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Obesity surgery and the management of excess: exploring the body multiple

Abstract

Drawing on ethnographic data gathered through observations and interviews at a surgical weight management clinic in a large hospital, this paper argues that while the core values governing the provision of obesity surgery (obesity = ill-health; obesity surgery = weight loss; weight loss = improved health and cost savings) can be seen as governing the clinical encounter, the singularity of these collective equations reflects neither the complexity of the patient experience of obesity surgery, nor the extent to which the “war on obesity” itself does not adhere strictly to those principles. Drawing on Annemarie Mol’s (2002) concept of *the body multiple*, and focusing on three different forms of “excess” (excess weight, excess consumption, and excess skin) that emerged in the course of the study, this paper argues that the rationalised singularity of obesity that is enacted in the obesity surgery clinic risks obscuring the uncertainties inherent to those practices, and the moral judgements and values that are ultimately inextricable from them.

Introduction

This paper begins with an extract from fieldnotes taken whilst observing a consultation between an obesity surgeon and a prospective patient (Janet), meeting for the first time at an obesity surgery clinic in a large National Health Service (NHS) hospital:

Janet is in her late 40’s / early 50’s. She has dressed smartly in a dark suit, and seems very nervous, fiddling with her hands and unsure where to sit in the cramped consultation room. She pauses by the bed, wondering whether the surgeon will want to examine her, but instead, he gestures to the seat next to his desk and introduces himself. He asks how long she’s been overweight and, looking down at her hands, she replies: “Always”. He asks if she has any weight-related health problems, and she hesitates. He prompts her: “Diabetes?” “Yes”; “Blood pressure?” “Yes”; “sleep apnoea” “Yes”. Janet has brought her prescriptions with her listing her different meds; she takes the papers out of her bag. There are three separate sheets; he lays them on the desk and runs down the lists with his pen, commenting as he goes: “Oh, joint problems as well” ... “Something for lipids”. He flips through the three sheets. “You’ve got loads”, he exclaims; “13 pills a day”, Janet confirms, blushing and looking back down at her hands. He runs down the list again, this time punching each medication with the tip of his pen, marking out all of the ones commonly associated with being overweight: “This one, and this one, and this one...” Janet is struggling to interpret the meaning of this emphatic listing, but clearly fears a telling-off. “I know,” she says quietly, “I’m so ashamed of myself”.

The surgeon doesn’t respond directly to her confession and continues animatedly: “I don’t think there’ll be anything left once you’ve lost the weight. I don’t want to be flippant about this, but wouldn’t it be wonderful if you didn’t need to test your sugar?” Janet looks relieved as she realises that she’s not being told off by the surgeon. But then he looks at her medical notes for her current weight [which was taken when she arrived at the clinic], and he tells her that she is twice the weight she

should be; he tells her that 10st of body fat is about half a million calories, which is how much she needs to lose. He tells her: “This extra is your weight problem; it is this excess that makes you ill”. He asks what job she does. “Book keeping”, she says, adding quietly: “Sitting down a lot”. But Janet has misread the surgeon’s intentions; he’s not trying to find out how sedentary she is, or to berate her for inactivity as other doctors probably have. Instead, he is trying to find a way to engage her in the energy balance calculation. Writing on a piece of paper between them on the desk he works out that she needs a calorie deficit of 500 calories over three years to lose her excess weight; he says that the gastric band will give her a deficit of 1000 calories for a year and a half and that she would never be able to do that on a diet. Pointing again to the prescriptions on the desk, he pronounces optimistically: “more than anyone else today, you’ll probably do best.”

Writing in the context of her clinical ethnographic study of atherosclerosis, Annemarie Mol argues that rather than constituting a pre-existing, objectively knowable entity, the disease (or a specific incarnation of it) is enacted co-operatively between the clinician and the patient in the consultation (2002: 21). As Mol notes of one patient: “Whatever the condition of her body before she entered the consulting room, in ethnographic terms, Mrs Tilstra did not yet have this disease before she visited a doctor. She didn’t *enact* it” (p. 22, original emphasis). A similar process is at work in the consultation between the surgeon and Janet, as between them, they enact not simply the unitary and universal “disease” of obesity, but the more specific “composite object” (p. 70) of “obesity that is amenable to surgical intervention”.

However, in this case, while working towards the same goal (of having her surgical candidacy confirmed), through her reluctance to name all of her health problems, and her confessions of shame and wrong-doing, Janet is not complying with the unwritten rules of the consultation process and instead, has to be coached through it by the surgeon (for example, by not responding to her shamed confessions). Her reluctance to detail her health problems reflects her concerns that she would be deemed an undeserving subject, or that she would be pronounced too fat for surgery – a fear compounded by that fact that she had recently been refused knee replacement surgery because of her size. For the surgeon, on the other hand, the more obesity-associated health problems she has, the more convincing his letter to her Primary Care Trust requesting funding. Following Mol, I want to suggest that the trickle of misunderstandings that arises from the intersecting, and divergent, goals that they bring to the encounter is not simply a matter of different competing perspectives on / experiences of obesity, but rather, that obesity is never singular; it is always *more than one*. The fat body is, to use Mol’s term, “the body multiple”. Consequently, while a particular “obesity” is enacted in the clinical encounter with the surgeon, in a different clinical context (that of Janet’s orthopaedic consultation, for example), an “obesity too dangerous to undergo surgery” was produced. Perspective, Mol argues, “multiplies the observers – but leaves the object observed alone. All alone. Untouched. It is only looked at. As if it were in the middle of a circle” (p.12). Instead, she argues that it is necessary to get “into the disease itself” (p 12) by focusing on the materialities and events of the clinical encounter in order to resist the notion of disease as singularly knowable.

Where Mol’s analysis of atherosclerosis focuses on the enactments of multiple atheroscleroses within a particular hospital, it is also possible to extend the concept of

the body multiple to 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 of the medical context in quite vociferous ways. This is evidenced by the “shameful obesity” that emerges in the consultation between Janet and the surgeon; the obesity that Janet feels needs to be pre-emptively confessed. This obesity could have been enacted in any one of the many everyday (medical and non-medical) locations where the fat body is derided for the moral failures it is presumed to signify, and which those who are fat have to negotiate. Janet, it is clear from the extract, is unclear *which* obesity is being enacted in the consultation.

In positing these multiple obesities, I am not suggesting an endlessly fragmented and divided obese body, but rather, with Mol, that *the body multiple* is always “more than one – but less than many.[...] Even if it is multiple, it also hangs together” (p. 55). These multiplicities are distributed across different locations, separating out potentially conflicting obesities, but between which there is constant flow, reinstating the body multiple, rather than a pluralistic body of clashing incompatibilities. It is “an intricately co-ordinated crowd” (p. viii). And if it is the case that a disease (obesity, in this case) is more than one, then, as Mol argues, it becomes necessary to interrogate *which* obesity is being enacted in any given moment (p. 159). This matters because interventions (which are determined by which obesity is being enacted) always have effects outside of those intended. The central question, therefore, becomes not whether an intervention is effective, but what those effects are (p.182). The body multiple, then, is a matter of ontological politics: “the way in which problems are framed, bodies are shaped and lives are pushed and pulled into one shape or another” (p. viii).

Taking Mol’s framework of disease as “events-in-practice” (p. 21), this paper explores an embodied, enacted multiplicity of obesities in the specific context of obesity surgery. In particular, the paper focuses on the role of designations of “excess” in the enactment of obesities, and argues that while the clinical enactment of obesity is as health-damaging “excess weight” that requires weight-diminishing intervention (surgery in this case), in practice, obesity (and its surgical management) is always about *more than* the management of specific health problems medically designated as obesity-related, and that the management of “excess” extends far beyond the simple “fact” of dangerous body weight. In short, neither “obesity” nor its associated “excesses” are singular. Consequently, I want to argue that even where obesity surgery is successful *in its own terms* as delineated by the clinic, it is, to use US anthropologist Cassandra White’s concept, an “uncertain cure” (White, 2009) – that is, one which, while having some success in relation to specific medically defined goals and practices, intersects with (and contributes to the enactment of) other obesities in ways that have to be negotiated, physically and socially, long after the end of the surgical treatment pathway.

In the remainder of the paper, I will briefly set out what obesity surgery involves, and in particular, the treatment procedure practiced in the clinic that was the focus of the study on which this paper draws. The next section introduces the methodology for the study. This is followed by the main body of the paper which addresses three different “excesses”: (1) excess weight; (2) excess consumption; and (3) excess skin. The paper concludes with a brief discussion of the implications of this analysis for thinking about obesity and its surgical management. Following Mol, I argue that it is necessary

to raise doubt in relation to obesity and its management (surgical or otherwise) rather than chase it away. This necessitates resisting the flattening out of complexity that comes with rationalising practices that assert the ontological singularity of obesity as a dangerous disease for which weight loss is the solution.

Obesity Surgery in the UK

Obesity surgery (or weight loss surgery, bariatric surgery), broadly defined, refers to a constellation of surgical interventions designed to reduce stomach capacity and / or intestinal length. This is done with the aim of limiting the amount of food the body can consume and absorb in order to produce significant and sustained weight loss. Obesity surgery remains a minority practice in the UK, although, according to the NHS Information Centre (2009), the number of surgeries being performed within the NHS more than doubled between 2006-7 and 2008-9, rising from 1950 to 4220 procedures. It is estimated that approximately 80% of all obesity surgery patients are women (Ellis et al. 2006).

In terms of health policy and medical practice, obesity surgery is conventionally conceptualised as a cost-saving intervention in relation to particular chronic diseases that can be both debilitating for the patient and expensive to treat over a patient's lifetime (e.g. diabetes, obstructive sleep apnoea and risk factors for cardiovascular disease and stroke). In the case of diabetes, for example, the Swedish Obese Subjects study found that 72% of the surgery patients in their study (across all procedures) had recovered from diabetes after 2 years, dropping to 36% at the 10 year point (Sjostrom, Lindroos et al. 2004: 2692; see also, Buchwald, Avidor et al. 2004; Singhal, Kitchen et al. 2008; Singhal and Super 2009), although significantly, the authors are unable to confirm that weight loss, as opposed to some other mechanism related to obesity surgery, was responsible for these positive outcomes. The surgeon with whom Janet's consultation took place spoke to me with evangelical enthusiasm about the potential that he saw in obesity surgery for resolving diabetes. Highlighting the differences between his treatment and that offered within the diabetes clinic with which the obesity surgery clinic shared physical space, he argued: "The rest palliate it [diabetes] with insulin and pills; we cure it. I'm the odd one out here."

According to the Guidance issued by the National Institute for Health and Clinical Excellence (NICE) in 2006, in order to be eligible for obesity surgery, patients must have a "a BMI of 40 kg/m² or more, or between 35 kg/m² and 40 kg/m² and other significant disease (for example, type 2 diabetes or high blood pressure) that could be improved if they lost weight" (NICE 2006: 54). However, while obesity surgery is playing an increasingly prominent role in anti-obesity policy and practice, and the number of surgeries performed annually continues to rise, simply meeting the criteria is not enough to guarantee acceptance as a patient. In England, the provision of publicly funded surgery is governed by Primary Care Trusts (PCTs). There are 151 PCTs in England, controlling 80% of the NHS budget, and they are able to set their own spending priorities in order to meet what they judge to be the particular health service needs of their area. Consequently, obesity surgery, as with many other elective procedures, is subject to a "postcode lottery", with many Primary Care Trusts either refusing to commission obesity surgeries at all, or setting higher BMI thresholds or other qualifying criteria in order to restrict access (Royal College of Surgeons 2010).

The clinic on which the research for this paper draws is located, along with a medical weight management clinic, within an endocrinology unit, reflecting the increasing use of obesity surgery as a treatment for diabetes (Buchwald, Avidor et al. 2004; Sjostrom, Lindroos et al. 2004; Singhal, Kitchen et al. 2008; Singhal and Super 2009). Patients attending for their first appointment meet with the surgeon, and then attend a dietician-led seminar, where they watch two short cartoon video clips about the surgery, and have the pre-and post-op diet explained to them, as well as being given opportunities to ask questions. Post-surgery, the patients have six consultations with specialist dietician as part of a two-year treatment pathway, as well as the possibility of support by telephone if required.

The procedure preferred by the surgeon is laparoscopic gastric banding. A band is passed around the top of the stomach and tightened, forming a small pouch at the top and a narrow restriction leading to the main body of the stomach. A tube runs from the band to a port under the skin, through which saline can be injected or withdrawn, filling or emptying a balloon around the inside of the band. This, in turn, increases or lessens the restriction provided by the band. The Swedish Obese Subjects study – a large prospective study of obesity surgery that has been running for almost two decades (Ryden and Torgerson 2006) – reported in 2007 that at the 10 year point post-surgery, weight losses for gastric banding were 14% from the baseline, compared to 25% for gastric bypass and 16% for vertical-banded gastroplasty (Sjostrom, Narbro et al. 2007). However, in spite of the lower weight losses, gastric banding requires much shorter hospital stays (often going home the same day), is reversible, and is associated with fewer complications (O'Brien 2007; Singhal and Super 2009).

Methodology

This paper draws on a research project entitled *Obesity Surgery: A Clinical Ethnography*. The research involved primarily the participant observation of clinical consultations conducted at an obesity surgery clinic at a large NHS hospital in the West Midlands. I visited the clinic a total of 29 times, observing both patient consultations with the surgeon or the dieticians, as well as dietician-led new-patient seminars. In total, I observed 153 patient consultations (103 women and 50 men), plus 8 seminars. These were all recorded in hand-written fieldnotes. The ethnographic fieldnotes were supplemented by 15 interviews with patients (11 women and 4 men) about their experiences of obesity surgery both within the clinic and beyond it. The interviewees were recruited through the distribution of an information sheet and pre-paid reply letter at the end of consultations during the last 15 clinic visits (with earlier visits used to develop the interview protocol). The interviewees were interviewed in their own homes, with interviews ranging from 45 minutes to over two hours. These were audio-recorded and transcribed. Given that the focus of the project was the patient experience of surgery, formal interviews were not conducted with clinicians, but extensive informal interviewing took place during visits between consultations, in schedule gaps (for example, when patients failed to attend), or after the clinic had concluded, and these exchanges were recorded in the field notes. With the exception of three patients who had had gastric bypass surgeries elsewhere and had subsequently obtained funding for dietician-led follow-up at the clinic, all of the patients I met and observed had either had, or were going to have, laparoscopic gastric banding. Ethics approval for this fieldwork was obtained through the Local Research Ethics Committee prior to the start of the project.

This core dataset (of fieldnotes and interview transcripts) was coded according to key themes, concepts and events, and the coded data were then analysed using a discourse analytic approach; that is, by focusing on talk and text as social practices that are always *doing* something (Wood and Kroger 2000: 4). The analysis, therefore, explored what explanations, accounts and actions were possible in any given context, and what that can tell us about the wider social and cultural context within which those actions and explanations are made meaningful. This analysis was supplemented by observation at major medical and policy conferences, press releases and other media coverage; these materials provided context for the specific dataset that had been generated in the course of the research.

Excess weight

In the context of the clinic, as in the extract cited at the opening of this paper, bodily weight designated as in “excess” – that is, that portion of weight between the patient’s actual weight and the highest weight within the range designated as “healthy” for their height – is held responsible for specific chronic health problems. As the surgeon explained to Janet: “It is this excess that makes you ill”. This version of obesity is enacted in the consultation by the contiguous discussion of Janet’s many illnesses and her “excess” weight. “Excess” here constitutes a quantifiable bodily property, the diminishing of which is anticipated to lead to an improvement in those conditions. Within this model of obesity, “excess weight” (“your weight problem”) does not belong to the body and can be separated out from it; the body can, in theory at least, be restored to health through surgically-facilitated dietary book-keeping. However, for individual patients, the experience of surgery is more complex.

Firstly, and perhaps most obviously, there is an inherent tension between the designation of the “excess weight” as making the individual ill, and the fact that surgery is anticipated to remove approximately 50% of that portion designated as “excess” (a modest expectation that is communicated repeatedly to patients). If “excess weight” is the difference between the patient’s highest “normal” weight for height and their starting weight, and if the average weight loss from the gastric band is 50-60% of that portion categorised as “excess”, then patients losing that amount are still likely to be medically categorised as overweight or obese at the end of a successful two-year pathway. The expectation of this residual excess is made explicit in the consultations; as the surgeon explained to one prospective female patient about the anticipated weight loss from surgery: “that’s a big chunk, and then you’d only be overweight like a lot of people”. Another male patient whose significant weight loss appeared to have settled at a BMI of 32 kg/m² was told by the dietician that “there’s still a bit of extra weight, but it’s not as dangerous as it was”. Here we can see an additional obesity emerging through the interaction between the patient and the clinicians, and one that is distinct from “obesity that is amenable to surgical intervention” and from the “dangerous obesity” of the public health messages (or the pre-surgical consultation); an obesity that is much less threatening to health. This is not just a matter of degree, but also of context and history: a patient presenting herself to a GP for the first time with a BMI of 35 would most likely be identified as requiring some form of weight loss intervention, but a patient whose BMI has fallen post-surgically from 65 to 35 is no longer seen as a target for any intervention. These are different obesities; surgery changes more than BMI.

Perhaps more significantly, even when the anticipated degree of weight loss occurs, not all health problems or risk factors conventionally understood as caused by “excess weight” improve, disrupting the normative presumption that “excess weight” lies at the heart of the problem (and that its elimination is the solution). For example, the Swedish Obese Subjects study found no differences in hypercholesterolemia (commonly associated with obesity) between the surgical group and the control group (Sjostrom, Lindroos et al. 2004: 2692). Even in the case of those conditions which are more strongly associated with improvements post-surgery (e.g. diabetes), not all patients experience those improvements, leaving those patients with unresolved health problems that had been always been blamed on their weight in previous encounters with medical professionals. Juliet, for example, was attending for her final consultation with the dietician, having lost 54% of her excess weight. She appeared slightly disappointed, noting: “But it’s not moving now. It’s pretty much stopped”. The dietician reminded her that this was what they would expect from the band, adding: “To make any changes is difficult from here...” The dietician then moved the conversation on to focus on the intended effects of weight loss rather than the weight loss itself, and asked about Juliet’s diabetes. Juliet reported that she is still on insulin, and that she still has hypertension; the dietician looked surprised, commenting, “That’s quite unusual”, and then adding, “That suggests a family history”. In this exchange, Juliet and the dietician enact another obesity (and another diabetes) – one whose “excess” is dislocated from chronic disease and replaced by a genetic predisposition which has been diagnosed through the obesity surgery process. The dietician then moved the discussion on, asking her what she can do now that she could not do before, and Juliet responded enthusiastically that she “couldn’t walk before”, but now goes walking and swimming, and can get up and down the stairs easily. The “excess weight” of obesity is redefined in this exchange as having inhibited mobility rather than causing certain chronic diseases.

This clinical encounter illustrates that even within a clinic whose fundamental purpose is defined in terms of measurable and cost-saving health improvements, other measures of success (e.g. improved mobility) are mobilised and celebrated. However, these benefits emerge as collateral positive outcomes rather than primary motivations in the context of a clinic where the primary enactment of obesity is as a disease causing specific chronic health problems. Indeed, in a discussion at the clinic between a dietician and a consultant from the medical weight management team about the potential suitability of a patient for obesity surgery, concern was expressed that she had described mobility issues as her primary reason for wanting surgery, whilst refusing to problematise her fatness *per se* as a health risk – a motivation that they felt signalled that “she’s not going to do very well”. In their paper summarising the key findings of the Swedish Obese Subjects study to date, Ryden and Torgersen (2006) warn about the limitations of using “traditional indicators” to evaluate obesity surgery, arguing that “paradoxically, better health according to such traditional indicators is not automatically accompanied by improved well-being or perceived health gain” (p. 559). They go on to argue that “one must not forget the patient’s perspective [...] Improvements in health-related quality of life, musculoskeletal pain, and effort-related calf pain might be as important to the afflicted individual as cardiovascular risk reduction “ (p. 559). This reminder of the importance of perspective could be reframed, in Mol’s terms, as a reminder about bodily multiplicity; that the obesity that causes chronic disease, and the obesity that causes

mobility problems are different diseases, rather than different perspectives on a single disease.

However, for some patients at the clinic, the decision to undergo obesity surgery was driven not simply by the desire to directly alleviate the health problems conventionally associated with obesity, but rather, as a step towards addressing a different set of ends for which weight loss had been deemed necessary – for example, where access to other medical interventions was subject to a maximum weight or BMI threshold. During my time at the clinic, I met patients who had been refused hip or knee replacements, a kidney transplant, heart bypass surgery, hernia repairs and IVF treatment on the grounds of their weight. However, given the limitations to post-surgical weight loss, many were still short of the BMI qualification thresholds (usually around 30 kg/m²) by the end of the treatment pathway. For the patients, therefore, rationalisations in one aspect of health care had driven them to engage with another, equally rationalised, intervention which, according to the expectations of the clinic, was unlikely to enable them to meet the imposed BMI threshold. This use of obesity surgery by patients can be understood as an example of what Lee Monaghan, drawing on Ritzer's thesis of the "McDonaldization of Society" (Ritzer 2004), describes as one of the "irrationalities, or unintended consequences" of a rationalized organisation or industry (Monaghan 2007: 68). However, as Monaghan argues in relation to the "irrationalities" of the weight loss industry, those unintended consequences can also constitute "meaningful resistances" to those processes of rationalisation (p. 68).

Maximum BMI thresholds for health interventions are conventionally justified on the basis of minimising risk and maximising treatment success (although also function as a means of rationalising the use of scarce public resources), with BMI functioning as a proxy indicator for a range of health indicators. This is the same logic that is used to make the conventional case for obesity surgery. But while it may appear irrational for someone to need to reach a particular BMI, and then to engage with a weight loss technology that is unlikely to enable them to achieve that target, it also became clear that patients were mobilising the fact of surgery itself in order to demonstrate their *moral* worthiness of treatment *in spite of* their remaining "excess weight". Bob, for example, had reached the end of his treatment pathway, and his weight loss had tapered off, and then finally stalled at several BMI points above the threshold he had been given to qualify for funding for a knee replacement. Instead of being defeated by this, he produced a chart from his pocket illustrating his weight loss. He planned to give this to his GP, insisting: "I've done my bit, now it's their turn". By positioning himself as a deserving patient who has taken responsibility to the greatest degree possible, Bob displays a strategic understanding of (anti-) obesity policy and practice as governed not simply by objective health measures, but also by moral assumptions about deserving and undeserving patients, whereby outstanding "excess" can become forgivable once it has been "confessed" (and by extension, steps have been taking to address it).

Not all "excess weight", then, is equal or ontologically similar, and it might be expected that these different obesities would come into conflict with each other (for example, since one is deemed as warranting surgical intervention, and the other is an obstacle to it). However, as Mol argues, "Incompatibilities between objects enacted are no obstacle to medicine's capabilities to intervene – as long as the incompatible

variants of an object are separated out.[...] The possible tensions between different variants of a disease disappear into the background when these variants are distributed over different sites” (Mol, 2002: 115). As with the term “atherosclerosis” in the case of Mol’s study, “obesity” functions as a “co-ordinating mechanism operative in conjunction with the various distributions”. Consequently, by bridging the boundaries between sites, it “helps to prevent distribution from becoming the pluralising of a disease into separate and unrelated objects” (p. 117). Bob’s strategic understanding of the multiplicity of obesities and of the moral values and judgements that are obscured by the obesity enacted in the obesity surgery clinic highlights the inextricability of clinical practice from those moral judgements which, in this case, facilitate the flow between potentially conflicting obesities.

The inextricability of the rationalised clinical enactment of obesity (that obesity causes dangerous (and expensive) chronic diseases that can be treated effectively by obesity surgery) from a wider moral context is brought sharply into focus by the rhetoric of “excess consumption”, through which more socially threatening enactments of obesity (and its surgical management) are practiced, as discussed in the following section.

Excess consumption

The familiar characterisation of fatness is of uncontained appetites; a shaming designation that attributes to the fat individual a moral incontinence that is literally given away by the body itself (Murray 2005). The acquired shame of (presumed) overconsumption – not only of food, but also of resources more generally – can be seen to flow into even the most well-intentioned medical encounter, as can be seen in Janet’s confession: “I’m so ashamed of myself”. The presumed excesses in consumption that fatness is read as embodying are not confined to food, but are also extended to public, and even global, resources, with fatness seen as responsible for negative impacts ranging from diverting the fire service from the work of saving innocent lives (Campbell 2009), to undermining national security (Herndon 2005), to causing global warming (Edwards and Roberts 2009). These presumptions about the failed citizenship of the fat body, and its greedy consumption of public resources, extend easily to the health sector, and those seeking obesity surgery find themselves under fire both for the presumed costs of treating health problems commonly associated with obesity, and for the anti-obesity interventions themselves.

In 2007, for example, the Foresight Report estimated the current costs of obesity to the NHS as £2.7 billion, with a predicted rise to £7.1 billion by 2050 (Foresight 2007: 50). In the context of these widely reported figures, those identified as candidates for NHS-funded obesity surgery are easily rendered the new “folk devils” (Cohen 2002) of the “war on obesity”, greedily gobbling up more than their fair share of scarce public resources. In October 2009, for example, UK tabloid newspaper, *The Sun* covered the story of “70 stone Paul [Mason]” under a full front page headline: “World’s Fattest Bloke Lives in Ipswich” (Morton 2009). On the inside pages, the traditionally jingoistic tabloid found itself torn between its obvious pride in a British superlative – “World’s Fattest Man is Brit” (p. 5) – and its pantomime horror at his consumption of both food and public resources: “Eats 20,000 calories a day. Stuck in his bed for 8 years. Costs public £100k a year” (p.5). The parallel presentation of his

calorific consumption and his consumption of public funds elides the two as similarly, and unacceptably, excessive. We are told that he needs “drastic stomach surgery to stop him eating and keep him alive – *at a cost of £20,000 to the NHS*” (p.5, emphasis added).

Significantly, within the obesity surgery clinic, there was never any suggestion that patients were making an illegitimate claim on public resources. Indeed, the clinic was premised on the conviction that obesity surgery conserves those resources in the long term, and in practice, the clinicians maintained a purposefully non-judgemental approach, especially in their refusal of the notion that weight management is a simple matter of will - something that was greatly appreciated by the patients. Nevertheless, as has been discussed in the previous section, even where these different “obesities” can be understood as distributed across different sites, the lived, complex realities of “obesity” mean that it is impossible to insulate the rationalised and purposefully non-judgemental obesity that is enacted in the clinic from the profoundly moralised and shameful “obesity” that is constantly reiterated and reproduced in the wider social context (and in which, anti-obesity medicine is ultimately implicated).

Consequently, patient concerns around the legitimacy of claims to resources seeped constantly into the clinical encounter. Post-surgical follow-up appointments usually began with a friendly greeting in the form of an open question (e.g. “How are things going?” / “How have things been?”). For those who had continued to lose weight between appointments, this usually elicited a strongly affirmative response, but for those who had either regained weight, or whose weight loss had stalled, this constituted a confessional opportunity – “I’ve been bad”; “You’re going to tell me off” - to signal awareness of dietary “transgression”; to demonstrate awareness of the “rules” of managing a gastric band; and to display a commitment to the process of “reskilling” (see also, Wheatley 2006: 68). In the first instance, these confessional responses reflect the struggles around managing food that many of the patients confronted every day, highlighting the moral dimensions to the work of managing body size that inevitably become part of all weight management consultations (see, for example, Webb 2009).

However, these confessional moments also highlight the extent to which surgery itself (as opposed to fatness *per se*) bears moral freight that has to be managed by the patients in relation to their “excess” consumption of public resources. One female patient, for example, in her first year post-surgery, had gained a small amount of weight since her last appointment, and was visibly upset by this, declaring: “I feel so bad because of all the time and money that’s been put into me”. Many of the patients also expressed concern about the potential impact of “doing badly” on the ability of other patients to get funding in the future and on the reputation of the surgeon, and the clinic more generally. For example, a female patient attending her final appointment instructed the dietician to “tell him [the surgeon] I’m sorry I’m not going to be among the best statistics”. Most seriously, the moral weight of surgery could also prevent patients from seeking help when they most needed it. Mary, for example, had struggled desperately with her gastric band, frequently regurgitating the more nutritious foods suggested by the dietician, and falling back on easy-to-digest, processed or sweet foods, leading to weight regain. In an interview with her, she wept quietly as she talked about the difficult situation she had found herself in, and her regrets that she had ever had the surgery done. I asked her if she had ever requested to

have the band removed, and shaking her head, she replied: “I’d be embarrassed to [have it out] because I had it done on the NHS and I’m thinking “all that money”. You know – “It could have been spent on...” and here’s me saying...[...] It is more the financial aspect that embarrasses me because it was public money.” Mary was an exception among the patients that I met in terms of her expressed desire to have the band removed. But what her case demonstrates clearly is the extent to which obesity surgery is not straightforwardly an intervention to address “excess weight”, but can also be experienced (and seen) as a form of excess consumption in its own right. Obesity (and its surgical management), therefore, can be enacted as either deserving or undeserving of public resources – moral judgements that are distinct from, but inextricably bound up with, clinical determinations of “need”, and which fall primarily to the patients to negotiate both within and outside of the clinic.

In the case of the consumption of public resources, the moral weight of surgery is most evident in those cases where surgery has had very limited success in producing sustained weight loss, since it is this scenario that most exposes patients to the accusation that they have “wasted” public money. However, even where significant weight loss occurs, patients still find themselves subject to accusations that they had “cheated” because their weight loss had occurred outside of the morally privileged weight loss strategies of diet and exercise (Throsby, 2008, Throsby, 2009). An obesity that is defined by morally problematic “excess consumption”, therefore, can endure even where a patient is no longer clinically obese post-surgery. And furthermore, surgery can be seen to *intensify* enactments of obesity as defined by “excess consumption”, rather than relieving patients of that sense of moral responsibility and failure – an unintended effect of surgery that only becomes apparent when, as Mol suggests, we ask of an intervention not “is it effective?”, but rather, “what effect does it have?”. Following this question, the final section of this paper focuses on another effect of “successful” obesity surgery, but this time, one that is not simply intensified by surgery, but which is the direct product of it: “excess skin”.

Excess skin

One of the common consequences of rapid and significant weight loss, especially in those who are older and therefore, whose skin has less elasticity, is “excess”, or “loose” skin. This was a major concern for the patients, and it was frequently raised in consultations with both the surgeon and the dietician in the hope that successful post-surgical weight loss would lead to a referral for skin removal surgery. However, reflecting the rationale behind the inclusion of obesity surgery within NHS anti-obesity policy, as well as the obesity being enacted in the clinic, the clinicians drew a clear distinction between health and aesthetic concerns. For example, following a consultation where a patient had asked about the possibility of surgery to remove the large apron of skin hanging down towards her thighs, the surgeon explained to me afterwards that: “It’s not a medical problem having skin. She could get a corset to hold it back in.” And when a prospective female patient’s teenage daughter asked him about the loose skin, he responded emphatically: “That’s a cosmetic issue. Fat can kill you; no-one dies from loose skin.”

However, for many of the patients, the issue of loose skin was inseparable from the experience of surgery. In a social and cultural context which prizes taut, smooth, muscular bodies (Bordo 1993; Balsamo 1999), the presence of wrinkled, soft, highly

mobile skin hanging from the body is strongly counter-normative, drawing stares and negative comments from others, as well as causing physical discomfort. Furthermore, the skin is evidence of former fatness, meaning that “excess weight” – and the moral failure that it stereotypically signifies – can never be fully eliminated, remaining literally written on the body. When the patients talked about it in the clinic, they would grab handfuls of skin around their abdomen and shake it up and down, or extend their arms outwards to expose the loose skin under their arms, making it swing back and forth exaggeratedly to illustrate their point. For many, the loose skin was experienced as *more* problematic than the fatness they had undergone surgery for, but they lacked the financial resources to undergo the surgery privately, and most GPs would not consider an NHS referral until the patients had reached a BMI of 30 kg/m². Julie, a woman in her 50’s, argued emphatically in a follow-up consultation with the dietician that “the excess skin is worse than the flab; I wouldn’t have had this [the gastric band] done if I couldn’t have that [the skin removal] done”. She went on to explain that she’d had the operation to “get slim”, and that she wouldn’t be thin without the skin removal surgery. Ironically, given the purpose of the clinic, the excess skin began acting as a *disincentive* to lose weight; Susan, for example, told the dietician that she didn’t want to lose any more weight beyond the four stones she had already lost because of the risk of exacerbating the skin problem further. She had also taken up swimming after her surgery in order to improve her fitness and flexibility, but no longer felt able to go because she was unable to find a costume that would contain her loose skin, exposing her to humiliating negative comments from children at the pool. I also heard anecdotal examples of post-surgical patients deliberately infecting the skin between the folds in order to improve their chances of qualifying for skin removal surgery within the NHS, as well as meeting several patients in the course of the research who, having fallen short of the BMI qualification threshold for cosmetic surgery, were turning to unsustainable and potentially health-damaging crash dieting practices in order to qualify for surgery within the NHS.

These can be understood as further examples of the unintended outcomes – the irrationalities - of the weight loss industry that Monaghan highlights (2007). These irrationalities, I want to contend, reflect the multiplicity of obesities that are enacted within an array of clinical settings, and outside the medical domain – a multiplicity that is obscured by the singular framing that dominates anti-obesity rhetoric and practice of a singular, knowable obesity that is harmful to health in predictable ways. For this dominant obesity to be sustained within the obesity surgery clinic, the issue of loose skin literally cannot be incorporated in its practice; to do so would be to disrupt fundamentally the kind of obesity that the clinic enacts, the practices that it invokes, and the indicators by which its success is measured. This is not to argue that obesity surgery is a primarily aesthetic intervention for the patients, and nor is it to argue that NHS obesity surgery clinics should provide cosmetic surgery services. But rather, this illustrates that in choosing to undergo obesity surgery, patients are hoping to resolve an interconnected constellation of problems, some of which may be successfully addressed, and some of which are unchanged or exacerbated by surgery. This constellation of concerns can include the amelioration or resolution of particular health problems conventionally understood as weight-related, but is not confined to it. It is in this sense that obesity surgery can be understood as what Cassandra White describes as an “uncertain cure” (White 2009).

Writing in the context of the treatment of leprosy in Brazil, White argues that even though multi-drug therapy will effectively kill the bacilli that cause leprosy, even after patients are pronounced “cured”, they continue to suffer from nerve damage and deformities caused by the disease, and from painful leprosy reactions – an immune response to dead leprosy bacilli in the body. Consequently, patients may still experience themselves sick and in need of treatment long after they have been discharged; furthermore, the physical deformities caused by leprosy continue to prompt responses of fear, rejection and social exclusion from others. A similar argument can be made for obesity surgery, which even at its most successful in its own terms, leaves patients still dealing with the physical effects of surgery. Furthermore, the moral judgements that attach so readily to those undergoing surgery, the physical and socially stigmatising consequences of dramatic weight loss, and in many cases, bodies that are still viewed by others as problematically big, remain unaddressed even by surgical outcomes designated as successful.

Conclusion

In this paper, I have argued that obesity surgery is conceptualised within anti-obesity policy and the public health care system as an expensive, but potentially cost-saving intervention, which will produce sustained weight loss in those experiencing extreme and intractable obesity. This, in turn, is anticipated to ameliorate or resolve a range of chronic (and expensive) health conditions that are considered to be caused by that bodily portion designated as “excess weight”. This rationalised, singular account of surgery contributes to a non-judgemental clinical environment that is welcomed by the patients, as is the possibility of improved health for those suffering from conditions identified as weight-related. However, this construction obscures the fact that for the patients, surgery, and the management of excess, is always about *more than* health, incorporating interconnected moral and aesthetic concerns, as well as other (equally multiple) health conditions, which inevitably impact upon the patients’ experiences, and evaluation, of surgery, as well as the safe long-term management of the gastric band. These concerns reflect the fact that the wider “war on obesity”, within which obesity surgery is embedded and within which the patients experience fatness, is also about *more than* health, and is replete with negative assumptions about the fat body that extend far beyond the presumed risk of certain chronic diseases.

Significantly, in making this argument, I am not suggesting that the clinicians are not performing their job adequately, or that this is simply a question of poor communication between clinicians and patients. Furthermore, I am not making an argument either for or against obesity surgery *per se*. Instead, at a point when the number of surgeries being performed in the UK is increasing exponentially, and obesity surgery is transitioning into a mainstream anti-obesity intervention, this paper aims to bring the *uncertainties* of obesity surgery (and by extension, obesity) into view. By focusing on three differently distributed, but ultimately interconnected, forms of “excess” that emerge through the enactment of “obesities” in this study, following Mol, it is possible to see that an emphasis on “ontological multiplicity [...] lays bear the permanent possibility of alternative configurations”. In a medical, social and cultural context of a “war on obesity” where the singular certainty that “fat kills” prevails with entrenched tenacity, and where medical practice is being rationalised in relation to that singular conviction, the ontological politics of *the body multiple* offers a means not of trying to separate out right from wrong, but rather, identifying what

Mol describes as “different ways of grading the good” (p. 182). As Mol argues, medical care is unlikely to be improved by the flattening out of complexity through rationalisation as opposed to opening up the professional domain to that complexity (p.183). This, I want to argue, provides a means of better understanding the multiple moments of divergence (and convergence) between the goals, convictions and everyday practices of clinicians and patients in (and outside of) the obesity surgery clinic; of resisting the over-simplification of what constitutes a “weight problem” in the current anti-obesity context; and of keeping the moral dimensions of the “war on obesity” in sight, especially in the context of those interventions which appear most removed from them by their clean singularity.

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