For Debate . . .

The COMA report: what it left out

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The panel on diet and cardiovascular disease of the Committee on Medical Aspects of Food Policy (COMA) has recently published its report.¹ In structure it is a radically different document from COMA's first effort on the subject 10 years ago.² The 1974 COMA report was essentially a summary of the scientific evidence on the possible causal relations between diet and heart disease. Its recommendations occupied exactly one page. The 1984 COMA report condenses the evidence from 600 scientific papers it surveyed into four pages, which are presented merely as the basis for its recommendations. The main body of the text is taken up with these recommendations and the means for achieving them.

Behind these differences lie two contrasting interpretations of the role of a scientific committee that is asked to consider a subject of topical public concern. The committee may decide, as the 1974 COMA panel did, to concentrate exclusively on what the optimum patterns of behaviour should be, based on available scientific evidence, leaving to others the question of how they should be achieved. On the other hand, it may decide, as the 1984 COMA panel did, that it should take the practicalities of implementation into account when formulating its recommendations.

For a committee composed exclusively of medical scientists the attempt to incorporate recommendations relevant to policy into its deliberations was a courageous decision. Perhaps the 1984 COMA panel's interpretation of its task was shaped by the pressing immediacy of public interest in diet related diseases. Perhaps it was conscious that the Department of Health and Social Security would definitely act on its recommendations; the chief medical officer publicly committed himself to implementation last April. What is indisputable is that at a key point in COMA's analysis considerations of practical policy influenced scientific judgment in a decisive manner.

Recommendation

The COMA panel's principal recommendation is that fat should account for no more than 35% of total food energy, including 15% from saturated fatty acids. In the crucial paragraph (2.1.1.3) the panel notes that its recommendations differ from those of the Expert Committee of the World Health Organisation³ and, it might have added, from those of the working party of the National Advisory Committee on Nutrition Education,⁴ both of which recommended figures of 30% for total fat intake and 10% for saturated fatty acids. It explains the difference as follows:

"Our recommendations . . . are designed to take account of practical considerations in the United Kingdom. We doubt whether the stringent

dietary changes which the World Health Organisation recommendation requires would be implemented by the general population at the present time."

Considerations of feasibility prevailed over nutritional desirability. In and of itself, this is not objectionable; it might be a sensible pragmatism. In fact, however, the panel's pessimism about achieving the desirable dietary change stems from a simple, narrow, and incomplete conception of the available means of facilitating nutritional improvement. In the policy section of the report the panel articulates the two models of change that underlie its recommendation.

"5.7 One method of implementing the recommendation for saturated fatty acids and for total fat in the United Kingdom diet is to decrease consumption of fat from each food item (which is a major source of fat in the national diet) by about one quarter."

This is the "consumer renunciation" model of change, which has dominated dietary thinking for so long. Domestic consumers are expected to give up substantial proportions of the foods they customarily eat while everyone else in the food chain carries on as before. Against this straw man, the panel then opts for:

"5.8 An alternative approach, likely to be more acceptable and therefore to be recommended, requires a smaller decrease in fat through an increase in polyunsaturated fatty acids."

Apprehensiveness, grounded in a restricted view of the options in policy, has led the panel to relax its fat recommendations above the proportions thought nutritionally desirable by many similar scientific committees in Britain and abroad.⁵⁻¹¹

Viewing the 1984 COMA report with a combination of sympathy for what it attempts, yet rigour in assessing what it actually achieves, we may see that it falls classically between two stools. It forsakes the impregnable purity of scientific detachment. It relates its recommendations to the real world more thoroughly than not only its 1974 predecessor but also many of those other committees that have made bolder proposals. Yet the policy options that it fails to consider are much greater than those to which it attends. Analysed below are the six key areas in which the 1984 COMA panel attempted something new and relevant but failed to develop completely the logic of its own case.

Key issues

(1) For the most part, the recommendations of the 1974 COMA report were directed, explicitly or implicitly, at domestic consumers. The 1984 panel has a much clearer and broader idea for whom it is writing. It includes recommendations for medical practitioners, health educators, the food industry, and government in addition to the general public. None the less, the panel still lays the major obligation for change on consumers rather than on any of the other interested parties who help to determine our patterns of

food consumption. The recommendations for the general public are longer than for all other groups put together. Consumers are given injunctions for action expressed in imperative tone and printed in bold type face. In contrast, the government is urged (in light type face) to "consult," to "consider," and to "enquire." The only firm recommendation for the food industry concerns better labelling, a worthwhile change but one that the government has already been pursuing for over a year now. The food that consumers eventually eat, however, comes to them by a complex process, international in scope, involving many commercial concerns linked in a food chain: producers, processors, manufacturers, distributors, caterers, and a host of intermediaries and interest groups. All could make contributions to a healthier diet.

(2) The real issue for the food industry concerns not labelling but the composition of manufactured foods—what is in the can, not just what is on it. As most of the fat consumed in Britain is eaten in "invisible" form, either as part of manufactured foods or as concealed intramuscular fat in carcase meats, the active engagement of industry in producing more nutritious products is essential to any food health policy. The panel acknowledges the issue but is then conspicuously, almost ostentatiously, vague in dealing with it. Firstly, it makes no firm recommendations on the composition of fat bearing foods; rather, it urges "consultations" to develop "alternative" products "where appropriate." Secondly, it does not even make a systematic, quantified assessment of the potential contribution that industry could make to fat reduction through changed formulation of products. The recommendations on fat intake for consumers are measured complexly and in detail, with ranges of acceptable patterns of consumption spelt out, depending on alternative ratios of polyunsaturated to saturated fatty acids. For industry the report enumerates possible gains only for milk and milk products, not for the other principal sources of fat intake—meat and meat products, margarine, cooking oils, and biscuits/pastries/cakes/breads. Such measured estimates were, however, available to the panel, both publicly¹² and privately, in a specially prepared background paper. Thirdly, the panel hardly mentions retailers, much less considers their role in determining the composition and availability of manufactured foods through their selection among competing suppliers, yet the alleged domination of food retailers over food manufacturers is now the subject of its second governmental investigation in less than five years.^{13,14} Finally, but most fundamentally, the panel's vision of dietary progress is still focused on providing healthy alternative products rather than on improving the nutritional quality of the mainstream items that most people eat most of the time. Here again, the panel is some way behind current thinking in the industry.¹⁵⁻¹⁷

(3) Unlike its predecessor, the 1984 panel recognises as background (paragraph 1.4.2) that economic policies may have an important effect on nutrition; it does not, however, act on that perception. There are no recommendations on pricing of foods. Economic variables make only one, disguised appearance in the report in a brief, abstract, and obscure paragraph on the Common Agricultural Policy (2.6.4), which does not mention, much less make recommendations on, the multiple price controls, tariffs, taxes, levies, rebates, discounts, subsidies, grants, production quotas, import quotas, export quotas, storage costs, conversion costs, dumping practices, "green" exchange rates, and other intervention devices through which the Common Agricultural Policy (and the British government itself) directly manipulates the cost of our food; yet the recurrent financial problems of the Common Agricultural Policy are just now reaching the point of crisis. Reform cannot be long postponed. Imminent change creates an opportunity to include nutritional as well as farming criteria into our food pricing policies.

Putting points 2 and 3 together, the panel has shown an inadequate awareness of how our present and future patterns of food consumption are shaped by the relative availability and prices of healthful and harmful products. Hence it has underestimated the potential for change.

(4) The panel includes caterers in its consideration but then makes only one trivial recommendation for them (paragraph

2.4.2), yet, according to the conservative estimates of the latest national food survey,¹⁸ 15% of all meals are eaten outside the home. Given the Escoffier traditions in our restaurant trade, given the prevalence of fried foods at the inexpensive end of the market, given the rapid growth of both the "fast food" and "snack" industries in recent years, we have reason to believe that food eaten outside the home has a very high fat content. Given the relative scarcity of information on this subject, a minimum proposal should have been for fact finding research.

(5) The report includes specific recommendations for government, but they concern what the government might do to others, not the easier if more embarrassing task of improving its own practices. There are no recommendations on the government's own food provision or food procurement services. The government is by far the nation's largest caterer, accounting for about a quarter of the entire industry. The limited, for the most part unpublished, evidence suggests that the food offered in government establishments does not meet COMA's or the National Advisory Committee on Nutrition Education's guidelines and may be even worse than the average national diet.^{19,21} The DHSS, the sponsoring ministry for COMA, might reasonably be expected to take the lead in setting standards for the whole of the public sector. In fact, the government is just now forcing hospital catering services to be put out to tender under its plans for privatisation without setting any controls on the nutritional quality of the food to be supplied other than for patients with specific clinical requirements. Yet COMA makes no recommendations. Improving hospital catering is the principal activity in the district food and health policies now being developed in more than 100 districts, yet COMA gives them no support. The National Health Service's supplies services are just now being thoroughly reorganised, yet there are no nutritional standards for food purchasing, no nutritionists or dietitians on the NHS Supplies Council, and no recommendations in COMA. Given the moral importance of putting one's own house in order first, these might have been among COMA's first proposals.

(6) The panel acknowledges that several types of legislation influence patterns of consumption but makes no recommendations on using food law for nutritional improvement. It writes (paragraph 1.4.2), "So far as we are aware no Government has attempted to enforce recommendations relating to nutrition and cardiovascular diseases by direct legislation." This is both technically inaccurate and substantively misleading. Both Belgium and Finland have introduced legislation to reduce the amount of salt that may be added to specified manufactured foods. More importantly, as the food industry has correctly pointed out, its operations are already subject to a substantial body of law.^{22,23} These standards specify in detail the composition of a large number of foods and do so on grounds of health. Our present regulations, however, are concerned with the 19th century health problem of adulteration and food safety, not the 20th century health problem of excessive and imbalanced consumption. Gradually adding nutritional content to our existing food standards requires neither public expenditure nor parliamentary legislation. It is one of the easiest and least expensive recommendations COMA could have made, but it failed to do so.

Conclusion

These then are some of the policy options that were omitted by the COMA panel. They are not arcane possibilities that the panel might understandably have overlooked. At one point (paragraph 1.5.1) the report boasts, "To the best of our knowledge all major papers relevant to the subject under review have been taken into consideration," yet for the past two years the Science and Engineering Research Council and the Economic and Social Research Council have jointly funded a research programme at Bradford University specifically concerned with public policies to reduce fat consumption. Its directors, Fallows and Wheelock, have published prolifically, suggesting many constructive steps that might be taken at all stages of the food chain.^{24,25} There is no indication in the bibliography, the models and concepts of dietary

change, or the specific recommendations that the panel "took into consideration" any of this research.

Clearly, policy considerations are becoming central to the debate on diet and disease. The moment of promised government action is almost upon us. The 1984 COMA panel was therefore correct to consider the practical implications of its recommendations. If it failed to do so adequately that is no cause for a retreat back into purely scientific committee work. On the contrary, it is cause for a serious effort to investigate and explicate the policy options for achieving desirable dietary change. Apart from the Bradford project, our research effort on this front is meagre. When the 1984 COMA panel wanted to review the evidence on diet and cardiovascular disease it had over 600 published scientific papers available to it. There is no equivalent body of research on the policy side, and the panel's recommendations suffered from the lack. If we begin now with a national programme of research into nutrition policy we might just be ready to help by the time the next COMA panel prepares its report.

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Lesson of the Week

A narrow escape from splenectomy

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Splenectomy may be performed for diagnostic purposes in lymphoma. Visceral leishmaniasis is well recognised in eastern Mediterranean countries but would rarely be linked with a holiday-maker returning from an area outside the Mediterranean such as the Algarve. We report here on a patient with visceral leishmaniasis who narrowly escaped splenectomy.

Case report

A 53 year old white housewife, resident in Brentwood, Essex, presented in June 1984 with a three month history of progressive malaise, lethargy, and fevers and a weight loss of 9.5 kg (21 lb). In February 1984 she had visited the Algarve for a two week holiday, after which she had suffered a 10 day episode of non-bloody diarrhoea. Her bowel habit had returned to normal, but she had continued to feel unwell.

On examination she was pale and had a swinging fever. There was no lymphadenopathy. She had an ill defined mass arising from the left hypo-

Tropical infections such as visceral leishmaniasis should be suspected in travellers to a wider range of European destinations than Mediterranean countries alone

chondrium, which was thought to be an enlarged spleen. Investigations showed: haemoglobin concentration 9.3 g/dl, mean corpuscular volume 77 fl, white cell count $3.0 \times 10^9/l$ with 64% neutrophils, 26% lymphocytes, and 8% monocytes, platelet count $107 \times 10^9/l$, reticulocytes 20×10^{-3} , erythrocyte sedimentation rate 75 mm in the first hour, direct Coombs' test weakly positive for C3d; her biochemical profile was normal; immunoglobulin electrophoresis showed a mild diffuse increase in IgG and IgM; culture and analysis of midstream urine yielded negative results; repeated blood cultures were sterile; no parasites, cysts, or ova were seen in her stools; and stool culture was negative. Serological tests for brucellosis, infectious mononucleosis, and amoebiasis were negative, and paired sera for antibodies to viruses, including cytomegalovirus, showed no rise in titres. Malarial parasites were not detected. Rheumatoid factor was weakly positive at a titre of 1/40 (RA Latex). Chest radiography showed an unfolded aorta consistent with hypertension. Computed tomography of the abdomen confirmed an enlarged spleen extending to the level of L5 with a normal liver. An initial sternal bone marrow aspirate showed mild iron deficiency alone, and routine cultures yielded no growth of bacteria.

Lymphoma was diagnosed clinically, with hypersplenism accounting for the peripheral blood picture. A second bone marrow aspirate and trephine were taken and laparotomy for diagnostic splenectomy planned. The day before her operation re-examination of the marrow film unexpectedly

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