be much shorter than it has to be, some alternative, which may be technically not as correct, but it says people who don't digest their lactose well can enjoy reduced or lactose-free dairy products as well as small portions of yogurt and cheese.

DR. DECKELBAUM: I agree that it's shorter and that's part of the point, but it misses a major point, is that most of the people who have low levels of the intestinal enzyme lactase can in fact enjoy full lactose products to some — in some amounts which would be more than at least a cup of milk a day, a serving of milk a day.

So this suggests —

DR. MURPHY: Small servings —

DR. DECKELBAUM: As well as —

DR. GARZA: How would you characterize that? As well as?

DR. DECKELBAUM: Regular servings of yogurt, cheese, and milk.

DR. GARZA: Okay.

DR. DECKELBAUM: Because I think it's — there's a — there's — there was quite a vocal community that reported input into this committee that suggested that lactose — that lactase deficiency — you have to be very careful with the words here. That lactase deficiency is associated with abdominal cramps, diarrhea, bloating, and discomfort.

And the actual facts are that in the majority of cases, with one cup of milk a day or sensible use of dairy products that you do not have bad adverse effects associated with lactase deficiency. A large number of people in this room are lactase deficient and don't know it.

DR. GARZA: Shiriki?

DR. KUMANYIKA: I'm not in favor of adding certainly not the long version of this. The text that I suggested was a rewrite of that paragraph and it included something about health issues, including intolerances to ceratin foods as an influence on what people choose to eat and picking up that point about if for some reason you don't choose foods from one of the groups — like you don't eat dairy products — then you have to look for your calcium and pretty much other nutrients someplace else.

I don't think there is a scientific basis for the lactose — lactose intolerance and food consumption in the way that some of the comments we got have indicated. And because there's not a — when I reviewed this, it was a while ago, it was for the WIC food package, that a detailed review of the up to date reference at the time was a 1988 supplement in the American Journal of Clinical Nutrition that goes into a lot of this research in great detail.

I don't know if there's something as good. I searched the web and I didn't find anything up to date and so you don't have to tell people that they don't get symptoms when they drink a glass of milk. They know that because if they get them, they stop drinking it.

So I don't — I don't understand how this advice is necessary because it gives the impression that the goal is that everybody should use dairy products. That is, I think, what some people find offensive and this doesn't address that.

If dairy products are not in your diet, all these things are phrased to tell you how, you know, even — how you can manage to get them into your diet. And that's what we should discuss, because I don't think that that's a message that we've decided on in the guidelines.

The dairy products are on the pyramid, but they are not the main source of those nutrients, and I don't think the approach of the guideline is to figure out how everybody can eat dairy products. It's really how, you know, everybody can get those equivalent nutrients. And so I'm against it for a couple of reasons. One is that I don't think we need to tell people that and the other is that I don't want to give the impression that everybody has to all — everybody has to have dairy products as a

part of their diet.

DR. DECKELBAUM: I'm fairly neutral on — on whether to include this or not, so I'll vote last.

DR. GARZA: Just as an educational piece, you're not persuaded that in fact even from the people that will feel given the — the prominence this has been given that you were ill and didn't know it? I mean, do we have to worry about things like that?

DR. DECKELBAUM: Well, just a lot of people who do have symptoms from lactose intolerance don't know that it's from milk or other dairy products. And I can give you specific examples because we see these kids in adolescence, people who use huge amounts of chocolate spreads, even on bread or, you know, there's a lot of hidden sources of lactose.

And not everyone who has some sort of functional bowel disease which is associated with — and some of them are associated with lactose intolerance recognize that it's from lactose intolerance.

DR. GARZA: Go ahead.

DR. KUMANYIKA: Well, I guess I'm thinking that the — there are lots of food allergies and intolerances out there. This one happens to be based on a general ethnic classification, but there was no evidence the last time that I looked at it that that was causing a widespread health problem or quality-of-life problem.

And so until I see evidence, I think it's a research issue. I've tried to survey this issue myself. It is hard to uncover a prevalent problem of this type. People have set their own level. If they eat cheese, they like it. If they eat yogurt, they don't. And I don't see the evidence that this is a problem that we need to address here.

DR. DECKELBAUM: I 100 percent agree with you. That's what I said. I do not think that this is a major health problem. It is a problem that has been raised very vocally to our committee and as have been other problems been raised very vocally to our committee. It doesn't mean we have to address them all.

DR. GARZA: So we should just put on the record why we chose to address them or not and that's what we're now doing and —

DR. KUMANYIKA: Well, I guess there's a chance that this would discourage dairy product consumption in a deterministic way among people who currently use dairy products as a source of nutrients. And I — that — that worries me because if you start telling people okay, now you're that, you probably could have a problem here.

I — I just don't think it's helpful to just make that decision on that basis.

DR. GARZA: Okay. Roland?

DR. WEINSIER: Yeah, I think Shiriki is right on target. I'm sure the rest of you also have been inundated with materials and individual letters that we are not being culturally as sensitive and that the three points that I make and some overlap with Shiriki's, mine is that we're not being sensitive to it. And I think your first sentence does show that we are sensitive and aware.

So I think it's worth considering putting it in, but I understand your point that we could be raising an issue that we shouldn't be addressing or making some people who didn't know they were lactose-intolerant all of a sudden think they should be.

And I think it shows that we are aware and sensitive to it. Second, is that your third sentence comes across as going against what I think people are at least telling me and that is that they want to see alternatives, the point that you're making, sure. Let's point out that yogurt and lactose, you know, reduced milk are an option, but also there are non-dairy options.

Let's just say it. So we're sensitive to it, we're aware, and there are options. And third the middle sentence that you had about lactose-intolerant people, I agree with Shiriki. My feeling would be they know it and we don't need to tell them, and whether they absolutely have lactose intolerance or not by hydrogen-breath test is not really the issue as we saw last year in the HHCN article.

They still demonstrate lactose intolerant systems. It may be perceptive, but if they have it, I don't think that we should try to tell them that they do or don't. So I think your first and last sentences are the key ones. And I think they —

DR. GARZA: Roland, would you put this in the rationale to say now here's the science. This is the way we considered it. If in fact you're doing it in response to public comment or does it merit inclusion in the guidelines because it will make — it will help people make choices?

DR. WEINSIER: You know, I think they would have to be in the latter context. I mean, I already stated that —

DR. GARZA: You can make those choices to lactose intolerance or would you just say look, if you don't want to drink milk, here are a variety of non-dairy and dairy sources of calcium?

DR. WEINSIER: Yeah.

DR. GARZA: Or would you say no, you know, if you're lactose intolerant, you know, here are some non-dairy sources of calcium and some non-dairy or dairy sources of calcium without lactose or just relegate all of that into the rationale?

I mean, it's going to be which way you're counseling us or advising —

DR. WEINSIER: No, I'm saying incorporate the first and third sentences in the text.

DR. GARZA: In the text.

DR. WEINSIER: I'm sorry. I meant to say in the text, and let the revision of the last sentence include non-dairy options or at least refer to Suzanne's —

(Simultaneous discussion.)

DR. WEINSIER: It just shows that we're aware, we're addressing it —

DR. GARZA: But you are doing it in response to public comment, which generally we try to do in — or it's because the science is such that you're concerned there's a public health problem we ought to be addressing, to answer Shiriki's point.

DR. WEINSIER: I guess it's both.

DR. GARZA: Okay.

DR. DECKELBAUM: Just to comment on what Roland said, I — I would rather I go Shiriki's way and just drop it or put it in a sentence similar to what I don't think you've read out yet.

DR. DECKELBAUM: But if we're — I would disagree with having the first sentence and the last sentence without the middle sentence because it gives a wrong health message because the majority of people who had low lactase have no symptoms or that bother them on their diets. Whether they've adapted to, you know, behavioral input, you know, some kind of hidden input to self-limiting their intake of lactose for whatever reason.

But the majority of people who are lactase deficient in the population, you know, do not walk around with abdominal pain and diarrhea. So if you just had — just read the first sentence and then read the last sentence and that's suggesting that a large proportion of the people who have this should, you know, go on to the special alternatives.

DR. GARZA: Johanna, you have your hand up.

DR. DWYER: Well, I think that I was commenting on Suzanne's —

DR. GARZA: No, go ahead. I think we're back and forth to both —

DR. DWYER: I thought it — could I just see it again? I thought it was pretty good.

DR. GARZA: So you would include it in the text, you mean?

DR. DWYER: I think that Shiriki's got a good — you've got a good point there, Shiriki, that if — if the committee does decide to go that way, that it would be a good idea to include calcium or vitamin D fortified soy milk or some — something

other than a specific food group that was rich in the nutrients.

The reason I'm concerned about including it is when Suzanne and I had our wars over the listing of sources of nutrients, I am concerned that people will get the idea that — I can't remember whether it was broccoli or whatever it was, is very high in calcium and I do think there is a problem with calcium intakes and vitamin D as well.

So I am concerned about not having people self — select themselves, thinking that they can eat a food when they probably can. But I'm not about to tell them what to eat.

DR. GARZA: Okay. Alyson and then back to Shiriki.

DR. LICHTENSTEIN: A soy-based beverage with added calcium is in box three and my understanding is that we're going to reference back to box three. Right?

DR. DWYER: But the point is that it should be — there always should be two options given, not just in box —

DR. GARZA: Shiriki?

DR. KUMANYIKA: The other — from the evidence point of view, the calcium intake levels are clearly lower — they're low in general — relative to recommendations and they're incredibly lower in — at least in some populations, African Americans included, but there have not been health problems associated with that.

In fact, it's the reverse so far. So it really presents an evidence paradox, because the populations with the most calcium related health problems are the populations with the higher calcium intake. So it's — it's really something that we don't know about at this point. And that's other populations that may have to do with other aspects of the dietary composition, but the fracture rates, which is the only input we really have to look at the osteoporadically are — they're there, but they're systematically lower and that's been shown in a variety of data sets.

It doesn't mean that it's going to remain lower forever or that calcium intake shouldn't be higher, but that's why we need to study it. There's something going on we don't understand in terms of this sort of paradox of low calcium intake, low fracture, ethnic differences, and it's not something we can solve simply.

Although I understand part of where some of the concerns are coming from, but my perception is that many of the people who were enlisted as sending the letters and so forth are — are reacting to the political overtones and don't have — and don't have an understanding of the full picture of the data. So I didn't count the input in terms of quantity since I didn't, you know, that there were a number of people who wrote in didn't impress me because I don't think that they really understand the full picture of the calcium issue.

DR. GARZA: So in order to answer your concern though that we — that we go beyond sort of the — the perception of pushing a particular commodity, that in fact would — would it be answered by saying people who don't digest lactose can enjoy other sources of calcium like one or two of them, refer people to box three, and enjoy reduced or lactose free dairy products as an option.

DR. KUMANYIKA: Well, maybe I could read what I wrote, because —

DR. GARZA: Okay.

DR. KUMANYIKA: — you can handle lactose intolerance to what I wrote in —

DR. GARZA: Can you do that?

DR. DECKELBAUM: I was going to suggest that Shiriki read what she wrote. Oh, you don't have a copy?

DR. KUMANYIKA: It was faxed to you because I didn't have a printer at the time. I e-mailed it.

DR. DECKELBAUM: Oh, okay.

DR. KUMANYIKA: It's just a one page —

DR. GRUNDY: Do you remember the gist of it?

DR. KUMANYIKA: Yeah, it — it's — there it is. Yeah, you have it in your hand. It's a revision — a lot of the text is the same text that's already in that section under the many healthful eating patterns and part of the reason that I wanted to do it this way is because the literature on lactose intolerance talks about the cultural habit of not drinking milk in adulthood that has nothing to do with lactose intolerance.

That non-dairy populations don't have to have it. They also don't have a lot of lactase, so I wanted to put it more in a cultural context. Some people just don't like dairy products. You know, give them all the enzyme you want. So it says different — different people like different foods and like to prepare the same foods in different ways. Food likes and dislikes are shaped by cultural and family background, religious beliefs, life experiences, and health issues, including intolerances or allergies to certain foods.

On a practical level, food selections are also influenced by what is available and how much it costs. Use the food guide pyramid as a starting point to shape your eating pattern. Choosing some foods from each group helps to assure that your diet has enough nutrients and the right balance.

There are many foods to choose from within each group on the food guide pyramid and they can be combined to suit your preferences. For example, those who like

Mexican food might choose tortillas from the grains group and beans from the meat and beans group. Those who like Asian foods might choose rice from the grains group and tofu from the meat and beans group.

If you usually choose from some of the food guide pyramid but not others, pay attention that getting enough of all of the nutrients you need from the types of food that you do choose. For example, if you do not usually eat any dairy products, choose other foods that are good sources of calcium, see box three, and be sure to get enough vitamin D.

So I was recommending something like that, and you could add a specific reference to lactose intolerance there if you want to flag that, but I didn't want to give it any more prominence.

DR. GARZA: I'm sorry. Johanna?

DR. DWYER: I think there's some good thoughts here, but I think the brevity of what Suzanne put up —

DR. KUMANYIKA: Well, this is the whole — it's already there. I rewrote the paragraphs that was already there. I didn't add all of that. I just wanted you to see the context of ethnic food preferences and also heath issues and working it into that section. That's why I read the whole thing.

DR. GARZA: All right. We have to get our transcript person a break. And I apologize for that, but we will go for five minutes, for a five minute break.

UNIDENTIFIED : And take a picture? A group picture?

DR. GARZA: Of course. And we'll take a group picture while we give our transcript person a break. And then —

(Off the record.)

DR. GARZA: We have just a few issues to deal with. On the lactose, what we'll do is work with Shiriki and with Richard to craft language that in fact will take the whole thing into account of that discussion that we had.

Meir — is he still here?

DR. GARZA: Okay. Wants to correct something that might have been misinterpreted in his and he wants to get it on the record. The other thing on my list is daily. We were going to deal with whether we wanted daily to appear in the — in the guidelines. And right now, I can remember them being in two. The grains and in the fruits and vegetables. Is that — am I — is my memory correct?

So is the issue do we later have the lack of congruence so that's the only place we say daily or are there reasons why the committee feels that we ought to — to keep

daily in, in those two guidelines, given the quantity of whatever other rationale you want to use?

So who wants to start?

DR. GARZA: And the physical activity, and there's three. There's physical activity and —

DR. TINKER: I brought the issue up, so maybe I can start. And it was only that we've got foods and vegetables we're encouraging daily, the grains that we're encouraging daily, but we're also encouraging physical activity daily and yet it doesn't appear in — in the guidelines.

I questioned whether or not for that purpose it would make sense that if we're trying to encourage the grains daily, fruits daily, and physical activity daily, that we have it in —

DR. GARZA: Okay. There was some issue of whether we should drop it in the other —

DR. TINKER: Yeah, or drop it.

DR. GARZA: Alice?

DR. LICHTENSTEIN: I would suggest dropping it because I think they essentially all apply to daily and I want people to keep their food safe daily. Also I want them to think about a healthy way to eat, and so I would suggest just dropping it.

DR. GARZA: Okay. Any other — any strong feelings one way or the other?

DR. KUMANYIKA: Well, I don't know if it's strong but I would like to add it to be physically active every day and keep it for fruits and grains because I think that as a rule of thumb for things that people haven't been doing, it refers specifically to a behavior. It might be helpful for them to get the idea of a routine.

DR. GARZA: Do we have a rationale from Roland? Any other rationales that you want to offer either for or against?

DR. DWYER: I just think we should drop it every place because as Alice says, it applies to everything and it's — these are so wordy.

DR. GARZA: Okay. So Johanna agrees with Alice. We'll take a vote and give each of you a chance to tell us who you agree with, but do you have any — any other rationales other than the two that are being presented?

Okay, then let's take a vote. All those who would like daily in fruits and vegetables, grains, and physical activity, all three, so we would have to wordsmith. Please raise

your hand. That's six. All those opposed or rather want to drop the name from all three. Three.

DR. MURPHY: I abstained.

DR. GARZA: Yeah. That's the daily. Oh, and then Meir had a statement.

DR. STAMPFER: Real quick. Just wanted to clarify a possible misinterpretation of what I said yesterday about the research proposal for the alcohol guideline. In discussing the elderly, I didn't want to imply that alcohol — problem drinking and alcoholism was not a problem in the elderly. It most certainly is an important problem in the elderly, but the research question that I had proposed was to try to determine what the risks of new alcohol problem drinking would be among mature adults who start drinking. So I just wanted to clarify that one point.

DR. GARZA: Let me — let me tell you where we are. And this — this is probably — at least from Carole Suitor's and my standpoint, an important piece that I want everybody's full attention. So if you could just hold off everything for just a bit. October 1st is a drop dead date in terms of getting — at least working through the revisions and getting your rationale.

So this is the 9th. That gives us about three weeks. Is that — that a reasonable time frame because what we'll start doing is based on the discussions, is start working with each of the chairs on the guidelines themselves.

That'll give you the next three weeks to concentrate exclusively on the rationale and making sure that in fact there is a — it included the sorts of issues that Scott raised and it's important to provide a background. Wherever you think we are then develop the data set, the data analysis, and bring it up to date.

So that's October 1st. That'll give us a month to work on that and get the whole report together so that in fact you can get a chance to see it, not to wordsmith it, but only for very substantive changes, because it's, you know, we forgot to mention the connection between lipids and cardiovascular disease.

I mean, a major, you know, what we would have done most of the tweaking, which means that the interim tweaking will be done with the chairs of the groups.

DR. DWYER: Well, we haven't really gotten a chance to do our — to get the final thing that you approved.

DR. GARZA: On salt. That's right. But that's — that's what I meant about the — we'll be working with the working group, but not as a committee as a whole on — we got everybody's comments and so we'll be moving forward. You'll get to see them one more time.

Having said that, please keep the October and the November, December dates still on your calendar. Do not give those days away because —

(Simultaneous discussion.)

DR. GARZA: And December 1st. November 29th, 30th, and December 1st.

(Simultaneous discussion.)

DR. GARZA: The one reason I think we may want to come back, you'll see there's the research recommendation and it's not to reopen the discussion on the guidelines or the rationale. What concerns me and it's something I'd like you to think about, is that every time you put groups like this together, we never have an opportunity to seriously look at all the research issues and providing as thoughtful guidance to those research questions as I think we do to the remainder of the report.

And so they're coming together for a maximum of two days, maybe just one and a half days, not to reach the consensus necessarily. I don't think that's necessary for research recommendations, but to at least have the benefit of the thought processes of everyone around the table as we forward that very piece of the report on to the Department.

Now, I don't know whether others feel that in fact that would be necessary or as we move through the rationale, I'm sorry, the research recommendations, that they're going to be in a shape that wouldn't really be worth our while to come together again.

Are there any strong feelings either way right now? Or do you want to leave it open?

DR. KUMANYIKA: For some reason, I feel very strongly that that would be an imposition to come together only to do that unless we knew that X million dollars had been set aside and we were shaping an agenda. Because research recommendations could just as well be a throw away. We have no idea what's going to be implemented.

And I will think very hard about them and will be on a conference call to discuss them, but I wouldn't want to make a trip to do something that opened ended. For the policy issues, I'm happy to come back.

DR. GARZA: Johanna?

DR. DWYER: There is one other thing that troubles me that it might worth to come together about. That is there's so many of these guidelines in — and they've been organized well into the A, B, C format, but I'm still not sure what the overall impact on consumers is. And if there — if there is feedback on that by the end of November, and if there's also feedback from the Department — because I gather what usually happens is it goes in and then it comes out.

I mean, there's that much dialogue with the committee about it, really that's the

way the departments want it, but if there were a chance for dialogue and then review of consumer materials as well as the research recommendations, I think that would be well worth the time spent together.

I agree with Shiriki that if it's just research recommendations, this is sort of a pro forma thing that you know that isn't going to go very far unless there's really research committed.

DR. GARZA: Okay.

DR. DECKELBAUM: Well, if we look at the green book the research recommendations come out at the end of the rationale sections. Those other recommendations — and some of them are research recommendations and some of them are not actual research and there's a mixture there.

So the question I have is if — if we really come up with a well thought out number of important recommendations along the lines of some of the major gaps that we had here during our deliberations, is — is there any likelihood that anyone will listen because if there's a likelihood that someone's going to listen to this and seriously consider funding, then I think we — I would vote for getting together and doing a very serious effort.

And I know I've maybe asked an impossible question, but this might be a first start, but I'd like some kind of input to know that someone may actually pay attention to that. If there's a high likelihood or there's some likelihood that that will happen, then I think it's worthwhile for —

DR. GARZA: Before I ask Kathryn, and I need to respond, let me hear from Eileen.

DR. KENNEDY: At some point would be very interesting and we do by mail is number one, we take the recommendations of people very seriously, including anything that comes out of the recommendations. And I think it really does help not only the dietary guidelines, but forward looking as there are unanswered questions.

I'm not going to be disingenuous here as what are the committed resources, because for us, there are so many unknowns as far as what our funding levels are and it's not simply looking at research from the perspective of what USDA has, because more and more we find that we're engaging in multiple departments — multiple institution funding mechanisms because of the complexity of issues we're dealing with.

So I think the simple answer we — we take the recommendations, including research recommendations, very seriously. What we wouldn't be able to tell you I don't think, I'd be interested in Kathryn's perspective by late November or even early January, I couldn't say to you for FY 2000 here is what we are definitively going to find out of your very well thought through list of recommendations.

I think what happens in — in some ways is much more indirect processes. As we get

documents like this, we go around talking about the translation of guidelines, of how we take the green book and release the report. I know I on a number of occasions — and I think others — also look at okay, action oriented, next steps. What weren't we able to do?

Where are there gaps? Where are there research needs. And which ones are we attacking early on? What are some strategies for later on? Including more and more how we're engaging the private sector in some of these issues. But let me — let me give you one specific one now that we're almost done.

We have for three years in a row — and I think Johanna knows this — had a — a major increase requested in our budget to upgrade our mutual database which underpins not only our CSFII but now that we're blending NHANES, CSFII, there will be more consumption surveys in the United States.

The fact that we're having a dialogue that's not simply USDA dialogue, but HHS. I think some of the discussion and since it's already taken place, I'm not — I'm not framing this discussion, it's already taken place, but some of the discussion earlier today talking about the — the needs of the surveys and a mutual database gives me one more piece of ammunition in my strategy that's already in the departments that we're trying to look forward to say it's not just USDA and HHS that thinks it's important, but a broader — a broader community of researchers.

So it's both from the point of view of identifying gaps, but it's also the point of view of advocacy. We take this very seriously but it's a much more forward process than here's the agenda, here's what we're doing, here's what I —

DR. GARZA: Kathryn?

MS. McMURRY: I think you summed it up very well. I don't — I would just second that and try to work in whatever recommendations we work into our process as we're going and there are longer term considerations also too. And I just want to respond to I think Johanna's question too about follow up and continued dialogue.

I think that's something that we should explore. I don't know if I can get — probably the government shut down in timing was a factor the last time, but in terms of —

DR. KENNEDY: Well, you were shut down. I wasn't.

MS. McMURRY: Sorry. Well, we were halfway shut down. I think it would be great to do some more follow-up with the committee as the departments negotiate through the final process to let you know.

DR. GARZA: I know that some of you want to leave in about twenty seconds, but let me just say thank you on behalf of everyone here. The staff, thank you to the staff. The committee I think has been very, very grateful to the staff. The staff is grateful to the Committee, because in fact it's been a — I don't want to sound like a masochist or a sadist, but it has been on the whole quite enjoyable.

(Laughter.)

DR. GARZA: So we will continue working together and we'll let you know, Scott, as soon as we can in terms of when it will come. It sounds to me as if there isn't much left to do. But that may evolve. Thank you very much.

(Whereupon, at 2:45 p.m., the hearing in the above-entitled matter was adjourned.)

CERTIFICATE OF REPORTER, TRANSCRIBER AND PROOFREADER

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Place of Hearing

September 9, 1999
Date of Hearing

We, the undersigned, do hereby certify that the foregoing pages, numbers 742 through 988, inclusive, constitute the true, accurate and complete transcript prepared from the tapes and notes prepared and reported by Sharon Bellamy, who was in attendance at the above identified hearing, in accordance with the applicable provisions of the current USDA contract, and have verified the accuracy of the transcript (1) by preparing the typewritten transcript from the reporting or recording accomplished at the hearing and (2) by comparing the final proofed typewritten transcript against the recording tapes and/or notes accomplished at the hearing.

9-16-99 Elizabeth Ball
Date Name and Signature of Transcriber
Heritage Reporting Corporation

9-17-99 George McGrath
Name and Signature of Proofreader
Heritage Reporting Corporation

9-9-99 Sharon Bellamy
Date Name and Signature of Reporter
Heritage Reporting Corporation