FOR THE RECORD

Dietary guidelines tell Americans to eat less food, but not what kind

New dietary guidelines from the United States Department of Agriculture (USDA) focus on fighting obesity, but pull some punches in naming foods to limit or avoid.

Because more than one-third of children and more than two-thirds of adults in the US are overweight or obese, the *Dietary Guidelines for Americans, 2010*, places stronger emphasis on "balancing" calorie consumption and increasing physical activity (www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/PolicyDoc/PolicyDoc.pdf).

"This is a crisis we can no longer ignore. … The bottom line is that most Americans need to trim our waistlines to reduce the risk of developing diet-related chronic disease," US Agriculture Secretary Tom Vilsack said in a press release (www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/PolicyDoc/PressRelease.pdf).

In addition to the standard call for the consumption of more fruits, vegetables and lean meats, the guidelines include new recommendations that Americans eat more whole grains, seafood, soy products and even select dietary supplements, such as vitamin D, folic acid among women of childbearing age, iron among pregnant women and vitamin B12 among people over 50.

The guidelines also urge "improved behaviours," including increased physical activity and improved eating habits such as the control of "total caloric intake to manage body weight." To that end, it also issued *Selected Messages for Consumers*, such as:

- Enjoy your food, but eat less.
- Avoid oversized portions.
- Make half your plate fruits and vegetables.
- Switch to fat-free or low-fat milk.
- Compare sodium in foods like soup, bread and frozen meals and choose the foods with the lowest numbers.
- Drink water instead of sugary drinks (www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/PolicyDoc/SelectedMessages.pdf).

Advice on what types of food products consumers should eat less of was buried deep within the 95-page policy document.

While the guidelines call for a reduction in the number of calories consumed from solid fats and added sugars, there are limited and unclear references to "worst offender" sources of such fats and sugars. For example, cookies, cakes and the like are opaquely referred to as "grain-based desserts."

Similarly, while the guidelines warn consumers against "refined grains," there's little guidance on what is meant by the term beyond "grains [that] have been milled to remove the bran and germ from the grain." References to "cakes, cookies, other desserts, and pizza," and "white bread, rolls, bagels, muffins, pasta and rice" appear in an appendix.

Like the 2005 guidelines, the 2010 edition doesn't change recommendations for the general public concerning total fat intake (20% to 35% of calories), saturated fat (less than 10%) or cholesterol (less than 300 mg).

While the guidelines recommend a reduced maximum daily sodium intake of 1500 mg for people aged 51 and over, African Americans and those who have hypertension, type 2 diabetes or chronic kidney disease, the recommendation for the general population remains at 2300 mg. That's short of the 1500 mg-limit set for everyone by the American Heart Association, and recommended in 2010 by the Dietary Guidelines Advisory Committee (www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/DGAC/Report/D-6-SodiumPotassiumWater.pdf).

Also included in the new USDA dietary guidelines was a recommendation on alcohol, which the department recognizes "may have beneficial effects when consumed in moderation." Moderate alcohol consumption is defined as up to one drink per day for women and up to two drinks per day for men.

The department will issue its next-generation "Food Pyramid" in the coming months. — Lauren Vogel, *CMAJ*

British Columbia selects drug reviewers

Five teams have been selected to conduct future drug reviews in British Columbia, including three headed by members of the University of British Columbia's Therapeutics Initiative (T.I.).

Each of the five teams will conduct some of the 15 to 25 clinical evidence reviews that the province is expected to seek annually. Costs of a review will be drawn down from a maximum $50 000 pool that has been set aside for each team annually.

The five teams and their respective team leaders are:

- BC Drug and Poison Information Centre — Debra Kent and Dr. Roy Pursell
- Providence Health Care Research Institute and Vancouver Coastal Health Research Institute — Aslam Anis and Stirling Bryan
- UBC Faculty of Medicine — Dr. Ken Bassett
- UBC Faculty of Medicine — Dr. Vijaya Musini
- UBC Faculty of Medicine — Barbara Mintzes

Minister of Health Services Colin Hansen argued in a press release that the selection of the three teams from UBC puts to rest concerns that the government was seeking to discontinue the involvement of the Therapeutics Initiative group in the process for determining which drugs are to be covered by the province's Pharmacare

plan (www.cmaj.ca/cgi/doi/10.1503/cmaj.109-3758).

"Members of the Therapeutics Initiative chose to apply to the RFQ [request for quotation] as three separate groups and all applicants were successful," the release states. "As a result, new contracts will be awarded for clinical evidence reviews with the team leads and the Therapeutics Initiative will continue to provide the other two services in their existing contract — health professional education and PharmaCare program evaluations, which evaluates whether drugs currently in use are safe and effective."

"Those who have stated that the Therapeutics Initiative is being eliminated or that we are bowing to industry pressures are completely wrong," added Hansen. "Three members of the T.I. successfully applied to our RFQ and I am pleased that we will continue to rely on their expertise as well as bring in the expertise of the other two successful reviewers."

"We are simply bringing in more expertise among clinical evidence reviewers to ensure British Columbians continue to receive the safest and most cost-effective coverage of pharmaceuticals," said Hansen. — Adrianna Banaszek, Ottawa, Ont.

WHO urges alcohol crackdown

Higher alcohol taxes and raised age limits for buyers are among measures that the World Health Organization (WHO) is urging to reduce the worldwide toll of alcohol-related injuries and deaths.

Many countries lack the prevention policies and programs required to adequately monitor use of the substance, according to *The Global Status Report on Alcohol and Health* (www.who.int/substance_abuse/msbalcstragegy.pdf).

Nearly 4% of all deaths — 2.5 million people annually — are linked to alcohol, the report says. That includes the deaths of 320 000 people between the ages of 15 and 29, or about 9% of all deaths within their group. Alcohol-related deaths were found to be more prevalent in men than women, accounting for 6.2% of all male deaths compared with 1.1% of female deaths.

"Harmful drinking is a major avoidable risk factor for neuropsychiatric disorders and other noncommunicable diseases such as cardiovascular diseases, cirrhosis of the liver and various cancers. For some diseases there is no evidence of a threshold effect in the relationship between the risk and level of alcohol consumption. The harmful use of alcohol is also associated with several infectious diseases like HIV/AIDS, tuberculosis and pneumonia. A significant proportion of the disease burden attributable to harmful drinking arises from unintentional and intentional injuries, including those due to road traffic crashes and violence, and suicides. Fatal injuries attributable to alcohol consumption tend to occur in relatively young people," the report states.

"Clearly much more needs to be done to reduce the loss of life and suffering associated with harmful alcohol use," Dr. Ala Alwan, WHO assistant director-general for noncommunicable diseases and mental health, said in a press release (www.who.int/mediacentre/news/releases/2011/alcohol_20110211/en/).

The report also found that alcohol abuse increasingly affects younger drinkers and people in developing countries. From 2001 to 2005, "marked increases" in consumption levels were seen in Africa and Southeast Asia. Global consumption of alcohol totals more than six litres of pure alcohol consumed annually per person aged 15 or older, the WHO estimates. But the majority of people in the world do not drink, with almost half of all men and two-thirds of all women abstaining in 2005. Those who do drink in countries with high abstention levels tend to consume alcohol at high rates.

A host of measures were recommended by the WHO in areas ranging from preventing drunk driving to marketing. Those included measures aimed at reducing the incidence of drunk driving, such as low regulatory limits for blood alcohol concentration among professional, young or novice drivers and more extensive use of ignition interlocks. Measures aimed at restricting the availability of alcoholic beverages included regulations of the days and hours of retail sales and "adopting policies to prevent sales to intoxicated persons and those below the legal age and considering the introduction of mechanisms for placing liability on sellers and servers in accordance with national legislations."

"Effective administrative and deterrence systems for infringements on marketing restrictions," were among measures urged to constrain alcohol marketing, while pricing based on the alcohol content of a beverage is encouraged to promote the consumption of lower alcohol content products. Measures aimed at reducing such negative consequences of intoxication as violence and disruptive behaviour included "serving alcohol in plastic containers or shatter-proof glass and management of alcohol-related issues at large-scale public events." The report also urges tighter regulation of home-brewed alcohol products, as well as stronger government monitoring and surveillance programs. — Jennie Russell, Ottawa, Ont.

Rough down under

Roughly 88% of Australia's general practitioners say they've been verbally abused by patients, 37% have experienced property theft or damages to their offices, 16% have been physically assaulted, 19% have been sexually harassed, 11% have been stalked and 2% have been sexually assaulted, according to a paper survey of 782 physicians conducted by the Australian Primary Health Care Research Institute. The numbers were even higher among 178 general practitioners who were surveyed online. Of the latter, 95% said they'd been verbally abused, 56% have experienced property theft or damages to their offices, 31% have been physically assaulted, 26% sexually harassed, 17% stalked and 6% sexually assaulted.

The study, *Patient initiated aggression and violence in the Australian general practice setting*, also indicated that office staff were subjected to similarly high levels of abuse (www.anu

.edu.au/aphcri/Hub_Research/Violence_In_General_Practice.pdf).

Conducted for the Australian Primary Health Care Research Institute at the Australian National University in Canberra, the study, which also included focus groups and in-depth interviews, casts verbal aggression as being a "daily occurrence."

"Triggers to patient initiated aggression included procedural issues such as long waiting times to see a doctor, unavailability of the doctor of choice, and refusal of specific patient-requested medication or treatment," according to the study. "Other triggers of aggression included issues of payment and refusal of bulk-billing. Some times of the day, the physical location of the practice and having young or inexperienced staff were also reported as risk factors for aggressive patient behaviour. There was also a suggestion that cultural difficulties with overseas trained doctors and gender bias encountered by some female GPs [general practitioners] could trigger aggressive incidents."

"Overall, participants agreed that patient initiated aggression was a problem in general practice, and many staff welcomed education, training, and other measures to maximise their safety, to maintain maximum possible service delivery and to ensure safety for other patients attending their practice. The strategies that were adopted to minimise the risk of harm from aggressive patients included interpersonal strategies where training and selective hiring of staff were seen as effective; procedural strategies focussing on policies to deal with aggressive patients; and structural strategies where modifications were made to the practice building, for example locks, alarms and constructing barriers," the study adds. — Wayne Kondro, *CMAJ*

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