The American Society for Clinical Nutrition as an academic society\(^1,2\)

Charles H Halsted

Ending my presidential year on the 30th anniversary of The American Society of Clinical Nutrition (ASCN) gives me the opportunity to reflect on our society's original goals and our success in meeting them. Thirty years ago, in September 1959, 10 academic physicians met in New York to establish a society "along the lines of the American Society for Clinical Investigation" that would parallel the purposes of the academic societies that met in Atlantic City every spring in those years. With Grace Goldsmith as their chair, they met a month later in New Orleans and further articulated three major goals: to advance the recognition of nutrition as a medical discipline, to improve standards of nutrition education, and to stimulate research on human nutrition and metabolism. The foremost goal of advancing the recognition of nutrition as a medical discipline encompasses the other two and continues to be the major purpose of our society. The second and third goals of fostering education and research are integral to establishing nutrition as a discipline in academic medicine.

Our society had its first organized meeting in 1960 in the old Haddon Hall in Atlantic City, attended by about 40 members who, with 29 other interested academicians, became the charter members. The relationship with The American Institute of Nutrition was rapidly agreed upon by both sides, and since then we have enjoyed the benefits of autonomy together with an association with basic scientists that is nearly unique to academic clinical societies. With the selection of our first officers, ASCN took over The American Journal of Clinical Nutrition as its official organ and established the high scientific standards for membership that endure to this day (1). (Original minutes of these meetings are recorded in the executive office of the society.)

Membership characteristics

Growth

Figure 1 shows the growth of our membership from the original 69 in 1960. The first 17 years saw gradual growth of about 15 new members per year, followed by slightly more rapid expansion of about 25 new members annually until 1988. In the past year we have more than quadrupled that rate, bringing in 109 new active members at this meeting for a total of 726 active members. With an additional 81 emeritus and 44 associate members, the grand total of the society's membership as of March 21, 1989, is 851. Those who joined our society in the past year are, for the most part, nutritionists who either did not know or needed a little persuasion to realize that, in an era of proliferating societies and journals, our society truly speaks for academic nutrition. To those purists who may ask why we need so many members, I will say that there is strength in numbers and, as I hope to show, we need strength to achieve our goals.

Demographics

During the past year the ASCN Executive Office conducted a comprehensive demographic survey of our membership. Data were compiled from a questionnaire mailed during calendar year 1988 to all categories of members, which had a response rate of 83.6%. As shown in Figure 2, in 1988 we were a mixture of about two-thirds MDs and one-half PhDs. About one-sixth of our members hold joint MD-PhDs, and about 3% are dentists, veterinarians, and masters of science and/or public health. These data will be altered somewhat by the influx of this year's new members, one-half of whom are MDs and the other half PhDs.

Among our physician members, about two-thirds hold primary board certification. Of the board-certified MDs, about one-half are internists, one-third are pediatricians, and one-sixth are surgeons (Fig 3). Among board-certified internists, about half have secondary certification in gastroenterology, endocrinology, hematology, nephrology, or cardiovascular medicine. A similar situation applies to board-certified pediatricians, half of whom are further subspecialized in neonatology, gastroenterology, endocrinology, hematology-oncology, nephrology, or cardiology.

---

1 Presidential Address, given at the annual meeting of The American Society for Clinical Nutrition on March 21, 1989, in New Orleans, LA.
2 Address reprint requests to CH Halsted, Division of Clinical Nutrition, TB 156, School of Medicine, University of California-Davis, Davis, CA.

Received April 14, 1989.
Accepted for publication April 18, 1989.
These data showing numerous professional backgrounds are mirrored by the diversity of research interests of our members (Fig 4). The most popular area of research is lipid metabolism and its relationship to atherosclerosis and other phenomena. This is followed by obesity and then a potpourri of basic and clinical areas from minerals to alcoholism. Obviously, these data might have been reported in other ways depending on the questionnaire. Nevertheless, this review illustrates that we truly are a society of diverse individuals, representing a wide universe of interests.

Common interests

Given the wide range of our professional backgrounds and research interests, what common thread binds us together? Defining our common interest is not only useful but essential for our dealings with each other, with our peers, with the public, and with governmental bodies. Our common interest can be encompassed by the following definition: Clinical nutrition is a science concerned with the basic knowledge, diagnosis, and treatment of diseases that affect the intake, intestinal absorption, and metabolism of constituents of the diet. This definition allows for diverse scientific explorations of the role of nutrition in health and disease. It also allows for methods ranging from basic biochemistry to clinical trials.

It is considered axiomatic that the public’s perception of the importance of nutrition in health is far ahead of the medical profession’s. The Surgeon General’s Report on Nutrition and Health may help to bridge this gap in understanding by emphasizing the relevance of the science of clinical nutrition to the nation’s health (2). As described in the report, 8 of the 10 leading causes of death in the United States may be prevented or modulated by changes in diet or reduced consumption of alcohol. With these data, the academic powers who control medical school curricula and the federal powers who oversee funding programs cannot escape the conclusion that nutrition belongs in the mainstream of clinical medicine.

Meeting the society’s goals

I will spend the remainder of my address reflecting on the ways in which our society’s present efforts and achievements approach the original goals of our founders.

Advancing recognition of nutrition as a medical discipline

Research. First, productivity and excellence of research are the yardsticks by which our peers will judge
FIG 2. Distribution of academic degrees among all categories of members in 1988 based on 614 questionnaire responses.

our efforts to advance academic recognition of nutrition as a clinical discipline. Many of our members are clearly scientific leaders in the areas of interest to which they have devoted their creativity. As scientists we must always be receptive to new methodologies and ways of thinking. For example, much of the fare of our annual meeting illustrates that cellular and molecular biology is as relevant to studies of diet and body function as it is to studies in other fields of academic medicine.

Clinical practice. Our recognition as an academic discipline also requires that we define standards of patient care for ourselves and our peers. By the mechanism of carefully prepared and critically reviewed position papers, our society has assumed leadership in this endeavor. Examples include the thorough appraisal of enteral nutritional requirements for infants and children (3) and of parenteral mineral requirements for adults (4). Publication of these and upcoming position papers in the journal will provide a steady stream of information to teachers, practitioners, and program administrators charged with implementing nutrition into modern clinical practice. In the future the committee's activities will expand to include periodic workshops in which experts will define other controversies in clinical nutrition practice.

Certification. For years many of us have struggled with the concept of certification, a process that will recognize special skills in clinical nutrition. Although the American Board of Nutrition (ABN) has provided an examination and certification for over 40 y, this certificate has gone unrecognized by our peers in academic medicine and is therefore of dubious value. I am pleased to report that this state of affairs may be changing.

Through the Intersociety Committee on Nutrition Credentialing, our society has placed its support behind the ABN as the sole body empowered to define and certify essential knowledge for clinical nutritionists. Our society strongly supports an application to incorporate the ABN as a member board in the American Board of Medical Specialties (ABMS). Once this application is approved, ABN certification will carry the same significance to a physician as specialty certification in medicine, pediatrics, or surgery. Individuals certified by ABN will clearly be recognized as the authorities in our field.

Improving standards of nutrition education

The second major objective of our founders was to improve standards of nutrition education. During the past year our Committees on Medical/Dental School Nutrition Education and on Subspecialty Training have continued to advance this objective by defining the basic core knowledge for medical students, developing strate-
FIG 3. Primary specialties of 278 responding board-certified physician members. “Other” includes pathology (n = 7), preventive medicine (n = 5), dermatology (n = 4), family practice (n = 1), and gynecology (n = 1).

FIG 4. Primary research interests of 578 responding members.
gies for implementing nutrition training in medical schools and residency programs, and continuing a process of defining the content of subspecialty clinical-nutrition training programs (5).

Despite these efforts, fewer than one-third of medical schools require nutrition in the curriculum (6), and fellowship programs and applicants remain few (7). Our ongoing challenge remains twofold: first, to convince our medical school colleagues of the relevance and importance of our field and, second, to demonstrate to future physicians the strength of clinical nutrition as a bona fide professional career choice.

Our postgraduate course rounds out our educational efforts. This annual event provides a superb program for our peers in other fields, our trainees, and ourselves. Having recently organized such a course, I perceive several less obvious benefits. By bringing together a faculty of experts from many fields, we help this diverse leadership group to develop an appreciation of the relevance of clinical nutrition to their own work. Also, by the annual organization and presentation of a series of state-of-the-art lectures, the subject matter of our field undergoes continuous reevaluation and redefinition.

**Stimulating research on human nutrition and metabolism**

The founders' third goal of stimulating research must leave us with a sense of alarm. Even while we are achieving recognized excellence in nutrition research, funding is in a state of stagnation. For example, the National Institutes of Health (NIH) Clinical Nutrition Research Unit (CNRU) program, originally slated for 12 centers, is now frozen at 8 with each center facing the possibility of elimination through stiff competition. NIH-sponsored nutrition training programs have shrunk from 12 in 1981 to 5 in 1988, and none is currently located in a clinical department.

To address these issues, a number of us have participated in workshops and discussions at NIH. Thus far, the issues and needs have been defined, but implementation will require ongoing effort. I am pleased to report that the new Director of the Division Digestive Diseases and Nutrition at NIH, Dr Jay Hoofnagle, has been, and promises to continue to be, receptive to our needs. However, funding priorities will not change by themselves, and we continue to face tough competition from our academic peers for the shrinking federal dollar. In the current state of affairs, we must take responsibility for ourselves and for tomorrow's nutrition scientists. Accordingly, I have suggested two approaches, one under discussion now in the Public Affairs Committee and the other my last presidential initiative.

**Public advocacy.** First, like other successful societies, it is essential to develop a public advocacy group. In light of public awareness of the importance of clinical nutrition—which far exceeds the nutrition-consciousness of funds administrators—a logical, high-potential approach is to encourage a lay organization to advocate for nutrition research and for responsible dissemination of the fruits of this research. One ultimate goal for our society would be to win a congressional mandate to fund the CNRUs and training programs we so urgently need.

**Clinical nutrition fellowships.** Second, like other societies, I believe we are now in a position to establish a few highly selective fellowships of our own. With an annual contribution of $100 000 from individual and sustaining associates, it should be possible to establish three competitive, sponsored, individual fellowships. To this end the council has approved the establishment of a voluntary contribution fund that will form the support base for a competitive fellowship application process.

**The future of ASCN**

What will be the role of ASCN in the evolution of clinical nutrition? I believe that clinical nutrition is on the verge of full academic recognition as a scientific discipline and that our society has established clear leadership in our field. Yet glaring needs persist, chief among them to assure adequate research funding, to bring nutrition into the curricula of all American medical schools, and to enhance awareness that clinical nutrition is a career choice for future physicians.

Academic recognition of our specialty requires continued and increasing excellence of research in clinical nutrition and of our journal. I believe that each of us should be committed to submit our very best work to our journal, which, as envisioned by our founders, strives to be on a par of excellence with the *Journal of Clinical Investigation*. Yet, hand in glove with the requirement for excellence in research is the need to ensure adequate research funding for ourselves and for the new clinical-nutrition investigators who will constitute our future society. The NIH-Clinical Nutrition Research Unit program, now entering its second decade, provides a solid and highly visible base for clinical nutrition research programs and must be expanded in parallel with the growth and recognition of our scientific discipline. Financial support of our fellowship training programs, together with full peer recognition of the process of certification of clinical nutritionists, will enhance the attractiveness of our field for future academicians.

At present less than half of eligible ASCN members have become certified by ABN. Eligibility for physicians requires primary certification in medicine, surgery, or pediatrics. In view of the pending increase in the value of ABN certification through recognition by ABMS, certification of all eligible members of our society is a reasonable goal which must strengthen our credibility as the premier clinical nutrition society in academic medicine.

The continued annual increase in our membership will provide the strength in numbers we need to expand our leadership role in academic nutrition. Our larger vigorous and vocal membership will provide the essential clout to argue for incorporation of nutrition into the
medical school curriculum and to guide our new public advocacy group in helping us make support for our research and training programs a national priority. As the premier academic clinical-nutrition society, we will continue to define the standards of care relevant to our rapidly evolving field. Positions will be developed and presented to our peers in the form of publications in the journal, regional workshops, and symposia at our annual meeting. Our annual postgraduate course will continue to grow in attendance and to serve as a forum for continued redefinition of the evolving science of clinical nutrition. In addition, our society will continue its leadership role in defining ethical controversies that confront scientists and practitioners of clinical nutrition, including such issues as accuracy in reporting and interpreting scientific results, responsibilities of investigators toward animal and human subjects, and the proper use of nutritional therapies for dying patients. An immediate issue is the clear restatement of our Code of Professional Responsibility, which defines the standards to which we must adhere in order to maintain professional objectivity as spokespersons for responsible nutrition policy.

In closing, I wish to recognize the pleasurable interaction I have had with our hard-working council and committees. In particular, I wish to express my gratitude to our able executive officer, Dr S Stephen Schiaffino, and to our staff who make this society tick. This has been a challenging and personally rewarding year for me, and I have much appreciated the trust of the membership. In passing on the leadership to our new president, Dr FX Pi-Sunyer, I have great confidence that all the current programs and future plans of our society will go forward.

References