Food Safety Conference

MEETING FOR A WHITE HOUSE
CONFERENCE ON FOOD,
NUTRITION, AND HEALTH

December 3, 1998

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Coronary Heart Disease Mortality Trends Among Whites and Blacks Appalachia and United States, 1980-1993

Although heart disease-associated mortality has declined steadily since the 1960s, heart disease remains the leading cause of death for both men and women of all races/ethnicities in the United States (1). This report compares temporal trends in coronary heart disease (CHD) death rates for blacks and whites from 1980 to 1993 (the latest year for which data were available) in the Appalachian Region * with trends for the entire United States. The findings indicate that among whites aged greater than or equal to 35 years the burden of CHD is greater in Appalachia than in the entire United States, with the disparity increasing over time, and among blacks, only slight differences in CHD rates between Appalachia and the United States were observed.

From 1980 through 1993, annual age-adjusted CHD death rates for persons aged greater than or equal to 35 years were calculated using mortality data compiled by CDC and population estimates from the Bureau of the Census. For both Appalachia and the United States, CHD death rates were calculated separately for blacks and whites by sex and age group (i.e., ages 35-64 and greater than or equal to 65 years). The 1980 U.S. population aged greater than or equal to 35 years was the standard for age adjustment. CHD deaths were defined as deaths for which the underlying cause was listed on the death certificate as codes 410.0-414.0 and 429.2 of the International Classification of Diseases, Ninth Revision (ICD-9). The cause of death is reported by attending physicians, medical examiners, and coroners on death certificates and is subsequently coded according to the ICD-9. Linear regression models, with year as the independent variable and log-transformed annual CHD death rate as the dependent variable, were estimated separately for each group. Beta coefficients from each model were used to calculate the average annual percentage change in CHD mortality.

CHD mortality declined from 1980 through 1993 for each of the demographic groups for both Appalachia and the United States; however, Appalachia and the United States differed in both the level of CHD mortality and the magnitude of decline for most demographic groups. Among persons aged 35-64 years, CHD death rates for whites in Appalachia were consistently higher than those for the entire United States (Figure 1). CHD death rates were 15% higher among white men aged 35-64 years in Appalachia than among white men in the United States in 1980; in 1993, rates were 19% higher for white men in Appalachia. Similarly, CHD death rates were 15% higher among white women aged 35-64 years in Appalachia than among white women in the United States in 1980; in 1993, rates were 21% higher for white women in Appalachia. In comparison, CHD death rates for blacks aged 35-64 years only differed slightly between Appalachia and the entire United States (Figure 1).

For Appalachian residents aged 35-64 years, the average annual declines in CHD mortality from 1980 through 1993 were 2.3% for black women, 3.1% for black men, 3.3% for white women, and 3.9% for white men. In the United States, average annual declines in the same age group were 2.7% for black men, 2.8% for black women, 3.4% for white women, and 4.3% for white men.

Among persons aged greater than or equal to 65 years, whites in Appalachia had slightly higher CHD death rates than whites in the same age group in the entire United States (6% higher in 1980 and 5% higher in 1993) (Figure 2). In comparison, blacks aged greater than or equal to 65 years experienced slightly lower CHD death rates in Appalachia than blacks in the same age group in the entire United States (Figure 2).

From 1980 through 1993, average annual declines in CHD mortality for Appalachian residents aged greater than or equal to 65 years were 1.8% for black men, 2.3% for black women, 3.2% for white men, and 3.3% for white women. In the United States, average annual declines for persons in the same age group were 1.6% for black men, 1.7% for black women, 3.1% for white women, and 3.3% for white men.

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Editorial Note

Editorial Note: The findings of this report corroborate recent reports showing important geographic and race/ethnicity variability in both levels and rates of decline in CHD mortality (3-7). The burden of CHD mortality observed among whites in Appalachia increased during 1980-1993. In both Appalachia and the entire United States, CHD death rates for blacks remained higher than rates for whites; however, among blacks there were only slight differences in CHD death rates between Appalachia and the entire United States.

The findings in this report are subject to at least two limitations. First, data used to calculate CHD death rates in this study include census undercounts of black populations and variations in the accuracy of reporting underlying cause of death on death certificates. Second, examination of CHD death rates for a large region such as Appalachia obscures important geographic variation in risk for heart disease within the region. Rural and less affluent counties within Appalachia were at highest risk for CHD mortality and were least likely to have adequate economic and medical-care resources (8).

The findings in this report suggest that the social and environmental conditions and resources that influence CHD mortality for whites aged greater than or equal to 35 years may differ between Appalachia and the United States. The Appalachian region is characterized by low levels of urbanization and lower standards of living than the nation (9). Life expectancy for both men and women is lower in Appalachian counties than the United States (10). In addition to low levels of economic resources, many Appalachian counties lack medical-care facilities (e.g., hospital coronary-care units and cardiac-rehabilitation units) for treatment of CHD (8). The population of Appalachia is predominantly white; however, blacks comprise 6% of the population, with several rural counties of southern Appalachia having black populations that are more than 20%. The similarity of CHD death rates for blacks in Appalachia with those in the nation overall suggests the need to examine the similarities in socioenvironmental conditions and resources for blacks in Appalachia compared with the United States. Increasing inequalities in CHD mortality trends for whites between Appalachia and the nation from 1980 through 1993 indicate the need for public health interventions focused on this disadvantaged region.

In Appalachia, policies and programs should be instituted that enhance both primary and secondary prevention of heart disease mortality. Secondary prevention of heart disease requires improved access to medical-care facilities and health-care professionals, especially for residents of isolated rural counties. In addition, persons with heart disease require social support from their families and communities, and access to facilities and programs for cardiac rehabilitation. Primary prevention of heart disease mortality requires communitywide

improvements in the social environment, including full employment in healthy work environments, access to affordable healthy foods and recreational facilities, and opportunities for social interaction and participation in civic life.

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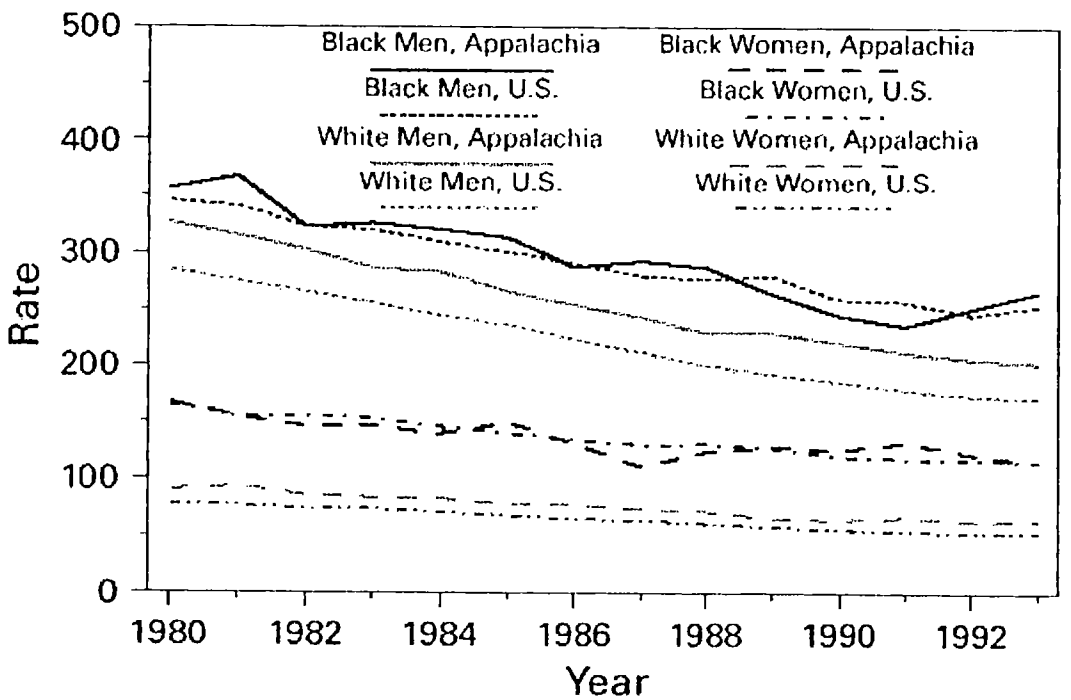
Appalachia is comprised of 399 counties, including all of West Virginia and parts of Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia (2).

Figure_1

FIGURE 1. Rates* of coronary heart disease mortality among persons aged 35–64 years, by year, race/ethnicity†, and sex — Appalachia and United States, 1980–1993



*Per 100,000 population.
†Race-specific rates were limited to blacks and whites because numbers for other racial/ethnic groups were too small for meaningful analysis.

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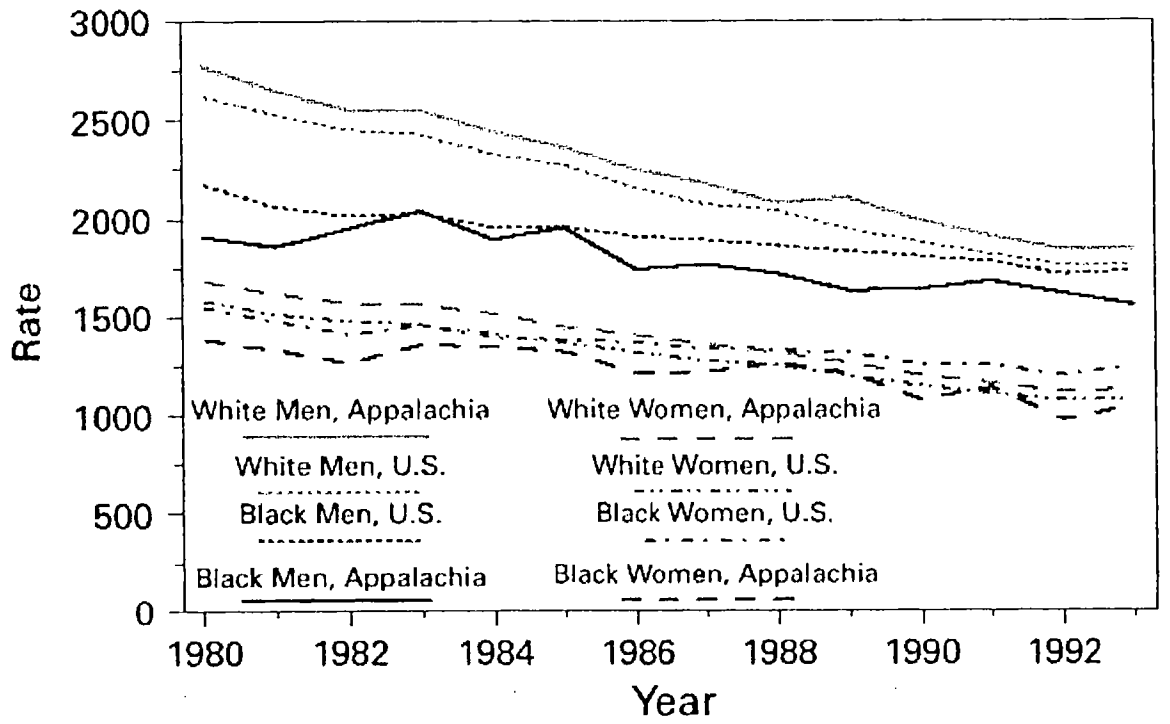
Figure_2

FIGURE 2. Rates* of coronary heart disease mortality among persons aged ≥65 years, by year, race/ethnicity†, and sex — Appalachia and United States, 1980–1993



*Per 100,000 population.
†Race-specific rates were limited to blacks and whites because numbers for other racial/ethnic groups were too small for meaningful analysis.

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The role for Food Technology

While Americans are redefining what they want their foods to provide, it is clear their actions are not following these definitions. They are looking for nutrition to optimize health, prevent disease, enhance mental function and improve athletic performance. A growing research base can identify beneficial food components and optimal levels of these components that will be a primary force driving product development. This will mean fortified, specially formulated and bioengineered foods.

Thanks to food technology the market place can change dramatically. The most recent example being food fortification of grain flours with folic acid which has virtually eliminated the risk of heart disease from hyperhomocystinemia. Other examples include fortification with calcium, phosphorous, magnesium, vitamin D and fluoride at levels needed to reduce the risk of chronic disease (osteoporosis) and to achieve optimal health and well-being. These levels can only be met by fortification.

New micronutrients and macronutrients will be discovered and recommended. These, together with the information we now have will form the basis for dietary guidelines and food guides for consumer education. New foods will need to be developed and current foods modified to provide optimal protective factors at levels of dietary components higher than naturally occur. In some cases the natural content of specific nutrients or other substances will need to be lowered, such as fat.

Research is needed to improve our ability to define, measure, and manipulate levels of protective constituents in foods through fortification, bioengineering and selective plant breeding. The goal is to go beyond the traditional nutrients and provide greater opportunity for tailored dietary recommendations to meet an individual's nutrient requirement for optimal healthy and well being.

A coalition organized to discuss the implications of the new Dietary Reference Intakes (DRIs) was co-sponsored by the American Society for Clinical Nutrition and spearheaded by Lori Hoolihan, Ph.D., R.D. at the Dairy Council

Assessment and Treatment of Obesity - A Development Edge

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We are at "the best of times and the worst of times" in terms of the assessment and treatment of obesity. The World Health Organization (WHO) has developed criteria for classification of obesity based on Body Mass Index (BMI kg/m2) and the link between obesity and disease has gain "substantial scientific evidence". The bad news is that obesity has increased at record levels with over 58 million American adults and 22 percent of children are now overweight.

This is not surprising when ones exams the source of calories using the Continuing Survey of Food Intakes by Individuals (CSFII)[1]
Food sources of energy intake are as follows:

Rank	Food	Percent			
1.	bread	9.8			
2.	beef	7.0			
3.	milk	5.7			
4.	cakes/cookies/ muffins/doughnuts	5.5			
5.	soft drinks/sodas	4.1	12.	potatoes	2.6
6.	poultry	3.9	13.	cereal(RTE)	2.6
7.	cheese	3.5	14.	alcohol	2.5
8.	salad dressing/mayo	3.1	15.	rice/grains	2.2
9.	margarine	3.0	16.	potato chips	2.1
10.	sugars/jams	2.9			
11.	pasta	2.6			

Ready-to-eat (RTE)cereals, primarily because of fortification, were among the top 10 food sources for 18 of 27 nutrients.

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[1] Food and nutrient intake by individuals in the United States (1989-91). Washington,D.C. USDA, Agricultural Research Service 1995. NFS Report 91-2. and Subar, AF, Krebs-Smith, SM, Cook A, Kahle, LL. Dietary sources of nutrients among US adults, 1989-1991. J Am Diet Assoc. 1998;98:537-547.

Coalition Members in Support of a White House Conference on Food, Nutrition, And Health

December, 1998

1. American Academy of Pediatrics
2. American Association of Retired People
3. American Cancer Society
4. American College for Advancement in Medicine
5. American Council on Exercise
6. American Diabetes Association
7. American Dietetic Association
8. American Institute for Cancer Research
9. American Society for Clinical Nutrition
10. Association of Women's Health, Obstetrics and Neonatal Nurses
11. Banner Pharmacaps
12. Better Homes Fund
13. Bread for the World
14. Catholic Bishops' Conference
15. Center for Science in the Public Interest
16. Dietary Managers Association
17. Distilled Spirits Council of the United States
18. Dole Food Company, Inc.
19. Egg Nutrition Center
20. Feinstein International Famine Center
21. Food Marketing Institute
22. Food Research and Action Center
23. Grocery Manufactures of America, Inc.
24. Hoffmann-La Roche, Inc.
25. Institute of Food Technologists
26. International Food Information Council

27. Italian Food & Wine Institute
28. Kellogg Company
29. La Leche League International
30. Lutheran Office for Governmental Affairs, ELCA
31. Meals on Wheels Association of America
32. Minority Health Resource Center
33. National Association for Sports and Physical Education
34. National Association of Margarine Manufacturers
35. National Association of Pediatric Nurse Associates and Practitioners
36. National Black Child Development Institute, Inc.
37. National Confectioners Association/Chocolate Manufacturers Association
38. National Consumers League
39. National Fisheries Institute, Inc.
40. National Food Processors Association
41. National Food Service Management Institute
42. National Pasta Association
43. National Pork Producers Council
44. North American Society to Study Obesity
45. Ocean Spray Cranberries, Inc.
46. Pharmavite Corporation
47. President's Council on Physical Fitness & Sports
48. Procter & Gamble
49. Produce Marketing Association
50. Salt Institute
51. Shape Up America!
52. Slim Fast Food, Co.
53. Society for Nutrition Education
54. The Bush Center for Child Development and Social Policy
55. The David & Lucile Packard Foundation

56. The End Hunger Network
57. The Sugar Association
58. The Vegetarian Resource Group
59. U.S. Apple Association
60. U.S. National Committee for World Food Day
61. United Fresh Fruit and Vegetable Association
62. USA Rice Federation
63. Wine Institute

Steering Committee in Support of a
White House Conference on Food, Nutrition, and Health

— Statement of Purpose —

November, 1998

Food is fundamental to life and health. What and how we eat can affect profoundly how we grow, develop, and age and our ability to enjoy life to its fullest. In America our food enterprise is the largest of all our industries, contributing 16 percent of our gross domestic product. Especially noteworthy is the promise of the biological and genetic revolutions in biomedicine and agriculture. With disease prevention becoming more important in this time of health care reform, advances in the nutrition and food science provide great opportunities to improve the lives of millions of Americans. The United States' preeminent role as a feeder to the world is a stunning example of how advances in science and technology have led to improved food production and processing. As a result, citizens in this country and in many other countries have available adequate amounts of nutritious and safe foods at reasonable cost.

The time is now to reevaluate how the nutrition agenda should be refined to provide a vision for programs, interventions, and research that lead us into the next century. In December of 1997, near the 30th anniversary of the 1969 White House Conference on Food, Nutrition and Health, a Steering Committee was formed to encourage another White House Conference to focus that vision.

The Steering Committee represents a broad group of public and private scientific and policy interests. More than 200 groups have expressed their support for a Conference to date, including presidents of professional associations, leaders of food industry, heads of advocacy groups, and others such as key government decision-makers.

Accomplishments of the 1969 White House Conference

President Nixon called the 1969 White House Conference on Food, Nutrition and Health to both reaffirm the United States commitment to a full and healthful diet for all Americans and to explore what we yet need to know and do to achieve that goal. The Conference successfully transformed the United States nutrition agenda and safety net and marked a turning-point in the history of food policy in the United States.

A series of direct actions can be linked to the 1969 Conference. The Food Stamp Program was expanded to become a nationwide household food security program and the WIC Program was started to provide supplemented food and nutrition education for at risk pregnant women, infants, and children. The School Lunch Program was expanded and the School Breakfast Program created.

Beginning in the mid-1970's, more research has focused on a better appreciation of the links between diet and chronic disease. During this period, a series of dietary recommendations

emerged, including the Senate Select Committee on Nutrition's Dietary Goals, closely followed by the 1980 *Dietary Guidelines for Americans*, which has been continuously updated every five years.

The Nutrition Facts Label and the Food Guide Pyramid are examples of two successful government sponsored activities that have occurred in the last decade to help Americans better understand and move towards a more healthful diet.

The Need for Another White House Conference

There has never been a greater body of knowledge which links food, nutrition, and diet to health and disease and never before a greater need to apply this knowledge to promote the health and well-being of the American population. We need to strengthen the links between basic research in human nutrition and the application of this knowledge to achieve improvements in the delivery of health services and cost-savings from disease prevention.

The aim of the next Conference will be to review the programs and policies which have been implemented since the first Conference, to examine their efforts, and to consider how we might now achieve the national goal of a good diet for every citizen.

The United States has a long rich history of public investment in nutrition. Much good has occurred as a result of the first Conference, and many positive independent efforts prevail, but much still needs to be done. There are no fast or easy answers to the nutritional problems facing America today, or to the unforeseen problems of the future.

Persistent hunger continues to plague segments of the U.S. and the developing world. Current estimates of future demand worldwide for food indicate that this need will be met only through continued investment in agricultural research - albeit at a level already reduced from the late 1970's and early 1980's. Yet this occurs at a time where dollars in agricultural research are declining. Federal nutrition support for human nutrition research has stagnated in real dollars since the early 1980's. The challenge is to meet the food and nutritional need in a taut budgetary environment.

But as we continue to strive to provide an adequate and healthful diet for those with too little food, the consequences of too much food have become one of the most urgent public health concerns in America today. More than half of all U.S. adults — 97 million people — are overweight or obese. Even more trying, the number of our children overweight or obese has doubled in the last 20 years, beginning at an earlier age than ever. The costs of obesity-associated diseases is estimated at $100 billion annually and contributes to 300,000 deaths each year. Clearly, the public health consequences of obesity are staggering and imminent.

We are in the tide of a revolution in agriculture, biotechnology, food production, and the capacity to improve the quality of our food supply, not only with respect to traditional nutrition and safety factors, but also in regard to special health promoting qualities of food and diet. The coalescence of American world leadership in agriculture science and nutrition science, projects an entirely new era of health promotion and well-being relating to food, diet and agriculture. The

opportunities provided by the robust activities in agriculture and nutritional sciences and genetics also present challenges to our systems of marketing, consumer education, and international trade which deserve attention at the highest levels of our political system.

Death, disease, and disability resulting from food-borne hazards continue to impose a large national burden and are largely preventable. The Centers for Disease Control and Prevention estimates that as many as 6.5 million cases of food-borne illness occur annually in this country, contributing to as many as 9,000 deaths, with an overall toll on society of $5 billion to $13 billion in medical costs and productivity loses. In addition, potential new threats to ensuring the safety and quality of America's food supply include microbial contaminants, pesticide and drug residues, and naturally occurring toxic or anti-nutrient food constituents.

These are just some of the challenges we face today and in the coming years. Although many of these and other concerns are being addressed at the public and/or private level, no program or group can overcome these complex challenges alone. The only way we can truly succeed at ensuring a healthful diet for all Americans is to come together to strengthen our national nutrition policies.

It is imperative that all groups (academia, health scientists, the food industry and food manufacturers, consumer organizations, representatives of poverty groups, local and national legislators and public administrators) unite at a forum to discuss the food and nutrition agenda for the next century.

It is our intent that the deliberations of the Conference will be thoughtful, constructive, and non-partisan, based upon the existing scientific evidence, with a clear vision both of competing national needs and of American's potential for achievement. We hope that this Conference, like the 1969 White House Conference, will be a catalyst for change in the structure, focus and direction of programs, and in the definition of national nutrition policies that lead us into the 21st century, and beyond.

Meeting for a White House Conference on Food, Nutrition, and Health

December 2, 1998

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Potential topic areas for a White House Conference on Food, Nutrition, and Health and Satellite Conferences, December, 1998

1) The state of nutrition of the American people

- Federal and State monitoring systems of dietary and nutritional evaluation
- Demographic and trends data
- Matching data on nutritional state with knowledge on diet and disease (e.g., child & maternal nutrition, heart disease, cancer, obesity, and diabetes)
- Setting standards for dietary and nutrition evaluation
- Projected nutrient needs into the 21st century

2) Reaching Americas' health goals through national food and nutrition policy with attention to vulnerable groups and special problems

- Poor and low income
- Pregnant and nursing women and infants
- Children and adolescents
- Degenerative conditions in middle age
- The aging and elderly
- The sick and disabled

3) Meeting our countries future food and nutritional needs

- The productivity of American agriculture (agriculture and the environment, organic farming, sustainable agriculture, biotechnology)
- Responding to changes in U.S. demographics in ethnic and minority populations
- Dealing with new science, new technologies, and new foods
- Dietary supplements
- Food fortification
- Safety and efficacy of ingredients/foods/supplements with purported health benefits
- The current and future role of healthcare professionals in providing nutrition services (cost effectiveness, access barriers, third party reimbursement, training and certification of professionals)

4) Evolving our food systems to meet the demands of the coming century

- Food delivery and distribution
- Advertising and marketing
- Packaging and labeling
- Ensuring food safety
- Recognizing long-term trends
- International issues in a global economy

5) Strengthening the design and effectiveness of our food assistance programs

- Establishing our needs today and tomorrow
- Helping special groups (infants and mothers, school children, elders, and disadvantaged)
- Looking at how we design intervention strategies and the role of research in developing those strategies
- Food recovery and gleaning

6) Improving public health through education and communication

- In public institutions (schools, military, hospitals, long-term care facilities, prisons)
- With food assistance programs
- Professional training
- Community nutrition and extension
- Physical activity
- Benefits and obstacles to life-long behavior change
- Public-private partnerships
- Nutrition promotion
- Electronic channels of communication (Internet and www)
- Funding of health education programs

7) Expanding and translating the science-base for human nutrition and health

- The Federal role in nutrition research, support, and training
- The role of State and private universities and research institutes
- The role of industry research and development
- The special challenge of applied and translational research for implementation in populations
- Application of science to improved quality of life (e.g., healthier pregnancy and child development, the prevention of degenerative conditions of aging)

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NEWS

October 27, 1998

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CONGRESS SUPPORTS WHITE HOUSE CONFERENCE ON FOOD, NUTRITION AND HEALTH

The 105th Congress' spending package expressed strong support for a White House Conference on Food, Nutrition and Health. The Senate report accompanying the 1999 fiscal year's Labor/Health and Human Services spending bill included this language:

"The Committee also notes that 1999 marks the 30th anniversary of the landmark White House Conference on Food, Nutrition and Health which lead to many major advancements in nutrition and health policy. The Committee encourages the Institute (National Institutes of Health) to plan and convene a conference to develop human nutrition policy recommendations for the next century. This conference should be developed in cooperation with the Agriculture Department and ensure full and appropriate private sector involvement."

"This is a significant step in the effort to convene a White House Conference," said John B. Cordaro, CRN's president and chief executive officer. "Now we must work with the next Congress, the administration and

--more--

all interested groups to ensure that the conference becomes the catalyst for enhancing U.S. food, health and nutrition policies and programs to benefit all Americans," he added.

At a March 1997 symposium before the U.S. Department of Agriculture advisory board, Cordaro had urged a conference to celebrate the 30-year anniversary of President Nixon's 1969 Conference on Food, Nutrition, and Health.

Since then, CRN has worked with the Tufts University School of Nutrition Science and Policy, members of Congress, executive agency officials and industry professionals to garner support for a conference in the year 2000. A steering committee formed in December 1997 has helped guide the concept and to date, numerous groups - including professional associations, the food industry, advocacy groups and government decision-makers - have expressed interest in and support for a conference.

Irwin Rosenberg, M.D., dean for nutrition sciences at Tufts, said, "We're enthusiastic about the opportunity to work with the new Congress, the administration and their various agencies to gain consensus on the application of advances in human nutrition research and better serve Americans' health needs into the 21st century."

CRN, founded in 1973, is a trade association representing approximately 100 companies in the dietary supplement industry. The Council and its members are dedicated to enhancing the health of the American public through responsible nutrition, including the appropriate use of dietary supplements.

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Meeting for a White House Conference on
Food, Nutrition, and Health

December 2, 1998
4:00 pm
Old Executive Office Building

— Agenda —

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Background and Purpose	Dr. Irwin Rosenberg *Tufts University*
Potential Topic Areas	Dr. George Blackburn *Harvard Medical School*
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Summary and Next Steps	Dr. George Blackburn *Harvard Medical School*

Health & Fitness
The New York Times

Nancy Doniger

PERSONAL HEALTH

Diet Is Not a Panacea, But It Cuts Risk of Cancer

By JANE E. BRODY

When words like "cure" and "prevention" appear in the title of a book about a chronic, disabling or life-threatening disease, they often enrich authors and publishers at the public's expense. Such is likely the case with a best seller, "The Breast Cancer Prevention Diet" by Dr. Bob Arnot, the medical correspondent for NBC.

The book's premise — that adopting a diet rich in soy, flaxseed and fish oils can prevent breast cancer — has been soundly denounced by breast cancer researchers and patient advocates alike as promising something it cannot possibly deliver.

As Fran Visco, president of the National Breast Cancer Coalition put it, "There is no breast cancer prevention diet," and the basis for Dr. Arnot's assertion is too flimsy to warrant a radical dietary shift based on a "bet," as he put it, that it will deliver the goods.

Faced with an onslaught of criticism, Dr. Arnot now says he should have used the words "risk reduction" instead of "prevention" in his book title. Critics say the book overextends laboratory findings that have yet to be confirmed in women, suggests dietary changes that have not been tested for long-term safety and intimates that, counter to all rules of sound medical science, it is foolhardy to wait for definitive proof of the effectiveness and safety of the diet.

Eating to Reduce Cancer Risk

No food can prevent cancer, but a diet that emphasizes fruits, vegetables and whole grains lowers the risk. Experts recommend these foods:

- Dried beans
- Tomatoes
- Broccoli
- Cabbage
- Milk
- Salmon
- Carrots
- Green tea
- All dark green leafy vegetables
- Garlic and onions
- Whole grains
- All-bran cereal
- All fruits, especially apples, oranges, strawberries and grapes
- Red peppers
- Olive oil

The New York Times

The Cancer-Diet Link

Dr. Arnot is not wrong in suggesting that diet plays an important role in reducing the risk of cancer, including breast cancer. The American Cancer Society estimates that diet is a primary factor in a third of cancer deaths. That estimate is derived from thousands of studies of people worldwide and is supported by findings in laboratory cell cultures and animal experiments.

These studies suggest that a reorientation of American eating habits — to emphasize fruits, vegetables and whole grains while minimizing red meats, total fat and especially saturated fats and alcohol — can significantly reduce the likelihood of developing most of the common cancers like those of the colon and rectum, lung, bladder, stomach, esophagus, mouth, throat and breast.

What cannot be said is that adopting a particular diet can assure that you won't get cancer or that, if you do, the diet will prevent the cancer from recurring.

Last year the American Institute for Cancer Research and the World Cancer Research Fund released an analysis of more than 4,500 studies that examined the relationship between cancer, diet and exercise. The conclusion, as summarized in the current issue of Nutrition Action Health Letter: "While there are no guarantees, there is plenty you can do to cut your risk." Simply eating more fruits and vegetables, for example, can eliminate about 20 percent of cancers, the analysis suggests.

> Good bets for good health: fruits, vegetables and exercise.

Perhaps most important is that the recommended anti-cancer diet is the very same diet that studies have shown can help to counter heart disease, high blood pressure, diabetes and obesity.

In other words, anyone who is interested in maximizing the chances of staying healthy would be wise to consider adopting a diet rich in whole grains, fruits and vegetables that are loaded with fiber, vitamins and minerals and other cancer-fighting chemicals that occur naturally in plant foods. A protective diet would also be moderate in animal protein — especially red meats — and low in fat, saturated fat, simple sugars and alcohol.

In contrast to the low-carbohydrate scheme advocated by Dr. Arnot, such a diet is rich in carbohydrates — not sugars, of course, but the complex carbohydrates, or starchy foods, particularly in their natural, unrefined, fiber-rich state. This is also a diet that can help fight obesity, which is strongly linked to an increased risk of breast, uterine and other cancers

Dietary Do's

The cancers most directly linked to diet are those that arise in lining tissues throughout the body, especially cancers of the colon and rectum, lung, bladder, stomach and, to a lesser extent, the breast, uterus and prostate. The following dietary suggestions are based on the strongest associations established in studies:

FRUITS AND VEGETABLES Evidence in people has accumulated rapidly in recent years to support the protective role of plant foods against most cancers. The average American eats only about three or four servings a day of vegetables and fruits, while five servings, and preferably nine, are recommended. Especially helpful are yellow, dark-green and orange vegetables rich in carotenoids; fruits like citrus, tomatoes and strawberries that are rich in vitamin C, and all the cabbage family vegetables like broccoli, brussels sprouts, cauliflower, collards, kale, bok choy and mustard and turnip greens. Such foods are linked to lower risks of lung, stomach, colon and rectum, oral cavity, esophagus and, to a lesser degree, breast, bladder, pancreas and larynx cancers.

Garlic, onions and leeks contain allium compounds that help ward off cancer, especially breast cancer. To reduce loss of the protective chemicals, these vegetables should be cut up and let stand for 10 minutes before they are cooked. Other recent findings suggest that the risk of prostate cancer can be reduced by eating lots of cooked tomato products, including ketchup, that are rich in a carotenoid called lycopene and foods rich in the mineral selenium, like meats, fish, grains and seeds.

SOY AND OTHER DRIED BEANS These contain plant estrogens that may be beneficial in reducing the risk of hormone-related cancers, including breast, uterine and possibly ovarian cancer. A soy-rich diet may in part explain why Asian women have a low risk of these cancers. Dried beans may also help against colon cancer. But experts say that beans are most likely to be protective when used in place of meats and when the rest of the diet is low in fat.

WHOLE GRAINS Wheat bran in whole-grain cereals and breads is strongly linked to reducing the risk of developing colon and rectal cancers, probably because they speed the passage of wastes and limit exposure of the lower gut to cancer-causing substances.

OTHER HELPFUL FOODS The list of possible dietary cancer weapons keeps growing. Among recent additions are green tea, olive oil (linked to a lower risk of breast cancer when used in place of other fats) and milk and other foods rich in calcium and vitamin D (linked to a reduced risk of breast and colon cancer). Though the evidence that flaxseed and fish oils can reduce the risk of developing breast or any other cancer is still highly preliminary, there are many other health benefits associated with eating more fish

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Nutrition Societies Presidents' Forum: Future challenges and opportunities for nutrition societies in the 21st century[1-4]

George L Blackburn, John A Milner, Barbara C Hansen, Steven B Heymsfield, April C Mason, and Gerald E Gaull

ABSTRACT The Chair introduced "Pasteur's Quadrant" as a potentially useful paradigm for modern science. Developed by Princeton's Donald E Stokes, the quadrant is two-by-two matrix that classifies knowledge as fundamental and/or applied. The Chair also noted the effect of competitive pressures, and the necessity for cooperation among nutrition societies. The Presidents of The American Society for Nutritional Sciences (ASNS), The American Society for Clinical Nutrition (ASCN), The American Society for Parenteral and Enteral Nutrition (ASPEN), and the Chair of the Institute of Food Technologist's (IFT) Nutrition Division presented their views on how societies can prepare to meet their members' upcoming needs. The Director of the Center for Food and Nutrition Policy discussed the future role of nutrition societies and how they might interact with various interest groups. The Forum, which included an opportunity for audience participation, took place soon after the February 1996 release of "Meeting the Challenge: A Research Agenda for America's Health, Safety, and Food." Published by the Executive Office of the President's Office of Science and Technology Policy, the report highlights the importance of nutrition to our nation's health. *Am J Clin Nutr* 1996;64:813–22.

KEY WORDS Nutrition research, science policy, nutrition societies, public policy, parenteral nutrition, enteral nutrition

INTRODUCTION

George L Blackburn, Forum Chair and President-elect of The American Society for Clinical Nutrition

I hope you all had the opportunity a few weeks ago to look into the heavens and watch Comet Hyakytake moving across the night sky. As rare and beautiful as the event was to us, just imagine the terror and wonder this spectacle would have caused in centuries past, when people used the stars as a sure and stable tool for navigating and for monitoring the change in seasons. We, of course, knew what to expect and could look up into the night with pleasurable anticipation.

So too can we look ahead to the next century with the same sense of promise and anticipation. Nutritional science has moved beyond the stage of identifying what is minimally needed to prevent deficiency and to sustain life into an exciting range of opportunities for realizing what is optimal to ensure a long, healthy, enjoyable life. How wonderful it is that we have so much *good* to accomplish in the coming years.

Indeed, in *Pursuing Happiness*, Wesleyan University economist Stanley Lebergoot writes that people want diversified, worthwhile experiences—experiences that provide beauty and amusement, that hold their attention, that deliver learning, pleasure, and spiritual fulfillment (1). He notes that consumer goods can be a means to that end by extending life or making it more pleasant or interesting. We need only look at advertisements to see the role of food in meeting this end.

No longer burdened by the need to tackle the negative aspects of nutritional science—deficiency, toxicity, and essentiality—we can focus on the "positive" challenges: the opportunities for using nutrition to prevent and treat disease, to extend and improve life quality, and to pursue happiness. Here, we can surely find common ground, despite our diverse methods for reaching it.

As illustrated by Stokes' *Pasteur's Quadrant* (2), work in both applied and fundamental science will produce results that bring tremendous benefit to society, even without "useful knowledge" in the strictest sense.

The concept of science policy began under President Roosevelt, with Vannevar Bush charged to organize the scientific community. His theme was "Science, the endless frontier." Now comes the Pasteur's Quadrant thesis (**Figure 1**) from Stokes, professor of politics and public affairs at Princeton's Woodrow Wilson School.

[1] From the Nutrition Support Service, Beth Israel Deaconess Medical Center/Harvard Medical School, Boston; the Department of Nutrition, The Pennsylvania State University, State College; the Department of Physiology, University of Maryland Medical School, Baltimore; the Obesity Research Center, St Luke's–Roosevelt Hospital, Columbia University, College of Physicians and Surgeons, New York; the Department of Foods and Nutrition, Purdue University, West Lafayette, IN; and The Center for Food and Nutrition Policy and The Ceres[R] Forum, Georgetown University, Washington, DC.

[2] Supported in part by NIH NIDDK grants 1P30 DK 6200 and DK 46574, and NCI grants CA45504 and CA56422.

[3] Presented at the 36th Annual Meeting of the American Society for Clinical Nutrition, April 14, 1996, in Washington, DC.

[4] Reprints not available. Address correspondence to GL Blackburn, Beth Israel Deaconess Medical Center, One Deaconess Road, Boston, MA 02215.