Social Theory & Health, 2005, 3, (341–358)

www.palgrave-journals.com/sth

'Fat Ethics' – The Obesity Discourse and Body Politics

EMMA RICH & JOHN EVANS

School of Sport and Exercise Sciences, Loughborough University, Loughborough, Leicestershire LE11 3TU, UK. E-mail: E.J.Rich@lboro.ac.uk

In recent years, significant attention has been given in the popular and academic press to an 'obesity crisis' that, purportedly, is both ever increasing and sweeping across the western world. In this paper, we raise a number of ethical issues about the ways in which discourses around this crisis have been socially constructed and publicly represented. We begin by outlining the ways in which these discourses seem to offer 'certainty' and 'authority' (of 'fact' and knowledge) from within the research field. Yet, as others have pointed out, on closer inspection few such certainties are to be found. We argue that attempts to erase uncertainty around the body, health and size/weight/fatness may be ethically problematic, not least because it can lead to forms of size discrimination and oppression that, ironically, may propel some people towards ill-health via disordered relationships with food, exercise and the body.
Social Theory & Health (2005) **3,** 341–358. doi:10.1057/palgrave.sth.8700057

Keywords: obesity; discourse; eating disorders; body; health; ethics

INTRODUCTION

In this paper, we explore how evidence about 'obesity' is variously presented and made accessible to the public and, in so doing, raise a number of questions about the ethical dimensions of public understandings of this putative 'health concern'. Public discourse around obesity is often based on a plethora of scientific evidence around causation and guidelines on prevention. However, we argue that unlike other serious health problems that might be associated with crisis (eg Cancer, AIDS, etc), seldom, if ever, does discourse on obesity[1] engage publicly with the moral and ethical dimensions of its position, or the variety of texts (reports, news coverage, TV programmes, etc) that it spawns. We are continually warned, in these texts, of the 'obesity crisis' and the need for measures to be taken to address it,

despite the fact that within the research field from which these claims are made, there are few certainties to be found. We argue that this narrative draws heavily upon a language of risk and morality with minimal discussion as to the ethical implications of the ways in which this discourse may impact upon the social identities and lives of people, and wider cultural understandings of health, weight and 'fat'. We build on the work of others (Gard and Wright, 2001; Campos, 2004; Ernsberger and Haskew, 1987) in exploring how obesity discourse, inasmuch as it attempts to erase uncertainty around the body, health and fatness, may be ethically problematic, not least because it may result in size discrimination, and rather ironically, propel some people towards a state of ill-health through disordered relationships with the body and food.

SCIENTIFICALLY UNCERTAIN

Concerns over an 'obesity epidemic' are frequently repeated in the national media, in feature reports that focus on the serious effects of being 'overweight', 'obese' and the ills of 'fat'. Consider for example, the headlines below taken from the British popular press, not only 'informing' the public's thinking on weight issues, but clearly also engendering alarm and moral panic around the nature of the obesity problem:

> War on Obesity: Docs Fight New Black Death (The Daily Mirror, February 12, 2004, p. 11).
> One foot in the grave – Fat Brits told exercise or die (The Sun, Friday April 30, 2004).

Typically in these texts, we see scientific 'evidence' recycled to give authority and certainty to the claims about rising levels of an obesity epidemic, what causes it and how best to address it. The obesity discourse tends to be dominated by these scientific issues. For example, discussions often ensue around the precise point at which ones body mass index (BMI) might be construed as 'obese', or what we might consider as 'ideal weight' figures, associated risk factors, and guidelines on preventative measures. While there is an obvious need for scientific understandings of health issues, we remain concerned by the ways in which a biomedical narrative dominates public understandings of obesity, often excluding or marginalizing important considerations around the influence of social structure. Moreover, as will be revealed, these 'facts' are routinely issued with authority and conviction despite there being very few, if any, certainties to be found in the primary research on obesity (see Gard and Wright, 2001). Indeed, the relationships

between obesity and health are far more tenuous, complex and contradictory than the 'obesity epidemic' discourse would have us believe (see, Evans, 2003; Gard and Wright, 2001; Flegal, 1999). There is a great deal we do not know about obesity, weight and its effect on health (see European Youth Heart Study Symposium, 2005). Despite this, the popular press, official health organizations documentation and other texts routinely recycle 'scientific evidence' on obesity, in ways that belie the uncertainties and ambiguities in the primary research field from which it emerges. Monaghan's and Aphramor's papers in this journal offer useful overviews and critiques of the obesity research, highlighting how standards applied to constructing and researching obesity sometimes fall short of those used in substantively similar fields. Similarly, Campos (2004) and Gard and Wright (2005) provide a searching critique of the scientific literature and expose the many uncertainties, ambiguities and myths that surround 'obesity'. Indeed, these are good places to start for anyone wishing to enhance their knowledge, and gain a more balanced perspective on obesity issues.

One of the most significant revelations in this literature is that the relationships between health, size and weight are not as significant as we are sometimes led to believe. For example, Brownell (1995, p. 386) notes that measuring weight is easy and inexpensive but measuring fat is not, and that 'consequently, overweight is often used as a proxy for obesity'. The conflation of overweight and obesity exaggerates the seriousness of 'the epidemic' and may create a moral panic where none is necessary. As Gard and Wright (2005) suggest, while the incidence of obesity may be rising, it is neither a 'disease' nor an 'epidemic'; yet, we are constantly warned that the UK is in the grip of a shocking obesity epidemic. While acknowledging that 'obesity' can be and often is a serious problem, for some people, in certain circumstances, our concern is that precious few texts on obesity reflect upon the methodological limitations, ambiguities, uncertainties and contradictions that reside in the databases of the primary research field (see Gard, 2004; Gard and Wright, 2005). In what follows, we explore how some of these uncertainties are not only scientifically shaky (Gard and Wright, 2005) but ethically problematic in terms of the types of universal values they promote in relation to thinness, and the ways in which this creates a moral panic around a health issue where none may be warranted.

EXCLUSION OF THE SOCIAL

Our purpose here, however, is not to pit one sort of scientific evidence against another. Rather, our attention turns to the ways in which a biomedical

narrative, based on uncertain scientific evidence (Gard and Wright, 2005), not only dominates obesity discourse, but does so to the exclusion of narratives that engage more critically with the moral and ethical aspects of the cultural ideals of the body and body politics. This omission constitutes an 'exclusion fallacy' (Schuftan, 2003), where what we 'choose' not to discuss is assumed to have no bearing on the issue. In other words, the stereotyping of fat, the feelings of guilt and shame that are produced through this discourse, and the tendencies towards a culture of healthism and individualism, are regarded as secondary to the primary concern to develop concrete scientific evidence to understand the causes of and treatment for the obesity epidemic. In effect, we witness the reassertion of a rational ascetic (Murphy, 1995) over more humanistic approaches to the body and health. Why should this concern us? Mainly, because public representations of obesity do not simply inform us of medical or biomedical 'facts', but create meanings that influence cultural understandings of health, the body and eating.

Although the aetiology of obesity is described neutrally in biomedicine as a positive imbalance between energy ingested and energy expended, its public representation is not value free. Public understandings of obesity develop from an engagement with a vast array of traditional sources ranging from medical literature and public health documents through to advice from medical practitioners. However, increasingly, research is suggesting that people are obtaining health information not just from traditional medical sources but from newspapers, magazines, television etc (Hepworth and Featherstone, 1998). Lawrence (2004, p. 62) suggests, 'the growth in real world obesity has been mirrored, though with some delay, in the growth of news coverage of obesity'. In this sense, there may be a high level of influence that certain media have upon the public's understanding of obesity. Miah (2005) argues that when the media rely on 'experts' for its understandings, it is necessary to distinguish between technical, scientific and ethical expertise. If the relationship between weight and health is not as clearly explicated as media representations of medical discourse would have us believe, then the warnings around rising levels of obesity may be linked as much to moral beliefs around 'normality' and weight, as they are to actual health risks. But seldom are the public invited to explore the ways in which the sort of moral panic created by the obesity discourse may be damaging to people's health through shame-based narratives it endorses around the body, eating and weight.

There is little doubt among public health experts and the media that obesity is a serious problem of epidemic proportions, caused by inactive lifestyles, fast food culture, and changes in our diets, affecting both adult and child populations. While these may seem 'neutral' scientific facts, they are

loaded with ideology and cultural beliefs about how we view 'fatness' (see Gard and Wright, 2005). Obesity has also been a matter of great interest to the academic community, with a proliferation of articles recently published on the topic. Burns and Gavey (2004, p. 550), for example, conducted an examination of articles listed on the medline database from 1996 to 2001, which revealed 184 articles with titles or abstracts containing the terms 'obesity' or 'overweight' and 'epidemic'. This groundswell of attention on the 'epidemic' raises 'questions for public policy makers, journalists, scholars, and other opinion leaders: What *kind* of a problem is obesity, what should be done about it, and by whom?' (Lawrence, 2004, p. 57). Lupton (1999) argues that for many lay people, the mass media constitute one of the most important sources of information about health and medicine. Bury (1997, cited in Lyons, 2000) suggests that there has also been a change in whose knowledge is made available, moving from a domination of medical practitioners towards a variety of voices including journalists, alternative therapists, academics, etc. These voices all have something to say from a biomedical perspective on how we might best 'tackle' obesity, but seldom invite the public to take a more critical perspective on the damaging features of obesity discourse and the ways in which it serves to normalize one particular body shape. As with any health problem, assigning responsibility for causes and solutions forms the crux of public discourse on the issue (Lawrence, 2004, p. 58). However, to do so, as with any 'health problem', also means adopting a particular perspective on the body and culture, about causation, appropriate treatment and, as Lawrence (2004) notes, who is responsible for these things. It is not simply a matter of articulating biomedical health risks. It also imparts a set of value imperatives about those who are 'overweight' and those who may make particular choices in relation to food and physical activity. As such, media representations of obesity do not only inform the public about medical facts but may also, as Lyons (2000, p. 350) suggests, create meanings that influence how certain sub-groups of the population are viewed and in this sense, take on an inherently moral and ethical form in terms of how we view the body and, in particular, the 'fat' body.

The above raises a number of questions about what properly constitutes care for the body in relation to weight and health issues, and the way in which a medical–scientific approach dominates public understandings of obesity. Seldom in this debate do we see discussion around the morality of the ways in which representations of the body affect young people's sense of self and embodied identity. If we further interrogate popular discourse on obesity, we can see that a number of different moralistic approaches to the body and health are present, yet seldom carved open for public consumption. Murphy's

(1995) review of various approaches to the body found within Western culture is useful here. They include the communitarian, rational ascetic, humanitarian and romantic. While there is no space to detail these, it is worth noting how the obesity discourse may draw upon these differing views of the body in various ways. In the sections below, we take a closer look at the moral and ethical positions inherent within the dominant cultural representations of obesity, but which are seldom 'spelled out' within public texts.

UNIVERSAL THINNESS/THINNESS FOR ALL?

A key feature of the obesity discourse is the emphasis on 'thinness' and 'weight loss' as a universal good. This is because, as Campos (2004) suggests, much of the obesity discourse rests on the assertion that there is a correlation between being overweight and ill-health and that losing weight will cure associated 'disease'. Campos goes on to suggest, however, that while various studies show a relation between weight and ill-health, that relationship is far more complicated than is suggested. A recent edition of the journal of the American Medical Association (Mark, 2005), for example, reported that 'for many reasons it is much more difficult to estimate the burden of disease due to obesity' than was previously thought and reported, and that 'although weight is an easily measured characteristic, at a conceptual level attributing deaths to obesity requires many assumptions that are often not fully spelled out in most media' (Mark, 2005). Indeed, weight and size may not be the problem at all when we consider now that many people who may be considered 'overweight' but are moderately active are actually healthier than their peers who are sedentary but thin. Losing weight may not provide the types of health benefits we are led to believe when we consider that 'the data linking overweight and death, as well as the data showing the beneficial effects of weight loss, are limited, fragmentary and often ambiguous' (Kassirer and Angell, 1998, cited in Aphramor, 2005). One of the key problems here then is the way in which obesity as a 'weight' issue leads to a discourse which encourages all of us to achieve an 'ideal weight'. Consider, for example, the ways in which BMI charts and concepts such as 'ideal weight' are often used in mapping the prevalence and incidence of obesity. BMI is an individual's weight in kilograms divided by height in metres squared, and defines 30 kg/m^2 or higher as above stated ideals (World Health Organization, 1998). It focuses only on weight, rather than measuring fat, and may tell us very little about someone's actual health. For example, BMI over-estimates fatness in people who are muscular or athletic and may be

'healthy', and it is not considered a good index for children and adolescents. Despite this, BMI has become the standard for determining population levels of obesity. These charts, however, are now typically presented to the public as a way for them to assess their health in relation to their weight (this is in spite of the contradictory scientific evidence around whether weight can even act as a determinant of someone's health). These are now littered in the public texts, available for all to assess their health and weight.

The prevalence of BMI and ideal weight is clear to see. The health industry (health education experts, government agencies and academics) has wholeheartedly embraced the questionable concept of ideal weight – 'the idea that weight associated with optimum health and longevity could be determined by height' (Seid, 1994, p. 7).Yet, scientists are unclear as to the precise point at which weight threatens health. Brownell (1995, p. 386), for example, notes that the precise point at which scientists and health officials believe increasing weight threatens health ranges from 5 to 30% above ideal weight, a considerable spread'.

We would not discount that morbid obesity is a serious problem, with associated health dangers, but these cases are the minority at the extreme end of a weight continuum. Campos (2004) reiterates the point that there is no scientific basis for the excessive fear of body fat, except with regard to groups who are at the extreme ends of body weight. However, those who might be 'overweight' or moderately obese are often included in the statistics on obesity and are subjected to the same forms of health promotion and warned against the same risks as those who are at the extreme ends of the continuum: it is taken that losing weight will provide health benefits for all of us, even though being thin may not have any more health benefits than being 'overweight' and moderately active (see Gard and Wright, 2005). Such an approach makes culturally universalistic demands, that everyone should participate in the culture of thinness, albeit on the premise that this is good for ones health, even though this may have damaging implications for people's self-esteem, embodied identities and understandings of health and self. This focus on thinness emerges as a universalistic value that not only rests on questionable assumptions about health benefits, but is loaded with implicit ideals around body norms. Within this discourse, weight loss is conceptualized essentially as an energy-in–energy-out equation, and as a consequence, health promotion strategies may fail to consider other socio-cultural and socio-economic factors that may determine health inequalities (Aldrich *et al.*, 2003). As Monaghan notes in this journal, the Whitehall studies (eg Marmot *et al.*, 1997) show that mortality risk is primarily determined by social factors; as such it would seem imperative that we consider social inequalities and forms of discrimination in any obesity

equation. The problem here is that 'health' and 'weight' are infinitely more complex than is suggested in the body-as-machine explanations that are to be found in the obesity discourse, which rely on universal ideas of optimum weight, and a mechanistic view of the body: that it will respond in the same way as long as we rightfully equate calories consumed with energy expended. 'Thinness' becomes a value that has to be reconciled with the specificities of being human; of local cultures, class, lifestyles, economics and health, and the particularities of each individual body, metabolism and genetics. Not everyone has the physiological, social and cultural resources to be thin: no matter how hard they try, it may simply not be possible. Indeed, as Aphramor (2005) points out, treatment programmes that typically focus on weight loss have been found to be 95% unsuccessful, reflecting this very point. Behaviour modification programmes that rest on this universal value, that we should all be striving towards the thin ideal, may not only be unsuccessful, but ethically irresponsible, particularly when we are reminded that achieving ideal weight, for some, may actually mean living in a condition of semi-starvation. As Stunkard (1974, cited in Aphramor, 2005) comments, 'behaviour modification may simply be helping someone who biologically should be obese [and not at any health risk] to live in a semi-starved state'. Moreover, weight loss programmes carry with them a number of risks including, for example, adverse effects on metabolic fitness, increased cardiovascular risk (Olson *et al.*, 2000), increased risk of binge eating and, given its low success rate, may lead to further feelings of isolation and hopelessness about one's body (Arphramor's paper in this journal gives a more comprehensive overview of these risks). Despite such low success rates, and accompanying risk factors, seldom are we invited to question whether such weight loss programmes typically endorsed by the obesity discourse are ethically responsible. Murphy's (1995, p. 104) reflections on universal value systems remind us here of the potentially oppressive nature of such body politics, asking whether

> all universals [are] merely particulars in disguise, particulars that have overreached themselves and have thereby become oppressive? Or is it perhaps, the case that universals are not ipso facto oppressive, but they can become so, and they become so because of the failure of politics?

If, as outlined above, weight is not the issue, then the demand within this discourse to make people thin may be an unnecessary universal one, which is given legitimacy through the biomedical voice of rational ascetism. This rational ascetic approach also drives the way in which research on obesity has traditionally been carried out, with its focus on 'scientific

discovery'. As Murphy (1995, p. 111) suggests, 'when the body becomes the object of science, it becomes the object of a systematic, analytical examination'. This perspective may be evident in approaches from the macro level with the spread across the health disciplines of the concepts of 'ideal weight', to the micro level, where educators and health professionals may systematically review, analyse and regulate the body of others through measurement of weight, health and activity. Such is this focus on weight that, even when trials reveal evidence to suggest weight is not the issue, often the conclusion, as Aprhamor notes, is to call for better trials, better behaviour change skills, rather than actually re-write the question. It becomes a universal value whereby, as Anderson (2005) notes 'often it seems we have a policy looking for an evidence base'. It is this sort of biomedical dominance, at the exclusion of critical social theory, that may be preventing us from taking obesity research and health policy in new and revealing directions. Because 'scientific discovery' carries such authority, this approach, as outlined above, has achieved a dominant position in public debate on obesity. However, as Murphy (1995, p. 112) argues, within a medical model, it is very difficult to deal with pre-rational and non-cognitive feelings, precisely because they demand 'acts of solidarity that cultivate feelings of belonging, and consensual modes of interaction and decision making that constitutes, from a rational ascetic point of view, an ''uneconomic'' and ''unsystematic'' distraction, and thus a vice'. In a culture that endorses weight loss, accompanying fears around guilt, shame, hopelessness and detachment from ones body are marginalized in public discussion. They are seen as an unsystematic distraction from issues that are properly of concern: biomedical approaches to help address the obesity epidemic. As Gard and Wright (2005) note, this may be an unhelpful and misleading way of thinking about population levels of overweight and obesity, not least because it oversimplifies the way in which the body operates, and that weight loss or weight gain may not only be affected by wider social, cultural and economic factors. None of this is to discount the important work that many obesity researchers are undertaking. Rather, our concern is with the tendency to universalize an approach to weight and health. This not only makes no scientific sense in respect of the uncertainties residing in the primary research field, but also ethically unsound. As Murphy (1995, p. 117) comments

> of course in part for the very reason that aesthetic pleasure involves a type of freedom – one cannot force aesthetic pleasure, and when any individual is made to participate in the culture of appearances against their will, this is certainly oppressive.

MORALITY AND THE BODY

In this section, we explore the various moral and ethical positions inherent within the dominant cultural representations of obesity, by drawing upon Murphy's (1995) review of the various approaches to, and views of, the body. We begin with what Murphy (1995) refers to as a communitarian conception of the body, which views the body as in need of 'protection' and as an ethic, focuses on maintaining and defending human life and reducing threats to life and the life world. A communitarian approach has traditionally understood harm to society not in individualistic terms but by 'rates of incidence' of certain malign phenomena (eg, disease), which are associated with certain groups. This sort of ethic can be seen in the ways in which the incidence of obesity is identified with certain social classes, who are identified with having higher rates of mortality attributable to obesity. Moreover, this perspective has tended to view the causes of such social problems as primarily connected to the social environment. Lawrence (2004, p. 57) suggests that in the public debate on obesity, there is a tendency to draw on two key frames in examining who or what is to blame for this epidemic; these are classified as individualizing or 'systemic' frames. Systemic frames have been drawn upon in the public debate on obesity by assigning responsibility to government, businesses and larger social forces. The idea that there are broader social ills that we might need protecting from, therefore, in some ways draws upon a sort of communitarian approach to the body. This position has been popular especially in the popular media, with headlines commonly appearing like 'obesity: who is to blame?' (BBC news online, 2004) followed by discussion around the extent to which fast food companies or individuals are to blame for the sudden 'obesity epidemic'. As Lawrence (2004, p. 62) suggests, many (though not all) 'public health experts and advocates frame obesity as a symptom of an unhealthy food and activity environment created, either inadvertently or intentionally, by corporate and public policy'.

The increasing interest in the negative effects of 'fast food' upon obesity has had a recent resurgence following the release of the documentary film *Super Size Me*, the publication of a series of texts on fast food culture such as Eric Schlosser's *Fast Food Nation*, and more recently, lawsuits filed against McDonalds by two teenage girls claiming that they were not adequately informed of the negative effect of McDonalds food on their health. This 'environmental' discourse asserts that the fast food culture has pervaded our society, including school cafeterias, and enticed people into 'risky' eating practices via their marketing promotions (eg the McDonalds

happy meal for children). These media narratives are set against a wider social, political and cultural context wherein there has been a governmental drive in the UK, for example, emphasizing the dangers of this environmental frame. Indeed a House of Commons (2004) report severely criticizes the food industry's 'relentless targeting of children through intense advertising and promotion campaigns'. Sir Liam Donaldson, a Chief Medical Doctor, and leader of the nations obesity taskforce is cited in one of the British Tabloids as

> calling for junk food firms to be banned from advertising during kids TV programmes and for all snack and fizzy drink machines to be removed from schools (The Sun, 4th July 2003).

The message here is that the obesity epidemic is related to poor nutritional advice and a symptom of an 'unhealthy food and activity environment created (either inadvertently or intentionally) by corporate and public policy' (Lawrence, 2004, p. 62). Gard and Wright (2001, p. 539) employ Beck's notion of risk to argue that 'obesity has been constructed as an undesirable side effect of modern western life and adds to the growing list of risks that this kind of life is charged with generating'. The language of risk not only suggests that intervention may be needed to regulate the body, but it also imparts notions of what is right and wrong, good or bad, normal or abnormal. It serves to pathologize those whose bodies fall outside of the norm by reducing bodily difference to a matter of personal responsibility and choice about lifestyle (Rich *et al.*, in press). Thus, at the heart of this position is the notion that society needs to be both regulated and protected. The premise here, to change and protect populations from such sedentary lifestyles, from this perspective is to give the illusionary promise of freedom from 'life-threatening' conditions.

The 'rational ascetic' (Murphy, 1995) attitude towards the body is clearly evident in the current discourse around obesity. The aim in this perspective is to subject the body to a systematic regime of 'rational conduct' (*ibid.*, p. 109). This approach works to 'discipline the body, to ensure that the body will behave (or move) in methodical and regular ways' (*ibid.*, p. 109). This takes on another inherently moral perspective that is seldom open for critique, by emphasizing the 'virtues of conscientiousness – virtues that are expressed in the careful and methodical way a person pursues a task, problem, issue or calling' (*ibid.*, p. 109). As Murphy (1995) argues, this sort of approach to the body is one that prohibits certain actions, such as idleness, but also institutes methodical practices. In the case of obesity, it can be most strongly seen in the need to encourage individuals to take responsibility for their choices about

physical activity and diet: to make deliberate decisions about their bodies and lifestyles.

> methodicality implies greater deliberateness (forethought, calculation) in human behaviour and that deliberateness puts human beings in a situation where they have to make (yes/no) choices about how they are going to act (Murphy, 1995, p. 110).

These approaches impart a particular version of virtue and conscientiousness, without any debate as to whether this might be morally sound (above and beyond biomedical health needs). Such approaches to the body can be found in the individualizing frames, which are also commonly used to make sense of obesity, whereby causes are located with particular individuals (those who are afflicted with the problem) (Lawrence, 2004). This issue of individualizing responsibility is one of the most morally problematic features of the obesity discourse, when we consider the current culture of healthism that resides in Western society, placing moral obligation on individuals for their health. The pressure to obtain the right body size/shape is not simply about being healthy but carries moral characterizations of the obese or overweight as lazy, self-indulgent and greedy (Gordon, 2000). In other words, feeling fat carries personal evidence of stigma (Goffman, 1963), which can evoke feelings of guilt, stigma and shame. The corollary of this is that control, virtue and goodness are to be found in slenderness and the processes of becoming (sometimes dangerously) thin: the sort of virtues of conscientiousness related to making deliberate choices that are found in the rational ascetic conceptualization of the body, health and medicine, which can accord a superior status to the thin. Weight loss in this context is about more than simply aiming to achieve a 'slim figure'. Within this discourse, individuals are deemed largely responsible for their own health and for 'making healthy choices' as if they were free of structural and cultural constraint that bear upon peoples opportunity to achieve the health behaviours prescribed. The central concern here is the placing of moral responsibility on the individual to have a good diet and make certain 'lifestyle' choices around physical activity. By designating certain behaviours (around food and exercise) as either 'good', 'bad' or 'risky', obesity discourse is instrumental in manufacturing a public 'health scare' (see Evans, 2003; Gard and Wright, 2001). It creates a 'moral panic' about the state of an individual's or a nation's health and the choices they are to make to rectify it. The media does so convincingly, 'by utilising scientific experts for both the explanation of science and the moral commentary that, typically, accompanies it' (Miah, 2005). Consider, for example, the alarmist overtone of the following section of the House of

Commons Health Committee report on Obesity in May 2004, which was then referred to in a number of media reports,

> Should the gloomier scenarios relating to obesity turn out to be true, the sight of amputees will become much more familiar. There will be more blind people. There will be huge demand for kidney dialysis. The positive trends of recent decades in combating heart disease, partly the consequence of the decline in smoking, will be reversed.

While operating under the guise of biomedical neutrality and rationality, this discourse adopts an inherently moral position about the nature of health and behaviour. This exemplifies Sontag's (1978) assertion that metaphors and images of illness in Western culture often function to place the blame of responsibility for disease with the individual.

CONCLUSION: ALTERNATIVE BODIES

There are a number of alternative discourses that take a more humanistic approach to weight and shape and value the diversity of body types. These approaches draw upon the idea that one may be fat and beautiful, or fat and healthy, as exemplified in the development of the size/fat acceptance movement, which attempts to change negative social, cultural and medical attitudes about fatness. This discourse has been given increasing currency following a range of studies that demonstrate that overweight is not associated with excess mortality (Flegal *et al.*, 2005) and that being 'overweight' does not preclude health or well-being. Similarly, Gregg *et al.* (2005) reported that obese people in the USA have better cardiovascular disease risk profiles than did their leaner counterparts 20–30 years ago. To reiterate the above, size may not be the issue at all in terms of health-related risks, and to focus on 'fatness' as a social ill in this way is to draw upon size discrimination that might, as Rogge *et al.* (2004) argue, be characterized as a form of 'civilised oppression'. However, these alternative approaches to obesity take a somewhat marginalized position in the public discourse on the issue. Indeed, 'size acceptance' movements, and studies that draw upon critical social theory to make sense of the discourse around the 'obesity epidemic', are often marginalized and criticized for distracting attention away from the more serious nature of finding medical cures and preventions for ill health. As Lupton (1995, p. 1) observed over a decade ago,

> Due to its close links with biomedicine, which favours positivistic forms of inquiry based on the gathering of quantifiable data, public health

> research has tended to undervalue more humanistic, critical and theoretical and interpretive approaches… [these] have been marginalised; at best treated with suspicion, at worst denigrated for being 'soft' and 'non-practical'. The tendency has been to accept the prevailing orthodoxies of public health and promotion, focusing on statistical measures, cost effectiveness and the evaluation of measurable effects, but devoting comparatively little attention to the critical analysis of the political implications of such endeavours.

We see here the resurgence of an emphasis on the biomedical, but at a social cost. As Hawks and Gast (2000, p. 14) suggest,

> Promoting weight loss essentially suggests that thinness is the desired goal irrespective of health. Inherent in that message is the underlying assumption that fatness is undesirable which in turn perpetuates size discrimination.

Why is this so problematic? Well, if, as Frost *et al.* (1997) suggest, people overestimate their risk to various health forms through an 'availability heuristic' because of how this is portrayed in the media, it may create a moral panic that fuels disordered relationships with the body and food.

A growing body of work has begun to illustrate the ways in which an unquestioning acceptance of the obesity discourse may be generating anxieties about the body with serious consequences for some people's health (see Gard and Wright, 2005; Campos, 2004; Evans *et al.*, 2003, 2004; Rich *et al.*, 2004). Elsewhere, we have documented the ways in which the obesity discourse has featured heavily in the routines of school life and has contributed towards alienating and isolating tendencies, propelling some young women towards disordered eating, other forms of ill-health and negative body–self relationships (Rich *et al.*, 2004). These are not minor conditions of body dissatisfaction or disaffection that one might experience on an everyday basis, but such extreme negative relations with the body, food and health that in some cases lead to serious eating disorders. In the UK, the Eating Disorders Association estimates that about 165,000 people have eating disorders and this condition is responsible for the highest number of deaths from psychiatric illness. Despite the increasing rate of anorexic and bulimia, 'fat' continues to be a stigmatized condition within Western culture, and this has seen a resurgence in the popular media in recent years. As English (1991) suggests, fat people are subjected to a particularly unique and intense form of stigmatization because of the visible nature of the obese condition and the tendency for society to attribute personal responsibility to fat people for their condition.

While much of the 'science' presented in media narratives may be presented as 'fact', supported by the use of 'expertise', the above has illustrated that there is a far more complex relationship between health and

weight loss than is commonly explicated. What mechanisms might be utilized to deconstruct and tease out scientific explanation from arbitrary social constructs, or moral commentary? It seems here we need health education or health promotion in a broad sense, which might be critical of the received wisdom of the obesity discourse. Miah (2005) argues that an ethical engagement with science may help alleviate many of the concerns about the limitations of scientific journalism, which are outlined above. This, he argues, is because the moral narrative surrounding science effectively contextualizes the subject and enhances the possibility of ensuring that non-experts come to terms with the significance of scientific news. What might be of concern here is not just the science but the type of society we want, and the body types that we value.

Offering alternative narratives on the obesity discourse may not only assist those who are labelled as 'overweight' to re(position) themselves in alternative discourses, but also contribute to wider political, social and cultural discussion on how we are to make sense of obesity. Research suggests that public opinion and the policy-making environment can shift when health risks are reframed in particular ways (Lawrence, 2004). As Gard and Wright (2001, p. 537) point out, 'media coverage of ''expert'' knowledge produced in reports serves to generate a public/popular discourse which speaks to politicians and funding bodies about the levels of community concern generated around the issue and so motivates further discussion'. On this basis, alternative discourses, may in turn, enhance the possibility of a renewed focus away from weight loss as a central feature of health in relation to governmental policy discussions on obesity. Unless the moral dimensions of obesity discourse are made more centrally public, then educators, parents, health professionals, etc may be ill equipped to adopt a more cautious attitude towards the way in which weight and health issues are represented. Failing this, there will be little space for any rational ascetic 'anomalies' – the fat and healthy – to have visible and legitimate space on the cultural terrain, whereas Monaghan notes, thinness becomes more about social fitness than it does about health. To create these alternative spaces, we must begin, as we have attempted to do so here, by asking different questions about the obesity epidemic, its cultural representations and the ways in which discourse around obesity becomes legitimated in a variety of social contexts and associated pedagogical fields.

Acknowledgements
We thank Lee Monaghan, Lucy Aprhamor, Paul Higgs and Graham Scambler for their collaboration and input into this discussion forum.

ENDNOTES

1 Drawing on discourse allows us to examine the values and interests that texts express and promote or challenge. Our use of the term discourse is influenced by post-structural theory and in particular by the analyses of contemporary culture by Foucault (1972, 1980). He emphasizes the: Constructing character of discourse, that is how, both in broader social formations (ie epistemes) and in local sites and uses discourse actually defines, constructs and positions human subjects. According to Foucault (1972, p. 49), discourses 'systematically form the objects about which they speak' shaping 'grids and hierarchies for the institutional categorisation and treatment of people' (Luke, 1995, p. 8).

REFERENCES

Aldrich R, Kemp L, Harris E, Simpson S, Wilson A, McGill K, Byles J, Lowe J, Jackson T (2003). Using socioeconomic evidence in clinical practice guidelines. *British Medical Journal* **327**: 1283–1285.

Anderson A (2005). Obesity prevention and management – evidence and policy (editorial). *Journal of Human Nutrition and Dietetics* **18**: 1–2.

Aphramor L (2005). Who says size matters? Paper presented at Weighty Issues: Representation, Identity and Practice in the areas of Eating Disorders, Obesity and Body Management, University of West of England, Bristol.

BBC news online (2004). http://news.bbc.co.uk/2/hi/health/3501512.stm.

Brownell KD (1995). Definition and classification of obesity. In: Brownell KD, Fairburn CG (eds). *Eating Disorders and Obesity: A Comprehensive Handbook*. Guilford Press: New York. pp. 386–391.

Burns M, Gavey N (2004). 'Healthy weight' at what cost? 'Bulimia' and a discourse of weight control. *Journal of Health Psychology* **9**: 549–565.

Bury M (1997). *Health and Illness in a Changing Society.* Routledge: London.

Campos P (2004). *The Obesity Myth*. Gotham Books: New York.

Ernsberger P, Haskew P (1987). Health implications of obesity: an alternative view. *Journal of Obesity and Weight Regulation* **6**: 58–137.

European Youth Heart Study Symposium (2005). Summary Statement on 'Children, Physical Activity and Health', 7–8th April, Methodist International Centre, London.

Evans J (2003). Physical education and health: a polemic or let them eat cake!. *European Physical Education Review* **9**: 87–101.

Evans J, Evans B, Rich E (2003). 'The only problem is they will like their chips'. Education and the discursive production of ill-health. *Pedagogy, Culture and Society* **11**: 215–241.

Evans J, Rich E, Holroyd R (2004). Disordered eating and disordered schooling: what schools do to middle class girls. *British Journal of Sociology of Education.* **25**: 123–142.

Flegal KM, Graubard BI, Williamson DF, Gail MH (2005). Excess deaths associated with underweight, overweight, and obesity. *Journal of the American Medical Association* **293**: 1861–1867.

Flegal KM (1999). The obesity epidemic in children and adults: current evidence and research issues. *Medicine and Science in Sports and Exercise* **31**: S509–S514.

Foucault M (1972). The Archaeology of Knowledge (A. Sheridan-Smith, trans.). Tavistock Publications: London.

Foucualt M (1980). Power/Knowledge. In: Gordon C (ed), Gordon C, Marshall L, Mephan J, Soper K (trans). Pantheon: New York.

Frost K, Frank E, Maibach E (1997). Relative risk in the news media: a quantification of misrepresentation. *American Journal of Public Health* **87**: 842–845.

Gard M (2004). An elephant in the room and a bridge too far; or physical education and the 'obesity epidemic'. In: Evans J, Davies B, Wright J (eds). *Body Knowledge and Control: Studies in the Sociology of Physical Education and Health*. Routledge: London.

Gard M, Wright J (2001). Managing uncertainty: obseity discourses and physical education in a risk society. *Studies in Philosophy and Education* **20**: 535–549.

Gard M, Wright J (2005). *The Obesity Epidemic: Science, Morality and Ideology*. Routledge: London.

Goffman E (1963). *Stigma: Notes on the Management of Spoiled Identity*. Prentice-Hall: New York.

Gordon RA (2000). *Eating Disorders: Anatomy of and Epidemic*. Blackwell: Oxford.

Gregg EW, Cheng YJ, Cadwell BL, Imperatore G, Williams DE, Flegal KM, Narayan KM, Williamson DF (2005). Secular trends in cardiovascular disease risk factors according to body mass index in US adults. *Journal of the American Medical Association* **293**: 1868–1874.

Hawks SR, Gast JA. (2000). The ethics of promoting weight loss. *Healthy Weight Journal* **14**: 25–26.

Hepworth M, Featherstone M (1998). The male menopause: lay accounts and the cultural reconstruction of midlife. In: Nettleton S, Watson J (eds). *The Body in Everyday Life*. Routledge: London. pp. 276–301.

Kassirer JP, Angell M (1998). Losing weight – an ill-fated New Year's resolution. *New England Journal of Medicine* **338**.

Lawrence RG (2004). Framing obesity: the evolution of news discourse on a public health issue. *The Harvard International Journal of Press/Politics* **9**: 56–75.

Luke A (1995). Text and discourse in education: an introduction to critical discourse analysis. In: Apple M (ed). *Review of Research in Education*. American Educational Research Association: Washington.

Lupton D (1995). *The Imperative of Health: Public Health and the Regulated Body*. Sage: London.

Lupton D (1999). Editorial: Health, illness and medicine in the media. *Health* **3**: 259–262.

Lyons AC (2000). Examining media representations: benefits for health psychology. *Journal of Health Psychology* **5**: 349–358.

Mark D (2005). Deaths attributable to obesity. *Journal American Medical Association* **293**: 1918–1919.

Marmot MG, Bosma H, Hemingway H, Brunner E, Stansfeld S (1997). Contribution of job control and other risk factors to social variations in coronary heart disease incidence. *The Lancet* **350**: 235–239.

Miah (2005). Genetics, cyberspace and bioethics: why not a public engagement with ethics? *Public Understanding of Science* **14**: 409–421.

Murphy P (1995). The body politic. In: Komesaroff PA (ed). *Troubled Bodies: Critical Perspectives on Postmodernism, Medical Ethics and The Body*. Duke University Press: Durham and London. pp. 103–124.

Olson MB, Kelsey SF, Bittner V, Reis SE, Reichek N, Handberg EM, Merz CN (2000). Weight cycling and high-density lipoprotein cholesterol in women: evidence of an adverse effect. *Journal of the American College of Cardiology* **36**: 1565–1571.

Rich E, Harjunen H, Evans J (2005). Normal gone bad – health discourses, schools and the female body. In: Twohig P, Kalitzkus V (eds). *Making Sense of Health Illness and Disease* (in press).

Rich E, Holroyd R, Evans J (2004). Hungry to be noticed: young women, anorexia and schooling. In: Evans J (ed). *Body Knowledge and Control*. Routledge: London. pp. 173–190.

Rogge MM, Greenwald M, Golden A (2004). Obesity, stigma and civilized oppression. *Advances in Nursing Science* **27**: 301–315.

Schuftan C (2003). Poverty and inequity in an era of globalization: our need to change and to re-conceptualize. *International Journal for Equity in Health* **2**:**4** 〈http://www.equityhealthj.com/content/2/1/4〉.

Seid RP (1994). Too 'close to the bone': the historical context for women's obsession with slenderness. In: Fallon P, Katzman MA, Wooley SC (eds). *Feminist Perspectives on Eating Disorders*. The Guildford Press: London. pp. 3–17.

Sontag S (1978). *Illness as Metaphor*. Allen lane: London.

Stunkard AJ (1974). Presidential Address, 1974. From exploration to action in psychosomatic medicine. *The Case of Obesity Psychom Med* **37**: 195–236.

World Health Organization (1998). *Obesity – preventing and managing the global epidemic*. Report of a WHO Consultation on Obesity. World Health Organization: Geneva.