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5 Doctor's Orders

Diagnosis, Medical Authority and the Exploitation of the Fat Body

Annemarie Jutel

INTRODUCTION

Medicine is pivotal in the discussion of overweight and obesity. Condemnation of overweight hinges on the premise that it is a disease that puts individuals at risk and renders populations vulnerable. Yet ironically, less than a century ago, plumpness was lauded as healthy, and slenderness a cause for concern. Medical textbooks were more likely to be preoccupied by the risk of underweight than of fatness. In 1929, J.P. MacLaren recommended to doctors undertaking medical insurance examinations that 'generally speaking, a moderate accumulation of fat up to the age of 40 or 45 is good,' and, he explained, 'if the subject has a broad chest, muscular frame, good digestion and circulation and active habits, his chances of longevity are distinctly good' (MacLaren 1929: 192). At odds with contemporary beliefs, MacLaren described the overweight youth as a much lower risk than the underweight to the potential insurer.

Weight on its own, outside of any health education initiative, cultural pressure or unexpected fluctuation, is unlikely to be perceived as illness by a heavy person. Illness might include shortness of breath, unusual swelling in the feet, or other forms of distress, but is unlikely to include measurement. I speak of illness in contrast to disease, that on the other hand, is a discrete entity, defined and scoped by the medical institution. Many people are heavy and feel no physical or social distress and hence would have no cause to consider themselves ill. As Eisenberg and Kleinman (1980: 13) point out, '[a] visit to the doctor is more likely when disease is present, but it is essential to understand that contracting a disease, feeling ill and being a patient are overlapping but not co-extensive states'.

Nonetheless, plumpness has been referred to as a problematic condition for centuries. Hippocrates (1978) made reference to an increase in mortality in fat people as compared to thin people. In contradistinction, preoccupation with overweight, and even the concept itself, are relatively recent. I will argue in this chapter that the medical and lay communities consider overweight—measured deviation from what is considered to be normal weight—to be a disease. This consideration is at the base

of exploitative commercial practices that fuel the idea that there is an epidemic of overweight. To present this argument, I will first introduce the evidence that supports my assertion that there has been a change in the past decade in the way that the medical literature has approached overweight as a clinical entity. Secondly, I will point out the convergence of conditions that have led to the consideration of overweight as disease rather than as measurement. Finally, I will demonstrate how the disease label provides an efficient and effective mechanism to exploit lay fear of fat and obesity for commercial ends. I will make this demonstration explicit through Zola's (1983) tenets of medicalization that posit that medicine exerts political power through its status as 'repository of truth' in contemporary society.

THE EMERGENCE OF OVERWEIGHT AS A DISEASE ENTITY

Diagnosis, or the identification of the presence of a disease, is pivotal in how medicine exerts social control. It legitimizes and normalizes, providing the boundaries for what is acceptable, as well as identifying what is problematic, and in need of redress. *Giving the name* is often the starting point for social labellers and is a *language of medicine* (Brown 1995). Diagnosis formalizes conditions that either individual or society identifies as problematic.

Diagnosis can also be enabling, providing a trajectory of treatment, prognosis and possibly prevention, and placing the patient in the conceptual company of others with the same affliction. Formal diagnoses organize symptoms into meaningful concepts. The urinary frequency becomes diabetes; the rash, lupus; and the cough, bronchitis. Whilst the diagnosis is not necessarily welcome, it nonetheless provides a structure for anticipating what will happen next and what measures to take to remedy or at least, palliate the condition.

But, diagnosis also controls, compelling the patient to become obedient to a new set of normative obligations including incapacity and therapeutic compliance, that can even be mandated, in the case of some diagnoses. Coughing—a symptom—might lead an individual to cover her mouth, and consult a doctor, whereas active tuberculosis or pertussis—diagnoses both—result in enforced respiratory isolation and mandatory reporting to health authorities. Diagnosis affects outcomes. As Hamilton and colleagues have revealed, giving a particular disease label, when a range of options is available may result in a different prognosis (Hamilton Campos and Creed 1996). Haynes and colleagues (1978) reported that labelling patients hypertensive, for example, increased absenteeism from work.

Many factors influence what will receive disease status. Technical knowledge, social values, the nature of the biological condition and institutionalized processes all contribute to what may receive a disease label.

For example, from the point of view of the World Health Organization or an insurance company rigid classification determines what can be counted statistically as disease or be deemed worthy of financial reimbursement for treatment. But the classification of diseases is fluid. Some diseases have not yet been discovered, others have not been named, and again others are not at this time considered diseases, although they may be so considered in other times or contexts. New diseases emerge while others fade into oblivion. Chlorosis, for example, an antique affliction, with a peak in prevalence in the nineteenth century and presumed today to be an iron-deficiency anaemia, has not been reported since the 1930s. Its disappearance is attributed by some to improved prophylactic measures and diagnostic skills, by others to improved social and hygienic conditions (Guggenheim 1995).

On the other hand, Alzheimer's disease was unknown until 1907. Its 'discovery' was made possible by the introduction of new laboratory techniques that enabled its differentiation from other forms of dementia and its description as a new complex clinicopathologic entity (Amaducci et al. 1986). This discovery does not reflect a new neurological process; rather new diagnostic tools capable of categorising what might previously have been considered an inevitable sign of normal aging. Medical science's ability to see and classify has changed. As the knowledge base changes, so too do the notions of what constitutes health and illness as well as what individuals are willing to endure without remedy or palliation.

Diseases also reflect social concern. For example, when Dr Cartwright (1981: 320) wrote his 1851 treatise on the 'diseases of Negroes' he described 'drapetomania', or 'the disease causing slaves to run away': an example of a condition that contemporary critics see firmly founded in social values, rather than in medicine or biology. More recently, in 1994, the American Psychiatric Association discarded the term 'homosexuality' from the *Diagnostic and Statistical Manual of Mental Disorders*, reflecting a change in the consideration of sexuality (Mendelson 2003). A contemporary example is the term 'excited delirium', in wide use by medical examiners to describe clinical manifestations resulting from presumed medical illness or substance abuse, necessitating forcible restraint, and often resulting in death (Channa Perera and Pollanen 2006; Pacquette 2003). Yet, one can argue that this diagnosis is not a medical condition, rather a mechanism for transferring the responsibility for death to a pathophysiological entity rather than to police brutality in the presence of difficult behaviours.

Historically, overweight has not always been treated as if it were a disease, but I argue in this chapter, that overweight gained disease status at the end of the twentieth century. I maintain that this transformation of the way that weight is considered by the medical community facilitates commercial claims about products targeting plump individuals. Note that I am not here speaking of obesity, that has its own classificatory framework, and definitions, and that merits its own analysis; rather I write about overweight, a

term that semantically refers to any amount of weight that is in excess of a particular standard.

A review of medical publications from 1964 to 2004, results of which I have published elsewhere (Jutel 2006) demonstrates a change in the language used to discuss overweight. Where the word overweight figured more prominently in titles of medical articles to refer to a sign or symptom, today, the word appears more frequently to describe a condition with its own set of risk factors, typologies, outcomes, treatment and prevention, all suggestive of overweight-as-disease. For example, earlier references would be predominantly to 'overweight persons', 'overweight in an obesity clinic', or 'overweight and hypertension' where the term is used as an adjective, or to describe a symptom, often subordinated to another condition. There is a distinct trend in recent years to refer to overweight as a disease on its own. This can be found in wording such as 'identification, evaluation and treatment of overweight', 'the epidemic of overweight', 'risk factors for overweight', or by using the word in a non-subordinate list of other recognized diagnoses.

Any one of a number of documents, often generated by authoritative organizations such as health ministries and their equivalents, mirror this general transformation in word use, using the language normally reserved for diseases to refer to overweight. For example, *Clinical Guidelines on the identification, evaluation, and treatment of overweight and obesity in adults*, by the National Institutes of Health (NIH) (1998) speaks of *treatment* and *prevention* of overweight, and are concerned with reducing its *prevalence*. The Centre for Disease Control (CDC) (2005) in its document 'Diseases and Conditions' includes overweight and provides links to teaching documents that explain the prevalence of overweight has increased to 'epidemic proportions'. By placing overweight as an object of epidemiological study, and using the language associated with the study of disease, the CDC confirms again the consideration of overweight as disease. Similarly, Australia, Great Britain, France, the United States, Canada, New Zealand and many other countries have an array of position papers, clinical guidelines and expert task force reports on the 'prevention' and 'treatment' of overweight (Jutel 2001).

THE CONVERGENCE OF CONDITIONS

A number of factors together combine to create the context in which overweight has come to be treated as a disease, rather than just a measurement. Firstly, an important principle that buttresses the pathologizing of overweight is the assumption that the appearance of the body reveals the nature of the individual; whether this be their moral or a physical nature, it is assumed to be observed externally by a person's form. A second fundamental factor in this transformation of overweight from statistical deviance to disease is the generalized ability to measure fatness. In

the scientific-based model, measurement is perceived to be an objective means of assessment, and scales thus become more reliable than individuals in establishing the truth. Thirdly, the tenets of evidence-based medicine (EBM) privilege quantitative measurement. The hierarchies of knowledge recognized by EBM place great importance on statistical analysis; a quantifiable category such as weight slots in this framework most harmoniously.



PURITY.

Figure 5.1 Purity

And finally, the rhetoric of medicine serves an important role in the marketing of products and services that, in turn, have a powerful participatory interest in promoting overweight as a disease.

Appearance Reveals Health

Writings as early as the New Testament—where the Virgin Mary's purity was associated with a spotless mirror, thus aligning perfection of image and of character—provide evidence of the longevity of assumptions about appearance conferring insights to a person's true nature. Books from the Renaissance; assumed that beauty reflected goodness ugliness, evil. For example, Baldessare Castiglione (1561/1948: 309) wrote: '[v]ery seldom [doth] an ill soule dwell in a beautifull bodie. And therefore is the outwarde beautie a true signe of the inwarde goodnesse'. Francis Bacon (1664: 245–6) echoed these ideas 100 years later when he asserted: '[d]eformed persons are commonly even with Nature, for as nature hath done ill by them, so do they by Nature, being for the most part (as the Scripture saith) *Void of natural Affection*'. The back of Leonardo da Vinci's portrait, *Ginevra de' Benci* carries the inscription: 'Beauty Adorns Virtue' (Brown 2001). In folk tales, heroes and heroines are either beautiful or will so become (Cinderella, Rapunzel, the Frog Prince), and villains are ugly. Frequently, pictures are used by publishers to illustrate character traits, as indicated in Figure 5.1.

By the end of the nineteenth century, however, the inner fibre captured in appearance was no longer virtue, but health. References to good health pervaded discussions of beauty. In 1896, Ayer advocated its Sarsaparilla as a blood cleanser: 'Beauty begins in the blood' and reports that 'Beauty is blood deep, not "skin deep"' (Ayer's Sarsaparilla 1896: 115). In the same magazine, The California Fig Syrup Company (1896: 115) reminded readers that 'one of the greatest factors in producing a clear, clean skin and therefore a perfect complexion, is the use of Syrup of Figs'. And the Pabst Brewing Company spoke of a young mother 'flushed with perfect health' after consuming Pabst Malt Extract, the 'best' tonic (Pabst Brewing Company, 1897: 115). Later, Andrews Liver Salts (a laxative) proposed 'inner cleanliness' as a beauty treatment. 'Andrews settles the stomach, corrects acidity . . . thus helping to clear up the spots due to digestive disturbance' (Andrew's Liver Salts 1941: 245) (see Figure 5.2).

This link between health and beauty is neither simply historical, nor limited to lay perspectives and advertising. How an individual looks when he or she presents for medical consultation is likely to have a strong influence on the diagnostic process. For example, Pat Croskerry (2002), writing on medical education, points out the important role that visual assessment plays in clinical reasoning; it establishes pattern recognition that sets the frame for the clinical work-up. This is understandable, and in many ways unproblematic. Visual cues, such as pallor, jaundice, pupil reactivity, swelling, and alopecia and so on are fundamental to diagnosis. However, as

TO KEEP YOUR LOOKS . . .



*Excuse me -
Inner Cleanliness
is your best beauty
treatment*

If you will only attend to your complexion from the inside—with Andrews for Inner Cleanliness—the shortage of cosmetics need not bother you. A naturally clear and healthy skin doesn't require much make-up. Andrews washes away the very poisons that cause spots and pimples.

FIRST . . Andrews cleans and refreshes the mouth.

THEN . . Andrews settles the stomach, corrects acidity and tones up the liver, thus helping to clear up the spots due to digestive disturbances.

FINALLY . . Andrews gently but thoroughly clears the bowels.

With your system cleansed by a regular glass of tonic-Andrews, your skin will be clearer, your eyes brighter. Economical. Buy a tin for yourself to-day. 10½d and 17½d, including purchase tax.

Figure 5.2 Andrews Liver Salt.

Stafford and colleagues (Stafford, La Puma and Schiedermayer 1989) caution, what clinicians see is also influenced by their perceptual preferences and can play out dangerously in medical judgments about the 'abnormal'. There is a standard of homogeneity, write Stafford et al., that governs how medical professionals respond to patients, how the law protects patient rights and what defines medical priorities.

Zola's (1983) discussion of medicalization asserts that medicine practices under what it, and society at large, considers to be noble neutrality and objectivity, justification for its role as repository of truth. Yet, cultural values are just as deeply ingrained in medicine as they are in other settings and to presume a greater objectivity of the medical eye is to overlook the fact that, 'there is no guarantee that merely doing the job of "healing" frees one from examining the context within that it is carried out' (p. 272).

Stafford and her colleagues (Stafford et al. 1989: 214) explain, '[t]he unstated perceptual norm that governs our reactions to patients is predicated on a symmetrical and minimalist conception of beauty'. They maintain that physiology, ethics and aesthetics attempted historically, and continue to attempt to capture the symmetry of beauty or of good. 'Good' numbers, like beautiful things, reflect a kind of perfection in geometry or of form that have implications for the notion of what it means to be healthy. Weighing the body is one important way for determining this symmetry and normality.

Corpulence is Quantified

Nineteenth century medical dictionaries highlight the qualitative, rather than quantitative, nature of adiposity. Obesity was, according to Herrick (1889: 272), in *A Reference Handbook of the Medical Sciences*, 'an increased bulk of the body, beyond what is slightly and healthy', and to Thomas (1891: 458), 'corpulence; fatness or grossness of the body . . . characterized by an excessive development of the adipose tissue'. That these descriptions should be qualitative is not surprising, given that scales were not necessarily readily available to the doctor. These were expensive tools that did not become prevalent until well into the twentieth century.

Historian Peter Stearns (1997) related that weight was not even part of medical record keeping until the late nineteenth century. Whilst the New England Hospital for Women and Children had pre-printed forms with spaces for pulse, temperature, respiratory rate and weight, the space for weight alone was often left blank. Scales were not necessarily part of the doctor's armoury. At the end of the nineteenth century, in presenting the 'Reliance Weighing Machine' in their 'Notes and Short Comment' section, the *Lancet* (1897: 1316) editors write that 'hitherto, these personal weighing machines have taken up too much room in a consulting room and the expense has been too great'. Whilst they may not have previously been part of the doctor's assessment tools, the importance of weighing undoubtedly grew with their availability, as well as with the primacy accorded to concepts of evidence in medicine. Public scales began to spread from 1891 onwards and scales for private homes first hit the market in 1913 (Stearns 1997).

Instruments of Precision

The transformation of obesity into a measurable state may have taken place at the beginning of the twentieth century, but this transformation did not

'take' immediately in the medical community. Whilst measurement of the body was part of a general endeavour to establish rules about the nature of mankind and of sub-groups within the species,¹ using measurement for the assessment of physical health, on the other hand, was not as prevalent. The earliest height and weight tables actually emerged from actuarial rather than medical research. The Medico-Actuarial society compiled the content of 812,221 client 'build cards', to identify actual and expected deaths of, and by extension, financial risk presented by, policy owners of varying weights (Joint Committee 1913).

These height/weight charts, designed to reply to the economic motive of insurance selection, were assimilated by the medical community, though initially with resistance. 'No weight table is sufficient by itself to base an estimate of the ideal state', wrote William Christie in 1927. 'Standard tables that show the average for men and women of our race at any given age and height are fallacious, because no allowance is made for the distinctions of personal physique, nor consideration given to obvious rolls of fat' (Christie 1927: 23). Dr Jean Leray, in his 1931 analysis of plumpness² and obesity expressed scepticism about tables, despite devoting a number of pages to the different formulas and tables that could be used to identify the perfect healthy weight. Leray referred to these calculations as being of 'theoretical interest' only, and instead used Leven's practice of defining safe body weight as the average weight a person in good health maintains over a number of years (Leray 1931). Leray argued that the correct weight for an individual could not be determined by standardized table.

On the other hand, Royal Copeland (1922), a prolific writer on the subject of obesity, made no qualms about using the 1913 Medico-Actuarial tables. It is worth noting that his *Overweight? guard your health* was a trade book, and perhaps sought a short cut to self-diagnosis, an important tool in product marketing as we will see over-leaf. Height and weight charts did however become standard fixtures in medical textbooks, and as late as 1940, Dr Hugo Rony's (1940) medical textbook *Obesity and Leanness* still relied upon the 1913 actuarial studies.

Scales became part of the trend towards, as Rosenberg (2002) describes, 'instruments of precision', that emerged in the late nineteenth century. These apparatuses, including microscopes, thermometers, and later manometers, radiology equipment, electrocardiogram machines, offered objective mechanisms for capturing, standardizing and monitoring disease. Being able to express results in standardized units enabled, Rosenberg argues, disease to be 'operationally understood and described. It was measured in units, represented in the visible forms of curves or continuous tracings' (p. 244). This standardisation and measurability form the base both of contemporary diagnosis, epidemiology and evidence-based medicine (EBM) that produces and reproduces overweight as a disease entity.

Evidence-based medicine, that has evolved in the last decades of the twentieth century, promotes particular forms of therapeutic knowledge. It

is a practice developed in a positivist framework that emerged from a series of lectures by epidemiologist, Archie Cochrane who argued that clinical decisions were too-often based on inadequate or dubious information, and that the medical profession should continuously evaluate the knowledge base upon that it made its decisions (Ashcroft 2004).

Evidence-based practice has since pervaded medical and allied health practice, and is the cornerstone to strategic plans and competency frameworks in medicine, nursing and other allied health fields. Proponents, such as David Sackett and colleagues (Sackett Straus Richardson Rosenberg and Haynes 2000) have published how-to guides to practicing and teaching EBM. Importantly it, as other textbooks (see, for example, Courtney 2005; DiCenso Guyatt and Ciliska 2005; Straus Richardson Glasziou and Haynes 2005) on evidence in health practice, ranks statistical (measurable/quantifiable) knowledge well above other forms. The hierarchical approach to knowledge situates systematic review and randomized controlled trials at the highest level of evidence, in front of non-randomized, case reports and case series.

What this does, however, is to privilege the tenets of experimental knowledge that itself is based upon values that enable standardisation. This requires variability to be defined, populations discerned, results compared and similarities to the patient established by clinicians. Implicit, therefore, in the research-based or experimental model is the quantification of cause and effect, and the measurement of, and focus on, in this case, body weight. In Sackett's personal introduction to the book he co-authors (Sackett et al. 2000) he expresses his interest in, and motivation to, implement evidence-based medicine as coming from a chance stint performing surveys of cardiovascular disease. He writes that it occurred to him that 'epidemiology and biostatistics could be made as relevant to clinical medicine as . . . research into the tubular transport of amino acids'. The purpose of this article is not to dispute this approach, although others have done so vigorously (see, for example, Holmes Murray Perron and Rail 2006; Morse 2006; Rolfe 2005). It is rather to show that an evidence-based framework of clinical practice contributes strongly to shifting the quantifiable category of overweight towards disease status.

With the ability to quantify corpulence comes the potential to track its distribution, prevalence and correlates. In turn, this allows a description of normality and a delineation of the bounds of normal build, which subsequently naturalizes concepts of difference and deviance. Numbers enable clinicians practicing in an evidence-based framework to rely upon information that is well placed in the information hierarchy. Information presented by the patient sits in a subordinated position on the hierarchy. It is assumed by science to be subjective and contaminated by patients' investments in their own lifestyles; information may be embellished, distorted or misrepresented. On the other hand, the scales don't lie. Furthermore, a strong anti-fat stigma adds to the negative perception of patient report. For example, a

study of physicians' automatic response to their obese patients found they thought these patients were bad and lazy (Hebl and Xu 2001). Crandall (1994) also found that health professionals thought heavy people were less reliable and trustworthy than thin. Scales, in this context and with these belief systems, would be perceived to provide a more valuable report.

Historian Hillel Schwartz (1986: 147) in his cultural history of diets argued, 'the body when weighed told the truth about the self. Once gluttony had been linked to fatness and fatness to heaviness, heaviness had still to be regularly identified by numbers on a scale, rather than by vague and subjective sensations'. As Foucault (1963) wrote in his history of the clinic, the medical gaze saw the patient as a barrier to the truth. 'In order to know the truth of the pathological fact, the doctor must abstract the patient . . . the medical gaze . . . [addresses] all that which is visible in illness, but starting from the patient, who hides that which is visible by showing it' (Foucault 1963: 8, my translation). In the clinical assessment, the patient's story is thus an obstruction to the clinician's discovery of the facts of the illness.

An example of silencing the patient can be seen in the National Institutes of Health (NIH) (1998) *Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults: The Evidence Report*. This document is considered a gold standard of evidence for the management of overweight by American and Western medical institutions in the context of evidencebased medicine. It makes treatment recommendations on the basis of extensive review of empirical studies. The treatment recommendations are summarized in an algorithm (see Figure 5.3). This schematic flow chart prompts doctors with respect to the appropriate actions to take to determine if a patient has a weight problem. However, said actions are purely measurementbased. The patient should be, according to these instructions, weighed and measured, but not interviewed. The only suggestion that a patient might have information to offer doctors assess his or her health is subordinated by the grammatical use of the conditional: patient input 'may' be helpful.

The result of this is to allow scales to dictate wellness and create a convenient mechanism for understanding corpulence. Because scales are no longer the preserve of the doctor, and are prevalent in most households, they enable self-diagnosis, and generate an exploitable condition, fruitful to the economic interest of a range of product and service providers, as we will see below.

Medicalization and the Exploitation of the Disease Label

I started this chapter by pointing out how diagnoses reflected the anxieties of a particular society at a particular time in the presence of technological tools enabling their definition. Perhaps we can see a circular relationship here. On the one hand, overweight as a diagnosis reflects the concern of a society that believes normative appearance to be predictive of health. On

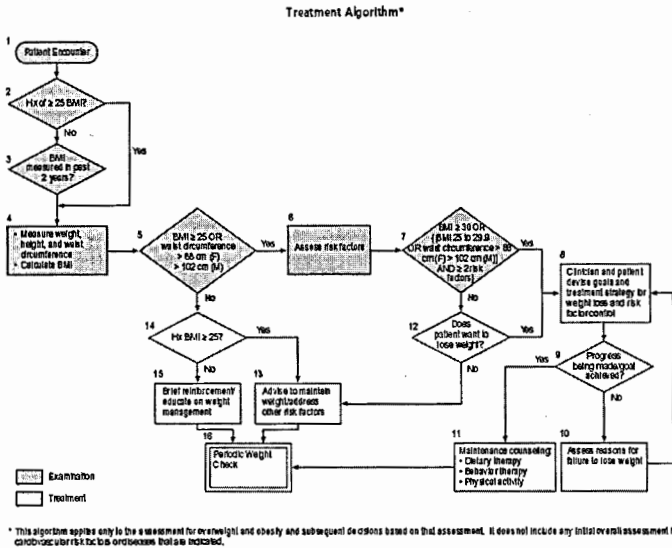


Figure 5.3 Algorithm.

the other, however, the power of medicine as an institution reproduces this anxiety as it validates and provides scientific credibility to the concern.

Diagnosis is pivotal in the way that medicine exerts its social control. It legitimizes that which either individual or society identify as problematic. In the sixteenth century, it was a psychiatrist who argued that witches should not be burned. They were insane, he argued, rather than possessed by the devil (Gevitz 2000). As mentioned above, homosexuality has variously been defined as moral decadence, biological illness, or a normal practice within the continuum of human sexuality; medicine, notably the American Psychiatric Association's *Diagnostic and Statistic Manual (DSM)*, has variably included and removed homosexuality as a clinical entity, typifying its changing social status (Mendelson 2003).

But medicine also serves to reproduce values through its rhetoric and endorsement. Zola coined the term 'medicalization' in the late 1960s, describing it as the means by which medicine's influence and jurisdiction expands to create a distinct political form of social control, usually to the detriment of any one of a number of vulnerable populations (Zola 1986). The discourses of medicine, its language and rhetoric, play an important role in extending its moral authority. 'There is an aura of objectivity', writes Zola, 'that surrounds not only medicine but its pronouncements' (p. 272). Thus, products that appear to respond to a medical need, whose promotion is couched in medicalese, or are supported by medical research, gain purchase in the popular psyche.

Helping people to consider themselves ill or at risk of illness provides a platform for piggybacking commercial interests onto medical authority. And, creating a disease category out of a self-identifiable statistical deviation such as weight enables the commercial exploitation of those so afflicted. Self-assessment tools generate significant consumer interest (McEntee 2003). Those conditions that can easily be diagnosed by a consumer without medical intervention are particularly attractive to industry. For example, Body Mass Index (BMI) calculators are popular features on pharmaceutical weight loss medications sites, as the Abbott Laboratories' promotion of sibutramine hydrochloride monohydrate, or Meridia (Abbott Laboratories 2007). But the weight loss industry extends well beyond the pharmaceutical companies alone and plays an important role in the generation and promulgation of the diagnosis of overweight.

The number of industries who stand to benefit from the belief that overweight is disease is strong, and results in significant lobbying and product promotion based on the disease label (Oliver 2006). Weight reduction, muscle tone and body shape are exceptionally strong markers of 'health' to consumers (Spitzack 1990). The gym, diet, self-help, cosmetic, pharmaceutical and many other industries all have a financial stake in ensuring that people see their weight as problematic from a medical point of view (Jutel and Buetow 2007).

Conrad (2005) has referred to the commercial interests as an important vehicle for medicalization. Examples of an implied medical endorsement for products and services are prevalent in advertising strategies, particularly in what Dixon and Banwell (2004) refer to as a 'diets-making complex', or a vehicle, often exploitative, for the dominance of health considerations in all facets of dietary discourse. By transferring such information to the consumer, there is an implied recognition of lay knowledge of health risk, buttressed by authoritative medical discourse and language that draw the individual into a closed circle of virtuous consumers who focus on important evidence-based truths.

The diet industry, but also others that stand to benefit from belief in overweight-as-disease use this abundantly. For example, milk advertisements quote model Elizabeth Hurley saying: 'I want to look great and milk helps. *Studies suggest* [italics mine] that people who drink milk regularly tend to weigh less and have less body fat than those who don't' (2424Milk 2006); Les Mills Gym publishes press releases from the World Health Organization to promote weight loss programmes (Les Mills 2006); and Schwinn Bicycles (Schwinn Fitness 2006) points out that 'being overweight can contribute to an increased risk in heart attack, diabetes, high blood pressure and other *life threatening illnesses* [italics mine]'. They also refer to *research* [italics mine] that reassures us we don't have to train too hard to remove these risk factors. Once the sales pitch is justified by the austere and respected guardian of Western culture—medical authority, the product has more clout and less frivolity. The consumer becomes a virtuous and docile subject as she complies through her purchasing decisions.

Overweight, like Adult Attention Deficit Hyperactivity Disorder (ADHD), Erectile Dysfunction and pregnancy, is a condition that, once defined as medical, exposes those who experience them to risks that are not present prior to such definition. A notable component of that risk results from the commercial target they have become, and the mongering of products that may ensue. But actually mongering the disease label, or encouraging individuals to believe themselves either sick or at risk of so becoming, is of growing concern to critical clinicians, advocates, and lay people (Moynihan and Henry 2006). Disease mongering creates a belief in and promotion of conditions for which clinical attention may cause more harm than benefit. Whether it be the pharmaceutical industry, peddling sibutramine or orlistat (known by the trade names of Reductil and Xenical); the media, promoting its diet or lifestyle modification reality shows (*Biggest Loser*, *Honey We're Killing the Kids*); the diet industry (Weight Watchers, Jenny Craig); the gym and fitness industry or many others, there is a vast array of commercial interests primed to wage battle, purportedly for the health of the nation, whilst cheerfully amassing the spoils of their continual and repeated victories for their shareholders; and many protect their interests through their lobbying and consultative role to health agencies. Australia's weight loss policy paper *Acting on Australia's Weight*, for example, uses the weight loss industry as a key player in the education for the prevention of overweight, which it identifies as an area for strategic action. The panel actually hands a portion of the responsibility for the prevention of overweight directly to this private industry player who stands to make significant financial gains from suggesting that weights should be monitored, controlled, and possibly reduced (Jutel 2001).

The victory is not thinness, it is the undying belief in overweight-as-disease. As long as mongerers of overweight, bolstered by medicine's implied endorsement, can continue to convince individuals to hold to the belief that plumpness attests to self-induced disease, they can reap certain benefit, selling their fitness programmes; dietary supplements; self-help guides; television shows; metabolism boosters; diet pills; cellulite busters; weight machines; diet plans; low-fat, high-protein, low-GI food stuffs; and so on.

CONCLUSION

Ivan Illich (1976: 104), in his scathing seminal work on the medicalization of the human existence, wrote that 'disease always intensifies stress, defines incapacity, imposes inactivity, and focuses apprehension on non-recovery, on uncertainty, and on one's dependence upon future medical findings'. He continues, '[o]nce a society organizes for a preventative disease-hunt, it gives epidemic proportions to diagnosis. This ultimate triumph of therapeutic culture turns the independence of the average healthy person into an intolerable form of deviance'. These words are particularly poignant when we reflect upon contemporary Western culture's focus on the slender body.

Not only does overweight-as-disease transform independence into deviance, the simplicity of its diagnostic work-up (simply step on the scales) enables dangerous constraints. Weight is only a number, but a very powerful one. Just as the perfect hourglass figure might have been 34–23–35, or the perfect size six, today's standards of perfection are captured in BMI, health policy, medical management and product sales.

Again, Illich (1976: 53): '[m]edicine is a moral enterprise, and therefore inevitably gives content to good and evil. In every society, medicine, like law and religion, defines what is normal, proper or desirable'. Overweight-as-disease uses detached objective numbers without regard to important principles about populations and individuals. It disenfranchises the individual as it privileges measurement over lived experience, validates presumed behaviours and reveals moral flaws.

But overweight-as-disease is a marketer's ploy made in heaven. Here we have a self-diagnosable condition that engenders a population-wide preoccupation with self-surveillance, treatment, prevention and cure. Monitoring is internalized; compliance to 'healthy' practices denotes virtue. The individual body is rendered docile by the medicalization of its management by commercial entities. As with the panopticon, the doctor need not be present to ensure compliance: the individual, with scales and ruler can diagnose overweight. A smorgasbord of web sites allows consumers to plug in numbers and push the button for instant BMI calculations (General Mills 2008; Jenny Craig 2008; Total Gym 2008). Once measured, it doesn't take a doctor to position the number within or outside of the acceptable standard,³ or to decide the range of interventions to take.

It is hard to appreciate the cultural content of a diagnosis that emerges from a contemporary context. As members of the society that suffers the anxiety over weight that results from its creation as disease, we don't have the same critical distance as we have with respect to hysteria or, say onanism. Most readers of this chapter will likely be aware of their body size and firmness, concerned if it increases, ostracized if they are large, and possibly even inclined to say 'make that trim milk please' when they have the option. Overweight is an excellent illustration of the influence of culture on diagnostic categories, and similarly of the important role that diagnosis plays in the production and reproduction of cultural values.

NOTES

1. The Body Mass Index, used today as an index of overweight and obesity, was devised by Adolphe Quetelet (1871) and was motivated by the religious incentive of discovering the presence of God's rules on earth.
2. It is interesting to note that the original French title of this book, *Embonpoint et obésité* flags an important conceptual shift. *Embonpoint*, translated here as 'plumpness' has as its etymological source 'en bon point' or 'en bon état' meaning being in good health, or looking well. Its modern

meaning, and indeed, its meaning at the time of Leray's writing, however, is to be plump.

3. The fact that population statistics are being used indiscriminately without regard to cultural group, and without identification of the sample group from which normative standards were derived, is neglected by both marketer, doctor and individual.

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