

DEFENDANTS' MEMORANDUM OF

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK**

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NEW YORK STATE RESTAURANT ASSOCIATION,

Plaintiff,

-against-

**DECLARATION OF
MARLENE B. SCHWARTZ,
Ph.D.**

**NEW YORK CITY BOARD OF HEALTH, NEW
YORK CITY DEPARTMENT OF HEALTH AND
MENTAL HYGIENE, and THOMAS R. FRIEDEN, In
His Official Capacity as Commissioner of the New York
City Department of Health and Mental Hygiene,**

08 Civ. 1000 (RJH)

Defendants.

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MARLENE B. SCHWARTZ, Ph.D., hereby declares under penalty of perjury:

1. I am the Deputy Director for the Rudd Center for Food Policy and Obesity at Yale University in New Haven, CT and Senior Research Scientist in the Psychology Department at Yale University. I received a Ph.D. in Psychology from Yale University in 1996 and I am a licensed psychologist in the State of Connecticut. I have conducted research and published papers in peer reviewed journals on many aspects of the etiology, prevention, and treatment of obesity. I have substantial clinical experience treating obesity and eating disorders, as I co-directed the Yale Center for Eating and Weight Disorders for a decade. I have no conflicts of interest to declare. My training and research have been funded exclusively by grants from the American Psychological Association, the Robert Wood Johnson Foundation, the National Institute of Mental Health, the Rudd Foundation, and Yale University. My CV is attached.

2. The New York City Board of Health enacted §81.50 in response to the obesity epidemic in New York City. The purpose of §81.50 is to inform consumers of chain restaurants of the calorie content of food options at the time and location at which consumers make their food purchase decisions. My clinical experience working with obese individuals who wish to lose weight and my knowledge of the relevant research leads me to conclude the following: (a) there is very clear and consistent research that consumers are not accurate in determining the calorie content of menu options at these restaurants (e.g., Chandon & Wansink, 2007), (b) without this information, it is virtually impossible to accurately track one's daily caloric intake when eating out, (c) calorie information **at the point of purchase** has a strong likelihood of educating consumers of the caloric content of the foods they are eating when they eat out, and (d) menu labeling will provide individuals with the opportunity to make nutritious choices. I also believe this measure has a reasonable likelihood of encouraging the restaurant industry to create and provide healthier options on their menus.

3. In his Declaration for the New York State Restaurant Association, Dr. Allison makes a number of assertions I would like to address.

4. Early in his declaration (p. 4), Dr. Allison states that he is restricting his comments to “whether there is scientific evidence showing that the revised Regulation 81.50...will achieve the objective of reducing obesity levels among NYC residents and/or people that dine in NYC. “ He states that he will not render an opinion regarding whether §81.50 is “‘good’, legally defensible, fair, adverse to legitimate economic interests, or ‘should’ be adopted...” However, the question for consideration is not whether there is

incontrovertible scientific proof that §81.50 will reduce obesity levels in NYC residents, but rather whether the Department has legitimate reason to believe that it might contribute to reducing obesity levels or slowing the obesity epidemic in NYC. These standards are quite different. Thus Dr. Allison has excused himself from addressing the scientific question that must be answered, and instead has introduced a scientific standard that is entirely inappropriate for policy-making, and in so doing is diverting attention from the key issues. The use of scientific evidence for policy-making is discussed in the declaration of Commissioner Frieden in the section: Standard of Evidence for Public Policy.

5. In providing a rationale for §81.50 in its Notice of Intent, the Department claimed that:

- Obesity is epidemic and an increasing cause of disease
- The obesity epidemic is mainly due to an excess of calorie consumption
- Chain restaurants serve food that is associated with excess calorie consumption and weight gain
- Consumers do not know how many calories are in restaurant foods and frequently underestimate the caloric content of foods
- Point-of-decision calorie information helps consumers
- Voluntary activities by restaurants to supply calorie information fall woefully short

Dr. Allison reframes these into seven “Propositions” and discusses each. In his discussion (pages 9-11) he fully accepts the first six of his “propositions”, which correspond to the first four claims above. He further considers a “proposition” that

“restaurants and restaurant foods are contributing to the epidemic in some manner that is above and beyond the contribution offered by any source of food energy” (p. 10). The Department did not word any claim in this way, and in fact I know of no expert who makes such a claim. In fact, Dr. Allison’s wording represents a broader framing of the risks of restaurant food: “I believe it is reasonable to conjecture that providing calorie information at the point of purchase in restaurants (especially in fast food restaurants) might be beneficial in reducing obesity levels”. **Thus the plaintiff’s expert is agreeing with the Department’s rationale for §81.50.**

6. Dr. Allison does not address the Department’s claims 5 and 6 above, but these are central to the rationale for §81.50. As stated in Dr. Frieden’s Declaration, when consumers are provided calorie information, through such means as labeling of packaged food, large percentages of them report using this information and changing their purchases based on this information (Burton et al., 2006; IFIC 2007; Levy & Derby, 1996).

7. In his Declaration, Dr. Allison fundamentally agrees with the claims made by the Department as its rationale for §81.50. To the extent that Dr. Allison disagrees with the Department it is disagreement on claims that the agency has not made and does not need to make to justify the rule. Thus Dr. Allison’s declaration supports §81.50.

8. When reviewing the research literature and drawing conclusions about the strength of the evidence, Dr. Allison confuses two distinct models used to approach the problem of obesity: the "medical model" and the "public health model" (see Schwartz & Brownell, 2007). Dr. Allison clearly articulates the medical model, which takes the view that health professionals use treatments that are developed for individuals and can be

reasonably tested in randomized controlled trials (RCTs). This model is appropriate for testing new drug therapies or other medical treatments, but is not the typical standard for public policy changes. For instance, if lead in gasoline creates pollution and harms health, one does not wait for a randomized trial showing that taking lead from gasoline makes people healthier. No randomized trials were done to show that placing nutrition labeling on packaged food drives down disease rate. Dr. Allison acknowledges this point himself in his declaration when he states that "for practical or ethical reasons, it is often impossible to conduct an RCT to address a particular question."

9. Dr. Allison justifies his decision to use the National Heart, Lung, and Blood Institute's rating scale for research on clinical guidelines for the treatment of obesity by citing his own recent paper from a project supported by the Coca-Cola Company entitled "Toward the reduction of population obesity: Macrolevel environmental approaches to the problems of food, eating and obesity" (Faith et al, 2007). This paper reviews a range of public health approaches to obesity (e.g., taxing foods, manipulating access to certain foods) and finds that "more studies are need to justify that altering these macro-environmental variables will necessarily reduce population obesity" (p. 205). But again, the authors acknowledge that while an RCT is the gold standard, "For the majority of possible approaches considered in this report, it would be extraordinarily difficult if not impossible to conduct such a study. It is difficult to blind people to many of the things under study, randomization is often impractical, and running studies for a sufficiently long period of time on a sufficiently large number of subjects may also be impractical" (p 223). This suggests again that Dr. Allison

understands that an RCT is **not** the appropriate research method for large public health interventions.

10. The appropriate way to approach the research relevant to menu labeling is to examine it through the public health model. This model focuses on **the public's right to safety and health**. Using the Allison logic, the Department wanting to sanction restaurants with cockroaches would first be required to conduct an RCT showing that patrons get healthier when the cockroaches are gone.

11. It is most important to consider whether there is reasonable evidence of benefit from a policy and a small chance of harm. In section H, Dr Allison reviews studies to support his conjecture that providing nutritional information for food sold in restaurants “could even be harmful” and states that such conjecture is “reasonable.” This is a stunning claim. I review the same studies below and conclude **that it is not reasonable to conjecture that menu labeling is likely to create any harm**.

12. Dr. Allison begins his argument by stating that the intuitions of even “well-trained experts are **often** [emphasis added] wrong especially on issues involved human behavior.” To support his conjecture, he selectively chooses four “examples,” which when read carefully and viewed in the context of the larger fields they represent (e.g., Stice, Shaw & Marti, 2007), as well as the “history of science, medicine, and psychology” **do not** provide evidence that expert intuition is **often** wrong, or leads to unintended harm.

13. To further support his position that conjecture about unintended harm is “reasonable,” Dr. Allison reviews four additional studies in greater detail. Again, when examined carefully, none provides convincing support for his concern. He first quotes

the dramatic and misleading press release title (not the actual report) from a CDC-sponsored study on increasing student access to fresh fruits and vegetables (CDC, 2006). This study actually found that the variety of fruits and vegetables ever eaten **significantly increased** for all three grades examined (5th, 8th, and 10th grade), and the attitude decrease cited by Dr. Allison was only observed in the 5th graders; the 8th graders had significantly **positive** increases in attitudes about fruit, their belief they can eat more fruit and their willingness to try it and 10th graders did not exhibit a significant change. It is notable that this study lacked a control group, which if present, would have been able to inform the researchers whether the decrease in positive attitudes in 5th graders is part of a natural developmental trend. In other words, it is possible that most children develop negative attitudes about fruits and vegetables between ages 9 and 10 due to other factors, such as exposure to food marketing for unhealthy foods at an age when they are still too young to understand the intent of advertising.

14. Dr. Allison cites a study by Boon et al (2002) as another example of possible negative outcomes from menu labeling. In reading this study carefully, it is clear that the intervention tested was not to tell people the number of calories in a range of food choices and allow them to choose what to eat, but rather, to tell people that the food they were being served (and were expected to eat as part of the taste-test experiment) was either high or low in calories – without disclosing the actual number of calories. The strongest finding from this study was that people eat more when distracted, suggesting that people should try to focus on enjoying their meal while eating, rather than doing other things. But, for the conditions of this study to be replicated in NYC restaurants, it would involve having the waitresses (instead of the researchers in this

study) go around and tell patrons, “that ice cream is extra creamy” or “that ice cream is from a firm that specializes in light products...” (p. 5), **not** having restaurants post calorie information on menus to be used at the point of purchase. This study is therefore irrelevant to the question of unintended harm from menu labeling.

15. Dr. Allison cites the Aaron et al.(1995) twice. First, in Table 1, he says it is “not directly relevant because the independent variable is calorie and fat content, not just calorie content” but then on page 32 he cites it as evidence of a possible negative effect menu labeling because calorie labeling in a college cafeteria led to an increase in calorie consumption for students. When the results from this short intervention are examined carefully it appears that the finding is being driven primarily by unrestrained eaters and males in the sample. This finding can be understood in the context of the self-reported data in the Krukowski et al (2006) study, which also found that college males say they are not likely to use restaurant food caloric information. These studies suggest that college males are a unique group that may be less likely to pay attention to and use menu labels to improve their diet. This is interesting given that even sedentary 19-20 year old males require an average of 2600 calories (according to mypyramid.gov), which is the highest number of calories in the sedentary column (active males this age require 3000 calories). This is quite different than the 2000 calorie reference that is given on the nutrition facts label, and perhaps makes this subgroup of the population feel that nutrition labels were not designed for them. Future initiatives may be useful to target this subgroup and help them find ways to use calorie information to improve their diets, but my view is that the available data do not cross the threshold of evidence strong enough to cause concern regarding unintended negative consequences of menu labeling.

16. Dr. Allison states that there is not “evidence that the method of providing caloric information mandated by §81.50 will reduce levels of obesity more than the methods currently used by the affected restaurants to provide this information” (p. 30). He neglects to note, however, that there is evidence that the industry’s recent efforts to create an image of healthfulness by making health claims on their foods **without providing accurate, factual calorie information** has made consumer’s ability to accurately estimate calories **worse** by creating a “health halo” effect (Chandon & Wansink, 2007). In other words, if the industry is not mandated to provide nutrition facts, rather than non-regulated self evaluations of the healthfulness of their foods, one can reasonably conjecture that **consumers are likely to underestimate calories by an even greater margin.**

17. In summary, Dr. Allison agrees with the claims that the Department has made in providing its rationale for §81.50 and agrees that §81.50 may reduce obesity levels in New York City, and thereby supports the regulation. To the extent that Dr. Allison criticizes the reasoning in the Notice of Intent for §81.50, his criticisms reflect an incorrect application of scientific evidence to policy-making. I declare under penalty of perjury pursuant to 28 U.S.C. §1746 that the foregoing is true and correct.

Executed on February 8, 2008.

MARLENE B. SCHWARTZ, Ph.D

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