

Responsibility for nutrition diagnosis

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Contemporary approaches to nutritionally-related health problems are often conveyed in apparently simple terms in dietary guidelines, messages for nutrition education, or points of a nutrition policy. And to some extent, at present, it may be possible to organize a framework for thinking about nutritional problems in straightforward terms. But the ultimate understanding of food-health connections in a comprehensive fashion will require a great deal more knowledge in disciplines as disparate as agricultural, food, animal, health and molecular science than is currently available. In the meantime, the best assessments of the nutritional status of communities and individuals must be made in order to prevent and alleviate the burden of nutritionally-related disease in both disadvantaged and affluent nations. The report of the Nutrition Task Force of the Better Health Commission (Commonwealth Dept of Health 1987) and many other groups attest to this.

In Australia, the major concerns about food intake patterns are chronic degenerative diseases — macrovascular, neoplastic, osteoporosis, diabetes, age-related, obesity-related and alcohol-related; but wasting states with nutritionally-preventable or reversible components are also seen.

Many different groups and disciplines are engaged in making nutrition assessments and in organizing these assessments into diagnoses of the problems so that solutions can be found. Historically, medicine has always been engaged in this process, to a lesser or greater extent. Currently, there is a recrudescence of interest in it, driven by a reappraisal of the basis of present disease patterns and by a community expectation that attention to lifestyle should yield further improvements in health.

Consequently, the Royal Australasian College of Physicians (RACP) commissioned a report from its Social Issues Committee to examine nutrition assessment and diagnosis, who assumes responsibility for it and how this responsibility should be discharged, given the current state of the art and science (Gracey & others 1989).

Groups and disciplines involved

The medical profession is only one group engaged in assessing nutritional status. Others include policy-makers (government and national organizations), food producers, manufacturers and retailers, educators (parents and guardians, child care services, teachers at all levels), food intake modifiers (promoters of dietary guidelines, weight control groups, health food shops), fitness personnel, and informa-

tion gatherers (journalists, market researchers and social scientists). Their roles and responsibilities are considered in the RACP report. So also are practitioners of alternative medicine and allied health care professionals.

For individuals, the medical profession has a particular role to define the relationship between food and nutrient intakes on the one hand and health and disease on the other, and to assess the relative importance of nutritional as opposed to other contributing factors — genetical, other environmental, lifestyle or iatrogenic. Herein is the medical practitioners' responsibility not only for nutrition assessment, but also for diagnosis, to provide the basis for prevention in others and management in the patient in question. Gaps in knowledge need to serve as catalysts for research.

Recommendations

Certain specific areas for attention are advanced in the RACP report:

That reliable nutrition knowledge be more widely disseminated by:

- family and community leaders — the traditional sources of food-health information
- the formal education system, primary, secondary and tertiary, as part of an overall education process, but with particular reference to social science, biological science, health studies and physical education
- the primary health care system. In Australia and New Zealand, primary health care delivery is effected principally by general medical practitioners, supported by medical specialists, by community pharmacists and by various alternative health care practitioners.

These avenues of dissemination require the participants to be better informed than at present and to have a more rational and scientific basis for advice given.

In so recommending, it is acknowledged that substantial efforts have recently been made by the NHMRC by way of dietary guidelines, and by Australian federal and state governments to formulate and advance food and nutrition policies. Most notable have been the reports of the Better Health Commission and the implementation of Victoria's Food and Nutrition Policy.

A reliably informed community will make for a better prospect of nutrition assessment and diagnosis.

That those responsible for dissemination of nutrition information and treating nutritional disorders develop a common approach with a sound scientific basis.

The first step towards this must be to take the opportunity which the network of general medical practice in Australia provides for nutritional assessment and diagnosis. It can be expected that other groups will be involved in this

process and that skill development will be as important for them.

That Government, the private sector and various benefactors acknowledge the need for increased nutrition research. Highest priority should be given to:

- the determinants of human eating behaviour and opportunities for effective change
- the variation possible in the human diet without adverse effect
- the particular food patterns and components responsible for or contributing to the major chronic and degenerative disorders: atherosclerotic vascular disease, neoplastic disease, osteoporosis, obesity, and to aging itself.
- greater emphasis on food science in respect of nutrient analysis of food eaten by Australians, non-nutrient components of biological significance, eg salicylates, phytoestrogens, residue levels and component interactions which affect nutrient bioavailability and other outcomes
- the application of molecular biology to nutrition science, eg the study of the effect of food components on mammalian messenger RNA turnover.

That the nutritional needs of high-risk groups be given special consideration, especially:

- Aboriginal Australians
- the frail aged
- educationally and socio-economically disadvantaged groups.

The more *general recommendations* were:

That self and community assessment of nutritional status be more readily and reliably available.

That nutritional assessment skills be more formally developed within and without the health care professions, but appropriate to the profession concerned.

In nutrition assessment and diagnosis, account must be taken of: the socio-cultural role of food, food beliefs, nutrition knowledge and skills, food intake, energy expenditure, relationship to performance, relationship to morbidity and relationship to mortality.

That there be more active research on the development of nutrition assessment and diagnostic methodology in each of the above aspects.

That the assessment of nutritional status be the basis of prospective studies of health outcomes, including performance, morbidity and mortality. In this way the contributions of food intake patterns to health will achieve better definition.

That, as a consequence of the definition of nutrition-related health problems, through nutrition assessment and diagnosis, there be the further development of individual and community responses, facilitated by government through policy, private industry through product development and marketing, through the education system at all levels, through the health care system, and through community groups.

References

Commonwealth Department of Health 1987 Report of the Nutrition Taskforce of the Better Health Commission. Towards better nutrition for Australians. Canberra: Australian Government Publishing Service.

Gracey M, Hetzel B, Strauss B, Tasman-Jones C, and Wahlqvist M L. 1989 Responsibility for Nutrition Diagnosis. A report of the Royal Australasian College of Physicians, Social Issues Committee, Working Party on Nutrition. London: Smith-Gordon.



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