Swedish Obesity Specialists:
Obesity and its Treatment at a Specialist Clinic in Stockholm

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Abstract
Swedish Obesity Specialists examines how obesity is conceptualized as a medical condition by the staff working at an obesity clinic in Stockholm Sweden. Through eight weeks of participant observations and eight semi-structured interviews this thesis answers the question of how specialist working in the field of obesity construct obesity as a medical site. The thesis aims at understanding how obesity is becoming an issue for medicine, further how obesity’s entry into medicine creates new understandings of the body and medical treatments. Through the theoretical concepts of global assemblages and bio-power I argue that obesity as a disease is defined through seemingly objective criteria aimed at defining a population of sufferers, simultaneously for obesity to be viewed as disease scientifically valid treatments on an individual level must be put into place. By viewing obesity’s entry into medicine as a process of shared consensus, this thesis examines the relationship between global levels of knowledge production and their application and negotiation at one clinic treating obesity. Here expert knowledge and governance are integrated to create both treatment and an idea of what obesity as a medical condition is. In this thesis I argue that the application of expert knowledge and global criteria leads to unexpected views on what can be conceived as medical treatment. Further the thesis discusses how the body of the patient becomes reinterpreted once obesity becomes a medical condition.

Key words: Obesity, medical expertise, global assemblages, governance, lifestyle alteration
To the Clinic.

Thank you all for allowing me to do fieldwork at the Clinic.
The dedication, respect and passion that you show in your day-to-day care of patients is truly inspiring.
Part 1: Introduction

A Z A N D E believe that some people are witches and can injure them in virtue of an inherent quality. A witch performs no rite, utters no spell, and possesses no medicine. An act of witchcraft is a psychic act. They believe also that sorcerers may do them ill by performing magic rites with bad medicines. Azande distinguish clearly between witches and sorcerers. Against both they employ diviners, oracles and medicines. The relation between these beliefs and rites are the subject of this book (E.E Evans Prichard 1976 [1937]: 1).

I have not travelled to a far-away country studying things so widely separated from my own life that I have to refer to my society to be able to understand. I have conducted fieldwork at a medical facility that from time to time conceptualises the world differently from my own concept. That from time to time seems to speak a different language from that which I speak. In the end, both *Witchcraft, Oracles, and Magic Among the Azande* and this thesis, are about belief systems and understanding how these beliefs are put into practice.

Since the beginning of December 2008 I have been studying obesity and its medical treatment at a specialist clinic located in Stockholm, Sweden. I entered my field with a specific entry point in mind. I was interested in how obesity, a condition that has previously been associated with luxury, the upper classes, excess, and later aesthetic undesire-ability (especially regarding women and body size), is now becoming medical (see Ulijaszek & Lofink 2006: 338, Orbach 2006 [1978], Bordo 2004[1993]). Specifically I wished to investigate how obesity is being made into a medical condition. I wished to study an area in medicine that is under change, perhaps even conception.

Being a novice at medicine and medical treatments for obesity I was struck by all the criteria, diagnoses, and scientific research used on a day-to-day basis at the Clinic. I quickly came to realize that these elements are central in defining obesity as a medical condition, but also that some of them are developed on global levels. Thus, I investigate not only obesity as a medical condition at a specific clinic, but also how this clinic applies itself to a higher level of knowledge production that is making obesity into a medical phenomenon.

In anthropology, studies of globalisation and global phenomena have become increasingly important (See Ong & Collier 2005, Helman 2006[1984]). Studies of global phenomena require new entry points and perspectives. Sociologist Saskia Sassen argues that studies of globalization have often focused on the obviously global, not taking into account that the phenomenon that we generally term as globalization is largely taking place inside nation-states and institutions (2006: 1ff). Global strategies and agendas thus become incorporated in institutions and nation-states leading to altered definitions of that which has previously been considered purely national. Public health is thus no longer defined only on national levels. The World Health Organization and other global organizations may be understood as central in
creating obesity as global site, but there are more abstract levels to this globality, such as definitions, criteria, technology, and knowledge production. In this thesis these intertwine with specifically national and local agendas that govern obesity as a medical site.

Obesity, in itself, is a global phenomenon but the text that follows focuses on the specific aspects of obesity that possess global qualities. Central is the knowledge used, developed, and negotiated at the medical clinic. Taking an in-depth look at how obesity is understood and conceived as a medical phenomenon by specialists working in the field of obesity this text discusses how the entry of obesity into medicine creates new interpretations of the body, of disease and medical treatment.

Aims and Research Questions
My aim is to approach an understanding of how obesity is being created as an issue in medicine. Focusing on expert knowledge systems and the negotiation of validity and treatment, this thesis aims at saying something about how medical knowledge is used, interpreted, and negotiated by a group of medical specialists treating obesity.

My research question is: How do specialists working in the field of obesity construct obesity as a medical site? On a broader level, what does the process of making obesity into a disease look like, through the eyes of one specialist clinic in Stockholm? Furthermore how do diseases such as obesity affect our notions of illness, health and our understanding of the body clinical? Quite literally this thesis will examine the creation of a disease.

Obesity as a topic of anthropological study involves several central themes. In the anthology *Fat: The Anthropology of an Obsession*, anthropologists Don Kulick and Anne Meneley argue that fat is a topic that has many different meanings. Fat has many different dimensions apart from dieting or weight loss; fat can be language, substance, aesthetic, or food (2005: 4). This thesis focuses on one interpretation of obesity’s meaning — the medical aspect. Obesity can be said to be a disease in the making, and specialist clinics such as the one at which I have conducted fieldwork, are pioneers in using medical treatments for obesity and attempting to alter the overweight body. Obesity’s entry into the medical realm involves new interpretations of the individual, new interpretations of embodiment, technology, nature and medicine. I conceptualize the medicalization of obesity as an issue that suggests notions of the “new”, or emergent. Paul Rabinow defines the emergent as phenomena “that can only be partially explained or comprehended by previous modes of analysis or existing practices (Rabinow 2008: 4).” The “partially explainable” in obesity is a matter of problematization in which a phenomenon enters into the play of true or false (Rabinow 2005:43). Rabinow explains problematization as a
consequence of when something has brought about a change in the conceptualization of a phenomenon. Obesity entry into medicine is one such issue.

The re-orientation of obesity or the altered (or additional) meaning of obesity, from an individual aesthetic way of looking to a medical condition requiring medical intervention is the starting point for my understanding of obesity. This reorientation, as I term it, brings into question notions of the individual in relation to population, the cultural in relation to the biological, and new understandings of embodiment linked to disease.

This thesis is about medical expertise from an anthropological perspective, it may be important to point out that I will not be discussing the truth or validity of the medical expert knowledge. The research question is on the topic of how experts understand obesity as a medical condition. Therefore patients’ narratives and experience of their condition, although interesting, have not been a focus of this thesis. My aims and research questions are thus centred on the expert system in which my informants work. That is to say, one specialist clinic working exclusively with obesity. This means that I have not been studying the patients who receive treatment at the clinic, nor have I wanted to understand how these patients understand themselves as diseased. My focus has only been on the caregivers. This is because of many issues, one being the issue of ethics in regard to studying patients and another being an attempt to limit the amount of material for this thesis.

Disposition

The text is structured in four different parts. The first part, the introductory chapter, is an attempt at placing the reader in the context of my fieldwork. In this section I outline what I have set out to do, how I have done it and what previous research and theoretical starting points are of relevance to the topic. I move on to discuss the medical treatment of obesity in Sweden today.

The second chapter is on the topic of the clinical understanding of obesity. Here I outline what kind of knowledge the Clinic in which I have done fieldwork works with. Every different section in this chapter contains ethnographic material from my field, and also an analysis of how I understand this material. This is placed in the overall theoretical context from which I view obesity – Global Assemblages. This section speaks about the global aspects of obesity, that is to say the knowledge, practice and notions tied to obesity that can be understood as global, mobile, and de-constructible. The different parts of obesity treatment, such as body mass index (BMI)\(^1\) or medications provided for obesity treatment are all in a sense global, they

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\(^1\) The advantages of BMI as a medical instrument are that it allows for weight comparison in people of different height. The problems with BMI is that it does not say anything about the amount of fat in the body of the person in
can be deconstructed, reconstructed, they can change their location, but they are, in the context of this text used and discussed by informants in their own situated contexts.

The third chapter is on the actual treatment of patients provided at the Clinic. In this context I discuss how the Clinic views its patients, the treatment and difficulties that may arise in treating obesity as a medical condition. This section aims at focusing on the assemblages that create obesity as an actual site in which the global aspects of obesity become part of the actual work of the Clinic. This chapter is also, like the previous chapter divided in sections, each section contains an analysis of my ethnographic material.

Finally the fourth chapter is a summary and a further analysis of my ethnographic material. In this section I discuss what obesity and its re-orientation might say about notions of health, illness and disease. This chapter also summarizes the previous two chapters and attempts to say something of the global assemblages of obesity.

Method

Fieldwork at The Clinic

My aim throughout this has been to study “episteme” as Tom Boellstorff might term it (Boellstorff 2008: 66). That is to say, I have set out to study knowledge systems and beliefs rather than capabilities and habits (ibid.) Being in the discipline of anthropology has meant that I have done so through the specific understandings of one specialist clinic. I have therefore strived toward doing ethnography specific to anthropology. Paul Henley defines this as:

A defining principle of anthropology as a form of knowledge about the world is that these connections between culture and society must be examined from the inside, on the basis of an extended first-person immersion in the day-to-day life of the ordinary people whose world it is (Henley 2006:171).

Gaining an understanding of the knowledge that the Clinic works with would have been impossible without participant observation, seeing how my informants spoke, how they understood their work and how they discussed it amongst themselves, with patients, and other professionals:

question or where that person stores there fat. This is a problem since medical research suggests that fat around the abdomen is much more dangerous than fat stored around the buttocks (ibid.) Waist measurements are therefore used when meeting individual patients as well as BMI calculations. A person of normal weight, according to the BMI scale, will have a BMI somewhere in between 18,5 kg/ m² and 25 kg/m². 25-30 kg/m² indicates overweight, 30-35/m² obese class one, 35-40 kg/m² obese class two, > 40 kilogram’s/ per square meter, class three obesity. Medical treatment in Sweden is offered patients who have a BMI over 40, but also to patients ranging from a BMI of 35 kg/m² or higher if they suffer from weight induced diseases (SBU 2002: 8).
Can you imagine a time when BMI is not an accurate measure of your body weight? Yvonne asked.
- When you’re pregnant, one patient replied.
- That’s right, said Yvonne, I’ve never thought of that. I usually use the example of young muscular men. BMI cannot tell the difference between muscles and fat so a body-builder would appear overweight on the BMI scale although they don’t have an ounce of fat on their bodies.

This discussion was held at the first lecture for new patients at The Clinic. Yvonne the chief physician, spoke about obesity as a medical condition. Yvonne had told me this at our first meeting. Saying that the diagnosis of obesity was based on the BMI of the individual in question; it said nothing about the reasons for obesity. Patients referred to the Clinic are all diagnosed as obese before their arrive. As a specialist treatment facility, The Clinic abides by the criteria that is a requirement for them to provide specialist care. These criteria include that patients must have tried other methods for weight loss which have been unsuccessful; they must have a body mass index of more than 40 kg/m² unless they have developed problems that can be related to their obesity, in which case the minimum BMI criteria is 35 kg/m².

When patients are called to the Clinic they are to attend an information meeting where they are introduced to how the Clinic works, how the treatment is structured, and what they can expect from it2. At the meeting patients are asked if they feel that they are in the wrong place. Generally this question is asked to find out if the patients feel that they are candidates for surgery rather than the non-surgical treatment that the Clinic provides. The patients leave the Clinic with a form, which they are to fill out and then book a second consultation to be weighed and measured. At this meeting they will receive a “food diary” where they are to record everything they have eaten for four days. Each item of food is to be written down separately and the amount of that food is also to be noted. This diary is then taken to the doctor’s consultation at which the patient can describe their overall health, their weight throughout their lives, medications and other treatments that they may have. At this meeting the doctor, either Yvonne or one of the other two doctors at the Clinic, will examine both their previous medical history and their food journals.

The patient is given a schedule that contains different dates and times for the lecture series, that all patients have to attend, before it is time to meet the doctor again. There were five lectures ranging from food and calorie information to exercise and health. It generally takes a patient about a month to complete all of these lectures. Thus the patients are given an

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2 The conservative government in Sweden had come to change the way in which specialist treatment is offered to patients. The new guarantee called “vårdgarantin” means that all patients referred to specialist treatment are to gain access to this treatment within three months (URL 1). This means that all patients referred to the Clinic are to begin treatment within this time. Lectures are a way of tackling the problems of many patients needing care where access to this care is limited.
opportunity to learn more about the theory behind weight loss as well as giving the caregivers time until each patient can start to receive individual care.

After this brief discussion of the structure of the Clinic I shall describe the issues of gaining access to my field, and later my fieldwork in more detail.

**Studying Up**

Medicine is a difficult area to gain access to, made no easier when one is a student of anthropology. Hammersley and Atkinson (2007) describe how problematic it can be to gain access to medical facilities. The authors discuss the power held by gatekeepers and the importance of personal contacts when attempting to gain access into such fields (ibid: 48f). Gaining access took a lot of work and the utilisation of all the contacts that I had in the medical realm. This I think can be viewed as an issue of studying up³, that is to say studying people or groups possessing more power than I do. Practically gaining access to my field took about two months. Getting refusal emails from several hospitals and research facilities, I came into contact with the Clinic in question after a couple of weeks, this was due to a telephone conversation with my father, an endocrinologist working mainly with diabetes. My father, it proved had worked with some obesity research and therefore knew of some places I might contact. He mentioned the Clinic, saying that he had met Yvonne, the head doctor, twice. He telephoned her to explain my research, and told me that she would like to receive an e-mail explaining what I wanted to do. Yvonne promptly called me after receiving the e-mail and asked me in what way the Clinic would benefit from my work. We discussed the possibilities of publishing results in medical journals and she agreed to discuss my presence with her staff. I contacted her again several times to see if she had had an opportunity of speaking with the staff at the Clinic. Eventually she informed me that they would agree to see me if I could send them a project proposal and they found it interesting. I did this, and eventually found my way to a meeting with the Clinic. This proved to be less a meeting than it was an initiation; given a key and an office to work in. I was in.

**Interviews and Participant Observation**

I came into this field in the beginning of December 2008. The Clinic in which I have done fieldwork is a specialist clinic that works with the non-surgical treatment of obesity. Their remit is to treat patients, who are not eligible for surgery, or have chosen to alter their weight by other means than surgery. Thirty percent of the Clinic’s work is directed at developing methods for the treatment of obesity in primary care. The Clinic works mainly by trying to alter lifestyles of the patients that had lead them to the weight they were when they entered the Clinic.

³ Hugh Gusterson defines studying up as adapting “traditional techniques of participant observation to the study of key sites of power in contemporary society” (Gusterson 1998:224).
The Clinic describes itself as working with a holistic view of disease, encompassing a wide array of issues that affect why people become obese.

I spent eight weeks at the Clinic, observing meetings with patients, lectures and meetings with other care facilities, talking to them during their lunch breaks and getting to know their understanding of obesity as a medical issue. For eight weeks I was present everyday in their work. This meant being part of all aspects of care to which I was allowed access. It also involved me engaging in conversations with the staff, eating lunch with them, sharing office space with them, as well as other everyday interactions.

Even the most unusual situations become strangely ordinary after a while. I myself developed a routine at the Clinic. During days when no meetings were held I would come in at nine o’clock. This meant that I had half an hour to write up notes from the previous day before the staff had their mid-morning coffee. At half past nine I would go and sit in the kitchen waiting for the others to finish their work. Coffee breaks often provided me with a lot of material. This could for example be because one of the caregivers wanted to discuss a difficult patient. Other breaks were spent talking about TV programmes and gave very little material. After the break I would go back to my room and write down what was discussed in the break. Later I came to understand that it was better to set up my computer in the kitchen where there was a small table that seated four people. Informants would walk in and out of the kitchen area and talk to me. Sometimes they even had post group meetings in the kitchen that they did not ask me to join if I was sitting in my office.

When sitting in the kitchen they noticed me and invited me to join. Lunch was at noon and staff members would sit in the coffee room for an hour, chatting. This was a good opportunity for asking questions about their work that often lead to discussions between the informants. A lot of the time I was at the mercy of my informants, some days informants would ask me to join in on their work, or in one instance look at an email they had received. Other days I was left to my own devices, spending my time waiting for coffee breaks. The last weeks of my fieldwork were more scattered, I would go with informants to meetings or lectures. A normal day in my field could mean a lot of different things. At team meetings, the Clinic’s personnel would go through their schedule and this enabled me to build a routine around my days there because I could write down which meetings and happenings I would be attending in the coming weeks. Most days I came in at nine o’clock and left around four o’clock, half an hour before the Clinic closed.

Being a student of social anthropology and suddenly finding myself at a specialist clinic was a strange experience. Initially I did not know how the Clinic viewed obesity, what they
thought about treatment or the attitude they had toward their patients. Much of my time was spent asking questions, trying to understand medical terminology and getting to know the caregivers. From time to time I sensed that the caregivers were nervous about what I was after in my study of obesity. Specifically the staff expressed concerns that I might interpret them as harsh or disrespectful toward their patients, four different informants brought this up at different times. This seems not to be unusual in medical anthropology or in the study of medicine in general. Philosopher Annemarie Mol writes, in regard to her fieldwork amongst medical professionals working with atherosclerosis, that some doctors were uneasy about how she interpreted them in their conduct with patients; if she felt that they were humane, she also phrases succinctly that she was after their standards rather than applying her own (Mol 2002: 2). This is very much true for me as well, although had I wanted to find inhumane treatment of patients I would have found myself disappointed.

After a while, I felt as though I was becoming part of the place itself. Much like when one begins a new job. After some time people have a tendency to become more relaxed, they get to know who you are and, with luck, even start to like you. My fourteen informants became people with whom I spoke everyday, people that I liked and felt at ease with. My initial feelings of being an outsider came to change as time went by and several times I came to realize that I was thinking along the same lines as they when they discussed treatment and obesity in general. This is of course one aspect of “going native” or becoming an insider so often described and problematized in anthropology (see Narayan 1993). Most of my informants were interested in my perspectives and sometimes asked me what I thought of them and their treatment of obesity.

Fourteen employees worked at the clinic, give or take a student or two. During my fieldwork I have considered all of these staff members my informants although about six of them became what one might term key informants with whom I often spoke and with whom I often spent time. In a sense the Clinic itself became the central site in my fieldwork, caregivers worked different days and had different appointments. The Clinic was where I placed my attention, being with those that happened to be there when I was. At some points I also travelled with the Clinic’s staff, going to different hospitals to discuss their cooperation or to hear the caregivers at the Clinic give lectures to other obesity clinics4.

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4 It is important to point out that I have focused on the professional rather than social lives of the staff. My interest has been on how my informants view obesity, how they treat obesity, what they think of obesity, how they feel that others relate to obesity, and so on. Although I have spent most days with them and have heard many conversations between them it has been their conversations in regard to treatment and obesity in general that I have paid attention to.
The Clinic staff includes three doctors, three nurses, two physiotherapists, three dieticians, one therapist, and two receptionists. I conducted six interviews with caregivers at the Clinic. Originally I had planned to do more interviews but since my time was limited I did not have the opportunity of speaking to all of the caregivers. I did, however, do interviews with most of the various professions at the Clinic and therefore feel that I got a reasonable feel for the different aspects of obesity treatment important to the caregivers there. I interviewed two nurses, two physiotherapists, one dietician, and one therapist. I chose not to interview any of the doctors at the Clinic. Originally I intended to interview one of them, but there were some difficulties in booking an appointment for the interview since she worked part time. I decided not to interview the head doctor mainly because I partook in so many activities that she was involved in that I became worried that her information would overshadow all other informants.

I also conducted two interviews with obesity surgeons. They were contacted by the chief physician at the Clinic and were contacts of hers. This was ethnographically important to my fieldwork for, even if the Clinic was my place of fieldwork, obesity surgery is an important element in the treatment of obesity. It would be difficult to say much about obesity and its medical treatment had I not had the narratives of these two surgeons.

The interviews were all semi-structured under different themes. They differed slightly from individual to individual that I interviewed. I had prepared about ten questions on each theme, the interviews consisted of three themes; the first was the personal experience of working at the Clinic and with obesity, the second was general understanding of the treatment of obesity including the status of obesity in medicine, and the third was devoted to the specific work of the caregiver in question. In the last section I made sure that I asked questions relating to things they had said during my observations. This was important to me because I wished them to fully understand that I listened to what they said outside the interview situation. In the interviews that went well, as most did, the caregivers spoke passionately about their jobs, in these circumstances I asked follow-up questions on what they discussed rather than sticking to my written questions.

Helman (2006 [1984]: 457) suggests that medical anthropologists should integrate four different levels of data. These are: “What people say they believe, think or do, What people actually do, what people really think or believe, The context of the above three points (ibid.) Seeing what people actually do becomes central to understanding if there are discrepancies between what people say and what they do. This is where participant observation comes in as a form of data gathering (ibid). During my fieldwork at the Clinic participant observations have been
important. Participant observations have shown how obesity treatment, that the caregivers so often spoke about, was put into practice.

The participant observations I did at the Clinic are difficult to account for, partly because there are so many different types of observations. First, there are the patient consultations. I only ever attended patient consultations with one nurse, one doctor and a therapist. I attended two group consultations in which patients sat together in a group of about ten and discussed what they were going through in terms of weight loss and their home life. In the individual consultations I sat with a nurse at the Clinic. She had worked there since the Clinic opened and was very secure in her position. The doctor with whom I sat was chief physician at the Clinic, also secure in her position. This may be one of the reasons why they permitted me to sit in on their meetings. Another may be that nurses and doctors, in contrast to dieticians, are quite used to “auskultering” which is when doctors or caregivers sit in on meetings for learning purposes. I attended group meetings with patients at which two caregivers lead the discussions on how the treatments are going for the patients involved. I had the opportunity of taking part in the summary of group meetings (rounds) in which the caregivers sat down and went through how each individual patient was progressing.

The caregiver asked all patients if they agreed to my sitting in on the meeting, explaining to them that I was not studying them as patients, only the caregivers. None of the patients refused and mostly pretended that I was not there. Some on the other hand tried to include me in the consultation. After all of these consultations I stayed in the room with the caregiver and asked how they had interpreted the meeting, what questions they wished to focus on in the care of the patients, why some questions they had asked were important and so on. These post-meetings were generally quite rewarding giving me an impression of how the actual work with the patients was structured. As I have mentioned, this thesis does not focus on the patients’ perspective of obesity, it is only in instances when patients have asked questions that have triggered responses from the caregivers that I have included these questions. In a sense, the patients at the Clinic make up a type of discourse. They were spoken about constantly. Different examples from patients are brought up to illustrate points by the caregivers. In these discussions I have chosen to keep these narratives.

Lectures were another important part of my observations. Besides the lectures given to patients at the Clinic that I have already accounted for there were lectures given to other medical professionals on how they could start focusing on obesity in their specific line of health care. I have attended one lecture series given to students working in other medical areas. Another type of lecture was the kind given to patients who were going to undergo surgery. The Clinic’s
personnel attends these lectures at a hospital to explain what these patients’ alternatives are if they decide not to have surgery.

I have been present at meetings with other clinics during my time in the field. Cooperation between different groups working with obesity is central to the Clinic’s way of working and these observations make up an important part of my material. They show how obesity was linked in different medical communities.

**Ethics**

I have abided by the American Anthropological Association’s ethical guidelines throughout my fieldwork. My responsibility has been to those whom I study as the AAA stipulates. This means that protection of these persons’ privacy and right to remain anonymous is central. Informed consent has been maintained throughout the research. Upon gaining access to the Clinic I sent them a project proposal describing what I intended to do in my research. All informants at the Clinic have had the opportunity to read the proposal. Following Hammersley and Atkinson I have done my best to describe the aims of my research, both through my project proposal and through explanations in person (2007: 210). The aim of this thesis has been to contextualise medical knowledge into a cultural context. Therefore I am not interested in communicating information that the professionals do not agree with. Their feedback on my understanding of interviews with them has been important. For this reason I have allowed my informants to remove statements they have made during our interview, if they feel that they are not representative.

Therefore I have transcribed all my interviews with them. The interviews were then handed back and the interviewees were allowed to say if there were any parts they wished to remove. They have also been allowed to add further responses to their interviews if they feel that they have formulated themselves in an unacceptable fashion.

All of my interviews were conducted in Swedish and I have translated them into English for this thesis. At times when I feel as though the English words differ from the Swedish phrasings of my informant’s I have added the Swedish word that they have used in the interview or observation. Translation brings with it new connotations that alter the statements. This has been a problem that I have tried to address by extensively writing what my informants are talking about, what is being discussed in the surrounding context. In short I have tried to provide a narrative of how and when the statements of my informants happened. I only use exact quotes

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5 I have wished my informants to feel that they are represented accurately in the interviews, however they have not taken part in the analysis of my material, nor have they made comments about the analysis.

6 Only one informant chose to remove statements she had made from the interview, other informants sometimes added explanations of their statements to clarify them
when referring to interviews that have been recorded word for word or when I have had the opportunity to write down my informants’ exact phrasings. For this reason the reader may notice that there are places in the text where I recount what has been said rather than including a long quote.

Throughout the text I call my fieldwork site “the Clinic”. This is to assure the anonymity of my informants. My informants have also been given fictitious names. Protection from harm in regard to the Clinic and those working in the Clinic has been taken into account therefore all the names have been changed including the hospitals and clinics that are mentioned in the thesis. I have done everything in my power to make sure that my research will have no consequences on the work of individuals in the Clinic.

Theory

Disease as an anthropological site: Medicalization

In Framing Disease, Charles E. Rosenberg and Janet Golden (1997) point to the manner in which we might interpret disease. Rosenberg and Golden argue that there is always a social element of interpretation to disease. In a sense diseases do not exist until we agree that they do. Disease classifications serve to legitimise and sanction relationships between institutions and individuals (ibid.) This is also my starting point when venturing to study the process of disease-making from an anthropological perspective.

To be able to discuss the process of disease-making one must first describe what the meaning of the term “disease” is. I use Lisbeth Sachs definition that links illness, disease and suffering to each other. Sachs describes illness as the culturally learnt way to communicate a feeling of suffering. Illness becomes the manner in which a person understands and rationalises their feelings of ill health in medical or social terms, which are understood by their surroundings. Thus when a patient visits a doctor they share a narrative of illness with the expert system (Sachs 2002: 97f). Disease, according to Sachs, is defined as a condition that a doctor creates when placing illness in terms of theories and expertise on the condition. She argues that this is part of the outside observation and description related to pathology and biomedical criteria that are interpreted by the doctor from the narrative of the patient (ibid: 89). Sickness on the other hand is the interpretation of illness or disease that the surroundings of the sufferer applied to the sufferer’s condition on the basis of notions of abnormality. This may lead to more suffering since the condition ascribed to the sufferer may be stigmatized (ibid: 99). Obesity can be understood as a combination of all three of the above-mentioned definitions, depending on from which context one chooses to examine it.
Sachs argues that biomedical understanding, institutions and social structure have a way of mirroring ideology. This becomes visible in diagnosis that is based on notions of normality rather than pathology. Biomedical criteria are based on notions of what is normal and this in itself creates abnormality. Abnormalities become medical problems when they become necessary to treat by means of medicine.

Sachs discusses the term medicalization, which she defines as the process of rewriting social problems into medical conditions. This term has according to Sachs become an important part of medical anthropology because it indicates how societal problems are re-interpreted into medical terms (ibid: 26). For Sachs, medicalization implies that a society chooses to act upon problems in a population by treating these problems by means of medical interventions. When studying the power that is held by medicine and medical knowledge this term is useful in the sense that medicalization allows for the analysis of the way in which political and social issues become clean-cut medical ones instead (ibid.) Medicalization is an important term in the context since it captures the very re-orientation from and individual brought-upon-oneself condition to a medical treatment plan, but as will become clear later on, medical intervention and treatment can mean many different things.

The reader will find that explanations of the biological workings of the body are central in conveying knowledge on obesity as a medical condition; therefore I deem these understandings of nature important. On this note Donna Haraway writes about the reinterpretation of humanity and the body in *Similians, Cyborgs and Women* (1991). Haraway discusses how the understanding of the body becomes altered by medical research and knowledge. By analyzing how primatologists have interpreted the relationship between human nature and that of primates Haraway argues that human nature and evolution become reinterpreted and recreated.

When discussing biomedical understandings of the human body Haraway also argues that the body becomes a system that can be read, understood, and interpreted as text and machine, which comes to create a body in its wake. Drawing upon Simone De Beauvoir’s famous quote that women are not born, they are made, she argues that bodies are not born, they are made. Haraway thus links notions of the nature of the human to notions of the culture (ibid: 252)

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7 Robert Connell (1995) also discusses the creation bodies by scientific language but on the topic of gender. Arguing that in the language of natural science the body becomes a natural machine that produces gender, through our genes and our hormones. Connell further argues that the power of biological claims surrounding the body lies in the metaphor of the body as a machine. The body is a site in which scientists find biological mechanisms that create functions. Bodies become objects of discipline since technology has made it possible to control them (ibid: 70ff).
Global Assemblages, Obesity and the Body

Aihwa Ong and Stephen Collier describe the uses of global assemblages:

It does not examine the changes associated with globalization in terms of broad structural transformations or new configurations of society or culture. Rather, it examines a specific range of phenomena that articulate such shifts: technoscience, circuits of licit and illicit exchange, systems of administration or governance, and regimes of ethics or values. These phenomena are distinguished by a particular quality we refer to as global. (Ong & Collier 2005:4)

Obesity is one such area. Obesity has qualities that can be understood as global. But I do not mean to use the concept to describe the global in a territorial sense. Ong and Collier argue that there may be a more principal or symbolic manner of interpreting the global (Ong & Collier 2005: 4). The global can be organized in any social or societal context. It is mobile, and possesses the quality of being able to deconstruct and reconstruct. Obesity is both transnational and has the capacity of placing itself in any territory. The World Health Organization describes obesity as an epidemic, and also declares it global in the sense that most places or countries are affected (URL 2). In this thesis the global is referred to as a concept that is almost ideal typical, it does not become actual until it is placed in a context and aligned with the different parts of the assemblages, as Ong and Collier propose (Ibid: 13). I view the global aspects of obesity as the expert knowledge used by the Clinic. This perspective is important because it captures that knowledge (specifically medical knowledge) is not only defined by nation-states. Knowledge and criteria governing obesity’s medical treatment is global (in a territorial sense) but it becomes negotiated and applied in specific settings bringing forth new configurations and issues in regard to obesity as a medical condition.

Aihwa Ong writes that global assemblages can be used to identify a problem space in which heterogeneous elements come together to form emergent relationships (Ong 2005:259). The global is about elements that can move and mobilize in different spaces. “Particular articulation of divers elements (re)territorialize new material, social, and discursive relationships, investing emergent sites with globality” (ibid.)

Obesity is, much like Ong and Collier argue on the topic of global assemblages in general, a space in which the global becomes territorialized. Obesity as a medical site puts into play a renegotiation. It is a “domain[n] in which the forms and values of individual and collective

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8 To be clear, the global is not an emic term, my informant do not refer to obesity as global in their discussions (in this thesis). I use Global Assemblages as an analytical framework that captures that knowledge and criteria used by the Clinic (and the medical community at large) are not defined by them. They are defined on national and global levels.
existence is problematized or at stake, in the sense that [it is] subject to technological, political, and ethical reflection and intervention” (Ong & Collier 2005:4).

An assemblage can be conceptualized as different phenomena that make the global specific. Or put into place the actual global (ibid: 13). The different phenomena that the assemblages intertwine with the global bring forward an emergent quality to the phenomenon – not necessarily new, but altered from the way they were.

Global implies broadly encompassing, seamless, and mobile; assemblage implies heterogeneous, contingent, unstable, partial, and situated (ibid: 12).

The global has the capacity of altering itself, of introducing itself to new contexts and situations, and to reconstruct itself in them. The assemblages become part of the global when it relocates, imbuing it with other phenomena and in creating an emergent quality to it.

Assemblages become part of the global when they are articulated in specific situations, such as the Clinic in which I have done my fieldwork. The assemblages should be understood as phenomena that make obesity become specific more than an ideal type. Obesity still possesses global qualities no matter where it is situated; these are still adaptable to new areas and spaces. Global Assemblages allow for the study of global phenomena in specific places and contexts without reducing it to the local. Avoiding the dichotomy between the global and the local is one of the strengths of global assemblages as a concept.

I am studying professionals that work with obesity. It is important to point out that the professionals that work at the Clinic are not defining obesity as such, these definitions come from state interventions, medical research and so on. Therefore my informants are applying themselves and their work to larger contexts that define obesity as a medical phenomenon. Global assemblages allows for the study of the emergent qualities of obesity and how we are to interpret them. My research question and outlining problem in the study of obesity is also outlined in the concept of the global assemblage. The emergent in obesity is the renegotiation of obesity from an individual condition to a medical site. Obesity as a medical site puts into play a new understanding of the individual in relation to collective and health in relation to disease.

I use the term problematization to capture what I mean by the -reorientation of obesity. According to Rabinow, problematization can be understood as “the ensemble of discursive and non-discursive practices that make something enter into the play of true and false and constitute it as an object of thought” (Rabinow 2005: 43). A problem implies that something, a part of a subject or the way in which we view a phenomenon, has become
altered. This alteration puts into play a rethinking of the phenomenon in question (ibid.) This might be explained as “at times inconsistent, branches of knowledge available during a period of time; that claim authority about the truth of the matter; and whose legitimacy to make such claims is accepted as plausible by other such claimants; as well as the power relations within which those claims are produced, established, contested, defeated, affirmed, and disseminated“ (Rabinow 2008: 4).

According to Rabinow problematization is created in the merging of economic, scientific knowledge and political interests (Rabinow 2005: 44). Problematization becomes a way of defining how a situation enters into an emergent relocation. As mentioned above obesity is one such area. Placing obesity in a medical setting brings forth implications in regard to healthcare and scientific knowledge. These strategies create a new way of understanding obesity. I am thus examining one aspect of this problematization: the scientific expert system in which obesity is placed.

Bio-power and Biological Citizenship

‘One calls epidemic diseases all those that attack, at the same time and with unaltered characteristics, a large number of persons’. There is no difference is [sic.] nature or species, therefore, between an individual disease and an epidemic phenomenon (Foucault 1973: 23).

Obesity’s move into the medical realm suggests different ways of handling the phenomenon itself. The context of obesity is thus related to many different areas of governance. The notion of the governance is particularly central in a Swedish context since the medical care in Sweden is governed by the state. Through paying taxes the Swedish population is guaranteed the majority of its medical treatment. It is therefore an institution that encompasses all citizens’ rights to health care.

Michel Foucault uses the term bio-power to highlight the state’s role in protecting life. Foucault argues that the (state’s) power of life evolved into two separate poles during the seventeenth century in which the body was interpreted in different ways. In the first the body was understood in terms of discipline, the function and capacity of the body was integrated “into systems of efficient and economic controls” (Foucault 1984: 260f). The second pole viewed the body in terms of species. That is to say the human body as a species, calculations on its mortality, life and health. These two poles constitute what Foucault understands to be a new conceptualization of life and death “around which the organization of power over life was deployed” (ibid: 262). These calculations of life and its management created an increase in calculations and mappings of the population. Bio-power thus brought with it control technologies over the population (ibid.) the merging of these two poles created means by which
the state could govern the subject on every level of society, from family to administration (1984:263). Foucault argues that the merging of these two poles created (1) an individualising disciplining mechanism on the one hand and (2) a totalising regulating mechanism that directed its efforts toward a population, on the other. Power was maintained through disciplining individual bodies and through regulating the life and health of a population.

Bio-power is tied to governmentality that can be understood as the ways in which a population’s living, health, and happiness are governed by different systems of expertise. Governance incorporates political plans and practices that are handed down as the work for different authorities in administering the lives of citizens. According to Rose and Miller Governance is based on the conceptions of what is good, healthy, normal as well as efficient. In creating these ideas of what indeed is good, normal, efficient knowledge and expertise is central. Modern forms of governance are thus not only about the State’s interaction and control or rule of the people. Rather it involves a multitude of different organizations and institutions (Rose & Miller 1992: 174ff).

Rose and Miller argue that modern forms of governance are linked to the neo-liberal context in which western states create ideas and understandings of the subject that is to be governed. In a neo-liberal form of governance the population should not to be controlled by force. Since the second part of the eighteenth century brought with it a new understanding of the subjects to be governed. “Government was to foster the self-organizing capacities of civil society” (ibid: 179). Responsibility over life and health and living is to be instilled in the citizens. They are to internalize notions of governance in themselves.

“The complex of actors, powers, institutions and bodies of knowledge that comprise expertise have come to play a crucial role in establishing the possibility of and legitimacy of government… By means of expertise, self regulatory techniques can be installed in citizens that will align their personal choices with the ends of government” (Rose & Miller 1992: 188f).

The regulation of health is a central part of governance, it incorporates not only notions of rights of persons requiring help, responsibility of government in providing help but also the citizens and citizenship projects. These relations have been studied by Adriana Petryna in Life Exposed: Biological Citizens After Chernobyl (2002). Petryna shows how the Chernobyl disaster came to change the concepts of citizenship and the Ukrainian state in its aftermath. Specifically Petryna focuses on peoples’ relationships with medical and scientific procedures and bureaucracies created in aftermath of the disaster.
Petryna defines the term “biological citizenship” “as a massive demand for but selective access to a form of social welfare based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it” (ibid: 6). In the Ukrainian context the disease or sickness of radiation poisoning is constantly being re-interpreted by scientists and clinicians (ibid: 215). Petryna also explains how patients internalize medical understandings. Learning how their symptoms can be related to medical experts’ understandings of the effects of radiation on the population.

Nikolas Rose and Carlos Novas (2005:439-464) share a similar view on the concept of biological citizenship although they expand it to incorporate not only those who struggle for compensation for their ailments, but to all projects in which biology becomes a part of one’s identity. They use the term to denote all citizenship projects that relate to the biological elements of its human population. Biological citizenship can thus be a method for claiming stakes and protection from the state in regard to one’s biological disposition on the basis of one’s citizenry rights (Rose & Novas 2005:440ff).

Regimes of the self, notions of being a good citizen, and being responsible become enmeshed with one’s biology. Responsibility also implies taking action for one’s health and biological predispositions. These issues are further complicated by new understandings of the self such as the human genome (ibid: 442).

Rose and Novas relate this to a new form of bio-sociality in which these patient groups are experts on their own conditions. This citizenship project is central to technologies of becoming scientifically literate, understanding one’s own condition and most importantly, the medical expert system is also beginning to see active citizenship as increasingly important (ibid: 448). Engaging with techniques of the self, become increasingly important in becoming well or healthy.

As I shall show later on this type of active biological citizenship is central in, not only the understanding of obesity as a medical phenomena, but also in treatment at the Clinic. Biological citizenship and notions of the self-governing individual are intrinsically linked with a neo-liberal understanding of the individual, governance responsibility for one’s health and the internalizing of medical expert knowledge, as well as how this expert knowledge is created and internalized in the medical community. Throughout this thesis I argue that it is possible to view

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9 In the definition of neoliberal forms of government I follow Aihwa Ong’s discussion of the same. Ong argues that neoliberalism is not so much a philosophical standpoint, rather it can be understood as a “rationalization of government”. Thus government can be understood as following neoliberal logic, in which citizens are governed by self-regulatory techniques (Ong 2005: 257f).
biological citizenship not only from patients perspective, but also from health care. Thus I discuss the concept of biological citizenship as an expectation and desired outcome of treatment.

**History**

**Obesity and its medical treatment in Sweden:**
This section is an attempt to place the reader in the context of my fieldwork: To understand the various discussions and conclusions, which create obesity as a medical domain amongst my informants. Here I am using literature that maps and explains the paradigms that currently govern treatment of obesity, and dictate the work of the Clinic.

Obesity’s relocation into the medical realm involves several important components that create notions of its treatment. Simplified one might say that obesity has become a major issue in Sweden today because of the sheer number of people affected, or afflicted by obesity; another factor is the technological interventions that have altered the treatment of obesity. The title of this thesis is an adaptation of an obesity study conducted at Sahlgrenska Akademin—"Swedish Obese Subjects"**10** (Sjöström & Lissner & Sjöström 1997). Obesity specialists in the medical community in Sweden refer to this study as SOS. The study itself has come to be highly debated in the medical community and amongst my informants.

The question that SOS posed was whether long-term weight loss decreases premature mortality and diseases associated with obesity. SOS showed that the health effects of weight loss in patients who had undergone gastric bypass surgery (GBP), in comparison to patients treated by means of diet, were not only greater, but gastric bypass patients managed to maintain a significant weight loss. SOS has had a profound effect on the way obesity is viewed in the Swedish medical community as will become clear to the reader further on.

For my informants the SOS study created a difficult situation. The notion of surgery being the only treatment for obesity that brings about significant long-term weight loss has resulted in problems. I have heard the Clinic’s own patients asking if it is true that surgery is the only option, and later demanding to know the Clinic’s results. For my informants, particularly the Clinic’s physician director surgery was not the only solution, furthermore the study had, according to her, been done in a fashion that could result in no other outcome. In her opinion SOS compared 2000 people treated with surgery to 2000 people treated with traditional remedies

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**10** The name of this thesis is both a pun that highlights the emergence of obesity in Swedish medicine today (SOS), and an example of the knowledge with which the expert system that I have been studying works. The SOS study created a paradigm shift in relation to how obesity should be treated in the Swedish medical context. This has been of great significance to me in my fieldwork.
for weight loss (1997). This is taken to mean diet, exercise and lifestyle change. But really the only treatment these patients received were checkups in primary care.

Obesity is defined by Stanley J. Ulijaszek and Hayley Lofink, in the article “Obesity in Biocultural Perspective”, as a condition in which body fat has accumulated to such an extent that a person’s health and ability to function are affected (2006:338). Ulijaszek and Lofink provide an understanding of obesity as a bio-cultural disease that stems from both biological predispositions and altered ways of life. The authors focus on the biomedical and genetic elements of obesity and place these in a context of social groups and geographical localities (ibid: 337-360). The social elements of obesity are, according to Ulijaszek and Lofink, changing patterns of diet and physical activity brought on by globalization, technology, social and economic factors changing our eating habits and exercise (ibid). Further they argue that obesity has come to shift from being a phenomenon mainly affecting the upper classes and being a sign of wealth (in ancient Greece and even England in the late eighteenth century) to becoming a disease most prevalent in lower socioeconomic classes today (ibid: 349). The authors also show that different populations are affected in different ways in regard to obesity. The main conclusions the authors make are that obesity is linked not only to genetics but also to changes in lifestyle. I mention the article because it provides a general understanding as to how obesity is understood in a medical context today. Obesity is both about lifestyle, “culture”, and genetic dispositions, according to the medical community. Obesity’s move into the medical realm has not changed it into a solely medical phenomenon diverted from individual responsibility.

In the medical community there are more succinct ways of defining obesity. The medical definition of obesity is based on BMI or Body Mass Index. BMI is calculated by dividing a person’s weight (in kilos) with that person’s height in meters squared. This calculation results in a number that gives that person’s body mass (SBU 2002: 7).

The SBU report *Fetma – Problem och Åtgärder* defines obesity as a risk factor rather than a disease. Not all individuals who are obese are sick or suffer from their obesity. A risk factor does not necessarily mean that an individual is diseased (ibid: 8). This definition is important in the context of studying the process of disease making since the medical community in itself does not know whether obesity should be defined as disease or a risk factor indicating the risks for developing other diseases and thereby shortening the life expectancy of sufferers as will become apparent further on in the text.

The treatment of obesity is centred on two methods, one of which is surgical intervention. There are several different types of operation offered patients’, the most scientifically documented is gastric bypass surgery (GBP) (ibid: 17). This is also the most
common surgical intervention for obesity in Sweden today. In gastric bypass surgery ninety percent of the stomach is removed along with the first part of the small intestine. The surgery works on two levels: restriction and malabsorption, limiting the amount of food a person can eat, and (by shortening the bowel) the body absorbs less nutrients and calories. Another surgical option for patients is gastric banding. A silicone band is attached round the stomach leaving a little pocket. This pocket acts as the actual stomach although the rest of the stomach is still in place. The silicone band creates a small opening from which food slowly passes to the rest of the stomach. This limits the quantity of food that a person can eat and also forces him or her to eat more slowly.

The non-surgical interventions for obesity are: 1 non-pharmacological, using lifestyle changes, such as lower calorie intake, increased exercise and possibly cognitive behavioural therapy. And 2: Pharmacological treatment, two types of medication are used in treatment, the first is orlistat. The drug works by limiting the amount of fat absorbed by the bowel. When eating fatty foods a patient on orlistat will get diarrhoea. This is both a side effect and treatment. The idea being that an upset stomach will teach the patient what foods contain fat. It also works as an incentive not to give in to temptation and risk the unpleasantness of diarrhoea. The second medicine is Sibutramine. Sibutramine is a mild form of antidepressant that decreases a patient’s appetite. Neither of these drugs are viewed as being very affective without other treatment (such as lifestyle alteration). Resulting in a weight loss of approximately five to seven kilos, it seldom brings about a significant weight loss on its own (SBU 2002: 16). Therefore medical treatment is also focused on diet and physical activity. Teaching patients how to eat, what to eat and to be more active. The Clinic works exclusively with this type of non-surgical intervention. Other methods of treating obesity are being developed at the Clinic, such as applying cognitive behavioural therapy (CBT) into the care of patients. After this brief summary of the medical understanding of obesity I shall now move on to the ethnography of obesity.
Part 2: The Global Aspects in Obesity

A few weeks after leaving my field I received an email from Yvonne, the Clinic’s chief physician. She sent me an article from an online journal called *the National*. The article was about the Canadian governments’ ambivalence in defining obesity as a disease.

The Public Health Agency of Canada says there is an ongoing debate as to whether obesity should be classified as a disease, which could in turn open the door for government-funded weight-loss programmes. Yvonne Berg for The National (URL 3).

The article exemplifies that, which has already been stated by the World Health Organization, obesity is a global issue affecting many countries around the world. However, regardless of whether or not obesity as a medical condition is global it requires the participation of the health care systems governed by nation-states themselves. The chapter that follows discusses definitions and criteria that are applied when defining obesity as a medical phenomenon. I understand the issues discussed in this chapter as having a global quality. Criteria, BMI, pharmaceuticals, and treatment are not created by the Clinic. They are not even created in Sweden. These phenomena can be interpreted as mobile objects and knowledge that has the capacity to construct and deconstruct in different settings. The following chapter discusses how these objects are applied and interpreted by Swedish obesity specialists.

Saskia Sassen writes:

> The epochal transformation we call globalization is taking place inside the national to a far larger extent than is usually recognized. It is here that the most complex meanings of the global are being constituted, and the national is also often one of the key enablers and enactors of the emergent global scale. (Sassen 2006: 1).

According to Sassen institutions inside the national are taking part in the processes of globalization to a much greater extent than is generally acknowledged. Sassen terms these processes “denationalization” and it is here that the global can operate (ibid: 2).

Obesity as a medical condition is based on a consensus of treatment; this can be understood as global in a territorial sense. BMI and methods of calculating obesity are general and applied in any territorial context. In Sweden, however, they become negotiated, as is the case even with the status of obesity as a medical condition, the pharmacological treatment of obesity, and in the letters of referral. In this context obesity is discussed in terms of “the objective knowledge” surrounding obesity that is mobile, deconstructable and reconstructable (Ong & Collier 2005). The medications offered patients undergoing treatment for obesity are also global on both a territorial level and on the level of technology. In this chapter they are placed in the context of how my informants think about them, use them, and apply them to specific settings. Since the chapter discusses these issues from a Swedish perspective the chapter it also refers to bio-power; the chapter deals with the governance of a population since criteria and technologies
are directed toward populations and therefore possess a totalizing quality (Foucault 2008: 225-226). Here I discuss obesity treatment directed toward populations rather than the individual disciplining factors in obesity treatment. Thus the issues discussed here have a totalizing nature.

**Body Mass Index: from individual to population**

Most rooms at the Clinic have a BMI scale somewhere in the room, on the desk or perhaps even in the sitting area. BMI is important. It is the patients’ key that gives admittance to the Clinic. When looking at referrals from other clinics or doctors, BMI is brought up. If a doctor has sent a referral without stating the patient’s BMI it is quickly calculated (if the referral provided height and weight). At the Clinic, Yvonne, Clinic’s physician director, is generally reflexive about the use of BMI. According to her it does not represent the truth as such. Rather it is a means of comparison devised for scientific purposes. She told me that she felt that it was an issue of bias to some extent, since there are many people who may be classified as obese but are both happy and healthy, “This is an issue of bias. We don’t see these people here since the people who come here suffer from their obesity”, she told me.

The most important thing in regard to BMI is how often it is used in communication between clinics and medical professionals. When the caregivers at the Clinic spoke with other care-facilities about a patient his or her BMI would be one of the first things brought up. BMI is a structure surrounding specialist care in obesity. This section takes a closer look at the uses and implications of BMI. I am arguing firstly; how medical paradigms are exemplified by means of calculations such as BMI, and on the other hand how these classifications create a diseased group, a population of sufferers, that also justifies the first instance.

BMI is quite simply a person’s weight (in kilos) divided by his or her height squared. This calculation gives a two-figure number that is read off the scale itself, and indicates what that persons’ body mass is in relation to normative “healthy” body mass. The interesting thing is that BMI, is both a definer of a persons weight and a diagnosis. In obesity it is BMI that gives the patient access to medical care.

BMI gives access to care, but as Yvonne said when introducing new patients to the Clinic, “BMI was developed to compare a population in scientific research. It does not say how much of our bodies are composed of fat or muscles, or even where the fat is stored”. So in individual patients the Clinic uses measurements and scales to see if the patient has lost weight. The scale is central in all obesity treatment at the Clinic. Karin, a physiotherapist at the Clinic, said that the scale could be understood as a receipt that told the patient if they are doing the right
thing. BMI is not used too often in the actual treatment of the patients, not once they have been accepted for treatment at the Clinic. It is not used in the treatment of the patients because it takes a large weight loss to achieve a significant reduction in BMI. Charlotte said that she did not like to use BMI in her individual care with patients:

BMI can be quite crushing for a patient. To see that if, [for example] I am to be within the normal range I have to lose 72 kilos for example. I try to put it aside and see every kilo as a step in the right direction…when someone has had a very high BMI and has lost a lot of weight and feel that they have done a great job but it’s quite demoralising to find that they are still obese on the BMI scale.

Irene felt that the BMI scale was useful in defining where the patient was in relation to their weight.

It gives me a guideline to see where the patient is, if he or she has risks or not…A lot of other things must be taken into account as well, like age and other health related behaviour, but it gives me a measurement. It's very hard to tell just by looking. It gives a feel for if one is normal, overweight or obese.

In my fieldwork BMI is also central in communications with patients, specifically at information meetings both at the Clinic and at the hospital that preceded surgery on patients. This is a way of defining who the specific target group of the medical treatment is. Together with some of the workers at the Clinic I attended a lecture for patients who were contemplating weight loss surgery. The lecture was given at a hospital that the Clinic worked closely with. We went there for two reasons, the Clinic was going to swap referral letters with the hospital and afterwards Yvonne was going to speak at the lecture to let patients know what their options were if they decided that they didn’t want surgery. At the referral meeting two of the workers at the hospital discussed the patients that might benefit more from the Clinic’s work. Three of the workers from the Clinic were there; there was Yvonne who was going to give the lecture. She also explained and talked about the referrals that they had brought with them. Lisa who also spoke about the state of the specific patients who were looking to be referred to surgery, and then Cecilia who was to join in because she was a new doctor, and needed to learn how both the surgery and the referral swapping worked.

The caregivers from the Clinic and the caregivers from the hospital discussed each individual patient. Mentioning their social security number and their BMI. Then explaining why they felt that the patient in question would benefit from surgery or treatment at the Clinic. The referral was then taken by the hospital or the Clinic. The referral contained the patient’s medical history and the criteria that made him or her eligible for treatment. After the meeting we made our way to the lecture.

The room was packed with patients who had already been referred to the hospital, but they did not yet know if they would be accepted for surgery. The lecture began with the staff
explaining the criteria involved in deciding who would be given surgery. BMI was one of the first things mentioned. One patient said that she had heard that private clinics did not require that one’s BMI be above 35 kg/m².

The next day Cecilia discussed this with Yvonne. Yvonne seemed provoked by the disregard for medical criteria, feeling that this was not surgery for health but rather aesthetic surgery if the BMI was not taken into account.

This reaction brought forward issues related not only to consensus but the actual implications of the shared medical criteria. It seems as if medical criteria are not followed then treatment is not about health; and in the context of obesity it becomes about aesthetics. Numbers do more than just signal truth in regard to bodies and disease; they recreate reality. BMI in fact, turns a physical body into an entity that is comparable to other bodies. It creates the idea of a specific group of sufferers who are all afflicted by obesity. Thus the BMI scale also recreates the body, when viewed from a Harawayque perspective. Here the body is something other than the actual physicality of the body (Haraway 1991). It becomes a number that generates an idea of what treatment is available for that body. Haraway argues that medical and scientific understandings of bodies are specific to the time and space in which they are created. The biomedical construction of the body creates a body in its wake that draws upon notions of scientific validity (ibid: 253). I interpret BMI in a similar fashion. BMI creates a new body -- defining when pathology is present. By creating a new body that is in fact not a body but rather a number, a distance is also generated to the physical appearance of the body itself and through this the implications of aesthetics are removed. This is revealing of how medicine re-interprets obesity from a condition in the individual to the medical realm. The stigmatisation of being fat thus became something devoid in the BMI scale. BMI does not say how the body looks, it only provides a number that gives access to medical treatment. BMI is objective it does not say anything about appearance -- it is about numbers.

BMI is not a stable entity created and then fixed in the medical community. One of the surgeons, Johan, told me that he had recently been part of a research team that had discussed the guidelines for obesity care. They had proposed that patients should be offered care if they had BMI over 35 kg/m², regardless of whether the patient showed symptoms of their obesity or not. According to Johan all patients on closer examination have some sort of ill effects of a BMI above 35 kg/m² on close examination.

“There is a discussion in Sweden today that everyone considered for surgery should have a BMI over 35kg/m². The international guidelines and the Swedish guidelines have set BMI at over 40 kg/m². 35 kg/m² if one has developed diseases from ones obesity. In the research group [arbetsgruppen] that I have
participated in, one has seen that many with a BMI of 35 kg/m² do have symptoms of their obesity, if you
look closely enough. Our suggestion has been to change the criteria to 35 kg/m².

In the introduction to this chapter I wrote that BMI is a global phenomenon. The
consensus created by BMI is even applied by the World Health Organization (URL 2). BMI thus
defines obesity on a global level. The BMI scale can be interpreted as a global aspect of the global
assemblage of obesity. In this context BMI can be used in any situation or any context and
thereby define who can be considered to sufferer from obesity. However, it becomes
contextualised and placed in its assemblage in the specialist community in Sweden. Johan
discusses how BMI is being reinterpreted in the context of the Swedish medical community. BMI
as a mobile entity can be renegotiated to fit the research done in a national context. The mobile,
global quality thus becomes visible and simultaneously national (Ong & Collier 2005: 11).

Here we may see that gastric by-pass surgery or other forms of specialist treatment
is granted from a lower BMI than the requirement stipulated by the World Health Organisation.
BMI as an entity, as a form of measurement, is still present, still global and moveable -- able to be
constructed and reconstructed in different contexts and situations.

Since BMI is the criterion for diagnosing obesity, it creates a stable entity in which
disease is either present or absent. It cannot show if a patient’s BMI has improved. Nor can it say
anything about that patient’s health. BMI creates an equilibrium in which a patient and his or her
diagnosis are fixed.

Irene: All the caregivers that they meet give them a feeling that they are reading them. They don't have to say
anything, it's the feeling when they [patients] meet the caregivers. Healthcare, or we as caregivers have given
ourselves mandate to ask people anything at anytime “how long have you been overweight?” Without
knowing anything about the person in question. Perhaps this person has recently lost 40 kilo's and then they
say that…
Mia: That they still appear overweight according to their BMI?
Irene: Yes exactly, instead of asking “what has your weight been like throughout your life” one can ask
questions in a different way if one wants to know an answer, but sometimes caregivers say things about
weight without having any purpose with the statement. It has nothing to do with why they[the patients] are
there but they take the opportunity to say something about weight as well.

BMI can be understood as a way of creating consensus in the medical community
and amongst institutions, but it also creates a standardisation in which a population becomes
visible. According to James Scott standardisation becomes a method for states to create a legible
entity, which can be investigated (1998: 3). These simplifications do not accurately describe the
reality of the matter, but recreate a new reality in its wake (ibid: 4). According to Scott, knowledge
and control sometimes call for simplifications or narrowing of vision that allow for viewing and
mapping only a certain part of reality. “[T]his very simplification, in turn, makes the
phenomenon at the center of the field of vision more susceptible to careful measurement and
calculation” (ibid: 11). This can be related to BMI in the context of medical research. In this context BMI has made body weight a calculation by which people may be compared with one another and something can thereby be said about the implications of weight in a population, while also mapping what the population weighs.

Most importantly BMI helps to categorize what is normal and what should be understood as pathological. This is clearly seen in the way in which the medical facilities communicated with each other on the topic of BMI. A consensus develops as to who should be treated and who should not. Since BMI is based on a shared consensus between medical professionals it legitimises the phenomenon of obesity in the medical context. As Susan Greenhalgh argues numbers are important in the governance of populations since numbers, being the language of science, evoke truth (Greenhalgh 2005: 356). Numbers become powerful because they calculate the attributes of a population, and do this by seemingly objective means. As Greenhalgh states these numbers become important for the control of population by government (ibid: 357). However, consensus does not exist in equilibrium, as BMI criteria can shift, seen in the discussion with the surgeon Johan. It is medical research and the production of knowledge that puts these changes into place. So here the truth of science can be altered by other truth claims posed by different (but equally valid) scientific research. Thereby altering that which has been seen as true previously.

Mary Douglas argues that institutions do not have minds of their own, instead ideas and knowledge are applied to institutions by people. In this context medical scientists, who make up institutions and these institutions make classifications, from which actions are generated. The actions require names and these names create people who respond to them according to Douglas (1986: 101). The classification of obesity generates an action plan that allows for its treatment. BMI thus becomes individualising and totalising at the same time (Ong & Collier 2005). The individuals suffering from obesity are allowed individual treatment that generates a change in their individual bodies. Simultaneously the BMI scale creates a population, in which normality and abnormality are classified thereby ensuring that certain levels of this abnormality will allow access to medical treatment. This is something that becomes visible in Yvonne’s reaction to BMI criteria that are not always followed by some private clinics. If criteria for disease are not followed it is no longer about disease. Thus if other actors use different criteria to define obesity as a medical condition they are no longer considering obesity as a disease but rather a question of aesthetics.

The concept of problematization becomes relevant in this context, since it is only when criteria are followed that obesity can be considered a medical condition. Criteria place
obesity in a medical site removing the problematization of true or false that otherwise might have been present in regard to obesity as a medical site (See Rabinow 2005).

Making BMI the marker of pathology also creates problems; BMI literally has a category called normal, this is problematic in treatment as well since most people with a BMI from above 35 kg/m² have little chance of actually becoming “normal weight”. Yvonne brought this up at the information meeting with new patients,

“50 per cent of our patients finish their treatment here…out of the patients that are left about one third achieve a considerable weight loss, comparable to that of surgery. One half loses approximately five per cent of their weight, but very few come close to normal weight.”

A patient responded by asking about Weight Watchers and that she had heard that many Weight Watchers achieved normal weight. “We do not have the same clientele as Weight Watchers. The patients who come here have a much higher BMI” Yvonne said. The diagnostic method thus creates a problem; although it gives access to care by creating a category of sufferers, it is not reasonable to think that patients would lose enough weight to become “normal”. Therefore patients were still “obese” according to their BMI score despite having successfully completed the weight loss programme at the Clinic. Simultaneously the patients who manage to lose enough weight to become normal are no longer sick on the BMI scale, raising the question of whether obesity should be viewed as a chronic disease or a temporary state of the body. When asking Lisa about this she said:

[If you become normal weight] you are disposed toward it [obesity]. You may have type 2 diabetes that you can get rid of, but you still have it…it’s the same way with many diseases, a rheumatic disease is chronic even if it does not always show itself. Until you get a flare up. One can view this as a flare up as well; only it does not come in one morning. You get there for different reasons. You must always pay attention to it. If you’ve ever been there you have to be careful.

The BMI scale itself creates a group of sufferers on the basis of shared criteria, sufferers are thus placed in the context of becoming a group of patients, whose goals and reasons for being at the Clinic are similar. But, as Yvonne pointed out, not all people with a BMI of 35 are sick. Therefore there is a discrepancy between those who seek help and those who do not. The BMI scale cannot tell the difference, because the BMI scale can say no more than the patient’s physical weight divided by his or her height squared. In this context BMI is of no value in differentiating those who suffer from their obesity from those who do not.

BMI offers a way for caregivers and medical experts to classify pathology (see Sachs 2002). BMI also permits the creation of a patient group that signifies only body weight and

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11 Weight Watchers is a commercial, non-medical weight loss group.
therefore gives legitimacy to treating obesity as its own medical site. Douglas argues that these classifications have a way of marking boundaries that affect lower levels of thinking (1986:102). This means that the afflicted persons will also classify themselves and others in their situation. BMI has the potential to do just this; create an idea of what one is which in turn allows for access to treatment.

As seen in this section BMI is an attempt at creating consensus and definitions of who is a sufferer, but I contains many paradoxes and inconsistencies. BMI is used to gain access to care, but is not used in actual treatment, BMI creates stability and fixes a diagnosis, but can be altered according to new findings in medical research. Never the less BMI is one step in the direction of creating disease but not sufficient to make obesity a high status condition to treat by medical professionals. The section that follows discusses the status of obesity as a medical condition.

**Obesity’s Status: Lifestyle Alteration and Surgery**

This section is about the status of obesity in medical treatment through the perspective of the staff at the Clinic and two surgeons working at other hospitals. I am attempting to place the description of the status of obesity in a wider context in which the two different treatments of obesity create problems in its status of obesity as such and also create obesity as a site in medicine. Notions of treatment become actualised through ideas of responsibility. This section is about the struggle in creating consensus on obesity as a medical site.

Karin and Yvonne were giving a lecture on the medical treatment of obesity to a class of chiropractor-students. Most of the class were young men who all seemed to spend a great deal of time at the gym. Karin and Yvonne joked about this fact after their first lecture. They were not used to the high levels of testosterone that they faced with this group. The aim of these lectures was to teach the chiropractor-students the medical effects of obesity, and also how to treat it and talk to patients about it. The caregivers at the Clinic often discuss how badly obese patients are treated in medical care and these types of lectures are important in educating medical staff on how to treat obese patients with respect, while simultaneously teaching caregivers the importance of treating obesity.

Yvonne began the lecture by speaking about the definitions of BMI and how it is used in regard to obesity. As I had seen her do before, she asked if the class knew of any instances when BMI was not applicable in the definition of obesity. She asked if there were any people in the class who were defined as overweight on the BMI scale. Three of the men put up there hands. Yvonne nodded, “BMI cannot distinguish between fat and muscle. Muscular people will probably be defined as overweight even if they are not”, she said. Yvonne then went on to
discuss how these classifications can be misleading, and then moved on to talking about why people become obese. While she was talking, a young man walked in. He was late and promptly sat down next to a friend. After a few moments of listening to Yvonne speak about the reasons for obesity he put up his hand. Given the opportunity by Yvonne, he asked why one often saw fat people together. Yvonne’s answer came instantly. ”Maybe they don’t feel comfortable being at the gym with you”. Speaking to Yvonne about this after the lecture she felt that this was a good example of what we had previously discussed. There was a lot of hate and disrespect directed at obesity and obese people, which is why it is so difficult to treat and talk about. She also felt that the chiropractor classes had been problematical. She wanted to show that obesity was about medicine and had therefore used a lot of medical jargon that these students had not really needed to know and probably did not understand. She had felt the need to show her own authority in relation to the class.

On my first day at the Clinic, Yvonne told me that obesity was a low status disease. This was made no better by the fact that the Clinic worked with consultations rather than medical technology. I made a point of discussing this with every caregiver that I interviewed because it was, in a sense, a foreign notion to me. I thought that obesity would have a considerable status in medicine because it was so interesting to the media. The Clinic treats patients who had opted for non-surgical specialist care. Carina said:

Traditionally the highest status lies in the areas that have the most advanced surgeons and technology. I think that it becomes low-status because there aren’t any interesting technologies or operations or anything that one can do. It becomes “we can’t treat it anyway” or “we can’t find a good treatment”. Well now they can operate, but I think that what has the most development in medicine is [where] often intelligent scientists, problem solvers, find new ways to solve problems. Then it’s not so interesting with “eat less, exercise more”. It falls outside medicine in many peoples’ eyes that’s why it’s low-status. Anything that isn’t high-tech is low-status: stress, pain, geriatrics, and obesity.

Lisa discusses obesity’s status in terms of how it is treated in primary care:

In primary care one treats the symptoms. One treats high blood pressure, one treats diabetes. But then one might not take care in the actual problem. …With other diseases one starts there and then one says, “You need to go to the hospital and get this fixed”. But if I can’t help a patient who will help them? You give up. That’s where we come in as the next step…we are supposed to be the last instance of care. It’s a problem; another problem is the attitudes that one finds at health centres [Vårdecentraler].

Lisa feels that primary care cannot offer treatment needed for obesity, due to the ambivalence in treating obesity itself. Primary care treats symptoms of obesity rather than obesity itself. The

12 De kanske inte känner sig bekväma på gymmet med dig.
attitudes in primary care can also be a problem according to Lisa. When a caregiver only has a short amount of time to speak with a patient it is difficult to discuss the problem candidly. Lisa goes on to discuss a conversation she had with a dietician in primary care:

The dietician says “this patient is a mystery” Ok, I said, is it the patient who thinks that this is a mystery? [That the patient has gained weight] “No I think so too,” she said. Ok, I thought what is it that is mysterious about this? This is where you can end up with a patient when they present, they truly feel that that they do this and that, and it must be something else. So then to sit there and say “you eat too much!” It’s about teasing out the real cause [locka fram] what happened. It is socially difficult, maybe that’s a part of it, difficult to be consistent perhaps. It doesn’t have to be much “she doesn’t eat much it looks great.” I think many people (caregivers) end up there when they don’t have time in health centres; you are to put in your hours. The visits are like this [Lisa makes a rapid hand movement to show how short the consultations are] you can’t sit and talk with the patient so you push it away

In these discussions obesity and its status are related to how well or perhaps how easily it can be treated by medicine. It is also about how the medical community at large chooses to interpret obesity as a condition that defines its status.

The Clinic does not interpret obesity and its sufferers as a single organ. They feel that obesity is not only an excess intake of calories in regard to calories used, but that there are reasons why people overeat. Getting to the bottom of these reasons is central in lifestyle-alteration. It is also in conflict with the surgical treatment. In surgery the patient becomes little more than a digestive system. Altering the stomach was the cure.

Both Yvonne and Irene view obesity and its status in terms of what causes it and who’s responsibility it is if a patient finds themselves in the situation.

Irene: [The most important thing to teach caregivers] is to have respect for this group of patients, and an understanding of how difficult it is to alter one’s lifestyle. All too often one hears “just do this”. With diabetes one sees a difference, it has a more powerful disease profile [sjukdomsbild] It is a disease in the mind of medicine, while overweight isn’t and too many people [caregivers]think it is brought on by the patient. One has to cope with it on one’s own. They don’t think it’s the responsibility of healthcare.

I asked Irene if she felt that this was connected to the marginalisation of obesity, and how she thought about stigma in relation to healthcare.

Irene: I don’t think normalising it is the answer. Think about cultures where it’s very common that people are fat. Somehow it’s accepted. But getting an improved status, this I think will happen when more and more people become affected. It has been lifted from an individual problem to a social problem. As long as it is an individual problem one can blame the individuals. But normalisation must not happen, then it won’t matter [if one is obese] “Big is beautiful or something like that. That won’t help the patients either. Some sort of strange balance between it being ok to be fat, but not ok from a health perspective. It shouldn’t be stigmatised.

Responsibility is connected to ideas of what can be defined as a disease, as Irene succinctly states. By giving obesity a higher status in medicine and acknowledging that obesity is a medical condition some of the responsibility is removed from the patient, or at least, the patient cannot
be held completely accountable. If viewed as a disease, obesity becomes lifted from an individual disorder to a societal problem. If obesity is a societal problem then society or the State must also offer help to those who are afflicted.

Some time after my interview with Irene I went back to the Clinic to meet her. We discussed the interview at the small table in the coffee room. Irene brought up the topic of the status of obesity. She told me that she had been thinking about its status when she had re-read the interview and that she felt that obesity had not yet found its place in medicine. “We have to offer patients further treatment, it’s our responsibility, but obesity isn’t there yet.” Irene said that there are other diseases that medicine offers treatment for despite the fact that they are considered to be caused by the patient, such as smokers being offered coronary artery surgery. So what is the problem with obesity? Irene argued.

Yvonne also brought up responsibility at one point. Obesity is to some extent brought on by the way that people live their lives, but this does not make it less of a disease. One becomes obese because one consumed too many calories and we live in a culture in which that happens quite easily, the same could be argued in regard to many diseases, HIV/AIDS for example, that one also can get from lifestyle. Homosexual men who often visit sauna clubs and engage in unprotected sex have a significantly increased risk of contracting HIV, according to Yvonne.

Notions of effective treatment seem to be central to the understanding of the status of disease. If there is no successful or easy way of treating a condition it has little importance in medicine. The surgeon, Johan, explained this to me. Treating obesity is generally viewed as simply eating less and exercising more, simultaneously obesity is viewed as the individual’s own fault. He was, however, quick to point out that there are differences between the surgical treatment of obesity and the non-surgical treatment that the Clinic works with.

Those of us who work with surgery have good results, those who don’t have quite poor results and that’s why it has a low status. Nobody wants to go to work and say what I accomplished today was to keep someone from gaining weight.

The status of obesity is, according to Johan, linked to obesity surgery. Here Carina’s interpretation of what constitutes interesting medicine becomes placed in the context of obesity treatment. Obesity surgery is both high-tech and has proved to give good results in scientific research.

The technological aspect of surgical treatment in regard to obesity was discussed by the surgeon Thomas. According to him obesity is definitely a disease. Why else would resources form the state be spent on treating patients?
People want surgery [det finns ett tryck efter kirurgi] There is an obesity epidemic. Well I don't know about the term epidemic but people are getting fatter. And it’s about results, and there the SOS study has helped a lot. It shows results on co-morbidity and mortality. There are huge health benefits associated with surgery.

Mia: Is obesity a disease?

Thomas: I thought that one defined obesity as a disease. In medicine it is accepted as a disease because surgery is to be offered through the healthcare system... It's a medical condition that one puts public medical resources toward treating. If it is brought-on by people themselves then it should be taken care of by people themselves, by paying for the surgery for example.... With surgery we know that we have an effect on diseases associated with obesity [följdsjukdomar]. That's where surgery is different from lifestyle-change. They haven't been able to show that lifestyle-change affects the diseases associated with it. They are not as effective. Surgery is effective... As long as there aren't any alternatives to surgery it is the only solution, it would be better if it could be treated medically but there isn't any treatment. If there was an effective pill we could stop treating surgically but there isn't anything, and obesity is going to continue to increase. We are ten to fifteen years behind the States and we know it will keep growing...

If obesity is not a disease then it is a natural corollary that obesity as a condition is something that the patients had brought upon themselves. And if this was the case then patients should pay for their own surgery. Thomas felt that since surgery is the only lasting cure for obesity it is necessary to provide this option to patients. According to Thomas, obesity is becoming an even bigger problem in society today and there is a huge demand for surgery. There is good reason for this as surgery has been validated by medical research such as the SOS study. The paradox is that surgery has a higher status. It offers a solution and scientifically validated results, its place in medicine is secure. However, there are those who do not want surgery or are not healthy enough to undergo surgery. Therefore there has to be a treatment even for them. When surgery became a part of the treatment of obesity it became part of the medical paradigm, but it is not possible to operate on every patient, therefore the Clinic works with the non-surgical options that from time to time are viewed as non-medical and low-status. Thomas never even seems to contemplate that lifestyle alteration is a medical remedy for obesity. When he speaks about medical rather than surgical treatment for obesity his idea is a pill that might treat it.

It is the remedies that one associates with biomedicine that are viewed as strategies for treating disease. The relationship between lasting cures for individuals undergoing treatment have to be posed against scientific research on populations. Following Jonathan Xavier Inda on the workings of governmentality, the knowledge and technologies that make obesity treatable are connected to governing citizens of a state, by means of knowledge and validated results that prove not only the importance of treating obesity but also the method for doing so (surgery).

[The intimate link between knowing and doing, thinking and acting, representing and intervening. The idea here is simply that knowledge is necessary for effective rule. It is that government needs to “know” reality in order to act upon it (Inda 2006: 23).

Only when there is a link between “knowing and doing” can the specialists speak about the truth in treatment (ibid).
According to Thomas there are many aspects that make surgery a better treatment for obesity than lifestyle-change. There are no studies that indicate that lifestyle alteration has any effects on diseases linked to obesity such as diabetes.

Diabetes is very common when we do gastric bypass operations. Patients are almost always cured from their diabetes after the operation long before it can be explained by weight loss. Sometimes they can stop taking insulin a couple of days after [the surgery]. They consume less nutrition after the surgery but that isn’t enough to explain why they don’t need insulin… This is important because it can teach us something about how diabetes works. It works so well that there is a discussion on operating on all patients who have type 2 diabetes whether they are obese or not.

The medical community does not know why this is, which also makes surgery an area of investigation that can reveal something about other diseases.

This section has discussed disease and individual responsibility. The treatment of patients in primary care, and the disrespect that some caregivers there might show the patients who are obese are about ideas of responsibility and the status of disease. On the other hand this section has also been about notions of treatment that seem to be firmly entrenched in notions of what constitutes an area domain in medicine. Here we are seeing that since obesity’s treatment at the Clinic is not about advanced technologies or treatments that provide easy solutions, the status is low.

The surgeons, on the other hand, have the ability to treat obesity by means of advanced technology. Technology also provides results that can be proved by scientific research. I am arguing that the status of obesity is linked to whether or not obesity is to be viewed as a disease. If obesity is to be considered to be a disease in the medical community it is reasonable to argue that the responsibility of the condition also shifts. An individual cannot be seen as completely responsible for his or her pathology, if it indeed is pathology. The staff at the Clinic that work exclusively with obesity as a medical condition feel that obesity is a medical issue that requires medical intervention, but they also relate to caregivers outside the Clinic, where obesity may not be viewed as a medical condition. In this context blame is placed on the patients for getting themselves into the state that they are in -- a condition that has been brought upon the individual by him or herself.

Notions of responsibility reflect notions of the re-orientation of obesity as a condition. It also evokes notions of problematization (Rabinow 2005). In this context there is no shared consensus on the definition of obesity. The question of responsibility i.e. whether or not obesity is an individual’s own fault or a larger issue of pathology, is thus left unanswered. The concept of disease creates a group of sufferers who cannot be seen as completely responsible for their pathology. However, the concept of disease seems to require general agreement that a
condition is a disease. Johan, the surgeon with whom I spoke, was quite open about the fact that surgery has a higher status than that of lifestyle alteration that the Clinic worked with. I interpret the high-status of technological solutions, such as gastric by-pass surgery, as a way of defining what is good and interesting medicine. Lifestyle change can in this context be understood as old news, perhaps even so old that it has no place in medicine as Carina discussed when saying that only highly advanced technology was seen as interesting and that teaching people to eat a suitable diet was not interesting. It was also related to what medicine felt that it could accomplish. Altering someone’s digestive system is possible, even easy, when the technology exists. Altering the soul or mind of the patient is quite different.

Technology has taken centre stage in medical treatment, as is seen in the narratives of the surgeons. Lifestyle alteration and preaching more exercise does little to make obesity an interesting disease to treat. Thomas relates obesity surgery to validity, since surgery according to him is the only treatment that gives long-term results. This might be interpreted as a medical paradigm where medical treatments are constituted by whether or not there are enough scientific results to prove whether or not a medical condition can be treated successfully. As mentioned above the correlation between knowing and doing are central in creating an area of governance (Inda 2006). It is the treatment that defines whether or not obesity is a site in which medicine should be working. If there is no treatment that can be validated by medical research it is not worthy of medical intervention. Foucault argues that the eighteenth century brought with it a double vision of the notions of individuals in regard to population. Here was born both the notion of the clinic in which individuals were privately treated as well as strategies for health care of a population (Foucault 1980: 166). Disease can only be disease if there is a cure for it, so in this context then medical research legitimizes the surgical remedies for obesity. Creating a population of sufferers who are simultaneously being mapped through their treatment so as to say something about how obesity as such can be treated. Medical technology as a solution for disease is also central in creating that very disorder, but, as mentioned before it also creates a problem; that all patients cannot be expected to undergo surgery, which leaves little other option than to treat obesity by teaching lifestyle-change. However, this type of treatment is not viewed as part of the medical paradigm even if it is part of the Swedish health care system.

In the context of health care, the state governs what is to be seen as a disease and requires treatment, so as to maintain a population of individuals who can be of service to and utilized by that state (ibid: 172). As Thomas points out we are seeing a state intervention. Obesity must be a disease since the state’s health care system offers treatment to the patients suffering from it. Another aspect that Thomas discusses is that of the SOS study. He suggests that it has
provided validity for surgery as treatment. These issues reveal “the national” in obesity treatment; simultaneously Thomas says that the national treatment of obesity is very important, since Sweden is ten years behind the United States in regard to obesity as a health problem. The global perspective thus functions as a measurement that can indicate the importance of treating obesity before it is as big a problem as it is in the USA. The global in obesity is discussed through the presumption that what has happened in the States will happen in Sweden in a matter of time. Here the nation’s relationship to the global becomes apparent. According to Saskia Sassen the global takes place within the nation-state to a far greater degree than is generally discussed.

A good part of globalization consists of an enormous variety of micro-processes that begin to denationalize what had been constituted as the national – whether policies, capital, political subjectivities, urban spaces, temporal frames, or any other of a variety of dynamics and domains (Sassen 2006: 1).

I interpret medicine to be one such area. Swedish medical care is governed through the State and it would be simple to keep viewing medical treatments as, in essence national, in obesity we are seeing something different. Here the notion of global disease affecting so many different areas and countries contains levels of the global even in the context of Swedish medical care. The section that follows takes a further look at the (national) criteria that defines access to medical treatment.

**The Letter of Referral**

In January I found myself waiting for my informants from the Clinic at a train station south of Stockholm. We were all going to a meeting with another obesity clinic that works exclusively with childhood obesity. Walking with Ulrika, Karin, Charlotte, and Pernilla we soon found ourselves at the doors of the clinic. Yvonne was waiting for us, having taken her car to the Clinic. It was an all-day meeting and I understood that the main reason for going was to exchange views on the treatment of obesity. The two clinics were also going to discuss the specific work that they do, who they treat and why. For the Clinic this was also an opportunity to describe which type of patients the other clinic could refer to them.

Referrals are always brought up when the Clinic meets with other clinics or caregivers who from time to time might meet patients who need help with their obesity. In these instances the Clinic will explain their criteria for accepting patients. Caregivers need to know that there are units that treat obesity to which they can send patients who need help. Making sure that caregivers know where to refer patients is central in placing the medical treatment of obesity on the map.

In accepting referrals the Clinic’s position as a specialist unit becomes clear. Lifestyle alteration and non-surgical treatments that the Clinic works with are, much like surgery,
not available in primary care. These methods of treatment are the last instance of treatment that the Swedish system of medical care can offer. Lisa defines the criteria as follows:

Well in the end you must have a BMI above 35 kg/m². Then, to come here, since we are a specialist unit, [a patient has to] have attempted weight loss through other means, Weight Watchers, some type of attempt to lose weight on your own. You might have pains in your joints, or levels that are associated to obesity; blood fat or diabetes, although we don’t accept insulin treated diabetics here.…

**Mia:** Are there other conditions that you don’t treat?

**Lisa:** No, or yes, If we find a severe eating disorder that falls in the criteria then we refer the patient on. But we don’t always find them to begin with. But if we get a referral that states that the patient suffers from a genuine eating disorder we send it back and write “send it here instead”. And then if there is a lot of psychiatry [psychiatric diagnoses]… if a person seems to have a psychiatric diagnosis that we feel won’t work [not treatable by the Clinic]. Schizophrenia or something.

**Mia:** There are boundaries to how ill you can be?

**Lisa:** Yes or rather if you are susceptible, I mean if you have schizophrenia and suffer from delusions or something we can’t do much…

Lisa, Yvonne, and Carina had a meeting in the end of January to go through new referrals that had come to the Clinic and see which of these patients they were to accept for treatment. Most of the referrals were from doctors that a patient had seen in primary care; these doctors had generally deemed it suitable to refer patients to the Clinic either because the patient had requested it or because the doctor him or herself considered that the patient needed treatment. Yvonne read the case history that the doctor had sent. This was in essence the patient’s disease history and contained the information that would grant the patient access to treatment. In some instances the doctor had written that the patient was interested in surgery, Yvonne and Lisa placed these referrals in a pile that was to be sent on to a hospital where weight loss surgery is performed. In some instances they read through the patient’s clinical history, mention the patient’s BMI and if the patient had any ill health related to their obesity.

Sometimes the BMI was not quoted in the referral. Yvonne and Lisa would calculate it (if the referring doctor had given the patient’s height and weight). In one case a doctor wrote that the patient said that their BMI was somewhere in the obese category. Yvonne and Lisa expressed annoyance at this. On the one hand, because the doctor has not checked the weight of the patient, which probably indicates that he or she found it shameful to weigh and measure the patient and on the other hand because it was unprofessional. Yvonne and Lisa joke that they might contemplate sending invitations to their education lectures to the doctors whose referrals are declined. “Maybe we should send invitations to education with the returned referral.”

“You get to know other doctors through looking at referrals” Yvonne commented.

In general referrals come from a few primary care centres. Yvonne told Carina and myself that there were different reasons why, “some send every obese patient to the Clinic, some send nothing at all, some send referrals selectively and others can treat the patients themselves”.


Lisa and Yvonne went through all of the referrals, making comments about why some were returned and others approved.

**Yvonne:** Some places have the ability to treat patients there. We have criteria, and in some instances nothing has been done. [Reading aloud from another referral] This patient would probably respond well to Sibutramine [weight loss medication] She would probably work well in the KM group as well, I sense a good girl luktar dukrig flicka lång väg.

The patients who are deemed as suitable for treatment were discussed; the presence or absence of other diagnoses that required other types of treatment than those at the Clinic. Some of the patients were seen as obvious candidates for the Clinic. This was exemplified in a referral of a young woman who was having problems getting pregnant. If she did not lose weight she would not be eligible for IVF\(^{13}\) treatment. These patients were given priority, Yvonne stated “when you are of a reproductive age and can’t reproduce, it’s serious” in these instances the system of medical care becomes clear. IVF will not be granted obese patients unless they have managed to lose weight. Responsibility for patients is structured through the acceptance of referrals by the Clinic. In some referrals, doctors describe some patients as suffering from eating disorders such as binge eating. The Clinic would then decide if they are to refer the patient to a clinic that treats eating disorders, if he or she matched the criteria.

The Clinic does not have the resources or the agenda to treat diabetes; they are only to treat obesity. Symptoms that grant patients access to the Clinic do not have the function of revealing anything new, their function, as Foucault (1973) argues is recognition, and results or outcomes of disease that the patient will face (90-91).

The criteria used at the Clinic, is much like BMI, a shared consensus on when obesity is to be treated by specialist care. This means that although there is obesity treatment in primary care the patients need to have been unsuccessful in that treatment. Pernilla had previously worked in primary care, as a dietician. There she had seen and applied their standards to the treatment of obesity.

The majority of referrals that we got in primary care were metabolic diseases like diabetes, cholesterol, high blood pressure, overweight and obesity. We haven’t counted but we estimated that they were a majority that came with those diagnoses. But then there is the rest with all the different diagnoses. And in primary care we can’t prioritize these diagnoses because they aren’t viewed as acute as malnutrition, [undernäring] kidney diseases, perhaps. There is a really big difference, here I work exclusively with it [obesity]. It’s the number one priority. The only thing we do and that’s nice.

Specialist care, such as the Clinic provides, is directed at one issue and one issue alone, giving them the time to treat the patients who need treatment. However, this also means a

\[13\] In-vitro fertilisation given patients who have difficulties in conceiving.
selection and rigorous following of criteria that make obesity a site of specialist medicine. One of the main problems in this context is, of course, how one is to define the problem of obesity. I heard Karin and Yvonne speak of this one day in the hall. They were discussing the DSM\textsuperscript{14} criteria in which eating disorders were defined. I asked them how they viewed obesity in relation to DSM. Karin felt that on a philosophical level one could indeed argue that obesity is an eating disorder, but it did not match the medical criteria stipulated, which meant that the care for obese patients was not to be treated by facilities that treat eating disorders.

The issues of who is to be treated and what criteria are to be used is a constant topic at the Clinic. It comes up not only in referrals, meetings with other clinics, and lectures to patients, but also in patient consultations. Yvonne generally asked her patients if they felt that they lost control while eating. She explained the difference between eating more than one had intended and going on (what she termed) “autopilot”, when one no longer had a chance of controlling when one was going to stop eating. I came to understand, after having witnessed this a couple of times that Yvonne was scanning for eating disorders, making sure that the Clinic could indeed treat the patient in question.

Criteria can be conceptualized as the guidelines that make an issue or condition medical. The Clinic’s way of applying itself to the criteria is an exercise in defining a group of sufferers who are both eligible and treatable by the Clinic. Simultaneously, a medical criterion orders the place of the patient, and the structure of medical treatment. It shows how the medical system is ordered but it also highlights the way in which criteria become important in dealing with disease. Diseases are defined and outlined in the context of criteria. They order what is to be treated and where it should be treated. Criteria thus create specific patients that are to be treated by the Clinic. Elisabeth C. Dunn argues that:

“[S]tandards function here as “fact factories.” Not only do they import knowledge about how things should be made, but also, by specifying particular forms of data collection, recording, and analysis, they act as engines for generating knowledge about products, processes, and people (Dunn, In Ong & Collier 2005:184).

Diseases seem to have their specific place and it is important to map who is suffering from what. But reality is seldom as simple as criteria as is seen in the context of eating disorders. Karin illustrates this well when she says that one can discuss obesity as an eating disorder on a philosophical level, but not based on the criteria demanded by DSM. The medical gaze of the Clinic is about applying standards that outline obesity as medical condition.

\textsuperscript{14} DSM is the abbreviation of Diagnostic and Statistical Manual of Mental Disorders which is used to categorize symptoms of mental disorders.
Foucault writes that the medical gaze (during the eighteenth Century) becomes structured so as to look for and order those symptoms that characterize that which is known as disease. Simultaneously the results of disease can be calculated (Foucault 1973: 91).

According to Foucault disease in this context becomes a whole because one can assign specific symptoms to it (ibid). In the context of letters of referral and patient consultations the Clinic is mapping the specific anomalies that can be viewed as symptoms of obesity. Thus when these symptoms are met disease becomes present. Teaching others how to interpret symptoms of obesity and teaching these caregivers where to refer the patients is central in constructing obesity as a medical site. Knowing where obesity ends and other diseases begin is illustrated by Lisa in her discussion of which patients the Clinic cannot treat, such as insulin treated patients or those with serious psychiatric diagnoses.

In meetings with patients it is equally important to ensure that these they are not suffering from other symptoms that are not in the realm of obesity. The clinical understanding of symptoms is also totalizing in the sense that “[i]t gave to the clinical field a new structure in which the individual in question was not so much a sick person as the endlessly reproducible pathological fact to be found in all patients suffering in a similar way” (Foucault 1973:97). In the context of understanding and looking for symptoms the individuality of each patient was replaced by the totality of disease. Chris Shore and Susan Wright also discuss creating totality in the article “Audit Cultures and Anthropology”. In the context of audit, they argue, that an entity is created in which all people’s individual efforts can be ranked in relation to the system created around the audit (Shore & Wright 1999:569). In the context of obesity the medical criteria work in a similar fashion.

The criteria involved in accepting patients to the Clinic illustrate another point. They show what aspects of obesity are deemed important. The notion of being infertile when a woman is of reproductive age means that the condition requires treatment. Normality in relation pathology is created in these instances. But the medical criteria governing who is given access to obesity treatment is also part of a process of disease making. Here the severity of obesity is mapped. Previously unsuccessful treatments come to mean that the patients in question cannot solve the problem by themselves. Instead medical remedies are needed.

Disease creating is also the central aspect in regard to letting caregivers know where to send their referrals – that there are specific units that will treat patients suffering from obesity, providing that they mach the diagnostic criteria. The Clinic is not responsible for making sure that patients are accepted, rather this responsibility lies on other medical professionals that write
the letters of referral to the Clinic. As Yvonne says, one can get to know doctors quite well just from reading their letters of referral.

Upon gaining access to medical care different strategies for treatment become important. The following section takes a closer look at the medications available in obesity treatment.

**Orlistat and Sibutramine**

Yvonne: Whatever treatment one discusses in regard to weight loss the principal is the same. Everything works if you consume less energy than you burn. The ideal pill would remove appetite, or would allow you eat any amount of food and still lose weight. In 1997 Orlistat came. It blocks [reduces] the uptake of fat from the gut, and results in oily diarrhoea. It helps impulse control, and with the right motivation it works well – like fat antabus [disulfiram]. Orlistat results in a three to five per cent weight loss. My colleagues think that it is a shit medication…

Yvonne went on to discuss sibutramine.

[Sibutramine is] a drug devised for depression, but one of its side effects is appetite suppression. It gives a four to five per cent weight loss. These numbers are typical in weight loss... 1/3 of patients respond well, 1/3 not at all, 1/3 have side effects from the medication. Orlistat is similar. One has to use it on the base of the individual. No medical studies work like this…

Here, Yvonne was describing the pharmacological treatment of obesity to the class of chiropractor students. This discussion emphasises that the pharmaceutical treatment is selective. It does not suit every patient. Drugs such as orlistat and sibutramine work very well in some individuals, but not in others. In medical research, drugs cannot only be tested on individuals who respond to them. They have to be tested on a large number of persons to see their validity. I understood Yvonne to mean that her colleagues’ feelings about the pharmaceuticals were connected to the poor results that they showed in tests on larger populations.

The two types of medication available for patients at the Clinic are orlistat and sibutramine. They work in different ways and are thus suitable for different patients. At Friday rounds, caregivers would summarise their patients’ progress. These summaries were lead by Yvonne. The caregivers would tell the others how the treatment was going, how much weight the patients had lost, or if they had stopped losing weight. They would also discuss their plans for continued treatment in specific patients. Sometimes the patients and the caregivers had already discussed medications that the patient might try in their treatment. The caregivers might ask Yvonne if she thought it would be suitable that the patient try one of the medications. This usually involves different aspects. If the patient wanted to try orlistat Yvonne needed to know that the patient did not have any bowel problems, she also needed to know what dietary problems the patient had, since orlistat works on fat not on sugar.
Shortly before Christmas and shortly after Christmas lunch at the Clinic I found myself at a patient consultation with Lisa. Most of the consultation was devoted to explaining how orlistat worked. The patient had been using it for a long time but had recently noticed that its effects were wearing off. Lisa tried to explain that orlistat had no effect if one had stopped eating fatty foods. But the patient had a hard time understanding why. After the consultation I followed Lisa to her room and we spoke about some of the misconception about orlistat. According to Lisa this was quite common. Orlistat is a drug that works when one eats fatty foods. The upset stomach that orlistat causes does not make the patient lose weight. Orlistat is devised as a method for teaching patients what foods have a high fat content, and as a bonus it acts as an incentive to stay away from fatty foods because the patient will want to avoid the unpleasant diarrhoea caused by eating fat. In our interview Lisa described orlistat:

It is a bit like methadone. If you drink you feel like shit and if you take Orlistat and eat fatty foods, well that’s not so pleasant either…in the study some did really well. It had a good effect while others lost the general kilos. There is no real difference between the drugs… The weight loss is four to five kilos. Does it make a difference if one weighs 150 kilos? … Some have good help from it others don’t.

Speaking to Lisa about this misconception of during our interview she said:

It’s difficult to know why. In the beginning it was prescribed, suddenly there was a drug. It was the first medication that was approved for weight loss. There was nothing. There were others but they had side effects but this was easy it only worked on the fat. It wasn’t dangerous…[the tape recorder stops while Lisa is describing how Orlistat works] … if the patient gets side effects then they haven’t been given enough information [Lisa is talking about that if the patient feels that diarrhoea is a side effect of the drug then they have not understood how the drug works since the “side effect” is in fact the function of the drug] And then you feel, ok this patient has not been given enough information. And then of course one thought that it could be given to anyone. That’s not the way it works if you don’t have a high intake of fat. Many patients don’t eat a lot of fat they only eat light products but maybe they drink a lot of fizzy drinks in that case you can take as much Orlistat as you want but nothing will happen. You have to know what the patient’s problem is. Is this suitable [as treatment] or is there something else

The staff at the Clinic described orlistat as being useful in their treatment of patients, when discussing the drug with another clinic treating childhood obesity. The Clinic sees the drug as a method for teaching impulse control. During the meeting Karin discussed a patient she had treated that had stopped taking orlistat but was still happy about having learnt what foods contained fat.

The two drugs available to patients who suffer from obesity are important, they are part of the treatment and they are often discussed not only in regard to specific patients who might be candidates for them but also with other care facilities. The drugs seem to be important

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15 Ja det är lite metadon stuk på det, om man super så mår man skit. Och om man tar Xenical och äter fet mat så är det inte så trevligt heller.
even in the context of obesity’s medical treatment. In our interview I asked Lisa if the drugs provide faith in the treatment. She felt that it probably do:

I think that one takes this [obesity] more seriously...If there are pharmaceuticals [that can be prescribed] one takes it [the condition more] seriously, instead of just telling patients to go to the woods and eat carrots”16

Drugs are important in outlining obesity as a medical condition.

Irene: I think that they (the drugs) are very important. It’s about getting health care to tackle a problem. But there must be something that can be done. As long as the only treatment is conversation therapy, that is also low status… A couple of advanced medications and surgery and it becomes… partly one can do more but it also gets a higher status.

Reynolds White, Van der Gees, and Hardon use the term commodification of health to denote the increased belief in pharmaceutical’s ability to achieve health. This commodification of health shifts the understanding of ill health from being about political, economic or social factors and instead relates them to factors that can be cured by pills (2002:79). The Clinic is careful not to treat patients with medications alone. Medications are seen as a part of the overall treatment in which lifestyle alteration is important. However, they have the function of increasing the validity of obesity as a medical disorder. In practice the Clinic only uses the drugs together with changes in the lifestyle of patients.

Sibutramine is a more complicated drug, since it works on the brain, and a mild anti-depressant. It requires that patient using it must not be on other psychiatric medicines and they must not have heart problems. It also requires that the caregivers at the Clinic are able to measure blood pressure in the patients using the drug, since high blood pressure is one of its side effects. Sibutramine suppresses appetite. The caregivers describe the results of treatment in the same manner as those on orlistat. It works very well in some patients and not so well on others. When visiting the childhood obesity clinic, the caregivers at the clinics began to compare their experiences of the drugs. Yvonne discussed the other clinic’s results on Sibutramine patients with one their doctors, Fredrik. They discussed the pros and cons of Sibutramine and also how it was to be used. The discussions on the use of the drugs between Fredrik and Yvonne was mainly centred around medical research, Yvonne discussed a study that she had read on sibutramine in which the patients who seemed to be least motivated toward lifestyle alteration had the best effect of Sibutramine. But she argued that the drugs could not replace other forms of weight loss treatment.

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16 Jag kan tro att det finns en mera, alltså att man tar det här på allvar… Om det då finns ett läkemedel gör ju att det tas på allvar istället för att bara hänvisa till skogen, morötterna. Så är det ju.
Neither of the drugs is seen to be able to work on their own without a patient’s alteration of lifestyle. But the drugs can be understood as playing a role in outlining obesity as a site in medicine. As seen in the section on Obesity’s Status, the surgeon Thomas discusses that medical treatment might be an alternative to surgery if there was an effective pill, but there is nothing like that at the moment. Thomas ignores sibutramine and orlistat since they do not provide adequate weight loss on their own.

Drugs provide status to the medical treatment of obesity. In Social Lives of Medicines, Reynolds White, Van der Geest and Hardon argue that pharmaceuticals are becoming more and more sought after. The authors suggest that there is an increasing belief in the need for pharmaceuticals all over the world (2002:79). Both the manufacturing and marketing of pharmaceuticals has become globalized. Ensuring both the availability of drugs and the demand for them (ibid). But the global can also be interpreted in a more subtle way. Saskia Sassen describes processes that are not always obviously global, but that can be understood as part of globalization:

These processes take place deep inside territories and institutional domains that have largely been constructed in national terms in much of the world. What makes these processes part of globalization even though they are localized in national, indeed subnational, settings is that they are oriented towards global agendas and systems (Sassen 2006:3).

Medications can be understood in these terms, they are in fact not only territorially global, they outline the agendas in regard to obesity on a global level, but there are used in the specific context of institutions such as the Clinic.

The interesting thing about these medications is that they cannot be seen as simply taking a pill and then obtaining health. They are not even aimed at changing the way the body works. Rather these medicines can be understood as changing the patient’s actions (by teaching or enforcing). The drugs discipline the individual but do not work on the population. On bio-power Foucault argues on bio-power that the state’s governance of citizens worked on two levels; the first being the governance and discipline of the individual and that individual’s specific body, the second technology governing the life and health of the overall population (Foucault 2008:225). The drugs used to treat obesity work on the individual; they have no effect on governing the overall health of the population. This is illuminating in regard to medical research that Yvonne problematizes. This type of research seems to be directed at the idea of governing populations, disciplining individuals is not one of its goals. However, it is enough to create and allow for these drugs to be used in treatment.
Part 3: The Situated Practices of the Clinic

This chapter is about the specific workings of the Clinic in where I did my fieldwork. Here, the medical knowledge and criteria that define obesity as a medical phenomenon become applied to the specific work of the Clinic. The chapter moves away from the aspects of obesity treatment, the knowledge and criteria that are stipulated from a higher level, and instead takes a closer look at what happens when the issues discussed in the previous chapter merge with the work of the Clinic and the treatment that it provides for patients with obesity.

Aihwa Ong and Stephen J. Collier argue that the global can be interpreted as an ideal type, such as market calculations. These global forms are devoid of social or cultural considerations. However, when examining their interactions with specific value orders they alter and reveal the emergent qualities that assemblages possess (ibid:13). After having looked at the aspect of obesity that pose global qualities I shall now move on to discuss what I interpret to be specific issues that highlight these ideal typical aspects. The chapter that follows places obesity and its treatment in the context of the Clinic and its remit in treating patients. Here I discuss lifestyle alteration as a treatment for obesity and how this treatment creates new ways of understanding the medical, biological body. The chapter also focuses on knowledge as a form of treatment, but also put into play questions of true knowledge regarding weight loss and incorrect ways of knowing.

Lifestyle as Treatment and Cause: “Nature” and “Culture”

The explanations of how obesity came to be

Lifestyle is a constant topic at the Clinic, partly because lifestyle can be viewed as both the cause of obesity and the method by which it should be treated. The notion of lifestyle and lifestyle change permeates the treatment on every level of the Clinic’s work. The importance of lifestyle also exemplifies how the Clinic understands obesity as a medical condition. This involved both ideas of the culture in which we live today and notions of our origins and how we as humans have lived prior to the manner of life we currently have. Lifestyle thus becomes both a method of explaining why obesity is a medical problem and how it is associated with the nature of human biology. This section will discuss the medical interpretations of the body that create obesity as medical condition.

At the first lecture given new patients at the Clinic Yvonne asked the patients how they could lose weight.
Why do we gain weight? How does one lose weight? [Yvonne drew a scale on the white board, on one side of the scale she wrote “in”, on the other she wrote “out”, symbolizing the intake of calories in comparison to the use of calories.] Ok, we are done here now, go home and eat less than you burn. Do you agree? [Eller?] It’s simple but also complicated. One can have an experience of something else. How many of you work as lumberjacks, fishermen or farmers? We move less than we are meant to… There are some diseases that cause weight gain or weight loss. These are often associated with the thyroid gland. women are generally more affected by these diseases. With the exception of severe childhood obesity, this is the only hormonal imbalance that affects weight… Has anyone here ever eaten more than they intended to?

Yvonne first discussed what diseases might cause weight gain, acknowledging that these conditions were in a sense outside the patients’ control. Simultaneously she juxtaposed the discussion of these diseases with asking if the patients had ever eaten more than they had intended. Yvonne went deeper into the discussion of lifestyle and lifestyle alteration:

Each one of you can make your own map. What is it that you can change? What causes you to do something other than you intended? No breakfast? No ordered mealtimes? What you eat. Can we eat as much as we want if we eat the right things? Have you been to Weight Watchers and heard this? …

Words have been given new meanings -- Cosy [mys] has come to mean sweets, Cosy Friday [fredagsmys] equals sweets. Coffee [fika] has come to mean company and eating. All of our big celebrations that stretch the year round have come to be associated with food. So when are we to start making changes? Some ordinary Tuesday in October? Fast food is easy to get hold of.

According to Yvonne obesity is not only about what a patient eats, or what their lifestyle was like:

There is also a strong hereditary factor in obesity. But what do we inherit? We inherit habits. I learnt how to cook from my mum, but I also inherited her appearance. Scientific research on twins who have not grown up together shows the correlation between genes and habits. The twin who has grown up in a fatter family will be fatter than the other twin, but thinner than the family… What makes it possible for some of us to grow up here without being fat? --Good genes, or bad genes. If we compare how we [people] ought to live 10,000 years ago these people would be dead. Biologically it’s not normal.

The correlation between lifestyle and genetics was made clear by Yvonne. Often message of lifestyle alteration and the genetic factors associated to obesity are intertwined in this manner at the Clinic. The five introductory lectures that the Clinic gave new patients were intended to give the patients an in-depth understanding of their condition – a theoretical foundation on which they, as patients, could base their own decisions on how to change their lifestyle and their weight.

As seen, Yvonne problematized the manner in which one can understand obesity as simply being a case of eating less and exercising more. She, along with other caregivers, often mentioned that the patients’ perception of eating might be quite different. A patient may consider that she does not eat anything at all; as Karin told me after one of her lectures, even if one may know that they are eating something their feeling of not eating anything is equally true. Yvonne made this experience of the patient clear in the lecture. She told the patients that the experience
of not eating was important, but that the way we live our lives has made weight loss difficult. Thereby illustrating that we have changed our ways of life. But according to the Clinic it is not only that the “culture” in which we live has changed, but also how our genes work against us in our attempts to lose weight. In her lecture on physical activity, Karin referred to how our habits had come to change as a response to the “culture” in which we live. Previously we walked about ten kilometres per day, today people in general walk about one kilometre. But we have not changed our intake of calories to match our exercise patterns.

There are generally two ways of referring to the “true nature” of mankind that is applied at the Clinic. The first is the discussion of how we as humans lived 10,000 years ago; these discussions are generally related to notions of genetics. In Yvonne’s lecture she also spoke about stress in a similar manner:

Stress releases cortisol. Stress is a reaction that goes back to the mammoth-hunter 10,000 years ago. Stress is a reaction to fear, it increases the pulse rate, causes sweating, shaking, and nausea. Our entire system goes into high gear to prepare us for fight, but if we don’t get to fight, and we instead sit while we are feeling this, the hormones alter from adrenalin to cortisol. This is something that one sees in patients who suffer from exhaustion symptoms -- increased levels of cortisol.

The relationship between biology and lifestyle become intertwined. In discussions of “cultural changes” the staff often refers to our recent history. Such as we have seen in Karin’s lecture. Here culture is discussed in relation to a time in which communications were not as good and we used to work in more physically active jobs. Another example, put forward by Carina in our interview:

In my head it’s about changes in society. It’s quite logical that previously when people worked as farmers or lumberjacks there were more physical injuries (belastningsskador). One worked in physically demanding jobs and that took its toll… In our society in Sweden we work with our brains and it’s not so strange that our health problems are centred around our minds…I’m not sure that we have had time to adapt when thinking about our biological development and evolution. When one speaks about stress research at any rate I feel that we are still quite like cave-people in our structure, but there are different demands and that’s why one should look at the mental stress. We can’t handle it just yet.

Mia: Do you relate obesity to these non-specific medical reasons or is it different?
Carina: I don’t know, I think it’s definitely connected to welfare state (välfärdssamhället) in that way it’s the same, we don’t work in physically demanding jobs anymore but we eat as much or more than we [people] used to. All this food is cheap, easy. And there is fast food. It’s not as difficult to explain, but it’s more specific. It’s logical and quite easy to explain how one gains weight. In some ways it’s the same connections, but it is different. Obesity isn’t difficult to explain…

Obesity is not difficult to explain, but it is difficult to treat. Pernilla views obesity in a similar manner to Carina:

Perhaps how society has evolved I think. I definitely don’t think that it helps what society looks like. We don’t need to walk where we are going, we can take the bus even if it is just one stop. We don’t move in our jobs. And the stress, everything is so stressful; everything has to be fast and easy. Society makes it difficult and then it requires motivation; self-discipline and that is true for everything. But society isn’t making it any easier to be self-disciplined.
In these narratives then, the reasons for obesity are the changed lifestyles of people in society today, but understanding why people become obese is about understanding our biology and our physical bodies. So these notions of our bodies become intertwined with notions of lifestyle and notions of “culture” that create the problem to begin with. As Yvonne told me in regard to obesity as a medical condition: “Everything cannot be biology because we are trying to teach patients to break patterns in regard to their eating habits”.

Calories are one way of describing the combination of the two, or perhaps a middle ground in which it is possible to intertwine ideas of “culture” and “biology” in a coherent system of medical knowledge about the body. The lecture on physical exercise that Karin generally gives is focused on calories. Exercise will burn calories, but not sufficiently to lose weight if a patient does not alter the amount and type of food that they eat. The scale can tell the patient whether they are doing the right thing or not. If they are losing weight they were burning more calories than they were eating. If, however, the patient’s weight remains constant or he/she gains weight he or she is still eating more than is being burnt. Pernilla describes obesity in terms of calories as well:

> It is a complex problem that can have many different causes. A person can be more or less prone to gaining weight. Then in the end it is always about that one's intake of calories exceeds one's use of calories. The theory is simple but in practice it's very difficult.

The logic of calories is both simple and complicated at the same time. An average woman burns about 2000 calories per day, according to Karin. If she eats 2000 calories each day her weight will remain constant. If she eats more she will gain weight, eating less will cause weight loss. This is, in the main quite straightforward but it illustrates the notions of patients’ feeling that they do everything right and still do not lose weight. Karin told me after her lecture that it really is as simple as saying that if you are not losing weight you are eating too many calories. If a patient goes from eating 10000 calories per day to 2000 the patient will feel as though they have made significant changes that should show on the scale, but it is not enough to lose weight. This understanding of calories is also tied to notions of how our bodies work when we try to lose weight. At some point the body will become accustomed to the new weight and lower intake of calories and weight loss stops. A small body requires less energy to function and therefore that person might have to reduce his or her calorie intake to maintain weight loss, Karin described.

I am arguing that calories as an explanation mode for obesity become the notion that ties together a way of understanding how we live today. How lifestyle has been altered by
“culture” and how the notions of the human body and human nature function. Interpreted in this fashion, calories create a bridge between that which the Clinic interprets as “nature” and “culture”, “culture” (society) is thus the reason for the increase in obesity, nature provides the explanation, the solution is creating an understanding of nature to create change in culture (or lifestyle). These interpretations of the body are central in creating obesity as a medical site. They are in fact a way of making issues such as “culture” medical. Anthropologist Jorun Solheim (2001) argues that modern Western culture promotes an understanding of the body as biological and natural. The body becomes a sphere associated with “pure” nature devoid of culture (2001:64-65). In the context of calories one might argue that the body becomes both. The Clinic interprets it as nature because it follows a logic associated with notions of our biology, it is simultaneously about culture because it is the over-consumption of calories that has lead obesity to be a societal and medical problem.

At the Clinic explanations of obesity are related to the individualizing and totalizing quality of obesity. Obviously it is the patients themselves who have to create the changes necessary to achieve weight loss as individuals, according to the caregivers. But the surrounding Notions of our “biology” and our “culture” create a population that can be discussed (Foucault 2008).

Foucault argues that notions of dietary regimes only become important in contexts in which the subject is viewed as living in a different manner from that which nature intended (1976:91-92). This is actually what the Clinic is discussing. The notions of how we as humans are meant to live also tie obesity to notions of “nature” and “culture”. When we go against our “nature” we are risking disease and today we seem to find ourselves in the precarious situation of living in a “culture” that creates problems for our true and inner “nature”. In the process of giving patients knowledge on how they are to understand their bodies, a new body is simultaneously created. A cyborg body if you will. Donna Haraway argues that medical knowledge creates a new body in its wake, a body that is made up of text, machine and body. In medicine the body becomes a semiotic system to be read interpreted and placed in a context of probability (Haraway 1991: 256ff). Haraway argues that bodies, much like gender, are not born they are made. The implications of creating a medical body, full of information, are that it simultaneously creates a bridge between the outside of the body and the inside of the body. The inside body is one that medical professionals understand, whereas the outside is the non-expert knowledge visible to all. The professional understanding of the causes of obesity thus create an expert knowledge that justifies obesity as a medical domain. What we are seeing here is how lifestyle alteration is being made into a medical issue by means of this expert knowledge.
Explaining the inside of the body is central in creating obesity as a site of medical expertise. It creates a distance between the visibility of obesity (and the previous notions of obesity as an individual issue) and the medical condition of obesity. Tove Holmqvist argues that notions of the nature of the body bring forth two different ways of interpreting it. The first is that the body existed prior to culture and secondly to speak about the natural body is therefore not part of culture (Holmqvist 2000:68). Having a body that is in a sense devoid of culture thus legitimises understandings of this body - it becomes objective. It also creates a system from which we can understand obesity as a phenomenon, partly there is the “natural function” of the body, and partly there is society that also presses problems upon the body.

This understanding of the obesity as both connected to nature and to culture seems quite novel in medicine. Here obesity as a medical site is in fact altering the ways that we interpret the place of medicine. Culture is in a sense in conflict with our nature.

In *Obesity’s Status* I argued that the means for treating obesity through surgery also creates a need to treat it through other means. When viewed through the concept of global assemblages one can see these new explanations of obesity, tied to lifestyle change, as emergent. The biological explanation of obesity becomes an assemblage that reveals the shifting forms of obesity (Ong & Collier 2005:12). Obesity, as a medical condition brings forward new explanations of the correlation between nature and culture.

The Clinic is not saying that obesity is strictly about either of the conditions but of the correlation between them. In doing so they also outline who is in need of help. It is not every single person in our society who needs to change his or her way of living, it is mainly people who suffer from both the genetic disposition and have issues with limiting and disciplining themselves in the cultural context in which we find ourselves today.

**Lifestyle Alteration Instilled in the Patient**

When interviewing Karin she told me that the concept of the Clinic was that all of the caregivers there had a similar view on how obesity should be treated, this to her was central, because it prevented a patient from receiving conflicting information from different caregivers.

Karin: That no matter who you go to you should get the same response. So that one cant go to someone and get one response and then go to someone else and get another, and then a third gives another diet because then the patient will feel “never mind, I don’t care, nobody seems to know what they are talking about so there is no point” And also we all work with development [Utveckling] of the patient. We try not to tell them what to do, no special method. Our method is how do you live? What do you like? What do you think tastes good? What do you usually do? It’s not like I never answer questions or come up with tips but they don’t get a ready made recipe “you have to eat this kind of food, or this much” … When it comes to setting goals it’s the patient who sets them. It can’t be me who decides what their goals should be…
There was a consensus that all caregivers shared at the Clinic. At one patient consultation, with Lisa, a patient felt that he had stopped losing weight, or at least was not losing weight as fast as he would have wanted to. Lisa did not recommend the patient to eat low calorie foods or give other weight loss solutions; rather she asked what he felt that he could do at the moment to decrease his weight. At the Clinic patients are to come up with ways of making lifestyle alterations that will help them lose and maintain weight loss. Carina felt that the treatment specifically in groups was to give the patients the opportunity of trying new ways of thinking and acting,

We usually describe the group programme [where patients are treated in groups] as a playground where one offers people an arena where they have the opportunity to vent what they think and feel…. There are different seesaws and equipment, and for every theme [meeting] that we give we can show that “there is this and if you think that this would suit you can do it”. And the next time we show something else… We never say “now use the swing for ten minuets” it’s very free…. I think that if there is anything we can offer it’s giving a person the opportunity to make a decision…. One must never tell a person how they are to work. One should never say never. There are some who ask what to do and then do it and that’s fine. One can’t say, “No I’m not going to tell you”. But for most of the people who are going to make lifestyle alterations the suggestions shouldn’t come from us, not through programmes or telling people to do this…

Lisa also describes the Clinic’s method as first giving a knowledge base for patients to stand on. Then allowing the patient to make decisions on how they want to apply this knowledge to their life. But to achieve a lifestyle change the patient has to want to change, or feel that their current lifestyle at the moment is causing problems.

What we do is that we give lectures where we provide a base. This is important based on the recommendations that exist, to feel good, be healthy. We need to exercise so that our bodies will function. So to present the facts that exist is the first part. Then the patient needs to take in these facts, lifestyle alteration. One can’t change something that one doesn’t view as a problem. If one feels that one’s lifestyle is causing problems. That’s what one needs to figure out with the patient. If they do feel that way how are they to change that feeling? How are they to get there? How are we to reach the goal? What should the road to that goal be?

The lectures can be understood as a way of giving the patient expert knowledge on themselves and their condition. I heard Karin phrase this succinctly to a group of patients when she said, “we are experts at this, but you are experts on yourselves”. I understood her to mean that the information they was given were based on sound knowledge, and that they knew how weight loss could be achieved, but the methods for achieving it were up to the patients who themselves were to decide what might work for them. After a group meeting held by Carina and Lisa they discussed one of the success stories of one patient in the group, she has gone from “impulse to choice”. Instead of going with what she usually did, she stuck to her planned way of eating; she thereby overcame the urges to overeat as she had previously, they said.
The individuality of the patient is central and is seen in every aspect of care given at the Clinic. If a patient is verbal and wants to be placed in group treatment they will be given the opportunity, if they on the other hand have diagnoses that made them unsuitable for group therapy or do not want to be together with other patients they would receive individual treatment. Everything is based on the notions of what treatments each patient will best respond to. Even in the context of individual care the patient is given a supervisor that Yvonne feels might benefit the patient in question. The caregivers have different personalities and strengths that the Clinic understands as important in the care of the patients. Karin is a good example of this, she had an interest in eating disorders and is well adapted to work with patients who have eating disorders but do not quite match the diagnostic criteria.

My type is the patient [is one] who either suffers from an eating disorder or has been at one of the eating disorder clinics, or the ones who didn’t quite match the criteria. I think I get the patients who need to work on their psychological obstacles. Sometimes their social roles can be an obstacle to treatment.

Although patients are viewed as individuals who have their own problems to overcome in regard to their weight, medicine and medical treatment require that the Clinic have a general view of how to influence the way in which these individual patients understand themselves. Carina pointed out that patients generally know what type of food they should eat and that they need exercise but somehow they do not manage to apply this in their daily life.

You probably know what kinds of food you should eat and that you need to exercise. You probably know it but it doesn’t quite happen “why don’t I do what I want to do?” … Maybe you’ve never thought about why it happens, maybe nobody has ever asked you why you stop and buy sweets on your way to the bus, when you don’t want to.

The food diary that patients fill out on their admittance to the Clinic is one step in this direction, even if it is not taken as being completely true. Lisa said that the food diary is to some extent a way of seeing how the patient is eating. But things happen when patients fill it out. Asking the patient if they feel that their eating is in general quite similar to their food diary provides a method for starting to work with the patient and discussing what can be altered in his or her diet.

You can be very motivated but still feel resistance in filling it out; maybe it becomes too clear to you when you fill it in. Maybe it’s not about not wanting to change but that one is scared. The patients who fill it out most openly are the ones who have psychiatric diagnoses. They are used to sharing everything so to speak… But in general very few manage to fill in everything. What happens is that when you do it [eat] you don’t tell anyone… Things happen when you come to write it down, perhaps you don’t eat [as you usually do] or that you just don’t write it down.
The food diary along with all the other methods for treating patients at the Clinic is based on the ideas and motivation of the patient in question. From time to time this leads to problems. According to the caregivers patients can sometimes be of the opinion that they are doing everything correctly, but yet the scales tells a different story. Mostly all the workers at the Clinic feel understanding towards the patients when this happens but from time to time they become frustrated. During a coffee break Lisa said, to no one in particular, that she was waiting for a patient who did everything right but was not losing any weight. The doing-everything-right patients were the most problematic, they had knowledge of how to achieve weight loss but for some reason they failed to. Most often this could mean that they were not sticking to the alterations that they said they were sticking to which lead to feelings of frustration such as Lisa’s. Karin, however, once voiced this in a different way. We were discussing her interview at the small table by the coffee machine. We were talking about the issue of patients doing everything right and still not losing weight when she said “The easy way of viewing this is that patients aren’t sticking to their plans for weight loss, but another way of looking at it is that there is no real medical research done on patients who are obese.” Therefore Karin felt that there might in fact be physical reasons explaining why these patients were not losing weight. According to her one did not yet know how an obese person’s metabolism functions. Perhaps there are biological differences that are difficult to account for?

The “newness” of obesity (in medicine) makes it difficult to say for certain why treatment works in some and not in others. Obesity as an emergent site becomes visible this instance, for it is here that Karin asks herself whether the metabolism of the individual in question might be at fault. Here the experts try to convey expert knowledge to the patient. On the one hand the patient is to be his or her expert and utilise the expert knowledge from the staff at the Clinic. But the Clinic must also base their expertise on expertise from a higher level. They need to find out if there are biological perspectives that create problems for the patient in managing to lose weight. At the moment there has been no scientific research that can explain how an obese patient’s metabolism functions. The caregivers cannot confirm whether or not the patient is doing everything, but suffers from metabolic problems that cannot yet be explained, or if the patient is not being honest about their intake of calories. This literally introduces the issue of true or false in regard to obesity as a medical condition, which can be related to problematization described by Rabinow as “the ensemble of discursive and non-discursive practices that make something enter into the play of true or false and constitute it as an object of thought” (Rabinow 2005:43).
The Clinic works towards helping patients achieve weight loss, but this is not only about food. It is about changing the patient’s reaction to food. So even if food and exercise are central in treatment, the treatment is based on making patients reflect on why they react to food in the way they do. In a sense then the caregivers work with the psychological understandings of the patient, but as Irene told me during our interview the caregiver must know where their expertise is.

It is always a therapeutic conversation when one is listening to someone else, but I do not always have the theoretical references when listening. It is a form of therapeutic conversation, but I have to know where my expertise ends. It's very difficult, but I think I have learnt how to do it.

In the Clinic’s work the consultations are central as treatment. It is the method that can be provided by medicine if the patient opts for non-surgical remedies in regard to achieve weight loss. The notions of lifestyle change are related firstly to placing notions of lifestyle in the context of medicine (as seen in the previous section). And to relating this understanding to the individual patient in question.

What is required from the Clinic is, firstly, a will from the patient to change, and the initiative on how this change is to be achieved. The caregivers are experts who can assist patients in making the correct choices, choices that do not endanger their health, but the patients themselves have to do most of the work.

This understanding of expertise is related to the concept of biological citizenship and the self-governing individual. Through actively absorbing knowledge the patient is to apply that knowledge to their own lives and take responsibility for their own health and lifestyle. This is summed up well by Carina and Lisa in regard to the patient who has gone from impulse to choice. In fact choice is a central concept in this context since the notion of choice relates strongly to notions of neo-liberal governmentality. The individual in treatment is seen as an active agent who has a capacity for changing his or her way of living. In this context, then, the individual is central to the treatment, but expert knowledge provides guidance and help, as well as a way of teaching the patient how to understand his or her body. As Rose and Novas argue “Citizenship in the contemporary age of biomedicine is manifested in a range of struggles of individual identities, forms of collectivization, demands for recognition, access to knowledge, and claims of expertise” (Rose & Novas 2005: 442). Treatment thus becomes a form of governance tied to biological citizenship. Aihwa Ong argues that citizenship is not only to be viewed as relationships between citizens and the state but based on strategies that enable to govern citizens (Ong 2005: 259).
In this context we are seeing an attempt to create citizens (patients) who internalize the expert system’s knowledge on weight loss. Rose and Novas discuss how citizens themselves take responsibility and become active biological citizens. However, in the context of the Clinic we are in fact seeing the process from above, that is to say from the expert system to the patients rather than from the patients. That is to say it is connected to governance as Miller and Rose argue. Expertise creates self-regulatory techniques that the citizen applies of his or her own free will. These techniques also tally with the specific ends of government (1992:188-189). Here the experts’ notions of active citizenship are to be internalized in the subject. It is the experts’ knowledge that is to be applied, but only through the perspective of patients being the true experts on themselves. In this context the patient who succeeds is also the patient who reaches self-understanding. As the patient who went from reaction to choice, discussed above. Simultaneously it highlights the problem of those who do not succeed, those patients who do everything right. They absorbed the expert knowledge; they are familiar with it but do not apply it to their lives.

The actual work of the Clinic can be related to Foucault’s writings on dietary regimes in ancient Greece. Foucault argues that notions of lifestyle change are to be viewed in a different manner from surgical interventions and medicines (Foucault 2002 [1976]: 97-98). Surgery and medicines work on the body, whereas lifestyle instils principles upon the soul. In ancient Greece, lifestyle was connected to the freeman whereas interventions upon the body were rather connected to slaves and those who received care without explanation. Medical treatment in the context of lifestyle creates a bridge between body and soul rather than working exclusively on the body. The similarities between what Foucault is discussing in regard to ancient Greece and the understanding of the obese body by the Clinic are at times striking. According to Foucault the patient is to examine himself, come to grips with how his body reacts to foods, rest and other bodily functions and then make the choice between good and bad. Taking care of oneself is thus a process in which the patient notes his or her habits and then makes informed choices. For Foucault however the idea is not to cure a patient from disease, as such, but rather to create subjects who understand their bodies correctly (ibid: 99).

How should one view the correlation of diet and medicine and medical knowledge in the context of the obesity Clinic? When considering the Clinic it is important to remember the differences between altering lifestyle as a way of prolonging life and actively treating a medical condition. At the Clinic, however, knowledge of how to lose weight is in a sense about instilling notions on the soul rather than on the body. This is made quite clear in the actual methods for treating patients. I understand this treatment as symptomatic for how obesity is interpreted in the
medical, non-surgical community. It tells us that obesity is a condition where the desires and action of a patient must be altered from within. Simultaneously it brings forth a problem (that has been discussed in the previous chapter). If obesity is viewed as a condition caused by habits and actions is it really medical? This questions obesity as a disease.

In the day-to-day work at the Clinic obesity is a disease simply because it is being performed as a disease in every interaction between patients and caregivers. The consultations and methods for bringing about the capacity for lifestyle change, are through the verbalisation of acts that the patient has taken part in. The food diary can be understood as a confession meant to bring about change in the patient, or as a conceptualisation of where they went wrong. Judith Butler writes that confessions in a psychoanalytical context have the capacity of recreating the body through speech (Butler 2006: 166ff). Butler is speaking about the confessions of sex and desire. In this context I feel that the desire for food and the proper way to live in relation to it is equally important. Through Foucault, Butler argues that confessions are a way of utilizing knowledge into a way of living one’s life (ibid). This is precisely what I am arguing in this context. The patient is to internalize knowledge that the Clinic provides and by this knowledge recreate his or her life to fit it. The patient is the one who is to understand what they can change in their lives and their diet. And this is done by the patients understanding of themselves.

Notions of lifestyle become situated in a specific realm when patients enter the Clinic, before they become part of the workings of the Clinic. Their manner of eating and the amount of physical exercise is a personal issue; it becomes medical in the sharing of the problem with the caregiver. Philosopher Annemarie Mol discussed this in the book *The Body Multiple* (2002). Mol discusses that the relationship between the doctor and patient requires the cooperation of both parties. This section began with Karin saying that everybody at the clinic needed to share a similar view of obesity as a condition so that patients do not receive conflicting information. This is one of the collectivising moments in obesity in which all caregivers at the Clinic must share consensus on how obesity is to be treated. The doctor cannot diagnose without the patient and their willingness to tell his or her story. What is required is the body of the patients and a narrative in which the problem is described and placed by the doctor in the medical field (ibid: 23ff).

**Magic and Myths**

One Friday before Christmas most of the Clinic’s staff was having coffee and buns before the rounds were to start. Karin came in a little later than the rest of us; she was holding a cup of tea and had just finished a bun. The tea label was hanging form the side of the cup and someone
noticed that Karin was drinking green tea. “Why are you drinking green tea?” they asked, “It neutralizes the bun I just ate”, said Karin, smiling. Most of the staff laughed, and others picked up the joke… “Oh, but that only counts if you actually eat the teabag”, someone else said and everybody laughed.

This joke offers an entry point into what Clifford Geertz (1973) might term “thick description”. Outside its context it might be little more than a statement explaining why Karin was drinking green tea, even if it would have been an odd statement. The reason the joke was funny was that the caregivers at the Clinic constantly heard or read about notions like this. There were many different notions about weight loss that the Clinic spoke about as myths. Often patients had read or heard about different weight loss methods that needed to be explained or contradicted by the caregivers. In this context, then, the joke revealed something about the situation of the caregivers at the Clinic and the myths that they worked with on a day-to-day basis.

I had come across some of these “myths” myself during my time at the Clinic. Several times during lectures patients would ask about the truth surrounding weight loss. The myths were often related to things that they had read in magazines or newspapers. During my time at the Clinic sugar addiction was often asked about. Usually when patients asked about these matters it was to find out what the Clinic’s position on the matter was. At one lecture that Ulrika was giving the issue of sugar addiction was brought up, Ulrika explained that the Clinic did not treat sugar addiction because it was difficult to draw the line between what could be conceived as addiction and what was something that one had made a habit of eating.

Sugar addiction came up in another lecture, held by Karin. She had a similar response. Most caregivers I have heard speak about sugar addiction agreed that if the patient feels that they are addicted to sugar they are free to stay away from it. Staying away from sugar will not cause patients to gain weight, so in this instance patients are free to try eliminating sugar from their diets.

In her lecture on physical exercise Karin took the time to go through how patients should interpret different tips in regard to weight loss that they might come across in the media. Karin brought up some popular myths that the patients might have heard and asked what they thought of them.

Some myths come from the athletic community or from scientists investigating things on a cellular level, when they are to be translated to reality they don’t quite work.

Yvonne also discussed myths in her clinic lecture on obesity. She brought up a myth that stated that exercise burned more calories if it was scheduled in the mornings before breakfast. She
asked the patients if they thought that this was applicable to them, but answered the question herself. It was not; it was not even applicable to her. This research was done on athletes such as Carolina Klüft\textsuperscript{17} and did not apply to people in general.

The Clinic takes the time to confront what they understand as myths about weight loss in the lectures, presumably as way of teaching patients how to interpret true research that was applicable to trying to lose weight. There was also a notable interest in the “truth” about weight loss, the real facts if you will, from the patients who attended the lectures. At most of the lectures I attended the patients were very active, asking questions and once even asking if they could have some of the overhead images that Karin had shown during the lecture. Karin asked why they might need them and the patients said that they would be a good thing to have and to be able to read at their leisure.

After the lecture Karin came to the room in which I was sitting. She wanted to know if I had any questions about her lecture. I asked her about the myths that she had spoken about, how she interpreted them. Karin explained that she felt that the myths sometimes worked as an incentive for patients to try to do something about their weight, but they could also work as procrastination devices in which patients felt that they needed something to make weight loss happen. We discussed these issues further in the interview I had with Karin a couple of weeks later.

Karin: I think that there is a discrepancy between what one believes that one does. There are a lot of people who express that I eat [nothing] and that experience is 100 per cent true. It is really about understanding and trusting that if a person says, “I don’t eat anything” well then we know that in a way that is a lie. We know that they eat something and, of course too much, even if it isn’t a lot. But at the same time the experience is important to take into account because if they feel that they don’t eat anything then it is a type of expression that they have a hard time seeing how they could eat less. And a lot of the time there is a feeling of unfairness “why can others eat and not me” or it is a process of mourning “if I accept that I must eat less I am in a mourning process’. To see that I can never again eat [inaudible] and as long as I can keep that away from me, food fills some type of need but if I keep that away from me I don’t have to take it in. As soon as I accept “ok, I eat too much, I have to eat less” then the demands increase as well…

Mia: Do you think that these myths work in the same way that one reads about?

Karin: Oh yes. I think that they help in keeping people in this [way of thinking], sadly, keeping them in this magical way of viewing it instead of taking care of the issue of food.

This idea of physiological defects that made it impossible for patients to lose weight came up from time to time, partly amongst the caregivers when discussing treatment, and sometimes at lectures when patients would say that something was wrong.

Myths are something that the Clinic’s work has to be related to by the patients. Since obesity is an issue so often discussed in the media, patients have many questions in regard to diets they had read about and whether or not the Clinic used them. Many ask about HFLC

\textsuperscript{17} Carolina Klüft is a Swedish athlete.
(High Fat Low Carb) diets and if the Clinic uses them. In these situations the Clinic tries to explain that they have to follow the guidelines that have scientific evidence showing that they actually work. Thus the treatment that the Clinic uses is distinctly different from weight loss advice one might read about as a lay person. Therefore this added a new level to teaching patients how to lose weight and become experts on themselves, as has been discussed in the section above. Here patients have to learn to distinguish between different types of expert information and simultaneously first and foremost be experts on themselves.

The discussion of myths evoked notions of classic anthropology. It is important for the Clinic’s work to debunk these myths. Anthropologist E. R. Leach writes that the function of the myth is to legitimise the current order:

I call it myth simply because, as will be apparent, the truth or untruth of a tale or any particular part of it is quite irrelevant; the tale exists and is preserved in order to justify present day attitudes and actions (Leach 1959:85).

The myths thus became a part of at least some patients’ ideas of how to lose weight. For the Clinic these myths are in stark contrast to reality and facts that had to be adhered to in order to attain successful weight loss. In this context Leach’s definition of the myth is quite true even in the context of the Clinic and might even be seen as revealing in regard to the different types of knowledge and expert systems that patients have to juggle. More importantly, however, myths on weight loss can be conceptualised as being factually incorrect or as being incorrectly interpreted. It is information that patients have picked up, that did not necessarily tally with the Clinic’s reality of obesity and its treatment. The will to learn the “right kind of knowledge” is important even to the patients, as is seen in Karin’s lecture, when patients asked for the information she had shown at the lecture. Simultaneously Karin expressed that patients needed to let go of the magical notions surrounding weight loss. However, these magical perceptions are all associated with notions of biology and the function of the body, such as having ruined one’s digestive system or simply not burning calories in a manner that was “normal”. I interpret these myths as reflections of the internalisation of expert knowledge, even if they do not possess the validity of truth according to the caregivers. (Rose & Novas 2005:446).

Following Rose and Novas, expert knowledge is becoming a part of the jargon and life of sufferers (ibid). The authors argue that new technologies such as the Internet provide forums for picking up and internalising expert knowledge. The authors further argue that this type of active citizen is becoming increasingly important even in medical care. This fact has been discussed in the section Lifestyle Alteration instilled in the Patient. But in the context of myths we are seeing something different. Here the knowledge that the patients pick up and internalise seems to be faulty, misapplied or simply untrue from the caregivers perspective.
The caregivers thus have to define the difference between valid knowledge and unreal myth. This contained a paradox; patients are to learn how to lose weight. Myths that the patients read about often contain information on how people can lose weight but they are not viewed as scientific facts (by the Clinic). Instead the patients are to learn correct facts that are also scientifically validated. Thus the Clinic is creating patients who are experts on themselves and can tell the difference between fact and other forms of knowledge. Regimes of the self, discussed by Rose and Novas, in which citizens are shaping their health through active choice is in this context created through passing on the capacity of defining what is to be viewed as true and what is to be understood as myth (ibid: 458). This can also be related to Charles L. Briggs term “sanitary citizens” who understand their bodies in terms of medical knowledge, and most importantly “recognize the monopoly of the medical profession in defining modes of disease prevention and treatment” (Briggs 2003:288). But it is belief in the expert system and in biology that aids the belief systems (termed as myths) that patients might enter the Clinic with. At the Clinic magical methods of weight loss pose an inherent problem in solving the individual’s obesity. The lay person has to be able to tell the difference between false and true facts. I interpret this as saying something of how expert knowledge is interpreted by people not possessing it. To them it is possible that these (to the Clinic) magical notions are just as biologically justifiable as the “true functions” of the biological body. Magic and bodies thus become intertwined.

Myths about weight loss pose a contrast between different systems of knowledge. Myths spring from popular culture; from magazines and the media. They are often not about medicine but are applicable to people others than those suffering from medical obesity. The myths are not applicable to patients at the Clinic. Even in this context one may notice the manner in which obesity as a medical site was being created or performed. Creating a difference between those who suffer from obesity and who just wanted to lose a bit of excess weight.

Embodying Health and Disease.

Mia: I suppose that it is a problem when something is so visible on the outside?
Karin: Yes but at the same time if you see someone who has a bad rash or someone who has yellow eyes as a caregiver you will notice it, even if the patient came in on account of blisters. “I wonder if we could run some tests on you” and that wouldn’t matter.

One day, just as I was leaving the Clinic, Karin called me to her desk. She has just received an email and wanted to know what I thought about it. The email was from someone who was interested in working at the Clinic. Karin read it out to me “Hello, my name is… I have read about your clinic and I am very interested in working with overweight people, I wonder what kind of education your need to work at you clinic…” Karin then read her own response to the
email. It was short, brisk but not unpleasant. She had written that this was a medical facility; therefore all the workers at the Clinic had some form of medical training. We cannot provide medical care for obesity without having an understanding of the medical body and diseases associated to obesity. She looked at me “what do you think, is this something you find interesting?” What is it about the email that you find interesting, I asked. “This is what we have been talking about, that this is an issue that everybody wants to be involved in. She thinks that she can come from “Friskvård” and work here, but this is medicine. We need to know and understand the serious health concerns that come with obesity, heart disease and such. It’s one thing to talk to people who are physically well and want to lose weight but these are patients. They are not well we can’t let just anyone work here.”

Karin went on to say that there was a notion that these people just did not know how to eat and that we can tell them and then we have done a good deed. I interpreted her to mean that patients were viewed as unintelligent, and that weight loss treatment was about telling them what they should eat because these patients did not seem to know. This was not the Clinic’s perspective. A couple of days latter Karin was in the kitchen and told me that she had got a reply from the person who had emailed her. Apparently the applicant had recently undergone weight loss surgery and felt that she had a lot to offer. Karin felt that the perspective of having been there oneself was a big mistake in treatment. It was dangerous to think that one automatically had the same experiences as everybody else. Karin used the term “newly converted” [nyfrälst] to describe how she interpreted some people like this. Yvonne who was listening to our conversation said that she herself had experienced this at the Clinic. At one point a woman had stormed into the kitchen where the caregivers were sitting and had exclaimed that she wished to know where one applied for jobs because she had to work here.

Having personal experience came up in other situations as well. At the chiropractor lectures Karin mentioned that patients might often ask if one as their caregiver had ever been overweight. This could be interpreted as a question asked to see if the treatment worked but perhaps even a question aimed at pinpointing if the caregivers themselves had experienced the difficulties of trying to lose weight. Embodiment was an issue that was ever present in the care of patients suffering from obesity. When visiting a hospital Lisa, Yvonne, Cecilia and I found ourselves in the coffee room all alone. The hospital that we were visiting had originally started the Clinic. A discussion of embodiment ensued when Lisa and Yvonne began to speak about the treatment of patients, and the cooperation between the hospital and the Clinic. Lisa brought up the fact that there had in the past been caregivers who suffered from eating disorders that had made treatment of patients very difficult for this caregiver. Yvonne said: “We all have eating
disorders, but you have to be friends with your eating disorders to work here”\(^1\)\(^8\). I had heard Yvonne say this as a joke several times and indeed the bodies of caregivers were to some extent important in the context of the Clinic’s work. If obesity indeed is a disease than caregivers treating it need to show that they are healthy. Disease and health were performed in the caregivers meetings with the patients as well. Obesity is visible, one could see who was a patient and who was a caregiver, and thus Karin raises the re-orientation of obesity as a medical problem when she says that obesity was visible, but many medical conditions are visible.

The embodiment and shame that is connected to obesity also became obvious to me as an outsider when sitting in on patient consultations. It is not uncommon that patients will cry when meeting Yvonne for the first time. Yvonne often asked why they were crying and then hand them a roll of paper tissues, saying “guess why I have this in here”. From time to time Yvonne did not get a response when she asked a patient why they were crying, in these instances she asked if they were crying because they were at the Clinic. After one of these patient consultations Yvonne and I discussed the emotional response to coming to the Clinic. Yvonne said that shame was an important issue to take into account when treating patients. Some did not want to come to the Clinic; others did not want to be seen at the lectures or information meetings. Yvonne began to speak about aspects of shame that the Clinic had discussed at one of the cognitive courses that they attended for learning purposes. Here they had all been asked to describe a situation in which they had been very angry, everybody had been able to recollect a story of immense anger, and then they moved on and were asked to recollect a story of when they had felt shame. This had proved to be more difficult. “Nobody wants to tell stories of when they have felt shame”, Yvonne said. Yvonne also mentioned that the most important thing in regard to shame and the Clinic’s work was to show patients that nothing was unique, nothing affects only one person and Yvonne herself felt that she had heard most things before. She was seldom chocked at what anyone told her in her consultations. But the issue of shame is tied to notions of responsibility (discussed previously) and thereby to morality. Meira Weiss argues that sufferers of stigmatized diseases such as AIDS often interpret themselves as being punished for their misconduct, disease therefore becomes about moral orders (Weiss 1997:465).

In the section on BMI we have seen how Irene had discussed one of the issues tied to embodying disease. She mentioned that patients had the feeling of being read by caregivers and that workers in medicine had been given mandate to ask about anything at any time.

The issues of embodying disease are problematic. As Karin said, if obesity is a medical condition then a caregiver should be able to point toward facts that seem to be health-

\(^1\)\(^8\) “Vi är alla ätstörda, men man måste vara kompis med sina ätstörningar för att jobba här.”
related problems. Simultaneously embodying obesity creates feelings of stigmatization and feelings of constantly being “read” as Irene terms it. Anthropologist Mark Graham uses the term lipoliteracy to denote how individuals in fat-obsessed cultures read fat as a method of saying something about a person (Graham 2005:178). This can be related to health care that Irene is describing. The meaning of fat in this context is something unhealthy, associated with risk and requiring intervention. If we, as Graham suggests, are lipoliterate then what follows is that not only caregivers have the capacity of reading fat. It is also done by others, by lay people and patients as becomes apparent when patients asked Karin if she had ever been overweight. But the connotations of reading fat are probably different in regard to the position of the person doing the reading. The experts at the Clinic can read fat, but do so with medical aids, such as BMI or scales. As becomes clear in Irene’s statement of the uses of BMI in defining how much of a sufferer a patient is. This was about being medically competent as one can see Karin’s reaction toward people who applied for jobs at the Clinic on the basis of shared experience of weight loss.

Obesity as a medical condition requires that it be treated by medical professionals. If the staff is not medically trained then it is not medical treatment. Shame, as Yvonne understood it, should be addressed and this was done, according to her, by showing that nothing is original and no one is alone. In a sense then the Clinic worked to normalize obesity as a medical condition that affected many, and by lessening the shame that an individual might feel. In the introduction to *Undoing Gender* Tiina Rosenberg writes that a central part in Judith Butler’s gender theory is the culturally comprehensible body. Not possessing a culturally comprehensible body thus creates the problem of non-classification (Rosenberg 2006:12). In obesity treatment bodies are being made comprehensible. The caregivers’ bodies are creating an intelligible idea of health whereas the bodies of the patients signify ill health. In the actual work of the Clinic, classifiable bodies are being created (not only as Butler suggests in regard to gender but also in regard to) into health and disease.

Disease and health are performed by means of appearance. Above I discussed Graham’s term Lipoliteracy. The notion of reading fat that Graham discusses is interesting when placed in the context of Butler’s heterosexual matrix. Butler argues that sex is performed by acts. These performances are governed by norms, which in turn make them intelligible (ibid: 216).

I am arguing that the same can be said for obesity as a medical condition. When creating obesity practically in the space of the Clinic bodies indicate the positions of the people inside that space. This of course requires that there is a space of health care treatment in which these bodies are made diseased, such as the Clinic. If we can speak about fat obsessed cultures in the manner that Graham proposes, and that fat indeed indicates disease then with this follows.
that healthy bodies and diseased bodies are performed and created. Bodies can be read and
categorised on the basis of healthy or unhealthy. Expert knowledge and healthy bodies are also in
a sense intertwined; this correlation is seen in the discussions of who is able to treat obesity.
Having experience of obesity personally is not medical and does not mean that one is able to
treat patients with obesity. So even if the healthy body of the caregiver is important it is mainly a
definer of that the caregiver has internalised knowledge regarding how to stay healthy. It does not
mean, as some who applied for jobs at the Clinic seemed to think, that one can treat obesity.
Part 4: Creating disease

Rosenberg and Golden write that diseases do not exist until we agree that they do by responding to them (1997:xIII). The previous chapters in this thesis have centred on how medical professionals respond to and conceptualise obesity as a medical condition.

Through Aihwa Ong and Stephen J. Collier (2005) I have proposed that it is possible to understand criteria, definitions, diagnostic methods, and referrals as possessing global qualities. Ong and Collier argue that the global is in a sense ideal typical. It is like a market principal, devoid of culture and emotion (ibid:13). The topics discussed in the chapter The Global in Obesity are relatable to this analogy. Here I have also been inspired by Saskia Sassen’s writings on the global, which according to her only become operable inside national domains (Sassen 2006: 2). This chapter relates not only to explicitly global definitions and criteria, but also to scientific research and national principals of health care and governance. When these global elements and “objective knowledge” meets the actual care given to patients suffering from obesity something else happens. In these assemblages other issues become visible; obesity is no longer about simple calculations (or yes or no answers). In the chapter The Situated Practices of the Clinic I have discussed how obesity is negotiated as a disease by teaching patients expert knowledge, by reinterpreting the body and by performing disease and health in the space of the Clinic.

These two chapters together formulate the emergent quality of obesity. Obesity when viewed from this perspective becomes something new — something that can be conceptualized as an issue in which individual or collective existence is problematized or at stake (Ong & Collier 2005: 4). What I have aimed at showing is that the global aspects of obesity together with its assemblages intertwine and create obesity as an emergent site; being negotiated as a disease.

Throughout the text I have used Foucault’s concept of bio-power, arguing that obesity is, in a sense, about both individualizing and totalizing structures. The totalizing structures in obesity become visible in the criteria and structures that are discussed in chapter 2. Criteria create a space in which disease is defined. Criteria, medications and other means of creating obesity as a medical site are totalizing; they both create and define populations of sufferers. If we cannot speak of a population we cannot speak of disease. The idea of treating a population is also described by means of expert knowledge and scientific research as was seen when the surgeon, Thomas, spoke about the legitimacy of surgical treatment that the SOS study had provided. Here governance as a form of expert knowledge becomes clear, its aim is to treat the health and reduce the mortality of a population and this is done by means of legitimate
scientific research much as Rose and Miller argue. One can literally understand the validity of scientific research as “the ways in which a populations’ living, health, and happiness are governed by different forms of expertise” (Rose & Miller 1992:175). But first it is necessary to outline a population of sufferers. I have argued that for obesity to be viewed as a medical phenomenon or even a disease the two disciplining structures of bio-power must be present. There must be a way of speaking of and defining a population of sufferers and there must be treatment that allows for disciplining subjects on an individualizing level. Thus making obesity into a medical condition revolves around the interplay between these two issues. Through out the text my informants problematize this fact while simultaneously applying their work to these ridged definitions of creating populations and treatment on individualising levels.

The BMI scale creates a group of sufferers. Simultaneously BMI is a means to compare weight in scientific research. BMI is a stable entity that allows for the creation of a population, but it is also a key of admission for patients to be accepted for treatment. Giving the appearance of being an entity that creates stability, BMI can also be renegotiated, as seen when the surgeon Johan discussed the proposal of altering BMI criteria to grant patients access from a BMI of 35 kg/m² and up.

The medical treatments offered obese patients also bring forth the validity of treatment, this time through medical research. Obesity surgery has a higher status than lifestyle alteration, mainly because obesity surgery can prove its results through scientifically validated research. The vocabulary and methods for mapping obesity are applied to the Clinic’s work, but they also become interwoven with the other issues that one may not have foreseen such as making lifestyle alteration into a medical treatment. This is no doubt due to many different factors that emerge in obesity treatment, such as technological intervention.

In Obesity’s Status, technology such as obesity surgery creates a means for treating obesity, it follows that it is impossible to treat all patients surgically. So there must be alternatives. But these alternatives (read lifestyle alteration) have not been validated by scientific research and therefore are seen as non-effective (at least by the surgeons, Thomas and Johan). This places my informants at the Clinic in the precarious situation of being forced to show the validity of their treatment. Thus I have argued that if one cannot prove the efficacy of treatment then the treatment risks being deemed as un-medical as my informants have discussed.

On another level the section Obesity’s Status deals with what is understood as disease in the conception of health care. This reveals a discrepancy, obesity and its treatment has been sanctioned as a medical condition because it is offered through the healthcare system, yet my informants speak about obesity as a condition that is viewed in health care as caused by the
individual themselves. Thus showing that obesity is not viewed as a medical condition simply because there are treatment facilities sanctioned by state healthcare. Obesity has to be a disease even in the minds of the people working in health care. Obesity as an emergent phenomenon in medicine therefore has to be negotiated. My informants do this by trying to convey that, although individuals may cause obesity in themselves, many other diseases that have authority in medicine are also caused by individuals’ choices and lifestyle. In the end however it is scientific research that has the ability of validating and creating cures for disease, which can lend truth and authority to obesity as a medical condition (c.f Rabinow 2008).

The use of obesity medications is also understood as valid or invalid based on whether or not they work on larger populations. Medical research requires that all test subjects show the same type of results. However, the medications do not work in this manner. Thus they are seen as having little effect on weight loss. Some of the caregivers argue that these medications work on individuals who had specific reasons for being overweight or obese. Orlistat works well in people who are obese from eating too much fat and have problems avoiding fatty foods. Thus medications are viewed as ineffective since they do not work on an entire population of sufferers.

The chapter The Global in Obesity has attempted to show how medical criteria both create legitimacy and problems in defining an issue as medical. It shows how criteria are based on notions of how populations should be treated, criteria that do not apply to an entire population (defined by medical research) thus becomes non-medical. When viewing the phenomena discussed in this section through the perspective of the Clinic there is a constant problem in the creation of a population and the individual care of the patients. Drugs do not work on everyone, not everybody with a BMI above 35 kg/m² suffers from their obesity and all patients who are obese cannot have surgery even if it is a cure that has scientifically validated results. The inherent problem that becomes apparent here is that when criteria, pharmaceuticals, and definitions are not applicable to entire populations they lose their validity. Medicine is to be objective, and when it cannot speak of entire populations it is not objective.

In chapter 3, knowledge has been the central issue under discussion. Knowledge and the application of the correct type of knowledge is the main form of treatment provided at the Clinic. I have argued that the Clinic is creating a treatment based on the self-disciplining capacity of the patients under treatment. The individualizing structure of bio-power becomes evident in this context. But it also means that the Clinic has to teach patients what the “right type” of knowledge is. Thus making patients literate in differentiating between that which the Clinic terms as knowledge and what can be dispelled as myth. Teaching patients to become
experts on themselves is crucial if they are to succeed in loosing weight. The patients have to internalize expert knowledge (Rose & Miller 1992).

From this perspective one might argue that obesity as a site for medical intervention involves aspects of governance in which expert knowledge not only provides solution and treatment but also that this expert knowledge (i.e. that obesity is a health threat that requires medical treatment) is also internalized in the citizen or patient. Thus not only are the obesity specialists teaching patients how to be healthy and lose weight, they are simultaneously creating the understanding of obesity as a health concern. As is seen in Irene’s comment about not normalizing obesity because it is bad for one’s health. Here medicine or medical practice has the capacity of lifting obesity from a stigmatized issue to an issue of health. This is possible if there is a genuine consensus on obesity as a medical problem.

Chapter 3 also discusses the interpretations of the biological body when obesity is made into an area domain in medicine. Obesity as a medical condition treatable at the Clinic creates new ways of understanding the body and body size. Through Butler I have argued that medical interpretations of obesity create a body that is classifiable and legible as diseased. At the Clinic obesity as a medical condition also requires descriptions of the inner workings of the body. I have argued, that this is central when creating obesity as a medical condition. It means that since obesity is caused by lifestyle choices, these lifestyle choices must be explained through biomedical language and explanations of the inner workings of the body. When obesity is being negotiated as a disease the body must be reinterpreted. Obesity has to be outlined as a problem even inside the body for it to be perceived as medical. “Nature” and “culture” become intertwined in an unexpected manner when obesity becomes a medical site. Suddenly obesity highlights the fact that our “culture” is in conflict with our “biology” and further more that culture suddenly becomes an issue for medicine. This can be interpreted as part of the assemblages that come together when obesity becomes a medical site.

When viewed from the perspective of global assemblages obesity is firstly defined through the criteria that allow for defining a population of sufferers. These criteria become applied to the institution of health care. Obesity and the criteria that are used to define it are in accordance with the overall rules of this institution. Thus the criteria are a part of the institution and also create new aims of that same institution. Mary Douglas (1986) argues:

Any institution that is going to keep its shape needs to gain legitimacy by distinctive grounding in nature and in reason; then it affords to its members a set of analogies with which to explore the world and with which to justify the naturalness and reasonableness of the instituted rules, and it can keep its identifiable continuing form (1986:112).
These criteria are mobile, deconstructable and reconstructable. They can be applied in different ways and in different contexts (c.f. Ong & Collier 2005: 3ff). But when these guidelines become applied to the actual work of the Clinic they set into play many different, and perhaps even conflicting notions of how obesity is to be viewed now that it is medical. Most notably that lifestyle becomes an issue for medicine, as both a form of treatment and a cause. This very view creates an altered way of understanding “biology” and “culture” at the Clinic. Our ”culture” creates problems and diseases in our “biology”. Simultaneously it creates novel forms of medical treatment that can be understood as “regimes of the self” (Rose & Novas 2005: 439-464).

I have wished to show that in the process of disease making understandings of the body, of technology and treatment become reinterpreted. Further I have wished to stress that which has become apparent to me when conducting fieldwork at the Clinic; namely that strategies and treatment are governed from a higher level than that of the specialists working at the Clinic. Through my readings and my fieldwork it has become increasingly plain that the very legitimacy of obesity’s entry into medicine is based on the notion of the world-wide threat that obesity poses on populations. Although, strategies, criteria, and knowledge are developed on global levels they are in fact imposed by the nation-states. We are seeing how the global is being incorporated in “micro processes” to Swedish health care (see Sassen 2006:1). The criteria that are set on global levels become negotiated and incorporated in national interventions and treatments, then applied to the specific work of the Clinic. We are seeing a form of “denationalization” as Sassen terms it (ibid: 3). The processes discussed here are not obviously global, but they follow an agenda that is (ibid). What the effects of global technologies and criteria have on creating disease and indeed what this denationalization of the state implies is something that must problematized. I have attempted to problematize this by discussing how the implementation of global knowledge merges with national levels of governance.

Obesity is a site that anthropology has hitherto left relatively untouched, I propose that further studies on obesity (and disease in general) should take the perspective of how global agendas become incorporated in national strategies governing the health and defining disease in populations within nation-states. Following Sassen I argue that it is important to reveal these global aspects that might otherwise continue to be represented as national (ibid: 4).

In this text I have attempted to make some of these issues visible by describing how the outlining of a problem (obesity) and the strategies of making this problem disappear (on higher levels of governance) become incorporated into the specialised treatment offered by Swedish obesity specialists.
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**Websites and URL’s:**
Appendix

Informants mentioned in the text:

Yvonne: The Clinic’s physician director. Works with adult patients.

Cecilia: New physician at the Clinic. Works with adult patients.

Lisa: Nurse at the Clinic.

Irene: Nurse at the Clinic. Works with empowerment and education.

Charlotte: Physiotherapist. Works with patients who have mental disabilities.

Karin: Physiotherapist.

Pernilla: Dietician

Ulrika: Dietician

Carina: Therapist, works with CBT

Johan: Obesity surgeon at a public hospital in Stockholm.

Thomas: Obesity surgeon at a hospital in Stockholm.