"It seems clear there is no one Mediterranean diet (MD). An ideal MD could be defined as a nutrient profile, a selection of foods, or as a cultural and historical artifact. However, any definition of an MD should recognize the factors that created it: social, cultural, historical, political, and economic. Transplanting an “ideal,” possibly idealized, diet into a different cultural and social context may transform an indigenous domestic cuisine into a foreign “national” cuisine, more closely associated with dining out, cookery books, and middle-class recreational consumption. The Mediterranean diet is probably not a useful basis for nutrition education toward chronic disease risk reduction in non-Mediterranean countries."

"...the dietary decisions of the hearth are deeply connected to the worlds of the neighborhood, the fields, the marketplace and even the religion of the region."¹

This paper first discusses the social construction of the Mediterranean diet as a “food guide” for health, with special reference to Australia. The idea of a “Mediterranean diet” is then compared with that of “Mediterranean cuisine” and some underlying sociocultural concepts are discussed, particularly their relevance to nutrition education practice.

THE SOCIAL CONSTRUCTION OF THE MEDITERRANEAN DIET AS DIETARY ADVICE

In 1995 in Nutrition Today, Kevin Nelson, a nutrition educator, raised some serious reservations about the Mediterranean diet (MD) in the management of coronary heart disease.² In his critique he noted some positive aspects of current interest in the MD, principally that it signaled the valuing of traditions and an appreciation of “whole diets” rather than specific nutritional components. However, he stated that this is precisely the reason NOT to advocate the diet to non-Mediterranean groups, as it constitutes a “foreign” tradition in this context.

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Conflating the concepts of “diet” and “traditional food practices” may be confusing.

Linking the medical science concept of diet and the cultural concept of traditional food practices could be either synergistic or confusing. This paper explores the potential difficulties caused by conflating these two concepts in dietary advice for non-Mediterranean populations.

WHERE DID THE MD COME FROM AND HOW HAS IT BEEN USED?

The idea of a health-promoting Mediterranean diet received widespread international publicity in 1993 through the conference sponsored...
by the Harvard School of Public Health, the World Health Organization and the Oldways Preservation and Exchange Trust. The conference promoted the use of the Mediterranean Diet Pyramid as a food guide. The contemporary debate about the MD first emerged through the 7 Countries Study, which involved approximately 12,800 men in the United States, Finland, the Netherlands, Italy, the former Yugoslavia (Croatia and Serbia), Greece, and Japan in the late 1950s. Sixteen cohorts of men aged between 40 and 59, were studied for risk factors and mortality from a number of diseases. They were studied again at 10 and 25 years follow-up. Interest in serum cholesterol as a risk factor led to the collection of information on the men’s diets. Differences in the quantity and quality of fat intake, carbohydrate, and fruit and vegetable consumption and their relationships with risk factor levels and causes of death were documented.3 A supplement to the American Journal of Clinical Nutrition published 17 papers from the 1993 conference in which nutrient profiles and food consumption patterns were discussed in relation to health outcomes.4 Papers from an earlier European conference on the same topic were published in the European Journal of Clinical Nutrition, with many similar recommendations.5

THE MEDITERRANEAN DIET IN AUSTRALIA: PHILIP MUSKETT, MICHAEL SYMONS, AND THE “CONTINENTAL COOKERY BOOK”

Philip Muskett, a Sydney physician, expressed concern about the diet of Australians in his book, “The Art of Living in Australia,” and declared that its main aim was to “... . . . . attempt to bring about some improvement in the extraordinary food-habits at present in vogue.”6 Muskett singles out the overconsumption of meat and the underconsumption of salads, wine, and fish as particular problems. He advocates a national diet in harmony with the geography and climate of Australia and criticizes British food traditions as inappropriate for Australians. He strongly advocates the value of Mediterranean food habits for Australians, and his views are supported in another Australian source, the “Continental Cookery Book”7 In the Forward the author states, “One keen ambition of the Continental Cookery Book is to flash a ray or two of light into the occasionally somewhat obscure recesses of traditional British cookery. Not for a moment, that the latter has no merits, but that for so many of its good points are unsuitable, or only half-suited, to Australian conditions” (p. 1).

“It is time for Australians to realise, in fact, that what one may call Mediterranean cookery has much to offer them. Italian cookery for instance, embodies ideas, aims and methods that have not only been ripening for literally thousands of years, but have been doing so under climatic conditions far more closely resembling those of Australia than do the British” (p. 2).

The foreword finishes “(Now), even a cursory examination of the recipes in this book will show how remarkably closely the time-honoured practice of competent cooks, of Mediterranean cooks especially, has coincided with the theory of modern science” (p. 3).

What is of interest in trying to understand the social construction of the “Mediterranean diet” in Australia is that Muskett’s book was published in the late 19th century (1893) and the “Continental Cookery Book” in the mid-1930s (1936?), the latter predating by more than 2 decades, Ancel and Margeret Keys own recipe books specifically linking the MD with coronary heart disease prevention.8 As Haber says, promoting the Mediterranean diet is not a new idea.9 She has traced this activity to the early 17th century when an Italian cook tried to persuade the English to eat a wider variety of vegetables and fruit.

More recently in the 1990s, Michael Symons, the Australian restaurateur and gastronome, has followed in this tradition.10 He offers, however, a more differentiated system advocating regional adoption of international cuisines according to climate and geography, eg, Chinese cuisine in northern Australia.

Clearly, to advocate the health-giving properties of the MD, it is neither necessary to know about the 7 Countries Study, nor to have any knowledge of modern biochemistry. Further, Philip Muskett in the 1890s and Symons more recently are more rational than the modern day advocates of the MD, since they both recognize the ecological implications of their recommendations. In contrast the 1993 conference seems to have relegated these concerns to something of an appendix to the medical rationale.11

DIFFERENT WAYS OF VIEWING THE MD

The MD could be described as a nutrient profile, a selection of foods, or as an historical and cultural artifact.
THE MD AS A NUTRIENT PROFILE

Within the Mediterranean region there is variability in dietary composition, to the extent that it may be misleading to think of one Mediterranean diet. For example, a comparison between France and Northern and Southern Italy in the 1960s shows that cereals contributed 36%, 42%, and 38% of total energy, respectively, while fruit and vegetable consumption varied from 12% of total energy in France to 8% and 9% in Northern and Southern Italy. In terms of amounts of foods consumed in these groups calculated as grams per day per consumption unit, this varied from 486 g/day of cereals for Southern Italy to 333 g/day in Northern Italy and 351 g/day in France. On the other hand, fruit and vegetable consumption was highest in France (473 g/day) with 426 g/day in Southern Italy and 298 g/day in Northern Italy. Clearly there are a number of Mediterranean diets, something that is fairly widely understood among nutritionists, but that leads some advocates to select a particular version for promotion.

Australians have greater longevity than most Mediterranean peoples.

The 1993 International Conference on the Diets of the Mediterranean reviewed the evidence that these dietary patterns lead to a reduced risk of chronic diseases. The MD was defined as “diets of the early 1960s in Greece, southern Italy and other Mediterranean regions in which olive oil was the principal source of fat.” However Ferro-Luzzi and Sette at an earlier conference on the MD concluded that, “... describing the Mediterranean Diet, which was supposed to be quite an easy task, has turned out to be a demanding and almost impossible enterprise since data are lacking, incomplete or too aggregated. It appears that currently there is insufficient material to give a proper definition of what the Mediterranean Diet is, or was, in either in well defined terms of chemical compounds, or even in terms of foods. We do not think we have succeeded in characterizing the Mediterranean diet in a satisfactory way. The closest we feel that one can come in terms of a definition of the Mediterranean Diet, is to assume that it resembles the diet eaten in Southern Italy in the early ’60s, as described by the Euratom Study ... The all-embracing term ‘Mediterranean Diet, while very attractive, should not be used in scientific literature until its composition, both in foods, nutrients and non-nutrients, is more clearly defined and the metabolic basis of its health-promoting virtues has been better explained” (p. 25-26).

THE MEDITERRANEAN DIET AS A SELECTION OF FOODS

Alberti-Fidanza prefers the term “Reference Mediterranean Diet,” because the classical MD pattern was achieved at different times and in different places in the Mediterranean area. She defines the MD in terms of foods as, “a frugal diet in which typical Mediterranean foods occupy a rational position in relation to energy adequacy, including both intake and expenditure. These foods are: cereals, pulse, vegetables, fruit, olive oil and fish. In Italy this type of diet was that of the southern working classes in the 1950s...” (p. 61).

However, the modern MD in Italy, as elsewhere in the region, is a moving target. Alberti-Fidanza recognizes the complications of advocating, for Mediterranean peoples, a return to the past and also the dangers of introducing the idea of the MD in a different cultural environment. She distinguishes between the Mediterranean diet and Mediterranean food habits and has reservations about using “classical meal patterns” as the basis for nutrition education.

“At this point without detracting from the virtues of the MD, we may wonder whether today it is right to categorically recommend its classical meal patterns. These were well suited to particular lifestyles, and for this reason we speak of ‘Mediterranean diet’ not only of Mediterranean food habits... Consequently foods such as bread, pasta, pulse, olive oil, could be introduced in the diet in an incorrect way” (p. 69).

THE MEDITERRANEAN DIET AS AN HISTORICAL AND CULTURAL ARTIFACT: HAUTE CUISINE OR DIET?

A cookbook published in 1994 clearly has the endorsement of the 1993 conference organizers. It contains an introduction by two of the major participants in the conference and acknowledges the sponsors of the 1993 conference. It seems fair to consider it as an approved method for implementing the MD in domestic practice. However, it seems possible that in practice, the MD has become a Mediterranean cuisine rather than a “diet.”

This issue is clarified by a particular extract concerning “Greek salad.”

“When Antonia Trichopoulou talks about the Mediterranean diet, which she does often in her role as director of the World Health Organization Collaborating Center for Nutrition Education in Athens, one ex-
ample of good, healthy Mediterranean food that she often cites . . . is Greek salad. This has evoked howts of derision from Americans used to the kind of Greek salad we get all too often in mom-and-pop corner restaurants, the one that's made with wet iceberg lettuce, hard tomatoes, and canned California black olives, dressed with Wishbone Italian Low-Cal Dressing. The salad Antonia makes when she entertains friends and colleagues at her summer house on the sea outside Athens is altogether different" (p. 75).

The recipe includes romaine lettuce, Greek or Romanian feta cheese, preferably sheep's milk feta, Kalamata olives and extra virgin olive oil. Here, we can surely detect a theme of social distinction, there are those who "know" and those who don't, the social status implications are clear.

How should the MD be interpreted when attempting to change people's existing food choices in the name of better health? The transition from nutrient profiles to cookbook suggests a change from "diet" to "cuisine," in fact a "national" or "high" cuisine as distinct from a "low" or domestic cuisine. In "Cooking, Cuisine and Class," Goody shows that the development of a differentiated cuisine, high and low, is related to social stratification. In more stratified societies, higher status groups are able to draw on resources created by the lower classes, to consume in a more affluent manner.

Both Michael Symons and Sidney Mintz have compared national, with regional, cuisines and concluded that "true" cuisines, that is distinctive foods and ways of producing and consuming them, are not dictated by political boundaries (eg, Italian, Greek, or Australian cuisine). "True" cuisines are regionally anchored in food-producing communities and are domestic cuisines, eaten at home, principally the responsibility of women. They also involve social components such as shared beliefs. According to Mintz,

"(I think) a cuisine requires a population that eats that cuisine with sufficient frequency to consider themselves experts on it. They all believe and care that they believe, that they know what it consists of, how it is made, and how it should taste. In short, a genuine cuisine has common social roots; it is the food of a community—albeit often a very large community" (p. 96).

On the other hand "National cuisines," eg, Australian or Italian cuisine, take the form of a collection of dishes derived from regional cuisines that become a public or restaurant-based phenomenon. Those who can afford to participate can become knowledgeable consumers, those who "know." National cuisines thus become haute cuisines with all the attendant problems that class distinctions create for nutrition education. In multicultural consumer countries like the United States and Australia, the culture of dining out is based on the seeking of novelty and the creation of a form of distinction affordable by the affluent. For example, in Australia, the 1993-1994 Household Expenditure Survey, shows that households in the highest 20% of incomes spend almost six times more than low income households on meals in restaurants, hotels and clubs, approximately $38 (Australian) per week compared to $6.40.

In non-Mediterranean countries the MD may become an haute cuisine and not a domestic cuisine.

THE MEDITERRANEAN DIET AS A HAUTE CUISINE

I will refer to Italian cuisine as an example but I believe the principles can be generalized to other cuisines. When "outsiders" discuss both Mediterranean cuisine and the Mediterranean diet, there are pleasant, sunny, tourist- and restaurant-oriented overtones. This bears little relationship to the hunger and oppression discussed by Italians themselves in the context of plenty and want in Italian history. Indeed, Trichopoulou has stated that the MD is not a peasant diet.

While most non-Italians would agree that Italian dishes are delicious, we speak from our restaurant experience, our travel, and our knowledge of the dishes that we have adopted into our own domestic repertoires as well as information from cookery books. This is the basis of an outsider's understanding of a national "Italian cuisine."

Such conceptions are not anchored in our own traditions of history, family, and community, and are often based on romantic interpretations of rural and working class lives.

Why has one MD been chosen, that is, a working class "diet" from Southern Italy in the 1950s? Social historians have documented the difficult and sometimes wretched lives of many southern Italians about this time. It is not too extreme to describe the social conditions on which the MD Pyramid is supposedly based, as close to that of a developing country. During the 1950s and 1960s, Italy was trying to recover from a disastrous war and 25 years of fascist government. Four million southern Italians became migrants, one million left their homes for Australia and America, and three million migrated to the more affluent north of their own country. Additional questions have been raised about the nature of the MD and its relationship to longevity and poverty through a recent study in Albania. The authors of this study argue that even though Albania is the poorest

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country in Europe, with the highest infant mortality, it has relatively high adult life expectancy and low coronary heart disease mortality. They suggest that the MD contributes to the explanation of this pattern; however, life expectancy at birth is well below that for Australia and the United States (67.8 years for men and 74.2 years for women). Is it possible to cleave the MD from its historical and social origins?

Many Mediterranean diets are possible; varying by place, time, and socioeconomic status, there is obviously good reason to choose "the nicest one" for promotion, not only because of the low heart disease mortality in Mediterranean countries but also because of the region’s beguiling images. Nevertheless, on the basis of life expectancy, Mediterranean countries are not advantaged in comparison with Australia. In the early 1990s life expectancy at birth was 75 years for Australian men and 80.9 for women, in Italy the equivalent figures for men and women were 73.7 and 80.5 years. In the same period in the United States, male life expectancy at birth was 72.2 years and for women it was 79.2 years.26

The less affluent cannot participate in restaurant culture.

The promotion of the MD in non-Mediterranean countries may create class distinctions that alienate those unable or unwilling to participate in novel and expensive domestic cooking or the haute cuisine, dining out customs, of multicultural societies.

CONCLUSION

This paper examines the promotion of the Mediterranean diet (MD) as a food guide and raises a number of questions. How “real” is the Mediterranean diet? Even if it can be defined, is it a nutrient pattern, a selection of foods or a cuisine? Is it appropriate to promote its retention in changing Mediterranean communities or its adoption in non-Mediterranean communities? Does it become another entity altogether when taken out of its cultural and regional contexts? The relationship between the food consumption, longevity, and poverty are far from simple.

The MD, as it has been promoted by the Harvard School of Public Health and the Oldways Preservation and Exchange Trust, has been examined on three levels: as a nutrient profile; a selection of foods; and as a social, cultural, and historical artifact.

It is concluded that the MD is not a well-defined entity at any of these levels and that the social, cultural, and historical features underpinning it have been ignored. The promotion of the Mediterranean diet as a food guide is based on a misunderstanding of culture as a determinant of food consumption and health patterns. Alberti-Fidanza44 may well be right, the Mediterranean nutrient profile, expressed not necessarily through Mediterranean foods or “classical meal patterns,” may be a better basis for nutrition education in non-Mediterranean contexts. However, this still leaves questions about what health advantages may result, particularly in countries such as Australia.

Nutritionists should be educated in historical, sociological and anthropological aspects of diet.

I have argued that medical experts have created an artifact, an ersatz consumption pattern. The construction of dietary advice has recently been housed in the least helpful academic disciplines, biochemistry, medicine, and physiology, all essential for the development of nutrition science, but unhelpful in understanding the practices of everyday life. It is anthropology, sociology, and psychology that inform us about culture, society, and human behavior.

The Mediterranean diet pyramid is a compelling argument for the education of nutritionists in historical, sociological, and anthropological perspectives on diet.

REFERENCES

Mediterranean Diet as Food Guide


INSTITUTE OF MEDICINE ELECTS NUTRITIONISTS

Fifty-five new members have been elected to the Institute of Medicine of the National Academy of Sciences for their contributions to health, medicine, and related fields. Among those in nutrition-related fields who were elected were William H. Dietz, MD, PhD, director, Division of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, US Department of Health and Human Services; Cuthbert Garza, MD, PhD, professor and vice provost, Cornell University, Ithaca, New York; Barbara Gilchrest, MD professor and chair, Department of Dermatology, Boston University School of Medicine; Rudolph L. Leibel, MD, professor of pediatrics and medicine, and head, Division of Molecular Genetics, College of Physicians and Surgeons, Columbia University, New York; Walter Willett, MD, DrPH, FJ Stare professor of epidemiology and chair, Department of Nutrition, Harvard School of Public Health; Catherine Woreck, PhD, undersecretary for food safety, US Department of Agriculture; and Johanna Dwyer, DSc, RD, professor of medicine and community health, Tufts University Schools of Medicine and Nutrition. The members serve as volunteers on committees engaged in a broad range of studies on health policy issues. Current projects of particular interest to nutritionists include studies on cancer research among minorities and the medically underserved, the prevention of perinatal transmission of HIV, and a continuing series of reports on dietary reference intakes, which will replace the 1989 Recommended Dietary Allowances. Over the past year the institute issued reports on American's

Children: Health Insurance and Access to Care: Control of Cardiovascular Disease in developing countries, addressing the emergence of cardiovascular diseases as a major health threat in the developing world, ensuring safe food from production and consumption on ways to improve federal oversight of the food safety system, and a study on Scientific Opportunities and Public Needs: Improving Priority Setting and Public Input at the National Institutes of Health, examining how NIH allocates its research funds and the role of the public in these decisions.

NEW ELECTRONICS

The Editor’s Pick is a free electronic newsletter, published monthly, on seasonal and unique resources for nutrition education. It is sponsored by Food & Health Communications, Inc. Judy Dougherty, from National Institutes of Health is the executive editor, and she can be reached at judydougherty@IBM.NET. The National Heart, Lung, and Blood Institute (NHLBI) of the NIH has revised the Healthy Heart Handbook for Women. It consists of over 100 pages of the latest information on preventing cardiovascular diseases like coronary heart disease, heart attack, high blood pressure, stroke, and chest pain. The handbook helps women develop a personal action plan for reducing the major risk factors. There’s also information on other issues relating to heart health like stress, birth control, alcohol, and facts on the role of hormone replacement therapy, aspirin, and vitamins. There is also a section on diagnostic tests, medications, warning signs, and advice on talking with doctors. Printed copies are available for $5.50 by calling 301-251-1222 or fax 301-251-1223 at the NHLBI Information Center, Box 30105, Bethesda, MD, 20825-0105.