The Medicalization of Body Size and Women’s Healthcare

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In this article we explore the issue of what it means to be “fat” for women in Western (British/North American) society. Contemporary gendered biomedical discourse currently dominates attitudes toward body shapes and sizes (Bordo, 1995). Further, under the rhetoric of “health,” a large body size has come to be symbolic of self-indulgence and moral failure. In this article we argue this may lead women to question both their sense of self and their rights to adequate health care. Our aims are threefold: first, to challenge rigid hegemonic biomedical perspectives on “fatness” and the oppressive unequal power relations they may create; second, to examine the process by which such perspectives come to be the only legitimate discourse; third, to consider the impact of pathological medicalised definitions of “obesity” on women’s perceptions of their bodies and experiences of health services.

In the United Kingdom there has been an increase in the amount of attention directed at “fatness.” This has been partly fuelled by the claims of scientific medical research, medical health practitioners and the World Health Organization (WHO), which has promoted the notion of “obesity as a global epidemic” (WHO, 1998). The idea that body weight and quality of health are linked has been further amplified by media reports that have associated obesity with a variety of both immediate and long-term effects on health. “Fat camps” target young people, offering “cures” for obesity (The Guardian, 1999), and medical doctors and practitioners link body fat to health risk (see, for example, Wilding, 1997; Ferriman, 1999). Indeed, in this article we argue discourse on body weight and size that is grounded in medical scientific knowledge is often used to legitimate the setting up of a wide range of
policies and practices within health care settings in the United Kingdom. This type of approach tends to diagnose fatness as a “pandemic” disease, labels it as “obesity,” and argues that it currently “pervades the whole world” (James, 2002). We are surrounded by medical information about diet, ideal body weight, and size and the negative consequences of becoming “fat.” The British Government has responded to this debate by highlighting “obesity” as a key issue and including it as a subject of public health policy (see Department of Health, 2004a). In a press release, Health Secretary John Reid states:

We recognise that these issues are not just a matter for Government–they involve individuals and the choices they make, as well as the food and leisure industry (Department of Health, 2004a).

Government and Department of Health policy interventions include the setting up of specialized morbid obesity services in local hospitals and a national partnership for obesity (Department of Health, 2002). This has led to an increase in the provision of obesity drugs and obesity and nutrition public health services. Government spending on the “obesity epidemic” continues to rise as new policies are put in place with an extra $3 million of Government funding received by the National Health Service (Department of Health, 2004a).

Yet despite this extra funding and policy there is no simple correlation between ill health and body weight (Bender, Trautner, Spraul, & Berger, 1998). In fact growing research evidence suggests body weight needs to be extremely high to increase morbidity risk (Ernsberger & Koletsky, 1999). Accordingly, in this article we examine biomedical discourse on fatness and consider the current obsession with body weight and size. We explore the pervasive, often invasive, effects of dominant gendered biomedical discourse on fatness in relation to women’s experience of and access to health care. We take the view that a large body size is only problematic when it is deemed to be by the person who inhabits that body, rather than on the basis of ever-changing unstable medical advice (Sobal, 1999). Accordingly, we define “fatness” as a bodily variation rather than an abnormality (Cooper, 1998).

Feminist writers have consistently questioned medical scientific knowledge; particularly, they argue regarding the pervasive patriarchal power relations embedded within it (Haraway, 1991; Harding, 1986; Lorber, 1998). This examination has focused on the production of biomedical scientific knowledge, the medicalization of women’s bodies, and the development of medicine as a male-dominated profession (Riessman, 1998). Additionally, it has been argued biomedical discourse constructs fatness as a female problem, that is, “fat is female” (Wolf, 1991, p. 192). This means that health propaganda on body weight and size is noticeably gendered, targeting
women and men differently (Bordo, 1995; Hesse-Biber, 1997; Witz, 2000). Hence, the biomedical and social regulatory discourses and practices that have traditionally focused on controlling women’s bodies are now also increasingly aimed at men (Monaghan, 2005).

This power to regulate bodies is linked to the legitimization of biomedical knowledge and the socioeconomic and political issues that influence it (Fleck, 1979; Foucault, 1973; Lyotard, 1984; Segal, 2003). Clinical knowledge and practice may act as regulatory mechanisms used to discipline bodies according to the provisional claims of scientific medical research (Fleck, 1979). In this process fatness is pathologized and comes to symbolize self-indulgence or moral failure. The use of biomedical categories, such as “clinical obesity” and “morbid obesity,” confer negative health connotations thereby endorsing the construction of fatness as disease (Lupton, 1996).

When medical scientific knowledge is used to legitimate practices within health care settings, the existing patriarchal power structures that can result in dominance of one group over another are often reinforced (LeBlanc, 1997). As will be seen in our article, this dominance can then be subliminally transmitted to women, resulting in unequal power relationships and oppressive practices. An example of this is current discourse in the United Kingdom around childbirth. The relationship between the midwife and the woman increasingly refers to a “partnership” with childbearing women (Fleming, 1998, 2000); however, partnership implies a less paternalistic approach and a sharing of knowledge and power (Gallant, Beaulieu & Carnevale, 2002). However, the traditional relationship of dominant expert midwife and passive client still persists in some areas of midwifery in the United Kingdom, and this can lead to “an uninformed and hierarchical model in an attempt to promote health” (LeBlanc, 1997:258). A consequence of this is that “fat” women then become marginalized within a dominant culture of oppression that labels “fatness” as anti-social.

This article is organized into three main sections. The first examines Western biomedical and social constructions of fatness and the underlying knowledge and concepts used to medicalize body fat as a disease. The second considers the impact of the pathologization of fatness on women’s experiences of health care in the United Kingdom. Finally, the third section concludes by arguing for an increased awareness of the impact of current biomedical discourse on women’s perceptions of their bodies and the health care they receive.

WESTERN BIOMEDICAL AND SOCIAL CONSTRUCTIONS OF “FATNESS”

In this section we consider how fatness is constructed within biomedical and social discourse. It is organized around three main themes. The first of
these examines the knowledge that underpins understandings and measures of fatness. The second focuses on the processes by which this knowledge gains credibility and comes to be legitimized. The third discusses the pathologization of fatness and its impact upon women’s perceptions of their bodies and experiences of health care.

The health risks associated with fatness are often communicated as scientifically based fact. A plethora of information exists on how to measure fatness using body mass index (BMI), which foods are “healthy,” and the consequences of disregarding the scientific evidence on which such advice is taken to be based. The outcome of this is that fatness is constructed as a disease to be suitably diagnosed and “cured.” However, such a position is often specific to Western culture and geography. Cross-culturally, a fat body size has been associated with a variety of meanings such as beauty, good health, wealth, and high social status (Sobal, 1999; Sobal and Stunkard, 1989). Yet these different perspectives have not influenced Western biomedical discourse, which continues to link thinness to health and fatness to illness.

Health promotion discourse on what constitutes a healthy diet has been linked to the development of food faddism and eating disorders in the United Kingdom (Burns & Gavey, 2004). In the British newspaper The Guardian (October 10, 2006), an article entitled “When Healthy Eating Turns Into a Disease” reports on the experiences of a woman who weighs five stone and insists that her disorder was never about the desire to be thin. Rather, she suggests her food obsessions have been dictated by the pursuit of health, “an ache to fill her body only with foods that are good and nutritious and ‘pure’.” This highlights the way that current public health strategies and public condemnation of ‘unhealthy’ eating and body fat may initiate feelings of guilt that can lead to disordered eating patterns (Bordo, 1995; Burns & Gavey, 2004; Lupton, 1996; Monaghan, 2005). Existing social values about food and body size are then shaped by these biomedical messages, and fatness is taken to signify laziness, irresponsibility, weakness and a general lack of fitness (Bordo, 1993; Burns & Gavey, 2004). These values and beliefs have the potential to generate prejudice within society as a whole and more specifically within clinical, social and health care practices (Sobal, 1999).

WHAT IS FATNESS?

The question of what constitutes “fatness” and its impact on health is highly contentious and certainly not as precise and certain as it is currently presented. BMI, a height to weight ratio, is often used to measure the medically defined condition of “obesity.” In this, a healthy body weight is based on a measure of body fat that falls within a numerical range of 18.5–25. However, this measure has been criticized by both social and medical scientists alike. It is not consistently applied because there is disagreement
amongst medical practitioners as to what optimum body weight actually is. For instance, scientific and medical attempts to establish a BMI for children have been particularly problematic (Mulligan & Voss, 1999). This has resulted in disagreement on whether “obesity” should instead be measured by waist circumference (Lean, Han, & Morrison, 1995). All of this suggests BMI as a measure of fatness is at best a blunt instrument and at worst a tool that might create moral panic, thereby reinforcing the notion of fatness as a disease requiring medical intervention. Despite this, there is widespread use of the BMI-based clinical definition of fatness as “disease,” within health care and other settings (Cooper, 1998).

This raises questions about why such disputable unstable knowledge is judged to be credible and legitimate by some academics, health care workers and members of the general public. A Foucauldian understanding of power discourse goes some way to explaining this. From this perspective, scientific discourse is part of a grid of disciplinary coercions that regulate women’s bodies through the jurisprudence of clinical knowledge (Foucault, 1980). In her paper on the medicalization of fitness, Wheatley (2005) draws on a Foucauldian perspective to argue “at risk” health behaviors, such as eating particular foods and body weight and size, are part of a wider form of surveillance and social control. Here, the normalizing gaze of clinical science serves as a disciplinary technique of power that controls individuals making it possible to “differentiate(s) and judge(s) them” (Foucault, 1977, p. 184). This clinical gaze produces bodies as “both subjects and objects of medical knowledge” (Wheatley, 2005, p. 203), and links health risk to body fat. This means that the clinical gaze is a technique of power, producing a hierarchy of healthy bodies, with those deemed “fat” placed at the bottom.

The stereotypical, sometimes prejudicial, approach of some health care workers toward those they define as fat is often evident in the rationalized sanitized care they give. This is noted by Carryer (2001) in her research examining the experience of “large-bodied women.” She points out that nursing, as a medical profession, is often uncritical of the medicalization of body weight and size with fatness often stereotyped and stigmatised as “willful and distasteful”:

Nurses have accepted the premise that a bodily state of largeness is a disease and a disease with such unacceptable consequences that weight must at all costs be reduced (p. 94).

Carryer (2001) goes on to argue for a reconceptualization of obesity that moves “beyond the simplistic medical behaviour of labelling body size” (p. 95).

The extent to which discourse on fatness as disease informs healthcare practice is apparent in the clinical regulation of bodies through prescriptive rules about diet and exercise, as Turner (1996) notes:
The government of the body is couched in a series of instructions and commandments, namely the dietary table, the manual of exercise and the food chart. Dietary compendia thus represent an interesting illustration of discourse on the body and the rationalization of behaviour (p. 160).

Prevailing attitudes toward fat are one manifestation of the climate of moral responsibility that has arisen from the invasion of rationalized biomedical discourse into the rights of individuals. Fat is literally “matter out of place”; it is stigmatized as an unclean, toxic, and dangerous feature of a “healthy” society (Douglas, 1970, p. 41). Labeling fat as dangerous may enforce conformity to biomedical and social governance because it generates a fear of stigmatization and rejection. This is evident in the recent moralistic debates, transmitted via the media, that have questioned the entitlement of those who do not closely adhere to medical advice to a range of medical and surgical procedures. In her research, on the reporting of food risks in three Australian newspapers, Lupton (2004) found almost half of the news stories focused on the perceived link between diet and “obesity” and individual responsibility for this:

In articles on overweight and obesity among Australians, therefore, the emphasis was almost entirely upon personal responsibility for these problems. Those who allowed themselves to become fat did so because they were unable to control their gluttonous appetite for unhealthy foods (…) The overweight body was portrayed, both in words and images, as disgusting and un Australian (p. 193).

Individuals who dispute the right of medical science to dictate their lives and pass judgment risk being labeled unworthy of health care. Fat bodies are constructed as out of control and because of this they are deemed to be a danger to society. Such messages appear to provoke moral panic and reinforce the idea that what is required is further medical scrutiny of bodies in order to control the “fat epidemic” by a variety of means such as medication, diet, counseling, or surgery (Douglas, 1970). A new army of medical “experts” specializing in “obesity” argue obesity surgery is an “unmet need” that should be available in “all large hospitals” (Baxter, 2000, p. 524). The argument here is that those defined as “medically obese” are discriminated against when surgery to decrease their stomach size is not offered as an option. Such approaches fail to acknowledge the psychological and social problems associated with this type of surgical intervention. Further, Baxter (2000) does not attempt to reflect on the knowledge/evidence base and the political and socioeconomic factors that underpin this perspective. This lack of critical engagement occurs because of the underlying assumption that scientific
medical knowledge is always value-free and unaffected by gendered power relations.

In an investigation into the power attached to particular knowledge constructs, Lyotard (1984) examines the politicized process through which knowledge comes to be validated within scientific discourse. He argues that the credibility of scientific knowledge is constructed and sustained via discursive power structures, which he terms “metanarratives of legitimation” (Lyotard, 1984, p. 8). In this, “science seeks its own internal and external legitimation” through the use of “narratives of knowledge” (Lyotard cited in Calhoun, 1992, p. 276). Ultimately this can mean that medical scientific knowledge, through the generation and testing of hypotheses and the practice of experimentation, validates and regulates itself. Each medical diagnosis is seen to build on previous claims and assumptions about theory and practice, with “treatment” assigned accordingly. Yet medical practitioners often ignore the precarious nature of scientific ontological and epistemological principles that form the basic foundations of biomedical knowledge. For instance, little attempt is made to consider how science is culturally embedded and “cannot be accepted as the detached mirror of reality” that it is often claimed to be (Segal, 2003, p. 6). Instead science is often regarded as a source of “pure” knowledge rather than the product of social, political, and cultural factors. This view of science as value-free serves to add credibility and status to medical discourse on fatness. Hence, it comes to be normalized as the only legitimate discourse rather than one of many (Foucault, 1977; Lyotard, 1984).

Ludwik Fleck (1979) has also argued that scientific “facts” are always in a state of emergence and are therefore subject to ongoing reinterpretation. Fleck (1979) concentrates on language and communication to highlight what happens to science when it is disseminated. In his thesis on the genesis and development of a scientific fact he argues scientists are aware that “thinking and facts are changeable” (1979, p. 50) and, as such, “facts are not objectively given but collectively created” (1979, p. 157). In this process a provisional scientific idea is continually transformed and reinforced as it is transmitted between individuals, until it becomes a “self-fulfilling scientific expectation” (1979, p. 33). Fleck argues that journal science invites even novices in the field to arbitrate on the validity of the claims being made. As a consequence of this process, science changes when it moves from the “esoteric” domain of the laboratory into more applied “popular” or “exoteric” settings (1979, p. 111). This means that scientific biomedical knowledge on fatness is always provisional, altering as it moves between individuals and into the public domain. As Fleck notes:

Whether an individual construes it as truth or error, understands it correctly or not, a set of findings meanders through the community, becoming polished, transformed, reinforced or attenuated, while influ-
ence other findings, concept formations, opinions and habits of thought (1979, p. 42).

Thus, it is perhaps inevitable that cultural and political ideologies will permeate medical knowledge and advice so that it becomes laden with moral, political, and cultural values (Haraway, 1991; Harding, 1986; Segal, 2003). Science is part of cultural narrative: “not only does culture include science but, more significantly, science includes culture” (Segal, 2003, p. 1). This suggests both scientific knowledge and research are always culturally laden. As Harding puts it,

(….) Science functions as a “black box”: whatever the moral and political values and interests responsible for selecting problems, theories, methods and interpretations of research, they reappear at the other end of inquiry as the moral and political universe that science projects as natural and thereby helps to legitimate. In this respect, science is no different from the proverbial description of computers: “junk in; junk out” (1986, pp. 250–251).

The “junk” in relation to discourse on fatness includes often unsubstantiated or overstated claims about the damaging effects of body fat on health (Burns & Gavey, 2004). Yet, we have found that something as seemingly obvious as this still remains highly contentious. This has meant that the health risks linked to weight reduction are often ignored, or simply do not enter into the public domain for discussion and debate (see, for example, Berg, 1999; Ernsberger & Koletsky, 1999). Through a variety of processes those knowledge claims about health and fatness that challenge or refute dominant biomedical knowledge are both discredited and subjugated (Foucault, 1980). This is often because they question the credibility of the biomedical monopoly on the so-called pandemic disease of “fatness.” This is particularly evident when considering how biomedical approaches often do not take account of the complex meanings attached to food and body shape. The western medical profession has, for example, tended to overlook feminist social research on the link between cultural ideologies of female beauty, body size, and health (Bordo, 1995).

Biomedicine and medical advice have a long history of making people ill (Foucault, 1973; Illich, 1976). In what remains a powerful critique of medical knowledge and practice, Ivan Illich argues the medical establishment is “a major threat to health” (1976, p. 3). He suggests there are three levels of “sickening medical impact” (1976, p. 9). First, the significant health damage caused by unnecessary medical intervention that is often “well documented and well repressed” (1976, p. 15). This is evident in the selective interpretation of research on “obesity,” which often hides the health risks associated with prescribed treatments. For instance, weight loss and regain
“increases human deaths from heart disease” (Ernsberger and Koletsky, 1999, p. 221). The second level of Illich’s analysis identifies a connection between unnecessary medical intervention and the expanding medicalization of everyday life. This is most clearly apparent in the constant labeling of new categories of disease and patients. Fatness is a good example of this; the “category” is obesity and the “patients” are those with a BMI defined as unacceptably high. The third level identified by Illich (1976) relates to the failure of medicine to acknowledge the effects of culture on health and self-care. He observes:

Wherever in the world a culture is medicalised, the traditional framework (…) is progressively trammeled by a mechanical system, a medical code by which individuals submit to the instructions emanating from hygienic custodians (p. 131).

An uncritical acceptance of the mechanical system of health that labels, diagnoses and prescribes cures for fatness, creates a tendency to submit to the rules and regulations dictated by professionals, the “hygienic custodians” of health. A likely effect of this is that biomedical knowledge comes to be the only discourse on what constitutes fatness and its impact on health. Through processes of professionalization, scientific medical knowledge gains the authority it requires, legislating behavior and pathologizing fatness.

Feminist writers have noted the extent to which western medical health propaganda has consistently targeted women’s bodies and minds (Bordo, 1995; Hesse-Biber, 1997; Wolf, 1991). Historically, women’s bodies have been exposed to a medical/clinical gaze, with medical practitioners sanctioning diet regimes aimed at changing body shape and size (Wolf, 1991). This appears to have fueled the social condemnation of fatness or thinness depending on the particular vogue of female beauty. Women have been advised to “get plump” or “get thin” subject to the hegemonic feminine ideals and medical fads of the time period. What is clear is that this preoccupation with women’s body size has increased rather than abated. The impact of this on women’s perception of their bodies is well documented (see, for example, Bordo, 1995; Burns & Gavey, 2004; Chernin, 1983; Orbach, 1978; Wolf, 1991).

In their article on bulimia and the discourse of weight control, Burns and Gavey (2004) posit a relationship between the construction of fatness as a health problem, the pathologization of the non-slender body and women’s dissatisfaction with their bodies. They argue:

A discourse of healthy weight provides the cultural conditions that support, rationalize, and to some extent normalize, practices that are described as “bulimic” (p. 561).
Consequently, Burns and Gavey (2004) suggest the weight management techniques that permeate biomedical- and health promotion-related discourses, are implicated in the production of unhealthy practices for women. This means that rather than producing healthy bodies and behaviors, they, paradoxically, contribute to the creation of poor health and body image among women.

Susie Orbach has also questioned both medical health propaganda and the portrayed stereotypical role of women in a society that “requires the woman to be a nurturing, caring person who gives emotional sustenance to the people around her” (1978, p. 93). She considers the way in which advertisers portray women’s different, often unattainable, body shapes and sizes in the media. However, with a few rare exceptions (see, for example Carryer, 2001), the relationship between women’s body size, access to health care services, and the care they receive remains hidden. Additionally, the question of how women defined as “fat” develop strategies of resistance to medical perspectives, attitudes, and practices requires further research.

**BODY WEIGHT AND OPPRESSION IN HEALTH CARE SETTINGS**

The attitudes of medical practitioners toward women who are deemed “fat” may be discriminatory and tinged with prejudice (Vireday, 2002). This is evident in the following example of a clinical encounter where Dunea (1995), a medical consultant, describes his treatment of a “heavy set woman” for rheumatoid arthritis with a drug called penicillamine, which causes her to lose her sense of taste:

(...) As her food now had no taste she experienced dramatic weight loss.
(...) Then her husband insisted that she stop taking the drug, because it was depriving him of his only pleasure left in life, eating out (p. 1075).

The consequences of the woman’s loss of taste due to the prescribed appetite suppressant, in relation to her well being and quality of life, are not regarded as significant issues by Dunea. The relationship between prejudicial attitudes and the type of health care fat women receive is apparent in this example. Any preferences expressed by the woman regarding her body and health appear to be ignored, whereas those of the “expert” male doctor and husband are commended and legitimized. A failure to challenge medical and health care workers makes it possible for medical practitioners to impose treatments that may impact on a woman’s quality of life (Sawicki, 1991).

Evidence of discriminatory medical ideology and practice is apparent in the health care provided for women throughout their lives. For example, although women are expected to gain weight during pregnancy, the actual amount deemed acceptable is medicalized by public health bodies, and
adherence to this checked by doctors and health workers (Williams & Potter, 1999). Women of a particular body shape and size have been advised to terminate their pregnancy because of their size, berated for being fat, and punished through a range of practices (Vireday, 2002; Williams & Potter, 1999).

Current biomedical research has also sought to establish a link between a woman’s body size in pregnancy and the cardiovascular health of her baby in adulthood (see for example, Ramsey et al., 2002). In a recent study by Ramsey et al. (2002), 47 “healthy” women in their third trimester of pregnancy were divided into “thin” and “obese” groups, based on an uncritically applied BMI measure of fatness. The main conclusion was that women medically defined as “obese” should reduce their body weight prior to conception to avoid risk to their child (Ramsey et al. 2002). Closer examination of the “evidence” reveals the scientific knowledge the study is based on is read as fact, and there is no evidence of any attempt to question it. This type of approach accomplishes two things. First, it reproduces the idea that all scientific knowledge is valid and credible and therefore does not need to be questioned (Lyotard, 1984). Second, it means that old science legitimizes “new” science, hence entrenched culturally laden medical knowledge and practice are continually revalidated, and the hierarchical ordering of knowledge is maintained (Lyotard, 1984).

There is a long history of medical control and hierarchy in healthcare, with doctors trying to gain control of women’s bodies in diverse ways. Menopause is a good example of this because it is often constructed as an illness requiring therapeutic intervention, such as hormone replacement therapy, antidepressants and lifestyle changes (Lorber, 1998). Feminist sociological and anthropological researchers have questioned the legitimacy and appropriateness of medical accounts on menopause that construct women’s bodies as deficient (Berger, 1999; Lock, 1998). Lorber (1998) argues that such accounts are often

(...) backed by a powerful medical ideology that translates natural processes into illnesses and routinises hormone replacement therapy (p. 62).

As Greer (1999) argues, women are led to believe that female fertility must be managed and that doctors are needed to manage fertility. As such, female fertility becomes a medical problem and even then,

If her body is thin enough, her breasts are sad. If her breasts are full, her arse is surely too big (Greer, 1999:19).

This is also evident in Western (Euro/American) societies where women are expected to monitor those physical changes to their bodies, such as
menopause, associated with ageing (Wray, 2007). Sontag (1978) refers to this as the “double standard of ageing,” a process that occurs where women, in contrast to men, are more likely to be defined and judged on the basis of their appearance as they age.

Negative fatness messages can often be transmitted to women subliminally through doctors and health practitioners. Vireday (2002) notes that fat women are more likely to receive rude judgmental comments from medical staff and have any health issues blamed on their body size. Women consequently become labeled as “obese” or “morbidly obese” and are portrayed as living in out-of-control bodies (Bordo, 1995; Duncan, 1994) in an egregiously biased way (Vireday, 2002, p. 28). This may in turn influence the types of health care women receive, as Vireday states:

The sad reality is that some of the most biased treatment comes from women with their own body issues, which influence their agenda for others (p. 31).

In today’s society, women’s bodies are often considered to occupy a space outside the “dominant culture’s fantasies concerning normality” (Cooper, 1998, p. 4). Women with a larger body size may be thought to be “physically compromised and socially undesirable” (Carryer, 2001, p. 92) rather than just another bodily variation (Cooper, 1998). Hegemonic biomedical perspectives on fatness may influence health care beliefs, values, and practices, possibly leading to a culture of intolerance toward body shapes and sizes that do not fit the norm. So, in a health-obsessed culture that purports to practice in a woman-centered manner, some health workers view fat women as “a statistic waiting to happen” (Vireday, 2002, p. 31), and may therefore fail to provide them with the individualized health care that is promoted in health policy documents in the United Kingdom (see, for example, Department of Health, 1993, 2004b).

CONCLUDING COMMENTS

Our article has focused on two main areas. The first of these examined the construction of medical discourse on fatness and the link between this and the production of labels and health care service practices that may stigmatize women. The second considered the processes by which these come to be legitimized and serve to influence health care policies and services for women. A central assertion of our paper is that dominant biomedical models have established body size and menopause as diseases, to be treated using a wide range of interventions and with “cure” as the final objective. This is despite the fact that the crude measures used to define obesity are unstable and based on tentative and provisional journal knowledge (Fleck, 1979).
Further, there is often no clear relationship between what is defined as obesity or menopause and many of the illnesses associated with them. We have argued that this is due to the distancing that occurs when scientific knowledge travels away from its sites of production and is transformed, by the media, into popular science. Through this process scientific knowledge is simplified and reconstructed as stable and fixed rather than transitory and preliminary (Fleck, 1979).

In this article we have sought to raise awareness of the problematic nature of the biomedical model and instigate the development of a more critical approach to women’s health care. We have argued that the media, as an ideological apparatus of biomedicine, promulgates gendered moralistic messages that link body size to desirability, capability and personality (Bordo, 1995; Chernin, 1983; Wolf, 1991). The discourse of “feel good/look good” is underpinned by simplified and popularized biomedical knowledge that encourages women to connect health to appearance. In order to understand the persuasive power of such discourses, critical reflection on the construction of scientific biomedical knowledge and its relation to formations of hegemonic power is essential. This means questioning the basic foundations of these knowledge claims and how they come to be invested with power to inform ideology, policy, and practice. Further, we need to consider the interplay between social, political, and cultural ideas and values and the production of scientific medical knowledge of what constitutes obesity and its impact on health.

A more equitable approach to health policy and services is proposed that is not reliant on media interpretations of unstable journal science that create uncertainty and panic about body weight or menopause. In relation to the stigmatization of women’s bodies and their access to good health care, two issues require further investigation. First, there is a need to identify the forms that new biomedical discourses on fatness and menopause take and how they diminish women’s power over their bodies and rights to good health care. Second, there is a requirement to examine the processes by which scientific knowledge becomes popularized and transformed into something “simplified, lucid and apodictic” and how this knowledge then comes to inform public health policy (Fleck, 1979, p. 112).

Women want access to a health care service that is able to address their needs and will not stigmatize and oppress them. A more critical and ethical stance from medical scientists and health practitioners regarding their interpretation of biomedical knowledge and how this then informs policy and practice would help to facilitate this. This should include discussion of why particular areas, such as body weight and menopause, are prioritized by biomedical research and pharmaceutical and government agencies. It should also take account of the impact of political and economic issues and policies on the agendas of scientific inquiry and research. Biomedical and cultural knowledge are simply two sides of the same coin and as such both are
implicated in the pathologization of women’s bodies and the construction of fatness and menopause as problematic. Yet, this important point is often not prioritized by biomedical scientists, government policy makers, and those involved in the provision of health care services. We need to consider how women might be empowered and supported to bring about change to health care. A way forward could be the setting up of women’s groups by healthcare workers in order to provide opportunities for women to consider how current medical practices might change now and in the future.

The evidence we have presented in this article suggests the stigmatization of fatness may lead to mistreatment and inappropriate health care. It has also highlighted the significant physiological and psychological harm that current media hysteria on body weight often generates. Health practitioners often fail to question the frequently patriarchal scientific and biomedical knowledge on which their practices are based. Instead, this knowledge may be used to legitimize potentially oppressive and discriminatory clinical customs and procedures. The pathologization of fatness as a dangerous disease is in itself dangerous, creating a new disease and defining more people as ill (Illich, 1976). Proposed solutions and cures, such as surgery, drugs, and diets are incorporated into the ever-expanding industry of “public health policy.”

It is evident that biomedical and cultural discourse that portrays “obesity” as an illness currently dominates society. As an ideological apparatus the media conveys an edited version of the latest scientific findings and medical advice to often unquestioning audiences (Fleck, 1979). This includes several persuasive warning messages relating to health, aesthetics, the cost of fatness to the U.K. economy, and morality. Although it is difficult to resist and question these often all too selective versions of medical science it is clear that failure to do this often reinforces the negative connotations associated with them. This, in turn, may increase the likelihood of oppressive discriminatory practice within health care settings. As such, further ethnographic research is required in order to understand health workers’ interpretations of biomedical knowledge, and how this informs the health care women receive.

REFERENCES


