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# **Multiple obesity.**

Understanding discourses and practices of  
obesity management in the UK.

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September 2019

I hereby declare that this thesis has not been and will not be, submitted in whole or in part to another University for the award of any other degree.

Signature: .....

## Summary

This thesis explores how obesity is enacted by different social actors in different settings of obesity management in the Brighton and Hove area in Southeast England.

It investigates the local trajectories of the hegemonic ‘obesity epidemic’ discourse and how relevant social actors navigate, (re)produce, reinvent, contest or align to it, considering the urgency, pervasiveness and normativity with which obesity is addressed in public health policy and public debate in the UK. Drawing on Mol’s (2002) concepts of *body multiple* and attending to the practicalities and materialities of obesity-management, this thesis argues that obesity is a *composite object*. An extensive body of literature critically analyses the epistemologies and body politics of the “obesity epidemic” discourse. This research draws on those works that question the purported neutrality of the medical discourse on obesity and exposes the reproduction of socio-material inequalities and neoliberal technologies of body and self in the current promotion of a healthy lifestyle. This thesis expands this literature by focusing on how obesity management is *brought about in practices*.

Over fifteen months of fieldwork, I interviewed GPs and practice nurses, weight-loss groups’ participants and leaders, and volunteered in three weight-loss programmes. I also applied discourse analysis to national policy related to obesity. The findings produced through this multi-sited ethnography powerfully reveal the multiplicity of meanings and practices inherent to obesity. They show how multiplicity is intrinsic to the authoritative discourse on obesity management and not only to the ways people perform or experience it.

Expanding Harwood’s idea of biopedagogies (2009), I use the concept of ‘*biopedagogies of healthy eating*’ to describe and explore the authoritative approach to food, weight and health that governs obesity-management interventions. I propose that despite the multiplicity inherent to them, these biopedagogies reproduce a normative idea of ‘healthy lifestyle’, identifying personal responsibility and caloric imbalance as privileged sites of interventions and silencing other possible explanations (e.g. socioeconomic factors or epigenetic factors) and solutions.

The findings also reveal how challenges to the authoritative discourse of obesity management are performed by and within what are generally considered the sources of authority around obesity, such as healthcare professionals and nutritionists. Lastly, they contribute to unpacking

the stigma attached to obesity by locating it into specific activities, practicalities and interactions. Finally, this thesis reflects on the potential implications these findings have for general healthcare practice and public health policy.

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## **List of acronyms**

ASA - Advertising Standards Authority

ASA – Association of Social Anthropologists of the UK and Commonwealth

BMI – Body mass Index

BSMS – Brighton and Sussex Medical School

CCG – Clinical Commissioning Group

GP – General Practitioner

JSNA – Joint Strategic Needs Assessment

LFC – Local Fitness Club

LNPO – Local Non-Profit Organization

NHS – National Health Service

PHE – Public health England

RGEC - Research Governance and Ethics Committee

WHO – World Health Organization

## Acknowledgments

I would like to acknowledge many people who have helped and supported me throughout this project. First, I would like to thank my supervisors, Prof. Maya Unnithan and Prof. Jackie Cassell. Your professional and personal support throughout each stage of my PhD have helped me not only realise this project, but also gain confidence as a researcher.

This research would not have been possible without the participation of the people who have shared their time, stories and experiences. You have invited me to your houses; taken time out your schedules to sit down and talk over a drink; you have welcomed my many questions and me. For this, I am deeply grateful.

I want to thank everyone who gave me the possibility to conduct my research in LNPO and LFC and welcomed me in their groups and aerobics classes. I want say thanks also to Dr Cooper, Jane and Sonia who have helped me orientate in the Brighton and Sussex Medical School, take part in departmental seminars and ACF conference, and get in contact with GPs.

Writing this thesis has been a long process that I have found rewarding as much as daunting at times. I want to thank Dr Pope for her support in this final stage. Your valuable advice and genuine encouragement have helped me overcome my writer's blocks. My friends and "writing comrades", Esra and Marias, have also been precious. Thanks for making our long writing sessions so enjoyable.

I am thankful to all the friends who have been by my side and made this PhD a less solitary journey. I want to thank my Sussex friends. Thanks to Caterina, Valerio and Idil, for being fun and thoughtful friends. Thanks to Faisal and Rebecca for your feedback and engaging conversations. Thanks to my friends in Italy, you are the companions of many adventures and your company is my safe place.

Finally, I would like to thank my family. My parents, for your infinite love and support. Thanks for respecting my curiosity and sense of freedom. My brothers, you are my compass, whichever journey I decide to embark upon. My nephew, you are my inexhaustible spark of joy. My grandparents, who have always been my favourite storytellers and my inspiration. Lastly, I want to thank my partner Yusufu, you always put a smile on my face. Thanks for being my best ally throughout and beyond this endeavour.

## Introduction

This thesis explores multiplicity in obesity management, following the ‘obesity epidemic’ discourse across multiple field sites of obesity management in the Brighton and Hove area in Southeast England. Obesity is commonly understood as a non-communicable disease and preventable cause of other major health conditions and a global epidemic<sup>1</sup>. Once associated with high-income countries, today obesity rates are increasing worldwide with low- and middle-income countries showing some of the highest incidences of obesity (WHO, 2018)<sup>2</sup>. Along with rising rates of obesity, normative messages and interventions of the ‘obesity epidemic’ discourse are spread and reproduced globally along with the urgency with which obesity is addressed in public health. By ‘obesity epidemic’ discourse, I refer to a hegemonic discourse on fatness, health and body size that has produced specific ‘truths’, assumptions and technologies of the body and the self, as discussed by a large body of literature in anthropology and critical fat studies. This discourse builds on pre-existing gendered ideals of slimness as positive and fatness as negative, especially among Western, white middle and upper classes, and a neoliberal understanding of health as the individual project of responsible citizens. This discourse is based on the medicalisation of fatness and the understanding of obesity as a global epidemic to address urgently and widely (see Wright and Harwood, 2009). The discourse on an epidemic of obesity and the promotion of a healthy lifestyle that accompanies it has produced pervasive technologies and meanings of body, self and health. These interventions are based on the promotion of healthy lifestyles through nutritional education and behavioural change that impose rationalistic and situated understandings of health, personal responsibility and choice (see Cohn, 2014) as universal categories. They dismiss the diversity and variety intrinsic to health, body ideals, food, cooking and eating as well as the structural factors in which they are embedded (see Yates-Doerr, 2015; 2016).

Consequently, investigating obesity from an anthropological perspective means critically engaging with hegemonic and pervasive knowledge around health and body size and bringing to

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<sup>1</sup> The main diseases associated with obesity are diabetes type 2, cardiovascular diseases, musculoskeletal disorders and some types of cancer.

<sup>2</sup> For example, today Mexico presents the second highest rates of adult obesity (32.4%) after the United States (38.2%) and South Africa has similar rates to the United Kingdom respectively 26.5% and 26.9% (OECD, 2017).

the fore the contested meanings and unintended effects produced by and around it. Looking at how “specific clinical practices (...) entangle global diagnostic categories with local social realities” (Lester, 2007, p.369) is a productive way of approaching obesity.

This thesis aims to explore how global categories of knowledge are enacted in local practices and discourses produced in and by everyday interactions and sheds light on the complex interrelations between obesity as a diagnostic category, a practice and an embodied experience. In fact, despite the many voices of contention and criticism – from fat activism, critical feminism and critical fat studies scholars to name some of the most influential – on the negative and stigmatising effects of the ‘obesity epidemic’ discourse and the fatphobic practices it engenders, the normativity of obesity messages is strong and ubiquitous in the UK. Obesity has been subject to public debate for about two decades, framed through biomedical categories and understood through situated ideals of the body, health, citizenship, gender, social class and food.

These observations are particularly relevant when considering that despite being a priority for public health for over two decades, interventions to prevent and reduce obesity have proved quite ineffective so far. Rates of obesity are either rising or stabilising worldwide. For example, in the United Kingdom, which remains the country with the highest incidence of adult obesity in the European region, rates of obesity are stabilising but not reversing (OECD, 2017).

I describe the informal conversations I have had throughout my PhD as anecdotal evidence of the seepage and pervasiveness of problematic, limited, but normative understandings of obesity in the context of this research. Throughout the different stages of this PhD, I have found myself talking about my research project in a wide variety of contexts and with many different interlocutors from various backgrounds and nationalities. These include colleagues in fashion retail and other PhD students, housemates, friends and researchers in different disciplines. What has always struck me in all these conversations is the extent and consistency of information that my interlocutors expressed. All agreed that obesity is a major public health problem, as people are getting bigger and bigger, especially in the UK compared to other European countries. Recurrent too was the idea that obesity is a complex problem characterised by overconsumption and a sedentary lifestyle as well as by increased availability of junk food and reduced affordability of healthy food. These widespread perceptions summarise four problematic assumptions of the ‘obesity epidemic’ discourse that are widely accepted and commonly used in the context of my research: a) Obesity is a health condition due to caloric imbalance; b) it is a significant concern and cost for public health; c) it affects mainly people with lower incomes; d) we live in an “obesogenic environment”.

These assumptions are at the core of public health policy in the UK along with the promotion of healthy lifestyle through nutritional education and behavioural change as the primary strategy to address and manage obesity, as I will show in Chapter Four. The analysis of reports and guidelines developed in this thesis shows how in public health, obesity management is presented as a set of suggested interventions identified at a national level and locally implemented through the partnership of relevant services. I refer to this process as ‘localisation of responsibility’ (Strong, 2018). Public health reports identify primary care and local weight-loss groups as main venues to manage obesity and encourage GPs and practice nurses to refer patients to the relevant weight-management service in the community. It is important to note that this approach assumes uniformity and consensus across services and settings in understanding obesity in biomedical and epidemiological terms, that is a health condition and major risk factor determined by excess weight due to caloric imbalance, caused by an obesogenic environment and treatable through weight-loss.

This ethnography aims to understand how these authoritative knowledges and technologies of obesity are performed in specific contexts of obesity management that despite sharing “concern” for obesity, have differing social history and status, and deploy different sets of knowledge and degrees of expertise around weight, health and lifestyle.

Through the fifteen months of this fieldwork, I interviewed GPs and practice nurses, weight-loss groups’ participants and leaders and analysed public health reports and guidelines on obesity management. I also volunteered in three weight-loss programmes, attended two aerobics classes and one conference on primary care. The findings reveal that obesity is a *composite object* (see Mol, 2002; Throsby, 2012) that is inherently multiple, and the coexistence of multiple obesity is ubiquitous across the sites of my fieldwork.

This thesis questions the representation of obesity as a fixed object: a uniform medical entity which is understood and experienced differently by different people. On the contrary, the findings show that obesity is a composite object to which multiplicity is inherent. Indeed, it is clear that the medicalisation of fatness has created a set of taken-for-granted concepts and social stigmatisation that powerfully inform individual experiences of fatness and local responses to tackle it, starting from the very idea that fatness is something that has to be indiscriminately tackled. The urgency, normativity and pervasiveness with which obesity is addressed as a health issue alongside its adherence to pre-existing body ideals, projects a sense of universal consensus.

Nonetheless, the findings show how public health knowledge around obesity is entrenched with multiple understandings of the causes of obesity and related interventions. Equally, different versions of obesity are enacted across and within general practice and weight-loss groups.

Looking at multiplicity allows to bring to the fore contested meanings and technologies of the authoritative knowledge on obesity and healthy lifestyles. For example, this thesis reveals how healthcare professionals and nutritionists challenge and contest authoritative practices and ‘truths’ of the obesity epidemic discourse, including the viability of the term obesity as a neutral medical term and diagnostic category.

This thesis also illustrates how multiplicity and contested meanings are made visible through specific activities, interactions, practicalities, and materialities through which obesity management is enacted, navigated and negotiated. It attends to the *praxis* of obesity management. This methodological and theoretical approach puts in the foreground the ways in which the normative discourse on obesity and healthy lifestyle is challenged, contested and entangled with perceptions of obesity as stigmatising. Attending to the multiplicity inherent to obesity allows disrupting the universality of obesity biomyths (Greenhalgh, 2015), disclosing alternative explanations and potential interventions, and locating stigma into specific activities and practicalities of obesity management and healthy lifestyle.

The centrality of stigma in shaping individuals’ experiences of obesity management informs all the field sites and unfolds throughout the thesis, suggesting that multiple enactments and challenges to authoritative knowledge on obesity can be understood as ways of negotiating stigma in practice. Finally, this thesis engages with public health discourses and suggests that these considerations have potential implications for general practice and public health, exploring in a final chapter, implications for public health and future research.

## **Outline of thesis**

**Chapter 1.** In this chapter, I introduce my research: I describe cultures of fatness and slimness in the UK; I outline research questions and original contributions

**Chapter 2.** In this chapter, I discuss the methodology and ethical implications of my research

**Chapter 3.** This chapter is dedicated to reviewing relevant literature and the theoretical frame of my research

**Chapter 4.** This is the first of five ethnographic chapters. Here I analyse obesity management in public health and primary care and focus on multiple explanations of causes of obesity



**Chapter 5.** This chapter focuses on GPs' and practice nurses' perception of obesity and weight as stigmatising. I analyse practical and organisational factors through which stigma is enacted, and interrogate the centrality of primary care to manage obesity and the medicalization of fatness

**Chapter 6.** This chapter shifts the attention to weight-management groups. Here, I analyse individuals' reasons to join a group and alternative explanations of obesity at work in these biosocial spaces. I discuss the importance of looking at weight-loss as a process

**Chapter 7.** Here I focus on three specific activities observed in weight-management groups to analyse the normative discourse on a healthy lifestyle. I introduce the idea of "biopedagogies of healthy eating" and multiple ontionorms as conceptual tools for my analysis

**Chapter 8.** In this final ethnographic chapter, I explore how measuring weight and BMI is carried out in weight-management groups. Looking at materialities, space and conversations, I discuss contested meanings and practices around weight and health

**Chapter 9.** This is my conclusive chapter where I highlight the main findings and contributions of my research, discussing multiplicity in obesity management. I conclude considering possible implications for general practice and public health policy

## 1. Context: Obesity in the UK

“...the reproduction of obesity knowledge is situated in wider social and cultural contexts which position thin as good and fat as bad” (Evans, 2006, p.263)

In this first chapter, I locate my ethnographic fieldwork and research questions presenting discourses of fatness and slimness in the UK and public health interventions to address obesity. I begin by describing cultures of fatness in the UK, drawing on research participants' descriptions and impressions of social practices, products and narratives related to body, food and obesity that they describe as relevant to their everyday experience of weight management and obesity as a social phenomenon in general. The construction of the biomedical category “obesity” and the consequent production of obese bodies and subjectivities does not happen in a vacuum. In exploring obesity and its management in the UK, it is important to situate it into the broader context of widespread representations, notions, practices and ideals around fatness, body size, food and health. I consider this particularly important in my thesis, as I draw on Bourdieu's (1977) understanding of practices as everyday social-and-bodily actions that inscribe social meanings into bodies and in turn reproduce them. My aim in utilising participants' quotes and comments is to convey and attend to the familiarity, everydayness and embeddedness of such practices and narratives, aware of the limited picture I am depicting through my authorship. I then move to present the research questions that arose in relation to this context and describe the original contributions of this research.

### 1.1 Cultures of slimness and fatness in the UK

In the summer of 2015 big posters showing the image of a blonde, slim and toned female model in a yellow bikini, asking the readers “are you beach body ready?” appeared in the London underground network and other cities. The poster advertised a range of weight-loss products produced by Protein World Ltd., a company producing slimming products. The campaign immediately provoked harsh critiques from the public, the Advertising Standard Authority received hundreds of complaints, and a petition was launched online to have it removed. The chief complaints addressed the campaign as offensive towards different body sizes and socially irresponsible as advertising toxic body image in the context of slimming products. Posters were removed before the Advertising Standards Authority (ASA) pronounced in favour of Protein World Ltd:

We recognised that “beach body” was a relatively well understood term that for some people had connotations of a toned, athletic physique similar to the image of the model in the ad (...). We considered the claim “ARE YOU BEACH BODY READY?” prompted readers

to think about whether they were in the shape they wanted to be for the summer and we did not consider that the accompanying image implied that a different body shape to that shown was not good enough or was inferior. We concluded that the headline and image were unlikely to cause serious or widespread offence (asa.org.uk, 2015)



Figure 1. "Are you beach body ready?" Protein World advert.

This campaign and the ASA's pronouncement well describe the types of normative messages and images that inform the sociocultural context of this research where slimness is valued and commonly accepted as a desirable outcome of individual work on the body. Moreover, it speaks to how these normative messages despite being pervasive are nevertheless mainly targeted at women. The fact that the campaign provoked immediate reactions that brought to posters being removed also testifies that these normative ideals, both physical and moral, are socially and politically contested.

I found this anecdote interesting because the term "beach-ready body" was used and criticised by a few research participants when discussing media messages around weight and obesity management. This suggests that concepts such as "*beach ready*" body and the slimming and toning techniques it entails have become largely embodied but still contested and negotiated in the every-day, sociocultural context where obesity management is produced.

Larry, who took part in an LNPO weight-management group and whom I interviewed, describes very vividly the kind of images diffused in magazines and the type of surveillance they produce:

(...) there's still gonna be those magazines take a picture, circle the cellulite and run away laughing like vultures! That kind of magazine give nothing but the ability to judge other people, and I have noticed that some of my female friends have lacked confidence about how they look, but it's never been something that really damaged them socially, it's more

that kind of "oh well I should probably start slimming now before summer" and that kind of "get your beach body ready" is the big catcher term, isn't it? "well you should start losing weight otherwise you can't wear all those lovely things that make you look beautiful"!

Larry suggests that these messages are targeted towards women more than men and have become socially accepted and embodied ways of (auto)evaluating and (auto)surveilling individuals' bodies.

Katherine, who is a nutrition therapist and works as a group leader in the Local Non-Profit Organisation where I volunteered (LNPO), seems to share Larry's negative perception of body images and monitoring promoted in the media. During our interview, when talking about media information around healthy eating and obesity, she describes very well how bodies and diets are portrayed and divulged. I use the term divulcation to refer to the process through which scientific and nutritional information are popularised, vulgarised and widely spread in popular culture. This process encompasses the coverage of news on research related to obesity, diet and healthy lifestyle as well as the use of pseudoscientific assumptions for commercial and marketing purposes.

What I absolutely and personally hate is magazines showing celebrities for example "beach body someone" "oh look at them now" and compare just like you know...what on earth! And celebrities promoting ridiculous diets "you can look like me in 30 days" it's absolute madness! And yeah, the ways media are portraying people who are overweight is pretty horrible, is quite nasty and can make people feel really awful

Katherine's quote suggests that negative portrayals of bigger bodies accompany the widespread of slim body ideals. It is interesting how both her and Larry portray a reality where body ideals are promoted within consumerist practices, such as buying slimming products or fitting in trendy clothes.

Normative body sizes are not promoted only through images and messages around ideal bodies, but they are also embedded in less explicit bodily practices, such as buying and wearing clothes. A survey conducted in two English cities, Liverpool and Coventry, on the body size of "male" and "female" mannequins used by high street fashion retailers, concluded that *"the body size of mannequins used to advertise female fashion (...) would be considered medically unhealthy in humans"* (Robinson and Aveyard, 2017, p. 6). Data also showed that male mannequins in stores *"targeting a younger age range"* were *"significantly smaller than in stores targeting all other age ranges"* (Ibid. p.4).

The impact of the fashion industry's sizing on people daily lives and subjectivity is well explained by Michelle, whom I met in an LNPO weight-management group that she was attending to lose weight. During our interview, talking about the depiction of weight in the media, she refers to her personal experience:

(...) you are not acceptable unless you're size eight or the way regular models look and actually high street shops what size they go up to it got to a point where I was really struggling to find clothes that I ... I mean I didn't want to spend money on nice clothes cos I was a size I didn't want to stay, so you end up looking like shit feeling like shit you're not proud of the clothes that you are wearing because you want to be in normal sizes, so I think it has a lot to do with that advertising clothes on the media. "Oh great that only goes up to size 14, I can't wear it. Bye-bye!"

This personal anecdote is particularly powerful in conveying the material and everyday consequences of hegemonic discourses.

These findings and Michelle's words also resonate with my experience as a sales assistant in two clothes boutiques where I worked before and during the first part of the fieldwork. In both shops, company guidelines instructed staff to display always the smaller size, that is size 6: a size that none of us working in the shop could fit into, although my colleagues and I could be categorised as healthy weight or BMI. Moreover, the largest size produced by the two companies I worked with was also very small, UK 12/14, and I remember this being the object of jokes, comments and often disappointment by customers who could not fit into it.

The different social aspects and products described so far as vehicles of normative body ideals and technologies of body and self are perceived as gendered.

I met Emily at LNPO, where she works as a nutritionist and weight-management leader. Her discussion of gender and weight in the media very well links three essential factors that have been described so far.

LB: do you think that men and women are targeted at a different degree?

E: yeah! Absolutely! I think women are targeted so much more by media. I mean it's starting to even out a bit more in terms there's now men's plus size models whereas there's been women plus size models for years and the focus on mannequins and models being too slim again this has started to even out in the men's world as well but even in terms of women magazines there's shelves and shelves whereas men's magazines, there's Men's Health or GQ but is not the same range. And I think this kind of health programmes on TV are generally watched by women ehm I think a lot of things around health, like leaflets, are often targeted to women, you have pictures of women on them and women celebrities endorse it.

Emily describes a context characterised by the "consumption" of body images and normalisation

of body size through a variety of media: magazines, TV programmes, social media and health-related leaflets. Secondly, her words reveal the overlapping and interweaving of aesthetic ideals and health messages in the production of sociocultural meanings around fatness and body size. Finally, it is evident that the perception of these wider contexts and messages is gendered.

### **Food, nutritional information and consumerism**

“(...) science reporting informs lay understandings of health and risk, policy priorities, blame and responsibility, and normative understandings of acceptable and desirable bodies” (Saguy and Almeling, 2008, p.26)

The importance of “consumption” and consumer identity in widespread messages and practices around healthy lifestyle and body size, becomes particularly evident when looking at food and eating. In the context of this research, healthy lifestyle and nutritional information despite being portrayed as domains of professional expertise, have been divulged across a variety of avenues, such as food branding, advertising and marketing (see Chrysochou, 2010). Lizzie, a nutritional therapist and fitness instructor, describes this context very well, stressing how the nutritional information is promoted in a variety of unspecialised contexts, like advertisements

it is really scary that people do not know how to cook anymore! Or know the nutritional value of food because people would see the advert for Denol or Activia or eggs ehm, and they might know eggs are a good source of protein might know that milk has got calcium or that something lower your cholesterol or whatever know little bits from advert

The divulgence of nutritional facts in advertisement, newspaper, magazines and blogs around food, diet and healthy eating is particularly interesting as it shows how public health messages and nutritional knowledge are used as legitimising devices to validate the quality and health benefits of specific products or information. Moreover, the popularisation of the nutritional language of healthy eating questions the assumption implicit in many interventions based on a healthy lifestyle that unhealthy habits are the result of nutritional ignorance (see Warin, 2018). Lizzie also describes the coexistence of what might seem opposing messages around food and eating concerning socialisation in a consumerist society:

I hate this little annual psycho we get ourselves on! At Christmas time everyone wants to lose weight, it is a new year resolution: “feel positive, let’s do it!”, so this full heavy diet programmes. But then Easter comes around, and it’s about family, being together, springtime, being happy, socialise, and food is tied into celebration and BBQ and family occasions. And then summer, and want to lose weight for bikini but then once summer is here is BBQs and drinking a lot of alcohol which is a major reason as well why people are putting on weight (...) and I don’t mean just alcohol, I mean coffee, smoothies and stuff like that then it’s kids going to McDonalds and parties and pier, having donuts, candy floss.

And then the kids go back to school, and you think “oh I let myself go” and “oh! Kids are back to school, you have your own time” and want to lose for Christmas and then the all cycle comes again, and all the magazines in the supermarket have their food to celebrate Mother’s Day and Valentine’s and BBQs in the summer and then weight loss again so we get in this cycle

Lizzie’s description is excellent in describing the kind of messages around eating and the channels that disseminate them, as well as their pervasiveness and embeddedness in everyday practices of food and eating. It also gives a vivid picture of how what might seem as contrasting messages, such as indulging and dieting, food availability and one’s ability to self-control, are informed and shaped around three common practices and assumptions: firstly, the idea of dieting as a normative and common practice. Secondly, the assumption that slimness is a desirable attribute and indicator of health. Thirdly, the assumption that it is an individual responsibility to obtain and maintain a slim body size.

### **Body image and obesity stigma**

One of the effects that Lizzy also describes is the importance given to body images. Walter, a GP and academic, is very open in his negative evaluation of the contemporary focus on body image and interprets it as a new trait in society

we are such a body-conscious society now, because you only have got to look at pictures of well-muscled men or various thin models and things like that, there seems to be an absolute, unreal focus upon body image (...)I think that area of society has worsened, I think, perhaps people’s engagement with trying to do something about their own bodies, because they know what other people think about them because it’s portrayed in the newspapers, and some of the newspapers aren’t quite so uhm careful about what they write

Interestingly, Walter describes a growing focus on body image as a recent and negative phenomenon and seems to identify a link with the spread of messages I described in the previous sections. It is also worth noticing that Walter’s account suggests that this anxiety with body image is perceived as targeting both women and men. This perception is made explicit by Janette, who is a practice nurse and mother of two teenage girls:

LB: do you think that men and women are targeted to a different degree in the media when it comes to body shape?

J: I would say yes, but my partner would say to you no! He says, you know we talk about it, cause we've got teenager daughters, you know, what they are exposed to (...) I think we weren't exposed to, but we are on a massive scale now, you know, everything is exposed, on their phones, everything, they can't get away from images, and I just think, and I'd say it's really, really difficult for teenage girls and he thinks is really difficult for teenage boys

LB: Why?

I: he thinks that all these images now you know lots of taking protein, milkshake, they've

got to look like this, they've got to look like that, and actually would say to you, it's hard for teenage boys too! Much more than when he was a teenager. He thinks it's hard for both of them but I think girls, they have to be absolutely perfect and boys don't worry about that, boys don't worry about it as much, although some boys really do, but I think they are a minority, although I think boys are beginning to feel the pressure

Dissatisfaction with body image, especially in younger generations, has been identified in critical fat studies (see Greenhalgh, 2015) as a common, however unintended, effect of widespread fatphobic messages and bodily technologies promoted by the “obesity epidemic” discourse. By putting health and not beauty at the core of body size concerns, that is making slimness a matter of good health more than of aesthetic, the “war on fat” produced by the “obesity epidemic” discourse shifts and transforms gender axes of body size (see Monaghan, 2008). Slimness is valued both for men and women but in different ways. For example, as shown by many scholars, such as Bordo (1993; 1999) and more recently Greenhalgh (2015), male body ideals are based more on a muscular body whilst female bodies are idealised as thin and toned. Interestingly, body image dissatisfaction has been addressed as a matter of public health concern in the UK. In a document published on May 2013 by Government Equalities Office, body image, defined as resulting by the interrelation between an individual’s body perception and body satisfaction, is described as strongly linked to body ideals promoted by society<sup>3</sup>. Nevertheless, in the document, there is no mention that this dissatisfaction could be in part an unintended effect of fatphobic messages and practices related to healthy lifestyle and anti-obesity interventions. Obesity and overweight are identified as main issues for body image and are described as primary causes of body dissatisfaction along with media images of ideal body shapes, influence of family and peers and individual psychological factors. Interestingly, the suggested solutions related to overweight and obesity recommend losing weight and maintaining a healthy weight to prevent and protect from negative body image rather than addressing social stigma towards fatness and larger body size.

A thorough analysis of this report and the public health approach to body image is beyond the scope of this research. However, it is worth noting that the way “maintaining a healthy weight” is addressed as a desirable solution to body image dissatisfaction to the detriment of a focus on stigmatisation of fatness, sheds light on two aspects that characterise the

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<sup>3</sup> The research found higher levels of dissatisfaction among young, white, middle class women but it also shows that dissatisfaction for body image is present in all groups identified.



authoritative discourse on obesity in the UK and the context of my research. Firstly, it conveys the hegemonic idea that obesity and overweight are always and unquestionably unhealthy and undesirable. Secondly, it shows how the public health debate on obesity is struggling to address stigma and its root causes. Further, I want to highlight that while healthy lifestyle messages and interventions that promote weight management and slim body size as healthy are ubiquitous in the context of my research, campaigns and even conversations around body image and possible effects of fat- and obesophobic discourses are rarer. Furthermore, they are not included or addressed in the current public health discourse on obesity. In the following section, I will describe some campaigns related to obesity which were taking place during my fieldwork and public health guidelines that address obesity and obesity management in the UK and whose analysis has contributed to framing my research questions.

## **1.2 Obesity in public health**

In the last three decades, obesity has been a priority for public health policies in the UK. National policies to tackle obesity describe, in line with WHO guidelines and the obesity epidemic discourse, the causes of obesity as ‘embedded in an extremely complex biological system, set within an equally complex societal framework’ and foresee a future where ‘by 2050, Britain could be a mainly obese society’ (Foresight, 2007,p.5). UK health policies also accept the definition of obesity as a biomedical condition that occurs when the Body Mass Index of an adult person is over 30, and this condition is understood as the result of an energy imbalance between calories consumed and calories expended daily (NAO, 2001). It follows that the leading prevention and intervention strategies aim to reduce and invert this imbalance, primarily through the promotion of a healthy lifestyle, summarised in the advice to ‘eat better and exercise more’. Given the alarm about the current rate of UK adult obesity, prevention is addressed as a critical strategy to reverse the trend and the NHS is recognised to have a central role in promoting healthy lifestyles both nationwide and locally (NICE guideline CG43, December 2006).

### **Obesity-related campaigns**

In 2008 the cross-government campaign “*Healthy Weight, Healthy Lives*” was launched in response to the Foresight “*Reducing Obesity: Future Choices*” report published in 2007. As mentioned earlier, the report portrays obesity with an alarmist tone, but it also recognises the relevance of addressing the “complex societal framework” (p.5) that causes obesity. It encourages obesity-related policy to “shift the emphasis (...) on the individual to a ‘broad set of social and environmental factors’ (DH, 2008a, p. 3)” (Evans et al., 2011, p.330). The weight-management programmes run by the LNPO where I volunteered were created as a part of a local

response to this campaign. Despite the shift recommended in the Foresight report, a behavioural change approach is at the basis of the weight-management programmes I researched and of healthy lifestyle interventions in general. This shows that a neoliberal understanding of health and individual responsibility (see Crawford, 2006; Evans et al., 2011) is still central to obesity management in the UK. During the fifteen months of fieldwork, the introduction of a *sugar tax* on soft drinks was up for debate. The tax aims at reducing the sugar content of soft drinks and introduces a levy for manufacturers that do not reformulate<sup>4</sup>. The sugar tax became effective on April 2018. To my knowledge, this is the only campaign that was going on during my fieldwork that targeted the food industry rather than individual behaviours.

LNPO, one of the field sites of this research, was an advocate of this tax. Interestingly, the campaign was rarely mentioned in the three weight-management programmes organised by LNPO where I volunteered in and usually only group leaders would bring it up when discussing the nutritional value of sugar. Similarly, research participants would rarely mention it during our interviews or informal conversations even when talking about the “obesogenic environment” and quality of food as main causes of obesity (see chapter 4.4 and 6.3). When asked directly what they thought about the sugar tax, they responded in various ways: some would support and appreciate that it targeted the food industry and what they considered root causes of obesity, others would find it inefficient and easy to get around, whilst others wouldn’t know much about it. Hence, I suggest that despite the *sugar tax* being a topical debate, the focus it posits on food industry is not well embedded in the authoritative knowledge and practices of obesity management commonly deployed in the context of this research.

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<sup>4</sup> The tax sets the following levies for companies that do not re-formulate the sugar content of soft drinks: 24p per litre of drink if it contains 8 grams of sugar per 100 millilitres and 18p per litre of drink if it contains between 5 – 8 grams of sugar per 100 millilitres (<https://www.gov.uk/government/news/soft-drinks-industry-levy-comes-into-effect>).



Figure 2. One You Campaign poster. Bus stop in Kemptown.

Finally, I want to present briefly another campaign that was launched during my fieldwork by Public Health England to address preventable disease, such as obesity, in adults. I found out about it thanks to a poster that appeared at the bus stop around the corner from where I lived: white letters reading “Do you snack on crisps, chocolate or autopilot?” on an aquamarine blue background. The “you” stands out: it is written in yellow and underlined (see Figure 2).

The campaign, launched in 2016, is titled *One You* and targets unhealthy habits such as inactivity, snacking, smoking, and drinking to prevent so-called lifestyle

diseases by encouraging adults to “take control of their health” and “reappraise their health behaviours” (Gov.uk, March 2016). The campaign’s focus on personal responsibility and behavioural change is evident and resonates with authoritative practices, explanations and biomyths (Greenhalgh, 2015) of the obesity epidemic that I will discuss and analyse in my thesis. Interestingly, on the campaign’s website, it is stated that whoever needs specialised nutrition advice due to be under- or overweight should contact a healthcare professional, in line with obesity management guidelines.

### Obesity management in public health reports and guidelines

In October 2014, Public Health England<sup>5</sup> published the strategic document “*From evidence into action: opportunities to protect and improve the nation’s health*” where it prioritises the areas of public health that must and can be effectively improved. Among the seven priorities identified, the first point is tackling obesity. The document lists five integrated strategies to address obesity

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<sup>5</sup> Public Health England is an executive agency of the Department of Health and Social Care and was formed by the reorganisation and integration of different bodies outlined in the Health and Social Care Act 2012. It became operative in April 2013 with the aim of “protect, and improve the nation’s health and wellbeing, and reduce health inequalities” (<https://www.gov.uk/government/organisations/public-health-england>).

with a focus on lifestyle by identifying the promotion of research on sugar and diet, and campaigns to promote healthy eating and physical activity. It also states that it is necessary to “support local authorities to deliver whole system approaches to tackle obesity” (PHE, October 2014). This document highlights three aspects that shape obesity in the field of this research: firstly, the construction of obesity as a priority for public health. Secondly, the focus on the promotion of healthy lifestyle, that is healthy eating and physical activity, as key strategy of prevention and intervention. Thirdly, the responsibility of local authorities in providing public health services as a result of the Health and Social Care Act 2012.

These three main aspects shape the authoritative knowledge of obesity in the field of my research, as well as the quality and quantity of services research participants, have access to, both within and outside the NHS. In particular, the construction of obesity and health promotion in public health shapes how health professionals I met in my fieldwork, understand and enact obesity and weight management, as I will discuss in chapter 4.

The public health guidelines on obesity management that I have analysed to identify field sites are contained in the *Healthy Lives, Healthy People: a call to action on obesity in England* paper published by the Department of Health in October 2011 and updated yearly. In these guidelines, obesity management is addressed as a matter of individual responsibility with the NHS ensuring that ‘people (...) make the best possible choices for themselves’ (Department of Health, 2011). They identify primary care as the privileged setting for the promotion of healthy messages and information around healthy choices at a local level and to identify, address and prevent specific ‘at risk’ individuals or behaviours. Since GPs and practice nurses are key health providers in primary care, they are considered to play a fundamental role in preventing, diagnosing and treating obesity (Ibid.). These premises have shaped a specific, formally recognised clinical pathway for obesity management: individuals who deem to have a problem with excess weight are prompted to meet their GP and discuss future steps with them. During the visit, general practitioners will diagnose whether the patient is overweight or obese by calculating the BMI and in some cases measuring the waist circumference. Once the disease has been diagnosed, GPs and/or practice nurses and patients will discuss an appropriate diet and physical activity routine to lose weight. In the presence of very high or “morbid obesity,” medications, such as Orlistat, can be prescribed and the patient will be referred to a specialist, for example to evaluate the possibility of bariatric surgery. When analysing these guidelines, two assumptions have caught my attention and importantly shaped the research questions. Firstly, the taken-for-granted idea that excess weight is commonly considered a good reason to seek out medical

advice. Weight-management is portrayed as a specialised practice within biomedical competence, and fatness medicalised into the clinical categories of overweight and obesity. Secondly, the assumption that conversations around weight and healthy lifestyle are easy to integrate into clinical encounters and general practice routine.

The centrality given to diet and physical activity in managing obesity has brought policymakers to recognise the involvement of weight-management groups, supplied by the NHS or commercial, as strategic in collaborating with National Health Service at a local level. Through this public health approach, pre-existing, commercial weight-loss groups such as Slimming World and Weight Watchers are integrated into recommended pathways to treat obesity within the national health care system. Likewise, various local organisations are prompted to deliver weight-management programmes and become part of collaborations to address obesity and healthy lifestyle in the community and at a local level. I find the integration of weight-loss programmes in public health strategies to address obesity particularly interesting and relatively new, at least in relation to my previous knowledge of obesity-related policy.

I refer to the weight-management groups that are integrated into local responses to obesity management guidelines as biosocial spaces. By using the term biosocial, I intend to highlight the fact that these weight-management groups have been formed or re-designed specifically to manage obesity. As such, these groups take shape out of a growing emphasis on “preventive administrative management of populations at risk” (Rabinow, 1996, in Inda, 2005, p. 186) and form “new individual identities and practices arising out of” (Ibid. p. 188) current ‘truths’ on obesity, risk and healthy lifestyle. These spaces lie at the margins of obesity science, primary care practices, personal experiences and daily contingencies; in these spaces, clinical diagnostic and treatment procedures (e.g. BMI calculation, referral) and informal practices of auto-diagnosing and auto-treatment are put into dialogue and negotiated.

So far, I have outlined the discourses and practices of fatness, slimness and obesity management in public health and popular culture in the UK. I have identified four aspects that are particularly relevant to outline the sociocultural context where obesity is produced in the UK. Firstly, the hegemonic idea that the body is an individual project and secondly, this individual bodily project is produced within a consumerist logic. Thirdly, slimness is the body ideal to aspire to whilst fatness is devalued. In addition, the aesthetic ideal of slimness is legitimised through the concept of health. These four aspects are recurring, although in different forms and degrees, in many societies where the “obesity epidemic” has been produced as hegemonic and a priority for public

health. Moreover, as discussed earlier (see section 1.1), research participants' accounts of popular and media debates around body size and food, reveal that although pervasive and authoritative, these messages are also contested and challenged.

I will next present the research questions that have emerged from these considerations.

### **1.3 Research questions**

My central research question arises from two observations around the production of obesity in the UK. The first is related to the integration of services at a local level as the leading public health strategy to manage obesity. Primary care and weight-loss groups are encouraged to collaborate, for example through the referral system, to address obesity in the community (see discussion in Chapter Four). Consequently, the management of obesity is not bound to clinical settings; instead, it is conceived as occurring across sites with primary care taking the role of gatekeeper and source of expertise. I suggest that these sites share an understanding of obesity as unhealthy but partly differ in the type of knowledge and practices of weight management they promote. This thesis explores the interrelations of these sites in managing obesity.

My second observation links to the first and concerns the types of authoritative messages and interventions around obesity. Public health policies reproduce the hegemonic idea that obesity is a health condition caused by individual unhealthy behaviours and that these behaviours are favoured by a modern lifestyle. Interventions are then targeted to promote and improve healthy behaviours, primarily around eating and exercising, by giving individuals the tools to make healthier choices and implement healthier behaviours. This focus on personal responsibility, choice and behaviours is common to public health, primary care and weight-loss groups.

Authors have explored the ways this hegemonic truth is produced through the "obesity epidemic" discourse (see Wright and Harwood, 2009), the moral judgment it creates (see Gard and Wright, 2005) and the disciplinary technologies of body and self it promotes (see Greenhalgh, 2015). Building on these perspectives, this thesis explores how these truths of the "obesity epidemic" discourse are performed in the specific context of obesity management in the UK. This research aims to explore how global health messages around obesity are locally reproduced in obesity management with a focus on the NHS primary care, weight-loss groups and public health policy. My interest lies not only on the discourses produced in these sites but also on how these discourses are performed by the people that inhabit them in relation to specific organisational, administrative and practical factors.

My overarching question is:

*what practices and discourses related to obesity management are produced in the UK, and what are their interrelations?*

With this, two main questions emerge: A) *How are existing categories of knowledge enacted in local practices and discourses produced in and by everyday interactions?* B) *What are the interrelations between obesity as a concept, obesity as a practice and obesity as an embodied experience?*

These questions lead to the identification of three field sites and to subsets of questions specific to each field site. This requires first an interrogation of

#### 1) Clinical discourses and practices of obesity management in the UK

- a) What are professionals' (GPs and nurses) language, attitude and understanding of obesity-related policies and the obesity epidemic discourse?
- b) What kind of power relations are negotiated and (re)shaped in their narratives?
- c) How do they enact obesity in clinical encounters?

Secondly, an exploration of:

#### 2) Discourses and practices of obesity management in public health communities

- a) What is weight-loss groups leaders' and participants' language, attitude and understanding of obesity-related policies and the obesity epidemic discourse?
- b) What kind of power relations are negotiated and (re)shaped in their narratives?
- c) How do they enact obesity and "healthy" lifestyle?

Finally, it entails an analysis of

#### 3) The discourses produced and/or reiterated in obesity-related health policy

- a) How is the 'obesity epidemic' discourse reproduced and enacted in national public health policy?
- b) What kind of power relations do they reproduce by identifying specific 'at-risk groups', health care providers and healthy lifestyle promoters?
- c) What kind of bodily practices do they reproduce, and which are their relations with the

broader discourses promoted?

#### 1.4 Contribution to the field

By ethnographically investigating day-to-day enactments of obesity in clinical and weight-management settings linked to obesity and healthy lifestyle, this research provides further insights on the practices of obesity management in the UK.

This thesis represents a timely contribution to the anthropological literature on obesity in the way it originally combines Mol's concept of '*body multiple*' with a critical medical anthropology approach to obesity. This thesis explores how specific material, organizational and practical contingencies shape the reproduction and negotiation of the obesity epidemic discourse in obesity-management settings. Likewise, it investigates how contested meanings and different experiences of obesity, health and body size are negotiated and what makes these negotiations possible. The importance of looking at how multiple experiences of obesity are performed in relation to the specific settings and materialities in which they are situated emerged during my previous fieldwork in an endocrinology department of a University Hospital in Italy where I explored stigma and processes of self-blaming in doctor-patient encounters around obesity and diet. Here, I observed how the medical understanding of obesity conveyed by nutritionists was often different with the obesity experienced by patients. I also observed that the negotiation of these different ideas and experiences of obesity was embedded in specific organisational, practical and material factors. The current research and its focus on how multiple obesity are performed and situated has taken shape out of this interest and awareness.

The literature I interrogated offered me a strong backbone to critically analyse the production of normative meanings and technologies around obesity. Nonetheless, I was left looking for works that would investigate how these meanings and technologies are done in practice and how these practices are situated within local health systems and public health communities with their distinct narratives, practicalities and materialities. To this end, I found Mol's (2002) concepts of "body multiple" and *enactment* two productive, methodological and theoretical tools to analyse multiple sites of obesity management with a focus on the practicalities and materialities specific to these sites. In her ethnography of atherosclerosis in a Dutch hospital, Mol explored how this disease was *enacted*, that is, how atherosclerosis was "made visible, audible, tangible and knowable" (ibid. p.33) by patients and different specialists in the daily encounters and routine of the hospital. By focusing on the specific objects, procedures, events that characterise the different contexts within which atherosclerosis is enacted, Mol observes the coexistence of



multiple definitions and descriptions of the same disease within the same hospital and use the concept of 'body multiple' to define this multiplicity. Referring to the different atheroscleroses observed, she explains that "despite the differences between them they are connected. Atherosclerosis enacted is more than one— but less than many. The body multiple is not fragmented" (Ibid.p.55). I will further analyse Mol's contribution to my research in the literature review (see section 3.3).

Moreover, social science research on interventions targeted to obesity tend to privilege one field site, for example either the clinic or weight-loss groups; multi-sited ethnographies of obesity management that explore the interrelations between different sites of obesity management are also rarer. This thesis explores these interrelations as public health interventions related to obesity in the UK encompass various stakeholders and venues, the most important being the clinic and the community. Therefore, in this thesis, I explore those biosocial realities like weight-loss groups that despite not being proper clinical contexts, yet they are mobilised by the obesity epidemic discourse; these realities have not been studied enough in social literature. Such insight is relevant both theoretically and practically. It will help a better understanding of the micro-level in which health policies take place, questioning the imaginary of biomedicine as a homogeneous entity (Good 1994) by foregrounding enacted obesity(ies) (Mol, 2003) with attention to 'the interpersonal agency implicated in the smaller, everyday conversations people have' and how 'intersectional agents in the realm of cultural politics act (...) with regard to institutional notions of health, (...), fitness' (LeBesco, 2004) individual responsibility, lifestyle and bodily techniques. Moreover, by investigating the role that local, clinical settings play in enacting practices and meanings around obesity, this thesis contributes to the critical anthropology of the clinic. It furthers understanding of professionals' everyday experiences by examining the ways they deal with practical, logistic and bureaucratic contingencies and how these factors shape specific ways of conveying biomedical knowledge, diagnosing and treating excessive weight. A critical, anthropological approach cannot overlook the wider sociocultural and political realities within which clinical settings and health care professionals are embedded. Consequently, I consider fundamental to reflect on professionals (GPs and nurses) also as individuals that live in a society in which discourses on fat as pathological and undesirable are widespread in public debate and media productions.

Finally, this thesis is an up-to-date contribution to critical anthropology of public health and to the anthropological debate on public health and biomedicine as authoritative knowledges in

shaping the social understanding of body, personhood and individual responsibility in contemporary, capitalistic societies. Furthermore, this thesis turns to reflect and experiment ways in which anthropology can speak to policymakers and general practice.

### **1.5 Summary**

Assessing, evaluating and scrutinising body shapes and sizes is a diffused, embodied practice in the broader context of my research. Body ideals and related bodily techniques, such as weight-loss, are presented in a variety of diffused and nuanced ways in the media, and are part of a broader, normative discourse around healthy lifestyles. Health and the measurability of health through body size are central concepts in the production of this healthy lifestyle discourse. The divulgation of scientific knowledge on weight, nutrition, and exercise interweaves with aesthetic and moral ideals around body size and shape. Moreover, meanings and technologies of slimness and healthy lifestyle entangle with consumerism and neoliberalism which inform specific ideas of health, responsibility and citizenship: the slim, trim body is both a responsible citizen and an informed consumer. These ideals, meanings and technologies are at work in public health policy in the UK. The promotion of local healthy lifestyle interventions through the integration of primary care and weight-loss services represents the main strategy to address obesity.

I then intend to explore obesity management in the UK, starting from the question: *what practices and discourses related to obesity management are produced in the UK, and what are their interrelations?*

## 2. Methodology

In this chapter, I present the methodology and locate the fieldwork. I will discuss why I conducted a multi-sited ethnography, my positionality and the ethical implications of researching obesity. I will present the actors and sites in the field. I will describe the different groups of research participants – general practitioners, practice nurses, weight-loss group participants and leaders – and how I got access to them. I will also present the various spaces and places where our interactions took place. Due to issues of confidentiality and anonymity, I have changed the names of all research participants and the two weight-management organisations whose classes I attended. Ethical considerations have also informed the use of images and photos from the fieldwork. To respect confidentiality and the anonymity of research participants, I have not taken any photo of them. I have photographed the rooms and materials used in the weight-loss groups where I volunteered, but I have deleted the names of the organisations where they showed, e.g. on food diaries and leaflets.

I consider the anthropological concepts of “subject” and “context” (see Clifford and Marcus, 1986) the most suitable to investigate the complexity of the phenomenon I am investigating and to establish the centrality of individuals’ agency in managing obesity. It follows that an ethnographic approach that draws upon these concepts is better positioned to investigate obesity management as a field of interrelations (Marcus, 1995) and as a practice, enacted (Mol, 2002; Throsby, 2009; Zivkovic et al., 2018) in everyday interactions. Ethnographic enquiry has the potential to generate “situated knowledges” (Haraway, 1988 in Forsey, 2010:570) and this is vital when exploring a phenomenon like obesity, which is extensively explained and understood through the authority and purportedly uniformity of biomedicine and epidemiology as privileged areas of knowledge. These two disciplines produce a mechanistic, physiological and rationalistic understanding of obesity. Biomedicine, based on a Cartesian understanding of disease (see Scheper-Hughes and Lock 1987), defines obesity as a risk factor and ill health, and explains its physiological aetiology. Building on this definition, and assisted by statistics, behavioural and environmental sciences, epidemiology utilises a “broad-scope approach” and “methodical sampling methods to extrapolate conclusions” (Campbell, 2010, p. 78) on the incidence of obesity at a population level.

These approaches are limited in exploring the body politics (Scheper-Hughes and Lock, 1987) of excess weight (Yates-Doerr, 2017) and the embodied (Csordas, 1990) quality of obesity as a lived

experience (see Bombak, 2014). It is accepted in health research that qualitative research like ethnography can reach aspects of complex (...) interactions which quantitative methods cannot" (Pope and Mays, 1995, p.45). An ethnographic approach to study obesity contributes to highlight and give voice to the grounded and nuanced experiences of obesity that get lost in the epidemiological description of this phenomenon but that are nonetheless fundamental to the ways in which knowledges and practices of obesity are locally translated, produced and made meaningful (see Yates-Doerr, 2012; 2014a). An ethnographic enquiry is better suited to understand the social, economic and political factors that shape and inform people's relations with weight, food, body and concur to produce 'weighty subjects' (Greenhalgh, 2012; 2015).

## **2.1 Methods**

This research is a multi-sited ethnography of obesity management, and the privileged sites of investigation are general practice, weight-loss groups and public health reports. Over the fifteen months of fieldwork, I have interviewed general practitioners, practice nurses and weight-loss group participants and leaders. I have volunteered in three ten-week-long weight-loss programmes run by a community-based organisation whose name I have anonymised in Local Non-Profit Organisation (LNPO). I have also joined two aerobics classes organised by a local, small business, which I have anonymised in Local Fitness Club (LFC), owned by Lizzie, who is a fitness instructor and nutritional therapist. I have also attended a primary care conference where I presented my early findings on general practice and obesity management. Before and throughout the fieldwork, I have analysed public health reports, guidelines and policies on obesity management in the UK.

### **Participant observation**

Participant observation is the method I used to collect data in LNPO weight-loss groups and LFC aerobics classes. In LNPO, I have carried out participation observation by volunteering in three weight-loss groups. In section 2.2 I will present more in detail the steps I took to get access to these sites, the people I met and my participation. As an overt researcher, at the beginning of the first session of each programme I briefly introduced myself and my research to the group participants, specifying that I was there in the double role of volunteer and researcher and asked for verbal consent to audio record the group sessions. I audio-recorded every section of the three LNPO programmes and although I did not transcribe the recordings of the sessions, I have listened to them, taking and coding notes to analyse the data. During each session I took field notes, although these were quite limited due to having to focus on the class as a volunteer. I wrote up fieldnotes on my laptop using Evernote, which allowed me to attach photos and other

material (e.g. Eatwell Plate poster, and food diary template) from the session to my fieldnotes. I usually wrote up fieldnotes soon after the session, often finding shelter in the city library to type them up on my laptop. All fieldnotes were coded. In LFC, I attended two aerobics classes. Lizzie, the instructor, introduced myself at the beginning of the first class and after briefly explaining my research I asked and gained verbal consent from the class participants. I did not audio record these two classes or took any photo, but I did write down fieldnotes on my notebook immediately after each class, and consequently wrote them up on my laptop using Evernote and coded them along with fieldnotes from my participant observation in LNPO weight-loss groups.

Participation observation has been particularly productive in collecting thick data on embodied experiences of obesity management and yielding understandings on the enactments of obesity. Taking part in weight-loss programmes has revealed the importance of focusing on materialities as much as meanings in researching obesity management. Food, clothing, scales, space, bodies, as well as kitchen appliances and kitchenware, have revealed to be fundamental to understand the lived experiences of obesity and weight management. I describe my participant observation as 'thick participation' (Samudra, 2008) to highlight the 'quality of being there' (Watson 1999) in my fieldwork. Samudra (2008) coined the term 'thick participation' in her research on the White Crane Silat, a Chinese-Indonesian martial art, to describe the bodily and embodied quality of ethnographic research on kinesthetic cultures, such as dance, boxing or martial arts. It describes fieldworks where cultural knowledge is 'recorded first in the anthropologist's body and only later externalized as visual or textual data for purposes of analysis' (Samudra, 2008, p. 667). I find this term useful to highlight the centrality that the body and participation in bodily technologies had in my fieldwork "to acquire shared cultural knowledge" (Ibid. p. 665) on weight management and healthy eating. By volunteering in weight-loss groups and taking part into fitness classes, I have become familiar with skills and 'techniques of the body' (Mauss, 1973 in Samudra, 1998, p.666) that constitutes specific ways of knowing body size, food, and health. As a volunteer in LNPO programmes, for over a year I took part into weekly activities on healthy food and eating, learning nutritional information, measuring food, discussing eating habits with the other participants, and doing physical activity with them. I describe these activities and weekly encounters in detail in Chapter Seven and Chapter Eight. The following quote well explains my approach to participant observation:

Ethnographic practice entails our multisensorial embodied engagements with others (perhaps through participation in activities, or exploring their understandings in part verbally) and with their social, material, discursive and sensory environments. It also requires us to reflect on these engagements, to conceptualise their meanings theoretically

and to seek ways to communicate the relatedness of experiential and intellectual meanings to others. (Pink, 2009, p. 24)

Since it would be limitative to summarise the details and challenges of doing thick participation in one short section, I have decided to discuss them throughout this chapter. In section 2.3, I will give a detailed description of the actors and multiple sites that populate my fieldwork, and the procedures implicated in carrying out participant observation within these sites. In section 2.3.1, I use my discussion of positionality as a moment to reflect on the implications and challenges of doing thick participation.

### **Interviews**

Interviews are another key method used for this research. The interviews I conducted were semi-structured in that I had prepared a set of question topics (Skinner, 2012) for each group of participants. Semi-structured interviews are characterised by open-ended questions outlined by the researcher (Skinner, 2012; Stuckey, 2013) and allow the interviewee to “determine the way, in which the interview is directed” (Stuckey, 2013, p.57). For my research, I produced three sets of questions (see Appendix A): one for GPs and practice nurses, one for weight-loss group leaders and one for weight-loss group participants. There was little variation in the topics covered for each sets of questions and the slight differences in the questions aimed to address how interviewees were differently positioned in relation to weight-management (for further details on questions and topics covered see Appendix A). I will also give further details and description of each group of interviewees in the dedicated sub-sections of section 2.3 ‘*Sites and actors*’.

I revised the questions throughout the fieldwork to accommodate the themes that started to reveal through the early analysis of the data as well as the feedback and suggestions from interviewees. As I worked across multiple sites and with different groups of research participants, semi-structured interviews represented the most suitable kind of qualitative interview as they “can provide reliable, comparable qualitative data” (Ibid.). In choosing semi-structured interviews, I also considered how they would best accommodate the spatial dislocation and time boundedness that characterise anthropology ‘at home’ (Hockey, 2002:210; Forsey, 2010) and multi-sited fieldwork (Marcus, 1995; Henry, 1999; Hannerz, 2003).

I conducted 19 interviews with interviewees from the four different groups of research participants: 4 GPs and 2 practice nurses; 6 weight-loss groups leaders, including LNPO, LFC and Slimming World; 7 weight-loss group participants in LNPO and LFC. The weight-loss group leader in Slimming World was also attending classes as a participant in the same organisation. I

interviewed each participant once. Eight interviewees were men and eleven were women. Five of the men I interviewed were attending LNPO programmes and the other three were GPs. All weight-loss group leaders I interviewed were women as well as the practice nurses.

Following the inclusion and exclusion criteria indicated in my ethics application, all interviewees were over the age of 18. The research participants I interviewed were between their early thirties and late sixties. Although I didn't ask the exact age to each of them as this research does not aim to produce quantitative statistics, interviewees would often start our interviews by telling their age or would describe stages and events of their life that would give an idea of their age range. Among healthcare professionals, I included only GPs and practice nurses working in NHS general practice in Brighton and Hove and excluded practitioners and nurses working only in private, weight-management or bariatric surgery clinics. Similarly, I interviewed only participants and leaders attending or working in weight-loss groups operating in Brighton and Hove. I provided each interviewee with a Participant Information Sheet and a Consent Form to read and sign before starting the interview, in accordance with my ethics approval. I also had many informal conversations with some of them outside of the interviews, in particular with LNPO weight-loss group participants and leaders, who I would meet weekly as a volunteer in LNPO programmes. Even though I haven't used these informal conversations as a primary source of data, I want to acknowledge how they have shaped our interactions during the interviews as well as some of the references, examples and topics discussed.

Interviews differed in length, depending on the participants' availability and time constraints, and lasted between one hour and two hours and a half and took place in various venues around the city, which I will describe more in details in section 2.3. The difference in length of the interviews in my field reflects Rapport's proposition that different kinds of interviews (i.e. structured, semi-structured and unstructured) should be considered to constitute a continuum (Rapport, 2012, p.57). It is not uncommon when interviewing in the fieldwork that "what begins by intending one kind of exchange develops into another" (Ibid.). All interviews were audio-recorded and subsequently transcribed verbatim to analyse the data. I started transcribing in the last months of the fieldwork and identifying emerging themes, and completed the transcription process a few months after the last interview. I used thematic analysis to analyse the transcriptions from the three groups of research participants and further develop and compare emerging themes through coding. I consider this type of analysis is the most "useful (...) in capturing the complexities of meaning within a textual data set" (Guest, McQueen, Namey,

2014, p.10). Data saturation was reached once “no new themes” were “identified upon reviewing new data” (Castleberry and Nolen, 2018, p.809). Through the “iterative, inductive process” (Starks & Brown Trinidad, 2007; also see Guest, McQueen, Namey, 2014) that characterises this type of interpretative analysis, I reassembled codes in themes and sub-themes. I used purposive sampling and snowballing as privileged strategies to recruit interviewees. Brighton and Sussex Medical School and LNPO have been privileged sites for recruiting interviewees among health professionals, weight-management groups’ leaders and participants. Aerobic classes, Clinical Commissioning Group (CCG), emails, text messages and face-to-face interactions have been other channels through which I have contacted interviewees.

Interviews have been my primary method to collect data around general practice by interviewing general practitioners and practice nurses working in Brighton and Hove. Considerations around the feasibility of gaining approval to do research with NHS patients dissuaded me from doing participant observation in GP surgeries. Therefore, health professionals’ accounts on obesity and healthy lifestyle have been my way of “stepping into the clinic”. Given the focus on my research on the materiality and enactment of obesity management and the lack of participant observation in GP surgeries, I relied on interviews as a method to explore the ways in which obesity is *done in practice* in these settings. Qualitative interviews have the advantage of getting access not only to people’s opinions and views, but also to the more mundane and material aspects of their life. In other words, interviews shine a light “on the workings of everyday exchange” (Rapport, 2012, p.68). The story people tell in an interview “doesn’t only reveal their perspective, but also tells about events they have lived through” (Mol, 2002, p.15). I consider the research interview an ethnographic encounter (see Forsey, 2010; Skinner, 2012) and “culturally appropriate form of participation in Britain” (Hockey, 2002, p.210).

In the interviews I held with GPs and practice nurses, they described in details and often using anecdotes, the kind of conversations they would have with patients; the way they would introduce weight as a health issue to discuss with a patient, the timing and the words they would use, and those they wouldn’t. They told me about their discomfort in having these conversations. They also told me about the limited time of the visits and their quick typing of referrals notes on the computer. Through semi-structured interviews with GPs and practice nurse I have been introduced to their ways of conducting clinical interviews around weight and lifestyle. Through these interviews, I have gotten familiar not only with GP’s and practice nurses’ ideas, opinions and emotions around obesity, but also with organisational factors of obesity



management in clinical settings, such as how referral works, the different types of GP contracts and practice nurses' specialisations. The relevance that these factors have in shaping experiences of and access to obesity management is an original finding and discussion in my analysis.

Interviews with different social actors have represented a way of stepping into those settings where I did not have physical access, like the clinic, or stepping out confined venues and the discourses associated to them, as in the case of weight-loss groups and fitness classes.

Semi-structured interviews in the field have been productive in unravelling the stigmatisation attached to the label obesity as perceived by different research participants. They have revealed the entanglements as well as the interrelations of multiple meanings and practices within and across sites of obesity management.

### **Discourse Analysis**

I have applied discourse analysis to public health documents, reports and guidelines to analyse how obesity as a biomedical and social category is produced in public health. I have approached these documents as historically situated products, trying to understand their dialectic relation with other social, political and economic processes. At a national level, I identified the Health and Social Care Act 2012 that initiated a series of reform in the structure of the NHS as the most relevant process to acknowledge in my analysis of public health documents related to obesity management. Other global and local processes that I have identified as part of the wider context within which to analyse these documents are the slow incorporation of health promotion into primary care, the emergence of lifestyle as a category of medical competence and the consolidation of obesity as a priority for public health. I discussed all these processes in Chapter Four. My analysis recognises that:

Human subjects use texts to make sense of their world and to construct social actions and relations in the labour of everyday life while at the same time, texts position and construct individuals, making available various meanings, ideas and versions of the world (Lucke 1996, p.12 in Mogashoa, 2014, p.104).

Existing research has shown the suitability of this analytical approach in health research (see Starks & Brown Trinidad, 2007; Hodges, Kuper & Reeves, 2008; Morgan, 2010) and in exploring the discourse on obesity in public and clinical contexts (see Throsby, 2007; Boero, 2007; Saguy & Almeling, 2008; Schneider et al. 2017; O'Hara & Taylor, 2018). Morgan (2010) and O'Hara & Taylor (2018) among others, highlight the importance of this critical approach to study some of the most prominent social issues. I follow Guest, McQueen & Namey (2014) in describing discourse analysis as an analytic technique within thematic analysis (p.3). Discourse analysis is a form of interpretive approach that "involves ways of thinking about discourse (...) and ways of

treating discourse as data” (Wood & Kroger, 2000, p. 2). I have chosen this approach for it allows a critical analysis of public health discourse on obesity. I consider the relevance and suitability of this analysis for my methodology and engagement with public health documents in my research twofold.

Firstly, following a Foucauldian understanding of discourse, I have chosen this analytical approach for it reveals the “production of power/knowledge” (Morgan, 2010, p. 3) and how this is implicated in the construction of what is ‘true’ about obesity. Moreover, I have used it to understand the prominent role of public health guidelines and interventions in reproducing authoritative discourses on obesity, obesity-management, and healthy lifestyle. I am interested in understanding the ‘truths’ on obesity-management that are produced in and through these texts and how they construct ‘obesity’ as an object of analysis and intervention. Secondly, by approaching “language (...) as social practice, as a way of doing things” (Wood & Kroger, 2000, p. 2) and putting “emphasis on discourse as practice” (Ibid. p. 22), discourse analysis allows to explore the ways in which the construction of obesity in public health texts is constitutive of the ways in which obesity is done in practice. This is of great importance for my multi-sited research. In fact, as I have stated before, my object of inquiry is obesity management as a field of interrelations (Marcus, 1996) and my focus is on the materiality as well as the meanings associated to obesity management. The discussion on measurements, weight and BMI in Chapter Eight offers an example of the type of analysis and insight that this approach has yielded in understanding the practical and material implications of public health discourse on obesity.

I followed the steps recommended by Wood and Kroger in “Doing Discourse Analysis: Methods for Studying Action in Talk and Text” (2000), and acknowledged broader discussions on critical discourse analysis that, as described above, considers discourse as ideological and constitute of social realities and texts as multifunctional and intertextual (Barker & Galasinski, 2001). The first stage consisted in collecting public health guidelines and reports on obesity and obesity management. I collected reports and guidelines that had been published between 2001 and 2015 and that pertained only to obesity and/or obesity management both at a national (England) and local level (Brighton and Hove). The rationale for the chronological criteria takes into consideration that the first comprehensive report on obesity in England as a response to WHO call (1998) was published in 2001 and that my fieldwork started in 2015. In the final stage of the analysis, I included reviews of previous reports published up to 2018 as a follow-up to check the persistence of the themes already identified.

I read and re-read the texts to familiarise with the content and identify some emerging themes. Once familiarised with the texts, I identified themes and codes. I was already familiar with some of these documents<sup>6</sup> as I had used them to design my fieldwork and identify relevant sites and actors. In this preliminary stage, I had already identified some possible themes to explore during the fieldwork. These initial themes were ‘responsibility’, ‘bodily techniques’, and ‘expertise’. These themes and codes were reviewed, and further analysis of textual data brought to the identification and coding of new themes, such as ‘aetiology’, and ‘heathy eating’ and related sub-themes emerged. I considered the saturation of data reached once no new themes emerged. The data are presented and discussed extensively in Chapter Four and they also inform the discussion in Chapter Eight.

### **2.1.1 Multi-sited ethnography: following a discourse**

Conducting a multi-sited ethnography has been fundamental to understand how authoritative knowledge of the obesity epidemic is reproduced, reiterated, resisted or contested, often in subtle and nuanced ways. Over the course of my fieldwork, I was teaching the module “Ethnographic Research Methods” at the University of Sussex. Since my fieldwork lasted 15 months, I happened to teach this same module twice, at the beginning and towards the end of my fieldwork. Both times, I found myself explaining how and why I would define my research a multi-sited ethnography. Only the second time, when I was about thirteen months into my fieldwork, I could explain, with the kind of knowledge that comes from experience and not just from theory, the practical and theoretical implications that define my research as multi-sited fieldwork rather than fieldwork in multiple sites (Marcus, 1995). My ethnography constructs as its primary subject of investigation the connections, interrelations, negotiations (ibid.) as well as discontinuities, gaps and tensions that characterise the multiple enactments of the ‘obesity epidemic’ discourse in different sites of obesity management in the UK. This research does not focus on one field site but instead on a field of interrelations as it follows the discourse on obesity management and healthy lifestyle across sites. This ethnography follows this discourse from the ways obesity management is formulated in national public health policies in the UK to its implementation in local weight-management settings, to the individual experiences of those

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<sup>6</sup> These were “Tackling Obesity in England”, published in February 2001 by the National Audit Office and described as the first comprehensive report on obesity in England, and the Foresight “*Reducing Obesity: Future Choices*” report published in 2007. At a local level, I had used the “*Annual Report of the Director of Public Health 2013-2014*” to design the fieldwork.

involved in managing weight. My research brings the different sites of obesity management – namely public health, primary care, and weight-loss groups – “into the same frame of study” (Ibid. p.100). I formulate obesity management as “significantly translocal” (Hannerz, 2003, p. 206). By this, I mean that in my research I approach obesity, and consequently obesity management, as a global category entangled with local clinical practices and social realities (see Lester, 2007). The field is thus not some random collection of local units (ibid.) as I expand on in my field research. Furthermore, since this multi-sited fieldwork investigates a normative discourse of and around the body, lifestyles, and food it does not follow only meanings, symbols and modes of thought (see Marcus, 1995) but also power/knowledge relations, practices and materialities shaped within, around, because of and despite that specific discourse.

The choice of conducting a multi-sited ethnography arises from methodological and ethnographic considerations. Firstly, in my research I draw on Mol’s (2002) concepts of multiplicity and enactment (see section 3.3) to explore obesity as a *composite object* (Mol, 2002) that is explained, experienced, treated and made meaningful in multiple ways by various social actors in different settings. Mol investigates how multiple atherosclerosis are brought about in practices in the different departments of a Dutch Hospital. She shows how in the interactions between patients and specialists, a slightly different atherosclerosis is discussed, measured, and observed. These differences, she notes, depend on the experiences and sets of knowledge deployed to understand atherosclerosis as much as on the materialities and practicalities that characterise each setting or interaction. Applying the same approach to my fieldwork, I explore the ways in which obesity and weight are brought about into practices in local settings of obesity management. Furthermore, these multiple and local experiences of obesity are informed and shaped by the authoritative knowledge around the ‘obesity epidemic’ that represents obesity as global diagnostic category. It is important to note that here the term local is not conceptualised as opposite to global, instead the global is defined as “*an integral part of parallel, related local situations rather than something monolithic or external to them*” (Marcus, 1995, p.102). Thus, conducting a multi-sited ethnography allows to attend to multiple practices and their interrelations across sites. Secondly, the analysis of national guidelines related to obesity have been my first point of interest in imaging and planning this fieldwork. I approached them as integral part of local responses and approaches to obesity and not as a whole, compact subject that can and has to be known outside or as separated from those local relations. In the UK, public health policy calls for local healthcare and weight-loss services to work together in the community to address obesity and implement obesity-management strategies. In particular,

they identify primary care and weight-loss groups as privileged sites of obesity management in the community and call for these settings to work in synergy. I consider a multi-sited ethnography the most productive way of exploring on the ground how the authoritative knowledge on obesity is locally negotiated, (re)produced and/or contested in these spaces. In particular, it allows to focus on the flows of meanings and practices across these sites – public health policy, general practice and weight-loss groups – and attend to their specific materialities and practicalities.

## **2.2 Locating the field**

This fieldwork is made of long bus rides through and across the city, from the centre to the university campus to neighbourhoods in the outskirts. Of getting lost looking for my participants' houses or the café chosen as venue for the interview. Of wandering around conference halls, participants' workplaces and the university campus to find some of my interviewees' offices. It is also made of long hours working in a boutique, learning and (re)producing discourses around body size and image, class and culture; of discussing obesity, food consumption, health and body ideals with colleagues, students, friends. It is also made of moments of frustration, for having to work along with doing research, for not having enough time or money to always deal with the uncertainties and challenges of ethnographic fieldwork. This fieldwork is about long interviews and casual conversations, afternoons spent volunteering in weight-management groups, sharing jokes, recipes and more intimate moments. Giving up sugar in my coffee and trying circuits and aerobics for the first time, getting familiar with medical jargon and acronyms, hiding my surprise every time pizza was used as the most obvious example of unhealthy food. It is about people, their interest, support, eagerness, willingness to tell, to help, to share their time and stories.

This fieldwork is located in Brighton and Hove, a city in the Southeast of England. The fieldwork I describe here started in September 2015, after two years of working, studying and living in the same city. The places where I have worked, studied and lived shaped my fieldwork, especially in terms of access to places, people and issues, participation and first-hand experience of the different social, cultural and economic realities present in the city.

The city of Brighton and Hove is part of the South East England region, the second richest of England, behind London, and it is indeed renowned for what is commonly considered a relaxed, “healthy”, and wealthy lifestyle. The city is celebrated for its sea and beaches, the markets and independent cafés that characterize the city centre, the cycle lanes that cross the city, with some of the highest rates, both nationally and regionally, of residents walking or cycling to work (Brighton & Hove City Snapshot – Summary of Statistics 2014). Food plays an important role in

the construction of Brighton and Hove as a 'healthy' and 'green' city: veganism and vegan restaurants are considered quintessential to the city's identity along with an established culture of pubs and independent cafes. I have met many of my research participants in their favourite cafes around the city for our interviews. Interestingly, along with this fame of a healthy, green city, Brighton and Hove "is just within the 20 percent most deprived authorities in England" (City Snapshot Report of Statistics, 2014, p.12), presenting a polarity in health between wealthy and less wealthy areas which is often mentioned by my informants when discussing obesity in the city. In fact, data consulted before starting the fieldwork, show that Brighton and Hove has a high proportion of people living in the second to most deprived group against a low proportion of people in the most affluent group (annual report of the Director of Public Health Brighton and Hove 2014/2015)<sup>7</sup>. Moreover, deprivation in the city is "most marked in the areas of health and disability, living environment, housing and employment" (Ibid).

This data becomes particularly important when looking at obesity, and the focus given in public health to the obesogenic environment as dominant explanation for high rates and to promotion of healthy lifestyle, that is healthy eating and physical activity. Given the high rate of deprivation in Brighton and Hove and the commonly accepted link between deprivation and obesity, what are the obesity rates in the city?

Obesity is the biggest public health challenge that we face. In Brighton & Hove, the signs are mixed. There has been year on year improvements in healthy weight figures for children and young people and policies on school meals, vending machine access and education around food and cooking (...) In adults, the picture is somewhat different and obesity rates are still increasing although the rate of increase is slowing. (Annual Report of the Director of Public Health 2013-2014- NHS Brighton & Hove City Council 2024)

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<sup>7</sup> The same report, documents that "56% of the city's residents live in areas included in the 40% most deprived in the country, and only 4% live in areas included in the 20% most affluent" (p.6). According to data reported in *Sussex Uncovered. Evaluating the needs and strengths of our communities* (Sussex Community Foundation, November 2013), Sussex registers the lowest mean annual wage in the Southeast region and significant areas are in the 5% most deprived in the UK, with deprivation centred particularly in coastal towns like Brighton and Hove. Every wards in the city have health deprivation worse than the England average with East Brighton, Queen's Park, Moulsecoomb, Bevendean and Whitehawk the most deprived in the urban area and Regency the most deprived ward in the whole Sussex for living environment, meaning that housing conditions and outdoors conditions such as air pollution and road safety are much lower than the national standards.

Data from 2014 onward, show that Brighton and Hove obesity rates are stably lower than national average with 20% of adults obese against respectively 24% and 3% morbidly obese which is similar to the national average (Brighton and Hove JSNA, 2013) and 48.3% of Brighton adult population is overweight or obese against 61.3% national rate (fingertips.phe.org.uk). Multiple reports affirm that while obesity is associated to deprivation, overweight isn't and individuals living in most deprived areas are 1.7 times more likely to be obese than those living in most affluent areas (City Snapshot Report of Statistics, 2014). Nonetheless, despite the lower rates than national average, obesity is described as the "biggest public health challenge" (Annual Report of the Director of Public Health 2013-2014- NHS Brighton & Hove City Council 2024) to face and then one of the public health priorities to address at the local level.

Following national guidelines, Brighton and Hove has implemented a variety of community-based programmes and interventions targeted at increasing physical activity and weight management. Most of these initiatives were prompted in response to the national programme "Healthy Weight, Healthy lives: A Cross-Government strategy for England", started in 2008 and aimed at developing local partnerships between the council, non-profit organisations and local businesses. Following this project, the initiatives created in Brighton and Hove focused on two main strategies: increasing physical activity and managing weight. The healthy weight programmes promoted by the Local Non-Profit Organisation (LNPO) where I volunteered are part of this strategy and the organisation had been contracted by the council to develop and provide the city's community healthy weight service<sup>8</sup>.

### **2.3 Sites and actors**

This research took place in many parts of the city, often depending on my informants' needs and availability. The sites are so various and different that it is not easy to spatially map out this multi-sited fieldwork into specific areas, as spaces are intrinsically linked to people. I will describe those places that I have identified as the primary sites of my research: general practice and weight-loss groups. For each site, I will present the actors that inhabit them and that are the research participants in this field. I will then move to describe coffee shops and some research participants' houses where I have met them for interviews.

#### **General practice**

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<sup>8</sup> From 2018, the council contracted a new organisation to deliver the service.

There are forty-six GP practices<sup>9</sup> in Brighton and Hove spread throughout the city. Practical considerations on being granted ethical approval to do research in general practice surgeries brought to the decision of not doing participants observations in any of them. We agreed with my supervisors that the ethical approval process would be too long and the outcome too uncertain, hindering the fieldwork. Instead, I interviewed GPs and practice nurses working locally in general practice and through their accounts I have gathered information on obesity management in primary care.

In the NHS, *general practice* is at the heart of primary care and general practitioners are the gatekeepers in the access to NHS services. For example, general practitioners and practice nurses can refer patients defined obese by their BMI to a variety of weight management services, such as nutritionist, weight-loss groups, and other specialists such as surgeons for bariatric surgery. As previously mentioned, health professionals working in primary care are identified by public health policy as key figures in preventing, diagnosing and treating obesity and promoting healthy weight and healthy lifestyle. Given the urgency with which obesity is addressed in public health debate and the focus on primary care to manage it, I was curious to know how much space is given to weight management and nutrition in their university and professional training. None of the doctors and nurses I interviewed had specific training on weight management. Sean, a GP, tells me:

Asking a doctor about nutrition, is (giggle), is a gamble! I think, there's no specific training. I did some specific study module on obesity when I was in medical school (...) but if I didn't want to, I could have avoided it, pretty well. Ehm the main reason why I learned about nutrition is my wife.

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<sup>9</sup> General practice is community based and provides continuing, comprehensive and person-based health care. To access general practice, and then other more specialised health care services, people must register with a general practice in their area, which boundaries are usually based on the local post code. For example, the general practice a person is signed with, is an information commonly asked in registration forms for a variety of services, such as gyms and exercise classes, or weight-loss programmes. Along with GPs, practice nurses deal with a wide range of activities around patient care, such as blood samples and can be expert in specific areas, for example diabetes or nutrition.



## GPs

During my fieldwork, I interviewed four general practitioners<sup>10</sup>, with different background, career history, age and gender. My main point of access has been the Brighton and Sussex Medical School (BSMS) where my supervisor introduced me to a GP and lecturer in that institution who has been my gatekeeper in recruiting other GPs. During the first year of my research, I also attended weekly seminars organised by the primary care division in the medical school. I hoped this could be a fruitful way to become familiar with prospective interviewees and enhance my chances of recruiting interviewees. Despite the many contacts and email sent, only one person replied to arrange an interview. In March 2016, I presented some early findings of my research at the National Primary Care ACF Conference that took place in Brighton. This gave me the possibility of familiarising with medical debates, approaches and language to study health issues as well as talking about my research and paying attention to the comments it received. I was especially interested in getting a sense of what organisational factors and public health language were commonly discussed, how patients were produced as research subjects and how qualitative methods were integrated in medical research. It became also an unexpected moment to gain more data on training GPs' opinions and experiences around weight and obesity. Here, I met Sean, a GP who works locally and who I interviewed few weeks after the conference.

My other channel to contact GPs was the Clinical Commissioning Group (CCG). I attended two open meetings the local CCG ran in central Brighton where I approached one of the members of the Governing Body who forwarded my email to their mailing list asking for research participants. Gina, a young GP who had recently started to work in Brighton after her training, contacted me to be interviewed after seeing the email. Interviews with general practitioners have been about an hour and a half long and have taken place in different venues: I met Matthew and Walter in their offices on campus, Gina in a coffee shops before her shift started, and Sean in a pub on his way back home from work.

## Practice Nurses

Within the general practice setting, nurses are also responsible for recognising at risk weight and

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<sup>10</sup> General practitioners are “expert medical generalist”, often the first point of contact within primary care, and deal with the “physical, psychological and social aspects of patients’ wellbeing” (<http://www.rcgp.org.uk/training-exams/becoming-a-gp/what-is-general-practice.aspx>).

have a central role in providing practical information on weight-management as part of their working routine. Practice nurses represent a particularity of the UK primary care system, being involved in a variety of activities within the surgeries, such as blood tests, and management of common conditions like diabetes and asthma, which elsewhere are carried out by different specialists. Many of the conditions they manage, like diabetes, blood pressure and asthma, are relevant for obesity as they can often concur. Therefore, their views on obesity are shaped through a direct and practical relation with patients.

During the fieldwork, I interviewed two practice nurses, Janette and Frances. Both had worked for several years in hospitals and/or outside the UK and one of them is specialised in diabetes. Getting in contact with practice nurses has been an unpredicted challenge of this fieldwork. I was aware that none of my contacts in BSMS were in nursing and for this reason I identified the CCG as my main channel. As previously mentioned, it took me a few months to get in contact with the local CCG and once I did manage to send an email around asking for participants, only one person replied. I managed to contact Janette, practice nurse and CCG member, halfway through the fieldwork thanks to a contact I found through my dance classes. I met Janette in a coffee shop in the city centre during her lunch break. We talked for almost two hours and at the end of the interview, she gave me the contact details of one of her colleagues, Frances, who is specialised in diabetes. I met Frances few weeks later after her shift and we had our long interview first in a patisserie close by and then in a restaurant while waiting for her to meet her family for dinner.

### **Weight-loss groups**

In designing my research, I had identified three main kind of organisations operating in the city: the LNPO, commercial weight-loss groups like Swimming World and Weight Watchers<sup>11</sup> and private businesses or franchising running exercise classes.

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<sup>11</sup> WeightWatchers is one of the most renowned diet-food companies specialised in weight loss programmes, it offers specific food products as well as weight-management meetings and online eating programmes; in Brighton and Hove there are three groups in different areas of the city, each one meeting on a weekly basis. SlimmingWorld is an English company and as Weightwatchers, it offers online dieting programmes and local group meetings and from 2001 GPs can refer attendance to these groups for a twelve weeks session. It currently has five groups in the Brighton and Hove district area, meeting on a weekly basis.

Both LNPO and commercial organisation require a BMI that defines the person as either overweight (BMI<25) or obese (BMI <30) to take part in their weight-loss programmes. In both cases, prospective members can either be referred by their GPs or self-refer.

In the research design stage, I had anticipated that my BMI, which is in the “healthy range”, would be a main issue to consider when seeking access to these biosocial spaces along with ethical consideration on doing covert or overt research. In fact, joining as a covert researcher goes against my methodological and ethical position and then I intended to participate in the programmes as a researcher and not as a participant.

With these ethical and methodological premises, I decided to contact the three organisations (LNPO, Weight Watchers and Slimming World) via email giving information about my research and the kind of involvement in their programme and attaching the Participant Information Sheet and Informed Consent to the email. At the same time, I tried to contact Slimming World and Weight Watchers either emailing or messaging local group leaders. I found their contact details through the organisations’ websites, the NHS websites, and from the banners displayed outside meeting points around the city. I did not get any reply from Weightwatchers. Holly, a local leader for Slimming World, replied to my message and agreed to meet for an interview. At the end of our interview, Holly suggested she could speak with the other members of her group about my research and if they were happy, invite me over a few times. She also gave me the contact of the organisation’s research manager and other local leaders who could be interested to take part in the research. In order to conduct research in local programmes, I needed to speak to the national research manager who unfortunately informed me that there were already many internal research projects going on and couldn’t allow me to take part in their programmes. Meanwhile, I tried to contact Holly again about the possibility she mentioned of turning up to one of her group meeting but didn’t hear back from her. None of the other leaders replied to my messages or email and I couldn’t see any other route to do participant observation in commercial weight-loss groups which would allow me to comply with my research ethics.

#### **Local Non-profit organization (LNPO)**

LNPO is one of the main organisations contracted by the council since the early 2000s<sup>12</sup> to provide the community healthy weight service in the city. Among a wide range of activities linked

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<sup>12</sup> At the moment I am writing the thesis, LNPO is not running these programmes as from April 2018 a new provider has taken over the contract.

to food, the organisation provides free weight-management programmes targeted to different groups of people. To join the programme, people need a BMI <30, or close, and can be referred from their GP or self-refer. During the fifteen months of my fieldwork, I volunteered in three LNPO weight-management programmes. I contacted the organisation by email and after a couple of meetings we agreed that volunteering would be the best way for me to conduct my research in their groups. The organisation also advertised my research in their newsletter, thanks to which I got contacted by two research participants: Paula, a former participant in LNPO groups, and Lizzie, a fitness instructor and nutritional therapist.

The three programmes where I volunteered lasted ten weeks each and were organised in the same way: weekly session of ninety minutes, divided in forty-five minutes of nutritional education and forty-five minutes of physical activity. The forty-five minutes of nutritional education combined nutritional information from the group leader with more interactive activities around the weekly topic. The topics and related activities followed the same weekly order in the three programmes. Each programme targeted different groups of people: the first group in which I volunteered was open to men and women, over 18-year-old, and took place in central Brighton on Wednesday evenings. The time and the place, central but close to the train station and car park and well served by bus, made it accessible to a variety of people coming from different areas of the city. I volunteered for the all ten weeks of the programmes. The five LNPO weight-loss group participants I interviewed were all attending this group. I will refer to this first group as LNPO group 1. The second group in which I volunteered started few weeks after the first one finished and was targeted to mum with babies (up to two-year old). This group took place in Hove and attracted mainly women who lived in the area and would walk there. It was the only group with three volunteers as during the class we would look after the babies. Due to some health issues, I had to skip four, non-consecutive sessions. I will refer to this group as LNPO group 2. The last group took part in Kemptown, near to where I lived, and was targeted to men and women working in the NHS. Interestingly, all participants were women, most of them worked in different roles in the nearby hospitals. The group leader, Katherine, who was also running the second group, told me that LNPO had been contacted by NHS to run this programme for local staff. I didn't recruit any interviewee among the participants as most people had a busy working schedule and would also commute. I will refer to this group as LNPO group 3.

I interviewed five group participants and four group leaders. Interviews varied from 45 minutes to two hours and half in length and took place in different venues: LNPO offices, coffee shops

and participants' houses. Despite the BMI criteria to sign up to the programme, I have encountered a wide variety of body sizes and weights in these groups. This is important to point out as "obesity" is strongly associated with a visual recognition of a particular body size.

### **Commercial aerobics classes**

As part of my fieldwork, I took part in two aerobics classes ran by Lizzie, who I also interviewed. Lizzie is a nutritional therapist and runs her own health and fitness club, which I will call Local Fitness Club (LFC). She runs different fitness classes and send a monthly newsletter to class members. The information given in the newsletter mostly follows the Healthy Food Guide, a magazine and online blog on healthy eating and weight loss. Lizzie contacted me after seeing the research advertised in the LNPO newsletter. I first attended her aerobics classes on a Wednesday morning:

The class was fun, mainly regulars, all women, in their 40's, 50's and 60's. As usual, I felt the one dragging behind! The class started with people getting weighed and log the weight on a diary, only people that wanted to. The general atmosphere felt very relaxed and "familiar". I was the only new participant, all other people in the class knew each other and had been going to Lizzie's classes for quite some time: they seem like a group of friends (fieldnotes 10-02-2016)

After the weighing and before starting the class, Lizzie introduced me and my research to the others: they all seemed at ease with me being there, although some members shared jokes about the difficult of the class and being fit. When the class finished, some asked questions about the research and I got the numbers of two participants who were happy to be interviewed. I managed to interview only one of them some weeks later, Susan. After the class, Lizzie and I stayed at a bar just around the corner for the interview, drinking some tea and talking for over two hours. I met Susan weeks later at her place. I went back to another aerobics class the week following my first class and interview with Lizzie.

### **Other sites: participants' houses and coffee shops**

Participants' houses and cafés in the city centre are also important sites of this multi-sited fieldwork. They have represented useful, informal venues not only to meet with research participants with various and different daily lives and work timetable but also to observe materiality and dynamics around food and eating that would not have emerged in other environments. The emplaced (Pink, 2009) quality of these interviews powerfully reveals the sociocultural and material qualities of food and eating. I suggest that having access to informal, intimate and familiar spaces, such as the house or a café has yielded important data on foodwork, eating as a social practice and food as matter. These observations have been

fundamental to reflect critically in my analysis on how food and eating are enacted in weight-management discourses and practices where commensality, emotions and the performative aspects of food and eating are rationalised, silenced and individualised. These sites have also given me a sense of how nutritional information and healthy eating discourse are originally negotiated and navigated in the everyday social and family life of weight-loss groups' participants, beyond the confined space and time of aerobics classes and/or weight-management programmes.

### **Participants' houses**

Three research participants invited me over to their houses for the interview: Michelle, Daniel and Susan. Michelle and Daniel attended LNPO group 1. I decided to ask them if they wanted to be interviewed around the fifth week of the ten-week long programme, hoping that by then we would have become familiar and they would not see it as an intrusion. When Daniel suggested meeting at his place for the interview, he joked: "Now I have to hide all the chocolate!".

Both often referred to examples from LNPO weight-management programme in their interviews. Michelle for example, showed me the new plates she had bought after we discussed plates and portion sizes in the LNPO group she attends. She shows me the old ones and uses her hand to highlight the difference in size, using her palm as a measure as recommended in the class. And she adds referred to the new set of plates: "They are my favourite colour!".

Michelle's interview was also emotionally powerful as she talked about personal issues linked to her weight, issues related to her health but also affections, work career and herself. In this sense, I feel that being in her comfort zone, at home, has represented a safe space where these emotions could be expressed freely. Moreover, many of the emotions and life events that she described as relevant to her weight, were often prompted by the environment, her home. For example, she talked about how the house used to be messy because she was unwell, the satisfaction in being able to buy it and the fear of not completing the house refurbishment because of her ill health.

Susan, who I met at Lizzie's aerobics class, invited me over her place for the interview. I got to Susan's house a bit late: she lives in area on the outskirts of the city that I did not know very well and I got lost in the neighbourhood after a long bus trip. When I finally ringed the bell, she came to open the door followed by her two children who were just come back home from school. Thomas, the younger brother was nine-year-old at that time, Laura, the elder sister, thirteen-year-old. We started the interview quite informally and for the whole time I spent there, Laura

would keep coming into the kitchen where Sarah and I were sitting. Thomas asked to go out to play a few minutes after the interview started. Laura's room was adjacent to the kitchen so she kept sneaking in, asking for snacks, joining the conversation, shouting something from her room occasionally, when she would eavesdrop Susan saying something she did not agree with. She would come to the kitchen and go to the cupboard or fridge for snacks: she got carrots and tomatoes, some fruit and a couple of times she asked for crisps and chocolate. In all these occasions, Susan would tell me, and remind Laura, that they were trying to keep as little crisps and chocolate in the cupboard as possible because they (i.e. Susan and her husband) wanted the children to get used to eat more vegetables and fruit. In one of her incursions in the kitchen, Laura tells me that at school they were asked to have fruit and vegetables in the lunch box instead of crisps or chocolate bars and how she did not mind it. Susan adds that unfortunately, a boy was allergic to tomatoes and the school decided to pull back on the "healthy lunch box" all together; Laura rinses her carrot and goes back to her room. When Laura is back to her room and we can hear the TV on, Susan tells me *"my husband and me are trying to cook healthy food, especially now that I am more careful to my diet, but it is not easy, especially with all these ads on telly"*. In a lower voice, she confides some of her secret ways of hiding or disguise vegetables in the food, especially for Thomas. She also adds that planning the meals ahead is a very good way of saving time and money and explains that her husband works as paramedic and she works as personal carer for the NHS. She also recently enrolled in an online university course and for the last few years, she is attending the aerobic classes where I met her, two or three days a week. Organising everyone's schedules is her daily routine and cooking healthy meals, it is part of this routine and a way of taking care of her children and herself. I left Sarah's house after almost two hours with a familiar feeling that reminded me of everyday family dynamics, and how food has an important role within them.

### **Coffee shops**

During our interview, Walter, a GP that I met through the BSMS, starts describing changes in food culture and the availability of food as causes of the prevalence of obesity in contemporary societies. Taking Brighton as an example, he states

I think you have to look at the profusion of food shops, coffee and tea shops (...) to know that food occupies a very, very (...) large part of what is in our faces every single day

Later, still discussing social changes in food habits and foodscapes, he adds:

you can't walk down a shop parade without seeing several food outlets for instance or the preoccupation with coffee for instance, as a relatively not coffee drinker I can't see what

people see in it but you only have to look around you to know that lots of people need their fix.

Many interviews where we discussed some of the same issues, took place exactly in those coffee shops that many research participants point as part of what it is commonly called an 'obesogenic environment'. I met six of the research participants in a coffee shop and one in a pub for our interviews. I met Janette one morning in a café close to her workplace, in the Lanes; she is a practice nurse and member of the CCG. I had just started indulging on peanut butter and toast when she came in. She ordered something to drink and few minutes later she was telling me that in her opinion obesity is caused by "*all this food, because years and years and years ago we didn't have all this, you know, all this access to food, just immediately, and it's everywhere, it's absolutely everywhere now*". Later, we were talking about what is healthy food, and she tells me

yesterday I said to a patient to go and get a big cake, because she didn't feel very well, and she just needed a cup of tea and a slice of cake, so just gonna buy a cake.

Few weeks later, I met with Frances, a practice nurse specialised in diabetes. I met her at the clinic where she works. Since she had just finished working, we moved to a patisserie few doors down the clinic for the first half of the interview. Sitting next to a colourful display of pastries and sipping our hot drinks, she says that in her opinion obesity

very much seems to be a disease of the first world (...). Ehm we seem to have lost the capability to know when we had enough to eat, we have far too much carbohydrate, far too much carbohydrate, and we don't have an active lifestyle anymore, our lifestyle is very sedentary.

Half an hour later, since the patisserie was closing, we moved to a popular fish and chips restaurant just across the street where she was meeting with her family for dinner. While we are sitting at the table finishing our conversation, she explains that having dinner in this place is their family treat and an occasion to be together. She then adds "*I only have half portion though, can't finish a whole portion*". These are other examples of how specific sites can produce insight on how food consumption and habits are a pivotal aspect of everyday socialisation. As previously suggested, this intrinsic aspect of food seems to disappear in the medicalisation of overweight and obesity, where food is described only in terms of caloric intake, stripped of any attachment to everyday and social values. I will further reflect on this important point in Chapter Seven.

### **2.3.1 Positionality**

Here, I reflect on my positionality to explicit the ways in which my presence in the field has influenced "the selection, collection and interpretation of data" (Finlay, 2002, p.531). This



reflection is informed by debates on reflexivity that have characterised anthropology and feminist scholarship since the 1980's. The works of Fabian, (1983), Clifford & Marcus, (1986), Okely & Callaway (1992) and more recently Finlay (2002), Foley (2002) and Punch (2012) are but a few examples of debates on the 'reflexive' quality of ethnographic encounters and writing in anthropology that recognise the researcher's active involvement in the construction of interpretations (Finlay, 2002, p. 532). Far from being an exercise in "navel gazing" (ibid.p.541), this reflection on my body size and outsider/insider status wants to address the "political dimensions of fieldwork and constructing knowledge" (Callaway, 1992 in Okeley and Callaway, p.33). At this end, a self-analysis of intersecting factors like gender, age, ethnicity, class (ibid.) and body size is of particular importance when doing research on the social and medical category 'obesity'. Moreover, discussing my positionality is also a fruitful way to reflect on the challenges and implications of doing 'thick participation' (Samudra, 2008) in settings of obesity management.

I am a white woman in her early thirties whose weight is "healthy" and BMI "normal" by medical standards. I have never been prescribed a weight-loss diet by a doctor, but I have repeatedly attempted to try some "faddy" ones when I was a teenager. I have never lost or gained much weight, but as a teenager I have gone through a phase of eating disorders and I have felt discomfort in my body shape for many years after my eating habits were back to "normal". A discomfort and dissatisfaction that are quick to resurface at times. As a young woman, I have experienced and embodied the assumed values of slimness and its gendered surveillance on body size and shape. I stopped checking calories and fats on food packaging such a long time ago that my eyes do not go straight to that information anymore. On the contrary, they carefully but automatically avoid it. Nevertheless, due to a long history of food allergies and intolerances, I have always been careful to what I eat, and reading labels and lists of ingredients on food packaging as well as limiting processed food is part of what I normally do as a consumer. It is important to mention these aspects of my relations with body size, food and food packaging as they are some of the normative ideals, practices and technologies that govern the discourses and sites of obesity management I researched.

Furthermore, the body is our first matter to be in the world and the first site where and through which socio-cultural meanings are powerfully inscribed and conveyed (see Bourdieu, 1984; Scheper Hughes and Lock, 1987; Csordas, 1990). Thus, it is important to highlight how in this specific field the body, its size and image, have a central relevance for my positionality,

representing the researcher's more direct and visible way of "being in the field". In the context of this research, body size is constant object and subject of discussion, evaluation, monitoring, negotiation, intervention, transformation, and knowledge. Moreover, my fieldwork is embedded in a broader context where bigger bodies are viewed as deviant and problematic against smaller bodies seen as normal and healthy. I follow Evans and Colls (2009), and Warin and Gunson (2013) in maintaining that:

A researcher's own body size matters, because bodies of a slim or "normal" size tread lightly yet weigh heavily in spaces and conversations, discomforting both participant and researcher (Warin and Gunson, 2013, p.1692).

Access, researcher's body size/BMI and insider/outsider status are the three features I have identified as more meaningful and problematic to reflect on when considering my positionality in the field. A constant negotiation of access to field sites has been a key element of being in the fieldwork and has been heavily shaped by my body size and BMI as well as by my status as simultaneously insider and outsider in relation to different sites, settings and research participants. I do consider access "not simply a matter of physical presence or absence" (Hammersley and Atkinson 2007, p. 43) into specific places, but a matter of my accessibility to experiences, practices, meanings, technologies and spaces. For both commercial and free weight-loss groups, the requirement to participate is a BMI over 25 and/or 30, identifying respectively overweight and obese. It is evident then that my BMI and body size wouldn't allow me to take part into weight-loss programmes as a weight-loser myself. BMI and weight have constituted a limit to overcome in negotiating my access to weight-management settings: my presence within these spaces was then based and justified on my status as a researcher and the role I took as a volunteer in LNPO programmes.

Less evident is how it has affected my accessibility to other spaces, both physical and symbolic, to specific technologies and to my interlocutors and their experiences. Very few times in the whole length of the fieldwork, my body size has been direct object of comments. Nevertheless, it is important to reflect on the powerful interconnections between knowledge exchange, power relations, expectations and body size within this field. In this field, the ethnographer's status as simultaneously an outsider and insider is informed by both my weight and professional status. I present two examples from the fieldwork that well illustrate these connections and how they inform my accessibility to data and constant repositioning within the field. The first example refers to my engagement with specific technologies of weight management. In designing the fieldwork, I decided to use weight-loss apps that were recommended by NHS and that other

research participants would use. During the fieldwork, *MyFitnessPal*<sup>13</sup> appeared to be the app most commonly used by research participants. I downloaded it, created a profile, inserted my measures and started a plan which aimed to maintain my “normal” and “healthy” weight as it was. After two weeks of sloppy attempts to track my daily meals and activity, I gave up. It followed a time of frustration and reflection on this unsuccessful attempt to collect data. I understood my lack of motivation in engaging with this technology as twofold: firstly, I lacked the main goal and drive for which the app was designed, that is losing weight. Secondly, logging my meals and activity felt like a time and energy consuming task which I perceived as extra load to add to my already busy routine. It is interesting to note how both motivation and (busy) daily routine are explanatory devices that I have identified as used by research participants from different groups to talk about and make sense of weight management and healthy eating<sup>14</sup>.

However, I never talked about this experience of frustration and struggle to keep track with weight management technologies in conversations and interviews I had in the field. I felt that since I did not have to lose weight, sharing this experience would position myself further as an outsider. The second example regards setting and following a SMART goal at the beginning of each LNPO programme I volunteered in. Every first session of each programme, participants were asked to choose a SMART (Specific, Measurable, Attainable, Realistic, Timely) goal to lose weight. For the first programme, I set the goal of giving up sugar in coffee and did stick with it. Nonetheless, since losing weight was not part of my goal, I never felt comfortable in bringing it up in the conversations and interviews I had with other group participants.

In designing the fieldwork, I had conceived this engagement with weight management technologies as a way to embody practices familiar to those of my participants in specific settings, i.e. weight-management groups, so to get closer to their experiences and widening

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<sup>13</sup> MyFitnessPal is a weight-loss app which tracks meals, calories, nutrients and physical activity. Members can log their meals over the day and activity and the app breaks down the nutrients and calories intake for the day and for the week. Michelle, a research participant I met in LNPO group, gave a very detailed explanation of how it works and how she uses it.

<sup>14</sup> Moreover, when I met Michelle, a participant in LNPO weight management group, for our interview, she explained in detail how MyFitnessPal works, how she uses it and why she finds it useful. I didn't mention my previous, unsuccessful attempt to use the app as I felt that wasn't particularly relevant or useful in the exchange we were having, thus assuming that my weight was more relevant in informing that specific exchange than my struggle to fit the app into my daily tasks.

common ground for conversation. In fact, I had considered using apps and weight-loss strategies promoted in the field settings not just as a way of collecting data but also as a useful tool to start conversations and share ideas with weight-loss group participants. My embodied positionality in the fieldwork proved the opposite: I felt that because of my weight and body size, my engagement with weight-loss techniques and technologies would be perceived as purely research-driven, further positioning myself as an outsider.

This reflection leads to consider the entanglement of my body size to my status as researcher and the different roles at play when researcher and research participants position themselves, and the consequent expectations, knowledge exchange and power dynamics. The different power relations and positions directly link with both the actual and expected knowledge carried, negotiated and exchanged by different actors. I have always presented my status as researcher overtly, which means that I have always had to present my research, either orally or through participant information sheets, to all my interlocutors. The aims and outcomes of my research have also been often part of less informal conversation during interviews and participation observation. This process of presenting and “chatting” about my research, has, not surprisingly, revealed that anthropology and ethnography, both as ways of understanding the world and ways of doing research, are still very unfamiliar to the wider public<sup>15</sup> (see Hammersley and Atkinson, 2007). I believe this partly played into the frequent misunderstandings about the kind of knowledge I had around obesity, nutrition and medicine and has maybe resulted sometimes in unmet expectations from my side. Although these expectations changed depending on the group of interlocutors<sup>16</sup>, their different positions within the field and towards weight management, there were two recurring areas of knowledge in which I was expected to be competent from all groups of research participants: nutrition and medical language, especially in the form of medical

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<sup>15</sup> This has represented a challenge as well as a resource in my field with important outcomes in terms of positionality. Prior to starting the fieldwork, I produced many different summaries and explanations to convey my research project to a “lay public”; a heterogeneous public, composed of social actors with different backgrounds, competencies, skills and possibly, different interests in the research.

<sup>16</sup> In the ethical approval, I identified four groups of research participants: GPs, practice nurses, weight-management group participants and weight-management group leaders. This categorisation is useful to think about access and positionality. Nevertheless, it should not be understood as a fixed categorisation of research participants through which to assume their competence, skills, understanding and experiences of obesity management or their social status.

abbreviation and acronyms. These assumptions work as research participants' ways of repositioning the researcher and became more evident during interviews than participation and observation. For example, LNPO group participants often associated me with LNPO staff and assumed my knowledge and familiarity with people and programmes within that organisation. Health professionals as well as weight-loss group participants and leaders, assumed I had a level of nutritional and biomedical competence: for example, they would use biomedical abbreviation and acronyms or comment "but you know more than me" or "you will probably find out with your research" when referring to nutritional and physiological aspects of weight loss and management. As Hammersley and Atkinson state, *"(...) people in the field will seek to place or locate the ethnographer within the social landscape defined by their experience"* (2007, p.63). I am aware that while my body size is immediately visible and easy to place, my social status is not<sup>17</sup>. The area where I lived and worked, my body shape, BMI and previous research experiences in obesity as well as my status as non-native, part-time PhD student and worker all contributed to shape my positionality in the field.

#### **2.4. The ethical approval process: translating ethnography**

Gaining ethical approval has been a long, challenging and interesting process. Given the engagement with NHS staff, I had to seek ethical approval from the Brighton and Sussex Medical School (BSMS) Research Governance and Ethics Committee (RGEC) instead of the Department of Anthropology. I consider this process an exercise in translating ethnography into a different language and methodology, a translation that has been both a resource and a challenge with important consequences on my approach to the fieldwork.

The Research Governance and Ethics Committee (RGEC) Application Form is designed for a type of scientific research that uses quantitative methods more than qualitative ones. Although it allows space for the use of qualitative methods and many biomedical and clinic researchers utilise qualitative interviews in their work, the kind of research rationale it requires is challenging to encompass the variability, uncertainty and fluidity of ethnographic research (Sleeboom-Faulkner et al. 2017). However, engaging with this approach has revealed to be very useful to reflect on my research, its organisation and relevance. To anticipate issues and possible solutions, and to consider the power relations and vulnerabilities at play. To map out the sites;

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<sup>17</sup> My habitus (Bourdieu1977) – my accent, voice, attitude, posture – does not reveal my social status as immediately readable or meaningful to research participants.

to attentively identify the channels through which to recruit participants. This has been possible by applying a reflexive gaze, characteristic of anthropological enquiry and methodology, to all aspects of the ethical approval.

In this process of translating my ethnographic project into a new language and research approach, I have built an awareness about the fieldwork, almost a projection into “being in the field”. I consider this a value and a resource of a multidisciplinary supervision. Reflecting in detail on all aspects of the field, from recruitment to confidentiality, from vulnerability to data storage, has given a solid and pragmatic structure to the future stages of my work in the field. It has also been a valuable resource to overcome difficulties, rejections, delays, and unforeseeable events characteristic of doing ethnography. This flexibility is a fundamental resource in a multi-sited ethnography (see Hockey, 2002) where people’s needs and timetables are very different as well as the physical sites of investigation, making the organisation of time and space a key aspect of the fieldwork. Moreover, considering my status as self-funded researcher and part-time worker in retail, covering distances (workplace, city centre, university, participants’ homes and weight-loss groups’ venues) and juggling different schedules (work, participation observation, volunteering, interviewing) has been a constant feature of this research. Being aware of the possible limitations and solutions I would encounter in the field before starting it, has been a powerful tool to manage difficulties and anxiety in the fifteen months of my fieldwork.

Translating an anthropological project into lay language has represented a moment to reflect on knowledge production and distribution, and knowledge exchange. Although the application form required to “...provide a summary of the project written in language accessible for a non-expert audience”, it was clear to me that for the rest of the application I was trying to explain my research to an audience who is actually expert but in a different area. The area of expertise I was negotiating with was that of science and biomedicine, as exemplified by phrases such as “*What is the purpose of this study? Please clearly state the aims of the study or hypothesis to be tested*”, “*What sort of participants will be involved? (i.e. how many, gender, ages)*” or options presented in the risk Assessment section like “*Physiological interventions or procedures outside of standard practice - These might include the administration of drugs or other substances; taking bodily samples or human tissue (e.g. blood, saliva, biopsy or urine) from participants; use of probes or other equipment to measure or monitor bodily performance*”. This is the same expertise and knowledge that is also subject of analysis in my research within a critical medical anthropology approach. Therefore, I consider necessary to recognise the importance this field of knowledge

has had in the design of my research and reflect on the possibility of bridging a critical medical anthropology approach to a multidisciplinary context of research.

The designing of the Participant Information Sheet (see Appendix C), Consent Form (see Appendix B) and Debriefing Form (see Appendix D) represent an important example of translating my research into a language accessible to a lay public. I produced four different Information sheets for the four different groups of people (GPs, practice nurses, weight-loss groups' participants and leaders); in all four sheets, I use the same formulas and explanation, describing my research as follow:

This study is part of a wider research exploring how people talk about and relate to obesity. I am interested in the experiences of the public and health professionals. I would like to talk to you about your views on health policies/campaigns, media, primary care, diet and physical activity based on your own experience. (Participant Information Sheet- Appendix C)

The consent and debriefing forms are the same for all groups of informants. I consider the choice of giving everyone the same information using the same register as a tool to value equally the different kind of knowledges my interlocutors were bringing into the discussion and avoid a reiteration of biomedical knowledge as authoritative. I saw it as a chance to make health professionals and weight-loss groups leaders (nutritionists or dieticians) aware that my interest was not only on what they know about obesity and the "obesity epidemic" discourse, but also on how they feel and what they think as individuals. Conversations about feelings, emotions and personal views have been some of the most interesting, reflexive and reciprocal moments of the conversations I had in the field. Equally, it served to encourage non-professional and non-elite interlocutors to talk not just about their experiences but also about their knowledge of obesity, nutrition, national policy and local campaigns or services.

Despite being a common practice for ethnographers working in health research to produce Participant Information Sheet and Debriefing Form, this type of documents are not listed as standard requirement of anthropological research by the Association of Social Anthropologists of the UK and the Commonwealth (ASA) Ethical Guidelines for good research practice (2011) . For example, even if the ethical centrality of informed consent is carefully stated, in these guidelines there is no indication that a Consent Form is strictly required or suggestion on how to prepare one. Recognising the variable and flexible nature of the fieldwork, these ethical guidelines state that "it is possible and appropriate (...) to obtain informed verbal consent" (ASA

Ethical Guidelines, 2011, p.2) and this is common practice for ethnographers in the field. I then consider the design and use of this kind of documents not just as a useful translation of my research into a language accessible to the lay public, but also as translation into another way of doing research. I consider it a negotiation between the variability, flexibility and uncertainty characteristic of ethnographic research and the ethical expectations of the verifiable and thesis-hypothesis-centred clinical research. My ethical approval process represents an example of bridging two different research approaches and methodologies and getting familiar with another language in the process, as well as an important moment to reflect on the (re)production of knowledge in the design of the fieldwork.

There have been moments during the fieldwork in which I have perceived this context of interdisciplinarity as an obstacle to my ability and possibility of embracing the many opportunities stemmed by the unpredictability of fieldwork contingencies. I felt that my capability to allow the required degree of flexibility (ASA Ethical Guidelines, 2011) was limited by the necessity of reporting any change of “strategy” involving ethical issues, for example, channels through which recruit informants, to the RGEC that would evaluate the suitability of such changes. I am now aware that this has limited some possibilities of engagement in the field. For example, finding practice nurses through the channels identified before the fieldwork has revealed to be more complicated than anticipated. After going through the BSMS, CCG and LMC with little success, I started considering different ways of getting into contact with practice nurses. An idea, discussed also with my supervisors, was to contact them through dedicated groups on Twitter and using Facebook. This implied writing to the ethical committee to notify the change in the recruitment criteria and evaluate ethical issue; at that stage of the research, feeling pressured to recruit practice nurses in a small lapse of time, I felt that such solution would have taken up too much time and decided to dismiss it.

This last example shows how having been granted ethical approval by the BSMS revealed a useful tool to negotiate my positionality in one specific field site. In the second half of the fieldwork, I volunteered for a weight-loss group targeted to NHS staff. To meet participants’ needs, it took place in an NHS building near the University Hospital in Kemptown. Since the organisation that promoted and led the programme was the same one I had already been volunteering with for a few months (i.e. LNPO), we decided to follow the same procedure adopted in previous weight-loss groups. At the beginning of the first day, the leader of the session introduced me to the participants as a volunteer and researcher, I briefly presented my research and asked for



everyone's consent for it to be carried on and for the sessions to be recorded. As often happens, new people joined the programme in the following week, and I made sure to inform everyone about my research. After three weeks into the programme, I received an email from one of the participants who was also NHS employee, asking explanation on the research and informing that in order to carry out a research within NHS premises, I had to ask permission from an NHS and University Hospital ethical commission. Although the request came quite unexpected, I replied with a briefing of the research and explained that the research had been ethically approved by BSMS RGEC. The participant seemed to be happy with this response and I could carry on with my participation observation. I propose that having an ethical approval by a committee internal to the medical school and designed within standards closer to clinical than anthropological research, has been fundamental in this occasion. It guaranteed a proof of suitability in that biomedical context: thanks to the ethical approval, I negotiated my presence in and access to this specific site.

#### **2.4.1 Ethical consideration on Terminology**

A critical approach and reflection on the terminology used is central to obesity research. It is important to explain why I have chosen to use the term *obesity* but to not use the adjective *obese* to refer to my research participants.

Since the research design stage, there has been a tension around whether, when and how to use the term obesity in my research. The first consideration this tension stemmed from was the risk of reinforcing biomedical authority, despite the critical medical anthropology approach I apply to the subject of my research. However, the aim of this research is to understand how "obesity" as a specific biomedically constructed category and entity, is originally and variously interpreted, embodied and experienced by relevant social actors. I am interested in exploring the practices, meanings, materiality, discourses, policy, and interventions that have been produced at a macro (public health policy and national guidelines) and especially micro level (local settings and everyday life) because of the medicalization of fatness through the production of the clinical category "obesity". At this end, obesity is the only term I can use. I am aware that it is necessary to address the power relation implied in the use of this term in obesity research and I aim to do so by showing the situatedness and multiplicity of the term obesity.

My second reservation on the terminology refers to the fact that obesity and especially the adjective obese are terms fraught with moral scrutiny and stigma. I have chosen to never address directly a research participant as obese, neither in our face-to-face conversations nor in

the thesis. Two main considerations underline this choice. Firstly, the awareness and concern that my interlocutors could feel offended, judged or confined by being defined “obese”. This consideration does not reflect a personal negative opinion towards fatness and obesity. I am not choosing to avoid referring to my research participants as *obese* because I personally agree with the authoritative knowledge that describes obesity as inherently problematic, both medically and morally. Rather, this choice derives by the awareness that both my body, as researcher, and research participants’ bodies are embedded in a sociocultural context where obesity and fat bodies are constructed as “unquestionably problematic” (see Warin and Gunson, 2013). It follows that my fieldwork as much as the embodied, material and discursive relations produced in and through it, are also “embedded in and shaped by both medical and moral fields” (Ibid. p.1689) where the term obese “is normalized” to represent a “discrediting attribute” (Goffman, 1963 in Warin and Gunson, 2013). Secondly, I am not a doctor. As a medical anthropologist, I am interested in the experiences produced in relation to the current “obesity discourse”. Referring to research participants that took part into weight-loss groups as obese would mean to impose a clinical label on them, to assume they self-define as such or “impose a fat identity” (Warin and Gunson, 2013, p.1688) on them. Nonetheless, I am aware that my research interest and the very possibility of my research depends on the fact that obesity is produced in a specific way within the societies I live in and where I do my research.

### 3. Review of literature

In this chapter, I outline the theoretical ground of this thesis through a review of the literature. I will present the works and approaches that constitute the theoretical framework of my research and analysis, being aware that this is not an exhaustive overview of the social science literature on obesity. In the last three decades, obesity has been object of fruitful investigation in social sciences and particularly in anthropology. Social sciences such as medical anthropology, sociology and feminist scholarship constitute privileged lens to look at the sociocultural and political implications of this phenomenon. Obesity as an object of enquiry resists strict disciplinary boundaries and this resistance shows in this review of literature. I will start presenting discussions on fatness and obesity as a socially, historically and geographically situated. In this section, I will try to focus on anthropological works on cross-cultural constructions of body size, but this focus is not exclusive. I will then move to present works from feminist scholars in different disciplines that look specifically at gender and fatness. These two sections ground my understanding of obesity in wider discussion on the body and fatness as sociocultural constructs. Then I will move to discuss literature that has been produced in specific relation to obesity and the 'obesity epidemic' discourse. In particular, I will focus on critical medical anthropology approaches to obesity, biopolitics, and Mol's concept of body multiple, for they constitute the backbone of my theoretical framework.

#### 3.1 Sociocultural and historical construction of fatness

"Obesity as a concept is a dimension of body image that is formulated around a particular society's consideration of acceptable body size" (Pollock, in de Garine, Pollock, 1995, p. XIV)

Scholarly interest in obesity has been lively since the late 1980s as part of a broader literature on body size as sociocultural product. Within this frame, anthropology, along with sociology and cultural studies, has investigated the peculiar ways fatness has been conceptualized in Western and capitalistic societies, revealing how obesity is a category historically informed by the western metaphysical dichotomy body/self and culture/nature (see Turner 1984 and Lock 1993). A comparative approach with non-western societies and concepts of body size is ubiquitous in all these contributions. Nevertheless, there are different trends: some studies address the hegemony of biomedicine in shaping western understanding of body size; others question taken-for-granted bodily concepts and practices by focusing on different conceptualisation of body and fatness in other parts of the world. Other works analyse the sociocultural and economic processes that have brought to the 'obesity epidemic'. In an attempt to give an exhaustive

overview of this literature, I have chosen those contributions that I consider to better exemplify some of the issues that I will investigate in my research.

Important researches in sociocultural anthropology have studied the “scientific discourse about the causes and effects of fatness” (Gremillion, 2005), highlighting how cultural and biological processes are interrelated. Building on the idea that biomedicine is a specific cultural framework for interpreting biological data, they investigate how the definition of obesity as a disease is an historical and cultural construction. These contributions have been mainly produced in the first phase of the so-called ‘obesity epidemic’ and therefore they have not addressed more recent issues such as the increasing rates of obesity in low- and middle-income countries. Moreover, they show a general tendency to apply a biocultural paradigm that ends up reproducing biomedical categories rather than questioning them. Nevertheless, their importance is paramount since they show how ‘obesity as a concept is a dimension of body image that is formulated around a particular society's consideration of acceptable body size’ (Pollock, in de Garine, and Pollock, 1995, p. XIV). Obesity is a product of western societies not only because consumerism and capitalism have settled the environmental and structural conditions to weight gain but also and especially because this particular view of fatness as unhealthy is possible within a theoretical and metaphysical frame that characterizes those societies. Therefore, they are fundamental to critically address current obesity-related policies and practices.

In her article ‘Obesity as a Culture-bound syndrome’ (1982), Ritenbaugh reflects on the sociocultural factors that inform the biomedical definition of obesity and reviews the events that have brought to it. This article is a first reflection on the main themes that now characterize the literature on obesity: historical construction of obesity as a disease, moral stigmatization of fatness, socioeconomic and political factors of the ‘obesity epidemic’. It describes how the biomedical measurements through which obesity is diagnosed and defined today, are indeed the result of esteems from insurance companies. From the beginning of the 1900’s, American insurance companies started to charge higher rate to extremely fat clients, on the base of the association of fatness with poor healthy condition. From this moment onwards, set standards were sought for in order to have a conventional definition of obesity and consequently of ideal weight and body size: ‘the epidemic of obesity (...) has been created in large measure by the lowering of ideal weight/height standards’ (Ritenbaugh 1982 p.356; see also Oliver, 2006). Moreover, she argues that the neutral definition of obesity as an energy imbalance resulting from overeating and/or under-exercising is the ‘biomedical gloss for the moral failings of gluttony

and sloth' (Ritenbaugh, 1982 p.352). Consequently, in a social context such as the American and western one, where self-control is socially pursued and valued, obesity is the 'visual representation of non-control' (Ibid.) and then assumes a moral connotation.

Finally, Ritenbaugh's reflection moves to the relevance that obesity has acquired in modern biomedicine, addressing gender and social status inequalities and revealing the cultural values at play. She suggests that thinness is highly valued in western societies as a consequence of its association with other two sociocultural values: youth and richness. She argues that biomedical standards around body size reflect a trend that is ongoing in upper class where the economic possibility of affording the "best" food has enhanced thinness as a symbol of beauty and health. She also highlights how body ideals of slimness and youth, are perceived as more relevant for women than for men and how it has influenced the different rates in measuring and evaluating obesity. In fact, she argues that 'weight standards for females show the most obvious steady downward trend and mirror the trend in popular media images' whilst 'higher mortality rates and health concerns focus on males, yet there has been no steady downward trend for them. Since an examination of cultural images suggests a much wider range of acceptable male body shapes (...)', it gives an idea of how 'changing biomedical standards have paralleled changing cultural values, rather than an accumulation of biomedical knowledge' (Ibid. p.357).

Other works have applied a comparative approach to historicize and question the universality of biomedical definition of fatness as a disease and thinness as an ideal body size. These works present sociocultural, mostly non-western contexts where fatness is positively valued as a symbol of social exchange (Becker, 1995), beauty, well-being and health (see deGariné, Pollock 1995). Thanks to cross-cultural analysis, fixed ideas of fatness as unhealthy and unattractive are questioned and relativized along with the western dualism body and self. It is important to notice that some of these works lack a reconceptualization of the duality nature/culture and a problematisation of biomedical knowledge. Nevertheless, I consider them fundamental to understand the cultural specificity of concepts that are now widespread and taken for granted in public debate on fatness and health. Indeed, the momentum gained by the 'obesity epidemic' discourse results in a common understanding of fatness as universally unhealthy and unattractive. This understanding is very much present in the research participants' accounts and experiences of obesity and constitute a fundamental source I draw on to reflect on the stigmatization of obesity in my field.

From an anthropological perspective, comparing different ways of thinking, working on, valuing and governing body size and fatness is a precious way to reflect on the body and self as social and cultural. For example, in her ethnography *Body, Self, and Society: The View from Fiji* (1995) Becker examines the meanings of body size and the relation body/self in a Fijian village. She highlights how in the context of her research fatness is seen as the positive result of community interexchange and then the focus is more on others' body than on individual body; this also results in a different conceptualization of body/self that is a testimony of the peculiarity of the western, Cartesian dualism. 'Fijians are not self-reflexive about their bodily habitus. What very much piques their interest, however, are other people's bodies (...). Body morphology is a primary lexicon of social processes, not a means of self-representation; it is a matter of social, not personal, concern' (Becker, 1995 p.1). I consider this ethnography very useful because it tells us of different ways of evaluating body sizes that deviate from the one at play in the "obesity epidemic" discourse. In fact, based on the data Becker collected about ideal body shapes, it results that fatness isn't perceived by research participants as desirable or attractive and the chosen ideal sizes are almost the same of those indicated by western individuals. So, why does this not result in a social, individual and medical condemn of obesity? For two main reasons whose understanding gives important insights on the assumptions that inform ideas of diet, physical activity, moral judgement and individual responsibility in the 'obesity epidemic' discourse. Firstly, since Fijians do not see the body neither as malleable nor as an individual project but rather as a community space, individual practices such as dieting and exercising to gain a specific body shape are meaningless in this society. Furthermore, social stigmatization of obesity is absent in this context due to the association of body size with concepts of caring and community rather than with concepts of beauty and health. Care, *viqwaravi*, is associated with weight and then overweight is valued as a positive feature in spite of not being considered an attractive body shape (Becker 1995). In fact, 'personal achievements are indexed not by bodily shape or by the disciplining of the body, but by one's connectedness with and performance of care in the social matrix of the family, the *mataqwali*, and the village' (Ibid. p. 57).

By presenting ethnographic data collected in different part of the world, de Garine and Pollock (1995) historicize the universality of the 'obesity epidemic' and related constructions of fatness as unhealthy, unfit and immoral. The chapter "Sociocultural Aspects of the Male Fattening Sessions Among the Massa of Northern Cameroon" (de Garine in de Garine, Pollock 1995) gives insightful examples of a context where obesity is linked to positive values and seen as a temporary phase rather than a genetic or individual fate. Male fattening sessions can be

individual or social and 'men are supposed to enter the *guru*, literally "eat (*ti*) the guru", in order to drink (*ci mira*), to become beautiful (*naa*-actually good and beautiful) and to grow (*nya*-increase, grow [for animals, plants and objects])' (Ibid.p. 46). This is a practice that works on fatness as a means to gain social values: a concept opposite to the moral and social stigmatization of fatness in the current public debate. Nonetheless, the body size achieved through the fattening sessions is considered desirable only for the period of the session itself. Indeed, obesity is not considered attractive and the ideal is a robust, strong and round body, that is a body that biomedicine would categorise as overweight.

Hattori's "Physique of Sumo Wrestlers in Relation to Some Cultural Characteristics of Japan" is a precious and unique example of obesity as a sport body ideal. Sumo is one of the main national sports in Japan and it is associated with traditional values. Consequently, even though sumo wrestlers' body isn't a general body ideal outside that specific context, nevertheless their body size 'is not perceive to be unattractive in Japan' (Hattori in de Garine, and Pollock 1995, p.41). The importance of this ethnography is twofold: in our society, fatness has been linked to ill health and sedentary life that is the opposite of athletes' lifestyle. Indeed, athletic bodies are considered the ideals of a healthy, fit and attractive body and obesity is considered the opposite of this ideal. Hattori's study powerfully addresses this taken-for-granted conceptualization. Moreover, it is interesting that such a testimony comes from a country that is industrialised and shares many similarities with Euro-American context.

### **3.1.1 Fatness as a gendered issue**

Drawing on the assumption that body size is a sociocultural product, feminist studies have focused on the gendered implications of fatness. Since the late 1970's, feminist interest for body weight as a women's issue has produced important reflections on how fatness is not only socially and historically but also politically constructed. The common assumption of all these contributions is that fatness is a 'feminist issue' (Orbach, 1978) and in this 'cult of thinness' we can see patriarchy (Rowe, 1990), capitalism and consumerism (Bordo, 1993) at work. Orbach's article 'Fat is a feminist issue' (1978) represents an essential step in the feminist study of body weight as a gendered issue. Here, the author argues that body hatred, weight preoccupation and eating disorders are the bodily consequences of patriarchal control over women. Starting from the common ground that 'fat is an adaptation to the oppression of women' (Orbach, 1978 p.22), a variety of issues has been addressed by different authors. Earlier works examine the sociocultural stigma and pressure put on female bodies as privileged places of social

manipulation in which inscribe power and patriarchal values linked to a capitalistic society. Thanks to such investigations, the role of sociocultural constructions in shaping and governing ideas of fatness and body has been powerfully addressed. Consequently, these works represent an important contribution to question and challenge biomedical ideas of obesity as a neutral and simply biological reality. Gender becomes an angle from which to powerfully unravel the cultural and political factors that inform obesity science and the intertwining of this with cultural body ideals promoted in the media.

An analysis of body image in public and media debate (see Wolf, 1990; Bordo, 1993; Lupton, 1996) is also fundamental to these works. Moreover, these cultural constructions are understood within the capitalistic and consumeristic context in which they are produced. In *'Unbearable Weight: Feminism, Western Culture, and the Body'* (1993), Bordo uses consumerist society and modern bodily techniques as core concepts and practices within which understand the gendered construction of fatness. She critically underlines the paradox that in capitalistic societies a growing multiplicity of bodily practices (such as diet, plastic surgery, physical activities, etc.) is aimed to one hegemonic body ideal, that of thinness. The promotion of slender body images and bodily practices to achieve them is the point where the mutual influence between media debate and biomedical knowledge is more evident: within and outside the biomedical realm, diet and physical activity are promoted as main techniques to work on and against a fat body. In my fieldwork, this reflection has been one of the starting points in analysing the ways diet and physical activities are thought and talked of from different actors and in different biosocial and clinical contexts. Bordo associates eating disorders, and obesity among them, to the dualism control/desire created by a consumerist society. She argues that in a consumerist context, individuals and especially women are trapped in a bind: on one side, as producers, people are prompted to control desires in order to be productive workers. On the other side, as consumers, individuals are encouraged to indulge and satisfy our desires. In my research, I have shifted this reflection from the macro level of the critique of capitalistic societies to the micro-analysis of individual everyday experiences in local contexts. In this thesis, I will analyse individuals' experiences and understanding of diet and physical activities in clinical and biosocial contexts based on their roles within those contexts, their socioeconomic status and their gender.

Thanks to works that bridge feminist perspective and food anthropology (see Lupton, 1996; Counihan and Van Esterik, 1997; Counihan, 1999), the role played by 'foodways' in reinforcing and challenging social and economic inequality 'in family and society' (Counihan, 1999) has been



addressed and acknowledged. Drawing on these reflections, I will investigate the role of 'desire' linked to food and dieting and how it changes in professionals', weight-loss leaders' and participants' narratives. I will investigate if and how gender influence languages and attitudes towards dieting. I will also explore meanings and practices of consuming 'healthy food' and whether they are linked to socioeconomic status. Are factors, such as time and money, taken in consideration in the narratives of professionals and weight-loss group leaders? Are desire, taste, food's price and food preparation time present in the campaigns and policies that promote healthy lifestyle? Critical literature on body and fatness has highlighted the role of food and body size politics in reproducing gender and socioeconomic status although less has been said about physical activity, its sociocultural understanding and its relation to power and gender.

More recent feminist approaches to fatness and body size have overcome some of the limits present in this early literature and foster an up-to-date comprehension of gender issues in the current 'obesity epidemic' discourse. One of the main limits of the literature presented so far is a generalisation of gender as a concept equally experienced and made meaningful by women coming from very different sociocultural, economic and geographic contexts. In other words, these contributions insightfully reveal the effects of patriarchal and capitalist power in shaping women's relation with fat but gloss over other power relations, such as socioeconomic status, that powerfully inform current discourses on fat and body ideals. Consequently, they do not explore enough 'the experience for women in this culture of *actually* being fat' (Fikkan and Rothblum, 2011 p.576) and overlook the agency of the subjects involved.

Works examining the actual experience of fat women have shown how weight bias is a phenomenon present in many different domains, from education to work places (see Rothblum et al.1988), from media to health care (see Joannisse and Synott in Sobal and Maurer, 1999; Ferraro and Holland, 2002). A focus on actual experiences of being fat has also the merit of producing works that highlight the agency of individual and groups in negotiating and reshaping practices, meanings and languages of fatness. Examining 'people's own meanings' and language is a powerful tool to replace 'the spoiled identity (...) of fatness with a more inhabitable subject position' and reveal unconventional and creative ways of thinking, living and talking of obesity (LeBesco, 2004 p.3). Widening the angle from which to investigate gender and obesity, gives the way to investigations that despite recognising the existing inequality in weight bias between man and women, nonetheless critique the absence of 'the ways in which fatness, muscularity and masculinity are intertwined' (Bell and McNaughton, 2007 p.108). I consider that examining men's

experiences and narratives of fatness is an important step towards a nuanced understanding of the current debate on obesity and a fruitful way to underline the multiplicity of practices and voices that inform it and foreground the agency of social actors in negotiating, (re)producing and contrasting the 'obesity epidemic' discourse.

### 3.2 Critical medical anthropology and obesity

A critical medical approach to understanding obesity is at the core of the theoretical and methodological frame of this research. In their landmark paper "*The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology*" (1987), Nancy Scheper/Hughes and Margaret Lock introduced the idea of the three bodies to critically address the reproduction of biomedical assumptions on the body in medical anthropology. They identify a) the *individual body*, understood as the phenomenally sensed body-self; b) the *social body*, understood as "a natural symbol to think about nature, society and culture" (Ibid.p.7). And c) the *body politic*, described as an artefact of social and political control, surveillance and regulation. Scheper-Hughes and Lock conceived the "three bodies" as a heuristic tool to investigate bodies, health and illness in ways that problematized and discarded dominant dualistic and Cartesian understandings of these domains and experiences. I build on this concept to approach obesity in this thesis and argue that obesity represents a privileged object of enquiry to realise the heuristic potential of the 'three bodies'. The two authors suggest that "three bodies" represent

(...) not only three separate and overlapping units of analysis, but also three different theoretical approaches and epistemologies: phenomenology (individual body, the lived self), structuralism and symbolism (the social body), and poststructuralism (the body politic) (ibid. p.8)

In utilising these units of analysis in my research, I do not conceive of them as "bounded entities" (Yates-Doerr, 2017, p.152) but as entangled heuristic approaches that are equally necessary in comprehending obesity. If we recognize that biomedicine is a socio-cultural product and the "Cartesian dualism" on which it is based is a "cultural and historical construction (...) not universally shared" (Scheper-Hughes and Lock 1987), practices and narratives of biomedicine become subjects of investigation and clinical contexts privileged sites for ethnographic fieldwork. Moreover, this allows unravelling the role of biomedicine as a specific authoritative knowledge in contemporary societies and the political economy of disease. This critical approach has been developed by recent ethnographic research in low- and middle-income countries, such South America and India (see Yates-Doerr, 2015; Gálvez, 2018). Focusing on the political economy of health and body size, these contributions powerfully reveal the structural, socioeconomic and

political factors linked to obesity and to the hegemonic discourses on nutrition and healthy lifestyle. In exploring how people navigate rapidly changing foodscapes and job markets along with contrasting and multiple ideas around health, food and eating, they critically analyse the universality of biomedical messages around obesity.

Drawing on these approaches, I question and problematize the biomedical construction of "obesity" as a fixed, universal and morally neutral category. Instead, I argue for an understanding of obesity as a category socio-culturally produced, historically and politically situated and shaped using biomedicine as authoritative knowledge. Likewise, I think of health professionals as situated social actors. The ways in which discourses around body size and fatness have been conceptualised as always health-related, risk factors and pathological (e.g. the "obesity epidemic" discourse), that is as exclusive objects of biomedical scrutiny, are the result of a specific western frame and worldview. These situated conceptualisations are in turn shaped by global and local economic and political systems. In this thesis, I critically approach obesity as a category whose social, cultural and political production is embedded within particular economic and political structures, the most important being neoliberalism (see Warin et al., 2008; Warin, 2010; Yates-Doerr, 2015; Gàlvez, 2018) and austerity (see Strong, 2017). This allows to look at the production of global diagnostic categories like obesity and public health interventions such as healthy lifestyle campaigns, as processes that have the potential to (re)produce stigma, and socioeconomic and health inequalities (see Clarke in Unnithan and Tremayne, 2011; McCollough & Hardin, 2013). This thesis builds on this awareness in exploring the unintended and stigmatising consequences (Bombak, 2014) of the 'obesity epidemic' discourse.

It follows that my understanding and interest in obesity and fatness is strongly shaped around critical approaches to biomedical categories, practices and technologies and their medicalisation of fatness through which sociocultural structural factors are naturalised, set aside and hidden underneath the urgency of a health epidemic. This calls for awareness on the relevance and importance that moral judgement and body size ideals play in biomedical settings when weight and diet are at stake and on the effects they might produce. For example, the urgency with which obesity is addressed, is characterized and broadly justified by the fact that it constitutes a risk for other diseases (e.g. Type 2 diabetes and heart disease); the centrality of individual responsibility in conducting healthy lifestyle is deemed to play a key role in effectively treating obesity. This reflection is linked to the aforementioned issues of stigmatization and moral judgment in the obesity epidemic and the ways it shapes fat subjects.

Building upon the literature cited above, interesting clinical ethnographies have been produced in the last decade with a specific interest in obesity-related policies and how they are performed at local level. Australia, Canada, USA and the UK are privileged sites for these works: here I will focus primarily on the latter, as it is more relevant for my fieldwork. The main, transversal aim of these contributions is an investigation of socioeconomic factors in shaping individual experiences of obesity and the role these factors play in biomedical settings and health policies. Embodiment (see Csordas, 1990), *habitus* (Bourdieu, 1977; 1984), gender and class are key concepts used to reflect on these issues, and narrative analysis the privileged methodology to analyse data. One of the main outcomes is the deconstruction of taken-for-granted concepts on obesity, revealing the limits of individualised, simplistic biomedical categories, reiterated in anti-obesity health programmes, by critically addressing the influence of social and economic contingencies of everyday experience. In other words, by “demonstrating the ways in which obesity is enmeshed in participants’ taken-for-granted, everyday practices” this research “problematize the universality of health-promotion messages” (Warin et al., 2008, p.97). Work conditions, social status and family roles become the angle from which critically investigate “the ways in which largeness is embodied, experienced and articulated within gendered and class-based lifestyles” (Ibid. p.98). Such a reflection also highlights the inequality, not always openly recognised, with which men and women are targeted by anti-obesity discourses.

### **3.2.1 Social status and gender in embodied experiences of largeness**

As we have already seen, the impact of social ideals of slimness and slenderness on women’s identities has been studied by social scientists and mostly in feminist literature for at least three decades (Orbach, 1978; Wolf, 1990; Bordo, 1993; Lupton, 1996). This literature is the starting point for recent researches on clinical narratives and practices of obesity that reflect more specifically on fatness, motherhood and childhood obesity. Being obese has been identified as a main risk in child bearing (NAO 2001) on two levels: it is deemed to increase threats for the health of the foetus and the pregnancy itself (Heslehurst in Unnithan and Tremayne, 2011); moreover, some data seem to show the higher incidence of obesity in children with obese parents (Foresight, 2007). Literature has shown that the ways in which health policies address maternal obesity can be understood only by reflecting on how “experiences of maternity are being shaped by (...) biomedicine and public health” (Unnithan and Tremayne 2011, p.2). It is also important to reflect on the construction of women’s social identity as primarily linked to motherhood (Bordo, 1993; Unnithan and Tremayne, 2011) and their family role, for example as responsible for the meals of all family (Lupton, 1996; Warin et al., 2008). In fact, in health policies

and obesity science “gender stereotypes about responsibility for feeding children are very much at play and invariably”, perpetuating moral judgment and female bodies standardisation in biomedical settings (McNaughton, 2011, p.180).

Interestingly, in a study researching healthcare professionals’ perception of the impact of maternal obesity on clinical services in the UK, the main, identified concerns are about costs, “complications that arise and the impact on the health of the mother and her infant (...), difficulties in carrying out certain procedures, and the impact on the psychological health of the mother” (Heslehurst et al., 2007, p.341). Identity, gender and socio-economic issues in the recounts of healthcare professionals are medicalised under the general category of “psychological health”; reflecting on this gap produces interesting insight on how power, biomedical practices and knowledge are negotiated in the everyday reality of the clinic and it will be central in my analysis of obesity management in primary care. Gender and socioeconomic status are also at the core of a more recent body of work on the impact of fat talk and treatments on men and negotiation of masculinity (Gill, Henwood, and McLean, 2005; Bell and McNaughton, 2007; Monaghan, 2008; Monaghan and Malson, 2013). The most original and interesting outcomes of this area of research show that men tend to positively talk of their overweight in terms of “big” and “bigness” as desirable, male characters. This positivity is however contexts-bounded and becomes critical or discriminating in certain social settings, for example in white, heterosexual and middle/upper-class environments. Moreover, in their narratives, men targeted as obese or overweight tend to construct masculinity in contrast to femininity: women are described as more vulnerable to body ideals since the cultural oppression to embody slenderness is more pressing on them than on men (Monaghan and Malson, 2013). In so doing, “men underscore(d) the (culturally enforced and/or ‘naturally’ psychological) gendered inequalities of body ‘ideals’ and weight concerns, rendering the public issue of obesity and associated private body troubles generally ‘worse’ for women and girls” (Ibid. p.317).

### **3.2.2 Biopolitics of the ‘obesity epidemic’**

The importance of Foucault’s (1976; 1980) concept of biopower in these works is evident as well as the contribution of authors like Rose and Beck in outlining the features of a medicalised ‘risk society’. The Foucauldian theory of biopower is a theoretical landmark for researches in social sciences that investigate bioscience and biomedicine as a ubiquitous, legitimate knowledge that shape, govern and normalize people lives, bodies and selves. Foucault’s notion of biopower is linked to the philosopher’s interest to understand the increasing involvement of states into

medical surveillance. The term refers to state's concern with and surveillance of the health, longevity and efficiency of the population to ensure nationhood and a healthy, productive workforce within capitalism. The centrality of the concept of risk in the obesity epidemic discourse is also evident and need to be critically addressed. The modern concept of risk is a product of modernization and its main paradigm (Beck, 1992; Giddens, 1991): post-industrial societies are characterized by the production of wealth using science and technology as an answer to former scarcity; consequently, risks are produced along and the distribution and management of risk have become a distinctive feature of modernity (Beck, 1992). As we have already seen, risk has also become a leading ideology in health care policies and in the ways in which we understand health, with important consequences on the role of individual responsibility in avoiding at-risk behaviours (Crawford, 1977).

Using the lens of biopolitics allows us to understand how the "obesity epidemic" is "one of the most powerful and pervasive discourse(s) currently influencing ways of thinking about health and about bodies" (Wright in Wright and Harwood, 2009, p.1). Looking at the strong relation between power and subjectivities is fundamental to comprehend how the strong use of normalizing, monitoring bodily practices and language in health policies, intervention programmes and public media, is adopted from the clinical contexts and how these practices and languages have a strong impact on how individuals perceive, think and work on their bodies and selves. It is then precious to engage with this pivotal body of work to show the powerful symbols, meanings and bodily techniques (re)produced by hegemonic discourses of healthy weight and their impact on daily life of people, the way we understand, value and work on our bodies following that set of knowledge and practices.

This approach has proved very useful in analysing national policy and guidelines related to obesity as well as weight-loss programmes and individuals' interventions on and comprehension of bodies and weight. Since the beginning though the fieldwork has powerfully shown some limits of this approach: how about the economic and health inequalities present at a local level and their impact on bodies? And how can they be connected to wider, structural factors?

There is also space in the literature to investigate further health professionals' emotions and experiences of dealing with fatness, obesity, diet and social stigma. Moreover, to investigate the impact of specific organisational and administrative factors in local contexts on the ways in which health professionals manage and perform obesity in their clinical routines and the impact these specific systems have in shaping experiences and emotions of professionals and patients.

Authors that apply a bio-political approach to the study of the obesity epidemic have produced a fundamental contribution to the literature. By foregrounding the role of power and subjectivities, these works have emphasized the role of obesity science in influencing other contexts outside the clinical domain. Through the concepts of biopolitics and biopower, these contributions support Wright's idea that the so-called obesity epidemic has become one of the authoritative discourses to define and think about health (Wright in Wright and Harwood, 2009). The 'truths' of the obesity epidemic, as they are re-contextualised in government policy, health promotion initiatives, web resources and school practices inform how people come to know their bodies and selves from a very young age (see Wright and Harwood, 2009; Greenhalgh, 2015). Harwood uses the term biopedagogies to indicate "the normalising and regulating practices in schools and disseminated more widely through the web and other forms of media, which have been generated by escalating concerns over claims of global 'obesity epidemic'" (Harwood in Wright and Harwood, 2009, p.23). I draw on this concept in my analysis of 'biopedagogies of healthy eating' that I present and discuss in detail in Chapter Seven.

Two outcomes are very interesting for my research: the strong use of normalizing, monitoring bodily practices and language in health policies, intervention programs and public media, adopted from the clinical contexts and how these practices and languages have a strong impact on how individuals perceive, think and work on their bodies and selves. Recent works by Vogel (2016;2017;2018) on weight-management in Holland expand this discussion and line of enquiry with important insights on healthy eating and mindfulness that I will draw on when exploring weight-loss programmes. Aware that the popularisation of science is a distinctive trend in contemporary societies (Fox Keller, 2000), I will reflect on practitioners' views and perceptions of the use of 'biomedical truth' on obesity in public media and health policies. For example, do they think that the popularisation of nutritional information influences their work and relations with patients? I will also investigate the role 'biopedagogies' have in local clinical realities. Since they are so powerful in shaping the ways people think of themselves, what other, alternative discourses do they leave aside or de-legitimate? What kind of subjectivities and relationships they promote? For example, does basing diagnosis exclusively on body measurements such as BMI and treatment on bodily practices such as diet and physical activity, minimize the role of other important socio-cultural, emotional and contingent factors? I also intend to give a vivid testimony of the diversity of voices that populate obesity management settings, questioning the imaginary of biomedicine, and in particular nutrition, as a homogeneous entity (Good, 1994), imaginary not critically addressed or even re-proposed by this body of works.

Recently, Susan Greenhalgh (2012; 2015) has studied the influence of what she calls the ‘U.S war on fat’ on young people in OC, California, examining this campaign “as a biopolitical field of science and governance that has emerged to manage the ‘obesity epidemic’ by remaking overweight and obese subjects into thin, fit, proper Americans” (Greenhalgh, 2012, p.473). The obesity epidemic campaign has introduced health as the authoritative, exclusive category to talk about and understand fatness, producing a ‘bio-discourse’, that is “a veritable epidemic of fat talk in which public and private discourse increasingly target weight as a matter of concern, lament, ridicule, and much more” (Ibid. p. 472). Moreover, the main outcome of such “fat talk” seems to be the broadly accepted imaginary that slim, “perfect bodies bring perfect lives” (Ibid.) with a clear, powerful shift from the biological realm of health to the social field of moral judgment. Again, Greenhalgh’s work reveals the socio-political implications of biomedicine in shaping subjects and subjectivities. In my research, I aim to critically address the role of moral judgment in clinical contexts: if it is true that “fat talk” permeates our societies and understanding of bodies, personhood, health and responsibility, what role does it play in shaping local clinical realities and narratives? Do GPs, nurses and other actors involved in treating obesity (e.g. weight loss groups’ leaders) reproduce this “fat talk” in clinical contexts? In other words, I propose to step the way backward, from diverse social domains to the clinical one, and investigate moral judgment in local health care activities and narratives.

The entanglement of “bio-scientific truth” and common sense (Gard and Wright, 2005) in shaping public narratives in contemporary, capitalistic societies (Beck, 1999; Fox Keller, 2000; Gard and Wright, 2005; Greenhalgh, 2012) has been object of study for social researchers from different disciplines such as sociology, education and health sciences. The “obesity epidemic” represents a fruitful field to reflect on the “scientification” of public discourse: “what scientists say about overweight and obesity is important because the public picks up pieces of scientific information, usually from media reports and commentaries and incorporates them into their existing beliefs about the world” (Gard and Wright, 2005, p.10). Moreover, in the current discourse on fatness, scientific information has had a key role in enhancing social stigmatization (Gard and Wright, 2005; Greenhalgh, 2012; 2015).

### **3.3 Multiple obesities and enactment**

Mol’s (2002) work on the ‘body multiple’ investigates multiple enactments of atherosclerosis in a clinical context, bridging philosophical investigation to ethnographic methodology. In her ethnography of day-to-day diagnosis and treatment of atherosclerosis in a Dutch Hospital, Mol



reflects on the multiple ways in which the disease is “enacted in practice” (Ibid., p.152) in different places and by different actors within the same hospital.

I present Mol’s work in this dedicated section because of the relevance it has for my theoretical and methodological framework and the original contributions its application has yielded in my research. I also consider this work a powerful contribution to a critical medical anthropology more broadly as it questions the physicality of disease as exclusive domain of biomedical enquiry and expertise. Instead, this work shows that ethnography can investigate diseases and not just the experiences, meanings and discourses produced around them. The reference to the distinction between disease, a physical condition that is competence of biomedicine, and illness, defined as the patients’ experience of a disease (see Kleiman, 1980), is clear. This distinction was first introduced by medical anthropologists in the late 1980s and it has since been problematised and criticised for its uncritical approach to biomedicine. The seminal article by Scheper-Hughes and Lock (1987) on the ‘mindful body’ (presented in the previous section, 3.2) is an example of this criticism. Nonetheless, I argue that in anthropological approaches to obesity there is a tendency to focus on the meanings and discourses produced by different perspectives and experiences around obesity and to leave the object itself, obesity, ‘only looked at’ and ‘untouched’ (Mol 2002, p.12). In this thesis, I bring the focus of analysis into the object by looking at how obesity is enacted. I argue that exploring the ways in which different actors *do* obesity *in practice*, allows for an ethnographic understanding of the *object* obesity that questions and problematises the hegemonic conceptualisation of obesity as a uniform, biomedical entity.

Before presenting Mol’s conceptualisation of practice and enactment in detail, I will briefly introduce the concepts of practice and discourse as discussed respectively by Bourdieu and Foucault. These concepts shape my approach to obesity management in this research and influence my engagement with Mol’s approach to explore ‘disease in practice’ (Ibid.). Bourdieu’s concept of habitus informs social science understanding of practice as everyday social-and-bodily actions that inscribe social meanings into bodies and in turn reproduce them. Bourdieu defines habitus as

systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations which can be objectively “regulated” and “regular” without in any way being the product of obedience to rules (Bourdieu, 1977, p.72).

Habitus describes the implicit practices and routines that structure the logic of everyday life (Ibid.). “To acquire habitus is to acquire means of knowing, handling and dealing with the world”

(Crossley, 2013, p.139) that is, to acquire a “practical comprehension” that is socially shared and that “causes practices to be immediately intelligible and foreseeable, and hence taken for granted” (Bourdieu, 1977, p. 80). The acquisition of habitus, that is, of shared, “lasting, transposable dispositions” (Ibid., p.82) and practical comprehension, passes through the body, it is embodied as “the actor incorporates social structures as habitus and perpetuates them, by force of habit, in their practices” (Crossley, 2013, p.141). Moreover, Bourdieu argues that these shared dispositions reproduce social structures and stratifications, such as class identity (Bourdieu, 1984), and function as a “matrix of perceptions, appreciations and actions” (Bourdieu, 1977, p.83). When studying obesity, habitus represents a fruitful “empirical prompt” (Wacquant, 2014, p.6) to approach everyday food, eating and bodily practices as socially shared, embodied, and taken-for-granted dispositions that reproduce and “relate to one’s social class, gender and identity” (Warin et al., 2016, p.64). Furthermore, habitus is malleable, adaptable to change and subject to be constantly altered, although never radically, by new experiences (Wacquant, 2014; Warin et al., 2016). As Wacquant (2014) notes, Bourdieu first introduced habitus “in order to account for cultural disjuncture and social transformation” (p.6). Hence, I suggest that using this concept to investigate obesity management also allows for an understanding of how practices are adapted, altered, tinkered with by relevant actors in day-to-day interactions.

Despite my engagement with habitus and the understanding of practice as embodied, I am aware that Mol (2002) does not refer to Bourdieu’s concept of habitus or practice in her work. A possible explanation for this might reside in Mol’s attention to the materiality of practice in doing diseases and the fact that the concept of habitus “does not include the materiality of the body” (Warin et al., 2016, p.64). Nonetheless, I maintain that it is possible and fruitful to apply this understanding of practice as embodied and expand it through the recognition of materiality - bodies and objects - as central to the ways in which clinical entities, for example obesity, are brought about in practice. In exploring obesity in this thesis, I draw on habitus to frame and approach the ways in which GPs, practice nurses, weight-loss group participants and leaders carry out and bring about obesity management.

In her discussion, Mol (2002) draws on the philosophical tradition of pragmatism to frame her understanding of medicine as practice and the multiplicity inherent to this practice. She also draws on Foucault’s idea of discourse and more recent interpretations of this concept to outline medical knowledge and practice as situated. In particular, she refers to Law (1994) in suggesting that we should look at discourses in the plural rather than the singular and consider them ‘order

attempts' rather than orders. Moreover, and most importantly for Mol's work, Law affirms that scholars should look at how discourses are "performed, embodied and told in different materials" (Law, 1994, p. 95 in Mol, 2002, p.69).

In my analysis, I follow Mol in drawing on Foucault's analysis and approach the 'obesity epidemic' discourse as a "discursive practice" in which "knowledge" and 'truth' about obesity, weight, health and responsibility "is formed and produced" (Hook, 2001, p.522) and I maintain that "what counts as 'the truth' is a product of discourse and power" (ibid. p. 524). The power of this discursive practice has the effect of making "virtually impossible to think outside of" it (Ibid.). The 'obesity epidemic' discourse has the power of delegitimising as 'not true' and silencing other possible explanations and understandings of obesity, weight, health and responsibility that do not conform to it. In the previous section 3.3.2., I have discussed some of the limitations of the literature that analyses the 'obesity epidemic' discourse, here I reflect on the possibility and benefits of using Mol's attention to multiplicity and enactment without dismissing a Foucauldian idea of discourse. I maintain with Hook (2001) that Foucault's conceptualisation of discourse is inclusive of the materiality and power relations that form and inform it: "in every society the production of discourse is at once controlled, selected, organised and redistributed by a number of procedures" (Foucault, 1981 p. 52 in Hook, 2000 p.522). In fact, Foucault affirms that there is a 'whole strata of practices' that underlies the production of truth (Ibid.), therefore suggesting that a discourse, its power and truth, are produced through "institutions, social structures and practices that (...) both reinforce and renew it" (Ibid.).

I consider biomedicine and nutrition, public health policy and healthcare systems an important part of the strata of practices that produce the discourse of truth (i.e. the 'obesity epidemic' discourse) on obesity. I add that these discursive practices also mobilise and function through embodied dispositions, or habitus, around food, eating, exercising, and measuring that make the instances of the obesity 'epidemic discourse' taken-for-granted, intelligible and sensible. Embodied practices produce not necessarily a 'regime of truth' but a more mundane and pervasive "commonsense world endowed with the objectivity secured by consensus on the meaning (sens) of practices and the world" (Bourdieu, 1977, p.80). I add that the embodied quality of this 'commonsense' passes through specific objects and acts, and to paraphrase Law (1994 in Mol, 2002) as cited above, is told in different materials – such as, bodies, utensils, packages, clothing, and paperwork. Therefore, I suggest that the materiality and practices through which obesity is produced and enacted become a central focus of analysis and show the theoretical and methodological possibility of merging a focus on the ways in which obesity is

done in practice with an attention to the power/knowledge hierarchies of the ‘obesity epidemic’ discourse, being one an integral part of the other.

In Mol’s approach to study atherosclerosis, the terms enactment and practice are interlinked, as “in practices objects are *enacted*” (Ibid. p.33). In fact, she argues for a theoretical and methodological approach to investigate clinical entities - or objects, in Mol’s words - that attends to the ways in which a specific disease is done in practice (i.e. enacted) rather than to the production of knowledge around that object and its validity. By applying this approach to the study of obesity, I intend to investigate how this specific object is enacted, that is how it is “made visible, audible, tangible and knowable” (Ibid.) in daily routines and encounters of obesity management. I approach obesity management as a practice, that is, as a set of “knowledge incorporated in daily events and activities” (Ibid. p.32) and carried out through particular material objects (e.g. scales, metres, food diaries, plastic foods, clothes) and procedures (e.g. clinical referrals). This means that my interest lies not only on the different ways in which research participants talk about and experience obesity management, but also on the activities, objects and procedures they engage with to manage obesity. It is evident that the influence of Mol’s work on my research is both theoretical and methodological. For example, in my fieldwork and analysis, I focus on how weight and BMI are measured and controlled using scales, metres, BMI charts and clothes; how food is talked about and handled using portion sizes, bowls, hands and palms.

I consider the application of Mol’s concept of enactment to the practice of obesity management a major contribution to the literature as it expands the understanding of the *object* obesity itself. This is an important contribution to a body of works that, to paraphrase Mol (2002), leaves obesity untouched. I refer to the fact that existing literature on obesity tends to focus on the production of the ‘obesity epidemic’ discourse (see section 3.1, 3.2.1 and 3.2.2) and on varied, and often competing, experiences of obesity and fatness (see sections 3.1, 3.1.1 and 3.4). In my research, looking at how obesity “*becomes a part of what is done in practice*” (Ibid. p.13) has revealed a fruitful way to explore what this object we call obesity is<sup>18</sup>.

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<sup>18</sup> I propose that addressing this question through the suggested theoretical and methodological framework is particularly relevant for obesity that, unlike atherosclerosis, does not have an unanimously accepted definition in the biomedical and healthcare communities. In fact, obesity is commonly defined as a risk factor both in biomedicine and public health, although in 2013 the American Medical Association (AMA) designated obesity as a disease diagnosed through BMI, with

This contribution is further expanded through the concept of the '*body multiple*' (Mol, 2002), which describes the multiplicity inherent to disease entities that are often presented as uniform biomedical categories. Mol clarifies how atherosclerosis is multiple but not plural. In fact, the concept of '*body multiple*' describes "a single disease that in practice appears to be more than one- without shifting into pluralism" (Ibid., p.150) and shows that the disease "enacted and practices of diagnosing and intervening belong together. They are intertwined" (ibid., p.159). In fact, she notes:

there are different atheroscleroses in the hospital but despite the differences between them they are connected. Atherosclerosis enacted is more than one— but less than many. The body multiple is not fragmented. Even if it is multiple, it also hangs together. The question to be asked, then, is how this is achieved. How are the different atheroscleroses enacted in the hospital related? How do they add up, fuse, come together? (Ibid.p.55)

It is through looking at the different enactments of atherosclerosis that Mol develops her conceptualisation of atherosclerosis as multiple. For example, she describes how the definition and description of atherosclerosis change when it comes from a patient, a haematologist or a dietician, and maintains that each defines and describes a slightly different object to which they refer with the same name, atherosclerosis. Moreover, she clearly shows how these multiple definitions and descriptions are produced through and by specific objects, procedures, events that characterise the context within which atherosclerosis is enacted. The following quote exemplifies this argument:

The practices of enacting clinical atherosclerosis and pathological atherosclerosis exclude one another. The first requires a patient who complains about pain in his legs. And the second requires a cross section of an artery visible under the microscope. These exigencies are incompatible, at least: they cannot be realized simultaneously. This is not a question of words that prove difficult to translate from one department to the other. Surgeons and

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traits of chronicity and not-communicability to it (see Pollack, 2013 and Stoner and Cornwall, 2014).

This decision has raised some praises and many aversions in the biomedical and healthcare communities; for example, the AMA Public Health and Science Committee advised against this definition (Stoner and Cornwall, 2014). The recognition of BMI as an 'imperfect tool to classify obesity' (Ibid. p. 462) and the attention to evidence that 'suggests individuals may be fat but fit' (Ibid. p.463) are two of the main arguments to those who oppose this decision. In the biomedical and healthcare sites of this research, obesity is officially described as a risk factor. From an anthropological approach, understanding how obesity is defined, both in theory and in practice, is important as the designation of a disease implicates specific "diagnostic, curative and preventing strategies to fall into place" (Jutel 2006, p. 2268) and consequently produces specific subjectivities.

pathologists who talk with one another tend to understand each other very well. It is not a question of looking from different perspectives either. Surgeons know how to look through microscopes and pathologists have learned how to talk to living patients. The incompatibility is a practical matter. It is a matter of patients who speak as against body parts that are sectioned. Of talking about pain as against estimating the size of cells. Of asking questions as against preparing slides. In the outpatient clinic and in the department of pathology, atherosclerosis is done differently.” (Ibid.pp.35-36)

In exploring obesity management in this thesis, I focus on the interrelations between obesity as a diagnostic category, an embodied experience and a practice and contend that obesity is multiple. Whilst Mol investigated different enactments within one site, I explore how obesity is enacted within and across multiple sites – the clinic, weight-loss groups and fitness classes.

Building on Mol’s work, Throsby (Throsby, 2012) has applied the idea of body multiple to the study of obesity surgery in the UK, noting:

it is also possible to extend the concept of the body multiple outside of that context – particularly in the case of obesity, which, unlike atherosclerosis, is constantly being enacted, re-enacted and reconstituted both within and outside the medical context in quite vociferous ways (Ibid. p.3).

Indeed, I argue that it is necessary to investigate non-clinical settings where obesity is also addressed and treated and analyse them in connection to clinical, formal settings as interconnected realities. Moreover, Throsby notes that

these multiplicities are distributed across different locations, separating out potentially conflicting obesities, but between which there is a constant flow, reinstating the body multiple, rather than a pluralistic body of clashing incompatibilities (Ibid.).

My aim is to focus also on the similarities within multiplicity that make this flow possible and not only on the multiplicity itself: focusing on the direction of the flow is a powerful way to address the power relation at work in the social and clinical making of obesity. Indeed, I believe that these contributions lack in addressing the power relations at play in the enactment of obesity in different settings; hence, I argue that a critical anthropological approach can not overlook these relations and it is by reflecting on why and how the flow goes in a certain direction rather than another that power dynamics and knowledge/power hierarchies are unravelled. These contributions excel in highlighting the multiplicity enacted in medical care but tend to overlook the role of hegemonic discourses in informing such multiplicity. Therefore, in this thesis I contribute to further the use of this approach in critical anthropological studies of obesity and

disease in general. I add that this approach must interrogate further the knowledge/power dynamics and hierarchies that make the 'body multiple' hang together rather than fragment into plurality (Mol, 2002). In other words, I propose that in studying obesity it is necessary to further interrogate the role that the hegemonic 'obesity epidemic' discourse and the public health programmes and interventions that promote it have in making the 'body multiple' to 'hang together'.

In an ethnographic study conducted between 2012 and 2014 in a disadvantaged suburb in South Australia, a team of anthropologists has explored "the meanings and enactments of large bodies that resist dominant social imaginings of fat as deficit" (Zivkovic et. al, 2018, p.373). Applying Mol's concept of 'body multiple' to the study of individuals' experiences of public health interventions on obesity in that specific community, the research shows multiple meanings and enactments of health. It details how fat is enacted as productive and positive by different social actors whilst highlighting the normativity of a public health discourse on fat. In this thesis, I extend this discussion by looking at multiple sites of obesity management in the UK and at multiple meanings and enactments of obesity within and across these sites. By approaching primary care and public health policy as sites of my analysis, I aim to look at the multiplicity that populates authoritative discourses and sites around obesity, which often tends to be represented as monolithic and uniform.

### **3.4 Moral stigmatization in doctor-patient encounter and public health policy**

Another important contribution to the literature is the reflection on stigmatisation and the role of moral judgment in the doctor-patient encounters when weight-related issues are at stake, highlighting that "through interaction the doctor and patient collaboratively construct obesity as a moral issue" (Webb, 2009). We can read the morality at work in obesity-related consultations as the outcome of the definition of obesity as a medical condition. In fact, obesity treatments target lifestyle behaviours, promoting diet and physical activity, and therefore rely on patients' responsibility: consultations turn into a trial of patients' commitment to cure (Silverman 1987 in Webb 2009) and this is where moral judgment comes into play. At the same time, fatness is morally despised by modern societies that foster a positive idea of thin bodies as the healthy, desirable symbols of capitalistic values: self-control and hard work (Bordo, 1993; Sobal 1995 in Sobal and Mauer, 1999). Furthermore, stigmatisation has a prominent role in new public policy and research on anti-tobacco and anti-alcohol campaigns represents a paradigmatic example to think about 'obesity epidemic' for critical social scientists (Bell, Salmon and McNaughton, 2011). A critical approach to public health policies in neo-liberal societies has highlighted that "the new

public health is characterised by an intense concern with the health status of populations (Peterson and Lupton, 1997 in Bell, Salmon and McNaughton, 2011) and its focus is increasingly on lifestyle, individual responsibility and self-control: the obesity epidemic discourse is paradigmatic of this trend (see Bombak, 2014). My research is an original contribution to understanding processes of social stigmatization in obesity management. In fact, it reveals how stigma can be (re)produced not only as a consequence of discursive assumptions of contemporary health policies but also as the result of practicalities characteristic of a specific health care setting. For example, in my analysis I reflect on how processes of stigmatisation can be located in practical aspects such as the average duration of a GP visit, the number of patients to visit within a day, and the amount of forms to fill in.



## **4. Cultures of preventing and managing obesity in public health and primary care**

In this chapter, I will briefly present the structure of the NHS and of primary care and will give an overview of recent changes in the relations between public health, health promotion, and primary care. This description intends to frame the context where cultures of obesity management and prevention are produced. It also intends to outline the organisational factors that the health professionals I interviewed address when talking about obesity management.

I will present an overview of the structure of the NHS, as it is relevant to frame the English National Health Service in its specificity of local healthcare system, politically, economically and historically situated. I also analyse the enactments of obesity and healthy lifestyle in public health. For over two decades, obesity has been produced as an urgent concern of public health to address primarily through promotion of healthy lifestyle and weight-loss interventions (see Wright and Harwood, 2009; Cohn, 2014; Warin, 2018). It is relevant to outline the bodies that oversee and produce public health and health promotion guidelines within the NHS and their connections. These bodies constitute institutional sites where obesity as a clinical and social category is produced and where causes as well as areas of interventions are identified and prioritised to shape obesity management. Moreover, these bodies and structures are also an integral part of the work experiences of practice nurses and GPs I interviewed and important factors in shaping local access to health services related to weight management. Therefore, I will briefly describe the structures within the NHS which are more relevant to understanding obesity in my field sites. I will then move to discuss GPs, and practice nurses' understandings of the causes of obesity, how they relate to those identified in public health policy and how they inform their own emotions and approaches to managing weight in clinical encounters with patients.

#### 4.1 UK health system: NHS health services and primary care



Figure 3. Olympics opening ceremony. London, Olympics Stadium, 2012.

Every time I paused to think about how to describe the NHS as the context of my research, a memory in a sequence of images would come to my mind.

It is the image of volunteers dressed as mid-century nurses, doctors and patients dancing around hospital beds to finally form a white,

shining NHS sign at the centre of the Olympic Stadium during the opening ceremony of the London Olympics game in 2012. Little I knew at that time that few years later the English NHS would be an important part of my research. As a spectator from a country with a similar public national health service, I found the choice<sup>19</sup> of showcasing a tribute to the English National Health Service in the opening of Olympics game, quite peculiar. As a social and medical anthropologist, instead, I found it intriguing.

As I found later, in 2012 the structure of the NHS was undergoing a phase of important and strongly debated reforms proposed and implemented through the Health and Social Care Act 2012. The changes and public debate induced by this reform define the healthcare system and climate in which part of my fieldwork took place. Some of the structures and bodies<sup>20</sup> that have been reformed in 2012, have a key role in producing the obesity-related practices and policies analysed in this research, as I will present in this chapter.

In England, the National Health Service began on the 5<sup>th</sup> of July 1948 as part of the nationalisation of many services and goods undertaken by the Labour party in the aftermath of the Second World War (Rivett, G.,1997). The NHS Act (1946) introduced for the first time in the UK a comprehensive health service available

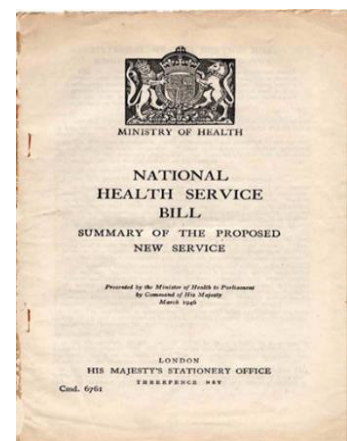


Figure 4. The National health Service Bill, 1946

<sup>19</sup> The performance was directed by the English film director Danny Boyle

<sup>20</sup> Such as the National Institute for Health and Care Excellence (NICE) and Public Health England

to all, free at the time of need and financed from taxation, which aimed at “the improvement in the physical and mental health of people...and the prevention, diagnosis and treatment of illness” (Anon., 1946). The new National Health Service organised under the same umbrella a multitude of health services<sup>21</sup> existing until then and was organised in a tripartite structure which has been maintained up until today: family practitioner services (primary care), hospital services (secondary care) and community services which included vaccination, maternity clinics and midwifery. All three parts of the structures indirectly referred to the Ministry of Health, through different in-between bodies, such as the Executive Councils for Family Practitioner Services. The coordination and integration between different levels and elements of the health service has been main topic of discussion since its foundation (Taylor & Bloor, 1994) and subject to many reforms<sup>22</sup> over the years, although the key structural characteristics<sup>23</sup> of general medical services have remained largely unchanged.

The Health and Social Care Act 2012 is generally described as “the most wide-ranging and controversial reform to the structure of the NHS”<sup>24</sup> (Powell, 2017) since 1948. With this reform, new bodies have been created with a redistribution of responsibilities and a growing commissioning of the provision of public health services from the NHS to local authorities

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<sup>21</sup> For example, the Lloyd George’s National Insurance Act (1911) covered general practice for workers but not for their families or unemployed people and hospitals, the most heavily affected by the war, were either voluntary (self-funded) or municipal (public).

<sup>22</sup> Such as the integration of health services in districts with population of 300,000, in 1975, to take into account the increase in disease with multiple causes, treated outside the hospital. This was a first step towards the recognition of the relevance of public health and health promotion in the community. Another important reform carried out in 1989/1990, brought to a new GP contract that introduced financial incentives for health promotion in general practice (Taylor & Bloor, 1994; Rivett, 1998).

<sup>23</sup> Key structural pillar of general practice are that “services are GP-led (i.e. other staff within the primary health care team have generally been subordinated to GPs)”; GPs ‘contracts are negotiated nationally and “GPs form small businesses independently contracted to NHS” (Lewis and Gillam, 1999, p.5).

<sup>24</sup> At the higher level of this structure, it is responsibility of the government to decide how much money the NHS receives, and the Secretary of State for Health oversees the Department of Health. This Department has been partly reformed in 2012, mainly in terms of funding and responsibility for the day-to-day running of the NHS, which have been decentralised from a national to a local level.

(Powell 2016). Some of the structures that have been reformed in 2012, such as the National Institute for Health and Care Excellence (NICE), have a key role in producing the obesity-related practices and policies analysed in this research.

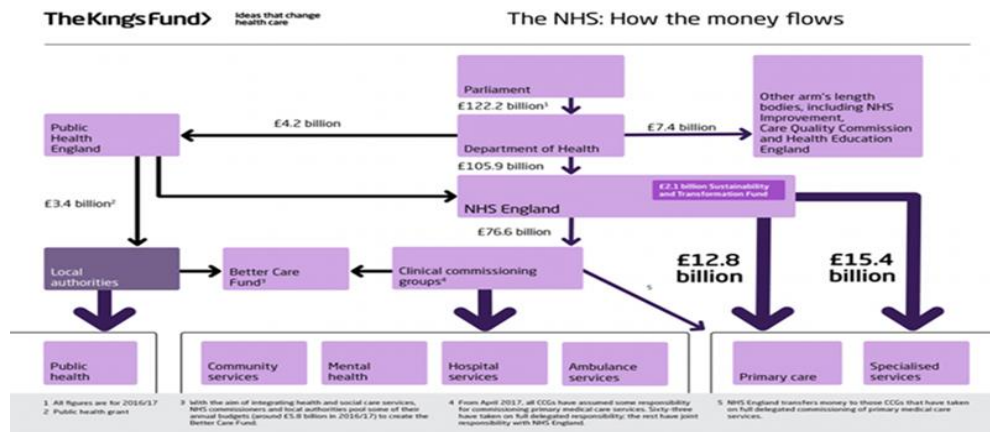


Figure 5. NHS structure and money flow after 2012 Reform

The main changes that directly impact on obesity management, can be summarised as follows: a shift of responsibilities where NHS England and Clinical Commissioning Groups (CCGs) took on statutory responsibility for commissioning health services and local authorities took on new public health responsibilities, and the creation of local Healthwatch (Powell, 2017).

Practically, these changes mean that the responsibility for identifying and delivering obesity-related interventions has been moved to a local level, through a process of 'localisation of responsibility' (Strong 2018), even though obesity is still identified as a main national concern for public health. By 'localisation of responsibility', I refer to the wider process of localism defined as a *"shift in policy making and practice to decentralise political power towards local institutions and local people"* (Wills, 2016 p. 7). Following Strong's research on food banks and localisation of responsibility, it is important to highlight how this process results not only in resources being shifted away from public institution but also in a transfer of accountability and ethical responsibility from state bodies and institutions to local communities (Strong, 2018). The localisation of responsibility within the context of this research describes a shifting of responsibilities for obesity management and promotion of healthy lifestyle from state institutions onto local authorities within a wider context of neoliberalisation<sup>25</sup> (ibid.).

<sup>25</sup> My understanding of localisation of responsibility has been shaped by researches made by social scientists and geographers (see Wills 2016 and Strong 2018) investigating austerity and inequality within neoliberal politics. Strong's ethnographic work on food banks in the UK is particularly relevant

I also suggest that acknowledging this shift is particularly relevant in the study of obesity due to the centrality given to individual responsibility in authoritative understandings of the causes and management of obesity. Since *“responsibilities are interwoven at a variety of scales and spaces as they become the subject and object of processes of power”* (Strong, 2018 p.4), it is important to pay attention at the institutional processes that inform the ways responsibilities are produced, understood and enacted in obesity management in the UK.

#### 4.1.1 Clinical Commissioning Groups

The Clinical Commissioning Groups (CCGs) are a result of the process of the localisation of responsibilities (Strong, 2018) promoted in the Health and Social Care Act 2012. They are a new local body comprising doctors, nurses and other professionals (e.g. lay person experienced in financial management) and have taken up the statutory responsibilities for commissioning the majority of NHS services. CCGs have the role of identifying local health needs and buying NHS, and/or private care accordingly, they are funded and supervised by NHS England<sup>26</sup> and every general practice has the duty to join the CCG for their area. They have an important impact on the organisation and availability of services related to obesity and weight management as well as on the access to them. In fact, both CCGs and NHS England have some shared statutory duties, some of them relevant to my informant’s working routine in the way they shape health professionals’ roles and responsibilities. For example, they are responsible for the access to health services, promoting wider patients’ involvement and addressing local

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in addressing how austerity is *“engendering new forms of responsibility that are unevenly distributed and performed—often by those already excluded, marginalised and impoverished”* (Strong 2018 p. 1). Despite the acknowledgment of an obesogenic environment, obesity is commonly explained as the result of unhealthy choices by the individual. The link between deprived areas and higher rates of obesity is also presented as a fact in scientific and public debate. There is space for further investigating how the localisation of responsibilities within a context of austerity in a neoliberal society impacts on people’s experiences of obesity and weight management and on the (re)production of sociomaterial inequalities.

<sup>26</sup> NHS England is a new body to which has been passed most of the finance from the Department of Health. NHS England has the key role of overseeing the commissioning, planning and buying of NHS services. For example, it is responsible for directly commissioning some services not covered by the CCGs at a national and regional level, such as specialised or general practice services when they are not delegated to the local Clinical Commissioning Group.

health inequalities, for securing constant improvement of the quality of the services and for fostering research and innovation.

The role of CCGs in everyday general practice and a sense of the wider discussion triggered by the 2012 reform, is well exemplified by Sean's comment. I interviewed Sean, a young GP working in Brighton and its surroundings, in a pub on his way back from work. We had been speaking for almost an hour, sipping our beer surrounded by the evening buzz of the pub, when Sean, asked about national campaigns related to obesity, ironically commented

well, I think the Tory government policy is to devolve responsibility for absolutely everything it can (laugh). It goes down to a local level where we call the CCG, do you know the CCG yeah? So each CCG is therefore the one responsible for patients' access to health sponsored programmes

I did know what a CCG is as I had identified the Brighton and Hove one as a likely point of access to general practitioners and practice nurses in my fieldwork. At the end of August 2015, I attended a public event organised by the local Clinical Commissioning Group on the commissioning of primary care. The public event took place in central Brighton on a Tuesday morning; GPs and members of the public, mainly patients and members of local organisations, met to discuss whether to opt for direct or delegated commissioning of primary care services, included GPs' contracts. My main reason for attending was to get in contact with prospective research participants, which did not happen in that occasion. Instead, I collected interesting data on the way CCGs operate, on the perception of public and patients' involvement, and on the focus on health inequalities in Brighton and Hove as a recurring concern for primary care. These inequalities were often exemplified using the different rates of type 2 diabetes throughout the town.

My interest for the use of type 2 diabetes by CCG members to discuss health inequalities derives from the fact that this non-communicable chronic disease is strongly linked with obesity. In fact, obesity is identified and described in public health and biomedical research as a major modifiable risk factor for type 2 diabetes. Moreover, both health conditions share similar explanations and interventions, such as the higher incidence of type 2 diabetes and obesity in people living in most deprived areas, the identification of lifestyle as a main cause for their onset and the consequent identification of weight management and healthy eating as privileged areas of intervention and treatment (see Adults with diabetes JSNA December 2010). The relevance of the data collected that morning to understand the wider frame of my field site, became evident

thanks to Sean's comment: whilst obesity was generally accepted as a key issue of public health, the structures and bodies responsible for addressing it were still in a phase of transition. In fact, the implementation of local responsibilities was still an ongoing process three years after the NHS Act was issued in 2012.

To summarise, Clinical Commissioning Groups are a new body created by the Health and Social Care Act 2012 and have statutory responsibility for commissioning the majority of NHS services at a local level. In the case of obesity-management, they are responsible for identifying needs, areas of interventions, services and stakeholders specific to obesity, nutrition and lifestyle in Brighton and Hove. They are also responsible for developing a local comprehensive weight management service from primary care to tertiary care. This means identifying and guaranteeing access to weight-management services, including the possibility for GPs to refer to weight-loss groups, such as LNPO programmes and Slimming World, as well as to surgery services. In this sense, Brighton and Hove CCG has a key role in shaping the type and quality of obesity-management services my fieldwork explores and their local integration. In identifying and commissioning these services, CCGs commit to follow the quality standards and guidelines produce by the National Institute for Care and Health Excellence (NICE). This body has been partly reformed by the Health and Care Act 2012 and has acquired statutory responsibility for developing guidance and quality standards for health and social care. NICE produces the guidelines on obesity prevention and intervention that inform both general practice and the weight-loss programmes where I did my research, setting priorities and policies for public health. For example, LNPO weight-loss programmes I volunteered in were designed following NICE guidelines on obesity, nutrition and healthy lifestyle.

Before moving to outline more in details NICE's role and national guidance on obesity in the next section, I want to highlight the importance of paying attention to the guidelines and criteria produced at a national level. Firstly, these guidelines contribute to the authoritative knowledge around obesity, its causes and solutions. They set out the relevance, focus, urgency and responsibilities in addressing obesity, informing specialised and public debate as well as personal experiences and understandings of health, obesity and lifestyle. Secondly, the criteria they set to evaluate the quality and efficiency of obesity-management services are normative but also contested. For example, in chapter five and six, it emerges that both healthcare professionals and weight-loss group leaders question the centrality of primary care in preventing and managing obesity, a centrality stated in national guidelines. Similarly, in chapter eight I will

discuss how guidelines' focus on weight as a measure of health and criteria of weight-management success is problematized by nutritionists and leaders in weight-loss groups.

### **The National Institute for Care and Health Excellence (NICE) and obesity management**

The National Institute for Care and Health Excellence (NICE) is the body responsible for publishing the quality standards that define what is high-quality healthcare and set the benchmark to evaluate CCGs' work and outcomes in quality of care. This institute was formed in 1999 as the National Institute of Clinical Excellence with the aim of reducing differences in the quality and availability of health services in England. In 2005, it took on the role of developing public health guidance for the promotion of healthy lifestyle. In 2013, the body took on statutory responsibility to develop guidance and quality standards in social care too and changed the name to National Institute for Health and Care Excellence (NICE).

The main function of NICE is to provide "evidence-based information for the NHS (...) on the effectiveness and cost-effectiveness of healthcare interventions" (Powell, 2017) and establishes guidance for mandatory technology appraisal. It is legal duty of CCGs and NHS England, as the two main NHS commissioners, to guarantee funding for the treatments and drugs necessary for the appraisals identified by NICE<sup>27</sup>. Clinical guideline 43 (CG43) is the first national guidance on obesity prevention, published in England in December 2006 and last updated in 2015. Here we read that "the clinical management of obesity cannot be viewed in isolation from the environment in which people live. (...) NICE continues to recognise the importance of an integrated approach to the prevention, identification, assessment and management of obesity" (NICE, 2006). This is an example of the recommendations given on the guidance page for obesity which is meant to inform health professionals' approach to weight and obesity:

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<sup>27</sup> NHS Improvement and the Care Quality Commission (CQC) are horizontal organisations to NHS England, directly subject to the Department of Health. The first body oversees all NHS providers and came into being in 2015 from the fusion of two previously distinct bodies, Monitor and NHS Trust Development Authority. Its primary focus is on finance and money management. CQC is an independent regulator, responsible for inspecting the quality of care both in the public and private sector. When standards aren't met, CQC has the power to take action through warnings, penalties, and cancellation of services or persecution of provider. This institute also publishes clinical and public health guidelines that commissioners are recommend but aren't required to implement at a local level.



1.1.2.1 Managers and health professionals in all primary care settings should ensure that preventing and managing obesity is a priority at both strategic and delivery levels. Dedicated resources should be allocated for action.

1.1.2.3 All primary care settings should ensure that systems are in place to implement the local obesity strategy. This should enable health professionals with specific training, including public health practitioners working singly and as part of multidisciplinary teams, to provide interventions to prevent and manage obesity.

1.1.2.4 All primary care settings should:

address the training needs of staff involved in preventing and managing obesity

allocate adequate time and space for staff to take action

enhance opportunities for health professionals to engage with a range of organisations and to develop multidisciplinary teams.

(...)

Delivery: for all health professionals

1.1.2.9 Health professionals should discuss weight, diet and activity with people at times when weight gain is more likely, such as during and after pregnancy, the menopause and while stopping smoking. (NICE, 2006)

I will use this guidance as part of the data, and I will then discuss it in more details in the following paragraphs. Here I just want to give an example of the kind of guidelines NICE produces and how they are presented.

To conclude, the localisation of responsibility (Strong, 2018) introduced with the Health and Social Care Act 2012 has resulted in the “*transferring responsibility for the provision of a range of public health services from the NHS to local authorities; the first time councils have had a statutory role in the provision of healthcare since 1973*”<sup>28</sup> (Powell, 2017, p:24). This change is particularly important in framing the field as it shapes directly the management of obesity-related services and the identification of national and local responsibilities, making local authorities accountable for promoting healthy lifestyle and addressing obesity as a public health issue. Treatments and guidelines to address obesity are identified and compiled at a national level, for example by NICE or Public Health England, in terms of public health research and with an advisory character. The implementation of such guidelines as well as the identification of specific local needs, the consequential choice of the most relevant interventions between those

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<sup>28</sup> Local authorities have also the statutory responsibility for Health and Wellbeing Boards (HWBs) which “oversee local commissioning, and the coordination of health and social care services” (Number CBP 07206, 7 July 2017, p.27). These boards produce documents on the social and health care need of the local areas which converge in strategy document aimed to guide and priorities the local commissioning of health services.

suggested, and the application of proposed guidelines in local general practices, is responsibility of local bodies, i.e. CCGs, and local authorities through a system approach, that is through the integration of networks of care, to obesity. This approach identifies the promotion of healthy lifestyle in primary care and referral to relevant weight-management services within the community as key strategies to prevent and address obesity. Since the role of healthcare professionals in promoting healthy lifestyle is a staple of public health and of the ‘obesity epidemic’ discourse, it is important to understand the slow incorporation of health promotion into general practice in relation to obesity over the past decades. This will help comprehend some of the tensions lived by the health professionals who participated in this ethnography.

## **4.2 General practice and the promotion of healthy lifestyles**

The GPs and practice nurses I met recount feelings of discomfort and disempowerment in talking about healthy eating, exercise and weight with patients whose BMI define as obese or overweight. They seem to suggest that promoting healthy lifestyle in general practice is not a straightforward and easy task as policies and guidelines suggest due to emotional, structural and organisational factors that shape the ways obesity is and can be discussed in clinical encounters. Before moving to analyse these factors and health professionals’ understanding of obesity in relation to lifestyle, general practice (chapter 4.4) and stigma (chapter 5), I want to outline how the promotion of healthy lifestyle has become a central aspect of public health first and obesity management later and it has gradually been integrated in general practice. In paragraphs 4.3 and 4.4, I will explore in more depth the construction of obesity in English public health policy and guidelines with a focus on the narratives of the causes of obesity and health professionals’ explanations of the “obesity epidemic”. The data I discuss in these sections were produced through a discourse analysis of public health documents as presented and discussed in the dedicated section of the methodology chapter in this thesis.

Here I want to focus briefly on how health promotion has become integral part of primary care in the UK to highlight some of the tensions experienced by health professionals around expectations of promoting healthy lifestyles and talking about weight.

Although becoming a major focus for public health since the late 1990’s when it was brought to international attention as an epidemic, obesity was already addressed in the early reports that have encouraged the development of public health and health promotion in the general health discourse, internationally and nationally. In these documents, lifestyle starts to be constructed as a matter of public intervention in the name of national health (see Rivett, 1998).

Today, promoting healthy lifestyles is one of the main roles recognised to primary care by public health guidelines and policies around obesity both nationally and internationally. In its call to action, WHO defined obesity as an ‘epidemic’ (1997, 2000) and major threat to public health internationally. National public health discourse and guidelines, which followed WHO call to action on obesity, adopt these definitions and the idea that primary health care is key in promoting healthy lifestyles. As discussed in the previous sections, with the Health and Care Act 2012 the focus on health promotion in primary care combines with the shift of public health responsibility to local authorities and commissioning of health services to local bodies (CCGs). The embeddedness of health promotion and education in general practice seems, at a first sight, a “taken-for-granted” of my field. Yet, the relation between health promotion and primary care has a history, and the way health education and promotion are integrated, or at least expected to be integrated, in primary care is quite a recent practice. This development intertwines national responses to international trends<sup>29</sup>. Two aspects of this development are particularly relevant to the context of my analysis: the production of the category ‘lifestyle’ in relation to obesity in public health and the integration of the promotion of a healthy lifestyle in the NHS primary care.

### **The Discourse on a Healthy Lifestyle**

In 1974, the Canadian Minister of National Health and Welfare produced a report titled “*A New Perspective on the Health of Canadians*”, known as the Lalonde Report, which paved the way to health promotion as central to both public health and health care systems<sup>30</sup>.

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<sup>29</sup> It is beyond the scope of this research depicting a thorough, historical account of the development of this relation in the NHS. Instead, I want to sketch some relevant passages and changes of this relation for three main, interconnected reasons: to contextualise the discourse of healthy lifestyle promotion in the NHS primary care, to promote a nuanced understanding of the (perceived) role of GPs and practice nurses and better comprehend some of the tensions they recount around responsibility in managing weight.

<sup>30</sup> The report had international relevance in shaping definitions of health, public health and health promotion, which are still accepted and working today. It introduces the concept of “health field” as formed by four main fields: human biology, environment, lifestyle and organisation of health care. This concept recognises that the health care system is one of the determinants of health but not the exclusive one and suggests that these four fields become the focus for public health, stating that both individuals and government must accept responsibility for health.

Some areas of interventions are identified in the report among which fat diet, obesity and lack of exercise are described as “part of the lifestyle of advanced, urban, industrial high-consumption societies” (in Rivett 1998, p.210). Obesity is already described as a public health concern and is described as a risk-factor proper of industrial, consumerist societies that produce what has subsequently been defined an ‘obesogenic environment’ (see Swinburn et al., 1999). It is important to notice how all these themes recur in the “obesity epidemic” discourse and strongly shape the current understanding of the causes of obesity, interventions and attributed responsibilities in public health policies produced in the UK in the last two decades. It is also important to notice that multiple explanations of the causes of obesity and consequent interventions coexist in public health policy, as I will discuss in section 4.3.

Nonetheless, the promotion of a healthy lifestyle conceptualised as the ability and willingness of the informed individual to make healthy choices, mainly in relation to eating and exercising, currently remains the main public health strategy to address obesity in the UK. This tendency to focus on individual health behaviours rather than on societal and political economic factors is not exclusive to obesity but it is rooted in the wider discourse on a healthy lifestyle. Over the years, the promotion of a healthy lifestyle has increasingly drawn on psychological and behavioural research to embed a behaviour-change approach as a key strategy. Implicit in this approach is the common understanding of behaviour as a rational individual choice which is measurable and then suitable to epidemiological description and analysis of health conditions. Health behaviours are then conceptualised as “the outcomes of an individual (...) determined (...) by motives, intentions, and the subjective reception of norms and cues” (Cohn 2014, p.159). The sum of health behaviours constitutes a person’s lifestyle. Lifestyle has become defined as “the discretionary activities which are a regular part of an individual’s daily pattern of living such as eating (both what and how much) (...)” (Maddox 1985 p.27 in Grace 1991, p.332). Promoting healthy lifestyle has then become primarily a matter of education and transmission of appropriate information, for example through nutritional education, to allow people to adopt healthy behaviours and lifestyle (see Swinburn, 2011; Cohn, 2014; Warin, 2018).

The individualisation of health behaviours, responsibility and agency in public health and clinical approaches to healthy lifestyle has produced an overshadowing of the sociomaterial, interrelational, affective and situational aspects of people’s actions (Cohn, 2014). Equally, it has produced a wide range of interventions that focuses more on changing individuals’ behaviours rather than addressing the underlying drivers and structural causes of the different health

conditions they are concerned with. In public health and clinical approaches to obesity, this has translated in high numbers of interventions targeted at promoting healthy behaviours and lifestyles and little effort to change the underlying causes of obesity, such as the production and distribution of food in a neoliberal global market and health inequalities (Cohn, 2014)<sup>31</sup>. This focus on the individual is authoritative and pervasive not just in public health, but also in research participants' understanding of obesity. For example, health professionals I interviewed, understand their roles as healthy lifestyle promoters in terms of conveying the right dietary information and motivation for patients to become healthier and lose weight. Moreover, they recount many tensions and challenges encountered in giving lifestyle advice and question the viability of general practice in managing weight-loss, as I will discuss in chapter five. Still they do not openly question or problematize whether promoting healthy lifestyle should be integral part of general practice. I read this lack of direct problematization as a sign of normalisation and integration of health promotion in current primary care. At this end, it is useful to outline briefly the process through which health promotion has become integrated into the NHS primary care.

#### **4.2.1 Health promotion in the NHS primary care**

The International Conference on primary health care organised by the WHO in Alma Ata, USSR, in September 1978, represents an important moment for the recognition of primary care as the privilege place to implement some of the key themes developed in the Lanlonde report (1974) described above. The declaration that followed, known as the Alma Ata declaration<sup>32</sup>, is considered a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of "Health for All" (Alma Ata 1978). It also states that governments are responsible for the health of their people and set the target to attain "by the year 2000 of a level of health that will permit them to lead a socially

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<sup>31</sup> "... cognitive strategies to combat overconsumption, such as weight-loss diets, can be successful for some individuals but are unlikely to be population solutions. Even weight-loss diets that are supported by trial data, such as high protein or low glycaemic index diets,100 might not be suitable as solutions for global obesity because of their detrimental effect on the environment (e.g., high meat protein diet 101) or staple food production (e.g., rice)" (Swinburn B. et.al 2011 p.809).

<sup>32</sup> This declaration is important under many aspects, one of which is the definition of health as a fundamental human right and as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (Alma Ata 1978).

and economically productive life” and identifies primary care as “key to attaining this target as part of development in the spirit of social justice” (Ibid.). At a national level, during the 1980’s some efforts were made in the UK to respond to international call on public health and change the limited culture of health promotion in the NHS (Taylor and Bloor 1994). The integration of public health responsibilities into primary care has been a long process.

A first passage has been the introduction of screening as responsibility of general practice: GPs were asked “to shift from dealing with illness to deal with health” (Rivett 1998, p.323). In 1990 a new contract for GPs was signed that introduced financial incentives for health promotion interventions in primary care. In practice, the aftermath of the new contract, didn’t see an immediate integration of health promotion into primary care; rather, it was segregated to special clinics and it was “hard to convert the rhetoric of health promotion into contractual language or guidance to GPs about what they should do” (Rivett, 1998,p.412). Two years later the government published the white paper “The health of the Nation” (1992), one of the first attempts at developing a policy approach to public health, as asked by the international community, and encouraging health promotion in the UK. In this document, seventeen areas of immediate action are identified: diet and physical activity are listed along with smoking and alcohol. Although reducing smoking and alcohol consumption catalysed public health attention in the 90’s, reducing “the average percentage of food energy derived by saturated fatty acids and from total fat” as well as reducing “the proportion of men and women aged 16-64 who are obese by at least 25% and 35% respectively by 2005” (in Taylor and Bloor 1994) were indicated as public health targets in the 1992 White Paper. In the following years “health promotion and illness prevention were increasingly seen as part of the routine of medical care and incorporated into the practice of many GPs” (Rivett 1998, p.379).

The necessary, direct involvement of local authorities in matters of public health was auspicated in the 2010 White Paper *“Healthy Lives, Healthy People: Our Strategy for Public Health in England”*, produced in response to the Marmot Report published in 2008 which urged action on health inequalities in England. The 2010 White Paper represents an important source of data to understand on the one hand how obesity is shaped and represented in and through public health policies and on the other hand the practical conditions of and services for obesity management to which people, and research participants, had access to. Moreover, it is necessary to note that falling under the responsibility of local health authorities, obesity is understood, represented and perceived as a public health issue before than as a disease or illness. In fact, in the new system,

local authorities provide or commission public health services, including those for “physical activity, anti-obesity provision, drug and alcohol misuse services and nutrition programmes” (Powell, 2017, p.24). For example, the organisation where I volunteered in the weight-loss groups, is partly funded by Public Health Brighton and Hove and by Brighton and Hove City Council as part of a local strategy and commissioning of services around obesity and weight management.

#### **4.3. Explaining the ‘obesity epidemic’: public health policy in the UK**

One of the pillars of public health promotion is the concept of ‘health field’, which recognises the interaction of biology, environment, lifestyle and organisation of health care as the main four determinants of individual and population health. The public health discourse around obesity has given extreme relevance to the first three fields, as it is evidence by the explanation of the causes of obesity as biologically and socially complex due “to an increased intake of energy-dense foods that are high in fat; and an increase in physical inactivity due to the increasingly sedentary nature of many forms of work, changing modes of transportation, and increasing urbanization” (WHO, 2018). The relation between obesity and a modern lifestyle that promotes sedentary lives and overconsumption of food was already identified in early public health documents produced at international and national levels, where obesity was described as a risk factor, “part of the lifestyle of advanced, urban, industrial high-consumption societies” (Lalonde Report, 1974 in Rivett 1998, p.210). This social explanation of obesity has been reproduced and expanded by the ‘obesity epidemic’ discourse along with a biomedical definition of obesity as excessive weight, gained due to caloric imbalance, explained as a result of an obesogenic environment which affects genetic and biological responses. Today, these definitions and correlations are presented as facts and sit at the base of the authoritative knowledge of the ‘obesity epidemic’:

- 1 Obesity occurs when a person puts on weight to the point that it seriously endangers health. Some people are more susceptible to weight gain for genetic reasons, but the fundamental cause of obesity is consuming more calories than are expended in daily life.
- 2(...) The growth of obesity in England reflects a world-wide trend which is most marked in, though not restricted to, developed countries. Most evidence suggests that the main reason for the rising prevalence is a combination of less active lifestyles and changes in eating patterns. (National Audit Office, 2001)

I highlight two main and interwoven differences in the public health construction of obesity between earlier stage and today: firstly, the centrality that “obesity” has gained today as normative and meaningful category to understand body size and health in general, and not just

fatness and its immediately related health risk. Secondly, the unquestioned definition of obesity as an epidemic. Both have important moral and political consequences which weren't still in place in the 1970s-1980s.

One of the consequences that I want to emphasize here, is how the focus on caloric imbalance, that is *"consuming more calories than are expended in daily life"*, as *"the fundamental cause of obesity"* is perceived as a dogmatic truth and has silenced other possible explanation of obesity, both biomedical and socioeconomic, limiting the array of possible interventions in public health policy. For example, in *Foresight Tackling Obesities: Future Choices – Project report* (Butland, B., Jebb, S., Kopelman, P. et al. 2007), a pillar for all guidelines and policies around obesity in the UK, causes of obesity are described as *"embedded in an extremely complex biological system, set within an equally complex societal framework"* (p.5) and it is suggested that:

interventions based on improved nutrition and increased physical activity can be effective for individuals but shifting the population distribution of obesity will require interventions that target elements of the obesogenic environment as well (Ibid.)

The report concludes by saying that:

Taken together, the evidence presented in this report provides a powerful challenge to the commonly held assumption that an individual's weight is a matter solely of personal responsibility or indeed individual choice. (...) Strategies based on personal motivation and individual responsibility alone do not provide an adequate response to the obesity problem. (p.124)

As evidenced by these excerpts, the report equally addresses behavioural and structural causes, calling for interventions aimed at changing structural elements of the 'obesity epidemic'. This shift of focus could potentially alleviate the centrality of individual responsibility for healthy lifestyles and reframes rationalistic understandings of choice as detached by the structures in which people live. The conceptualisation of the causes of obesity as multifaceted has also the potential of allowing interventions targeted at structural changes, possibly targeting root causes of obesity, such as food production and distribution as well as health inequalities.

The understanding of the causes of obesity as complex and multifaceted has become part of the authoritative, public health discourse on obesity in the UK. Nonetheless, interventions that target food industry and health inequalities to address obesity are rare (see Swinburn, 2011; Cohn, 2014). In fact, the acknowledgement of structural causes coexists with a focus on caloric imbalance and lifestyle as venues of intervention. I argue that this example shows how different conceptualisations of the causes of obesity result in different type of interventions, and in turn



affect understanding of personal responsibility and moral judgment around obesity. Moreover, these multiple explanations coexist in public health representations of obesity although they are given different relevance. Further, this multiplicity is at play in the ways in which health professionals explain the aetiology and treatment of obesity, representing a powerful but strictly normative device to manage weight in clinical encounters, as I will discuss in the following section 4.4. I argue that the 'obesogenic environment' theory used in public health policy serves as a way to silence the importance of structural causes and reinforce the focus on healthy lifestyle as it interprets social and environmental factors as explanation for the caloric imbalance. This theory argues that our "current environment is characterized by an essentially unlimited supply of convenient, relatively inexpensive, highly palatable, energy-dense foods coupled" with a sedentary lifestyle that "promotes high energy intake and low energy expenditure" (Hill and Peters, 1998, p. 1371, in Guthman, 2013). From its academic formalization, the theory has been embedded in the authoritative knowledge produced through the obesity epidemic discourse and national policies related to obesity to explain the complex causes of weight gain.

The introduction of the 'obesogenic environment' theory in the 'obesity epidemic' discourse opens to the acknowledgement of non-biomedical aspects of body size and weight, at least in explaining the causes of obesity. Nonetheless, this explanation does not question the focus on the centrality given to biomedical explanation and consequently to individual responsibility. As some scholars have pointed out, "the obesity environment theory (...) takes healthism's notions of the good life and projects particular ideals and aesthetics onto the built environment" (Guthman, 2011, p. 192). This thesis thus overlooks the political, economic and structural circumstances that shape the built environment and that make some places, food and eating habits affordable and desirable (see Guthman, 2011; 2013). Equally, the underlying conception of obesity as a clinical entity, a risk factor and a health condition which individual are ultimately accountable for, is left unproblematised. The silencing of the structural causes of obesity and the reiteration of obesity as a health condition and personal responsibility is at play in the health policies and healthcare professionals' understanding of the causes of obesity I present in this chapter. In fact, the "*cultural, environmental and social framework*" described by both national public health policies and the health professionals I interviewed, is used as a possible explanation of obesity and the forces that contribute to the onset of weight gain in contemporary societies but does not bring to a more inclusive and multifaceted definition of obesity itself.

Jutel explains that the definition of clinical entities leads to the identification of “diagnostic, curative and preventing strategies” (Jutel, 2006, p.2268) appropriate to that definition, determining what is relevant, efficient and appropriate for those strategies and what is not. Drawing on this point, I suggest that the biometric definition of obesity as BMI<30, that is, as an indication of excessive weight, results in a silencing of the socioeconomic and environmental factors that intertwine in the production and experiences of the category obesity. The definition of obesity as a clinical entity casts non-medical explanations and interventions from the authoritative knowledge and common-sense assumptions around obesity. In public health policy and healthcare professionals’ explanations, the normative understanding of obesity as a clinical entity represents it as domain of biomedical knowledge, technologies and interventions through the reliance on diet and exercise as privileged treatments. This definition is enmeshed in the neoliberal understanding of health and body as individual projects.

In the next section, I will expand this reflection by exploring the ways in which this authoritative discourse is reproduced and navigated by GPs and practice nurses.

#### **4.4 Making sense of the ‘obesity epidemic’: health professionals’ explanatory narratives**

When I ask Janette what the causes of obesity are in her opinion, her first response is *“not being able to cook”*, which she says she realised from an encounter with a patient who was asking for bariatric surgery and by investigating his food habit, his inability to cook came up as a first reason for his weight. Janette then decided to sign him up for cooking classes, but unfortunately, she hadn’t any follow-up with him and doesn’t know if the classes were useful in avoiding the surgery and helping him lose weight:

A patient came in and he said to me - he came to talk about weight- but he said to me, after the consultation - he was coming to ask for surgery, that’s what he was coming in for- so I started with “so what you eat during your day?” and he kept saying that family members kept bringing around his food. And I said, “why does that happen?” and he said, “cause I don’t know how to cook”. So I put him on a cooking course, I didn’t give him a gastric band and anything like that. He couldn’t cook, he didn’t know how to cook. And that for me was a real awakening cos it never crossed my mind that people would be obese because of that reason, I don’t know why, it’s quite obvious actually! But probably is not one of the first things you immediately think of.

In her account, Janette relays how her understanding of obesity has been shaped by a clinical encounter with a patient asking for bariatric surgery. In this brief account, many interesting aspects of obesity management are revealed, for example: the centrality of investigating eating

habits to make a diagnosis, and the steps to follow in order to be referred for bariatric surgery. But also, the kind of interaction and talks that happen in daily clinical encounters around obesity in primary care. Janette's words show the importance that these encounters can have in health professionals' understanding and perception of the problem, through an investigation that goes beyond the physical boundaries of the disease and touches on aspects of patients' sociality and, in this specific case, family dynamics and cooking skills. A type of investigation that is centred in the practice of rapport building and that the health professionals in this research perceive as characteristic of general practice. This perception is well articulated by Matthew, who, after explaining some of the main causes of obesity in his opinion, adds:

I was going to say something else about ehm can't remember oh yes what I was going to say is General practitioners are in a very unique position, ok, so we see people all the time (...) you know you get an incredible insight into society. People tell you their secrets, people tell you everything cos they trust you, so you get privileged perspective on life. So I think GPs are aware of what it's going on, I think they do understand the issues but they feel powerless because of this tidal wave because we know that as primary care physicians we can't stop burger vans, McDonald's, sweets and tv adverts; that's massive, these are powerful forces in society and primary care isn't, you know, we only have limited powers, really.

In Matthew's account, the awareness of "powerful forces" that favour the onset of obesity, that is the "insight into society" gained through the privileged relation with patients in primary care, echoes the dominant explanation of the 'obesogenic environment'. This theory proposes that contemporary urban environments have negative impact on people's health, creating an environment favourable to the onset of obesity. However, Matthew does not refer to public health guidelines and biomedical explanations as the sources he mobilises to make sense of these obesogenic factors directly. Instead, he utilises the privileged rapport and dialogues that general practitioners have with patients to understand the reality of obesity outside the biomedical context. In these accounts, I see an important negotiation of the authoritative knowledge on the causes of obesity: a shift in the source of knowledge and understanding. That is, despite reproducing dominant ideas of contemporary lifestyle as main cause of the 'obesity epidemic', Janette and Matthew do not refer directly to health policies and guidelines as sources of their knowledge. Instead, they derive their understanding of the onset of obesity from an empirical and pragmatic knowledge of weight, lifestyle and social factors, acquired through a privileged look into the lived experiences of patients. A look that they consider to be possible only thanks to the special doctor-patient rapport at the core of primary care.

In Matthew's account, the reproduction of an authoritative explanation of the causes of obesity links to feelings of "powerlessness" towards bigger and wider forces that impose their effects on people's lives and body sizes, beyond and despite primary care:

So I think GPs are aware of what it's going on, I think they do understand the issues but they feel powerless because of this tidal wave because we know that as primary care physicians we can't stop burger vans, McDonald's, sweets and tv adverts; that's massive, these are powerful forces in society and primary care isn't.

When talking about dealing with weight-loss, GPs and practice nurses often recount similar feelings of demotivation and uncertainty. In accepting that "weight is under individual control" and weight-loss treatments always work (see Greenhalgh, 2015), these negative emotions are attributed to patients' lack of motivation to lose weight, that is to individual responsibility within a process of victim blaming. What is interesting and nuanced in Walter's words here is that he refers a feeling of "powerlessness" in understanding the causes of obesity on a wider scale and not only when it comes to obesity management in the daily routine of general practice. I argue that such recognition is pointing to non-individual factors, that is, the wider socioeconomic causes of obesity which are silenced in the production of an authoritative biomedical and epidemiological knowledge. The acknowledgment of the disproportion of forces at play, global economic system and trends on one side and general practice on the other, and the feelings that derive from such awareness, is not translated into practice. When managing obesity in clinical encounters, the focus is re-shifted and re-aligned towards the dominant clinical pathway: lifestyle, diet and exercise.

Walter's words follow Matthew's reasoning and well exemplify this idea:

I think food and drink has become very much a big business, you only have to look at the rise of hamburger kingdom, McDonald's et cetera, ehm to recognise that. So I think there's been a big change in society, a big change in sense of the big food companies, that's been accompanied by increasing advertising, I think in general there are more people living a sedentary occupation these days, living a sedentary life I mean and have got sedentary occupation, sitting in front of a computer all day long. And so I think you've got a mixture of societal effects on let's say diet, exercise and the link with obesity

Food companies, food advertising and a sedentary life are the societal factors that Walter links to the current widespread of obesity for the impact they have on diet and exercise, that is on the two terms of the caloric imbalance that is at the basis of obesity. Walter's explanation embeds the key elements of the obesogenic environment theory adopted in public health and health policy and affirms that those social changes that favour an epidemiological spread of excessive

weight are evident in the built environment in the form of McDonald's and computers. Here, health professional's explanation of the causes of obesity exemplifies the obesogenic environment thesis that "thoroughly embeds the energy-balance model in its assumption that it is high energy intake and low energy expenditure that the environment is responsible for" (Guthman, 2013, p.143).

Sean's discussion of the causes of obesity is quite extended and resonates with Walter's words, and exemplifies to the last point of this analysis: the focus on diet and exercise as domain of biomedical expertise and the silencing of other possible biomedical explanations as well as of socioeconomic factors.

*S: ehmm so the causes of obesity are multifactorial in that they are societal, possible genetic based, and certainly some people are predisposed to obesity and ... then there are the habitual forces so a tendency to avoid exercise or ehm tendency to eat food that is obesogenic*

*LB: mmm, do you wanna*

*S: (laugh) do you want me to elaborate?! Ehm on what aspects? Soo societal causes would include food advertising, ehm increased calories and calories density of meals and food, tendency towards faster food, and reduction in home preparation of meal, the medical causes of obesity are generally rarer than the habitual causes, so a genetic cause for obesity like the Prader-Willi syndrome or something like that where there's an insatiable appetite, and that can happen and I have experience of it. And then there are the... the reduction in exercise, and increased consumption which I think is what predominantly, when I see most patients I feel that there's something that could be done around energy in versus energy expended. And focus on it.*

Sean sees the causes of obesity as multifactorial, meaning that obesity depends on societal, genetic and habitual causes. Although he recognises the possible role of medical causes of obesity, he affirms that these are much rarer than habitual causes such as food consumption and lack of exercise and the energy imbalance that derives from these habits. He identifies as societal causes food advertising, calorie density of food, culture of fast food and eating out.

Here, Sean reproduces a common knowledge produced and spread through public health and public debate around the obesity epidemic and, despite taking into account a variety of synergetic factors, he reduces the main cause of weight gain to caloric imbalance. The stress on the caloric imbalance expressed as *"when I see most patients I feel that there's something that could be done around energy in versus energy expended. And focus on it"*, can be understood as a common acceptance that weight loss is the effective response to obesity from a biomedical view. This acceptance has important consequences on the silencing and/or medicalisation of other important factors, which falls outside the biomedical domain, such as food industry and

food consumption, and on the attribution of responsibility. The health professionals I have met reproduce in their accounts this understanding of weight-loss as the more effective treatment for obesity. Consequently, they understand the success and efficacy of weight-loss as dependent on the patients' will power and compliance to diet and exercise. It is also important to notice that the causes highlighted in Sean's explanation coincide with the areas of intervention. Within a biomedical understanding of body, disease and treatment re-establishing caloric balance through diet and exercise advice is deemed to be within health professionals' ability and competence, unlike addressing wider systemic and socioeconomic factors. Biomedicine sees "social relations as (...) discontinuous with health or sickness" (Scheper-Hughes and Lock, 1987, p. 17) and locate the source of disease and illness in the physiology of the body. The physiology of the body is where biomedicine can intervene to re-establish good health. Social factors are acknowledged to have an important impact on people's health, especially for so-called 'lifestyle' conditions like obesity. However, they fall outside a mechanistic, physiological understanding of the body and illness (Ibid.). Consequently, I suggest that health professionals enact obesity as caloric imbalance because this is the type of explanation that better adjust to biomedical knowledge and competence.

The acknowledgment of both socioeconomic, political and genetic causes non-dependent, or not entirely dependent, on individual control (e.g. consumerism, food industry or genetics) are silenced in favour of what seems a most amenable and viable explanation to biomedicine: the imbalance between calories eaten (diet) and calories burnt (physical activity). An explanation that is at the same time an area of intervention, as seen before. As in Matthew's and Janette's accounts presented earlier in the paragraph, Sean, despite echoing a discourse formulated in obesity-related health policy and guidelines, does not openly refer to any of them. Rather, he draws his opinion on clinical encounters with patients, that is on the enactment of obesity management in clinical encounters:

when I see most patients, I feel that there's something that could be done around energy in versus energy expended. And focus on it.

His understanding of lifestyle, that is lack of exercise and increase of food consumption as "predominant" causes of the obesity epidemic, resonates with Matthew's:

you know I think there are lots, there's a whole range of causes ranging from ehm fetal programming right the way to ehm you know genetic risk ethnic risk and obviously lifestyle so I think there is a whole range of causes but the one which really springs to my mind and this how I see it, is what one of my colleagues here, actually I don't know who... said they call it walking deficiency syndrome so I will see obesity as something as an epidemic that

just come on in my life time. You know when I was a teenager we used to think 'ah those Americans are all so fat! Look at those Americans!' and now we have ended up exactly like them. So I think it's a new problem and it is driven by lack of exercise and high you know...easy access to high calories food but for me exercise is probably the key thing...or lack of it!

In this account, social, political and economic changes are directly addressed and linked to the concept of lifestyle, still they are relevant not for the possible implication this might have in re-shaping narratives and practices of responsibility within weight-management but to better understand the lack of physical activity which determines one side of the caloric imbalance.

It is worth notice, that in Sean's explanation, the focus on lifestyle, "*habitual causes*", overcomes other biomedical explanations, not just socioeconomic ones, such as "Willi-Prader syndrome". Janette also talks of medical causes that might increase patients' weight gain, in her long lists of the possible causes of obesity:

Mental health, your mental health will have a massive impact on your weight (...) also some medications. So we, you know, treat people for conditions, you know, medical conditions, and some of them actually would make it harder for people to lose weight or they put weight on.

In Janette's account, the relevance of these alternative explanations of weight gain which do not focus entirely and primarily on individual behaviour and lifestyle choices, is set aside in favour of weight-loss treatments as privileged ways of managing obesity in general practice.

What is worth notice here, is that the pervasiveness of an authoritative knowledge on the aetiology of obesity brings about processes that silence not only socioeconomic factors but also other biomedical explanations of weight gain which can't be reduced to lifestyle, such as mental health, genetic and epigenetic causes. Gina's words very well summarise this process:

Obviously, there are some other reasons why people can be overweight, some medical reasons, but ninety-nine times out of a hundred, it's not anything to do with medical problem, it's just food and inactivity.

This process of silencing is particularly interesting if we maintain with Guthman that "*the assumption that since 1980 people have increased the number of calories they take in relative to those they expend has simply not been demonstrated*" (2011, p.93). Many scholars have highlighted how research on the increase of caloric intake in the last thirty years hasn't produced any definitive result and yields often contradictory evidence (see Gard and Wright, 2005). An explanation of the centrality given to the caloric imbalance and obesogenic environment explanations in public health, is that looking at the built environment offers easier solutions that looking at other causes such as economic inequalities, food industry or toxins – all possible causes

of the incidence of obesity- and at solutions such as increasing cycling lanes or fresh food markets in some urban areas (see Guthman, 2011). Here, I suggest that such focus in primary care also depend on the viability of exercise and diet as domain of biomedical expertise: giving nutritional and physical activity advice to patients is now recognised as integral part of general practice through the integration of health promotion in primary care. Hence, health professionals recognise weight-loss treatments in the shape of nutritional and exercise guidance as something already embedded in their professional expertise and routine.

To conclude, the moment fatness is defined using biometric measures (BMI, but also girth), pathologized into obesity through an authoritative knowledge spread, and legitimised in public health discourse, the relevance and validity of non-biological factors slips into the background. The focus on caloric imbalance also shadows other possible medical aetiologies of obesity, such as genetic and epigenetic causes. However, these concurring and alternative causes seem to resurface in explanatory accounts as well as face-to-face interaction in medical encounters, creating underlying but powerful tensions. The ways health professionals navigate and negotiate these explanations and tensions are nuanced. They also show a tendency to silence alternative factors that cannot be reduced to weight-loss treatment, lifestyle and personal responsibility, when managing obesity in practice. It is important to notice that they identify day-to-day encounters with patients and the privileged rapport they have with them in primary care as their source of knowledge around obesity. Moreover, feelings of powerlessness and recognition of a disparity of the forces at play, economic system on one side and primary care on the other, are deployed to silence the first. Lastly, the integration of health promotion in general practice shapes diet and exercise as viable responses within GPs' and nurses' expertise.

As we have seen, the 'obesogenic environment' theory is central in aetiological explanations of obesity and it is reproduced by health professionals in their understanding of patients' lived experiences of obesity. The deployment of this theory, by drawing attention to food industry, advertisement, and city planning, could have the potential of including alternative explanations of obesity and interventions, firstly by shifting the responsibility from the individual to wider forces and consequently "diminish the moral scrutiny and invocations of personal responsibility that typically accompany discussions of obesity's causes" (Guthman, 2015, p.143). Still, by not questioning or problematising the centrality of the caloric imbalance and then weight-loss as the most efficient intervention to treat obesity, health professionals' understandings of the aetiology of obesity silence those causes related to the built environment and socioeconomic factors, re-



shifting the focus on patients' individual responsibility to lose weight. This has important consequences on the ways in which obesity is treated and talked about in general practice, especially in terms of moral scrutiny and stigma, as I will explore in the following chapter.

#### 4.5 Summary

In this chapter, I have described how the integration of public health promotion within general practice and identification of GPs and practice nurses as key actors in promoting healthy lifestyles is relatively new but central in obesity-management policy. In fact, I have shown that despite the acknowledgment of the multifaceted causes of obesity, public health policy focuses on the promotion of a healthy lifestyle as main venue of prevention and intervention to address obesity. In so doing, they locally reproduce the hegemonic 'obesity epidemic' discourse and silence alternative explanations and interventions that do not align with the enactment of obesity as caloric imbalance. I argue for a coexistence of multiple explanations of obesity in public health. Although this authoritative discourse has seeped in health professionals' understandings of obesity as a biomedical entity, in their day-to-day negotiation of weight management they deploy ulterior and nuanced narratives to make sense of these multiple explanations. In particular, I have explored how they navigate the tensions that arise from acknowledging the structural causes of obesity and intervening exclusively on individual behaviours.

I have identified three main factors to consider in analysing these tensions: a) the privileged "rapport" with patients as a window into society; b) limited role of primary care within society; c) diet and exercise as biomedical expertise. Some of these explanations are particularly embedded in representations and expectations of primary care in the NHS, which I will discuss in chapter five. These ways of negotiating the authoritative knowledge on the aetiology of obesity, neither disrupt it nor produce ulterior explanations or envisage alternative interventions. In fact, their relevance does not reside in their creative power but in their ability to reveal the gap and tensions in the explanatory discourse of obesity and at the same time testify to the hegemony of this discourse. Hence, I argue that GPs and practice nurses enact multiple explanations of obesity, but this multiplicity is silenced when *doing* obesity management in clinical encounters. In fact, their focus of intervention remains on the individual and their physical body, and on behavioural change towards restabilising caloric balance through diet and exercise. I argue that this focus on diet and exercise, that is, on bodily functions, derives not only from the normativity of the obesity epidemic discourse and public health policy but also, and most importantly from the fact that caloric imbalance and bodily functions are objects

of biomedical competence, unlike structural causes. Hence, I suggest that health professionals enact the obesity that is more suitable and agreeable to their competence and the health system in which they operate.

## 5. The perception of obesity as a stigmatising word: complicating the medicalisation of fatness

In this chapter, I focus on the stigma attached to obesity as perceived by healthcare professionals and how it shapes their use of the terms “*obesity*”, “*obese*” and “*overweight*” in clinical encounters. I expand the analysis developed in the previous chapter and explore some of the tensions that GPs and practice nurses encounter when managing obesity.

As seen in Chapter Four, GPs’ and practice nurses’ conversations around the aetiology of obesity as an epidemic reveal tensions in identifying the causes of obesity as both structural and behavioural. However, the perception of obesity as stigmatising is not mentioned in these explanatory narratives of obesity and in the ‘obesity epidemic’ discourse they both contest and reproduce. Instead, GPs’ and nurses’ perception of stigma attached to obesity emerges with force in their descriptions of obesity management in the clinic. Their accounts convey feelings of uneasiness in using the terms obesity/obese to refer to patients and discomfort in talking about excess weight. In this chapter, I argue that this perception of stigma is entangled with healthcare professionals’ understanding of the role of general practice within the NHS and the special focus on rapport building with patients. I will then move to unpack the stigma attached to obesity as presented by GPs and practice nurses, their preference for the term overweight and whether obesity is perceived by both health professionals and patients as a good reason to see a GP. Interviews with healthcare professionals often moved from discussing the causes of obesity towards the management of weight in general practice. In these accounts, GPs and practice nurses describe examples of how conversations around weight would usually be conducted in the routine of a medical visit. This is a unique way for me to have a glimpse, although partial as relayed only by health professionals, of what happens when GPs and practice nurses deal with obesity as a lived experience and not just as a biomedical category defined through public health policy.

### 5.1 The role of GPs and practice nurses

The ways in which general practice is perceived by the GPs and practice nurses that took part in this research are important to understand how obesity and weight management are navigated in everyday clinical encounters. In primary care, responsibility for promoting healthy lifestyle intertwines with the importance of building a lasting rapport with patients.

This section focuses on the role of GPs and practice nurses, as experienced by my interviewees. The relevance of this section is twofold: firstly, it depicts how GPs and practice nurses represent

their “unique” roles in the NHS. Secondly, it introduces key themes to understand health professionals’ perception of the stigma attached to the term “obesity” and “obese” and how this perception shapes obesity management in general practice. The perception of the uniqueness and centrality of primary care is common in the accounts of all the health professionals that took part in this research. At the core of their representation of their role is the unique relation with patients that goes beyond a mere knowledge of physical conditions. The reason for the rapport seems to lie in the continuity of care at the heart of primary care and general practice.

The specificity and particularity of these roles reside on the type of relation with the patients enabled by rapport. In fact, at the core of primary care is the idea of continuity of care epitomised in the expressions “family doctor” (which I found in textbooks but never heard from any of the research participants) and “from cradle to grave”, that is the idea that one doctor might have the same patient for his or her whole life, and often having more members of the same family. Janette’s words very well exemplify it:

I think for us in primary care it is so important to have a good relationship with our patients and build on it, cos our relations are completely different to those in hospitals cos there, there are so many people, and people just come and go whereas we have some people who’ve been on our books for fifty years, we have their entire family, it’s completely different

Such a long relation involves not just a biomedical knowledge of patients’ health but also and equally a more social and personal knowledge based on trust: the patient’s trust in their GP and practice nurses. Gina, a young GP who has recently started to work, talks about the space for emotions and life events in clinical encounter. She tells me:

*...it’s an amazing thing that people tell GP things they might not even tell their friends. People come to the GP about so much more than health problems.*

Matthew, who has been working as a GP for a long time, reflecting on the same aspect of clinical consultations as Gina, echoes her words:

(...) General practitioners are in a very unique position ok? so we see people all the time  
(...) you know you get an incredible insight into society. People tell you their secrets, people tell you everything cos they trust you, so you get privileged perspectives on life

Gina and Matthew describe their perception that clinical encounters are about “*more than just health*”. They stress the fact that patients would confide in doctors intimate and personal aspects of their life. This intimacy is perceived by healthcare professionals as something to cultivate through trust and rapport building.

I find the concept of continuity of care particularly meaningful to comprehend the importance GPs and practice nurses give to 'building a rapport' with patients and the consequences it has on the ways they deal with weight management. My understanding is that although continuity of care in terms of the same doctor seeing the same patient is becoming less and less the norm, it is still used as the distinguishing feature of primary care. Research participants use it as the most relevant category to understand, explain and make meaningful the ways they, as health professionals, feel about doctor-patient encounter when weight is at stake. They also deploy it to understand their role, and the difficulties and pitfalls in building a rapport.

The idea of continuity of care informs the strategies and resources that healthcare professionals apply or draw upon in order to build a trustworthy and not-judgemental rapport. On the one side, continuity of care has shaped representations and practices of NHS primary care, partly in contraposition to secondary care. Seeing the same patients over a long time span, creates expectations and obligations around building a relation based on trust and respect. Although the first input to start this clinical rapport lies in the physical body, the development and success of it rely on communication, dialogue and the language. Sharing meanings and finding a common ground is particularly important in primary care not just for compliance but also because of the frequency and familiarity of the encounter. This aspect is fundamental to understand the ways in which the term obesity is avoided in clinical routine. On the other hand, all participants lament an increasingly lack of continuity of care in contemporary general practice, as described by Sean:

So as a GP is very unusual you'll just be a GP, increasingly rare. So, for instance, I do my research as well as doing GP therefore I do fewer days of general practice, so that's me. Someone else might work in the management side of GP, therefore when they're doing those day or two a week they're not seeing patients

This is due to some changes such as the 48 hours access to primary care services<sup>33</sup> and career expectations, as described by Sean. For some, having to see different doctors and telling your story over and over is detrimental to weight management either because it can be discouraging or because it is important to know patients' individuality in order to manage it properly, as discussed by Walter:

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<sup>33</sup> This sets the rule for patients to get access to a GP within 48 hours, resulting on patients potentially seeing different GPs every time.

W: one thing I would say is that one of the issues that has changed in general practice is that because of the forty-eight hours access, so people not having to wait. They don't get to see the same GP, they more often see a different GP

LB: yeah

W: now, that is a problem because continuity of care, let's say I'm your GP and I've known you for five or ten years, you get to know people quite well. It does improve how you interact with people in most cases

LB: yeah

W: if you are constantly having to retell your story to a different doctor and it's the same ongoing problem, you'll get frustration, you got put off by it, the doctors also then have to go back to square one again...

Walter also recognises that having to see different GPs might be an opportunity for patients to try new approaches, and possibly finding doctors better specialised in weight management.

W: ehm I mean, it can be the other way cos obviously there are times where you don't get on with your doctor or maybe they aren't skilled enough in the area and you might want somebody else but...

What is important to notice is that in both scenarios, the focus is on the possibility of building a rapport between health professional and patient as a premise for compliance.

Communication and language are described as having a key role for this relation to happen, grow and continue. Choosing the right words and knowing how to phrase them, without sounding judgemental or offensive, plays an important part in the everyday work of general practice professionals and their professional training. As Matthew explains: *"You can lose a patient just on one word"*.

## **5.2 Rapport building and the perception of obesity as stigmatic**

In practice, promoting healthy weight in primary care means having conversations around how and what people eat (see Ferzacca, 2004), how much they exercise, what kind of life they have. These conversations often lead to more personal and comprehensive topics around emotions, mental health, working and economic conditions. I discuss that in these clinical encounters and conversations around weight clinical expectations on "building a rapport" and compliance intersect with biopolitical discourses around health, body size, and social status with important moral and practical consequences. In fact, within the current understanding of health as an individual project and duty of the responsible citizen (see Rose, 2007; Rabinow, 2008; Wright and Harwood, 2009) and the increasing measuring of health in terms of body size and weight, within a biomedical and sociocultural promotion of slimness, talking about weight entails a whole range of discourses around personal responsibility, morality and aesthetics. Today, talking about excessive weight, food habits, and exercise inevitably implies talking about people's appearance,

as well as their ability and willingness to take responsibility for their health as good citizens should do. It follows that being able to talk about weight in an understanding and not judgmental way so as not to jeopardise the possibility of “building a rapport” is considered very problematic and challenging by the GPs and nurses who took part in this research. Janette is talking about the importance of patient's individual motivation for weight-loss to be successful, when she tells me that she finds weight “*the hardest thing to talk about*” with patients. I then ask her why; Janette takes a pause before answering:

J: it's because I want to say is so personal, but I talk of all sorts of things with people that are much more personal than that, really personal, and I don't have problem with. Really, I find weight the most..., I think I might offend somebody.

LB: ok...

J: Even though I'm a health professional, they come to see me, they want advice, blah blah blah, if they have no understanding their weight is making an impact on their health, then they might be really angry at me. I suppose if they're angry, they resent what I say and they...so learning to word it quite well so not cause offense, that's quite difficult! I think

The main concern of her reflection is on the importance of building a rapport of trust and respect with patients without them having the impression of being negatively judged. Healthcare professionals recognise that using the terms obesity/obese could disrupt or hinder the rapport with patients because of the stigmatic potential the terms have. I suggest that this indicates that in clinical encounters, GPs and practice nurses perceive the moral meanings inscribed in the term obesity as an indicator of corpulence more productive than the meanings inscribe in obesity as a medical category.

Janette's attention is drawn to the importance of maintaining the rapport with patients and she shows some of the dynamics and power relations that might go on in clinical encounters, dynamics in which words have a fundamental importance. Janette re-affirms the personal nature of the conversations between health professionals and patients in general practice, which becomes the key to understand her uneasiness to talk about weight. The problem of talking about weight is not because it is a personal topic, as Janette says; she is used to talking about even more personal topics than weight. The tension lies in the implication that talking about weight might have in terms of offense and resentment: the perception and fear that addressing weight might result in patients feeling offended or resenting the health professional for their words, making it difficult for them to talk about weight and find shared solutions. Here, Janette links these possible negative outcomes particularly to conversations where patients are unaware of the impact that their weight has on their health.

Consequently, knowing how to word the problem of obesity from a healthcare perspective so that patients are “on board” becomes particularly important. I ask Janette how she feels about using the word obesity with patients:

J: if I’ve done the BMI, sometimes I’ve done the BMI, so I might say, if it’s over thirty, they fit in the category obese, so I would say “your BMI is blah blah. This actually put you into the obese category”. So I can say that ‘cause I have obviously done something with them to give them an answer, you know, if they’ve done the height and weight they are expecting something back from me. So I can use that. But if I say to somebody...I don’t know how I feel about using the word obesity...Uncomfortable.

LB: and why do you think it’s uncomfortable to use that word?

J: because I think you’re just really saying, the word obesity for me is such a negative word that I suppose if I’m saying somebody, you know, you’re on, do you understand you are obese? Or blah blah blah then actually I’m being quite negative towards them. That’s what it is. Cause I think it is negative that’s my struggle with.

Janette recognises her negative perception of the word obesity and shift from identifying patients’ unawareness of the health implications of their excessive weight as the main reason that makes weight talks problematic, to recognising her negative perception of obesity as fundamental in her choice of not using that word with patients.

Listening to Janette and her difficulty to have weight conversations with patients resonates with Gina’s interview in the adjectives she uses to describe these conversations. Here Gina is replying to my question on people’s awareness and approach to excessive weight and whether she noted any changes in the way patients address it:

I think in general some people, you know, if you tell them that they’re overweight, that they, you know, should think about losing weight, I think some people will tackle it quite head-on and other people would be very much in denial saying “my weight is not a problem” and I think it’s still something quite harsh to talk to patients about.

Sean also says something similar, in a matter-of-fact way when talking about continuity of care and its importance in treating condition with chronic aspects like obesity:

I think rapport building certainly helps you, you know, you don’t lose weight overnight! you want to see the follow up and encourage the follow up (noise) the care of people. So certainly, it makes it easier to have a difficult conversation, and weight is definitely one of those difficult conversations.

Two aspects need to be highlighted here for their recurrence in all my interviewees’ accounts as well as for the strong impact they have on obesity management in general practice. Firstly, the shared idea that weight is a difficult conversation to have with patients. This brings me to question the effects that the “obesity epidemic” discourse, with its calls to action, public health campaigns and media coverage, is having on the management of obesity in primary care. This



links to the second aspect, which is the “matter-of-fact” approach with which health professionals perceive “weight conversations” as problematic, almost as a shared, common knowledge within general practice. This has important consequences in the ways obesity and weight are managed in primary care in terms of diagnoses, access to treatments, and emotions, both of healthcare professionals and patients. I will describe some of these consequences in section 5.4.

At the core of health professionals’ perception of weight as a difficult conversation lies the recognition of obesity/obese as stigmatic terms, a recognition that strongly resists the idea of obesity as a neutral, medical measure for fatness. In section 5.3, I will examine how the term “overweight” is preferred to obesity as the “accepted”, “kind” term with which to discuss excess weight in general practice. Here, I want to focus first on the stigma attached to obesity in health professionals’ perception. None of the health professionals I interviewed pinpointed specific traits that make obesity a stigmatising label, but they all suggest some key aspects to reflect on. I have identified two main recurring themes that can help understand the stigma attached to obesity: moral and aesthetic judgments. These themes have been largely debated by social scientists, especially feminist scholars and medical anthropologists who highlight the sociocultural roots of biomedical discourse on fatness, that is the aesthetic and moral ideals at play in the ways in which obesity has been produced as a medical entity. I next go to expand on this debate and suggest that the effects of these surfacing ideals in GPs’ and practice nurses’ management of obesity question the medicalisation of fatness. I show how they reveal the coexistence of multiple and competing uses of obesity in the practice of weight management.

### **5.2.1 Aesthetics of health and obesity**

The seepage of moral values and aesthetics of health (Spitzack, 1990) in local settings is particularly evident in the ways health professionals navigate weight management in their working routine and it is made more critical by the rapport-building specific to primary care and general practice in the NHS. Appearance has an important role in assessing people’s “true” inner self (Jutel, 2005), and in Western societies, biomedicine has often become the knowledge through which the belief that bodily measurements are indicators of self and individual character was legitimised: “the association between fatness and deficiency of character” is grounded in this belief. (Ibid.p.117). The stigma attached to big bodies and excessive weight, rooted in pre-existing and underlying sociocultural ideals of body size, has been reproduced in the last thirty years within and by the “obesity epidemic” discourse in original ways. This discourse has formed

a new language and framework where not only body size is understood as an indicator of health but also health in the shape of body size is posited as an indicator of beauty. Moreover, the new aesthetics of health produced by the “obesity epidemic” discourse, where slimness has become the visual indicator of good health and fatness of ill health, and in which health in the shape of slimness is the desirable goal, yields implicit moral values. A body size identifiable with “obesity”, immediately conveys the idea of “ill health”, and then “undesirability”, since health has become a standard of attractiveness (Spitzack in Jutel 2005), as well as a symbol of “lack of control”, “laziness”, “self-indulgence” (Jutel 2005; Gard and Wright, 2005).

Many social scientists (see Kleinman, 1980; Ritenbaugh, 1982; Bordo, 1993; Gard and Wright, 2005; Gremillion, 2005; Crawford, 2006; Lock & Nguyen, 2010; Reichardt, 2018) have focused their attention on the ways in which social cultural beliefs and values permeate biomedicine and how in turn biomedicine itself moulds and (re)produces, through the legitimation of scientific, empirical evidence and language, sociocultural ideals and moral values (see Stafford et al. 1989). Drawing on this awareness, early research on the “obesity epidemic” have highlighted how contemporary concern for unhealthy weights are significantly embedded and shaped by pre-existing body ideals and moral values around body size and self. These ideals value slimness over fatness, self-control over indulgence and associate body appearance to spiritual and moral qualities. In particular, they propagate the idea that a large body means a lack of self-control and laziness (see Ritenbaugh 1982; Gard and Wright, 2005; Greenhalgh 2015). Within the “obesity epidemic” discourse, cultural beliefs and moral scrutiny are medicalised and normalised in bodily techniques and neutralised through neoliberal concepts of personal responsibility for body size, and citizens’ right and duty to choose healthy lifestyle in the name of the ‘health of the nation’. Body size becomes also a visual sign of individual failure to comply with a citizen’s duty to be healthy (see Rose and Novas, 2005; Rose 2007; Wright and Harwood, 2012; Greenhalgh 2012 and Greenhalgh 2015).

The new “overweight and obese” subjectivities (Greenhalgh 2012; 2015) created through the ‘obesity epidemic’ discourse represent a challenge to purported neutrality of the medical understanding of fatness in clinical settings. Obesity management in primary care is powerfully shaped by moral and sociocultural beliefs and scrutiny produced within the obesity epidemic discourse and the primacy given to weight, slimness and healthy lifestyle as indicators of health and moral value. In this context, obesity from a medical measurement of fatness becomes a label that describes the self as well as the body size and ill health: it describes the self through the

body (see Becker, 1995). In my interviewees' experiences, defining a patient as "obese" is perceived as offensive, negative and counterproductive, proving that the moral judgment attached to obesity is stronger than the "neutral", bodily fact it is intended to describe. This has important consequences on the ways weight loss treatments, identified as the main and most effective intervention to address obesity, are enacted in general practice.

France's perception of obesity as a negative term as well as negative health state is very direct; she is describing how she would usually approach conversations about weight-loss with patients and I ask her if she would preferably use the term obese or overweight:

LB: mh what does make obese or obesity uncomfortable to you?

F: it's ...it's because it is in the news, isn't it? I think we all have got a view of an obese person and we are just thinking of this very fat, blobby type of person and I don't think is very helpful, I don't think is a very helpful label to say you are obese. You know "you've put on quite a bit of weight" or "your weight is quite more than it should be", ideally ehm (*pause*) I just don't think it helps giving somebody an image of themselves and they'll say "oh no I need to lose a couple of stone" and I usually say "why don't you start up with seven pounds and see how much better you feel". We start with small things rather than say "you are obese and you need to lose two stone in weight", you've lost them immediately.

Later in our conversation, Frances describes a BMI over thirty-nine, that is close to morbidly obese, as "horrendous" and assumes that patients with that BMI feel bad for their weight and wouldn't react positively to the words "morbidly obese". On the contrary, she deems this phrase unhelpful in compelling patients to be motivated to lose weight. Interestingly, Frances describes obesity as a label, not a disease or risk factor, and maintains the negative connotation of the label even when defined in terms of BMI. Frances identifies the ways in which obese people are depicted in the news as the source of the negative images obesity is now attached with, "we all have got a view of an obese person and we are just thinking of this very fat, blobby type of person".

Both Gina and Sean refer to body size and image when talking about the stigma attached to obesity, or the "connotations attached to it" as phrased by Sean.

Sean has just finished describing the ice-breaking technique he uses when talking about weight with his patients and we are now talking about the effects of the public and media debate around obesity:

S: (...) So the plus-size models on the magazines and things...and I, speaking not as GP but personally, I'm not sure how I view that. In the sense, I think having over skinny people in magazines is potentially damaging, and you will see rises in anorexia, and other forms of

eating disorders, but t kind of say “ok, well, will have an obese model on front of magazine to try and normalise that”, from a health perspective, I’m not sure that’s a right step to take. I understand why they’re doing it and understand why people have mental states about their self-esteem and things but to say that someone who is obese is therefore normal is potentially damaging in reference to the kind of prospective I was talking about earlier about what a society, or a socio-community uses as normal. Is potentially damaging from that perspective. If you see obese as normal than we are in for trouble because we know that with obesity comes the increase of heart disease, diabetes, joints problems, also lungs problem, all sorts of...so we have to be conscious!

LB: but do you think that is kind of mainstream or is still quite...? Like is not that popular...

S: is not that popular...yeah, the majority are super ridiculously skinny people (laugh)

Gina’s reflection on media presentation of bigger bodies resonates with Sean’s words:

there’s all the stuff in the media, you know, about people who are overweight at some time, you know, portrayed in a good way like feel beautiful and have confidence whatever weight you are, and that sort of things which is, I mean is obviously good to be confident however you look, but at the same time they often ignore the fact that is unhealthy to be in a certain way

Here, Spitzack’s idea of aesthetics of health is particularly useful to understand the link between appearance in terms of body size and health and the stigma perceived by my informants. Health has become a “standard of attractiveness” (Spitzack, 1990 in Jutel, 2005), and through the focus on healthy weight promoted by the “obesity epidemic” discourse, the standard is set on body size as a visual and truthful sign of health as well as beauty.

I suggest that these accounts show how more than a shift from a discourse of health to a discourse of body ideals there is a merging of the two levels: the undesirability of large body size is understood and explained in terms of health, with the assumption that fatness is always unhealthy and then universally undesirable. By equating health with weight, health becomes immediately visible and then accessible through appearance (Stafford et al., 1989; Jutel, 2005). Appearance and aesthetics become measures of health within clinical contexts of weight management along with the assumption that this aesthetics is shared, desired and achievable by everyone. I suggest that GPs and practice nurses mobilise obesity as a descriptor of corpulence more than as a diagnostic category. In addition, they assume that the negative connotations they attach to obesity as an aesthetic descriptor are shared by patients. Obesity become then a category to avoid in the encounter with patients who present that body size.

### **5.2.2 Surfacing moral judgment**

The entanglement of this health aesthetic of body size with moral judgement of the self is another aspect that strongly surfaces in health professionals’ accounts of managing obesity as a

lived experience. In this section, I argue that this aspect is an important part of the stigma attached to obesity. This entanglement surfaces in healthcare professionals' accounts, even those where there is not a direct discussion of bodily size in terms of appearance.

As seen in section 5.2.1, Frances justifies her choice of not using the label obesity in clinical encounters as she considers it an "horrendous" term and assumes that patients with excessive weight "*are probably already feeling bad*". Janette's main concern with using this label is to result offensive, implying then that "obesity" is a category that describes not just bodily accumulation of weight but also, and mainly, personal qualities: it is a label that does not describe only a body size, but also the self, based on one's body size. Sean suggests something similar and he seems to be referring in part to his experience of losing weight:

LB: and why do you think weight is a sensitive topic?

S: (laugh) ehm I think because it's tied up to a lot of things. I think it's one of those things which is given us from a very early age now, tied to body image, and I think we put a lot of stock in how we look and the weight to think it's constantly reminded of weight from TV, from magazines, from whatever and we think we probably feel responsible for ourselves for one reason or another we can't manage it and it's...There's a degree of disappointment in yourself when you're larger, I think. You're disappointed in yourself, you got into these habits, and become a cycle of food comforting you and you know this is wrong, you know you need to do something about it but other things are going on in your life and you can't necessarily tackle it right now

Sean brings together social body ideals and moral scrutiny on the self from both the society and the individual, "*There's a degree of disappointment in yourself when you're larger, I think. You're disappointed in yourself*". Ideas of laziness, lack of self-control and motivation, emerge in health professionals understanding of obesity and their choice of not using it when referring to patients and this choice is linked to the assumption that patients with excessive weight feel disappointed in themselves. The moral scrutiny produced by the authoritative knowledge on the obesity epidemic is very much at play in these accounts of weight management. Moral judgment, or the fear of morally judging patients by using the terms "obese" or "obesity", rather than biomedical definitions and categorisation of weight, guide health professionals' approach to weight management. The stigmatisation of excessive weight and consequently of "weighty subjects" (Greenhalgh, 2012) produced by the biopolitics of the obesity epidemic, permeates the ways in which weight is talked about, addressed, and managed in local clinical settings and lies at the core of health professionals' resistance to the medicalisation of fatness. An important effect of stigma on weight management in general practice which has been analysed in some literature focused on clinical settings and patient-doctor encounters, is the "lack of trust" from healthcare

professionals into patients' account of their eating habits. This lack of trust from into patients' accounts has important consequences on processes of 'victim blaming' (see Crawford, 1977), which are often present in clinical encounters where patients have excessive weight (see Webb, 1999). A lack of trust in overweight or obese patients is a recurring theme of ethnographies that look at weight management in clinical settings and clearly surfaces in my findings. It is common perception among my interviewees that obese people tend to hide or do not tell the truth about their eating habits and physical activity.

This is exemplified by the following quotes by Janette and Gina. Janette's identifies this problem in relation to finding motivation to lose weight and patients' awareness of their weight as unhealthy " 'cos a lot of people are 'well I don't eat very much', well somewhere along the line they have, in theory they have (...)". Gina sees this lack of transparency or awareness around food habits as a limitation to "weight conversations" with patients:

I think when it comes to weight, obviously you can weigh someone, and tell them what their weight should be and what their weight was but it's kind of more difficult to have that conversation because you know, you could ask them what they eat and maybe it's the truth or maybe it's not but they often say "oh I just eat three small meals a day", "I don't snack", you know, they say they do all the right things but that's not reflected in their weight.

The dominant explanation of obesity in terms of caloric imbalance due to individual unhealthy choices, namely eating too much (diet) and not burning enough (exercise), shapes health professionals' focus on nutrition and physical activity as key aspects of clinical investigation with overweight and obese patients. Clinical lifestyle investigations based on food and exercise habits reproduce moral assumptions and judgments of "weighty subjects". The stigma attached to obesity works in nuanced ways and at different levels of the clinical encounter when weight management is at stake. In the following section, I will analyse how the perception of obesity as stigmatising gives space to a redefinition of overweight as the accepted term to describe fatness in medical encounters and the consequent process of "re-medicalisation" of obesity through the use of BMI.

### **5.3 De-medicalising overweight, re-medicalising obesity**

I find the following anecdote relevant for three main reasons: firstly, it shows the tension that emerges by using the word obesity in clinical settings, not just primary care, problematising the biomedical neutrality of the term and addressing stigma. It also shows the preference for overweight as a more productive term to describe excessive weight in clinical encounters. Finally, it suggests the need to re-medicalise obesity by specifying that the patient is "*medically*

*obese*”, or “*on a medical scale you are classified as obese*”, in order for this label to be used as a clinical category. Asked about the use of the terms “overweight” and “obese” with patients, Sean relays the following anecdote and give me an example of how he would talk about weight with obese patients, using the technique called “ice-breaking”:

S: Ehm so one friend of mine is a surgeon and she went for her interview and one think she, she played patient scenario and one was that she had to tell a patient that she couldn’t do surgery because the patient was obese.

LB: morbidly?

S: yeah. And she eehm, she’s from Cyprus and she has a slightly direct approach when she speaks English, so the patient was English and so she said to the patient “you know, you’re, you’re obese!” and..., and, and she was adamant but the patient got very upset, the actor got very upset for being told that she was obese. But my friend thought that it was ok to tell someone “you’re obese” like that, because it’s a medical term and there aren’t connotations associated with that. But I think in the public there are connotations associated with the word obese, (...) and I’m really careful in my use of it. We have this technique called ice breaking when you are breaking some bad news, you just say “oh ok, you know, I think that you and I both know that you’re carrying a bit more weight than it is healthy” and so it is “ok, I can see you where you’re going with this” and “you are aware that on a medical scale you are classified as obese” and suddenly you can see some penny dropping and stuff like that, and it’s a bit a more sensitive way of approaching that term. So overweight for me is something that you can say to a lot of people and they “yeah, fair enough, I am, I suppose, overweight”. Whereas obese has connotations attached to it that you have to be a bit sensitive about using it.

Jutel’s analysis (2006) of how the term overweight has shifted from an adjective “descriptor of corpulence” to become a clinical entity, represents a useful starting point to reflect on the ways obesity and overweight are perceived and enacted by the health professionals I met. In her discussion of how the term overweight from an “adjective descriptor of corpulence” has become a disease entity and measure of fatness (Jutel 2006), Jutel argues that *“both the semantic and diagnostic differences between -overweight and obesity- have important consequences for medical practice and for social attitudes towards the body”* (Jutel 2006, p.122). The findings I present reveal that the healthcare professionals I interviewed locate this difference in the value and effects that the terms obesity and overweight have as adjective descriptors of corpulence. And in doing so, they disregard or minimise the fact that the two terms describe different diagnostic and clinical entities.

The health professionals I interviewed agree in considering overweight to be a more suitable, productive and “nicer” label to use. The common perception of “overweight” as an un-stigmatised, and therefore more useful label to address excessive weight with patients, as relayed by the health professionals in their interviews, shows both a semantic and a diagnostic

differentiation. I suggest that this differentiation is based on moral and ethical considerations, that is the perception of stigma, before and more than on diagnostic evaluation. The reason why GPs and practice nurses prefer to use overweight depends primarily on their perception of “obesity” as stigmatising and “overweight” as less stigmatising rather than on the actual BMI of the patient. Overweight is perceived as not offensive and then a more useful label to build trustful, respectful, and arguably compliant rapport with patients. I argue that in the experiences recounted by health professionals in this research, both obesity and overweight are understood and used in clinical encounters on the basis of the sociocultural body ideals and morality they carry and reproduce as descriptors of corpulence. Health professionals in this research, accepted the idea that overweight can represent a health risk, mainly in the sense that if not controlled it can lead to obesity. But they seem to resist the definition of overweight as a disease in itself.

When I ask Matthew what he thinks of the often overlapping of the term obesity and overweight, he replies that overweight is a useful label to have as it gives “hope” to patients *“because actually the language we use with patients is so critical ‘cos you can lose a patient just on one word, you know”*, and he adds:

I find that the word overweight is quite useful ‘cos I can say ‘technically you are not obese but you can see here that the risk factors have built up’ (...) being able to say, ‘there’s a problem, but there’s a distance for you to change things’ gives them a bit of hope.

Matthew’s consideration is embedded in a wider discussion following the causes of obesity and the ways weight management take place in general practice; a discussion in which Matthew often stresses the importance of “hope” as key to address obesity and weight loss efficiently. He discusses GPs’ feelings of powerlessness in dealing with obese patients and their weight management due to the imbalance of the forces at play, food industry and capitalism on the one side, NHS and primary care on the other. In his reflection on the use of overweight and obesity, the two terms take on the status of both different weight diagnoses and semantic labels that convey different judgment of values. It remains unclear if it would use the word “overweight” with patients whose BMI defines them as obese.

Frances is very direct in saying that she prefers to use the label “overweight” with patients, despite their actual BMI, as it *“sounds nicer”*, and does not offend them or put them off:

F: I usually say overweight (take a sip of her tea). I try to be kind, so I talk about body mass index. When you’ve got body mass index twenty-five to thirty that is considered overweight and then over thirty is obese and then when it is over forty it is morbidly obese. I tend not to use those terms because I don’t think it is helpful.



LB: why?

F: so let's say someone has got body mass index of thirty-nine which is not great, I mean it's pretty *horrendous*, but I'm not gonna say that to them because they are probably already feeling bad so my job is not to make them feel worse (...)

LB: and why do you think overweight is nicer than obese?

F: just sounds nicer! In my view...

Frances understands "overweight" as an acceptable label that, unlike obesity, can motivate the patient to lose weight, resonating with Matthew's idea that "obesity" conveys a sense of hopelessness, which hinders weight management and people's motivation and compliance.

Frances' perception of "obesity" is particularly negative, and she uses the adjective "horrendous" to describe a BMI over thirty-nine. Moreover, she affirms that she would never use the term "obesity" to refer to a patient, not even in conjunction with the patient's Body Mass Index. It is interesting how she briefly but precisely lists the different BMI ranges that define overweight, obese, and morbidly obese as distinct diagnostic categories and immediately dismiss these distinctions by saying that she doesn't use the term "obesity" with patients. Her understanding of obesity and morbid obesity as negative adjectives prevails on her biomedical knowledge of diagnostic categories: she prefers to use "overweight", even with patients whose BMI defines obese or morbidly obese. Unlike other health professionals, Frances does not see any convenience in specifying "*medically obese*" or "*your BMI defines you as obese*" when talking to patients, further challenging the medicalisation of fatness.

Asked about the consequences of using overweight and obesity in conjunction as they are often used in public health reports, healthy lifestyle campaigns, and in the media, Janette, who had already discussed her discomfort in using the word obesity with patients due to the very negative connotation she attaches to it, presents a reflection where body size, BMI and stigma interplays in interesting ways:

I don't think it's very fair now you said it. I've never thought about it, but I don't think it's very fair because anyone can be overweight for many reasons, some people just stay overweight, but it might be just overweight I think there's a very narrow margin there especially when we look at BMI between overweight and obesity it's only five points...and I have had people that I think were overweight and then when you calculate the BMI they're obese Although there's a lot of literature about BMI not being the best to use, you know, there is that, but it is the best thing we have at the moment although you know rugby players and boxers have got a lot of muscles, I'm not gonna go over it, but I think it's unfair and unhealthy because you get somebody who is overweight and somebody who is super super obese, you know, it's not the same by any stretch of the imagination I mean it really isn't because somebody who's really obese, morbidly obese, is not able to move very well, but I mean if someone is just overweight, you know, might be really fit, just overweight. Yeah it is actually really, really, really unfair.

Janette resists the authoritative knowledge of the “obesity epidemic” discourse that being overweight is always a health risk when she says that overweight people “*might be really fit, just overweight*”. She also recognises that the difference between overweight and obesity as biometric measures and clinical entities is not always visible, so that people whose body size seems just “overweight” are actually “obese” by their BMI: obesity defined in terms of BMI is not immediately recognisable in terms of body size. The focus is then shifted to the difference between overweight and “*super obese*” but the moral stigma attached to “obesity” is maintained.

Overall, the data indicate that in “weight talks” in primary care, the term “overweight” is preferred and it is used in place of obesity, regardless of their differences in terms of BMI, that is, regardless of them being two different diagnostic categories. Healthcare professionals perceive “overweight” as a more appropriate term to building trust and ensuring compliance in the rapport with patients. Overweight is the term used to create relations in clinical encounters around weight. The reference to overweight and obesity as different measurements of fatness is deployed and becomes relevant primarily as a tool to alleviate the stigma attached to obesity rather than as two different diagnostic entities. Healthcare professionals’ need to bring “obesity” back into biomedicine by using medical indicators such as the BMI or by stating that the person is “medically obese”, recurs in many accounts from health professionals, weight-loss groups’ leaders and even participants. The BMI index is used to “justify” the use of the term obesity to refer to patients. I propose that this process of negotiation can be read as a re-medicalisation of “obesity” as a biometric entity, as we have seen in Sean’s account at the beginning of this paragraph. The findings show that healthcare professionals enact obesity as a descriptive label fraught with moral judgement that needs to be re-medicalised using BMI and ulterior descriptions and periphrasis such as “medically obese”, or “on a medical scale”, “your BMI defines you as obese”, in order to be accepted and utilised in weight management in general practice.

#### **5.4 Is obesity a good reason to see a GP?**

The data collected talking with health professionals shows a picture in which weight is very rarely the first reason that brings people to see a doctor. On the contrary, weight is often brought up in the consultation because of its link to other health conditions or diseases, such

as diabetes, heart conditions, and cholesterol. Hence, I suggest that in clinical encounters, obesity becomes relevant and is treated primarily as a 'risk factor'.

Sean gives a vividly example of how weight is rarely the first reason patients would go to see a GP and instead it is often brought up into the conversation because of related health problems or concerns.

LB: does it happen that people come to you saying "I've got weight problems and I need to lose weight"? So, is that the primary reason why they come?

S: not necessarily, not very often actually! Not very often at all. Sometimes. I mean, the way we present it tends to be I see someone, they are overweight or they are quite clearly obese and I will kind of mention it as part of the, just part of it, and they often would say they were aware of it and I will encourage them to lose weight. For instance, today I saw a man who I had seen with his children yesterday, he came back to see me today about something that essentially was indigestion, but he was worried it might be his heart and both of those are related to his weight. He has a very large stomach, and the way I phrased it to him was "if you are worried for your heart the main thing you can do is to try and lose some weight". We discussed a bit of diet, a bit of exercise and he's also a taxi driver and he's very sedentary and can't find time from work to do it but if you kind of hanging it, put on a hook and you mention the fact, "I saw you with your kids yesterday, they are both very young, it's very important for you to be, you know, active and healthy and see your kids reach middle age, you know" (giggle) 'cos it's as serious as that. I think as a doctor you kind of forget how strong your words can be to someone! And as a doctor you say "(...) the one thing you can do to make that as unlikely as possible is to focus on losing some of this extra weight that you carry. And even small amount makes a big difference to your health problems", just realistic goal setting is important.

In this quote, Sean describes an anecdote that vividly conveys how conversations around obesity and weight-loss are prompted in relation to other health conditions, in this case the patient's concern of a heart condition. This anecdote is also a helpful example of how weight conversations are carried out in clinical encounters and the discursive strategies that GPs deploy to have these sensitive conversations without hindering the doctor-patient rapport, as discussed in section 5.2.

When I ask Gina if she sees many patients coming to see her for their weight, her response resonates with Sean's: *"it doesn't happen very often that patients come to me asking about how to lose weight"*. And she adds:

(...) I mean often, you know, you see someone who is at high risk of having a heart attack maybe they have high blood pressure, and that can be related to their weight or they have high cholesterol so, you know, it's often something we talk about, but it's not often the primary problem that a patient would come to you about.

These accounts reveal the complex ways in which weight and obesity are performed and enacted in primary care, in contrast to the linearity and uniformity that characterises public health guidelines on obesity management (see Chapter Four). In health professionals' accounts, weight is not just an *"unpalatable"*, *"uncomfortable"*, *"harsh"* and *"the most difficult conversation"* to have with patients, it is also unlikely to be the primary reason for patients to see a GP. The experiences they relate depict weight conversations with patients as consequential to other health conditions often linked to excessive weight. In their experience, GPs and practice nurses often find themselves in the position of being the ones to initiate weight conversations with patients, since it is rarely presented by patients as the problem to discuss. I suggest that this circumstance further shapes healthcare professionals' feelings and approaches to weight conversations and obesity management that I have analysed in sections 5.2 and 5.3. Moreover, the enactment of obesity as a 'risk factor' rather than a disease in clinical encounters aligns with healthcare professionals' explanations of the causes of obesity presented in section 4.4 where they situate the importance of addressing obesity in its correlation to other diseases, such as diabetes and cardiovascular diseases. This understanding of obesity as primarily a risk factor is also reproduced in public health reports (see Chapter Four and section 1.2), further testifying the multiplicity inherent to obesity.

### **The referral system**

The prevailing understanding of obesity as a risk factor and healthcare professionals' perception of weight as a difficult topic of conversation to have with patients entangles with organisational aspects of the NHS primary care and public health strategies. As seen in section 5.2, GPs and practice nurses I interviewed identify lack of continuity of care and follow-ups, and the limited length of visits as factors that negatively affect weight management in primary care. They describe the need to retell the same stories to different doctors and nurses as potentially off-putting for patients, especially given the short time of consultations. They also address the limited chance of having follow-ups with the same healthcare professional as detrimental to manage long-term treatments like weight-loss, for as Sean points out: *"you don't lose weight overnight!"*. The possibility for GPs and practice nurses to refer to local weight-loss services, such as weight-loss groups and gyms, can be read as an acknowledgement by policymakers of some of these limitations. Whilst at the same time the identification of health lifestyle services as privileged venues to refer to, reinforce the centrality of personal responsibility and behavioural change in managing obesity. From a critical medical anthropology perspective, it is essential to reflect on how understanding of responsibility and processes of victim blaming

(Crawford, 1977) are circulated and reproduced in health professionals' referral choices when weight-loss is at stake.

In public health guidelines, general practice assumes the role of advising and directing patients who are overweight or obese towards the right service, such as weight-loss groups, weight counsellors, gyms, cooking classes, through the referral system. GPs and practice nurses are encouraged through the NICE guidelines to refer patients whose weight is considered "at risk" to the service deemed as more viable and suitable for the patient's needs. Two of the many guidelines produced by the National Institute for Health and Care Excellence on obesity, are particularly useful to understand the strategies of integration of services as well as the focus on the community which is part of what I have defined as the 'localisation of responsibility' (Strong, 2018) in obesity management: *"Obesity: working with local communities"* (2012) and *"Weight management: lifestyle services for overweight or obese adults"* (2014). For example, the latter document reads:

This guideline makes recommendations on the provision of effective multi-component lifestyle weight management services for adults who are overweight or obese (aged 18 and over). It covers weight management programmes, courses, clubs or groups that aim to change someone's behaviour to reduce their energy intake and encourage them to be physically active.

The aim is to help meet a range of public health goals. These include helping reduce the risk of the main diseases associated with obesity, for example: coronary heart disease, stroke, hypertension, osteoarthritis, type 2 diabetes and various cancers (endometrial, breast, kidney and colon).

The focus is on lifestyle weight management programmes that:

accept self-referrals or referrals from health or social care practitioners are provided by the public, private or voluntary sector

are based in the community, workplaces, primary care or online.

(...) Clinical judgement will be needed to determine whether they are suitable for people with conditions that increase the risk of, or are associated with, obesity or who have complex needs (NICE 2014 p.8).

The idea that referring is a time-consuming and possibly ineffective procedure for weight-loss is recurrent in GPs' and practice nurses' accounts. Sean describes for me when and how a referral is usually done in his working day in the practice and express his preference for patients to self-refer:

S: as a GP one of the things I try to encourage is self-referral because the referral work is huge! It takes so much more time, you see, you have your consultation, and then you leave it at the end of the morning, patient would talk over the amount of time they have, anyway, if you are a good GP, you'll run late! And then at the end of it, you have to do all your referral things. For something like that is really helpful if patients need to be motivated to attend, I shouldn't be dictating they go. It's really helpful that they can self-

refer. Same with mental health services, telling the patient, here's the number, refer yourself, it shows that there's a step they're making, "I want you to make this change", you know. I haven't been to my GP and I have passively been swept away with no options. No, in order to make this happen, you have to make this positive step. Do it and take a start! Start taking the ownership eh which is really helpful. But from a work perspective is vital!

LB: so how does referral work?

S: there are various referral ways, outlined letter, dictated letter, or there will be pro-forma that you have to complete. It all takes time!

LB: and you do that at the end of the visit?

S: sometimes you try to sneak it in between patients and stuff but just means that you run later and later and they say "you really running late". It's practical administration really and you want to minimise that, to get the most out of your visits. It's just out of the burden of GPs and we need to discourage that whenever we can! So, patients being self-referring is vital! Yes, make GP aware but making rely on GP referral is not the way to go

In Sean's account, practical and administrative aspects of general practice entangle with underlying assumptions on individual responsibility and motivation as central factors to lose weight and change unhealthy behaviours. As a matter of fact, the people I met in LNPO groups and FLC were self-referred. However, the reasons they present for their choice to self-refer to weight-loss groups differ from the idea of motivation recurring in GPs' and practice nurses' accounts. I will present these reasons in detail in Chapter Six.

Janette also describes her negative feelings around referring and her words resonate with Sean's:

LB: and this is really going to the practice but, you do referral?

L: yeah

LB: ok. So how do you feel about that? Is it extra work for you? Do you use referral quite often? Especially when it comes to weight. do you think is a good way of treating overweight, obesity or...I don't know

J: I don't refer very often. I'm really honest.

L: ok

J: (...) referral are a bit of a faff if I can be really honest! And I don't refer very often. And also I think things like Slimming World and Weight Watchers, they've got a lot behind them, a lot, you know, they, well, you don't know how many people have done it and not being successful, you only know about the success, don't you? (...) It seems all my doing is still learning about my referral system. Sometimes I forget and then I think "how do I do it?" ... So, it's ok. It's just another ref, you know, it's another referral! But there's no way around it really, they've got, you know, they've got to be done properly. And you've got to try within a note to say this has been done so

Janette describes briefly how referring works. After expressing her doubts on the efficiency of commercial weight-loss, she also tells me that in her experience weight management depends on the individual's motivation and she cites a research that shows that people who pay for their weight-loss services are more likely to lose weight.

I argue that in these accounts problematic assumptions around personal responsibility in obesity-management are located in specific clinical practices within the NHS, such as the use of the referral system. In addition, healthcare professionals understand weight loss as a long and complex process that needs time and consistency to be properly addressed, hence the organisational and administrative limitations they identify. At the same time, this awareness coexists with the normative and problematic assumption that weight-loss is easily achievable through personal commitment to diet and physical activity, as expressed by the concept of 'motivation'. Whilst this last idea is highly represented in public health policy and interventions around obesity, the complexity and procedural aspects of obesity management are silenced in the authoritative discourses on obesity. I suggest that this analysis is also useful to comprehend limitations to the local integration of services planned in public health policy.

### 5.5 Summary

In this chapter, I have analysed healthcare professionals' perception of obesity as a stigmatising label and how they navigate the perceived stigma in clinical encounters. In my analysis, I have identified two aspects that surface in GPs' and practice nurses' conversations: the entanglement of moral judgment and aesthetic ideals with discourses on health. From this analysis, stigma emerges as an important finding, mobilised through specific interactions, practices and representation of primary care. The data shows that healthcare professionals working in primary care perceive weight management as a difficult task. This is due to the fact that weight is perceived and enacted as a difficult and uncomfortable topic to discuss with heavy patients. Obesity is considered a label fraught with stigma and then unusable with patients for its negative and offensive connotations that could weaken health professional-patient rapport and hamper compliance. Moreover, even though the stigmatising connotations of the term are strongly perceived by health professionals and importantly shape the way weight-management is enacted in the clinic, they find it difficult to locate the sources of the stigma. The stigma attached to "obesity" is presented as self-evident and in a matter-of-fact way.

The findings also reveal that the relevance given to stigma by healthcare professionals must be understood in relation to organisational and performative aspects specific to NHS primary care. In particular, I have identified the centrality given to *rapport building* in general practice and the referral system as productive venues to understand the enactment of stigma. GPs and practice nurses also identify lack of continuity of care and limited length of consultations as practical limitation to manage weight in primary care. Moreover, GPs and practice nurses describe how

weight conversations mostly come up when overweight and obesity are identified as “risk factors” or possible causes of other health conditions, such as diabetes and heart disease, which are generally the reason why the patients came to the doctor in the first place. Excessive weight is not perceived as a valid enough reason to see a doctor or as a “disease entity” (Jutel, 2006) that health professionals would normally address if not related to other diseases. In clinical encounters described by interviewees, obesity is enacted primarily as a ‘risk factor’. The analysis also shows the preference to use the term *overweight* in clinical encounters as it is considered a ‘nicer’ term than ‘obese’. These findings show that both the terms obesity and overweight are used primarily for their quality as descriptors of corpulence rather as appropriate diagnostic categories or disease entities.

To conclude, the findings analysed in this chapter reveal that healthcare professionals I met challenge the centrality of primary care in managing obesity. They also reveal that multiple meanings of obesity and overweight are enacted by health professionals when managing weight. Obesity as a stigmatising descriptor of corpulence, a diagnostic category, a risk factor and disease are present in healthcare professionals’ accounts and practices of obesity and which one is relevant is contextually and situationally decided. Public health interventions and biomedical depictions often reproduce weight bias and stigmatising assumptions on obese patients (see Bombak, 2014). My analysis shows the urgency for biomedical research and public health to address and eradicate the reproduction of obesity stigma in clinical settings and health messages. This becomes particularly relevant when considering the ways health professionals describe the term obesity as “unpalatable”, “negative”, and “horrendous”. What impact does it have in the ways people live their bodies? And on the actual possibility of managing obesity in primary care? It is important to ask these questions in order to foster more positive clinical encounters and ‘inclusive, and non-stigmatizing public health programs’ (Ibid. p.7) related to obesity.



## 6. Obesity management in the community: weight-loss groups

This chapter focuses on individual explanations to join a weight-loss group and the explanatory narratives of obesity presented by weight-loss group participants and leaders. Here, I explore weight-management in the community, drawing on data collected through volunteering in three weight-management programmes in LNPO, taking part in two LFC aerobics classes, and qualitative interviews with groups' leaders and participants. Some of the interviewees have been both members and leaders in weight-loss groups. A few group participants were joining a weight-loss programme for the second or third time. I start by situating weight-loss groups within the institutional frame of public health interventions around obesity. I define them as biosocial spaces that have been reshaped by the discourse on the 'obesity epidemic' and their inclusion in public health strategy. They are popular settings that promote normative practices of working on the body and the self and have been recently embedded in an institutional and clinical discourse through public health guidelines and policies around obesity. Rabinow's concept of biosociality (1996) is fruitful to explore the emergence of new groupings and identities around discourses and practices of life, health and risk. Weight-management groups can be approached as spaces where new groupings are formed around the understanding of obesity as a major risk to the global and national health. As mentioned in section 1.4, weight-management groups respond to the logic of "preventive administrative management of populations at risk" (Rabinow, 1996, in Inda, 2005, p. 186) that informs current biopolitical practices and discourse (Ibid.) in general and public health responses to obesity in particular. "New individual identities and practices arising out of" (Ibid. p. 188) widespread 'truths' on obesity, risk and healthy lifestyle are formed through interactions in these groups. The authoritative definition of obesity as a risk factor and the focus on maximising healthy behaviours while discouraging unhealthy ones is at the core of weight-management groups. This also offers the rationale for their integration into obesity-management interventions.

As seen in Chapter One and Chapter Four, public health reports and guidelines, promote the recognition of weight-loss groups as essential players in the management of obesity. The relevance of weight-loss programmes, such as Weight Watchers and Slimming World as well as fitness classes, can be read through the lens of what Greenhalgh (2015) defines a biomyth of the 'war on fat': the assumption that weight-loss is always effective. In Chapter Four, I have shown how the relevance given to local weight-loss services is also the effect of a process of 'localisation of responsibility' (Strong, 2018) brought about by the recent reform of the NHS and the

consequent promotion of synergetic strategies in the community. In public health guidelines, general practice assumes the role of advising and directing patients who are overweight or obese towards the right service, such as weight-loss groups, weight counsellors, gyms, cooking classes, through the referral system. As seen in Chapter Five, the focus on referring is problematic in practical terms, as most GPs and practice nurses admit that they rarely refer to weight-management services. They also often use the importance of individual motivation to explain why this kind of referral is seen unnecessary or a “waste of time”: self-referral to weight-loss groups is often described as more effective as it shows motivation from the patient and they deem motivation key for weight-loss to be successful. People working in the Local Non-Profit Organisation (LNPO) where I volunteered lament the lack of referral from local GP surgeries. The group participants I interviewed explain their choice to self-refer to weight-loss programmes in terms of the better structure and lack of judgement that they would find in these venues compared to primary care. However, they also affirm that they would not consider weight gain a valid reason to seek medical advice unless it is related to other health conditions, as also recounted by health professionals (see 5.4). At this end, it is important to consider how modern dieting and weight-loss are activities that have been embedded in common social practices for decades before obesity was internationally targeted as an epidemic. I will briefly illustrate this point in the next section and then I will move to analyse the data around participants’ choices to join a weight-loss group and explanations of the ‘obesity epidemic’.

### **6.1 Weight-loss as a sociocultural practice**

During the fieldwork, I attended two fitness classes in a local fitness club (LFC). Lizzie, the owner and fitness instructor, who is also a nutritional therapist, tells me that she bought the business after joining a similar slimming club based on aerobics and a low-fat diet. This club started in the early 1980s when the “aerobic craze” (Lizzie) entered people’s house through workout videos and programmes mostly targeted to women. Holly, one of my interviewees, is a participant and leader in Slimming World, a commercial slimming organisation founded in 1969. Some of the group participants had taken part at least once in Weight Watchers, another famous commercial slimming group that was established in the early ’60s in the US by Jean Nidetch. As briefly evidenced by these dates, the culture of dieting and joining slimming clubs has a history which is decades longer than the current public health debate on obesity. Furthermore, this culture has shaped the ways obesity treatments have been defined and readily accepted (see Kulick and Meneley 2005; Wright and Harwood 2009).

Bordo's *"Unbearable Weight. Feminism, Western Culture, and the body"* (1993) is a theoretical and methodological milestone for any research investigating sociocultural production of body size and slimness. Focusing on anorexia, it analyses the gendered production of slim and fat bodies in Western, consumer capitalist societies. Given the presence of many descriptions and images of TV and magazine adverts promoting ideals of slenderness and weight-loss products in the 1990s, I also find this book a valuable source of examples to compare to current images and messages on weight. A look at the messages and images around slimness and weight management produced before the "obesity epidemic" discourse became pervasive and hegemonic is useful to see how micro-practices of weight management precede current debates on obesity as well as to notice the new meanings produced by the 'obesity epidemic' discourse. The chapter titled *"Hunger as ideology"* opens with the description of a TV commercial advertising FibreThin, a weight-loss product. In analysing the messages conveyed, Bordo notes that this kind of products were often presented as "mysterious, prized, (...) 'secrets'" that had nothing to share with "something so crass and 'medical' and pragmatic as a diet pill" (p.99).

Today similar weight-loss products use the language of biomedicine, nutrition and health as a benefit and legitimising strategy: as to convey the message that their concern is with health, not appearance. It is evident that weight-loss programmes, slimming clubs and products, fad diets and fitness classes have been part of English society for decades and become mundane bodily practices to manage body shape, size and weight. Instead, their integration within a biomedical discourse of health and public health interventions is more recent and linked to the management of obesity as a national priority. For example, during the fieldwork I searched the NHS webpage dedicated to obesity and the recommended steps to take are to *"eat a balanced, calorie-controlled diet as recommended by your GP or weight loss management health professional (such as a dietitian)"* and *"join a local weight loss group"* (NHS, 2019).

Joining a local weight-loss group is now recognised by the NHS as a valid, safe and healthy way of losing weight within obesity treatment and prevention. Through the NHS website is also possible to find a list of weight-loss groups operating in a chosen area; for example, for Brighton and Hove the research indicates a long list of local groups affiliated to Slimming World and Weight Watchers and LFC classes. The NHS also offers an online weight-loss plan and advises that to lose weight healthily people should expect a rate of 0.5/1 kg a week and to be wary of weight loss programmes that say otherwise or do not comply with NICE guidelines. Again, it states that being referred to a weight-loss group is a possibility when assessing weight and

weight management with GPs or practice nurses and that the groups can be either free or at a reduced cost depending on where the patients live (NHS, LiveWell, 2019). This means that there is not a set national policy on the referral of weight-loss programmes, but the decision is made by local authorities and CCGs.

The public health re-evaluation of weight-loss outside the biomedical context through the integration of different health services and actors at the local level is part of the broader process of localisation of responsibility (Strong, 2018). As discussed in Chapter Four, obesity is framed as a national issue whose prevention and management are better performed through a community-based approach. Weight-loss organisations, both free and commercial, also promote this integration of services and publicise being part of the NHS referral scheme on their websites and leaflets. For example, on their website, it says that Slimming World has pioneered the NHS weight management referral scheme (Slimming World website) joining in in 2001. From Weight Watchers website, I collect the information that they have also been working at local level with health professional referral and self-referral (Weight Watchers website) since 2005 and have taken part into health trials to assess the efficacy of local partnership as a cost-effective intervention to lose weight. LNPO also operates within a partnership that integrates different health organisations and services, trying to work in synergy with local general practice to refer patients to their free weight-loss programmes. All three organisations refer to NICE guidelines as the best practice to follow, in line with the integration of weight management services promoted in public health policy.

It is important to note that the weight-loss organisations listed on the NHS website for the Brighton and Hove area bear and display competing interests and power/knowledge hierarchies. As mentioned above, Weight Watchers and Slimming World are commercial organisations created in the late 1960s and have been successfully operating decades before public health concern for the 'obesity epidemic'. These commercial organisations promote trademarked weight-loss diets, branded foods and bodily technologies that have been objects of academic critiques, especially from feminist scholars (see Stinson, 2001; Heyes, 2006). These critiques identify weight-loss dieting and so-called slimming clubs that promote it as examples of "...the tyranny of slenderness and the enforcement, by patriarchal disciplinary practices, of an ideal body type (...)" (Heyes, 2006, p.126). For example, these conceptions can be seen underlie in Jannete's quote where discussing her approach to referring she says that "*things like Slimming World and WeightWatchers, they've got a lot behind them, a lot, you know, they, well, you don't*

*know how many people have done it and not being successful”* (see section 5.4). In the context of this research, these organisations are integrated into the public health strategy to address obesity and consequently legitimised as sites of nutritional expertise alongside professional nutritionists and dietitians. In this way, public health guidelines equate these commercial weight-loss organisations with programmes that have been designed more recently in response to obesity-related policy and that are free and based on nutrition, such as LNPO. As I will explore in Chapter Seven, nutritionists working in LNPO describe the organisation’s programme as based on weight-management and healthy eating programme rather than on dieting or weight-loss. They also reiterated that the programme is based on scientific and up-to-date research and is free. All these qualities are presented as evidence of the nutritional expertise and efficiency of LNPO programmes and in open contrast to Weight Watchers and Slimming World diets. I argue that pre-existing, sociocultural preconceptions on so-called slimming clubs and diets surface in the weight-loss settings of my research and inform the local integration of services auspicated in public health guidelines.

The data collected on the ground paints a picture where the integration of different services to manage obesity is still an ongoing process. They also speak of a combination and coexistence of different settings, practices and systems of knowledge that happens across sites, practices and meanings of obesity management, through people’s agency. For example, not only were all the people I met in and through weight-loss programmes self-referred, but they all had and still were deploying various devices of weight management, slimming and healthy lifestyle outside weight-loss programmes. Within these trajectories, seeking weight management in primary care seems to have a more marginal role than self-managing weight through different kinds of exercise, diets, healthy eating and weight-loss groups. In the following sections, I aim to give voice to these trajectories and experiences. I will describe why the people I met decided to join a weight-loss group at some time in their life and what explanations they give of the ‘epidemic of obesity’. I will use these as examples of entanglements of public health notions, authoritative knowledge, lived experiences of excess weight and bodily practices of eating and exercising to understand the enactments of obesity in biosocial settings of obesity management.

## **6.2 Joining a weight-loss group**

Research participant’s narratives of how and why they decided to join a weight-loss group reveal two crucial aspects of obesity management as experienced by group participants and leaders. Firstly, they introduce the idea of weight-management as a process. Secondly, they reveal

expectations around weight-loss that I consider fundamental to comprehend the authoritative discourses at play in weight-loss groups. I suggest that these discourses inform the ways weight-loss programmes are organised and vice versa. Participants' narratives of weight management are relevant to understand how obesity is enacted in these biosocial spaces.

Most interviews with weight-loss group participants started with the question "*why are you taking part in a weight-loss programme?*" a question that prompted lengthy answers that veered towards wider narratives of weight and weight gain throughout life. Here, I relate the stories recounted by three participants in LNPO group 1: Daniel, Steve and Michelle. For reasons of brevity and focus, I have selected those parts of their responses that directly address their decisions to join a weight-loss group. However, I want to specify that these are parts of broader narratives where weight gain and weight management are recounted as embedded in complex social webs, relational practices and life events.

### **Daniel**

Daniel took part in the first weight-management group I volunteered in. I meet him at his house at the end of February while the programme is still going on. After talking a bit about some music he was playing when I came in, we sit at a table in the living room, I switch the audio recorder on, and we start our interview:

LB: the first thing I would like to talk about is why you are taking part in a weight-loss programme?

D: ah ah yeah, that's fine! Well, because I'm overweight! That's the first one, and I've tried losing weight on my own, and it didn't work very well. I think it's better to have that sort of support really, partly that sort of encouragement but also, can't find the word, but it's the other side of that, which is obligation, really, to look like you're losing weight. So you are with a group of people, and if you are not taking the weight loss seriously it will become obvious kind of thing. So it's kind of positive support because everybody is in the same position but it's also that kind of a bit more ehm I suppose bit more of a structured thing really

Daniel talks about his weight in a jolly and matter-of-factly way, often laughing or making jokes about it, and in telling his reasons for joining a weight-loss group, he talks about looking for support and structure after trying to lose weight by himself. The way he describes support is also interesting: both as encouragement and surveillance. These reasons to join a weight-loss group programme as well as previous experiences of managing weight in different ways, such as diets, or through different type of weight-loss programmes, are recurring in many of my interviewees' accounts.

I also ask Daniel if he has considered seeking medical advice to manage his weight loss:

LB: did you think "I'm putting on weight I have to do something", or it came from some GPs, or someone told you about it?

D: GP did tell me about it, but that was much more recently (...) over the last five years really and one of those kinds of ...I do not know how they call them Wellman [Men's health week] or something. That kind of stuff where you go, and they take your blood pressure and cholesterol. They put me on a chart and said "oh you are a bit..." and then I could just tell from clothes, you know, and then about two years ago kind of really kind of picked, but no it didn't really come from a medical thing. I was just aware of it my, partner sort of mentioned it as well "you are putting on a bit of weight" sort of thing

Daniel describes the health check-up where he was told about his excess weight as an event that mainly confirmed something that he already knew through a material ("*could just tell from clothes* ") and relational aspects of his everyday life ("*my partner sort of mentioned it*"). The encounter with a medical and public health context was the moment where this lived experience became measured and medically categorised, but it is not understood by Daniel as the input to manage his weight. Moreover, it is interesting that he decided to self-manage his weight and join a weight-loss programme rather than seeking medical advice.

### Steve

Steve is also attending the first LNPO group I volunteered in. We met in a café in Brighton for the interview, and when we meet, the programme has started for a few weeks. When I ask Steve why he joined a weight-loss group, he says:

S: cos I've already done it before, but the reasons were pretty similar and it is that I felt like I needed external help to motivate myself. I'm still not quite sure is working, but I definitely need external help to get myself to be a bit more (giggle), and it's nice to have something structured on a certain time and once you're there is already happening, see what I mean, and getting reminded again about the stuff I had learnt, which I wanted to learn in the first place honestly, which is about the food packaging and become a bit more aware of what I was eating as a general thing

LB: do you remember the first time what did bring you to

S: what motivated me to do the first one? (...) There's a community centre, and they were doing a thing aimed at over fifty or over sixty and I went there with my dad (...) One of them was weight and realising that I think - which I'm still quite surprised about now - I think I'm over it now, but I thought I was on the edge of the band which leads to not obese, overweight, or it was obesity? There's a big band, and I was at the top of the band

Talking about the first time he decided to join a weight-loss programme becomes for Steve the occasion to narrate some parts of his story with his weight that goes beyond that specific event in time - the check-up at the community centre- where his weight was measured in terms of BMI and explained in the language of overweight and obesity. In Steve's account, this event

prompted him to take part in a weight management group the first time. Like Daniel, Steve talks about the need to have a structure and support throughout the process of losing weight. After joining a weight-loss programme a first time and gaining weight again in the following couple of years, he decided to join another weight-loss group in the same organisation as the first one, which is where I met him. This time, Steve was not prompted by a health check-up but by the realisation that to lose weight he needs extra motivation and support, and he identifies the weight-loss programme he had previously attended as the right place where to find them. Steve says that having something structured helps him because for him just going to the group session is part of the process of losing weight: *“it's nice to have something structured on a certain time and once you're there is already happening”*. He also talks about gaining or being reminded of nutritional knowledge as a reason that prompted him to join the type of programme promoted by LNPO. Steve links losing weight to becoming more aware of the quality of the food he is eating, reproducing ideas of healthy eating and nutritional information that entangle health and consumerist discourses.

### **Michelle**

Michelle's explanation takes a similar but more intimate trajectory to Steve's response. Michelle takes part in the same LNPO group as Daniel and Steve. She invited me over to her place for the interview. Talking about the journey that brought her to join the LNPO group is very emotive for Michelle as she retraces a difficult time for her general health and consequently for her professional and social life. Weight management plays a central role in this challenging time both as a trigger for poor health and as an aspiration to regain control of the body and better health. I will briefly present Michelle's journey towards joining an LNPO group by summarising the main steps that she relays. Michelle tells me that in 2012 she started to exercise every day after work and limited her caloric intake to lose some weight. After a few weeks of this strict regime, she fell ill. For many months she would suffer from fevers, infections, flu and fatigue. As a consequence of her poor health, she had to stay at home from work for a long time. Eventually, she was diagnosed with post-viral fatigue and underactive thyroid. In this long space of time she also put on weight and now that she is feeling better, has decided to join a weight-management group:

(...) that's a really long way to explain why I have done it, but it was a tough time. So the reason why I signed up to that [LNPO group] is because I wanted the support and structure and to re-educate myself and to try and do it the right way, but to really concentrate on it - if that makes sense - not to be just like “I need to eat right and I need to exercise”. I've done that, I know that I can lose weight; losing weight is actually really easy if you stick to it, it is when you're not sticking to it... But my problem was that I would be doing these



things, then I'll get sick. So this time I'm really focused on what I'm eating, try to support my immune system.

Michelle's decision to join a weight-loss programme is driven by her concerns with not falling ill in the attempt of losing weight. Taking part in the LNPO group represents for Michelle a way of losing weight without compromising her general health thanks to the nutritional knowledge she can access and the supervision of the group's leaders. Support, structure and nutritional education are then recurring themes in Michelle's account too. It is important to note how in Michelle's narratives competing health concerns – underactive hypothyroidism, post-viral fatigue and excess weight – are reconciled in the attempt of losing weight. The fact that her attempt to lose weight had negative consequences for health does not bring Michelle to reevaluate weight-loss and its health benefits. On the contrary, Michelle reiterates the idea that excess weight is unhealthy. She wants to lose weight, and she looks for a programme that would allow her to do it whilst also taking care of her immune system:

(...) When I was consciously making an effort to lose weight I'd get sick and then I was "I'm not gonna bother for a while", and then I was sick again and thought "I have to do something about it" because being fat does make you ill. It's not good to be overweight, there's gonna be a health impact. If you are fat and sick and if you try not to be fat, you get sicker, then where do you go from there?

Michelle found the answer to her question in joining an LNPO group where she could monitor her nutritional intake and levels of exercise so to lose weight without getting ill again. Given the centrality of health concerns in Michelle's approach to weight loss, it is important to understand the reasons that she identifies for joining a weight-loss group rather than seeking medical advice:

LB: have you ever been suggested by your GP, like refer to something?

M: no I found that [the LNPO group] on line by looking for not a slimming group as such, but re-education and stuff like that. So I found the LNPO one because it was free, which is obviously very attractive and also it incorporated exercise, but that is monitored more than just going in and run, I'd wear myself off! So here I won't overdo it and have advice on hand... It's not a diet, diet is very simple is calories in calories out and I needed something that worked where my mind, my headspace was and I found it online. When I went to the doctor to discuss my weight (...) she kind of said "well you just need to exercise more", and for someone who's suffering from post viral fatigue syndrome, you know, exercise isn't making me feeling any better so it goes from upset to anger to frustrated! And then, I was given tablets that if you eat fat, you poo orange - I might still have them [she stands up and goes to look for them in a cupboard in the kitchen](...)- But I don't eat that much high-fat food, so they weren't working! I was unable to exercise, so I'm given these tablets, she's saying to me "you know it's quite simple, just eat less and lose weight" oh my gosh I would have punched her!

A feeling of frustration characterises Michelle's account of her experience of weight management in general practice. This feeling seems to be situated in a tension between her expectations and the GP's advice. Michelle, who has tried different weight-loss practices and finds herself in the situation of associating poor health with her attempt to lose weight, is seeking for specific nutritional advice that would overcome her conundrum: *"If you are fat and sick and if you try not to be fat but then you get sicker then where do you go from there?"* (Michelle). She perceives the advice given by her GP as ineffective, like the tablets, or unnecessary, since it reiterates weight-loss suggestions based on caloric imbalance which are familiar to Michele but hard to follow because of her health condition. Interestingly, both Michelle and her GP reproduce a general idea of weight-loss and dieting as straightforward practices: *"losing weight is actually really easy if you stick to it"*. Michelle's sense of frustration towards the reproduction of this idea in her GPs' medical advice is due to the fact that this type of weight-loss cannot be applied to her specific situation.

Ideas of support and structure are recurrent in the accounts of research participants I met in weight-loss groups to explain their choices of joining a weight-loss organisation rather than seeking medical advice. As mentioned at the beginning of this section, their conversations around weight and weight management encompass a variety of life events, daily actions and relations around food, eating and socialisation that goes far beyond the specific time and space of weight-loss sessions. One of the aspects that emerges and that I want to highlight is the representation of weight management as a complex process.

### 6.2.1 Weight-loss as a process

Going through weight-management more than once throughout life is a recurrent experience told by participants in weight-loss groups. For example, Michelle had attended the commercial groups Weight Watchers and Slimming World at different times in previous years:

M: I've done slimming groups in the past, I went to Weight Watchers with my mum when I was quite young, my brother was getting married and we did that

LB: how was it?

M: back then was all right cos my mum wanted to do it and was kind of girls together kind of thing and I made a really good friend out of it, I'm still in contact with her (...) [it was] much more a social thing for me, but I did lose weight and I looked absolutely amazing on my brother's wedding! Like size fourteen, curvy twelve and I looked amazing! I was about twenty, twenty-two, I had youth on my side as well! But that [Weight watchers diet] was baffling, it was taking the focus away from real food (...) In that system [Weight Watchers] it's like "oh if I'm not in this system, I can't possibly continue to lose weight" and then you lost weight, you'd stop going (...) It is the same as Slimming World, you can eat as much as

you like “all right then, I will!” How is that right? I did Slimming World just before getting with my boyfriend. I went with friends; again it was a very social thing for me.

Before joining the LNPO groups where I met her, Michelle had tried Weight Watchers and Slimming Worlds as well as self-managing her weight with diet and exercise at different times over a lapse of about ten, fifteen years. Despite losing weight and being satisfied with the body size achieved by taking part in Weight Watchers, Michelle criticises the kind of dieting promoted in the organisation and refer it to as “baffling” and “taking the focus away from real food”, critiques that she also moves to Slimming World. Michelle describes her taking part in these groups as a social activity. The events that Michelle associates with her weight-loss are also social: she talks about losing weight for her brother’s wedding and more recently for her friend’s wedding as moments that prompted her to lose weight. Similarly, she associates attending Slimming World with meeting with her current husband. In Michelle’s accounts, losing weight for social events, such as weddings, is presented as a common practice, especially for women. This suggests that in Michelle’s experience, weight management is a technology of the body and the self, associated not only to health concerns, but also to gendered performances of body size. Drawing on feminist debates on gender and body size (see section 3.1.1), I suggest that Michelle’s association of weight-loss with gendered performances and relations manifests that “for women, dieting (...) strikes directly at issues of self-identity” (Stinson, 2001, p. 51). Furthermore, Michelle has successfully lost weight at times throughout the years, but this weight-loss has always been temporary, despite Michelle’s alignment with disciplinary and normative technologies promoted by the healthy lifestyle discourse.

Holly is a participant and leader in a local Slimming World group and some aspects of her experience of weight management resonate with Michelle’s:

H: well, for me I have always struggled with my own weight for my whole life ever since I was a child, really. So I’ve always been an overweight child myself and then growing up through puberty and into my adult life I continued to be overweight and always struggled with the diet or be fit myself, you know. So personally for me it was to find something that would work because I tried lots of other things, you know, my mum would help me try to cook healthy food or would help me find different organisations, for example I tried Weight Watchers once

LB: ok

H: and going to Weight Watchers it was good because it was structured, and I had something to follow because I didn’t really have that experience of what healthy food look like while I was growing up. And initially I lost weight with Weight Watchers pretty well and losing three stone [19kg] originally with them, but then I found that it was so restrictive and I didn’t feel like I could have a life very much or still go out and see my friends and take part into what they do. So in a way by being on a diet I felt quite alienated.

Not being able to socialise with my friends, you know, they would be out to go to the pub I'd be like "oh, I can't go 'cos I'm being on a diet" and I didn't like it!

Like Michelle, Holly describes her experience with Weight Watchers as very successful in terms of weight-loss, but she also describes it as limiting her social life. Unlike Michelle who was critical towards commercial organisations' approaches to diet, describing Weight Watcher's diet as "baffling", Holly points to the diet promoted in Weight Watchers as too restrictive. In her account, eating is described as an essential aspect of her social life. She says that she found a better approach in Slimming World:

So, my experience with Slimming World has been extremely different! (...) There is no restrictions, so it's much more about, the focus is on a huge amount of food that you can enjoy freely because it's good for your health and limiting those other areas that aren't good for your health. And naturally, you get a weight loss from that.

Here, Holly reproduces the normative idea of healthy eating as a precondition to weight-loss, an idea that is at the core of the healthy eating programme promoted in LNPO, as I will discuss in Chapter Seven. Interestingly, Holly attributes to the purported lack of restriction on food in Slimming World programme a positive value. The same aspect that raised Michelle's criticism, it is seen by Holly as a positive feature that has convinced her to enrol and stay in the programme.

Holly also describes weight management as a lifelong process that she is engaging with since her childhood. In her recounts of weight-management, she does not point to any health concern or specific events that have prompted her to want to lose weight. Instead, Holly conveys a normative understanding of her overweight and body size as 'abnormal' and in need of discipline. When I met Holly, she had been attending Slimming World for about seven years, and she tells me that despite having lost four and half stone (28KG), she still has not reached her ideal weight: *"I'm four and half stone (28Kg) down now! So I'm not where I want to be but because I'm still going to that group where I can get support I know that I would get where I want to be"*.

Further, despite the positive experience she presents, she does not describe it as a smooth, linear journey:

I went as a member initially in two thousand and nine and I went for a year and had lost about two and a half stone [16 kg] at the time and then I felt like I had hit a wall and found hard to continue to the point that I gave up (...) And then, because I was ashamed, you know, I put more weight on and I just, I couldn't go back. I was so worried about going back. But then, when I found the courage to go back, I didn't need to worry because they just welcome you back and you just go back in it! But even then, on my second time, I didn't get to lose the weight that I wanted to

Holly does not give specific details on the reasons that brought her “to give up” the first and second time and what instead brought her to join the same organisation again; she presents these events as recurring aspects of weight-management, even when weight-loss is successful in terms of stones shed.

Steve, who has taken part twice over three years in the same programme run by LNPO, remembers the first time he gained weight:

(...)I wasn't a fat kid, I was quite a thin kid. Then I was diagnosed being anaemic, and then I had some tonics given to me, which I think was iron tonic and there were two sets of tonics and that caused me to put on weight. I don't know if there was any sort of medical reason for that or whether I just ate differently, I don't know but then I am pretty certain I was about eleven stone when I was about eleven or twelve, which is quite a lot, bearing in mind that technically I'm supposed to be twelve stone now (...) And then ended up at some point I was bullied

Steve's memory on what he did to lose weight as a child is quite fuzzy, and he does not recall any specific intervention. Nonetheless, he tells me that as an adult he had tried to lose weight in different ways, for example using *Slim-Fast* products:

LB: Have you ever tried any diet by yourself?

S: actual diet, yes! I don't remember when it was and I vaguely thought about starting it again, but I've done massively nothing about that. Slim Fast, I tried (...) it's American. It's milkshakes and stuff, the idea was a milkshake for breakfast and a milkshake for lunch and then a small meal in the evening (...)

LB: And did it work?

S: The first time it did! I think but it's a very vague memory I haven't really done lots of diet in my life really, and that was probably twenty years ago my mid 20's maybe

Steve has tried different weight-loss practices at different stages of his life. Rather than describing weight-management as a lifelong effort, as it is the case for Holly and partly for Michelle, he describes it as a series of sporadic events scattered over a long time.

Daniel describes his weight gain as relatively recent and links it to specific changes in his work and lifestyle:

LB: ehm and when it comes to weight have you always had problems with weight or...how come that...

D: mhm it's always gone up and down a bit and I was fine up until my thirties I guess so twenty years ago now so about thirty-five ehm because I didn't get a car until I was in my thirties so I used to walk and cycle everywhere ehm John my son didn't come around since I was thirty-four ehm so it was mostly just doing what I wanted to do which is a lot of swimming and cycling and although I ate quite a lot and drank quite a lot of beer ehm I was doing a lot of exercise

LB: And then it changed

D: and then it slowed down my job changed so I was in an office a lot and I cycled when I could but it was a bit awkward cos I was meant to wear a suit or that sort of thing you know ehm yeah so just the whole lifestyle changed over a bit

Daniel joined LNPO after trying to self manage his weight:

LB: Have you tried any other group? Like Weight Watchers or...

D: ehm I thought about it and I had got to the point where I was thinking I would go to Weight Watchers because there's one that meets up at the community centre, but I also knew about the [LNPO] one from the community centre and I looked up the website and at that point, about a year ago, they were doing their one-to-one advice, you could sign up for, so that's when I signed up

LB: So you did the one-to-one first?

D: I did the one-to-one first and that finished kind of late summer, September or October I think, something around that, and then at that point they said they were starting a new group in January and I said "I'll do that! Go for it!"

Daniel links his weight gain to specific life events: becoming a parent and changes in the work environment. Although these events stretch over about twenty years, Daniel's engagement with weight-management seems to be more recent. Nonetheless, he does describe weight management as a process that is going on for a few years by the time we met.

Listening to these accounts of joining a weight-loss programme and how they are often part of more extensive stories of weight management over a space of time that goes well beyond the ten or twelve weeks of the weight-loss programmes strongly delineates the temporal dimension of weight-loss as a process. I suggest that weight management can be understood as a process on two interconnected but distinct levels: a process in the sense of a "treatment" that takes place through a long but specific lapse of time. Here I refer to weight-management programmes that usually have a duration of several weeks, about ten or twelve, and can be extended or repeated on the basis of the organisations' eligibility criteria and personal weight-loss. This process is linked to the idea of support, structure and nutritional information present in the accounts of joining a weight-loss group. This process challenges the centrality of primary care in managing obesity but at the same time reproduces ideas of motivation and behavioural change proper of the healthy lifestyle discourse. Weight-management as narrated by the people I met, it is also a process that lasts, with different intensity and priority, over decades, sometimes a lifelong process that starts at a very early age, from primary school or adolescence, and it is not limited or defined to the duration of a specific weight-loss programmes, although it contains it. Weight-loss is a complex, time and resource-consuming process that is embedded in personal,

familial and social webs and events. These accounts challenge the normative idea that “weight is under individual control” and that weight-loss treatments always work as long as the individual is motivated to keep up with exercise and diet (Greenhalgh, 2012, p.30). The people I met describes experiences where weight management and weight loss are complex, multifaceted and sinuous processes that do not depend exclusively on individual motivation and compliance with healthy lifestyle discourses. The weight-loss group participants I met reproduce authoritative ideas of personal responsibility and behavioural change in the ways they approach and experience weight management. They also recount to have successfully and repeatedly lost weight. Nonetheless, weight-loss is rarely long-lasting, despite individual motivation and awareness of healthy lifestyle practices. This observation problematizes the authoritative idea that the behavioural change prompted by nutritional information can have long-lasting effects. This idea is based on a rationalistic understanding of behaviour and choice and education as information (see Warin, 2017). I will further discuss the limitations of such approach in Chapter Seven. In light of the complexity of weight management relayed by participants in weight-loss groups, I want to reflect on how these lived experiences are navigated and negotiated through specific narratives of the causes of obesity in these biosocial spaces.

### **6.3 What is obesity? Co-existing alternative explanations of obesity**

In this section, I move to reflect on the explanations that group leaders and participants give around the causes of the ‘obesity epidemic’. I propose that the variety of causes they identify and the relevance they give to some of these causes interrelate with the healthy lifestyle discourse promoted in these settings. In addition, these explanations mobilise the same ideas of structure and support present in group participants’ explanations to join a weight-loss group.

In the interviews with leaders and participants in weight-loss groups, I asked them about the causes of obesity in their opinion. Going through their responses and because of the organisation I have given to the presentation of the findings in this thesis, I found myself drawing a comparison with the explanations given by health professionals. From this comparison, it emerges that despite the caloric imbalance remains central to understand the widespread of obesity in contemporary societies, leaders and participants in weight-loss programmes portray a more nuanced picture than that portrayed by healthcare professionals. Alternative explanations of weight gain are presented along with authoritative ones. I want to specify that these aetiological explanations do not privilege medical, e.g. iatrogenic or endocrinological, or social causes of weight gain.

On the contrary, they seem to confirm that the 'obesogenic environment' theory has become a normalised and widely accepted narrative to make sense of obesity and excess weight in general. What is alternative is the relevance that groups participants and leaders give to some aspects of this shared authoritative knowledge, such as the availability and quality of food as well the relevance of cooking skills. These explanations also show how meanings around personal responsibility, causes of obesity and lifestyle are enacted and negotiated by people for whom excess weight is a lived experience.

I interviewed Katherine in the café of the community centre where LNPO is based a few weeks before I started volunteering in LNPO group 2 where she was the group leader. Katherine has experiences running different weight-management groups, for example, she leads a programme targeted only to women who have recently had a baby and one targeted only to men. As a nutritional therapist, she also has one-to-one consultations with people who are trying to lose weight. After describing the differences and similarities between these groups and the one-to-one consultations, I asked her about the causes of obesity in her opinion:

K: what do I think the causes are? I think it is a very individual thing for people, and it can be a mixture of things. It can be mainly one thing and other things around that. So a lot of people I see is the way they have been brought up to making probably not the right food choices, so their background really, and they are often telling me "oh my mum was quite overweight" or "my dad was, has always been overweight" and is generally something like that with a lot of people, not everyone. It can be anything to do with medical reasons why they are putting on more weight. It can be medications they are on; it could be genetics; it could be that they aren't eating mindfully for example and people have lost their connection with food, and the obesogenic society we're in. Food available everywhere and there's a theory that when low-fat food came in, the sugar that replaced the fat had a massive impact on global obesity. It could be to do with a trauma that may have happened to them in childhood or whenever and eating is a way of coping. So it could be more if mental health psychological kind of thing like an addiction

LB: and you see a mix of all of them...and which one do you think is a bit more key

K: ooh ehm I really, really don't know! Well definitely for everyone there's a bit of emotional aspect

Listening to Katherine's response, I found particularly interesting the different causes she identifies and how the "*obesogenic society we're in*" is listed as one of the many causes along with medications, genetics and upbringing. The stress on the "emotional" aspects of people's relations with food and the importance of the social and familial context in shaping food habits that can determine obesity and overweight is recurring in group leaders' explanation of weight gain. These aspects are also recurring in people's stories of weight throughout their life.



Emily's response to my question about the causes of obesity is probably one of the longest and more articulated I have had in the fieldwork. I have tried to synthesise it without cutting off any point of her explanation and maintaining the flow. In her extended response, Emily details the 'obesogenic environment' explanation along with many other causes, some of which were also identified by Katherine.

Oh, so many! I mean from a sort of population perspective, I think our own societies are geared around food and food is just so accessible absolutely everywhere! I mean these places, which are open 24 hours selling food. You might go to a petrol station, pay for the petrol and get some food, and there's a lot of visual triggers. People think "oh actually I'll grab something to eat". I think we've lost touch with what hunger is (...) Portions are gone bigger and bigger and bigger (...) That's what've got accustomed to so we are getting larger and also I think the perception of what overweight is, is warped because we see overweight people so frequently that we might not recognise that we are or someone else might be overweight and is only when we see the extreme, obesity, we think "actually they've got some problem with their weight". But there are so many psychological elements to it as well. Behaviours that people are brought up with, behaviours around food obviously (...) I think lots of time is about education around food and cooking, how to cook food for yourself that is healthy and balanced. We see quite a lot of people coming and saying "tell me what to eat!" (...) Not having much confidence cooking and not having much knowledge. And money is a massive factor as well. So people have a perception of fruit and veg being really expensive and it absolutely can be, but it doesn't have to be. But it's about having the confidence and the skills to know what to do with it. So people rely on those convenience and highly processed food without really knowing what is going in it. Also, it is marketing around food as well (...) so looking at well-being 'cos people are overeating for so many different reasons and a lot of them have a lot of interest in nutrition and are fully aware of what they should be eating in terms of healthy diet and is about breaking down those barriers (...)

I want to highlight both the recurring explanations of an obesogenic environment, such as food availability, portion sizes and normalisation of overweight and the identification of food habits, family upbringing and cooking skills as equally important in determining weight gain. Emily seems to shift from a "*population perspective*", where environmental and structural causes are particularly relevant to understand the increase in obesity, to a more "personal level" where "*psychological elements*" of food behaviours, the impact of upbringing and cooking skills, become meaningful explanations of weight gain. By 'personal level', I mean the interconnection of behavioural, psychological, and social aspects as well more practical aspects like cooking skills. I suggest that this personal level is perceived as fundamental to understand weight gain by nutritionists and dietitians working in weight-management in contrast to health professionals working in primary care. In Chapter Four, I argued that healthcare professionals' explanations of the causes of obesity tend to highlight structural causes of the obesity 'epidemic'.

Here, I suggest that the different relevance given to individual, emotional and structural aspects of weight gain and weight management in primary care and weight-loss groups is informed by the different time and space given to obesity management in these two contexts. The different degrees of importance given to multiple explanations of obesity interrelates with the organisation and duration of weight-loss programmes as well as the understanding of weight-loss as a process. For example, all LNPO weight-loss programmes last about ten weeks during which the same group of people meets once a week for one hour and half, a much longer time than that of a GP consultation.

### **6.3.1 Structural causes: the availability of processed food**

In this section, I narrow my analysis and reflect on the space given to food as a cause of the 'obesity epidemic' by groups participants and leaders' explanations of the 'obesity epidemic'. In line with health professionals' descriptions of "powerful forces" in society, identified in the food industry and big food chains against which primary care is perceived as "powerless", the people I met in weight-loss programmes share the idea that contemporary societies have developed an environment where food is constantly available. Moreover, they stress the fact that the food available is processed food that lack nutritional values and favour weight gain. The food industry and neoliberal market are identified as key players in creating the socioeconomic conditions that bring people to gain weight. Michelle's response very well illustrates this point:

the causes? Is no real food! I really believe that because you go into a supermarket and you look at the food that's available it's packets it's things that you poke holes and put in a microwave processed they make it taste nice by putting salt and sugar in it so much sugar in everything they make things low fat to market it towards the people who are desperately trying to lose weight they're eating food product they are not eating food! do you know what I mean? sooo...everything is processed nothing looks like real food anymore (...) supermarkets are huge huge business such a lot of money in it they need stuff on the shelves for as long as possible so it needs to last as long as possible

During her interview, Michelle often refers to processed food as "*food products*" and links it to a disconnection with actual food due to life rhythms that bring people to have less and less time to cook. The themes and issues that Michelle identifies in her explanation of the causes of obesity, are recurring in LNPO weight-loss programmes where they are addressed through specific activities (see Chapter Seven) and presented as facts.

Larry's response resonates with Michelle's in describing the availability of processed food and its lack of nutritional value:

LB: talking a bit more generally what do you think are the causes of obesity?

L: uffff ehm convenience! It's just the cheapest most accessible form of food are the least nutritious accessible in terms of what is advertised and what is dispersed is cheap and fatty and stodgy and very much lacking in nutrition

Daniel echoes Larry and Michelle by replying that the cause of obesity is *“too much food...everywhere and that's one of the things I kind of knew but has become really clear now following part of this course just how much food there is out there you know”*

Daniel explicitly says how his awareness of the impact of food availability and quality on obesity has been strengthened by the information and activities promoted in the LNPO group he attends. This short quote also offers an insight in how recurring explanations are shaped around the kind of information promoted in the weight-loss programme research participants either take part into or work in and in turn, shape the kind of activities and food knowledge that is shared within these biosocial settings. In Chapter Seven, I will discuss how these explanatory narratives entangle with specific activities of healthy eating by describing three activities observed in the LNPO groups where I volunteered.

## 6.4 Summary

The data analysed in this chapter reveal fundamental and interconnected aspects of obesity management in weight-loss groups. Firstly, I have described how these biosocial spaces are socially and historically situated in various ways and how their integration in public health weight-management strategy is a new phenomenon. I have then moved to reflect on people's choices to join a weight-loss group. Ideas of structure, support and not-judgemental environment are recurring expectations in participants' choice of joining a weight-loss programme. The analysis of group participants' experiences of weight management also reveals how this is a long, time- and resource- consuming process that does not follow a linear development. On the contrary, people's experiences of managing and losing weight show the complexity of a practice that invest them well beyond the time and space of weight-loss group's sessions. Despite reproducing normative ideas of personal responsibility and healthy lifestyle and having lost weight successfully, their experiences highlight the struggles to maintain weight loss. Their accounts problematize the rationalistic and straightforward representation of weight-loss as an effective, long-lasting and straightforward practice that is at the core of the discourse on a healthy lifestyle.

In this chapter, I have also analysed the explanatory narratives of the causes of obesity presented by leaders and participants in weight-loss groups. I have focused on the interrelations between these narratives and the type of activities promoted in LNPO groups as well as compared them to healthcare professionals' ones. The authority of an 'obesogenic environment' explanation of obesity and the recognition of the structural conditions implicated in the onset of weight gain, created by the food industry and food market, shape the explanatory narratives of weight-loss programmes' participants and leaders. I suggest that the ways these explanations are integrated and shape weight-management within these biosocial settings are different from the responses I have been presented with in primary care. I argue that these differences are to a large extent due to the different organisation of weight management in these two contexts, general practice and weight-loss programmes, and particular to the different time dedicated to weight management, as well as to different understanding of weight-gain and weight-management. What I mean here is that the 'obesity epidemic' discourse remains unquestioned and hegemonic in both contexts, but the relevance given to some aspects of this discourse varies. In other words, there are differences in the ways obesity and weight management are enacted.

## 7. Biopedagogies of food and eating: shifting the focus from diet to healthy eating

In this chapter, I reflect on the discursive and practical shift from dieting to healthy eating observed in weight-loss groups. I will use the concept of biopedagogies to analyse the practices this shift produces, both in continuation and in contraposition with “dieting”. I will then move to explore specific activities around food and eating observed in these groups, to reflect on the medicalisation of food and the different understandings of the relations of food, eating and body, promoted through these activities. In this analysis, *healthy eating* is both a conceptual tool I use to analyse the data and an authoritative discourse emerging in these specific sites. I argue that this shift to “healthy eating” is used to navigate and negotiate stigma and some contested discourses of the authoritative knowledge around obesity. I will draw on Mol’s concepts of enactment and ontotnorm to look at how different ideas of nutritional knowledge coexist in weight management settings. I finally move to analyse how weight-loss group participants enact healthy eating in everyday life as “enabling” practices. This final reflection attends to individuals’ agency in a context of surveillance and further problematizes the dominant idea that losing weight is simple and straightforward (see Chapter Six). This analysis also contributes to understanding further the medicalisation of food in obesity management, drawing on social and cultural anthropological approaches to food and eating.

### The discourse on healthy eating

On the first session of the first weight-loss group where I volunteered, Jane, the group leader, describes the programme as a “*long-term lifestyle changes programme*” and soon after underlines that: “We are not Weightwatchers or Slimming World. We are not trying to sell you a diet”. Interestingly, a similar narrative is also deployed in those commercial weight-loss organisations that are often addressed by LNPO leaders as the epitome of the very model of diet from which “healthy eating” is purportedly moving away. For example, Holly, a group consultant and member at Slimming World, describes the organisation’s approach as a “*healthy eating plan*”:

So at Slimming World what is the diet, if you like, is a healthy eating plan, is so different from anything I’ve ever tried before. There is no restriction, so it’s much more about, the focus is on a huge amount of food that you can enjoy freely because it’s good for your health

Holly suggests that one of the main differences between diet and healthy eating plans is the different degree of food restriction. This view is also presented on the website of the commercial

weight-loss organisation she is a member of, which promises users they will “*Discover a world of weight loss without dieting*” (Slimming World website).

These examples show an underlying understanding of the differences between dieting and healthy eating that is recurring in most participants’ accounts. In the messages, conversations and practices I observed in weight-loss groups, dieting is assumed to be a restrictive, unsustainable and inefficient regime. On the contrary, healthy eating is described as allowing more freedom in consuming “*huge amount*” (see Holly cited above) of food and only limiting the ‘unhealthy’ choices. What is healthy and what is unhealthy food is unstated and taken for granted.<sup>34</sup> This discursive shift from dieting and increased focus on healthy eating is central to the healthy lifestyle discourse that governs the weight-loss settings in this fieldwork.

This shift is also promoted in public health interventions. As seen in section 4.2.1, behavioural change through nutritional and dietary education is at the core of current public health promotion of healthy lifestyle in obesity-related policies in the UK. In recent years, public health messages and interventions prefer to use terms like ‘healthy lifestyle’, ‘healthy eating’, and ‘healthy weight’ over terms like ‘diet’ and ‘normal weight’.

In research participants’ conversations, the term “diet” seems to assume an intrinsically pejorative and less-scientific quality compared to healthy eating. This is often presented as an underlying, shared assumption but rarely explained. I suggest that this assumption can be interpreted as the result of three aspects. Firstly, it serves to re-establish food and eating as domain of nutritional expertise, against a backdrop of countless fad diets promoted by non-experts over the last five decades. Secondly, it implicitly negotiates the inefficacy of weight-loss diets in managing obesity as an epidemic (see Swinburn et al., 2011) and the stigma associated to excess weight. In this sense ‘healthy eating’ is presented and understood as a more efficient, scientifically based, and neutral approach to losing weight where the focus is purportedly on health rather than on weight and/or body size. Lastly, competing local weight-loss services use this discourse to advertise and validate the quality of their weight-management programmes. For example, LNPO advertise their programmes as weight-management courses based on nutritional education and healthy eating. The lack of commercial goals is also used as a self-evident guarantee for the scientific basis of the programme. This process is embedded in the

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<sup>34</sup> As I will examine in the following subsections, despite nutrients being the new normative value to define “healthy food”, in contrast to calories which are central to most diet regimes, this is still inferred to be food with low caloric values, like fruit and vegetables.

localisation of obesity management services fostered by current public health strategy to address obesity in the UK (see Chapter Four).

This chapter aims to explore how the discourse on healthy eating is brought about in practices. By volunteering in LNPO programmes, three aspects of the information and activities promoted in those sites raised my interest: firstly, the pedagogical way nutritional knowledge was conveyed and received. Weekly meetings were organised as workshops, nutritional information communicated through slides, peer discussion, leaflets and practical activities. Group participants were invited to do their “homework”: that is to implement the nutritional information received in the group sessions and transform it in improved food and eating habits. Secondly, the participants I interviewed were actively implementing “healthy eating” information and using nutritional knowledge as the privilege device to understand and shape their eating and food habits. Moreover, many were confidently using a variety of technologies and information, gathered both within and outside the weight-loss programmes, to monitor and discipline their daily eating. Thirdly, it became immediately evident that healthy eating was a way of doing not just of knowing or thinking. Enacting healthy eating in weight-management programmes and everyday life encompasses specific materiality and actions: the way food is stored, handled, chewed, and tasted; the type of kitchenware that is better to use; how to manage food packages confidently to read ingredient and nutritional labels. For this reason, I analyse data collected through participant observation in three LNPO weight-loss programmes and interviews with weight-loss participant and leaders. My analysis is also informed by data collected through materials like leaflets and newsletters distributed by LNPO and LFC. My analysis will focus on three specific activities I have taken part when volunteering in LNPO groups, called *meal planning*, *hunger triggers* and *mindful eating*. Before moving to explore these activities, I want to define biopedagogies of healthy eating and explain why I found this concept useful for my observation and analysis.

### **7.1 Biopedagogies of healthy eating**

I use the concept of *biopedagogies of healthy eating* to examine the set of nutritional and bodily practices and competencies promoted through the discourse of healthy eating in the sites of this research. I draw on the concept of biopedagogy as conceptualised by Harwood (Wright and Harwood 2009) who combines Foucauldian theory of biopower with the social science theorisation of pedagogy as a “*relational cultural practice through which knowledge is produced*” (Harwood in Wright and Harwood 2009, p.21). Harwood deploys this concept to analyse the

disciplinary and normalising discourses and practices produced around and in response to the 'obesity epidemic'. Thus, in the context of obesity-related research biopedagogies can be defined as normalising and regulating practices generated by the 'obesity epidemic' discourse. I apply this definition to analyse the practices and knowledge promoted in the weight-loss groups that I researched and to the specific discourse of healthy eating that governs these settings. I find this concept particularly useful for my analysis as it allows for bridging understandings of how biopolitics operates through the discourse of healthy eating with a critical understanding of nutritional education as an authoritative knowledge.

Mayes and Thompson (2015), maintain that in contemporary neoliberal societies, biopolitics operates through "governing the putatively free choices and behaviours of individuals" (p.588) to promote the health of the population. They note, "the biopolitical imperative for individuals to live healthy lives is particularly intense in the area of food and diet" (Ibid). This imperative is central to the 'obesity epidemic' discourse and therefore it is particularly pressing for those interventions aimed at obesity management and for those people targeted by these interventions. Nutritional science is the authoritative knowledge used "to reinforce messages about healthy eating" (ibid.). Nutritional education is the primary cultural practice through which this knowledge is conveyed and inscribed in people's food and eating habits. Through nutritional education, food, eating and bodies are regulated, disciplined and governed, and specific subjectivities produced. Nutritional education promotes a rationalisation of behaviour, choice and food that silences the interrelation, affective, material, socioeconomic and cultural features of food, eating and health behaviours<sup>35</sup> (Cohn, 2014). In the biopedagogies of healthy eating, food is reduced to its nutritional value, and eating behaviours are conceptualised and acted upon as isolated actions determined solely by individuals' free choice, motivation and nutritional competence. The structural and situational factors that inform individuals' choices, the sociocultural meanings attached to food and eating, and the sensorial relations with food are put in the background. In analysing the healthy eating activities on 'hunger triggers' and 'mindful eating', I will further explore how bodily triggers and senses, like taste and pleasure, are assumed to be problematic and then in need of rational control (see 7.2.2 and 7.2.3).

Another important aspect that defines the biopedagogies of healthy eating is the way in which nutritional education is also understood in rationalist terms. As argued by Warin (2018) in her

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<sup>35</sup> I have discussed this aspect in section 4.2.1.



ethnography of weight-loss intervention in an Australian community targeted as obesogenic, interventions to address obesity deploy a specific understanding of knowledge as the transmission of information (p.114). Following this understanding, people can adopt healthier behaviours and ultimately lose weight by being instructed with the relevant nutritional information. I observed this kind of approach in the weight-loss settings of this research where people who want to lose weight are equipped with normative, preformed nutritional information to use in their everyday life so to adopt healthy eating habits. This information is usually imparted through charts, leaflets, recommendations, recipes and food diaries based on the Eatwell guide.

I follow Warin's (2018) discussion in identifying two problematic assumptions of this conceptualisation of nutritional education, assumptions that I argue are embedded in the biopedagogies of healthy eating. Firstly, this approach assumes that people defined as overweight or obese are ignorant; that is, they lack nutritional knowledge. Further, the lack of nutritional education tends to be associated with specific social status. In the UK, higher obesity rates are increasingly identified with lower-income groups and deprived areas, and the correlation between deprivation and obesity is now understood as a fact. In the healthy lifestyle messages and conversations around obesity with which I engaged in the fieldwork, these assumptions are uncritically presented as facts and detached from the social, structural, and health inequalities in which they are embedded (see Chapter Four and Six). This uncritical detachment runs the risk of reproducing classed, moralising and stigmatising assumption that obesity is the result of individual lack of knowledge and education (Warin, 2018). The research findings I will discuss in section 7.3 strongly problematize these assumptions. As Michelle, an LNPO group participant puts it during our interview: *"I'm not stupid, I know how to lose weight"*. Many of the people that take part into weight-management interventions are already aware of the nutritional information they are going to receive but still they struggle to use them in everyday life and over a long time. It is also important to consider that those who do not comply with this normative nutritional education are nonetheless promoting different food habits that do not find space within obesity-management initiatives.

Secondly, the healthy eating discourse reproduces the idea that food knowledge is a cognitive, rational process based on causation. Biopedagogies of healthy eating deploy "a model in which patterns of approved conduct are instilled by knowledge delivered as explicit instruction from expert to novice" (Warin 2018 p.116). The idea of food as nutrients and behaviours as individual

free choices are central to this understanding of education as information. This instructive model of education underplays the embodied skills and practices that are fundamental to food knowledge.

To summarise, biopedagogies of healthy eating involve *“a double process of medicalization and moralization that entails changing inadequate dietary habits and transforming them through learning into a new set of good practices”* (Gracia-Arnaiz, 2010 p. 223). I describe biopedagogies of healthy eating as disciplinary practices characterised by a shift from dieting to healthy eating within the broader frame of obesity-management. Nutrition is the authoritative knowledge that governs these biopedagogies, which are based on rationalistic understanding of education, food, eating and choice. This understanding is problematic, limited and stigmatising as it reproduces moralising and classed judgments around education and health. As I will show in the following sections, biopedagogies of healthy eating are technologies of the body and the self that promote self-control and discipline as privileged tools to achieve weight-loss and individual betterment. I will also discuss how they are inherently multiple and contested despite the uniformity they purport.

## **7.2 Enacting healthy eating**

In the weight-loss programmes where I did my research, nutritional information is the main device through which participants are educated to change unhealthy food habits and adopt healthier ones. I define and approach the information, activities and practices promoted throughout the weeks in the LNPO groups where I volunteered as biopedagogies of healthy eating. In this section, I suggest that the focal shift from diet to healthy eating can be understood as a response to the stigmatisation of obesity and the perception of weight as a sensitive topic in weight-loss groups. Moreover, since biopedagogies of healthy eating are centred on food and eating, I argue that it is productive for my analysis to look closely at how food and eating are enacted in weight-management programmes. In this section, I use Mol's (2012;2014) and Vogel's (2014) analysis of food and dieting in dietary interventions in The Netherlands where they show the coexistence of different sets of knowledge used to enact food and the body within nutritional education. To explore these enactments, Mol coins the term *ontonorms* and defines it as a methodological tool that “sensitises us to materialities and issues of good and bad at the same time” (Ibid.p.3). Mol proposes that this methodological tool allows to attend to “ontologies as well as normativities” in analysing “particular practice where ‘science’ interferes with ‘daily life’”, such as dieting (Ibid.). In other words, ontonorm is a methodological tool useful

to explore how different dieting techniques enact different foods and different bodies while conveying different ideals, dangers and other goods and bads that intertwine and clash with one another in a dazzling range of ways. (Mol, 2012, p. 13)

It is possible to unravel the multiple sets of knowledge - such as physiology, nutrition, biochemistry - that coexist in nutritional interventions whilst attending to the normative discourses and practices that govern them. I welcome Mol's invitation to experiment with this novel term in my research. I use it to explore and analyse the multiple and at times competing knowledges and practices around food and bodies that I observed in LNPO programmes. I suggest that this multiplicity is a feature of the biopedagogies of healthy eating that are at play in the weight-management settings where I conducted my research.

I also find Mol's attention to food as matter particularly productive for my analysis, as it allows thinking of food and eating as made meaningful through embodied experiences as much as through systems of knowledge and through interaction. In my exploration of healthy eating activities in LNPO groups, I bridge this approach to food with Warin's (2018) discussion of the limitations of the conceptualisation of nutritional education as instructive (i.e. based on information) rather than as also embodied and practical (i.e. based on practical experiences and skills), as I presented in section 7.1.

The shift from dieting to healthy eating is evident in the activities promoted in LNPO programmes. This shift reproduces a growing understanding of weight-management as life-long process rather than a goal achievable within the shorter time of a diet. The overarching message promoted through the healthy eating activities I observed equates managing weight with adopting a healthy lifestyle, where lifestyle is understood as the combination of healthy eating and exercise made visible in someone's body size and quantifiable through weight. The new focus on healthy lifestyle well adjusts to the growing neoliberal ideology of health as a life-long individual project of the responsible biocitizen (see Crawford, 1977, 2006; Greenhalgh, 2015). In this sense, the shift to healthy eating can be seen as a new language to describe old and well-established dieting regimes: "if 'slimming' or 'reducing' do not capture the contemporary (female) imagination, then 'lifestyle change' with its aura of enlightenment, progress, and self-improvement surely does" (Heyes, 2006 p.129). At the same time, I suggest that this shift can be read in a more nuanced way as a negotiation on the ground between people's expectations, everyday lives, authoritative discourses of obesity and health, and need for funding. The data I have collected describes a shift where dieting is still an authoritative underlying discourse that

resurfaces in the language and bodily techniques used in weight-management programmes based on ‘healthy weight’. At the same time, some core practices of dieting, like weighing and calories counting are discouraged or limited by the approach promoted in these programmes. In the next three sections, I will analyse three activities around healthy eating that I observed in LNPO programmes. The data I present was collected in the three LNPO groups where I volunteered. LNPO groups are organised in the same way, using the same information, materials and weekly succession for each activity. My main sources of data are field notes, slides, leaflets, food diaries, conversations as well as interactions with objects like scales, food, plates.

### **7.2.1 Meal planning**

As mentioned before, promoting a long-term lifestyle change in participants’ habits towards food, eating and exercising is the primary goal of LNPO weight-management programmes. Promoting information on and practices around how to plan a balanced meal has a significant part in the achievement of such change. Hence, I will start my analysis by looking at the first of three activities I have chosen to explore the enactment of healthy eating: “meal planning”.

Under the label “meal planning”, I refer to three activities run in three consecutive weeks, focused on planning a balanced meal. The three activities are:

Week 1- getting to know the “*Eatwell Guide*”, a visual representation of four food groups on the base of their nutritional value. The guide is produced by Public Health England and is designed to easily communicate the UK healthy eating model to consumers (British Nutrition Foundation, 2016).

Week 2- “*Portion sizes*”, this week’s activity uses the Eatwell Guide to look at healthy portions for each food group.

Week 3 - “*Portions in action*”, a more interactive session focused on how to spread healthy food group portions throughout the day.



Figure 6. The Eatwell Guide

### WEEK 1- The Eatwell Guide

It is a cloudy mid-October afternoon and the second week of volunteering in my third weight-management group. Three new participants have joined the group. When the session starts, Katherine, the group leader, asks the group how they got along with the SMART goal they set the previous week, whether they made any change in terms of portions and eating habits. Participants' responses become the perfect cue for Katherine to present today's argument: a *balanced meal and the Eatwell guide*. Katherine sets up the slides while I hand out to each participant a booklet that contains the image of the Eatwell guide (figure 6) and bullet-point information on the food groups included in the plate. The Eatwell guide shows what food groups people need to eat and in what proportions to have a healthy diet. "Are you familiar with the Eatwell guide?" Katherine asks the group. Most participants had seen this graphic before and seem familiar with the information included in the booklet.

This whole session is based on nutritional information for each group of food: starchy food, fruit and vegetables, proteins, dairy or alternatives and oil and spread. Foods and drinks high in fat and sugar are considered an extra group which should be avoided or limited as much as possible as it has "*no nutritional value whatsoever!*", Katherine explains. In this group are included crisps, chocolates, fizzy drinks, and most processed food.

As also observed in the other two LNPO groups, the session on the healthy plate tends to be the least interactive of all as it is very instructive. The interaction mainly consists of participants' responding to group leaders' questions on each food group, such as: *"Do you know what kind of fat are good for health?"*, *"Do you know why we need proteins? And where do we find them?"* or *"Who does not have breakfast?"*. After every question, the group leaders explain why the specific food group is important, mainly in terms of nutritional values and often add practical suggestions in response to participants' habits or comments, for example explaining why it is important to have breakfast and what food group to have for breakfast.

For example, this is how Katherine explains "why we need proteins":

Proteins are important for muscles repair and growth. Also, they gonna make you feel full for longer...because they regulate blood sugars level, they also have iron and B12 which is good for immunity and stuff like that

Similar explanations are given by group leaders for other food groups, for example when talking about starchy food and carbohydrates both Jane and Katherine advise to choose whole grain because as Katherine explains *"refined, white flour is almost like sugar, it goes whoop just down, whole grain instead takes longer to break down, to digest, so it keeps you going for longer"*.

In these exchanges and explanations, food is a matter made meaningful in terms of its nutritional value, deploying a biochemical and physiological set of knowledge. *"Foods are nutrients"* (Mol 2012 p.7) and these nutrients (biochemistry) need to be both balanced and varied for the body to function properly (physiology) and be healthy. Participants who want to eat healthy and lose weight are required not only to know the different food groups, their nutritional values, and proportions; they are also informed on how these nutrients work in the body and what effects they have on appetite, for example in terms of digestion and blood sugar levels.

This kind of specialised knowledge is negotiated, expected and reproduced by group participants who often ask very specific questions that reveal already existing awareness and knowledge around nutritional information. For example, vegetarians in both LNPO group1 and group 3 ask Jane and Katherine where to find alternative sources of calcium, vitamin B12 and iron; they also enquiry about the use of supplements, and share information gathered on their own time on nutrients and food substitutes. At the end of this session on the Eatwell Guide, participants are asked to do some homework and fill out a diary with meals they have throughout a day and divide each meal in the five food groups to evaluate how much balance they have. They are also given a magnet of the Eatwell guide to *"put it on your fridge or carry it around as a reminder when you prepare your meals"* as Jane suggests.

Despite the evident centrality of a biochemical understanding of food, the underlying focus remains on weight-loss and consequently on the caloric balance. In fact, the idea of a balanced and healthy meal based on food as nutrient entangles with the idea that a healthy meal necessarily leads to weight-loss or at least does not favour weight-gain. Emily is a nutritionist who works in LNPO and ran some sessions of LNPO group 1. Her words enlighten this entanglement: *“if we can focus on health and nutrition and relationship with food quite often weight will follow from that”*.

### **Week 2- Portion sizes**

The biophysical explanation centred on the caloric imbalance acquires more centrality in the following two weeks where the focus is on portion sizes. In the week focused on portion sizes, the Eatwell Guide is broken down into meals and portions from each food group to plan a balanced meal in terms of both nutritional and caloric value.

Jane and Katherine present portion size and their importance in very similar ways. Jane explains to participants in LNPO group 1 that looking at portion sizes is important to

get the balance right...and although we don't really focus on calories, what is outlined in this book is the amount of portions for each of these groups you need to achieve a certain number of calories which will see you lose weight.

Similarly, in LNPO group 3 Katherine announces:

So we look at sizes today and see where we could potentially start making some changes so we are not saying you have to start measuring things and all that annoying stuff.

And later, in response to the question from one of the participants on how many chips make one portion of carbohydrates, Katherine says:

I don't want you to get too finicky about 'I must count out things', it's not about that, it is about handful, palm size, roughly

From these comments, two aspects become particularly clear. Firstly, when talking about portion sizes the long-established language and logic of dieting where food is fuel for the body-machine (see Gard and Wright, 2005; Wright and Harwood, 2009; Mol, 2012) powerfully surfaces. The authoritative explanation that weight gain is the direct consequence of caloric imbalance is maintained as well as the assumption that today's environment is one that favours this imbalance, so that all bodies are potentially at risk. As Jane's words exemplify:

Food sizes have changed over the past years, look at bagels, crisps, and we don't compensate that with exercise, so we eat more and consume less.

Secondly, within the frame of ‘healthy eating’ the practices that characterize dieting regimes, namely calories counting and food weighing, are openly discouraged in favour of other disciplining practices of food rationalization. These practices of measuring food through “handful” and “palm size” share with dieting the biophysical definition of food as fuel where foods are sources of energy quantified in kilocalories and kilojoules. But they also introduce the idea of food as matter that can be handled, touched, measured using one’s hands, as opposite to the practice of calorie counting where food is medicalized into a sterile matter with specific values (caloric content) that are only accessible through an external source of information (caloric labels). The different materiality promoted - scales and cups for diet, hands and palms for healthy eating - produce different sensorial relations with food.

It is important to note that looking at portion sizes is not just another way of looking at calories and then reproducing the exact same bodily techniques and understanding of food promoted through the discourse on dieting. The kind of surveillance on the body and self also differs, for example by discouraging participants to weigh themselves, as I will illustrate in Chapter Eight.



*Figure 7. Plastic food and plate used in LNPO, "Meal Planning" activity.*

For the first activity on portion sizes, participants are divided in smaller groups and asked to use their food diaries from the week before. They are instructed to choose three meals from the food diaries and divide them first into food groups and then to divide each food group into portions. Both Jane and Katherine use plastic food, like plastic tomatoes, chicken breast, and bread as samples of portions. In both weight-loss

groups, this activity was participated in a very interactive way. While I move from table to table, answering questions, exchanging comments, laughing at jokes from the participants, I have the feeling that people actively engage with the nutritional recommendations shared by the group leaders and that most of their interaction runs around exchanging tips, ideas and recipes to stick to portion sizes and food groups' balance. Interestingly, by the end of the activity a few participants exclaim, not without surprise: "I need more proteins!", or "I need more of everything!".



I suggest that these findings reveal how the shift of focus from calories counting to nutritional values maintains the assumption that overweight is mainly a consequence of overeating. They also evidence a different approach to food: while in the calories-counting model overeating is intended primarily in terms of quantity of food, in the healthy eating model overeating is framed in terms of quality of food. Looking at food as nutrients partly shuffles the assumptions on weight gain and food associated with food as energy. This enables participants with the idea that they are not eating enough of the “right food” rather than reproducing the idea that they are simply eating too much.

### Week 3- Portions in action



Figure 8. Cereals, raisins, plastic food and kitchenware used for the activity "Portions in Actions", LNPO group 3

The third week dedicated to meal planning is called “Portions in action” and for the first time since we started the programme four weeks earlier, the group activity includes actual food like pasta, rice, and breakfast cereals, and participants are encouraged to use kitchenware, like breakfast bowls, plates, and spoons. Divided in small groups, participants are asked to use their food diaries and “*what they would normally have*” or “*what they think is the right portion*” of food for each food group in each meal throughout the day. Daily meals are divided in breakfast, morning snack, lunch, afternoon snack, dinner. For example, if they normally have cereals for breakfast, they are asked to pour as much as they would normally have in the bowl and then work out how many portions of carbohydrates that adds up to. Also, they are asked to experiment with different bowls and plates sizes to visualize how their perception of portions

changes. This is a very interactive and engaging activity, and going from table to table I hear participants exchanging comments, laughing, asking questions to each other and to the group leader, while they use their hands, cups, plates, and scales to measure up portions of breakfast cereals, rice, pasta.

In this activity, tactile and practical experiences of food are disciplined through the measurement of portions and nutrients. Like in previous weeks, participants are asked to do some homework related to the activity and information shared during the session so to initiate small changes in their eating habits. The aim for and importance of making changes in participants' eating habits is openly stated and often repeated by group leaders. Moreover, each session concludes with tips and suggestions from the group leader on how to implement these changes. For example, Jane concludes this third week on portion sizes and planning a balanced meal in LNPO group 1, giving some tips on how to reduce portion sizes, indications which are also present on the materials handed out to participants over the weeks. These instructions are particularly interesting for the levels of competence and aspects of everyday life they address. The most frequent are: "plan your meals ahead", "measure before cooking", "fill half your plate with vegetables", "don't eat in front of telly", "chew and if possible, buy smaller bowls and plates". All these eating and cooking techniques bring food back into the kitchen and the supermarket. They attempt to promote embodied and skilled relations to food but subordinate them to instructive and rationalistic models of nutritional education. These activities reproduce the idea that a healthy weight, i.e. a normal BMI, is the mere consequence of informed consumption and eating choices.

The regulating and disciplinary nature of the biopedagogies of healthy eating act upon and normalize people's eating habits in many spheres of everyday life and require active engagement in all these spheres. It is evident here that Gracia-Arnaiz's (2010) argument on dieting regime as establishing not only what people can eat, but also when, where and with whom can also be applied to the healthy eating model. Through these regulatory practices, food, defined mainly as nutrients, is also resocialised and commodified. In order to eat healthily and lose weight, weight-loss group participants have to navigate different subjectivities and status: the healthy and responsible citizen, the informed and savvy consumer, the competent and organised cook. I suggest that the main difference with dieting regimes is the different focus on body and weight. Dieting, which is centred on calorie counting and weight-loss, posits the body as privileged target

of surveillance. The healthy eating discourse, instead, sets its focus on food and eating habits as principal sites of surveillance.

### 7.2.2 Hunger triggers

In the three LNPO groups where I volunteered, the seventh week of the programme is dedicated to the subject of “hunger triggers”, which is to those external and internal stimuli that are deemed to induce people to overeat. Rita, the group leader who is covering for Katherine in LNPO group 3, introduces the session on “hunger triggers” as follow:

Today we look more to the psychological side, thought patterns and think about changing patterns. Do you have habits around food? ‘Cos at the end of the day we all know what a healthy balanced diet is and [the point] is ‘why we don’t do it? Why we can’t do it? Why are our thought patterns telling us it is OK to eat this or that’ and this is what changing habits it is about. With every action that we do around food, generally there is always a trigger.

From Rita’s words, three assumptions at work in LNPO programmes become evident: firstly, that changing habits is the main goal to lose weight by eating healthily. Secondly, that the knowledge of what is a healthy diet is considered acquired or common sense. Thirdly, that eating is strongly associated to emotions and that these emotions are depicted as inherently problematic. This third point is at the basis of the information and activities around hunger triggers.

In the information shared by group leaders, triggers are divided in external and internal, although “many internal and external triggers overlap” (Emily, nutritionist, LNPO group 1). External triggers are described as physical inputs like smelling and seeing food while internal triggers are described as feelings, emotions, behaviours and psychological inputs. In describing the activity on hunger triggers, I will mainly draw on data collected in the LNPO group 1, as this is the group for which I wrote more extensive field notes for this activity. I, nonetheless, rely also on observations from the other two groups.

Emily, who is covering for Jane in LNPO group 1, opens the sessions on hunger triggers explaining what they are and how to recognise them. She mentions social occasions where everyone eats as an example of external triggers. She describes internal triggers as “(...) *based on feelings and emotions, what’s going on with us*”. She then adds, asking participants to think about possible solutions to control hunger triggers: “(...) *trying to think of what is really going on, rather than having that sort of habit of having something to eat, can help us with making our choices around food*”. In her words too both the body and emotions are addressed as problematic and in need of control. Participants are invited to monitor and act upon their instincts so to better understand

and control them. These information and practices are promoted through two specific activities. The first one, which I describe here, requires participants to work together to recognise triggers and find possible solutions. The second activity, which happens in the consecutive week, is based on mindful eating and I will describe it in the next section (7.2.3)

For the first activity, participants are divided into two small groups and are asked to think of examples from their daily life for each category of triggers and suggest possible solutions that do not involve eating. Each group write triggers and possible solutions on a whiteboard. After about twenty minutes, each group is asked to share and compare with the other group some examples and solutions they have identified. Many triggers and possible solutions are similar and recurring in the three groups where I volunteered.

### **External triggers**

By identifying external triggers in possible any life circumstance that involves food, from walking down a street full of coffee shops and takeaways to coffee breaks at work or social gatherings and special occasions, discourses of self-control are mobilized in relation to socialization.

For example, some recurring suggestions from participants to avoid overeating at home, at work or in social occasions are: *“if you are around people eating pudding, get some water, or a tea instead, or think what you might do with the money you save”, “bring healthy alternatives to work, or social gatherings”, “have one treat but do not overdo, control portions, tell people you are cutting down”, “swap unhealthy options like biscuits with healthy ones, like apples in the house or on your desk at work”*(fieldnotes 03-02-2016). All these suggestions, many of which come from group participants who have already deployed some of them, focus on socio-material circumstances and the ability to control both the self and the environment, e.g. co-workers, friends, family. It is worth noting how in these sites, the request to invest on weight-management in social settings exists along with the rooted and common idea that weight is a sensitive and intimate topic. This is an example of how the healthy eating discourse can be understood as a way of negotiating the stigma attached to weight by shifting the focus from diet to health, as it is also evidenced by the recurring reference to healthy or nutritious food rather than to calories or energy. This shift is remarked by participants, as it is evidenced in the following comment from Danielle, a young participant working for the NHS: *“people are much more supportive when I say that I am trying to eat healthy rather than I am on a diet”* (participant in LNPO group 3) or in appreciations such as *“I particularly appreciate it is about healthy eating and not dieting”* (anonymous comment).

### Internal triggers

The same kind of suggestions on healthy food habits is used to discuss possible solutions to internal triggers. Participants identify internal triggers with emotions such as stress or boredom and the view of food as reward. In this instance, all the strategies suggested, require the individual to control their own habits, even the most unconscious ones, through both a work on the self and bodily techniques. For example, a recurring suggestion among participants is that if people think they eat because of stress, *“they can try to deal with it walking, getting fresh air, reading, or listening to music instead”*. Whereas if food is eaten out of boredom or as a reward, people could try and *“find something else to do or can be another kind of reward, like a bubble bath, or something you like”* (fieldnotes).

As discussed in the previous section (7.2.1), activities around meal planning, enact food and eating habits as sites of surveillance. On the contrary, in identifying hunger triggers and possible solutions, the person becomes the site of control and discipline. External triggers demand the individual to take control of social and material relations; internal triggers demand to control and work on the self (emotions, feelings) as much as on the body (cravings, hunger). This reveals that bodily discipline underlies the ways in which hunger triggers are understood and practiced. I suggest that these examples show the multiplicity inherent in the biopedagogies of healthy eating where both loci of surveillance coexist. The kind of normative and disciplinary technologies that biopedagogies of healthy eating demand is evidenced in the handout for the week on hunger triggers. Participants are invited to complete the food and mood diary and experiment with some of the strategies discussed in the session to control the internal triggers, which are informing their unhealthy eating behaviours. Emily describes the best way for participants *“to recognise the craving and get in control of that situation”*:

Find your 3 best strategies and if you have tried all three of them and still want to eat that food, that is absolutely fine, we don't have to punish ourselves so don't be too hard on you and if you have tried three things that is absolutely fantastic, it's a lot more control than most people have

In talking about internal triggers, food is enacted as a reward, and source of pleasure and bodily sensations, like hunger and cravings, are depicted as problematic and misleading as they are assumed to drive the person towards the wrong food choices. In other words, this biopedagogy of healthy eating reinforces the idea that people are “normally” driven towards unhealthy food, where unhealthy means lacking the right nutrients and having plenty of the wrong ones, for

example sugar and fats that favour weight gain. In order to “*challenge these behaviours*” (Emily), control becomes a central technology where the nutritionally well informed and motivated self takes control over misleading emotions and a pleasure-seeking body. The acknowledgment of pleasure and commensality as fundamental aspects of eating coexist with the normativity of food as nutrients. This coexistence rests on a hierarchical web of meanings and practices where nutrition is the authoritative and normative understanding of food and eating (see Vogel and Mol, 20114). Pleasure and commensality are reduced to problematic aspects of food and eating to control and discipline. The biochemical enactment of food overrides all other understandings of food, eating and body and requires group participants to accept and practice this hierarchy when and if they want to lose weight. It is also worth noting that the promotion of strict disciplinary technologies of the self are accompanied by the suggestion of not being “*too hard on you*” (Emily), as it is also repeated by Jane:

What you have to do when you have a lapse, put a bit of weight on, is not to beat yourself up, but be positive, move on, think about your goals, long-term goals, why you are trying to lose weight and learn from experience

I suggest that this kind of recommendations respond to group participants’ expectations of “lack of judgement” and support in weight-management programmes so that rather than being punished or told off for lacking control, participants are encouraged to be kind to themselves and reassured that weight-gain and lapses are a common part of the long weight-loss process. I also suggest that unlike a common representation of dieting regimes as one-off, time-limited activities, programmes based on healthy eating recognise weight-loss as a long, non-linear process. They thus normalize lapses and weight-gain within weight-management. However, this normalisation is functional to the weight-loss promoted through the healthy lifestyle discourse: lapses are recognised and accepted as a strategy to maintain motivation to lose weight. I, therefore, propose that even though these suggestions of self-care seem to loosen the centrality of control, they do reinforce it. In the activities of hunger triggers, lapses and weight-gain are made acceptable within a frame of self-control. Participants are instructed to value their ability to control their inherently problematic bodies and emotions over a long lapse of time, as evidenced by Emily’s suggestion that “*if you have tried three things [strategies to control hunger triggers] that is absolutely fantastic, it’s a lot more control than most people have*”.

In the next section, I will present the activity on mindful eating and further develop my analysis on how healthy eating practices address alternative aspects of eating – such commensality,

pleasure and taste- but at the same time reinforce the normativity of nutritional values and the paradigm of control.

### 7.2.3 Mindful eating

The integration of mindful eating in weight-loss programmes is relatively new, and despite a common agreement among nutritionists and psychologists on the benefits of mindfulness on promoting healthy eating behaviours, the long-term effects of this strategy on weight-loss have still to be assessed (see Mantzios and Wilson, 2015; Tapper, 2017; Landry et al. 2018). As Jane says when presenting the activity to participants in LNPO group 1, the organisation had only very recently introduced mindful eating as part of its weight-management programmes. However, few participants were familiar with the idea of mindfulness and its application to eating. In this section, I explore how mindful eating, which is based on sensation and pleasure, rather than control and measuring (see Vogel and Mol, 2014; Landry et al., 2018) is negotiated and appropriated in LNPO programmes that promote biopedagogies of healthy eating (see section 7.1). I will start by describing the session on mindful eating run in LNPO group 1 by Jane, the same activity and information were shared in LNPO group 3. Unfortunately, I was not present to this session in LNPO group 2.

The session on mindful eating follows the one on hunger triggers and starts with a recap of hunger triggers from the group leader and participants, who share experiences of what strategies they have used to control their triggers over the week. Jane welcomes people's anecdotes and suggestions on how to control their hunger triggers and eating behaviours, reminding the group that *"most of the time when we eat, it's not because we are hungry, is because of boredom, or loneliness, or anxiety or sadness...but we resort to food to fill that gap"*. Here, the link between emotions and food is recognised and stressed, and the importance of control over emotions reiterated. Jane also repeats a few times the importance of not being too harsh on oneself and to recognise that weight-loss is a long process, which requires the individual to be extremely resourceful: *"it is normal to have lapses when you are making a big change"*. Continuing on the importance of managing lapses, Jane also talks of how life events and material circumstances can affect people's ability to maintain that kind of control that weight-management requires, she explains that *"being unwell, moving house, new job, this sort of things can really take a while, so don't be hard on yourself [if you have lapses]"*. Jane recognises the relevance and impact that life events and personal circumstances have for weight-management, mobilising the idea that weight-management is a complex and demanding

practice that cannot be reduced to a rationalistic understanding of choice and nutritional knowledge. Nonetheless, the importance of relational, social and personal circumstances in people's relation to food, eating and weight is once again disciplined through technologies of self-control, as also seen in section 7.2.2. Thus, the opening conversation on lapses and hunger triggers serves as a way of reiterating the importance of self-control and as an introduction to the idea of mindfulness and mindful eating. Jane asks if anyone is familiar with the term mindfulness, and a few participants reply that mindfulness is about "*being in the present moment*". Jane then explains how:

We often eat out of a habit, and [eating] can be a swap for an emotional thing (...) so being mindful is about slowing down, bring attention to the moment and being present.

She then asks the group when they think mindless eating happens. In their replies, participants describe day-to-day activities related to eating that had been discussed the previous week as triggers to unhealthy eating. Participants mention snacking in front of the telly or the laptop, picking when cooking, or talking over the phone and Jane adds stress, sadness, or even "*being happy like at a party*" can trigger overeating. She introduces mindfulness as a strategy to work on the self and on the body, to recognise and tame hunger triggers through a mindful relationship with food. She reminds participants that:

So the steps we recommend to be more mindful is to pause, wait a moment and ask oneself "am I hungry? Is it food I really want?" (...) and if it is food that you really want, by all means eat! But remind yourself to wait and think before your instinct takes over and you start eating.

She then introduces the activity on mindful eating:

We gonna do a little activity now on mindfulness, everybody likes raisins? So we gonna do an activity where there's a lot of talking from me and not talking from you, I will ask a lot of questions but you don't have to give me any answer is more for you to think about (...) it is an interesting activity, we have done a couple of time and it is about you being present.

As usual, we are all sitting in a semicircle and Jane is at the centre, so that everyone can see her. After distributing a raisin to each participant, I sit down and take part in the activity. We sit silently, listening to Jane's calm and soft voice. She gives us instructions on what to do with the raisin. The introspective atmosphere, the tone of Jane's voice, the concentration in the group, the silence, reminds me of a yoga class. Jane tells us to take our time to silently reflect on and reply to the questions she is about to ask around the raisin we are holding in the palm of our hands. First, she says to hold it, look at it, "*what does it look like?*", she asks. No one replies, but we all observe the raisin in our hand. She instructs to "*notice the shape, the colour of it, turn it*



*around in your hand*". Then she invites us to focus on how it feels to touch, and ask ourselves *"where does it come from? Where was it harvested? How did it come here?"*. Next, Jane says calmly to *"Bring it up to your ears"*; we are asked to listen to the sound of the raisin when we touch it, gently squeeze it. The raisin is still in our palm; the immersion and concentration in the group are palpable. After bringing it up to our nose to smell it, Jane instructs us: *"Now touch it with your lips"*. Then she asks us to place the raisin on our tongue and hold it in our mouth: *"How's the texture?"*. We are invited to pause a moment to take the flavour in before we hold the raisin between our teeth, take a bite and chew slowly: *"Did the flavour change? Does it develop?"* Silence. Now Jane instructs us to chew slowly before swallowing the raisin, and *"really notice how the flavour changed, how the texture changes in your mouth"*. We are encouraged to keep chewing slowly and focus on the flavour and *"then when you have finished, take a moment to think how the raisin tasted"*. Jane falls silent for a few seconds while everyone takes their time to finish swallowing and appreciating the flavour. Everyone is still quiet when Jane starts asking questions again. Overall, the activity lasted about eight minutes.

Slowly, people start talking. Jane asks some general questions on the experience, and participants talk about the flavour and the texture of the raisin. Finally, Jane clarifies:

it is unrealistic to eat every mouthful as you just did, but the real message is to be more thoughtful about it. So, chewing can really bring out the flavour and make you more satisfied about what you are eating (...) engaging your senses can really help with feeling full and satisfied.

She also explains that in order to understand and control triggers, participants can put hunger on a scale from 0 to 10 and *"aim for a six or seven to have a snack or meal"*. In her explanations of mindful eating as strategy to recognise and control supposedly unhealthy triggers, the sensorial engagement with food that this practice mobilises is silenced.

I consider mindful eating a productive activity to explore for two reasons. Firstly, it differs from the other activities related to healthy eating I observed since it promotes an idea of food as pleasure and mobilises bodily sensations as sources of knowledge and experience of food. The activity on mindful eating enacts food as pleasure and bodily sensations as positive. The sensorial relations with food it promotes dismiss nutritional value, control and measurements as normative. Secondly, although this activity mobilises pleasure, taste and the senses, it reframes and restrains them as functional to the normative paradigm of self-control.

As illustrated by Vogel and Mol (2014) in their ethnography of alternative weight-loss practices in The Netherlands, mindful eating is used within new weight-management approaches that see the “control versus pleasure” paradigm as unhelpful or counterproductive and instead promote a relation with food based on self-care, pleasure and satisfaction. The idea that the body has “*an internal feedback system that keeps them in balance*” and that “*pleasure is a crucial part of this feedback system because it signals ‘enough’*” (Vogel and Mol, 2014 p.307) is at the basis of this approach. Pleasure and satisfaction are seen as central to appetite and flavour is central to satisfaction; this approach claims that if a food is tasty it is also more satisfying and consequently the person eating that food will feel full sooner. Furthermore, the ability to taste and fully appreciate flavours in food can be enhanced and practised through attentiveness, by focusing on food and eating rather than the environment around. Thus, attentiveness can be reached through mindfulness since mindful eating trains the person to attend to the present moment by engaging all five senses in the act of eating. The “Enjoy your food” approach analysed by Vogel and Mol (2014), is only one of the many applications of mindful eating to weight-management. Mindfulness is used in weight-management as an umbrella label that encompasses a wide range of strategies and interventions centred on the idea of being in the present moment. The category that is used in the LNPO programmes is the one that Tapper (2018) defines “present moment awareness” and is targeted to the “reduction of eating automaticity” (ibid. p.128) rather to embracing taste, pleasure and self-care.

It is evident that in the context of LNPO mindful eating is used as a strategy to reduce caloric intake by avoiding mindless eating and rehabilitate healthy eating behaviours, which is a strategy for the “reduction of eating automaticity”. It is also important to highlight that despite using a self-care approach to recognise hunger and triggers, by “learning to feel what you need” (Vogel and Mol, 2014, p. 310), this approach coexists and is used as a tool to enhance self-control over hunger triggers (see section 7.2.2). The following exchange between a group leader and a group participant exemplifies how taste alongside pleasure is disciplined. This exchange between Emily, the group leader, and Steve, a group participant happened during the week on hunger triggers in LNPO group 1 but it resonates with a general approach to avoiding conversations on taste that I have observed in the three groups where I volunteered:

E: swap unhealthy options like biscuits with healthy ones, like apples in the house or on your desk at work

S: how can you convince yourself that an apple tastes as good as chocolate?

E: I’m not saying they taste the same but if I have chocolate biscuits in front of me I’m tempted to have a couple, whether I’m hungry or not, if apples are there if I’m feeling

genuinely hungry I've got a perfect nutritious snack there, stay off any craving and give me a good source of nutrition but it gets you really thinking 'am I actually hungry?'. It gives you that choice.

This anecdote reveals that taste and pleasure, like body and emotions (see section 7.2.2), are understood as drives for unhealthy choices and weight gain. Rather than cultivating them (Vogel and Mol, 2014), the healthy eating discourse promoted in LNPO programmes provides group participants with technologies of the body and the self aimed at disciplining bodily inputs through self-control. Mindful eating, which has the potential to establish the centrality of taste, self-care and pleasure, is instead used as a technology to enable and enhance self-control over the senses. Since flavour and pleasure are either marginalised or dismissed, self-care here is subjected to the centrality of control and nutritional value as paradigm of healthy eating. Instead of disrupting or challenging the centrality of measuring and control and bringing taste back in the promotion of healthy eating, mindfulness is enacted as another way of measuring and controlling hunger.

To conclude, the analysis of three activities on healthy eating in LNPO groups shows how weight-management addresses a wide range of day-to-day circumstances that involve food and eating. Weight management is a bodily practice where people are trained to control physical stimuli as well as a holistic practice of the self where control means challenging, restraining and redirecting emotions, feelings, and physical sensations (e.g. cravings and hunger).

Consequently, group participants need to embrace weight-management and healthy eating as a salient feature of their identity and invest in it as a pressing individual project. In order to lose weight by adopting healthy eating habits people are asked to align to dominant and normative assumptions on body, eating and food promoted by biopedagogies of healthy eating. In the next section, I will present the ways in which group participants use weight-management technologies in their everyday life.

### **7.3 Healthy eating in everyday life: enabling through disciplining**

From the analysis presented in the previous sections, it clearly appears that biopedagogies of healthy eating promote practices around food and eating that become pervasive in the life of people who want to lose weight. They foster a relation with food based on nutrients and control. The weight-loss group participants I interviewed actively decided to "subject themselves" to a time-consuming and self-disciplining "regime" (Heyes, 2006, p.136) of weight management. As I have illustrated in section 6.2, the group participants I interviewed value some of the

disciplining aspects of weight-loss programmes. They describe the structure, support and lack of judgement they expect to find in weight-loss groups as positive and desirable features of what I have defined biopedagogies of healthy eating (see section 7.1). I draw on Heyes' (2006) discussion of weight-loss techniques and information as "enabling practices" to explore the ways in which group participants originally enact weight-management in their daily lives. Heyes develops the idea of "enabling practices" to analyse weight-loss technologies promoted in a commercial weight-loss group she attended. Her work is grounded in the feminist debate around women's dieting as a form of patriarchal oppression. In her work, she aims to attend to the *"increases in capacities"* that weight-management enables without necessarily *"acceding to the intensification of disciplinary power it currently requires"* (Heyes, 2006, p.127). She focuses her analysis on the "paradox" that *"normalizing disciplinary practices are also enabling of new skills and capacities"* (Ibid., p. 128). In my analysis, I build on her discussion of this "paradox" as it allows to give voice to participants' agency in performing and negotiating the healthy lifestyle discourse. Despite being aware of the gendered performativity of weight-management practices, my focus is on the materiality and discourses mobilised by group participants in their everyday enactments of weight management and of the biopedagogies of healthy eating. In my analysis, I attend to the normativity of weight-loss discourses whilst at the same time highlighting the agency of the actors at play. Both the perception of weight-loss science as a monolithic set of ideas and techniques and the hegemonic assumption that overweight people lack adequate nutritional competence are questioned.

The data I present in this section are drawn from participant observation on LNPO groups as well as from interviews with weight-loss group participants in LNPO group 1. Each session usually starts with early comers sharing tips and comments on healthy eating, such as adjusting family meals to the Eatwell Guide or bringing healthy snacks in the office. Before starting each session, groups leaders usually ask the group how they are getting along with portion sizes, measuring food, planning meals, controlling triggers, and sticking to their goals. These informal conversations and exchanges are fruitful sources of information to understand how group participants use the various strategies promoted in LNPO.

### **Larry**

Jane opens the session on mindful eating in LNPO group 1, asking the group how they did with controlling their hunger triggers, the topic discussed the previous week. Larry eagerly replies with an anecdote:

I had a stressful Monday, after work I hanged out with friends. It is our usual Monday meeting and [when we meet] there are always snacks and I thought: 'hang on a second!' and I bought a salad, grapes and a bottle of water and a pack of mixed nuts and fruit to have something to snack on and the minute I got there, I started interacting with people, I calmed immediately. I know if had gone there with any food at all, I would have just eaten the snacks that are there, not interacting at all (...) It was a proof that interaction cheers me up more than food.

It is evident how Larry used some of the strategies to recognise and control hunger triggers discussed the previous week to shape and negotiate his social life and weight management. By being able to recognise stress and snacks as internal and external factors that prompt what he identifies as his unhealthy habits, such as mindless eating - *"I would have just eaten the snacks that are there, not interacting at all"* - Larry has felt able to participate in his social routine. But it has done so in a way that he also considers favourable for his "healthy eating"; that is, by choosing food in line with the nutritional information promoted in the LNPO programme. Larry has enacted healthy eating technologies as an enabling rather than limiting his social routine by changing the quality of food and consequently the quality of interaction involved in this routine.

During our interview, Larry tells me of how he has changed his lunch habits, especially at works, as well as his attitudes and judgments towards convenience food:

What's really nice is, especially through this group [LNPO], I started to change my lunch habits. I feel incredibly smug around my colleagues [laugh]. Well cos they are all coming back from a corner shop with a pasta and a packet of crisps and I'm just looking at them and going "oh my god that is awf[ul]" .and I'm just sitting there and they ask "what you've got there" [and I reply] "oh is avocado and red peppers and chicken breast" and they are like "oh where did you get that from?" (...) and I say "I just made it myself!"

It is interesting how once again Larry talks about a daily routine, lunch breaks at work, and interaction, with colleagues. And once again he describes how by using nutritional advice around portions, food groups and balanced meals (*"...avocado and red peppers and chicken breast"*) he has started to change not just food habits but also judgment on food (*"oh my god that is awf[ul]"*). Moreover, this change in his lunch break has also enabled a new kind of interaction around food. In fact, Larry tells me that he loves cooking and since he has started taking his cooked lunch instead of buying it, he has also started sharing recipes with some of his colleagues.

I've always noted there's a good group to talk to when it comes to that [cooking from scratch] and there's one they just don't care. So, the older people, people with families, especially the mums, they've cooked something, they've brought something in and looks delicious. There's this older lady Janine that walked me through how to make a traditional Thai stir fry and it's delicious, so savoury! But it's not packed full of salt it's not that fat and that's the stuff I'm trying to do a lot more of now cos I love food and I love cooking

Biopedagogies of healthy eating promoted in LNPO groups are enacted by Larry in his workplace through social interactions with three main effects. Firstly, cooking food from scratch, a practice fostered in LNPO programmes as a fundamental step towards healthy food habits, re-shapes Larry's relations within the workplace, although probably in the limited time of the lunch break. Through cooking his own food, Larry expands relations with colleagues and repositions himself within these relations. As he affirms, conversations about cooking happen with women and older colleagues that usually consume and appreciate food brought from home. Secondly, the exchanges mobilised by the act of bringing his own cooked food to work instead of buying convenience food, enable Larry to learn new recipes; that is, to acquire new skills in something that he sees as a source of pleasure, namely cooking. Considering the marginal and problematic space given to pleasure in healthy eating discourses in the LNPO activities previously described, it is interesting how Larry utilizes pleasure and love for food as meaningful and enabling categories to implement daily the healthy eating habits promoted in those programmes.

Finally, it is evident how Larry navigates these new interactions and exchanges using nutritional knowledge as a meter to evaluate them. For example, when describing the Thai stir fry, he mobilises both pleasure (*it's delicious, so savoury!*) and nutrition (*"not full of salt, it's not that fat"*) to evaluate it. I suggest that Larry's accounts of healthy eating practices in every-day social and work contexts, shows how he enacts them as enabling practices to navigate social relations, gain new skills around food, and enhance his understanding of the self in relation to food. Rather than becoming a barrier to social life and commensality, healthy eating practices are used by Larry to originally shape and negotiate routinely social relations. Nonetheless, it is important to underline that what represents an enabling practice in one social context might be lived as a barrier in another. For example, carrying on with his account on how much he loves cooking, Larry tells me that his relationship with his housemate makes cooking at home a bit difficult. Thus, it is important to be aware that the enabling aspects of one practice change from context to context in the experience of the same person.

### **Daniel**

Daniel has joined the LNPO group after completing his one-to-one sessions in the same organisation. Overall, he has been managing his weight by following LNPO different programmes for about a year and he has lost about two stone (equivalent of 12.7 kilos). When I ask him how

he gets on with adjusting the information promoted in LNPO group to his everyday life, he replies that he still has to think about it:

Yeah...I am a bit excitant because I'm terrible, I just love food [giggle] so I did find it difficult it's still kind of a conscious thing, I haven't got to the point where my lifestyle has changed enough that I don't think about it...but that's OK, I think that's just the way it is going to be [having to think about them] [laugh]

Daniel talks about lifestyle and shows awareness that behavioural change purportedly consists in transforming healthy eating practices and nutritional knowledge into unconscious eating and food habits. In Daniel's experiences, healthy eating technologies are experienced and enacted as disciplining actions and choices that must be consciously and constantly thought through and performed. Moreover, while Larry uses pleasure as an enabling category, Daniel describes his love for food as a barrier or limit to the possibility of changing his eating habits.

Later in our conversations, I ask Daniel if he reckons that LNPO programme he is following has changed his way of cooking or his taste:

no, not really but because I have become more aware of it [nutrition and balanced meals], I suppose, I'm making decisions to have more interesting food because I eat less of it (...) So there's been a little bit of a shift (...) And although I learned about the Eatwell plate [guide] in the one-to-one, I was still really focusing on calories. For me counting is easy, but I think that the balance suffered from that. I think is easier to cut something out because you lose a lot of calories potentially, but my dairy virtually disappeared, which is not necessarily healthy, so the course made me think about how I balance it out, which is good

This account reaffirms how adjusting healthy eating practices to daily habits represents a commitment for Daniel. However, it also introduces two new aspects. Firstly, by consciously choosing what to eat in alignment with the nutritional knowledge acquired through LNPO programmes, Daniel is focusing on the flavour of food instead of on its quantity or calories. He seems to think of this attention to *"more interesting food"* as a valuable and positive change that enhances his relationship with food and the nutritional quality of the food he eats. Secondly, in this account Daniel describes the coexistence of different approaches to weight-loss in his daily management of weight and how a negotiation of the two has brought him to revisit his food intake in ways that he considers healthier. He says that despite having been presented with the Eatwell plate in the one-to-one sessions, he has mainly resorted to calories counting as preferred way of measuring and controlling food intake as he says that for him *"counting is natural"*. Daniel describes his preference for calories counting as a practice that he perceives as more easily applicable rather than limiting or coercive. Still, he disciplines this preference by applying the healthy eating discourse promoted in LNPO programmes. In fact, Daniel affirms that looking at

nutrients and balance rather than calories has enabled him to identify some limits of his diet that could be counterproductive for his overall health (i.e. deficiency in calcium). Daniel enacts health instead of weight loss as the normative criterion to evaluate weight management, reproducing a coexistence of multiple and competing discourses that is present in biopedagogies of healthy eating (see section 7.1).

### **Michelle**

The co-existence of different weight-loss practices and ontionorms in participants' daily enactments of healthy eating, is also exemplified by Michelle's accounts. Throughout her life, Michelle has tried many different weight-loss practices and groups, such as Slimming World and WeightWatchers, as well as self-managing weight through exercising and calories counting. I met Michelle in LNPO group 1 to which she signed up after a long period of convalescence (as described in section 6.2). The most recent experience which brought her to join the LNPO programme is described by Michelle as a long cycle spread over about four years of getting ill while trying to lose weight. This is how she describes the way in which she was self-managing her weight loss before falling ill and joining LNPO:

I was working out and eating healthily, but I was doing it really unhealthily. So, I was counting my calories and going for really long walks after work. So, I'd finish work at 6 o'clock, I'd put on my trainers, get my stuff in my backpack and I'd just go for a walk and I wouldn't get home until nine or ten o'clock at night so I was like wearing myself out (...)

Michelle describes a very rigid regime she forced on herself in order to lose weight following the authoritative assumptions and advice on weight-loss and healthy lifestyle (see Chapter Four): eating healthily and exercising as the axioms of a healthy reduction in weight. Michelle reproduces the authoritative understanding of fat as pathological, despite falling ill because of her attempts to lose weight. Instead of using this experience to challenge the assumption that fatness is a health risk, she uses it to navigate and negotiate different approaches to weight-loss in her daily life. Michelle's concern in losing weight entangles with her fear of getting ill, which strongly shapes the ways in which she adjusts healthy eating practices to her everyday life.

During the interview, Michelle often repeats that her main preoccupation is to maintain nutritional balance that permits her immune system to stay healthy whilst losing weight: “ *this time I want to focus on what I'm eating, trying to support my immune system cos that is paramount for myself* ”. The nutritional information and expertise present in the LNPO programme, enables Michelle to work simultaneously on her approach to weight loss as much as on her preoccupation for her general health. Nonetheless, Michelle appears to be particularly proactive in tinkering with the information and techniques of healthy eating promoted in the



LNPO's programme. She uses her previous experiences of weight-loss and preoccupation for her general health to evaluate the information and practices promoted in the group. She decides what to discard, what to retain and what to adjust based on what she considers more or less functional to her goal of losing weight without getting ill. For example, at the beginning of the interview she tells me that despite going to the group, she also wants to manage her weight on her own. For this reason, she does physical activity in her free time, going for long bike rides. Few minutes later, talking about portion sizes, she shows me the new set of plates and bowls she bought after the LNPO group session on portion sizes, following Jane's suggestion of buying smaller plates. She shows me the plates saying that she bought them in her favourite colours and exclaims: "*portion sizes are so important!*", as often repeated by LNPO group leaders. Soon after, she tells me that because she needs to pay detailed attention to nutrients, she doesn't use the food diary suggested in LNPO group. She prefers to use an application on her mobile:

I don't use the paper thing that she gave us I use a mobile app anyway it's called My Fitness Pal. I'll show it to you do you want to see it? [Michelle goes and fetch her phone to show me the app]. So, this is the app. It's a healthy way of losing weight and you put in how much you weigh and what your activity levels are like and how tall you are and male or female and it gives you an amount of calories for wanting to lose one pound a week or two pound a week. So, your calories in versus calories out, it makes sense! And really it is what they're trying to achieve with the group as well, but they're trying to make it rather than by weighing something, by using your hand [instead] and it does work! So I'm trying to do two at the same time... what they are teaching us there [in the LNPO group] is in real terms this: what food group you should be eating, these many portions of carbs, fat, etcetera... all makes sense and actually when you weigh it, it works out, but I think for me, I need to have a bit more of a fine tune, like a bit more detail because I need it so badly and because I need to do it healthily.

In her everyday life, Michelle actively adopts a level of discipline and surveillance of her eating habits and food intake, which is stricter than the one promoted in the weight-loss group she is attending. Like Daniel, she utilises both calories counting and nutritional values as privileged tools to manage her weight and food intake. In fact, the app she shows me is centred on calories counting and using it on a daily basis makes it possible for Michelle to keep under control the number of calories in and out as well as pounds lost in a day and a week. The app also counts the nutrients for each meal, and this is a very important feature for Michelle: "*the point is we are going to the nutrients value on a daily basis*". This kind of caloric surveillance means that everyday Michelle has to input in the app details of the foods and quantities she consumes throughout the day. Rather than seeing this constant surveillance as hindering, Michelle seeks

it. Moreover, she uses the app and the calories counting system to evaluate the efficacy and validity of the practices promoted in the LNPO group, such as using hands to weigh food. Integrating the nutritional information promoted in the LNPO programme with the features present in the app, enables Michelle to keep control of nutrients along with monitoring her weight-loss. Unlike Daniel, who enacts nutritional values as preferable to calories counting, Michelle uses both technologies at the same time and use one (calories counting) to test the efficacy of the other (palm sizes) and vice versa. Michelle's degree of information and surveillance around nutrients, as well as their experience and knowledge in handling different technologies of weight loss, challenges the common assumption that weight gain is due to lack of knowledge around healthy habits (Greenhalgh, 2015; Warin, 2018). Furthermore, Michelle actively seeks disciplining technologies that impose surveillance over food and her body and that are more resonant with dieting than with the healthy lifestyle discourse promoted in LNPO groups and obesity-related interventions more generally.

These three experiences give a glimpse of the various, multiple and original ways in which weight-loss group participants I met in the field deploy weight-management technologies in their everyday life. In my analysis, I have focused on those accounts that relate to the biopedagogies of healthy eating promoted in LNPO programmes. The coexistence of multiple ontologies and technologies of weight loss is present in all the accounts presented, but the interrelations between normative discourses vary. Looking at these technologies and discourses as "enabling practices" (Heyes, 2006), I have shown how the same practices can be enabling in one context but not in another. Furthermore, some participants, like Michelle, find "*the intensification of disciplinary power*" (Ibid.) that can come with weight management a feature to cultivate and pursue as they find it enabling. This final section has explored how biopedagogies of healthy eating are negotiated, interpreted, rejected and tinkered with in the process of enacting them in everyday life of different social actors.

#### **7.4 Summary**

In this chapter, I have analysed how the authoritative discourse on a healthy lifestyle is enacted in the weight-loss programmes where I volunteered. I have utilised the concept of biopedagogies of healthy eating to analyse the practices and knowledge promoted in these settings and the specific discourse of healthy eating that governs them. In these settings, the language of *diet* tends to be substituted by the language of *healthy eating* and this shift is often remarked from both leaders and participants to signal that diet and healthy eating are different approaches and

that the latter is preferable. In this sense, healthy eating is both a finding which emerge from the analysis of the data and a conceptual tool that I use to analyse the discourses and practices of food and eating in my research. I propose that shifting the focus on healthy eating is a strategy used in weight-management groups to alleviate the stigmatisation implicit in dieting due to its focus on weight. The data presented show that healthy eating is based on nutritional knowledge: nutrients and nutritional value are presented as the main indicators of healthy food. Despite resisting some of the assumptions on dieting and calories counting, biopedagogies of healthy eating reinstate a medicalization of healthy food based on nutrients. They centre the value of food on its nutritional value. Healthy food is the medicine, the substance that can re-establish health where health means both a well-functioning body and a body that does not gain weight. This signals a surfacing of “dieting” in the biopedagogies of healthy eating, as ideas of weight-loss, control, and discipline proper of diet are very much central to healthy eating, as in the case of the activity on hunger triggers. I have examined the transformative aspects of the shift to “healthy eating” and the practices it produces by analysing three specific activities of healthy eating in LNPO groups: *meal planning*, *hunger triggers* and *mindful eating*. I draw on Mol’s term of ontonorm to analyse the different and normative ideas that coexist and are entrenched in healthy eating discourses. From this analysis, it emerges that these activities of healthy eating enact bodies, as well as emotions, as intrinsically problematic and in need of control and re-education, reproducing assumptions of the ‘obesity epidemic’ discourse. At the same time, the discursive move towards “healthy eating” has produced a change in the kind of nutritional information and practices that are promoted, for example calorie counting has been substituted by portion sizes and balanced meal planning. The materiality involved in healthy eating – palms, hands, bowls - differs from the stricter use of scales associated with diet. Moreover, this different materiality is associated with a dismissal of calorie counting and precise measures of food and body weight, which instead is central to dieting. Nevertheless, the focus on individual responsibility to realize a behavioural change through technologies of the body and the self remains unchanged. These biopedagogies foster practices that regulate everyday life of social actors and are not limited to the act of consuming food. Instead, they establish “*on a daily basis what, how much, how and with whom a person should eat*” (Gracia-Arnaiz, 2010 p. 223). I then concluded this chapter, by looking at the ways in which weight-loss participants I interviewed navigate, negotiate, and reproduce these biopedagogies of healthy eating in their everyday life. Drawing on Heyes’ (2006) concept of “enabling practices”, this analysis has attended to social actors’ agency whilst at the same time highlighting the disciplinary and normative power of the healthy eating discourse.

## 8. Weighing: measuring health and negotiating stigma

In this chapter, I focus on how weight is enacted in the LNPO groups and LFC aerobics classes I attended. I will explore the organisation of the space and the time dedicated to weighing, as well as how weight is talked about.

In the settings where I have conducted my research, weight and Body Mass Index are the criteria used to evaluate weight-management programmes, be it in a non-profit organisation that needs funding or a commercial club that needs members. As previously mentioned in section 6.1, a long history of dieting and slimming has produced bodily techniques of weighing and measuring as normalising, socially valued practices (see Bordo, 1993). The ‘obesity epidemic’ discourse has drawn on these techniques of the body and the self, reproducing them within a frame of health and biocitizenship (see Rose, 2007) where weight becomes an indicator of the good citizen’s responsibility for their health (see Harwood and Wright 2009; Greenhalgh 2015). Body Mass Index, calculated by dividing a person’s weight for the square of their height, is the principal indicator used in epidemiological, clinical and public health research and reports to define obesity. Consequently, BMI and weight are also used to measure the success of weight-loss and the efficacy of obesity-management interventions as a decrease in weight determines a lower BMI.

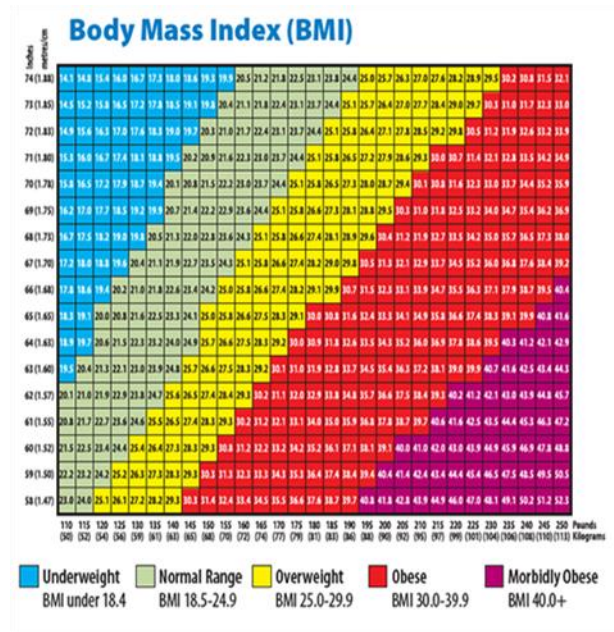


Figure 9. BMI Chart 1

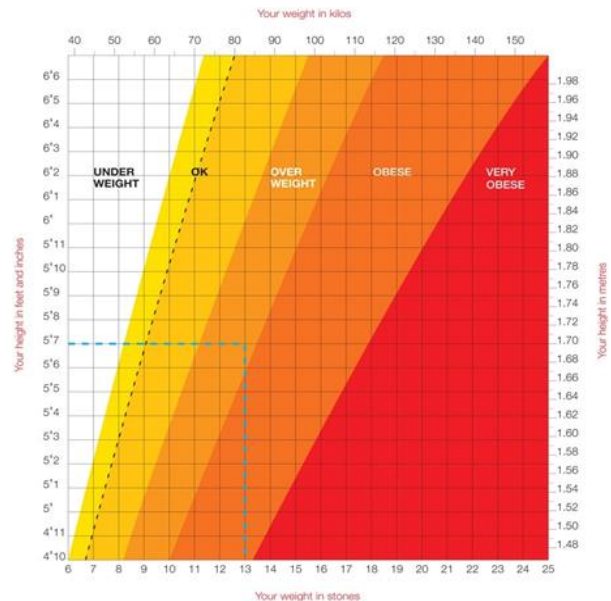


Figure 10. BMI Chart 2

As seen in the previous chapter, the biopedagogies of healthy eating I observed in LNPO groups promote activities and information that discourage technologies proper of dieting, such as calorie counting and weighing food on scales. The relaxation of measuring in relation to food parallels a relaxation of measuring in relation to body weight. Research participants, and especially nutritionists and nutritional therapists in weight-loss groups, describe the focus on body weight and weighing as problematic and associate it with dieting. Thus, in the following analysis I approach meanings and practices around weight as embedded in the healthy eating discourse that I have described in Chapter Seven. In particular, the ways in which weight is enacted must be analysed in light of the underlying shift away from dieting. Hence, I analyse the ways measurement is carried out and talked about in weight-loss groups as an integral part of the shift from dieting to healthy eating. For this analysis, I draw extensively on data collected in the three LNPO weight-loss programmes where I volunteered. The programmes follow the same procedures and weekly schedule for weighing and logging measurements. Different group leaders share similar views and approaches to these measurements too, as I will show in the following discussion. I will also draw on data collected in two LFC aerobics classes. I integrate these findings with data collected through interviews with weight-loss groups' leaders and participants, both in LNPO and LFC, to deepen my analysis. I start this analysis by describing how weight and BMI are categorised as evaluation criteria in public health guidelines related to obesity.

### **8.1 Weight and BMI as evaluation criteria**

Local initiatives and programmes related to obesity, such as weight-loss groups, slimming clubs, fitness and cooking classes, are now recognised by the NHS as integral services to address obesity and are partly integrated in the referral system (see section 6.1). As part of this integration, weight-loss programmes must follow national guidelines on weight-management produced by governmental bodies within the NHS, in particular the National Institute for Health and Care Excellence (NICE)<sup>36</sup> and the National Obesity Observatory (NOO)<sup>37</sup>.

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<sup>36</sup> The main bodies that produce national guidelines related to obesity are NICE (National Institute for Health and Care Excellence), an independent body sponsored by the Department of Health and Social Care (for more information see chapter 4.1.1), and NOO (National Obesity Observatory), part of Public Health England (for more information on NOO see following footnote ).

<sup>37</sup> National Obesity Observatory (NOO) "was established to provide a single point of contact for wide ranging authoritative information on data and evidence related to obesity, overweight, underweight

The ways in which public health policy formulates the national strategy to address obesity inform the activities and terminologies promoted in local weight-loss programmes around weight and BMI. Thus, in the ways in which weight is enacted in weight-loss groups we can see the interrelations between global biomedical categories and local biosocial settings.

For the evaluation of short-term weight-management programmes, such as the ones I volunteered in, national guidelines recognise the unlikelihood of important changes in the BMI and weight of the participants. Accordingly, they suggest that the focus should be more on increased levels of physical activity and adoption of healthy behaviours when evaluating the outcomes of this type of programmes. For example, in the guideline *Standard Evaluation Framework for Weight Management Interventions* (2009) produced by the National Obesity Observatory, we read:

It is important to be realistic about the impact a project can have on these key indicators. In most cases, weight management interventions have the ultimate aim of reducing or maintaining body weight (usually expressed as Body Mass Index (BMI) – (...). It may be unlikely a project will have a measurable impact on BMI in the short term, but it may change one or more of the other determinants of obesity such as eating behaviour and physical activity. In this instance, while data on height and weight (and hence BMI) should be collected, the key measure would not be BMI but a measure of food intake or physical activity behaviour. (NOO, 2009, p.14)

Nevertheless, despite recognising the possibility that short-term programmes might have little impact on people's weight, the collection of weight and height to calculate the BMI of participants remains an essential criterion for all weight-management interventions, as stated in the same document:

It is essential to collect the height and weight of participants, in order to calculate their Body Mass Index (BMI). Even if changing BMI is not the primary objective of the intervention, or BMI is not expected to change in the short term, height and weight should be measured throughout any weight management intervention to assess any changes in BMI in the long term. (NOO, 2009, p.31)

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and their determinants" (NOO 2009) and received funding by the Department of Health in 2008 as part of the government's *Healthy Weight, Healthy lives strategy*. Working with a variety of organisations, it produces guidelines and reports for policy makers and health professionals working in obesity or related areas. Following the Health and Social Care Act 2012, it is now part of Public Health England.

These two excerpts show the centrality given to BMI and weight by public health guidelines to measure the impact of weight-management interventions. This centrality is accompanied by the acknowledgement that short-term interventions are unlikely to prompt measurable changes in the BMI and weight of participants. Nonetheless, this is the most common type of intervention in public health strategy to address obesity in the UK. As shown in Chapter Four, national public health policy privileges weight-management interventions, such as weight-loss groups, based on behavioural change and healthy lifestyles to address obesity. Weight-loss programmes that promote lifestyle changes are usually ten- or twelve- week long and as the findings show in Chapter Six and Chapter Seven, these changes rarely have long-term effects. Thus, I suggest that the focus on BMI and weight “*to assess any changes in BMI in the long term*” (NOO, 2009) is problematic in practice. This focus reiterates the normativity of the caloric imbalance. The biomedical premise that “health” is “located in the metrics of body size” (Yates-Doerr, in McCullough & Hardin, 2013, p.49), is reproduced in public health definition of obesity. This definition of health as located in and measurable through body size exists together with the authoritative discourse on a healthy lifestyle that locates health in food and eating habits (see Chapter Seven). In the next sections, I will discuss how this normativity of measures is further contested by research participants in weight-loss groups.

## **8.2 Enacting weight in weight-loss groups**

In this section, I draw on data collected in LNPO group 1 to describe how weight and BMI are enacted in weight-management settings. As already mentioned, LNPO programmes follow the same weekly organisation to take measures and use the same information materials around healthy weight and BMI. Over the ten weeks of LNPO programmes, measurements happen three times: the first week, the fifth week and the tenth week. The first week, all participants are weighed, their waist circumference measured, and their BMI is calculated, all these measures are written down in their booklet and logged on a register handled by the group leaders. In the fifth week, only weight and waist circumference are measured and logged and compared with the ones taken from the first week. BMI is calculated again in the final session in week ten. All measurements are done at the end of the first part of the session when the forty-five minutes of physical activity starts.

On my first day as a volunteer in LNPO, Jane, the group leader, asked me to meet about an hour before the session started so that she had time to show me around, introduce the material we would use, explain what I had to do and illustrate the overall programmes. Among many things,

she tells me that Emily, a colleague, would join us on this first session to help with measuring. She also explains to me that measuring is often an intimate and emotional moment where participants open up and share personal information. For this reason, she suggests I do not take part in it. Nonetheless, she agrees for me to leave my audio recorder in the corner where the measurement happens.

The room we are in is big and reminds me of a conference room, with dark blue carpet and big windows on one side; it is a quiet space, on the fourth floor of a tall building. On the left side of the room, by the door, there are two tables where we have displayed the material needed for this first session: fliers, booklets and leaflets that I hand out to the participants when they come in. A few minutes before the session is due to start, participants start to arrive. I welcome them, check the register and write their name on a sticky tag. This group is equally attended by men and women. I also notice a variety of body sizes in this group, which, unlike the gender balance, will show to be a recurring feature of the weight-loss groups I attended. Most participants are middle-aged and English; two ladies are in their late 60's and there is also a young girl in her early 20's. Tamara, who is the only non-British participant and has recently moved to Brighton from South-America, is accompanied by her son in this first session to help with the language. Tamara's English turns out to be very good and I remember her as one of the most engaged participants, despite some initial shyness.

We have arranged the chair in a semicircle in the middle of the room (Figure 11), Jane sits at the far end of the semicircle, facing everybody, and she has a whiteboard and projector next to her.



*Figure 11. Room and chairs disposed in a semicircle. LNPO Group*

I am sitting here and there, handing out materials and helping people to fill in a questionnaire regarding some general health information. Jane starts the session introducing herself, and I say a few words about my research, asking for the participants' consent to carry on my research and audio record the group sessions. Every



participant is given a booklet; Jane illustrates it and suggests bringing it to every session. The booklet is like a diary in which participants can write their goal and keep track of their measurements. It also contains tips on how to lose weight and keep up the motivation; one page is dedicated to the benefits of losing weight, with a blank space for participants to fill in with their reasons to join the group and lose weight. This booklet is intended as a tool for participants to keep track of their weight management and to help with motivation by reminding them their goals, as well as a quick reminder of healthy habits and nutritional information.

This booklet exemplifies the simultaneity of discourses on diet and healthy lifestyle in the biopedagogies of healthy eating (see Chapter Seven). Soon after introducing the overall programme, Jane informs the participants about the measuring. Reassuringly, she says:

and a quick word about the measure because I know a lot of people get sort of bit anxious about that. We don't weigh in every week, you're welcome to weigh if you want to, I can bring the scale. It's not a formal part of this, we weigh you at the beginning and we weigh you at the end; so, today and in week ten. We also take a measure in week five, a weight measure, just because in the past a lot of people couldn't fulfil the whole ten weeks and we lose quite important data about how people are getting on and what's being happening and of course we really rely on the stats to sort of prove the worth of this programme. So, you can weigh every week if you find it motivational and want to do it, but it is not part of the programme.

When Jane explains to the group participants the importance of collecting their weight and Body Mass Index to evaluate the programme, she indirectly refers to the guidelines described in section 8.1. In her words, it emerges a tension between measuring participants' weight and BMI as required by public health guidelines and the perception of weight as stigmatising and sensitive. In the way Jane talks about weighing, as well as the fact that she asked me not to be present in the space where weighing is carried on, weight is enacted as a sensitive topic.

Jane's awareness of the fact that people can get "*anxious*" about being weighed is based on previous experiences, as she explains to me before we start the session. Nonetheless, she does not mention any event or reason that explain why weighing could be received with anxiety by participants. Other group leaders in LNPO recount the same narratives and arguments around weighing. Weight-loss group leaders assume weight to be implicitly sensitive and potentially stigmatising, similarly to the accounts of health professionals around their perception of weight and obesity as stigmatising and sensitive topics (see Chapter Five). This further shows how across the field sites, research participants share the common perception of weight as a sensitive topic and perceive, as well as enact it as an inherent trait of excess weight. Furthermore, Jane specifies that weighing is not "*a formal part*" of the programme, which instead is focused on healthy

eating. She clarifies that weight and BMI are used to produce statistics through which the “*worth of the programme*” is assessed. I argue that this type of clarification, which is recurrent in the ways in which weighing is presented in LNPO groups, serves to negotiate the stigma attached to obesity as perceived in weight-loss programmes.

Once Jane has finished presenting the programme, we start our first activity of the session. The activity consists in setting a goal that is specific, measurable, achievable, relevant and time-limited (SMART); the aim is for participants to set a goal that is specific to their eating habits and achievable in the short time of the programme. All participants have some time to think about it, and then write it on a post-it and stick it on a whiteboard. Some participants are familiar with setting this kind of goals, others instead struggle to identify a possible target that relate to some of their food or eating habits. Jane asks me to check how participants are doing with setting their SMART goals. The majority set as their goals to change food and eating habits, such as cutting down on takeaways, having chocolate only once a week, eating vegetable in every meal. A few participants set goals that are about increasing their daily and weekly exercise, such as using the stairs, and going for a short walk every lunch break. I sit with Teresa, who is undecided on what type of SMART goal to set. She tells me that she is the one who cooks for the family, which includes her husband, sons and grandchildren and therefore she finds it difficult to set a goal round food and eating. She finally convenes that reducing her portion sizes would be an achievable goal.

Once everyone has set a goal, Jane gives some latest information around healthy weight-loss as defined by WHO and NHS guidelines. She says that losing one or two pounds a week (0.5 to 1kg per week) is a healthy and feasible expectation. She explains that given the length of the programme, participants could expect to lose from ten to twenty pound by the end of the ten weeks. She uses two orangey-yellow funny-shaped stones that represent respectively one and five pounds of fat. The room fills with surprise at the sight of these rubber shapes of fat. They pass them around; some hold the shapes, gauge them and seem positively impressed; others make comments and jokes on how big they are.

These rubber “stones” serve as visual inputs to quantify weight-loss and a motivational tool:

(...) so when you’re like “oh I have only lost three pound”, that’s actually quite a lot, isn’t it? So remember that, cos some people get disheartened by their weight-loss and actually that is pretty remarkable still.



Figure 12. Plastic shape used to represent 5 pounds of fat in LNPO groups.

Through this visual prompt (see figure 12), fat, and by extension excess weight, is presented and made visible as a specific substance that “*does not belong to the body and can be separated out from it*” (Throsby, 2012, p. 6). I propose that in LNPO groups, this enactment of fat and weight as a tangible matter separate from the body is used as a motivational tool to alleviate the simultaneous enactment of weight and fat as sensitive and stigmatising descriptors (see Chapter Five).

### 8.2.1 Negotiating stigma through space

In this section, I expand my discussion on how weight and stigma are negotiated and co-produced by weight-loss groups’ participants and leaders, by turning to analyse the space in which measuring takes place. I look at how measuring weight and body mass index are staged in the groups in which I participated. I integrate this description of spaces and objects with comments and ideas around weight collected through interviews and conversations with group participants and leaders. When I started revisiting the data on weight-management groups, the ways in which weighing was spatially organised in these settings caught my attention. In fact, measuring was the only activity in weight-loss groups that was carried out in a private space as a one-to-one activity. For example, all the activities I observed in LNPO programmes, such as those described in sections 7.2.1, 7.2.2 and 7.2.3, were participated by the whole group in a shared space. On the opposite, weighing was spatially contained and performed as a personal and intimate moment rather than a group activity. I observed a similar approach and spatial organisation in the LFC classes I attended, where before the class started, some participants weighed themselves voluntarily. I continue this chapter with the description of how measuring was performed on LNPO group 1, LNPO group 2 and LFC classes.

### LNPO group 1



*Figure 13. Movable shield and scale. LNPO group 1.*

It is the first session of LNPO group 1. Participants have finished setting their SMART goals (see section 8.2) when Rita, the physical activity instructor comes in. Rita starts introducing herself and the exercise programme while Jane and I set the chairs aside to clear enough space for people to exercise. The physical activity session starts along with the measuring.

We have placed a movable shield on the right-end corner of the room, away from the centre of the room where the physical activity is taking place; behind the shield, there is a scale (figure 13). On the other side of the room,

Emily, the group leader who is helping Jane with taking measurements, has set up a movable stadiometer to measure participants' height (figure 14). Jane calls each participant's name in alphabetical order while they are exercising; Jane weighs them, measures the waist circumference and writes the measures down on the participant personal booklet and LNPO register. Then they go to Emily who measures their height and calculate the BMI and logs it down on the booklet and register too. While Jane and Emily carry on the measuring, I am taking part in the physical activity, helping Rita setting up the circuit while trying to keep an eye on the back of the room where weighing and BMI measuring were taking place.

My first impression is that the way space is organised to carry out this activity mirrors Jane's introductory words that weighing is a necessary yet marginal part of the programme. Equally, the measuring takes place in a marginal part of the room. The circuit occupies the centre of the room, where we run, do push-



*Figure 14. Stadiometre (to measure height). LNPO group 1*

ups, jumping jacks, squats, abs, and other exercises to the rhythm of the music in the background. Some participants make jokes such as *“thanks for saving me from the push-ups”*, or *“here we go!”* when Jane calls their name. The measuring lasts only a few minutes for each participant and interferes minimally with the physical activity session, to which participants smoothly come back, without commenting or talking about the measurements. In week five and ten, the measurement takes place in the same way and in the same room. As anticipated by Jane (see section 8.2), only a few participants were present to all three measurements. To my knowledge, none of the participants asked Jane to weight themselves outside of the three measurements set by the programme, and both weight and weight-loss were rarely the subject of conversations among participants. I propose that in this group the perception of weight as sensitive and stigmatising is enacted as well as alleviated through the spatial, visual and acoustic organisation of measuring.

### **LNPO group 3**

In LNPO group 3, measuring was organised in the same way as LNPO group1 and took place in the first, fifth and tenth week. The group met in a room on the ground floor of a building that is part of an NHS department. Despite being open to women and men, all participants in this group are women. The room is split into two by a folding door that we usually leave open and use the smaller space to store useful material such as tools for the circuit, flyers, plastic food to use for group activities. On the three measuring days, we close the folding door to create a separated and private space for carrying out measuring. As in LNPO group 1, participants are weighed, their height measured and their BMI calculated and written down on their booklet and LNPO register, out of the way from the main room where the rest of the group is exercising.

On the first week, Katherine, the group leader, asks me if I can help with measuring: the calculator she brought does not work, and her mobile phone has low battery, so she asks to use mine to calculate participants' BMI. We quickly prepare the smaller room, plugging in the scale, unfolding the movable metre and putting it in place. Meanwhile, John, the fitness instructor is also setting up the circuit in the main room and introduces the overall exercising programme for the ten weeks. John is in his mid-20's and has recently started working as a fitness instructor as part of his specialisation. He is the only man in this group whose participants and leaders are all women, including me. This group is targeted to NHS staff, and participants' age ranges from those in their late 20's to those in their early 60's.

Katherine asks me to call the participants for the measurement following the alphabetical order on the register. During the measurement, I calculate the BMI on my phone and write down their measures on the organisation register while Katherine does the same on their booklet. When they come in, each participant is asked by Katherine to take their shoes off. Then she measures their height, their weight and finally their waist circumference. I notice that there is quite a variety in the BMI of the participants. For example, two of them are the upper bit of the overweight range, but nonetheless decided to join the group and were considered eligible. None of the participants seems to be openly distressed about their BMI and weight being measured. However, they comment on their measures, for example, explaining why they gained weight or what eating habit they struggle with, and most of them show to have already an idea of their weight and BMI. Katherine listens to participants' comments without dwelling on the measures and avoiding remarks about their weight and BMI. From my field notes, it appears that Katherine focuses more on waist circumference measures, whereas participants comment more on their weight and BMI. Aligning myself to the idea that the activity I am taking part in is in fact a sensitive one, and aware of the power relations<sup>38</sup> at play, I avoid participating in these conversations. While the measuring goes on, the rest of the group continues exercising without giving too much attention to what is happening in the adjacent room and every participant goes back to the circuit after the measuring. My impression is that both leaders and participants are acting and responding to measuring in ways similar to those observed almost a year earlier in LNPO group 1.

On the afternoon of the fifth session, I arrive few minutes earlier than usual to help setting up the room and prepare the material to hand out. Some participants are already in the room, gathered in a small group, and chatting. I overhear that their conversation is about weight: *"ready for measures?"*, *"Do you think you lost anything?"*. They do not dwell on weight for too long and the conversation moves to portion sizes; Katherine gets briefly involved to then go back to setting up the room. Participants continue talking about where to eat in Brighton when going out, what kind of take-away they have, what they have changed in terms of portions, and share some funny anecdotes on their holidays and being vegetarian. From this informal conversation,

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<sup>38</sup> Here I refer to the fact that in the room, Katherine is the one whom people directly address and recognise as the authoritative and knowledgeable figure. As a volunteer on my first day, my position and role are unclear.

it appears that participants do give relevance to weight-loss, despite group leaders' recommendation and comments about healthy eating being more important than weight loss. This time, I am not helping Katherine with the measurement as another group leader from LNPO has joined us to help with it. Instead, I take part in the exercise. In this group, weight and BMI are enacted in similar ways to LNPO group 1. From the informal conversations among participants, it surfaces that weight-loss is a relevant criterion not only for public health policy but also for group participants. In their conversations, they negotiate biopedagogies of healthy eating (e.g. comments on portion sizes, and nutrients) and their expectations of losing weight.

### **LFC aerobics class**

When I arrive to the gym to attend my first LFC aerobics class, Lizzie, the fitness instructor, is in the hall chatting to people. I soon realise that I am the only new person and all the other women (there are no men in this class) know each other as they have been going to Lizzie's classes for quite some time. The studio where the class takes place is big, with wooden floor and mirrors covering one side of the room. We all gather at the far end side of the big room, opposite to the entrance door, where there is a long shelf where we keep our stuff: shoes, gym bags, jackets. Meanwhile, Lizzie sets up a scale and a chair on the opposite side of the room, by the door. I walk close to Lizzie and she explains to me that before the class starts, some members would like to be weighed and that weighing is completely voluntary. Those who want to check their weight, join Lizzie one by one to get on the scale. Lizzie checks the weight and writes it down on the participant's diary. In the two classes I attended, only a few participants volunteered to check their weight. The space isn't divided by any shield or physical separation between the weighing area and the rest of the room. Nonetheless, there is a physical distance between the group gathered at the far end of the room and the small area, by the door, where the weighing happens. The distance is also visual and acoustic. The rest of the group cannot hear Lizzie, the person weighed and me. In addition, everyone in the group is talking to someone else, avoiding looking towards Lizzie and the person weighed, and thus creating a further, imaginary, barrier between the two spaces by distancing the two scenes both visually and acoustically.

As explained by Lizzie, measuring weight is a voluntary activity in her classes. Unlike LNPO programmes, LFC classes are not required to follow specific, public health guidelines on tracking participants' measures. In this setting, BMI and weight do not represent evaluation criteria required by a third party. Nonetheless, the ways in which weight is enacted is very similar to those observed in LNPO groups. Not only the space is organised in a similar way, but also the

comments and attitude of participants are similar. The space where weighing takes place is contained and distanced through the ways in which group participants actively takes their focus away from it.

To conclude, I argue that the spatial, visual and acoustic distance in which weighing is performed in weight-loss groups enact weight as simultaneously marginal and sensitive. I also propose that through the spatial organisation of measuring, group leaders and participants navigate and negotiate the stigma attached to obesity and excess weight. Competing meanings and objects of weight and fat are simultaneously present in the ways in which group leaders and participants approach and perform weight. For example, in LNPO groups, weight-loss and measuring are presented as marginal aspect of the programme. Group leaders present them as evaluation criteria that are more relevant to public health statistics than to the healthy lifestyle approach that the programme promotes. Nonetheless, in the information and material shared in the groups, weight-loss surfaces as an important aspect of healthy eating programmes. For example, the plastic representation of one and five pound of fat (see figure 11) is used as a motivational tool for participants to lose weight along with the explanation of what constitutes a healthy weight-loss. Here, excess weight is enacted as a substance that is and can be removed from the body and a descriptor of corpulence that is perceived as stigmatising, as I will further discuss in section 8.3.1. I suggest that the ways in which weight and BMI are brought into practices are shaped by the shared understanding among participants and leaders of excess weight as a stigmatising and negative descriptor. In these settings, group leaders and participants approach and coproduce weight-loss as simultaneously marginal, stigmatising, and desirable. These competing but coexistent positions surface also in the ways group leaders talk about weight and BMI as indicators of health, as I will describe in the next sections.

### **8.3 Talking about BMI and weight**

Weight-loss group leaders talk about excess weight, BMI and obesity as sensitive topics and potentially stigmatising terms, echoing healthcare professionals' perception of obesity as stigmatising (see Chapter Five). In the previous session, I have shown how this stigma is negotiated through the ways in which weighing is performed in LNPO and LFC. In group leaders' accounts around weight and BMI, contested meanings of these measures as useful and exact indicators of good or ill health, powerfully surface. They challenge normative conceptions of the relation between health and weight and question public health policy and biomedical



overreliance on BMI and weight-loss. These recounts present a nuanced understanding of weight and BMI but do not relay a unified and firm refusal of the viability of these two measures.

### 8.3.1 Contested meanings of BMI and weight in group leaders' accounts

Lizzie talks about weight and weighing a few times during our interview. She recurrently mentions class participants, which she often refers to as “my ladies”, as examples to illustrate her points. She has been talking for a long time about how she came to run fitness classes, and what kind of people would join them today as compared to the past. At this point, she mentions the average body shape of class participants and how it is hard to tell their BMI or weight just by looking at them: “...if you walked down the street, you wouldn't look at any of those ladies and think ‘she needs to lose weight’”. Then she carries on talking about how in her opinion it is healthier to be active and fit, rather than a normal weight or BMI:

(...) most of my members lost their weight, but they keep coming so most of those ladies are fit enough and we keep that up a bit. So that's why I changed it, we used to be called weight loss and fitness but I call it weight management cos not many people lose their weight. Sometimes they all stay the same for so long; and we've got an obesogenic environment and people on average gain a pound a year so for them to stay the same is kind alright really! And because they are exercising, they are bringing down their metabolic age because they're burning fat, building muscles, their bones are stronger. So it's all those things, it's not just what you weigh, it's your health (...) A BMI 29 and exercising weekly, eating fairly well, as long as your BMI is under 30, you are so much more likely not to have all those health problems, diabetes and heart disease and stuff. So, my ladies, providing they are staying active and eat fairly healthily, I think they're fairly healthy BMI 29. And rather than feeling “you have to go back to BMI 25”... As you get older, I think the BMI 25 becomes a bit harder for them to think about

Lizzie does not dismiss the viability of BMI as an indicator of health, rather she questions its universality through her and other class members' experiences. She uses gender, age and the health benefits of physical activity as main categories to redefine what a healthy BMI is, using personal and working experience, as well as social (“we've got an obesogenic environment and people on average gain a pound a year”) and scientific explanations (“they are bringing down their metabolic age because they're burning fat, building muscles, their bones are stronger”) to question the authoritative definition of overweight as an unhealthy or “at risk” BMI. Lizzie also acknowledges the fact that in many cases attending fitness programmes does not result in constantly losing weight, and rather people tend to stay the same weight for a long time while getting fitter. Lizzie explains that this is the reason why she decided to advertise her classes as “weight-management” instead of “weight-loss”. Lizzie's explanation resonates with the

normative discourse on healthy lifestyles and healthy weights that governs obesity management in the context of this research (see Chapter Four and Seven).

In Lizzie's account, weight and BMI are still relevant category to define health but their centrality and normalizing effects, especially on women bodies, are re-defined based on physical activity: she uses weight-maintenance rather than weight-loss as main indicator of good health and effectiveness of the programme. Body Mass Index remains a useful indicator of health, but the boundaries of a healthy BMI are pushed forward. Lizzie describes overweight as a healthy, desirable and achievable BMI, especially for elderly women. Simultaneously, she reproduces the idea of obesity (BMI = or >30) as a risk factor.

Following on her conversation on BMI, Lizzie talks about measuring members' weight:

L: most of them [class members] just want to weight weekly to keep an eye on it

LB: so they are happy to be weighed

L: yeah. Sometimes it can have a negative impact on them because they think they've done well, they've been good and I have to put that on the newsletter because if you've been good doesn't mean you have been better than normal, it doesn't mean you have been good enough to lose weight, but sometimes you weigh them and they think they deserved they lost weight and they didn't. Then they just think "what's the point?", go out and eat more. So, lots of them sometime just stay away from that. It's optional

Here, Lizzie presents weighing as having two possible effects: on the one hand, it is used as a motivational and observational tool used by members with a regular frequency, e.g. weekly, "*to keep an eye*" on their weight, embodying a technologies proper to the discourse on dieting. On the other end, weighing can result in demotivation if the expectations on weight-loss are unmet. She concludes saying that weighing "*is optional*", it is up to class members deciding whether weighing themselves or not, what relevance give to weight and how to enact their weight-management every week.

Emily, a nutritionist in LNPO, seems to share with Lizzie some common ideas on BMI and weight. When I ask her what she thinks about the use of obesity and overweight as almost synonyms, she replies:

E: I refer to BMI markers for overweight and obese (...)\_BMI is a very crude marker and I do explain it to people a lot because at the end of the day is your weight on the scale, is your skin, bone, muscles and water and dehydration is a massive factor that affect weight; your bone density, there are so many factors. And ideally, we should be looking at lean body mass and fat body mass, but we just haven't got the tool to be able to do that. So, I think it would be great if we had another way and we need more consistency across... and I completely forgot what the question was now

LB: the difference between being overweight and obese

E: I think weight is just so crude! Because you can have visceral fat or cutaneous fat, visceral fat being so much more harmful than cutaneous fat. And then I think if we can focus on health and nutrition and relationship with food quite often weight will follow from that, and also if someone is cardio metabolically fit there's an argument that that is much more important than weight. And there is this dietitian that has this programme called *"health at every size"*, it is really interesting! She's looking at a way people can be happy with the weight they are at, but she actually works with BMI 25 to 30, so overweight, because her theory shows there's no increased risk of heart attack or stroke. Actually, fat is protective, particularly for the older generation (...) So these approach of *"be happy with your weight"* are very much about an open relationship with food more than a focus on weight. I think weight is a very easy scale it doesn't take into account the many components (...)

Emily seems to refer to the same source as Lizzie when she speaks of some research arguing that *"there's no increased risk of heart attack or stroke"* for people with a BMI 25 to 30, that is overweight. She uses this evidence to support her idea that *"if we can focus on health and nutrition and relationship with food quite often weight will follow from that"*, the same idea that is at the basis of the healthy eating approach promoted in LNPO programmes (see Chapter Seven). Emily describes BMI and weight as *"crude"* markers as they do not reflect the many components that form one person's body mass. Where Lizzie used gender and age as main factors to redefine authoritative and normalizing BMI categories, Emily refers to physical and biological components of human bodies to explain why *"weight"* is in itself a weak and imprecise indicator of health. She refers to different composition of body mass: *"ideally we should be looking at lean body mass and fat body mass"*, suggesting that weight is composite object and that the parts that compose it are more relevant for health than the weight itself. She also talks of different types of fat: *"you can have visceral fat or cutaneous fat, visceral fat being so much more harmful than cutaneous fat"*. In Emily's account, fat is also represented as multiple and composite (see Zivkovic et al., 2018). Here, Emily talks of different types of fat that are more or less harmful depending on their disposition in the body. Furthermore, she mentions the positive and protective effects of a certain type of fat for health. She uses the adjective *"crude"* to describe weight and BMI as these measures overlook and erase the variety and multiple objects that compose weight and fat. Emily affirms that this variety and multiplicity is more relevant than weight and BMI to assess a person's health.

Nonetheless, Emily does not entirely dismiss BMI and sees it as a viable criterion to use when talking to participants about their weight. In particular, she explains that using the biomedical language of BMI becomes a useful way to deal with the stigma attached to the term obesity:

I think is actually useful to tell people “you are in this category”, “it just puts you in the obese category” and people might just go “I thought I might be” and how do you feel about that and I think it helps building a relationship with people as well, I definitely do that in a one-to-one situation

Emily contests and resists the centrality given to BMI and weight as accurate indicators of health when dealing with obesity and overweight, but she re-negotiates the viability of BMI and she does so in relation to stigma. In fact, she uses the Body Mass Index category not because it is a precise descriptor of a person’s health but because it functions as a useful biomedical term that can help minimize the stigmatic connotations attached to the label “obesity”, making the condition more acceptable to the person defined through it. Her approach to the use of BMI as a way of alleviating the stigma attached to the term obesity resonates with some healthcare professionals’ accounts presented in Chapter Five. Emily shares the idea that obesity is a stigmatising term and criticises BMI for being a crude indicator of health. Nonetheless, when interacting with people, she uses the BMI as a tool to re-medicalise obesity (see section 5.3) and alleviate the stigma attached to it.

Katherine moves the same criticism as Lizzie towards the inaccuracy of BMI and weight. She describes them as normalizing measures that dismiss the different components of body weight and the diversity of individual bodies:

LB: do you use the BMI? I mean, you said you had a lot of results, how do you see the results [in LNPO programmes]? Do you use the BMI?

K: ok! it's a reduction in overweight. We do have the scale that can measure body fat and muscle and stuff but we don't use them! Well, I used to use them when I was doing weight-management coaching, we only had those scales, so you could see the difference in muscles, and you could see the difference in the BMI and waist circumference as well. So, we used those three figures but unfortunately here [in LNPO groups] we just do overweight, it's more targeted. And that's what we did at the stadium [she refers to a programme run at Brighton stadium only for men], we look at all the figures, not just overweight. So if they have put on muscle and lost body fat, that is great, more than weight, that is what we are looking at, really

LB: so what do you think about the BMI?

K: I don't think is that accurate because people can be really fit and healthy and have high BMI, they might not be overweight but have a huge weight of muscles or be very tall and super healthy and they might not have any body fat, really! I don't think is fair, I think it'd be good to get rid of it (giggle) if I'm honest

Katherine explains that there are scales that can measure body mass composition, showing the percentage of fat and that of muscles. She describes how using those measures along with waist circumference gives a more accurate picture of a person’s health. She also echoes Lizzie and

Emily in saying that physical activity, which does not necessarily result in weight-loss, but rather in body fat reduction and muscles growth, is a better indicator of one person's general health: *"if they have put on muscle and lost body fat, that is great, more than weight [loss] (...)".* Interestingly, she also says that weight and BMI are *"more targeted"* than measures that look at body fat and lean body mass, and that if used together she deems could give a more accurate image of the person's health. Here, Katherine seems to echo Jane's introductory words to LNPO group 1 (see section 8.2), where she explained the need of BMI and weight measures to produce report and evaluate the programme, as it is also clearly stated in national guidelines, (see NOO 2009). Unlike most group leaders who, despite being critical toward the inaccuracy of BMI and weight, renegotiate the value and use of these two markers, Katherine concludes that BMI is an *"unfair"* indicator and *"it'd be good to get rid of it"*.

The findings presented in this section reveal the multiple and contested meanings of weight and BMI as indicator of health mobilised by weight-loss group leaders. The nutritionists and nutritional therapists I met recurrently refer to BMI and weight as *"crude"* and poor indicators of health. They explain that both weight and BMI produce an imprecise and vague picture of the body, as they do not detail the composition and distribution of fat in the body. They mobilise different sets and sources of knowledge to explain their criticism. For example, Emily details the different types of fat and distributions of fat in the body and how they have a different impact on people's health, suggesting that some type of fat is beneficial to health. Here, she enacts both weight and fat as composite objects that can be measured and separate from the body. Lizzie, instead, refers more often to age and gender to explain the variability on BMI. She explains that with age it becomes harder for women to lose weight and suggests that a BMI equivalent to overweight is healthy if the person exercises regularly. She derives this understanding from her long experience as fitness instructor and nutritional therapist, as well as recent research on the healthy effect of physical activity. Furthermore, they describe different approaches to the use of BMI. Katherine suggests that it is an unfair indicator and dismisses it whereas Emily finds it useful to use with group members. She describes how using the BMI chart is a useful tool to alleviate and negotiate the potentially stigmatising meanings attributed to excess weight and obesity, echoing healthcare professionals' accounts presented in Chapter Five.

In the next section, I will reflect on how measurements are understood and performed by weight-loss group participants in their day-to-day lives in relation to the practices and discourses promoted in the programmes they attend.

### 8.3.2 Enacting weight in everyday life: meanings and materiality

In this last section, I focus on Daniels' experience of weight and weighing in his day-to-day life. The coexistence of multiple ways of approaching weight and bodily measurements emerges in many group participants' interviews. It also surfaces in the ways they daily reproduce, dismiss and mobilise healthy eating practices promoted in LNPO groups, as discussed in section 7.3. I have chosen to detail Daniel's account, as it is particularly effective in showing the nuances and interrelations of discourses and technologies around weight promoted in weight-management settings and performed in everyday life. Daniel is talking about when he started the one-to-one sessions in LNPO and how, after losing some weight, decided to sign up for the programme where I met him. When he talks about losing weight and setting the standards for weight-loss, he mentions advice given by Emily and other consultants in LNPO and describes how he used that advice:

D: yeah I've lost about two stone but I need to lose a bit more but that's fine

LB: when you say I need to lose a bit more, who sets the standard?

D: it's partly me, partly also the reference from the BMI chart or that kind of thing. For my height, according to the chart I should be about twelve and half stone can't remember in kilos but when I mentioned it to, I think it was Emily, she said "don't worry too much about that as long as you are kind of back towards the line that's fine" so I...I mean I can't remember the last time I was under thirteen stone it was quite some time ago, so if I can get somewhere around thirteen, thirteen four, I think it'd be really good. I feel better already, I feel lighter and all that sort of thing feel fitter, and that's what I really want to do it's not really what I weigh it's how I feel and I definitely feel better for being... for having less weight

Emily's criticism towards the accuracy of BMI and weight translates into her advice to Daniel to not give BMI too much relevance in setting his weight-loss goal. However, Daniel uses both the BMI chart and his own experience of what he considers his most recent lighter weight, to set his goal and expectations in terms of weight-loss. Moreover, Daniel refers to his weight-loss in positive terms saying that he feels *better, lighter, fitter* and here his focus shifts from weight in itself to a general sense of wellbeing, "*and that's what I really want to do it's not really what I weigh it's how I feel and I definitely feel better for being... for having less weight*". In Daniel's words, weight-loss becomes a means to an end, to "*feel better*": losing weight is not the end goal in itself, but it is through weight loss that this goal can be achieved. It is also interesting to note that Daniel does not mention any specific health condition but talks generally about "feeling better" rather than being healthier, suggesting that weight-loss has to be understood not just as a technology of the body but also of the self (see Heyes, 2006).

He carries on telling me how he used to use clothes to evaluate his body size and how he has realized that this technique is actually more and more unreliable due to the phenomenon called “vanity sizing”, which is the tendency in high street chain to sell sizes which are actually bigger than the standard. This brings him to talk about the weighing and measuring in the LNPO group, as our interview happened to be on the same week that the measuring took place:

D: yeah! I mean I'm not an expert but certainly for men's clothes [vanity sizing] is absolutely [happening] which is why is quite interesting in the one-to-one and the course on Wednesdays, is being measured

LB: so you don't mind that

D: no! I think is a really good idea because you can't trust your clothes to tell you what size you are

LB: and you wouldn't do that by yourself

D: I probably wouldn't, no, I could do... I do weigh myself; I did buy some scales. When I went to the one-to-one [sessions in LNPO] I was asking about the scale and, I can't remember her name [Emily], but she said if you are coming once a month to see us, don't worry too much about the scale cos sometimes people just end up weighing themselves too much... but I thought I'll get one and I do weigh every two weeks, just get on it and ...is good...I don't want to do it every day (...) but I think measuring [waist circumference] myself, I probably wouldn't do that

I suggest that Daniel's account of measuring in weight-management group and weighing at home offers an interesting and nuanced view on these bodily practices and the enactment of weight-loss. In Daniel's experience, weighing becomes an *enabling* moment or practice (see Heyes, 2006) through which he negotiates and takes control over his body and weight-management, partly disregarding the authoritative advice of nutritionists and dietitians he meets in weight-management programmes, both one-to-one consultations and group sessions.

I want to highlight two aspects that I find particularly important. Firstly, Daniel describes the measuring in the group session as a “*really good idea*” that enables him to surveil his body size using techniques that he would not necessarily reproduce outside that context: “*I think measuring myself I probably wouldn't do that*”. Secondly, he chooses to buy a scale and weigh himself at home in spite of his consultant's advice of not doing so. I suggest that the power relations and bodily practices at work here evidence the discursive shift from dieting to healthy eating that is taking place in most weight-management programmes.

Daniel's account is a potent example of how the multiple positions towards weight and weight-loss entangle one with the other and highlights the importance of group participants' agency in navigating and reproducing bodily practices and meanings.

#### 8.4 Summary

The findings presented in this chapter reveal that tensions emerge in the ways group leaders and participants talk about and enact weight. I suggest that this tension derives from having to navigate three positions: the acknowledgement of weight as a sensitive and possibly stigmatic topic; a resistance to the over reliance on BMI and weight as indicator of health, and finally the use of weight and BMI as standards to evaluate the success of weight-loss programmes and getting access to funding. Measuring weight is a practice that is central to obesity and obesity management: through the Body Mass Index and definitions of normal and excess weight, obesity is defined as a clinical category. Within a discursive and practical shift from diet to healthy eating, where weight is understood as less focal than eating behaviour changes, measures, in particular weight and BMI, remain fundamental criteria of evaluation.

Weight-loss group leaders describe both weight and BMI as weak indicators of health; some suggest that body composition would be a more precise measurement, others stress that physical activity is a better indicator of health than weight. They also seem to rely on previous experiences and awareness of the possible adverse effects that weighing can have on people's relation with their bodies. The promotion of a healthy eating discourse seems to entail a problematization and refusal of weighing, which is conceptualised as either an unhealthy or an unproductive practice. In these weight-management groups, measuring, and in particular weighing, as an individual bodily practice is either discouraged or marginalised by those who represent the authoritative knowledge and expertise, namely group leaders and nutritionists. The understanding of BMI and weight as poor indicators of health is practically and materially visible in the ways weighing is carried out in the weight-loss groups. The ways weight and BMI are enacted in weight-loss groups powerfully reveals the tensions at play in the local and everyday implementation of public health guidelines based on the "obesity epidemic" discourse. The enactment of these biomedical indicators exposes their contested meanings.

In fact, BMI and weight remains the main criteria used by policymakers and funding organisations to evaluate the efficacy of the programmes. Moreover, weight-loss and a decrease in BMI are leading criteria that health professionals and individuals use to evaluate and assess risk, health and the success of weight-management. This creates a tension between promoting a view of weight management that focuses more on healthy habits than weight itself and the centrality that weight has in evaluating health in general and obesity management programmes in particular. Moreover, the findings presented in this chapter show that the ways in which



weighing is carried out and talked about, can be read as strategies put in place by group leaders and participants to navigate and negotiate the stigma attached to weight and obesity. I suggest that this is where tensions between authoritative discourses of obesity as a public health category and everyday management of obesity as a lived experience are particularly visible and tangible. I conclude by suggesting that policymakers should relax the centrality given to measurement and weight as a way to address stigma and facilitate obesity management and health professionals' work.

## 9. Conclusion

It is a cold, windy morning in Brighton. I am on a bus ride to the university campus. From the

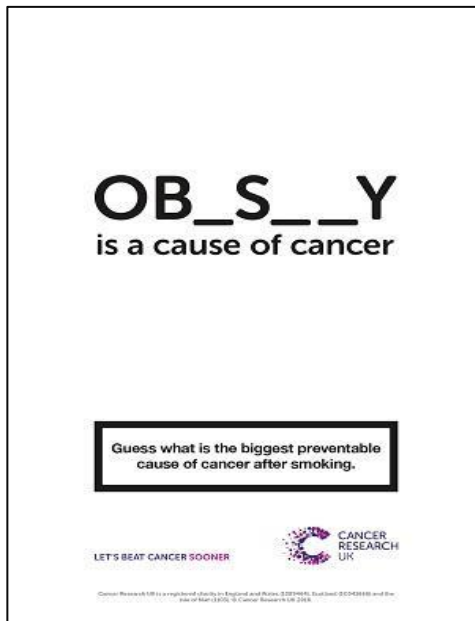


Figure 15. Campaign Poster by Cancer Research UK.

window, a poster at a bus stop catches my eye. The bus goes past it too fast for me to reach for my phone and take a photo. The poster spells big black letters to form the word obesity, and in the style of the hangman game, some letters are missing. Below the word, there is a caption: “Guess which is the second preventable cause of cancer after smoking”. A rhetorical question. Later that day, I look for information about this campaign and read that Cancer Research UK launched it to inform the public about the increasingly evidenced link between obesity and some type of cancer. I also read that the campaign attracted harsh criticism for being fatphobic and stigmatising. I wonder how the people I met in the

fieldwork would comment on this campaign, but I am in the final stage of my PhD at this point. This anecdote shows something familiar and recurrent when studying obesity as a socially and politically meaningful issue: the urgency with which obesity is addressed in public health campaigns in the UK in epidemiological terms, and the unintended consequences and contested meanings they produce.

(...) biomedical and global health organisations (such as the WHO) often uncritically reproduce stigmatising assumptions about large bodies and privilege biomedical perspectives as ‘fundamental’, while problematically presenting simplistic understandings of ‘society’ as fact. (Reichardt 2018, p.2)

This kind of public health message along with alarming news on the health and financial costs of obesity, advertisement of weight-loss diets and organizations, the promotion of ‘healthy’ lifestyles and depictions of fatness as always unhealthy, are ubiquitous in the UK. They form the lens and hegemonic knowledge through which obesity is understood as both a risk factor and health condition due to caloric imbalance resulting from overconsumption of food and sedentary lives, and easily treatable through weight-loss. This knowledge is based on three problematic and intertwined assumptions. Firstly, the uncritical association of obesity with modernity and the “obesogenic environment” it brings about, where obesity is depicted as an unwanted but

inevitable consequence of modernity (See Yates-Doerr, 2015). Secondly, the focus on the individual as the main locus of responsibility to address obesity. Through a rationalised and neoliberal understanding of health and choice (see Crawford, 1977, 2006; Wright and Harwood, 2009; Warin, 2018) individuals are asked to take responsibility for their health and adopt healthy behaviours - eating healthily and exercising- to lose weight. Finally, the belief that weight-loss is always achievable and when it doesn't work is for lack of motivation, compliance and will power of the dieter, what Greenhalgh (2015) refers to as the first biomyth of the war on fat. In this thesis, I critically refer to this hegemonic knowledge as the 'obesity epidemic' discourse.

The research presented in this thesis has comprehended the local trajectories of the authoritative 'obesity epidemic' discourse and how relevant social actors navigate, (re)produce, reinvent, contest or align to it. It has explored how the urgency, pervasiveness and normativity with which obesity is addressed in public health policy and public debate, shape local and individual experiences of obesity management. The research then focused on the local implementation of public health policies related to obesity management to answer the question *"what practices and discourses related to obesity management are produced in the UK and what is their interrelation?"*. To answer this question, I have conducted a multi-sited ethnography of obesity management in the Brighton and Hove area in Southeast England. Following public health guidelines, I have identified general practice and weight-loss groups as privileged field-sites. I also considered public health reports and guidelines a field site and have analysed them as historically situated products.

This thesis has shown that the promotion of a 'healthy' lifestyle through nutritional education and behavioural change is identified by public health policy, the National Health Service and public debate, as the chosen strategy to manage obesity and promote weight-loss in the UK. The analysis of guidelines and reports has revealed that public health policies identify primary care and weight-loss groups as privileged sites to prevent and manage obesity. Further, they claim integration of services and stakeholders at a local level as more effective than at a national level. In Chapter Four, I have described this strategy as a 'localisation of responsibility' (Strong, 2018) brought forth by the Health and Social Care Act 2012, which has moved responsibilities for identifying and delivering obesity-related interventions to local authorities. Through this process, obesity is portrayed as a national emergency whose prevention and management are responsibility of local government and communities.

From my previous ethnographic research in the endocrinology department of a University Hospital in Italy, where I observed dietary consultation with obese patients, I became aware of

the importance of focusing not just on what it is said, but also on what it is done and with what in clinical encounters around weight and diet. As discussed in Chapter Three, there is space in the literature to further investigate these practicalities and materialities of obesity management in the UK and keep them the focus of analysis and interpretation. Approaching my fieldwork with this perspective, I have focused not only on what people say and the different perspectives and experiences that populate clinical encounters around obesity management, but also on their materialities and practicalities. Beyond the clinical settings, I expanded this approach to weight-loss groups.

My methodology and analysis build on Mol's (2002) concepts of *body multiple* and *enactment* (2002; 2012): the practices of obesity management are my main focus of analysis. Applying these concepts to obesity management and drawing upon Throsby's discussion of multiplicity in obesity surgery in the UK, I argue that obesity is not one but multiple objects (Mol, 2002): (...) *the body multiple is always 'more than one – but less than many ... Even if it is multiple, it also hangs together'* (Mol, 2002, p.55 in Throsby, 2012, p.3). In this thesis, I argue that multiple objects of obesity are enacted in public health policy, in clinical encounters in general practice and in weight-loss groups based on nutritional information.

The application of the idea of enactment to obesity management has informed my fieldwork and methods. A focus on the interrelations between the obesity-management settings identified in public health policy has meant that I have chosen to carry out a multi-sited ethnography. As discussed in the methodology chapter (see section 2.1.1), I consider multi-sited ethnography the best approach to investigate the multiple meanings of obesity as well as the practicalities and materialities of obesity management in my field. I consider this an original contribution to the study of obesity in anthropology. To my knowledge, my research is a first application of the concepts of enactment and 'body multiple' (Mol, 2002) to a multi-sited ethnography of obesity management in the UK. This has proven to be a productive method to explore obesity management as a field of interrelations (see Marcus, 1995) by following the discourses on obesity management and healthy lifestyle across sites. Without this approach, I wouldn't have been able to produce the original findings that I present in this thesis on the multiplicity inherent to obesity management, the contested meanings and practices that this multiplicity reveals and the mobilisation of this multiplicity as a way of navigating stigma. A multi-sited approach has also allowed me to locate stigma in specific practices across sites - such as doctor-patient encounters, referring, measuring weight and BMI in weight-management groups – while simultaneously reflect on the interconnectedness of these practices. As discussed in this thesis,

public health and policymakers are increasingly calling for an integration of services and cooperation of different stakeholders to design and implement obesity management. The 'localisation of responsibility (Strong, 2018) described in this thesis and mentioned above, is a clear example of this tendency. I therefore consider multi-sited ethnography a fruitful and privileged approach to explore obesity as a category that is co-produced through and across "translocal linkages" and "bundles of relationships" (Hannerz, 2003, p.206).

I have used participation observation and semi-structured interviews as privileged methods to collect data. I volunteered in three free weight-management programmes organised by the Local Non-Profit Organisation (LNPO), each one ten-week long, organised following the same structure and based on the promotion of healthy lifestyle and healthy weights. Here I recorded each session, took field notes and interviewed some group leaders and participants. I also took part in two aerobics classes ran by Lizzie, the owner of a small, local fitness club I have anonymised into LFC, interviewing her and one of the class participants. The findings I analyse draw on these conversations, as well as on the material and practical aspects I observed, such as scales and kitchenware, food diaries, the organisation of space, forms and procedures.

Interviews with GPs and practice nurses have been my way of stepping into clinical practice. Following my supervisors' considerations both on practicalities and on the difficulties of gaining ethical approval to conduct research with NHS staff and patients, I decided to interview healthcare professionals without conducting participant observation in GP surgeries. The ways the GPs and practice nurses talked about the technicalities and practices of obesity management in their working routine have given me invaluable access to practical aspects of clinical encounters around weight and obesity. For example, they have brought to light the relevance that organisational and administrative factors and tools have in weight-talks in doctor-patient encounters, and in patients' access to weight-management services such as weight-loss groups. In the next sections of this conclusion, I summarise my main findings around multiplicity in obesity management and conclude reflecting on the relevance that these findings have for general practice and public health policy.

### **9.1 Multiplicity in obesity-management**

For the last three decades, social scientists have been prolific in exploring the medicalisation of fatness and the production of a hegemonic discourse on the epidemic of obesity. The idea that the obesity epidemic is "one of the most powerful and pervasive discourse(s) currently

influencing ways of thinking about health and about bodies” (Wright and Harwood, 2009, p.1) is ubiquitous in current literature. A conspicuous body of works has also highlighted how the ‘truths’ of the obesity epidemic are re-contextualised in government policy, health promotion initiatives, web resources and school practices with important consequences for how people come to know and judge themselves (Ibid.). This results in a pervasiveness of health as the authoritative category to talk about and understand fatness, producing a ‘bio-discourse’, that is, ‘a veritable epidemic of fat talk in which public and private discourse increasingly target weight as a matter of concern, lament, ridicule’ (Greenhalgh, 2012, p.472 ) shifting from the biological realm of health to the social field of moral judgment. Simultaneously, a critical approach to public health policies in neo-liberal societies has highlighted that the current public health discourse is characterised by concern with the health status of populations (Bell, Salmon and McNaughton, 2011) and its focus is increasingly on lifestyle, individual responsibility and self-control.

The construction of obesity as a biomedical category is paradigmatic of this trend. Moreover, clinical and public health ethnographies have revealed the role of socioeconomic factors in shaping individual experiences of obesity and the role these factors play in biomedical settings and health policies. By revealing ‘the ways in which obesity is enmeshed in participants’ taken-for-granted, everyday practices’ these works ‘problematize the universality of health-promotion messages’ (Warin et al., 2008, p.97). Other anthropological works on clinical narratives and practices of obesity have shown how gender stereotypes are at play in health policies, perpetuating moral judgment and the standardisation of female bodies in biomedical settings (McNaughton, 2011; Unnithan and Tremayne, 2011). These ethnographic works have revealed the variety of perspectives that populate the knowledge production and experiences of obesity, often comparing and highlighting the contrast between prescriptive approaches and explanations offered by experts and healthcare professionals and patients’ embodied experiences of fatness. They have also exposed the reproduction of sociomaterial inequalities by disciplinary, neoliberal technologies of body and self that are inherent to the current public health promotion of healthy lifestyle as privileged interventions to address obesity (see Wright and Harwood, 2009; Greenhalgh, 2012).

Interestingly, few works have focused primarily on the ways in which obesity, the authoritative knowledge around it and its contested meanings and experiences are *enacted* (see Zivkovic, T. et al., 2018), that is, how they are “*brought into being, sustained, or allowed to wither away in common, day-to-day, sociomaterial practices. Medical practices among them*” (Mol, 2002, p. 6).

Throsby's (2012) application of Mol's concept of 'body multiple' to obesity surgery in the UK is an excellent example and powerfully reveals the enactments of multiple obesities in clinical encounters. To my knowledge, my research is a first application of this concept to a multi-sited ethnography of obesity management in the UK. My thesis is then a timely contribution to this field of research and to critical fat studies more broadly.

This thesis builds on a wide body of literature that critically analyses the epistemologies and body politics of the "obesity epidemic" discourse and expands it by looking at how this authoritative knowledge is *brought about in practices*. My analysis draws on critical social science debates about the different politics, experiences, meanings and perspectives around obesity and attends to the ways they are enacted in local settings of obesity management. In this sense, I think of my research as a *praxiography* (Mol, 2002) *of obesity management* that also attends to the hierarchies of knowledge that are entrenched in the enactments of multiple obesities. The observation and description of material and spatial details of the contexts researched is at the core of ethnography and the thick description it is expected to produce. As such, my attention to materialities and practicalities of obesity management belongs to the tradition of the discipline. The originality of my research resides in the space it gives to the analysis of these material and spatial details in producing obesity. In medical anthropology and clinical ethnographies, these details are usually used to contextualise and situate the exchanges, situations and encounters through which meanings, experiences and knowledge about diseases, obesity among them, are produced and experienced. By contrast, the findings of my research reveal that these material, practical, and spatial details are integral part of the meanings, experiences and knowledge around obesity. They are not just props in the backdrop where obesity management is enacted, they are at the very core of this enactment.

The findings analysed in this thesis vividly present the multiplicity of meanings, practices, narratives and experiences that populate the sites of obesity-management: public health, general practice and weight-loss groups. Furthermore, the findings reveal how this multiplicity is often produced through the strategies that relevant actors mobilise to address and mitigate the stigma attached to obesity. This is particularly evident in health professionals' perception and use of the terms "overweight" and "obese" (Chapter Five) and in the ways in which weighing is performed in weight-loss groups (Chapter Eight). Many scholars (see Aphramor, 2005; Kulick & Meneley, 2005; Webb, 2009; Bell, Salmon and McNaughton, 2011; Bombak, 2014) have studied stigma in obesity. The originality of my argument resides specifically in the way in which stigma as a main finding emerges from the analysis of multiplicity. Moreover, my analysis reveals

a discrepancy between the understanding of the causes of obesity as structural and the implementation of interventions predominantly focused on behavioural change and personal responsibility. I argue that this discrepancy can be understood through the coexistence of multiple objects of obesity within obesity management. The two objects that coexist are obesity as the result of structural changes and inequalities on the one side, and obesity as the result of excess weight due to unhealthy habits on the other side. I also argue that these multiple objects are not equally normative in the ways in which obesity is enacted. On the contrary, structural factors are silenced in obesity management whereas personal responsibility for behavioural change becomes the privileged explanation and locus of intervention. The normativity of personal responsibility in obesity management interventions is made visible in the biopedagogies of healthy eating that promote self-control and discipline, as discussed in Chapter Seven.

Two assumptions around personal responsibility for weight-loss are reproduced in these interventions. Firstly, the idea that weight gain and weight-loss depend exclusively on individual control. Secondly, this approach assumes that weight-management is a straightforward and simple process, while the data presented in this thesis shows the opposite. These interventions are based on a limited, rationalistic understanding of choice that depicts choice and behaviours as detached from the structures in which people live. The importance of social, economic and personal circumstances in people's relation to food, eating and weight are silenced and reduced to a simplistic matter of individual responsibility, information and motivation. I will discuss the implications of these assumptions for public health and healthcare practice in section 9.2. Here, I want to highlight the relation between these moralising assumptions and stigma. I locate stigma in the reproduction of the normative idea of personal responsibility for weight-loss and the tensions it creates in the management of obesity. As I explained above, I maintain that the multiplicity I observed in my field sites is produced as a way of mitigating the stigma attached to obesity. I add that this stigma stems from a problematic and moralising enactment of personal responsibility as the exclusive area of intervention to manage obesity. To summarise, my understanding of stigma and individual responsibility as entangled stems from my central argument on multiplicity.



### 9.1.1 Multiplicity, contested meanings and stigma

By attending to this multiplicity, my analysis reveals how authoritative practices and discourses of obesity management are challenged and contested by and within what are generally considered the sources of this authority. The findings show an internal resistance to the centrality of primary care in managing obesity set in public health policy on obesity management. For example, some of the weight-loss group participants I interviewed recount anecdotes of clinical encounters where they felt negatively or inappropriately judged for their weight, as presented in Chapter Six, confirming a recurring theme in the literature on clinical management of obesity (see Webb, 2009). Interestingly, the findings reveal that they also do not consider weight gain as a good reason to see a GP, a perspective also shared by those group leaders and healthcare professionals that have gone through weight management in their lives. Interviewees from all different groups of research participants, consider weight management and weight-loss as matters of common sense and support around eating healthily and exercising more than issues that require medical expertise. Moreover, as seen in Chapter Six, research participants bring up a variety of reasons that brought them to want to lose weight at different moments in life; these reasons entangle with health concerns but are far from limited to them. Having put on weight, no longer fitting into clothes, participating in social events, for example a wedding, are all motives that participants use to explain their willingness to lose weight. Explicit references to obesity as a risk factor or disease to treat through weight loss are rarer and they are never cited as main reasons to lose weight. I therefore argue that both fatness, a body size socioculturally understood, and obesity, a health condition medically defined, are enacted and coexist in research participants' choice of losing weight and how to do it. It is also important to note that while these enactments question the identification of primary care as a privileged site to manage obesity, and consequently the primacy of biomedical expertise, they reiterate the idea of excess weight as negative.

The GPs and practice nurses I met contest the centrality and ability of general practice to manage obesity, as discussed in Chapter Four and Chapter Five. Firstly, they describe organisational and administrative factors that negatively affect obesity management, specifically the short time of visits (ten minutes for patients) and the lack of continuity of care due to the 48-hour access requirement in primary care. They also describe referring as a time-consuming practice and admit that they usually avoid referring to weight-loss services. This is an important point that questions the integration of services auspicated in public health policy and locates the problematic focus on personal responsibility in specific clinical practices within the NHS. I will

further explore this point in 9.2. Furthermore, the GPs and practice nurses I interviewed perform and talk about obesity as a “risk factor” more than a disease entity. This is an important contribution to the literature that tends to represent healthcare professional as accepting and reproducing the normative idea of obesity as a disease entity.

Secondly, health professionals are particularly vocal in describing obesity as stigmatised and weight conversation as particularly sensitive. They describe the difficulties they encounter in talking about weight with patients and their perception of obesity as a stigmatising, negative term. In this way, they resist their role in promoting and managing healthy weight that public health policy bestows on them. Moreover, my analysis locates their perception of the stigma attached to obesity and weight within the specificity of the NHS primary care and their understanding of rapport building as at the core of their work. GPs and practice nurses see talking about weight and obesity with patients as potentially harmful and counterproductive to building a rapport with patients as they assume patients would feel negatively judged or demoralised. I argue that in the way they perform their role in relation to weight and obesity in clinical encounters, health professionals contest the purportedly neutrality of obesity as a biomedical category. They powerfully expose the moral values and aesthetic ideals at work in obesity management.

As seen in Chapter Eight, weight-loss group leaders share this perception of obesity as stigmatising and never use the term with group participants. The word obesity is also absent from informative material- flyers, food diaries, slides- circulated within LNPO sessions. The perception of obesity as stigmatising is strongly linked to the ways overweight and obesity are enacted in general practice and weight-loss groups. The findings show a coexistence of obesity and overweight as both “adjective descriptors of corpulence” and diagnostic categories (Jutel, 2006). Health professionals and weight-loss group leaders share the perception of the term “overweight” as less stigmatising than obesity, and therefore preferable to use with patients or group participants. In the interactions they described and those I observed, overweight is enacted as an acceptable descriptor of body size unlike obesity, which is instead perceived as morally fraught and then to be avoided. In order for the term obesity to be usable, it needs to be re-medicalised using phrases like “your BMI puts you in the obesity range” or “you are medically obese”. As discussed in Chapter Five, many research participants say they use the term obesity only when performing BMI measurements, suggesting that enacting obesity as a diagnostic category through specific procedures and objects – the BMI chart, the scale, the

metre, and the calculator- strips obesity of the moral judgment attached to it when enacted as a descriptor of corpulence.

Along with the centrality of primary care, another premise of public health policy on obesity management and of the wider “obesity epidemic” discourse is contested: the normative focus on weight. In the weight-loss programmes and fitness classes I attended, where healthy lifestyle is the normative discourse through which obesity management is enacted, participants were discouraged from tracking their weight. As shown in Chapter Eight, weighing, along with BMI calculation, was presented, often regrettably, as an evaluation criterion for the effectiveness of the programme and was not promoted as a useful bodily technology of obesity management. Furthermore, most group leaders suggested that weight and BMI are crude measures and therefore poor indicators of health. A few group leaders openly suggested that exercise and healthy eating are better indicators of health than weight, at least within a certain weight range. These understandings are performed and evidenced in the ways weighing is carried out, for example in the organisation of space and time dedicated to it, as presented in Chapter Eight. In this thesis, I argue that the ways weight is enacted in these groups should also be understood as a way to navigate and negotiate the stigma attached to obesity through practices that minimise the relevance of weight as an indicator of health.

The normativity of weight and BMI as indicators of health and the centrality of primary care in managing obesity are two constitutive assumptions of the authoritative knowledge on the obesity epidemic, as well as of the public health strategy to address obesity in the UK. This means that by revealing the ways these assumptions are contested by health professionals and nutritionists in weight-loss programmes, my findings interrogate and illuminate the local implementation of public health guidelines around obesity management. I suggest that ethnographic research on the integration of services in relation to the implementation of healthy lifestyle interventions is a fruitful field for further investigation.

### **9.1.2 The coexistence of multiple obesities**

The findings show the coexistence of multiple obesity across and within the sites of obesity management I have explored: general practice, weight-management groups and public health reports. This multiplicity is particularly evident when looking at explanations of the causes of obesity and biopedagogies of healthy eating. Multiple but recurring causes of obesity are identified by all groups of research participants and in public health reports. As discussed in Chapter Four, healthcare professionals point at structural causes, namely the “obesogenic

environment” – power of the food industry, quality and availability of processed food, inactivity - and health inequalities when explaining the main causes of obesity. They lament feelings of powerlessness in addressing obesity, as they are aware of the difference of forces at play: socioeconomic structures on the one side and primary care on the other. Despite their awareness, these structural causes are silenced when *doing* obesity management with patients and another object is enacted: obesity as the result of individual unhealthy choices. Patients’ habits and bodies become the loci of intervention in general practice. Now, healthy eating and exercising are presented as straightforward, equally and easily accessible by all. This same tension exists in public health discourse on obesity and I argue it is entrenched in current obesity management interventions in the UK, as explored in Chapter Four.

The findings presented in Chapter Six show that these same causes are also identified by weight-management group leaders and participants along with others such as sociomaterial conditions, upbringing, life events, emotional wellbeing and medications. Moreover, they give to these alternative causes the same relevance as they do to the more commonly accepted “obesogenic environment” explanation. Equally, they also enact obesity as the result of individual choice by promoting healthy lifestyle activities based on behavioural change. Furthermore, “healthy lifestyle” emerges as the authoritative discourse in the sites of obesity management in the UK. The emergence of this discourse as normative has been documented in many recent ethnographies of obesity worldwide (see Gracia-Arnaiz, 2010; Cohn, 2014; Warin, 2018). My analysis expands the understanding of how healthy lifestyle is enacted, and especially focuses on the coexistence of multiple healthy eating practices and ontonorms (Mol, 2012), as analysed in Chapter Seven.

A comparison of healthy eating practices across the field sites shows the coexistence of weight-loss enacted as a straightforward and easily accessible practice in policy and primary care with the enactment of weight-loss as a complex and enduring process in weight-loss groups and participants’ lives. In the analysis of the different activities promoted in LNPO programmes developed in Chapter Seven, with their specific materialities and practicalities, it becomes evident that original practices of healthy eating coexist with pre-existing practices and discourses of dieting. For example, on the one side healthy eating activities around portion sizes and meal planning openly discourage measurement, like calorie counting and food weighing, portrayed as too restrictive and counterproductive. Instead, they encourage a less restrictive and more tactile relation with food using hands and “by eye” measurements. Scales are substituted by plates, bowls, and hand palms. On the other side though, they reproduce a rationalisation of food and

eating, by substituting nutrients to calories, as the normative value of food. They also reinstate self-control as the privileged technology to manage obesity. The tensions and alternative spaces opened to include taste and commensality as aspects inherent to food and eating are silenced through the enactment of obesity as a matter of personal choice. This enactment is the one that better suits the behavioural approach adopted in these settings. For example, as shown in section 7.2.3, a sensorial relation to food is central to the activity on *mindful eating* where group participants are invited to engage with their senses in the simple act of eating a raisin. Unlike any other activity I observed in LNPO groups, mindful eating embraces texture, smell, taste and pleasure as fundamental aspects of food and eating. Nonetheless, as the analysis shows, the sensorial engagement with food is restrained and used as functional to self-control. Mindful eating is promoted as a technology to establish control over hunger triggers, and this reinforces the idea of the body and its inputs –like hunger and pleasure– as problematic and in need of restrain through behavioural change.

In this thesis, I argue that the coexistence of multiple obesities is ubiquitous in settings of obesity management in the UK, and the different relevance given to one or the other is situational and is reflected in specific practical activities. This demonstrates that in the multiple sites of this research, relevant social actors enact the specific '*composite object*' (Mol, 2002, p.70) of obesity that is '*amenable*', that is suitable and conformable, to the intervention and set of knowledge that govern that specific site (Throsby, 2012). My analysis supports the importance of attending to praxis as well and as much as at meanings and narratives, to better understand how specific subjectivities around obesity are produced and enacted. Moreover, it suggests that these subjectivities are not static. Instead, they are dynamic and situational.

To conclude, the findings reveal the coexistence within and across sites of obesity as slightly different objects that go under the same name: a risk factor, an embodied experience, the result of unhealthy behaviours and the inevitable outcome of structural factors. Each time, different aetiologies, explanations, materialities, priorities, and interventions are put into motions. It is important to note that this multiplicity of obesities does not result in a cacophony of contrasting and incommensurable voices. Rather, I observed a constant flow from one enactment to the other, both within and across sites. For example, this is evidenced by the multiple explanations of the causes of obesity recounted by healthcare professionals (see Chapter Four) and by leaders and participants in weight-loss groups (see Chapter Six). Recurring, authoritative explanations are present in these accounts, but the relevance given to one explanation or the other change from primary care to LNPO groups. I propose that this variation depends on organisational

factors as much as on the type of knowledges and interventions promoted. For example, LNPO group leaders tends to stress the relevance of the quality of food available, as well as of participants' emotions, eating habits and upbringing in determining weight gain. These explanations suit the type of nutritional information promoted in this setting and the length of the programme. This multiplicity is also present within the same setting as evidenced, for example, by the coexistence of the awareness of the structural causes of obesity and focus on personal responsibility in healthcare professionals' accounts.

Further, the coexistence of multiple obesities does not mean that they are all equally relevant or normative. On the contrary, they testify a multiplicity of contested meanings and original negotiations that are all pulled together in one specific direction: the enactment of obesity as the result of individual unhealthy choices. For example, the focus on individual responsibility and behavioural change in clinical encounters eclipses the relevance of structural causes. In this thesis, I argue that such silencing limits the understanding of the processes of stigmatization in clinical obesity management and contributes to reproduce stigma, for example by assuming that weight-loss is a straightforward practice readily and easily accessible and desirable to all. The difficulty of losing weight is reduced to a mere matter of willpower and motivation. Similarly, in weight-loss groups, attention to emotions, life events, and the sensorial as part of individual and collective relations to food and eating, is subordinated to the normativity and rationalisation of nutrition and self- control. Moreover, by reinforcing the common idea of obesity as a *"rationalised singularity"* (Throsby, 2012, p.1), public health policies around obesity management silence *"the uncertainties inherent to those practices and the moral judgements and values that are ultimately inextricable from them"* (Ibid.). I reinforce this argument, showing that this *"hanging together"* of multiple obesities silences alternative explanations and interventions of obesity management, as discussed in Chapter Four and Chapter Seven.

This thesis has presented multiple explanatory narratives of obesity; multiple meanings attached to terms *obesity*, *obese* and *overweight*; multiple norms around nutrition, diet and healthy eating. It has also shown how this multiple meanings and practices are ultimately re-aligned to a normative enactment of obesity as a caloric imbalance due to unhealthy behaviours. In the obesity-management sites I researched, the normativity of the concepts of personal responsibility and behavioural change reproduces the idea of obesity as a singular object. It is especially important to bring to the fore the contested meanings, alternative explanations and practices inherent to obesity management and the authoritative discourse of the *"obesity*

epidemic”, and to understand how they contribute to and reveal processes of stigmatization and to the reproduction of health inequalities.

## 9.2 Implications for healthcare practice and public health policy

This section takes shape out of the many conversations I had with my supervisors around my findings and how they could speak to policymakers and health practitioners. A reflection on how to communicate the relevance of my ethnographic findings for general practice and public health policy runs through this final section. I consider this exercise in communication a challenge and a potential for future research. The investigation and evaluation of specific strategies to address stigma in public health policy and general practice is not within the explicit scope of this research. Nonetheless, the findings presented in this thesis powerfully reveal the centrality of stigma as perceived by research participants in informing, shaping and at some degree limiting their approaches to obesity-management. The data analysed shows evidence that stigma should be addressed in public health policy on obesity. It evidences the need to address the processes of stigmatisation produced through and by the “obesity epidemic” discourse and its enactment in national policy and local interventions.

Three important aspects emerge from health professionals’ accounts of obesity management in this research. Firstly, their strong perception of obesity as a stigmatising term and weight as a highly sensitive topic. Secondly, they relay a recurring sense of powerlessness towards what they understand as a medical condition whose aetiology lies within socioeconomic structures. Finally, despite the stigma and feelings of powerlessness, none of the health professionals I met debunked the idea of obesity as a medical condition or dismissed the relevance of biomedical interventions.

I paraphrase Throsby and contend that “(...) *in the context of the clinic* (...)” as described by the health professionals I met “*the primary enactment of obesity is*” not “*as a disease*” but as the result of personal unhealthy choices that cause “*specific chronic health problems*” (Throsby, 2012, p. 6). In other words, healthcare professionals I interviewed, understand and enact obesity as a risk factor more than a disease itself. This is a particularly important premise for my analysis of stigma in obesity management and its implications for healthcare practice and public health policy. The importance of addressing stigma in relation to health and disease is a recurring theme and recommendation in ethnographic works and public health debates. Demonstrating ways to practically address it, is a more complicated matter. And as such, I don’t have solutions. Nonetheless, I believe that my methodological and analytical approach has yielded important

findings by locating stigma in specific practices of obesity management, which are susceptible to further examination. I want to present one specific anecdote from the fieldwork that opens space for further investigation. Katherine, a nutritionist and weight-management group leader tells me that the organisation she works for has scales that calculate body mass composition, but they do not use it since policy makers require BMI as an evaluation criterion (see section 8.3.1). This anecdote is particularly interesting because BMI is considered by experts a crude indicator of health unlike body composition which gives a more precise measurement of fat in the body. Body mass composition is recognised as a better indicator of health than weight or BMI. Nonetheless, in the sites of my research it is not used. It would be interesting to further investigate the reasons behind this choice, as well as what difference it makes for patients to focus on body composition rather than BMI and weight in terms of their relationship with body size and perception of stigma. I also suggest that this type of analysis or evaluation should focus on the materialities and practicalities involved in the two different types of measurement.

Following Parker and Aggleton (2003) discussion on stigma in HIV, I understand stigma attached to obesity not as a static attribute but as a dynamic and often contested process. I also suggest that in the way the term obesity is perceived or talked about as stigmatising, this “(...)stigma comes to be seen as something in the person stigmatized, rather than as a designation that others attach to that individual” (Link and Phelan, 2001 in Parker and Aggleton, 2003, p. 15). I then discuss some of the processes of stigmatisation that I have located in the specific sites of obesity management I have researched.

I start by looking at the problematic focus on personal responsibility. A large body of literature discusses the problematic focus given to personal responsibility in health discourses (see Crawford, 2006) and particularly in obesity (see Wright and Harwood, 2009; Greenhalgh, 2015; Warin, 2018). My findings add to this literature showing how this focus on personal responsibility in losing weight and making healthy choices create tensions in clinical encounters. These tensions derive from the moral judgments entrenched in discourses and simplistic assumptions around personal choice, lifestyle and nutritional education/ignorance: GPs and practice nurses perceive weight and obesity conversations as potentially judgmental with important effects on how obesity is managed in primary care. This perception is deeply rooted in their understanding of their unique role within the NHS and the importance of building a rapport with patients. Obesity and weight are perceived as detrimental and potentially harmful issues to address in clinical encounters. The effects of this performativity of both stigma and general practice should be further explored.



Moreover, this perception by health professionals is based on previous experiences with patients as much as on preconceptions of obesity as stigmatising that are spread in the contemporary, obesophobic society. I suggest that the current focus on behavioural change as a privileged strategy to prevent and manage obesity in the UK plays a fundamental role in intensifying this process of stigmatisation, for example by silencing or delegitimizing the relevance of alternative explanations and consequently alternative interventions.

The problematic focus on personal responsibility and the related understanding of obesity as a risk factor resulting from wrong individual choices intertwines with the understanding of obesity as a descriptor of corpulence. Diagnostic categories are never neutral but in the case of obesity, the entanglement of ideas of health with aesthetic ideals is particularly deep and scarcely addressed in public health policy and clinical settings. Trying to disentangle aesthetics and moral judgment from health is hard. However, I argue that it is necessary to rethink and reframe narratives of obesity in public health, possibly by engaging with those more directly involved, so to understand how we could separate stigmatising ideas of desirability of body size from health conversations. Another important observation regards the ways weight-loss is presented in public health and clinical practice as a straightforward, readily and equally accessible practice. This narrative and practical approach eclipses the complexity of weight-management along with the sociomaterial inequalities embedded in it. I suggest further investigation of the potential that the recognition of weight-management as a complex, enduring, resource- consuming process might have in alleviating stigma.

## Appendix A



## Topic guide

**Semi-structured interviews with GPs and Nurses****Proposed questions**

- 1 *Obesity is considered a main health issue worldwide. Would you like to talk about which are the causes of obesity, in your opinion?*
- 2 *Do you think that socio-economic factors play an important role in the onset of obesity? If yes, why and how? If not, why?*
- 3 *In your opinion and experience, do socioeconomic and cultural factors influence the ways people perceive their weight? Do they also effect the access to healthy food/activities and health services?*
- 4 *According to your professional experience, what do you think about the ways obesity is diagnosed and treated in primary care?*
- 5 *Emotions and life events seem to have an important impact on the ways people deal with weight gain and eating habits. Do you think these factors are effectively address in medical consultation? Do you think that there is space for different approaches to address/deal with obese patients in medical settings?*
- 6 *Obesity and overweight are often addressed jointly both in health policy and public debate. Do you think this is appropriate? Or does it create confusion and a misrepresentation of fatness that might lead to social stigma? From you professional point of view, which are the differences between obesity and overweight?*
- 7 *Public and media debate on obesity and overweight is more and more widespread. Do you think that this trend have a positive impact on public perception of the issue? For example, have you seen any difference in patients' awareness and knowledge of obesity, obesity-related issues and bodily techniques?*
- 8 *Considering the increasing concern in health policy to prevent/diminish obesity and overweight and thinking of your working routine, would you express your views on the implementation of obesity-related guidelines in primary care? For example, have you recently received any specific training/ course on the matter?*
- 9 *Since you have started working, have you seen a significant change in the numbers of obese patients or obese related disease? Any*

*significant change in the ways obese patients are been taken care of? Or in your way of perceiving the problem and dealing with obese patients?*

- 10 *Narrowing the conversation to a local level, would you like to express your ideas about the impact of obesity and overweight in Brighton and Hove, compared to national and international situation? Do you know any campaigns or associations that address obesity and/or promote healthy lifestyle in Brighton and Hove?*
- 11 *Would you like to add anything? Do you have any question you would like to ask?*



### **Topic guide**

#### **Semi-structured interviews with weight-loss groups' leaders**

#### **Proposed questions**

- 1 *Would you like to talk about your experience as weight-loss leaders? For example, why and when did you start working in this programme? Have you ever taken part in a similar programme as a participant before?*
- 2 *Obesity is considered a main health issue worldwide. Would you like to talk about which are the causes of obesity, in your opinion?*
- 3 *Drawing upon your personal experience, do you think that socio-economic factors play an important role in the onset of obesity? If yes, why and how? If not, why?*
- 4 *In your opinion and experience, do socioeconomic and cultural factors influence the ways people perceive their weight? Do they also effect the access to healthy food/activities and health services/programmes?*
- 5 *According to your personal experience, what do you think about the ways obesity is diagnosed and treated in primary care?*
- 6 *Emotions and life events seem to have an important impact on the ways people deal with weight gain and eating habits. Do you think*

*these factors are effectively addressed in weight-loss programmes? Do you think that there is space for different approaches to address/deal with obese people both in medical settings and weight-management programmes?*

- 7 *Obesity and overweight are often addressed jointly both in health policy and public debate. Do you think this is appropriate? Or does it create confusion and a misrepresentation of fatness that might lead to social stigma? From your personal point of view, which are the differences between obesity and overweight?*
- 8 *Public and media debate on obesity and overweight is more and more widespread. Do you think that this trend have a positive impact on public perception of the issue? For example, have you seen any difference in groups' participants' awareness of obesity, eating habits and physical activity?*
- 9 *Considering the increasing concern in national and local health policy to prevent/diminish obesity and overweight, what is your idea of these policy/programmes? For example, have you noticed their impact on the community and the people attending your group meetings?*
- 10 *Since you have started working, what changes have seen in the numbers of people and the ways participants take part in weight-loss groups? Has your perception of obesity changed over the years?*
- 11 *Narrowing the conversation to a local level, would you like to express your ideas about the impact of obesity and overweight in Brighton and Hove, compared to national and international situation?*
- 12 *Would you like to add anything? Do you have any question you would like to ask?*

### Topic guide

#### **Semi-structured interviews with weight-loss groups' participants**

#### Proposed questions

- 1 *Would you like to talk about your experience as a participant in a weight-loss programme? For example, why have you decided to take part in it? Is it the first time you attend a weight-loss*

*programme? When did you start attending this group? Do you like taking part in it?*

- 2 *Does attending this programme affect your everyday life? For example, can you easily adjust it with your daily tasks and commitments? Since you have started this programme, have you noticed change in the relationship you have with yourself or other aspects of your life?*
- 3 *Talking more generally, which are, in your opinion, the causes of obesity?*
- 4 *Do you think that socio-economic factors play an important role in the onset of obesity? If yes, why and how? If not, why?*
- 5 *In your opinion and experience, do socioeconomic and cultural factors influence the ways people perceive their weight? Do they also effect the access to healthy food/activities and health services/programmes?*
- 6 *According to your personal experience, what do you think about the ways obesity is diagnosed and treated in primary care?*
- 7 *Emotions and life events seem to have an important impact on the ways people deal with weight gain and eating habits. Do you think these factors are effectively addressed in weight-loss programmes and primary care? Do you think that there is space for different approaches to address/deal with weight problems both in medical settings and weight-management programmes?*
- 8 *Obesity and overweight are often addressed jointly. Do you think this is appropriate? Or does it create confusion and a misrepresentation of fatness that might lead to social stigma? From your personal point of view, which are the differences between obesity and overweight?*
- 9 *Public and media debate on obesity and overweight is more and more widespread. Do you think that this trend have a positive impact on public perception of the issue?*
- 10 *According to your experience, do you think that obesity-related campaigns and programmes address the right issues? Are they effective? For example, have seen any change in the ways GPs or nurses deal with weight-gain problems?*
- 11 *Narrowing the conversation to a local level, do you think that the city where you live influences your weight problems? Does your work and/or family?*
- 12 *Do you know other programmes/initiatives locally developed to tackle obesity? Do you think the NHS supply the right services to help cope with this health issue?*

13 *Would you like to add anything? Do you have any question you would like to ask?*

## Appendix B

**Participant Information Sheet*****Discourses of obesity in health care and weight-loss settings in Brighton and Hove: a qualitative study*****Name of researcher: Lavinia Bertini****Dear Participant**

You are being invited to be involved in this research study. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully.

Please contact me if anything is unclear or if you would like more information. Take time decide whether or not you wish to take part. Thank you for reading this.

**What is the purpose of the study?**

This study is part of a wider research exploring how people talk about and relate to obesity.

I am interested in the experiences of the public and health professionals. I would like to talk to you about your views on health policies/campaigns, media, primary care, diet and physical activity based on your own experience.

**Why have I been invited?**

You are being invited to take part in this study due to your work role as general practitioner.

**Do I have to take part?**

No. It is up to you to decide whether to take part. If you decide to participate you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

**What will I have to do?**

If you agree to take part in the research, you will be asked to take part in a first semi/structured qualitative interview. I shall meet you at the University of Sussex or in any other venue that is convenient for you. The semi-structured interview will take approximately 60 minutes. It is intended as an opportunity for you to express your views on the 'obesity epidemic' in general and obesity-related local policies. If, at the end of this first session, you feel there is more you would like to say, you will be invited to meet again for more qualitative interviews and to take part to two focus groups.

With your consent, interviews and focus groups will be recorded and transcribed.

**Are there any possible disadvantages or risks of taking part?**

It will take time out of your day but every effort will be made to minimise inconvenience.

It will be possible to take a break or stop at any point of the interview.

**What are the possible benefits of taking part?**

Although this research is unlikely to be of direct benefit to you, it is an opportunity to talk about your experiences and express your opinion on a variety of subjects to an interested listener.

**What will happen if I don't want to carry on with the study?**

You are free to withdraw at any time and without giving a reason. However, I will ask to be able to use the data collected up to the point of your withdrawal, which will be kept subject to confidentiality procedures. You are free to deny it and the data will be withdrawn and destroyed.

**What if there is a problem?**

It is not expected that any problem will occur during this study.



However, if you do have any concern or complaint about any aspect of this study or the conduct of the researcher, please feel free to contact my supervisors (details are provided below).

**Will my taking part in the study be kept confidential?**

Yes, all the information about your participation in this research and all information collected during the fieldwork will be kept strictly confidential.

All data will be stored securely at the University of Sussex.

Every step will be taken to assure anonymity. However, in reporting the data I would like permission to refer to your age and gender.

**What will happen to the results of the research study?**

The results of the study will be written up and be part of a doctoral thesis. They will also be used for publication in specialised journals and on-line resources and/or presented at conferences. A summary report of the doctoral thesis will be provided to research participants.

**Who is organising and funding the research?**

The research has been organised and funded by the researcher and doctoral student, Lavinia Bertini.

**Who has reviewed this study?**

This study has been reviewed by my supervisors, Professor Jackie Cassell and Professor Maya Unnithan and peer-reviewed by an anonymous academic member at the University of Sussex, School of Global Studies.

This study has received ethical approval from *the Brighton and Sussex Medical School Research Governance and Ethics Committee (BSMS RGEC)*

Thank you for taking the time to read this information sheet.

## Appendix C



### Debriefing Form

**Title of Project: Discourses of obesity in health care and weight-loss settings in Brighton and Hove: a qualitative study**

**Name of Researcher: Lavinia Bertini**

Thank you very much for taking part in the study and for your time- it is very much appreciated.

The aim of this research was to explore every-day experiences and personal opinions related to obesity, diet, primary care, and healthy lifestyle promotion in Brighton and Hove. The audio-recordings taken during this study will be transcribed and anonymised. The researcher did not use any deception and a summary of this study will be available to you at your request.

If you have any other question, please contact:

Lavinia Bertini – Tel 0782 3696518 or e-mail [l.bertini@sussex.ac.uk](mailto:l.bertini@sussex.ac.uk)

The researcher has tried to ensure that the study did not cause you any distress. However, if you feel that the study has raised any issue for you, it might be useful to contact the following services and organisations.

Your general practitioner (GP) or practice nurse

NHS Choices- Your Health, your choices ([www.nhs.uk](http://www.nhs.uk))

<http://www.nationalcounsellingsociety.org>

**[www.chances4change.org.uk/brighton-hove](http://www.chances4change.org.uk/brighton-hove)**

The Samaritans of Brighton, Hove and District ([www.samaritans.org](http://www.samaritans.org))

Dubarry House  
Newton Road, Hove  
East Sussex BN3 6AE

## Appendix D



Discourses of obesity in health care and weight-loss settings in Brighton and Hove: a qualitative study

### CONSENT FORM

Name of Researcher: Lavinia Bertini

Please initial box

I confirm that I have read and understood the information sheet dated \_\_\_\_\_ for the study

**Discourses of obesity in health care and weight-loss settings in Brighton and Hove: a qualitative study.** I have had the chance to read the information and ask questions about the study and am satisfied with the answers I have been given.

☐

I understand that my participation in this study is voluntary and that I am free to stop at any time, and I do not have to give a reason for doing so.

☐

I understand that my interview/focus group/meeting (delete as needed) will be recorded and I agree to take part in the study.

☐

I understand that the Focus Group Discussion will include health professionals/members of the public (delete as needed).

☐

I agree to take part in the above study.

☐

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

- 
- I have explained the information in this document, encouraged the participant to ask questions and provided adequate time to answer them.

**Lavinia Bertini**

Name of Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

When completed: 1 copy for the participant; 1 copy for the researcher site file.

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