CORRES- MC QUARRIE

UNIVERSITY OF MINNESOTA
TWIN CITIES

Laboratory of Physiological Hygiene
School of Public Health
Stadium Gate 27
611 Beacon Street S.E.
Minneapolis, Minnesota 55455

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Dr. Donald C. McQuarrie
Professor of Surgery
Veterans Administration Hospital
4801 East 54th Street
Minneapolis, MN 55417

Dear Colleague:

Your point is well taken about Dr. Kottke's program. I can assure you that any approach that Dr. Kottke or anyone associated with this Lab would take would be to present all the evidence. On the other hand, decision-making in preventive practice, as well as public health policy, involve the same sorts of uncertainties of evidence that they do in surgical treatment. We have to go ahead on the best evidence, with the intervention of the greatest potential.

Sometime we can have a chat about whether one can really say that smoking is the "largest risk characteristic" in the Framingham, or in any other American study. The interaction of risk factors is strongly population and culture dependent and difficult to establish by such criteria as risk ratios or size of correlation coefficients. For example, in our Seven Countries cultural comparisons, smoking can hardly be considered a powerful risk factors for atherosclerosis at all, because the Japanese are heavy smokers and don't have much atherosclerosis. On the contrary, in U.S. populations such as our Minnesota and Railroad studies, smoking, as you point out, is extremely important and additive. In Europe where the smoking may be different in nature, one finds again different levels of contribution of smoking to disease, though obviously, the relation of smoking to cerebral and peripheral arterial disease is central.

The question of choosing what is the appropriate balance of an educational effort according to level of risk is a complex one. I guess we would agree with you in a general way that the degree of risk determines the degree of emphasis. However, the ability to modify the risk characteristic enters centrally into the equation.

Your conclusion about the devotion of the entire research effort of this Lab to that of nutrition is a common public perception. It is inaccurate, as you would find if you examined the research output of this Laboratory now, or even under Keys.

In regard to achieving a balanced-multiple risk factor strategy, this Laboratory is probably among the originators of the multiple risk factor concept and proposed it as a trial to NIH in the late 1960's now under way both in the Multiple Risk Factor Intervention Trial nationally and in our present research and demonstration project in Minnesota communities where the message is indeed a very broad and balanced one and has nothing to do with any special attitudes about diet and blood lipids.

I was interested in your personal reaction about Dr. Keys' "promotional pronouncements". I have sought very hard to find such pronouncements in his scientific writings and can't find them. As a matter of fact, you would be amused to know that it is he who guards the academic view and dabbles very little in public health stances or pronouncements. He is particularly critical of me, for example, for adopting public health stances which I believe responsible investigators must do on the best evidence attainable, while still looking for new evidence.

Needless to say, I am grateful however for your comments and interest and for the intellectual rigor and expository vigor of your reply. I'm sure we would enjoy knowing each other better and perhaps that will come about. Any any rate our own faculty should be as well informed about us as those outside the University.

In am enclosing Ancel's latest, the closure to our longterm work on the Seven Countries Study, just published by Harvard Press. It is a solid scientific conclusion and by no means a promotional one. It says we have more to learn.

Cordially,

Henry Blackburn, M.D.
Professor and Director

HB:mb

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