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Author(s): Karen Throsby

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'I'd kill anyone who tried to take my band away': obesity surgery, critical fat politics and the 'problem' of patient demand.

Karen Throsby

Department of Sociology

University of Warwick

Coventry CV4 7AL

UK

K.Throsby@warwick.ac.uk

TEL: +44 24 76575129

Abstract

Obesity surgery is commonly figured within Fat Studies as the violent mutilation of the fat body, and as the unjustifiable apotheosis of the war on obesity.

However, while calls to stop obesity surgery are politically appealing, they are unable to account for positive accounts of surgery, or the rising demand for it, outside of narratives of victimhood or false consciousness. This paper asks how a critical perspective can account for those surgery patients who, regardless of any problems that they or others may have encountered in the process, remain positive advocates for surgery. Drawing on interviews with obesity surgery patients and observations in an obesity surgery clinic, this paper argues that obesity surgery is usefully conceptualised not simply as acquiescence to the anti-fat imperative, or its brutal implementation, but as a complex interaction of interests, desire and power relations which is inseparable from deeply problematic anti-obesity ideologies, but which is not confined to them. I conclude that the small resistances that are evident in the everyday experience of obesity surgery signal one way in which it may be possible to identify new, unexpected spaces for critique and contestation, and to open up novel and inclusive avenues for critical thought. This opens up the possibility of taking patient demand for, and endorsement of, obesity surgery seriously as part of a critical fat politics, rather than as anomalous to it.

Key words: obesity surgery, Fat Studies, resistance, situated knowledges.

...as far as I'm concerned, weight-loss surgery is a mutilation of healthy body parts. It is never justified. Besides, it doesn't work. In real life, most survivors of this surgery do not keep off whatever weight they lose. Often, the only permanent results are grim, lifelong side-effects, including dangerous and hard-to-treat vitamin deficiencies. When someone comes at you with a knife, the healthy choice is to get away from them as quickly as possible. (Wann 1998: 41)

I'd kill anyone who tried to take my band away. (Katy, laparoscopic gastric band patient, 2 years post-op)

A striking feature of the growing field of contemporary Fat Studies (see, for example, Rothblum and Solovay 2009; Tomrley and Kaloski Naylor 2009; Cooper 2010), at least for me as a researcher working specifically in the area of obesity surgery, is the status of surgical interventions into (against?) the fat body as the apotheosis of fat hatred and the violent and experimental brutalisation of fat bodies. In published materials, blogs, and presentations, surgery is repeatedly figured in talk and text as the one intervention that those working within critical fat politics can unite behind as inherently and irretrievably problematic and harmful. It provides a focal point around which an otherwise diverse and often conflicted movement can rally. Indeed, it could be argued that obesity surgery¹

¹ The term "obesity surgery" is, in itself, contested, with many seeing "obesity" as problematically and offensively medicalising fatness. I have chosen to use

has become a synecdoche for the war on obesity; a potent shorthand for all that is egregious about the contemporary attack on fat. Fat activist, Marilyn Wann, exemplifies this position, generating a volley of rhetorically potent alternative labels for obesity surgery – gastric mutilation, stomach amputation, gastric bonsai (Wann 2009) – to signal her contempt for the practice. Health At Every Size (HAES) advocate, Linda Bacon is equally dismissive, arguing that surgery ‘would be more appropriately labelled high-risk disease-inducing cosmetic surgery than a health-enhancing procedure’ (Bacon 2010: 62). This position is supported in policy statements issued by both the National Association to Advance Fat Acceptance (NAAFA) and the International Size Acceptance Association (ISAA), who argue that ‘all gastrointestinal weight loss surgeries be discontinued’ (NAAFA 1993) and that they ‘cannot support the option of weight loss surgery, even as a very last resort’ (ISAA 2002)².

I have some sympathy with this position. Obesity surgery is still relatively experimental, it is at best revisable (but not reversible in the case of all procedures except the gastric band) and it carries the risk of a wide range of

“obesity surgery” not because I endorse the view of fatness as a medical problem, but because that terminology most directly reflects how the procedure is framed and delivered by health services – as a surgical procedure for a medical problem. My research aims to critique this by demonstrating the complexity that characterizes the experience and practice of obesity surgery, and which belies this over-simplistic figuration.

² The examples used here are from the US, and have been selected as the most pronounced examples of the phenomenon I am discussing. I have encountered similar repudiations at conferences in the UK and Australia, as well as in personal blogs, and would not see this kind of repudiation as a strictly US phenomenon (although the early adoption of obesity surgery as a mainstream anti-obesity intervention in the US, and the high numbers of surgeries being performed, may well have contributed to such definitive statements of resistance).

chronic and acute side effects and complications (see, for example, Flum, Salem et al. 2005). Furthermore, like all weight loss interventions, and especially those delivered through health care systems, obesity surgery is premised on the certain conviction that fatness causes (expensive) ill health, and that weight loss is the necessary and urgent 'cure' (James, Leach et al. 2001; NAO 2001; House of Commons Health Committee 2004; NICE 2006; Foresight 2007; Haslam and Haslam 2009). This conviction has been challenged extensively (see, for example, Aphramor 2005; Gard and Wright 2005; Monaghan 2005; Bacon 2010; Bacon and Aphramor 2011; Gard 2011) but nevertheless constitutes the declared basis for the sustained, moralising attack on the fat body that marks the contemporary war on obesity. Many of these concerns have informed my own critical writing on obesity surgery (Throsby 2008; Throsby 2009; Throsby 2009; Throsby 2011), as well as that of others researching this topic (Murray 2005; Murray 2009; Boero 2010; Murray 2010). Indeed, amidst the celebratory 'after' images that dominate the advertising of obesity surgery (Boero 2007; Boero 2010), it is important to remember that surgery can also end in weight regain, morbidity or even mortality. These are outcomes from which the surgeons and the procedures are generally insulated, with responsibility falling easily to the patients themselves (Boero 2010).

It is also important to note that these strong refusals of obesity surgery, such as those from Wann and Bacon, are not without compassion for those who engage with it or without understanding of the reasons that might lead individuals to make what they see as a mistaken choice. As Wann notes:

'I really do understand why someone would consider this extreme option. The stigma attached to even the slightest amount of body fat can be daunting, and the surgeon's sales pitch can be very slick.' (Wann 1998: 41)

However, this understanding is premised on combined notions of both submission to overwhelming oppression, and of seduction into ill-informed treatment decisions by the false promises of anti-obesity professionals. These are both perspectives which leave little space for individual agency. Bacon offers a similar explanation for the decision to 'submit' to surgery, arguing that 'it's easy to get caught up in the fantasy that a pill or a scalpel can give you what you want' (p. 59). Consequently, while the outright rejection of obesity surgery as unwarranted bodily mutilation is a politically appealing and compassionate response, this 'will to innocence' (LeBesco 2004: 111) in relation to those undergoing surgery (as tricked, or as victims) is also highly problematic. While the anger and protest here is oriented primarily towards those advocating, funding, performing and profiting from obesity surgery, it positions those undergoing surgery as either victims of a monolithic power structure against which there is no meaningful resistance, or as lost in a fog of false consciousness where anti-fat rhetoric has been absorbed uncritically. Those undergoing surgery, therefore, risk being cast by critical others not only as the perpetrators of unnecessary violence against the self, but also by extension as traitorously complicit with fat-hating ideologies, and therefore as perpetrators of fat-phobia and its associated manifold harms to others (Throsby 2008). The ISAA policy attempts to address this problem directly, arguing that 'ISAA's policy is against the surgery, not the people who have surgery' (ISAA 2002). However, given the

elective nature of the intervention, plus the fact that it is patients themselves who do the everyday work of obesity surgery, this is an unsustainable distinction. This leaves few options for support from within critical fat politics for those who have chosen to undergo surgery, and especially in those cases of obesity surgery patients who continue to offer positive accounts of it. Consequently, the challenge remains that while those who have had bad experiences of surgery and are now testifying against it are easily incorporated within critical fat politics, those who, as in the title quote of this paper, remain positive about their surgery, are much less so.

This tension raises a fundamental set of questions in relation to conducting critical research on obesity surgery (and obesity more generally): How is it possible to write, think and work critically in relation to significantly problematic anti-obesity practices such as obesity surgery in ways that are still able to account for patient demand, endorsement and experience in a respectful, supportive and non-patronising way? How can we continue the work of challenging the dominant rhetoric, claims and practices of the war on obesity without giving individuals, and especially women, yet more to feel guilty about in relation to their bodies? How can a critical perspective account for those surgery patients who, regardless of any problems that they or others may have encountered in the process, remain positive advocates for surgery?

I want to argue that one possible path through this conundrum is to move towards a closer focus on the everyday experience of obesity surgery in search of the ambivalence and complexity that marks that engagement with it. Feminist

theory has long been engaged in the knotty problem of how to engage with experiential knowledge, and standpoint approaches which position (some) women's experiences as *the* authentic vision from below have proved as problematic as those postmodern approaches which locate women's experiences, and their associated knowledges, as just one discourse of equal status among many. Kathy Davis, in her book about the making of the classic feminist text, 'Our Bodies Ourselves', argues that 'the very notion that feminist scholars should have to choose between treating experience unreflexively as an authentic source of knowledge or rejecting it as ideologically contaminated is itself a 'false dilemma' (Alcoff 2000, 45)' (Davis 2007: 133). This same resistance to these polarised dilemmas has been articulated by Donna Haraway, who argues instead that the problem is 'how to have *simultaneously* an account of radical historical contingency for all knowledge claims and knowing subject, a critical practice for recognising our own 'semiotic technologies' for making meanings, *and* a no-nonsense commitment to faithful accounts of a 'real' world [...]' (Haraway [1991] 2004: 85, original emphasis). Rather than totalization, she argues that the alternative to relativism is 'situated knowledges'; that is, 'partial, locatable, critical knowledges sustaining the possible web of connections called solidarity in politics and shared conversations in epistemology' (2004: 89).

Feminist theorist, Dorothy Smith, in her classic critique of sociology and its inability to include women except on its own terms ([1974] 2004), argues that 'there are and must be different experiences of the world and different bases of experience' (p. 30). Therefore, she insists:

'We may not rewrite the other's world or impose upon it a conceptual framework which extracts from it what fits with ours. Our conceptual procedures should be capable of explicating and analyzing the properties of their experienced world rather than administering it. Their reality, their varieties of experience must be an unconditional datum.' (p. 30)

This approach, Smith argues, enables us to see how the world is put together (p. 32). This is not, however, to argue that the voices of those who have undergone surgery are what Donna Haraway calls '“innocent” positions' ([1991] 2004: 88), but rather, constitute a 'preferred positioning' (p. 89). As Haraway argues: 'We do not seek partiality for its own sake, but for the sake of the connections and unexpected openings situated knowledges make possible' (p. 93).

In the case of obesity surgery, then, I argue that an informed critical position in relation to obesity surgery demands not only the inclusion of those negative experiences which conform to a critical view, but also those positive ones which do not. This is not proposed simply in the service of a 'truer' or more complete picture of obesity surgery, or to facilitate a 'weighing up' of each position, but rather, constitutes a starting point for critical interrogation, and by extension, political action. As Kathy Davis argues: 'individual women's subjective accounts of their experiences and how they affect their everyday practices need to be linked to a critical interrogation of the cultural discourses, institutional arrangements and geopolitical contexts in which these accounts are invariably embedded and which give meaning to them' (2007: 133). This is what gets lost in the outright repudiation (or embrace) of obesity surgery.

Instead, I argue that obesity surgery is usefully conceptualised not simply as acquiescence to the anti-fat imperative, or its brutal implementation, but as a complex interaction of interests, desire and power relations which is inseparable from deeply problematic anti-obesity ideologies, but which is not confined to them. Political scientist, James Scott argues:

So long as we confine our conception of the political to activity that is openly declared, we are driven to conclude that subordinate groups essentially lack a political life, or that what political life they do have is restricted to those exceptional moments of popular explosion. To do so is to miss the immense political terrain that lies between quiescence and revolt that, for better or worse, is the political environments of subject classes. It is to focus on the visible coastline of politics and miss the continent that lies beyond it. (Scott 1990: 199)

It is here, I suggest, that many of the obesity surgery patients I have met are situated – somewhere between quiescence and revolt – in relation to the war on obesity, and to their specific experiences of obesity surgery. This approach, I suggest, provides an opportunity to rethink what constitutes resistance in relation to the contemporary attack on fat, and to find unexpected sites of resistance in unlikely places, as well as to identify the manifold small breaks and disjunctures in the weave of anti-obesity rhetoric, where the work of unsettling certainties can gain hold. These are the ‘unexpected openings’ that Haraway finds in situated knowledges, and while this approach lacks the

spectacular gesture of refusal, it nevertheless offers valuable insight not only into the structures of power that sustain the war on obesity, but also into the inconsistencies upon which it is reliant and the 'relations of ruling' (Smith 1990) through which the dominant discourse (and opposition to it) are constituted. This is not, however, to fall into the trap of romanticising resistance (Abu-Lughod 1990), but rather to create an analytical space that can accommodate the complex simultaneity of both resistance and compliance.

This introduction is followed by brief discussion of the research project upon which this paper draws. The remainder of the paper explores the everyday resistances of the experience of obesity surgery. Drawing on Scott's concept of 'hidden transcripts' (1990), I explore the ways in which patients express resistance discretely in their everyday experiences of obesity surgery, even while conforming (or appearing to conform) to its dominant values and practices. This includes strategies such as 'non-compliance' to prescribed dietary practices as well as more fundamental challenges to the values of the war on obesity. I then move on to explore positive endorsements of the experience of surgery that exist alongside those moments of resistance. This discussion highlights the importance of incorporating not just the lived experience of obesity surgery into critical discussions of it, but also individual interpretations of those experiences. The paper concludes that categorical rejections of the practice of surgery are premised on the exclusion (or dismissal) of positive accounts of it. This not only excludes those undergoing and living with surgery from a political and intellectual movement that potentially has much to offer them, but also denies fat activism a rich opportunity to explore the complex relations of power, risk

and desire that constitute the lived experience of obesity surgery (and the war on obesity within which it is situated). This conclusion, however, is tempered with a caveat against the over-optimistic reading of these acts of resistance.

Methodology

This paper is based on an ethnographic study, conducted in 2008-9, of a surgical weight management clinic in a large NHS hospital in the West Midlands region of the UK³ (see also, Throsby 2011). In the course of the research, I observed 153 patient consultations either with the surgeon, or with the specialist dieticians who saw the patients up to eight times during their two-year post-surgical treatment pathway. In addition to informal interviews with patients and clinicians in the clinic, and 15 formal interviews with patients outside of the clinic, I observed four surgeries, as well as several band adjustment procedures, and attended professional and policy conferences. With the exception of three patients who had undergone gastric bypass surgeries elsewhere and who had since been referred to the clinic for follow-up care, all of the patients had undergone (or were waiting to undergo) laparoscopic gastric banding. This procedure is preferred by the surgeon because of its lower risks and shorter hospitalisations (see, for example, Kurian, Thompson et al. 2005; O'Brien 2007; Singhal and Super 2009). By focusing primarily on experiences of one specific procedure, I am not suggesting that the particular experiences and resistances demonstrated here are universal across obesity surgery procedures. Instead, I

³ This research project received the required Local Research Ethics Committee approvals prior to the beginning of fieldwork. All participant names are pseudonyms and clinicians are referred to by their professions in order to preserve anonymity.

am arguing that evidence of that complexity in this *particular* setting suggests a similar complexity (however diversely manifested) in the context of other obesity surgery procedures.

This fieldwork generated a collective dataset comprised primarily of transcripts and fieldnotes; these were coded using the qualitative data analysis software, NVivo, and then analysed using a discourse analysis approach. This involves focusing on talk and text as social practices that are always *doing* something (Potter and Wetherell 1987; Burman and Parker 1993; Gill 2000; Wood and Kroger 2000), and asking what particular incidence of talk or activity was oriented towards achieving and what that can tell us about the social context within which that activity took place.

Everyday resistance

Writing about systems of extreme oppression such as slavery or serfdom, James Scott argues that subordinated groups, whilst displaying hegemonic public conduct, 'are likely to create and defend a social space in which offstage dissent to the official transcript of power relations may be voiced' (Scott 1990: xi). These 'hidden transcripts' represent 'a critique of power spoken behind the back of the dominant' (ibid.: xii). This is significant in the context of this paper because it challenges readings of normative behaviours as necessarily whole-hearted absorption of those hegemonic values. From this perspective, then, false consciousness is an inadequate explanation for conformity. Research interviews provide a social space for the articulation of this kind of dissent, but it was also the case that the clinical encounter in itself also provided opportunities, as

discussed below. This section of the paper explores two aspects of these hidden transcripts: firstly, 'non-compliance' and the negotiation of this with clinicians; and secondly, the challenging of the core values and practices of the war on obesity. This is followed by a discussion of positive endorsements of surgery that occurred alongside these critiques.

Following surgery, patients are given a set of dietary rules which are oriented towards maximising weight loss and minimising negative side effects (Throsby 2008). Weight regain, or a weight loss that is deemed insufficient, is generally attributed to the patient's failure to comply with these rules (Boero 2010). Similarly, weight loss is presumed to have resulted from following the prescribed regimen, creating a familiar dynamic whereby weight loss successes are attributable to the intervention, but failures fall to the individual's perceived inability to comply. However, a closer look at the everyday experience of obesity surgery offers a much more complex picture, as this fieldnotes extract from a consultation between a dietician (a lean, athletic male in his 20's) and a gastric banding patient (a woman in her 50's, one year post-op) demonstrates:

[The dietician] asks her what she eats on a typical day. She runs through breakfast – 'Oat-So-Simple [instant porridge] with 6 strawberries, not too runny'. She says that she has a sandwich for lunch, or sometimes more porridge, and a Muller Corner yoghurt. He asks: 'One a day?' (in a way that suggests that she should have no more than that). She replies: 'Could be two – depends what's in the cupboard. I'm trying to do what Mr Smith says and use what's in the cupboard.' (Mr Smith is the consultant at her local

weight management clinic who she still has regular appointments with).

The dietician says: 'Mr Smith doesn't have a gastric band.' The patient gestures at the dietician and retorts: 'Neither have you by the looks of it'.

This defiant response about who can be a legitimate knower about the experience of fatness and its management was one way that the patients would 'set the scene' in the follow-up consultations for disclosure of eating practices that fell outside of the 'rules' they had been issued post-surgery. They are establishing that *in their case*, a given rule (one yoghurt a day) needs to be downgraded to a suggestion or guideline because it does not suit their bodily needs or specific circumstances, and that only they can really determine how to proceed effectively and sustainably. Ironically, in the clinic, the patients are repeatedly exhorted to become the 'experts' in the management of their post-surgical bodies (Throsby 2010), and this discourse of individual expertise lays the groundwork for these claims to self-knowledge as a basis for 'non-compliance'. Furthermore, the conflicting advice and philosophies of the weight loss industry within which the patient is thoroughly embedded also provide the resources for this resistance, enabling her to play one source of advice strategically against another.

Patients make decisions on a daily basis about the dietary sacrifices that they are prepared to make and those that they are not, moving in and out of the rules that they've been given, and balancing risks and benefits across diverse dimensions, including not only the likelihood of weight loss or gain, but also social belonging and participation, pleasure, domestic economy etc. This episodic de-

prioritisation of weight loss is, in itself, resistant in the face of the dominant construction of obesity as *the* urgent problem to be solved. These small, everyday acts of dissent signal disjunctures between the dominant ideologies governing the practices of obesity surgery and their everyday realities, highlighting the extent to which the patients are never simply passive victims, or misled dupes in relation to those technologies.

Similar incidences of ‘talking back’, or the active refusal of advice, were regular occurrences in consultations with the dieticians. These were key moments which highlighted conflicting values and expectations between clinicians and patients, but which also brought to the fore the hierarchy of power relations *within* the clinic, since I never witnessed similar behaviour in interaction with the surgeon, the potential alienation of whom was considered to be far more risky. After all, it is the surgeon who performs the surgery, and who has the final clinical (but not financial) word in approving or refusing access to it. These silences in interaction with the surgeon are also intriguing moments of resistance. However, while the patients may meet the surgeon on just one or two (albeit pivotal) occasions, the treatment pathway also includes up to eight consultations over a two year period with the dietician. Consequently, while the spectacular moments of medical intervention are the domain of the surgeon, it is the dietician who oversees and supports the *everyday* work of managing the post-surgical body, as well as functioning as a gatekeeper to the surgeon. Consequently, while resistance towards the dietician is clearly less risky from the patients’ perspective than directly towards the surgeon, it is not risk-free and requires a careful balancing act on the part of the patient. This makes the dietician consultations a key site for

exploring the everyday resistances of the patients, rather than those with the surgeon.

The retorts described above, then, can be seen as forms of what Scott calls 'grumbling' – one of the ways in which subordinate groups can insinuate their resistance in disguised forms into the public transcript (1990: 136):

Usually the intention behind the grumbling is to communicate a general sense of dissatisfaction without taking responsibility for an open, specific complaint. It may be clear enough to the listener from the context exactly what the complaint is, but, via the grumble, the complainer has avoided an incident and can, if pressed, disavow any intention to complain. (ibid.: 154)

For example, I witnessed several occasions when patients mobilised class differences between themselves and the unambiguously middle class dieticians in order to resist the tone or content of the consultation. In one such encounter, the patient – a woman in her 40's who had been having a difficult time managing her gastric band – was asked what she drank during the day. She replied that she usually had several cups of tea, with milk and one sugar, adding: 'I know that's bad'. On the surface, this 'confession' follows a familiar, and normative, pattern whereby the patient 'confesses' deviance from the rules and then reiterates those rules for the dietician as part of a recommitment to the process (Wheatley 2006; Throsby 2011). However, when the dietician prompted the patient to begin this reiteration by asking why she thought that this was 'bad', the patient snapped back irritably, 'Don't ask me. You're the doctor – I just work at

Morrisons [a low price supermarket chain]'. Similarly, a male patient, on becoming annoyed at having to list his average daily consumption (another part of the follow-up consultation ritual), when asked by the dietician what he had for lunch, replied defiantly, 'We call that "dinner" round here'. Another common site of resistance was the dieticians' regular suggestion that patients should slow down their eating and limit portion size by using children's cutlery and a small tea plate. This was a prospect which many found inappropriate and embarrassing, and which was frequently met with either passive refusal, or occasionally, active resistance. As one male patient retorted: 'I'm fat...I'm not a baby.'

In general, this 'grumbling' necessarily took the form of sharp retorts followed by the conversation being moved on by the dietician, but in the relative privacy of the research interview, these hidden transcripts were much more explicitly and forcefully articulated. Ellen, for example, was frustrated by her slow weight loss and wanted to have her band tightened to further limit what she was able to eat. However, this request had been refused by the surgeon, and she had been advised to attend a meeting with the dietician to review her eating. In an interview at her home, she expostulated:

I'm thinking.... Well...I sit there, and [the dietician], god bless her, five star, but she's like a cracked record. I know what I should eat, I know what I shouldn't eat erm...If I didn't have a problem with food and things, I wouldn't have needed a band and this is what bugs me, they're saying 'You should eat this you should eat that, and you can't do that'. I'm not stupid.

I'm an intelligent woman. I know what I'm supposed to eat. I have a gastric band because I have a really bad relationship with food. [...] She's just like a cracked record telling me all these things all the time and I feel like saying to [the dietician], 'Shut up!' You know...'You're really winding me up!' It's very hard to get past that mentality if somebody skinny's sitting there telling you what you should eat....

Ellen's imagined (but never executed) confrontation with the dietician is a hidden transcript that demonstrates her profound, experiential understanding of the manifold inadequacies of weight management practice. In particular, she highlights the limitations of a knowledge deficit model that presumes her own ignorance, and she challenges directly the ability of a 'skinny' dietician to comprehend the lived realities of her situation. Nevertheless, in spite of the fact that a few times she has 'wanted to punch people', she still cautioned a friend who was seeking surgery to 'play the game if you want them to do it [perform surgery]' – a knowing recommendation of compliance (or at least, the performance of compliance) that is far removed from a passive or naïve engagement with the technology. As has been demonstrated in relation to other contested body technologies such as gender reassignment (Prosser 1998), abortion (Hadley 1997) and IVF (Throsby 2004) learning to tell the 'right story' (or, in Scott's terms, the public transcript) is not the same thing as believing that narrative to be a true reflection of one's own experience or motivation.

Ellen's resistant narrative reflects years of engagement with weight management specialists and dietary advice, none of which has been successful in her case.

Indeed, many of the patients expressed frustration at being returned to those very same strategies whose efficacy they already had good reason to doubt. This resentment was particularly strongly felt when, on reaching the end of the treatment pathway, patients were recommended by the dieticians to join (or more realistically, given their long dieting histories, rejoin) a commercial slimming organisation in order to gain support for continued weight loss or maintenance. As one female interviewee pointed out: 'I had this done so that I wouldn't have to keep doing that – what was the point?'. These frustrated responses assert the patients' own status as knowers in relation to obesity and its management, constituting small, but collectively significant moments of resistance that not only expose some of the more troubling assumptions that underpin the provision of obesity surgery, but also the lack of consensus around them. Indeed, their long histories with the full constellation of weight management interventions – a requirement for surgery (NICE 2006)– makes obesity surgery patients among the *most* informed commentators on the war on obesity and its illogics and fallibilities, rather than its most gullible victims. This is evident not only in critiques of weight management practice, but also, as discussed next, in critical commentaries offered in relation to the values and motivations of the war on obesity itself.

Michael was introduced to me as a clinic 'success story'. He had lost almost 17 stones since having his gastric band fitted, and had gone from being virtually housebound by his size to living independently and enjoying his new-found mobility. He talked enthusiastically about the surgery having triggered a lot of positive changes in his life, but he also remained skeptical (to me in the

interview, but not in the clinic), particularly in relation to the way in which his weight loss (and former fatness) continued to dominate his relationship with others. Although he had moved out of the family home to live with his partner in another city, when he returned to his local area for visits, he told me: 'Whenever I walk into a room the subject always seemed to change to weight. It's like ok, it is tolerable sometimes, but when it's constant, you're like, 'please talk about something else'. In a way, it's almost like they were killing me with kindness, you know, stifling me in a way.' Another interviewee from the clinic, Sharon, told me how it infuriated her that the other women at the children's playground where she took her foster children would now engage her in conversation – something which they had not done while she was fat. Another interviewee, Debbie, told me that the fuss that people made over her dramatic weight loss, including congratulating her on how wonderful she looked, made her wonder what they must have been thinking of her before. This led her to doubt the sincerity of their relations with her, which appeared to her to be based primarily on assessments of her appearance (or, perhaps, the associated moral judgments about prior fatness).

This skepticism also extended to the proclaimed certainties of the war on obesity, particularly in relation to health. Ellen, for example, had recently experienced a serious flare-up of arthritis, and she reflected on this in the light of her significant weight loss over the previous year:

So, I'm thinking that probably I've coped with the arthritis and stuff better because of the weight and I'm thinking it probably would have happened

anyway, erm...but people just think that if you're thin, everything in your world is rosy. That you must be healthy, that you must feel great, you must do this and that....And I do feel better, there's no doubt about that. But the chronic issues that I have in life, the physical issues are chronic and when I go to the rheumatoid clinic, not everybody there is overweight, in fact, the majority of them are underweight...they're all thin...so there's all these assumptions that I have because I was fat, you know....

Ellen's own experience had led her to disconnect weight from a health problem that is commonly associated with obesity, constituting a fundamental challenge to the rationale for the contemporary attack on fat. However, this extract also demonstrates the limitations of Scott's concepts of hidden and public transcripts as a means of thinking about this resistance. For Scott, and in the context of the very extreme, violently imposed forms of subordination he is exploring, all conformity to hegemony is strategic performance, with resistance sustained offstage not as a substitute for rare moments of practical and public resistance, but as a condition for it (1990: 191). However, for Ellen, in spite of her resistance to the link between health and weight which her own experience has unsettled, she remains positive about her obesity surgery and the resultant weight loss that she had not been able to achieve through any other weight loss intervention: 'I do feel better, there's no doubt about that'. It is, as Arlene MacLeod suggests in relation to the practice of veiling in Cairo, a form of protest that is 'firmly bound to accommodation' (MacLeod 1992: 552).

This endorsement of obesity surgery, even in the face of significant side effects or a growing critical awareness of the inadequacies and illogics of anti-obesity interventions, is a repeated feature of the interviews and observations that I have conducted, signaling the simultaneous nature of resistance and compliance in the experience of obesity surgery (rather than resistance simply operating beneath a performance of compliance). For example, Katherine (a woman in her 30's, and mother of two) had lost 15 stone following gastric banding, and had also recently undergone an abdominoplasty to remove the loose skin around her stomach. With tears in her eyes, she spoke enthusiastically about her post-surgical, post-weight loss life:

...it was a second chance at giving my kids, while they're still young as such, giving them a Mum that they deserve. To be able to take them swimming or go and have a kick around with the football, trying to do handstands with my daughter, no matter how unsuccessful it is [laughs]. [...] But to be able to walk down the street but know that they're not looking at you because you wobble when you walk [...] You know, it's just...it makes me feel a completely different person. My confidence is way up here....absolutely fantastic.

It could be argued, of course, that the constraints that Katherine is addressing through surgically-induced weight loss are social in nature, and could (should?) be addressed through interventions into the social and material worlds. As the NAAFA policy on obesity surgery states: 'NAAFA believes that the psychosocial suffering that fat people face is more appropriately relieved by social and

political reform than by surgery' (NAAFA 1993). However, if we are to take her own account of her everyday experience of both fatness and surgically-facilitated (relative) slimness seriously, then it is necessary to accept that, however politically problematic, Katherine *did* lose weight with surgery, and *does* feel better as a result of it – both psychosocially and in terms of improved mobility – even alongside the recollections of pain, fear and incidences of vomiting and other side effects that also punctuate her story. Similarly, for all Michael's disillusionment at the way his body continued to be defined by its size by others, and a series of what he described as 'dark moments' in the process of living with a gastric band, he was still a fervent advocate for surgery.

My point here is not to suggest that individual self-defined positive outcomes disprove the critics of obesity surgery. But rather, I want to suggest that categorical rejections of obesity surgery are unable to incorporate those positive accounts as 'faithful' (to use Donna Haraway's term ([1991] 2004: 85)), whilst still relying on negative accounts as meaningful. This is exemplified by Bacon's endorsement of the following quotation from one of her post-surgical clients:

Scratch a 'success story' and you find someone having numerous complications, but they are so brainwashed to believe they were going to die from fat, and so desperate for social approval, that they actually believe they are healthier and better off for having the surgery. (Bacon 2010: 65)

This is problematic because it imposes meaning on claims to positive experiences in precisely the ways that Smith argues so cogently against ([1974]

2004). Furthermore, attention to the everyday experience of obesity surgery, and its associated points of resistance, highlight the extent to which the patients in my study at least, are far from 'brainwashed'. The refusal to consider surgery, therefore, as anything other than the bodily mutilation smooths over the complexity of obesity surgery, missing a valuable opportunity to appreciate more fully the contradictory nature of those experiences, their problems and constraints, and, simultaneously, their pleasures.

Conclusion

In this paper, I have argued that the repudiation of obesity surgery is politically appealing, both in terms of the potential harms inherent in the practice, as well as its role as a unifying rallying point. However, the outright rejection of surgery that is a recurrent theme within much of the work of critical fat politics and scholarship fails to account for the complexity (and faithfulness) of the lived experiences of those practices, and for the 'immense political terrain', to reinstate Scott's term, that lies between 'quiescence and revolt'. I have argued that not only does the categorical rejection of obesity surgery risk excluding those engaging with it from a movement from which they could potentially gain valued support, but it also overlooks the resistance that marks the everyday experience of surgery. Instead, I have argued that through a focus on those everyday experiences, we can see not simply submission, or compliance, but also trivial-seeming resistances that quietly pick away at the proclaimed certainties of the war on obesity. As Anindita Ghosh argues in the introduction to her edited collection on the everyday resistances of women in colonial South Asia, even resistance that does not contribute to immediate social change still 'constantly

realigns power relations. It establishes that dominant power structures, far from being autonomous and monolithic, are being constantly fractured and rearranged by struggle' (Ghosh 2008: 14-15).

This is not simply to argue that 'compliance' with obesity surgery is forgivable because it is not really compliance ('the will to innocence'). Instead, my point is that this complexity is what obesity surgery *is*; it is not a static, passively consumed and objectively knowable practice, but one which is endlessly contingent, and constantly under negotiation and reconfiguration. As Judith Butler argues in relation to the political desire to identify the subject of feminism as a foundation for action, the moment that such foundations are articulated, "there is resistance and factionalization within the very constituency that is supposed to be *unified* by the articulation of its common element" (Butler 1995: 49). The same argument, reformulated, can be applied to the repudiation of obesity surgery. It's mobilization as a foundational conviction for the fat activist movement is immediately exclusive; there is no space here for an unrepentant, post-surgical fat activist. Rather than seeking to resolve the rifts that open up in these moments through the redrawing of inclusionary boundaries, Butler argues that such rifts should be "safeguarded and prized", giving them "play as a site where unanticipated meanings might come to bear" (ibid.). With this in mind, this paper argues for a more contingent approach to categorical claims about obesity surgery; not a censoring of those claims, but rather, the recognition of the exclusions that they produce, of the resistances at work and of the 'connections and unexpected openings' (to reiterate Haraway's term) that are

made visible in that process. This approach has the potential to open up new and inclusive possibilities for a critical fat politics.

This is an argument that is perhaps a little optimistic for some; a little too politically timid and strategically vague for others. I share these concerns, and find it difficult myself to articulate in advance what this kind of critical questioning might look like in sustained practice, since its outcomes are inherently unpredictable. Furthermore, there are moments when even where resistance is present, you simply have to look too hard for it. Even while writing this paper, I could not help but think about the patient who sat and cried during our interview because, unable to live with her gastric band, she wanted to have it removed but was too ashamed to ask because the surgery had been publicly funded. I recalled the woman who sat in the clinic with fresh self-inflicted cuts down her arms and legs, asking to have her band emptied because she was using it to facilitate bulimic behaviours, only to have the surgeon try to persuade her otherwise because she would regain weight without the band. And even among those examples of resistance that I have drawn out in this paper, a rush of caveats come to mind; a witty class-based retort, for example, does not change the many forms of material and social disadvantage that many of the clinic's patients experienced on a daily basis, but which were pushed into the background by the prioritized concern over fat.

But nevertheless, I stand by my starting premise that critical fat politics has to be able to account for someone who claims that she would kill anyone who tried to take her band away, just as much as it has to be able to incorporate negative

experiences of obesity surgery – not least because these may well come from the same individual. I have argued that it is only by taking seriously the lived experience of obesity surgery, in all its complexity, and for all the partiality and situatedness of those knowledges, that we can come close to understanding not only the specific experience of obesity surgery, but more importantly, the complex and contradictory relations of power that provide the context for those experiences. Instead of the oppressed victims, or brainwashed dupes, of obesity surgery, those engaging with it can be conceptualized as a valuable resource in the ongoing project of trying to make sense of, and resist, the war on obesity, in all its seductive appeal and sometimes frightening cruelty. The small resistances that I have drawn out in this paper represent one way in which it may be possible to identify new, unexpected spaces for critique and contestation, and to open up novel and inclusive avenues for critical thought. This opens up the possibility of taking patient demand for, and endorsement of, obesity surgery seriously *as part of* a critical fat politics, rather than simply as a corrective challenge to it.

Bibliography

- Abu-Lughod, L. (1990). 'The romance of resistance: tracing transformations of power through Bedouin women.' *American Ethnologist* 17(1), pp. 41-55.
- Aphramor, L. (2005). 'Is a weight-centred health framework salutogenic? Some thoughts on unhinging certain dietary ideologies.' *Social Theory and Health* 3, pp. 315-340.

- Bacon, L. (2010). *Health At Every Size: The Surprising Truth About Your Weight*, 2nd Edition, BenBella Books
- Bacon, L. and L. Aphramor (2011). 'Weight science: evaluating the evidence for a paradigm shift.' *Nutrition Journal* 10(1), pp 9 -
- Boero, N. (2007). 'All the news that's fat to print: the American 'obesity epidemic' and the media.' *Qualitative Sociology* 30, pp. 41-60.
- Boero, N. (2010). 'Bypassing blame: bariatric surgery and the case of biomedical failure', in *Biomedicalization: Technoscience, Health and Illness in the US*, eds. A. E. Clarke, L. Mamo, J. R. Fosket, F. J. R and J. K. Shim, Durham, London: Duke University Press, pp. 307-330.
- Burman, E. and I. Parker (Eds.) (1993). *Discourse Analytic Research. Repertoires and Reading of Texts in Action*. London; New York: Routledge.
- Butler, J. (1995) 'Contingent Foundations', in *Feminist Contentions: A Philosophical Exchange*, eds. Benhabib, S, Butler, J, Cornell, D and Fraser, N. London: Routledge, Ch. 2
- .Cooper, C. (2010). 'Fat studies: mapping the field.' *Sociological Compass* 4(12), pp. 1020-1034.
- Davis, K. (2007). *The Making of Our Bodies, Ourselves: How Feminism Travels Across Borders*. Durham; London: Duke University Press.
- Flum, D. R., L. Salem, et al. (2005). 'Early mortality among medicare beneficiaries undergoing bariatric surgical procedures.' *JAMA*, 294(15), pp. 1903-1908.
- Foresight (2007). *Tackling Obesity: Future Choices - Project Report*. London: Government Office for Science.
- Gard, M. (2011). *The End of the Obesity Epidemic*. London: Routledge.

- Gard, M. and Wright, J. (2005). *The Obesity Epidemic: Science, Morality and Ideology*. London: Routledge.
- Ghosh, A. (2008). 'Introduction'. In *Behind the Veil: Resistance, Women and the Everyday in Colonial South Asia*. ed. A. Ghosh. Houndmills: Palgrave Macmillan, pp. 1-20.
- Gill, R. (2000). 'Discourse Analysis'. In *Qualitative Researching with Text, Image and Sound: A Practical Handbook*. Ed. M. W. Bauer and G. Gaskell, London: Sage Publications, pp. 172-190.
- Hadley, J. (1997). *Abortion. Between Freedom and Necessity*. London: Virago Press.
- Haraway, D. [1991](2004). 'Situated knowledges: the science question in feminism and the privilege of partial perspective'. In *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies*. Ed. S. Harding. London: Routledge, pp. 81-101.
- Haslam, D. and Haslam, F. (2009). *Fat, Gluttony and Sloth: Obesity in Literature, Art and Medicine*. Liverpool: Liverpool University Press.
- House of Commons Health Committee (2004). *Obesity*. London: House of Commons.
- ISAA. (2002). 'Position on weight loss surgery.' Retrieved 28 December, 2007, from http://www.size-acceptance.org/wls_position.html.
- James, P. T., Leach, R. et al. (2001). 'The Worldwide Obesity Epidemic.' *Obesity Research* 9(Supplement 4), pp. 228S-233S.
- Kurian, M. S., Thompson, B. et al. (2005). *Weight Loss Surgery for Dummies*. Indianapolis: Wiley Publishing.

- LeBesco, K. (2004). *Revolting Bodies: The Struggle to Redefine Fat Identity*.
Amherst: University of Massachusetts Press.
- MacLeod, A. E. (1992). 'Hegemonic relations and gender resistance: the new veiling as accommodating protest in Cairo.' *Signs* 17(3), pp. 533-557.
- Monaghan, L. F. (2005). 'Discussion piece: a critical take on the obesity debate.' *Social Theory and Health* 3, pp. 302-314.
- Murray, C. (2005). 'The social meanings of prosthesis use.' *Journal of Health Psychology* 10(3), pp. 425-441.
- Murray, S. (2009). "Banded bodies': the somatechnics of gastric banding'. In *Somatechnics: queering the technologisation of bodies*. Eds. N. Sullivan and S. Murray. Farnham: Ashgate, pp. 153-170.
- Murray, S. (2010). 'Women In / Under Control? Embodying Eating After Gastric Banding.' *Radical Psychology* 8, pp. 1.
- NAAFA. (1993). 'NAAFA Policy: Weight Loss Surgery.' Retrieved 28 December, 2007, from <http://www.naafa.org/documents/policies/wls.html>.
- NAO (2001). *Tackling Obesity in England*. London: National Audit Office
- NICE (2006). *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE Guideline. First draft for consultation, March 2006*. London: National Institute for Health and Clinical Excellence.
- O'Brien, P. (2007). *The Lap-Band Solution: A partnership for weight loss*.
Melbourne: Melbourne University Publishing.
- Potter, J. and M. Wetherell (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London: Sage.

- Prosser, J. (1998). *Second Skins: the Body Narratives of Transsexuality*. New York: Columbia University Press.
- Rothblum, E. and S. Solovay (Eds.) (2009). *The Fat Studies Reader*. New York: New York University Press.
- Scott, J. C. (1990). *Domination and the Arts of Resistance: Hidden Transcripts*. New Haven: Yale University Press.
- Singhal, R. and Super, P. (2009). 'Role of laparoscopic adjustable gastric banding in the treatment of obesity and related disorders.' *British Journal of Diabetes and Vascular Disease* 9(3), pp. 131-133.
- Smith, D. E. (1990). *Texts, Facts and Femininity: Exploring the Relations of Ruling*. London: Routledge.
- Smith, D. E. [1974] (2004). 'Women's Perspective as a Radical Critique of Sociology'. In *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies*. Ed. S. Harding. London: Routledge, pp. 21-33.
- Throsby, K. (2004). *When IVF Fails: Feminism, Infertility and the Negotiation of Normality*. Basingstoke: Palgrave.
- Throsby, K. (2008). 'Happy Re-birthday: weight loss surgery and the 'new me''. *Body & Society* 14(1), pp. 117-133.
- Throsby, K. (2008). 'That's a bit drastic': risk, blame in accounts of obesity surgery. In *Gender and Interpersonal Violence: Language, Action and Representation*. Eds. K. Throsby and F. Alexander. Basingstoke: Palgrave, pp. 83-99.
- Throsby, K. (2009). "'There's something in my brain that doesn't work properly': weight loss surgery and the medicalisation of obesity'. In *Critical Feminist*

- Perspectives on Eating Dis/Orders: An International Reader*. Eds. H. Malson and M. Burns. London: Routledge.
- Throsby, K. (2009). 'The war on obesity as a moral project: weight loss drugs, obesity surgery and negotiating failure.' *Science as Culture* 18(2), pp. 201-216.
- Throsby, K (2010) 'You're the expert now': obesity surgery and the governance of the fat body', unpublished seminar paper, *Biopolitics of Science Seminar Series*, Sydney University (9 September, 2010)
- Throsby, K. (2011). 'Obesity surgery and the management of excess: exploring the body multiple.' *Sociology of Health and Illness* (early online version)
- Tomrley, C. and Kaloski Naylor, A. (Eds.) (2009). *Fat Studies in the UK*. York: Raw Nerve Books.
- Wann, M. (1998). *Fat!So? Because You Don't Have to Apologise for your Size*. Berkeley, CA: Ten Speed Press.
- Wann, M. (2009). 'Foreword. Fat Studies: An Invitation to Revolution'. In *The Fat Studies Reader*. Eds. E. Rothblum and S. Solovay. New York: New York University Press, pp. ix-xxv.
- Wheatley, E. E. (2006). *Bodies at Risk: An Ethnography of Heart Disease*. Aldershot: Ashgate.
- Wood, L. A. and Kroger, R. O. (2000). *Doing Discourse Analysis: Methods for Studying Action in Talk and Texts*. London: Sage.