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Mediating the spaces of diet and health: A critical analysis of reporting on nutrition and colorectal cancer in the UK

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ABSTRACT

The media are one of the main arenas in which nutrition information is framed and developed. Research has shown a predominantly individualistic framing of diet-related health issues such as obesity, type-2 diabetes and coronary heart disease in international media coverage. These issues are framed as personal, 'lifestyle' issues rather than requiring policy or structural change. In addition, research has shown a tendency in nutrition research and media coverage of it, to emphasize individual ingredients or components more than overall diet. The media have a tendency to report diet related research simplistically, often without contextualization. Taking a case study approach, this paper analyses UK news media coverage and framing of British Medical Journal (BMJ) published research into dietary fibre and bowel cancer risk. I investigate how the health issue fibre and bowel cancer is framed and dissect the process of mediation (from press release to mass media to local media), analysing the shifting 'geographies of responsibility' that result. This paper argues that media coverage of research into diet and bowel cancer can be explained by the technologies, conventions and routines of media representation. Key gatekeepers were found to have an important role in framing the information that was reported. Taking a critical approach, this paper argues that like obesity, type 2 diabetes and coronary heart disease, coverage of nutritional means of preventing bowel cancer is set predominantly in the 'lifestyle' frame, laying responsibility for increasing dietary fibre at the door of the individual rather than looking at broader social, economic, or political drivers of dietary change.

1. Introduction

Colorectal or bowel cancer is the second most common cause of cancer death in the UK and the fourth most common cancer. Over 40,000 men and women are diagnosed with it every year (Bowel Cancer UK, 2016). Since at least the 1990s, a north-south divide in bowel cancer incidence has existed in Britain. The highest incidence rates for men are in areas of Scotland, Northern Ireland and the north of England. However, for women a clear divide is much less evident, with many parts of England experiencing high incidence rates, for example areas in the east and south-west (Cancer Research UK, 2016). There is a small association between deprivation and bowel cancer incidence for men (incidence rates are 13% higher for men living in the most deprived areas) but there is no evidence of such an association for women (Cancer Research UK, 2016). This raises issues of geographically- and gender-related health inequalities.

A large body of evidence suggests a strong link between diet and the risk of developing bowel cancer (Sandhu et al., 2001; Bingham et al., 2003; Parkin, 2011; World Cancer Research Fund, 2011). Since the mass media have long been identified as one of the key public arenas in which social problems are framed and grow (Hilgartner and Bosk, 1988) and it is well recognised that the media is a vital source of contemporary information on nutrition and health (Fernández-Celemín and Jung, 2006), this paper asks three key research questions: How is nutrition discourse about diet and bowel cancer mediated by the UK press?; how does UK press coverage frame nutrition messages such as responsibility for diet?; and can this framing be explained by media routines and conventions? In addition the work of health geographers is drawn on to explore the way nutritional research is reported in the UK press; the developments in health geography are viewed from a food policy perspective.

1.1. Food policy, geography and health inequalities

Food policy scholars have argued for a move away from healthcare to prevention as the primary focus of public health (Lang and

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Rayner, 2012). This builds on a larger debate in public health about the importance of addressing the social determinants of health and health inequalities (McKeown, 1976; Szreter, 2002). Food policy's call is echoed by health geographers who have attempted to move away from a purely medical geography towards one that embraces a wider notion of health (Kearns, 1993). Health geographers contend that the 'manifold geographies of public health' deserve greater attention within a 'post-medical' geography – that is to say a geography that focuses on health deserves more attention than one that focuses on the 'medical' (Parr, 2002; Herrick, 2007). Both these fields, food policy and health geography, argue that health is more than the absence of disease and in the case of food policy, suggest that the vital role nutrition plays in prevention is often overlooked. Indeed, although it is an established branch of science, nutrition still suffers from relatively low engagement with mainstream public policy (Lang et al., 2009). As in public health, there could be seen to be 'manifold geographies of nutrition'; a personalized approach is insufficient since nutrition is also dependent on food production, cultural background, economics as well as environmental and political issues. This chimes with a re-engagement among health geographers with the idea that 'place' and 'context' matter for health as well as individual characteristics and behaviours (Cummins et al., 2007) and can be seen as part of a 'new public health' movement that stemmed from work in the 1970s and was particularly embraced by health geographers in the early 1990s (Kearns, 1993; Brown and Duncan, 2002; Cummins et al., 2007). This 'new' public health recognised the social dimensions of health as well as the biomedical and health geographers sought to identify the influence of bodily practices, space and place on human health (Petersen and Lupton, 1996; Brown and Duncan, 2002). However within this context and since policymakers have adopted new strategies to take into account the importance of place in public health policy (for example in an attempt to tackle what's become known as the 'obesogenic environment') a body of work has emerged in critical health geography offering a more nuanced view. Here scholars warn of uncertainty in the evidence around diet and physical environment (Townshend and Lake, 2009) as well as raising concerns that the problematisation of 'unhealthy' bodies can contribute to fat shaming and prejudice (Mansfield, 2008; Guthman, 2008; Evans et al., 2012; Hayes-Conroy and Hayes-Conroy, 2013). Evans et al. (2012) argue that an increased ecological perspective can lead to generalised assumptions and stereotypes of individuals and identities in urban design and public health policies. They call for a more holistic notion of health within planning practice (Evans et al., 2012). Similarly, Cummins et al. (2007) warn against assuming that space and place 'exerts an effect on an individual's health that is independent of the individual's own characteristics' (Cummins et al., 2007, p. 1833). They take a relational approach, exploring the idea that 'conventional' ideas of place and space which are physical locations with geographical boundaries can be more helpfully viewed relationally by thinking of places as nodes within networks rather than 'discrete and autonomous bounded spatial units' (Cummins et al., 2007, p. 1827).

1.2. Nutrition and geographies of responsibility

Massey (2004) pushed the idea of a relational thinking of space/place, coining the term 'geographies of responsibility' to explore the relationship between identity and responsibility and thinking of 'space/place in terms of flows and (dis)connectivities rather than in terms only of territories' (Massey, 2004, p. 11). This issue of responsibility is at the heart of current debates around public health nutrition in the UK. For example, while there is a large body of scientific evidence suggesting a strong link between diet and the risk of developing bowel cancer (Bingham et al., 2003; Sandhu et al., 2001; Parkin, 2011; World Cancer Research Fund, 2011), who should take responsibility for diet has been the subject of debate. While, as outlined above, the disciplines of food policy and health geography have argued that diet is socially, geographically and culturally constructed (Lang et al., 2009; Smyth, 2007), the current Conservative and previous Conservative-led coalition government have adopted a neo-liberal approach in which the Government takes less responsibility for public health while individuals, notionally helped by industry, take more (Panjwani and Caraher, 2014). This has impacted on UK government policy on cancer prevention and diet's role in it, which is the core focus of this paper.

The UK government advises that a diet high in fibre and low in red and processed meat may reduce bowel cancer risk (NHS Choices, 2014) as part of a wider recognition that 'up to half of all cancers could be prevented by changes in lifestyle behaviours' (Department of Health, 2011). This belies the inherent individualized approach to diet and cancer prevention in current government policy. Responsibility for cancer prevention lies with Public Health England (PHE), which came into being in April 2013 as part of the then coalition government's Health and Social Care Bill. A major focus of PHE is a 'partnership' with industry, NGOs, the voluntary sector and local government to 'help people make healthier choices' (Department of Health, 2011, p36, 4.9) – the implication being that national government bears less responsibility for our health while individuals, in partnership with industry bear most responsibility. This approach, particularly the Public Health Responsibility Deal has been widely criticised by food policy experts for its reliance on corporate responsibility (Lang and Rayner, 2012; Hastings, 2012) that is voluntary and unreasonably expects big business to prioritise public health interests above its own (Panjwani and Caraher, 2014). Some see this as part of a wider trend moving to preserve freedom of choice within a more supportive system of government in an attempt to use libertarian paternalism to resolve conflict between the interventionist state and the liberal market (Pykett et al., 2011). This has manifested itself not only in the Responsibility Deal but in other 'nudge' strategies, in which the public are encouraged to adopt healthier behaviours by government 'without forbidding any options or significantly changing their economic incentives' (Thaler and Sunstein, 2008, p. 6). Successive UK governments have embraced the 'nudge' theory, for example the Labour government's Change4-Life programme (NHS, 2015) which they introduced in 2009 and which continued under both the Conservative/Liberal Democrat Coalition government and the current Conservative government (NHS, 2015). However, the prevailing and continuing focus on individual responsibility is seen by some as an unhelpful approach, which misses an opportunity for a more nuanced account of collective responsibility (Colls and Evans, 2008; Guthman and DuPuis, 2006). Colls and Evans (2008) draw on Massey's (2004) Geographies of Responsibility to unpick the placing of responsibility in domestic food shopping and identify an 'embodied geography of responsible relations' (Colls and Evans, 2008, p. 617) in terms of where responsibility for children's diets is placed, variously shifting between supermarkets, parents, children and the government. Similarly Meah (2014) uses Massey's framings of responsibility and that of 'victim blaming' in a study on domestic food safety practices. Drawing on work by Jackson et al. (2010) which looked at geographies of responsibility in the chicken supply chain, Meah (2014) sees a tendency in the scientific community to prioritise individuals' responsibility for food safety, this within a wider context of Beck's (1992) 'risk distributing' society where all participants seek to pass responsibility of risk on to others. I seek to extend this argument by applying this concept of geographies of responsibility to the way responsibility for diet is placed and framed in newspaper coverage of nutrition research into bowel

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