THE SOCIAL CONSTRUCTION OF OBESITY IN NEW ZEALAND PRIME TIME TELEVISION MEDIA

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Abstract

Obesity is an issue that has always been associated with morality, however in more recent times it has become defined as a health problem (or disease) of epidemic proportions. The construction of obesity as a problem is partly associated with the eternal quest for thinness. Media representations play a role in the construction of obesity and may be increasingly influential as media is becoming more and more prevalent in Western society. Furthermore, media have been shown to have considerable influence in affecting health behaviours and body image. Previous research has shown that media representations of obesity have been predominately negative and obese people are underrepresented in most types of television programming. The goal of this research was to discover how obesity is socially constructed in New Zealand prime time television. Data was collected over the period of a month, forming a synthetic week of recorded television programming that covered the prime viewing period between 6.00pm to 10.30pm. A discourse analytical approach was used to identify three main themes, morality medicalisation, and factual versus fictional. The moral theme involved discourses in which moral judgements were made about obese individuals, on both their character and actions, generally positioning the obese person as morally lacking. The medicalisation theme contained discourses around obesity as a health issue that constructed health issues as the fault of the individual which could be solved only one way- by losing weight. This functioned to position obese people as sick or unhealthy. The third theme, factual versus fiction presents the differences found between depictions of fictional obese characters and real people on television. Overall, obesity was found to be constructed negatively in television media. On television, the obese person is one which is either invisible, or is the object of moral judgements about the obese individuals worth as a person and their perceived poor health. Television representations of obesity, in some part, lead to the marginalisation of obese people. However the loathing for excess weight has been around for centuries and is so deeply ingrained in public discourse that to make a difference in how obese people are seen and treated, there would have to be a change in how society thinks about obesity, not just in how the media portrays obese people.

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Chapter One: Obesity In Context

Introduction

Health beliefs and perceptions and definitions of illness are constructed, represented, and reproduced through language that is culturally specific, ideologically laden and never value free" (Evans, Rich & Davies, 2004, p. 381)

Obesity has become one of the most discussed health problems in Western society, and has evolved into an extremely popular topic for mass media. However, though there has been an increase in the discussion about obesity, the topic of excess weight itself is hardly a new one. The difference in the present discourse about obesity compared with the past is the construction of obesity as a health problem of epidemic proportions. The construction of obesity as a concern to health is one that has evolved over many years, alongside the enduring constructions of obesity as a moral failure and as aesthetically repugnant. However, today this construction of obesity as a risk to health is becoming the most overtly dominant.

Although media (especially news media) has increasingly focused on the supposed health problems associated with obesity, the construction of obesity as a moral issue has never abated. The difference in modern society is that it is no longer politically correct to openly deride a person for their 'abnormal' appearance, and obesity is considered to be a body that falls outside the normal parameters of acceptable weight. However, it is acceptable to tell a person that they need to lose weight because it is damaging their health, and this premise is one that media has seized upon to enable them to point out why fat is bad.

The three major ways in which obesity has been constructed in Western society (health issue, moral issue, aesthetic issue) is partly due to how obesity and obese people are portrayed in media. There are endless news stories about the evils of excess weight and the increase of obesity in newspapers, television, magazines, and the internet and so on. Media play an important role in relaying information to the public, and information about health and wellbeing is no exception. Media also play a big role in defining social problems (Kim & Willis, 2007). Media coverage of whatever social problem is currently popular can influence the public in focusing on this problem and the quest to solve it. Media also helps shape dominant knowledge (Evans, 2006) which in the case of obesity contributes to the general public increasingly using the medical discourse surrounding reports of obesity. Media stories about the risk to health for obese people help to perpetuate the construction of obesity as health risk, and moral failing.

Media influence on the construction of obesity is not just about news stories, reports or overt references to obesity, it is also about how obese people are positioned in more subtle ways, and the spin that is put on news stories an so on. The way in which obese people are positioned in media, particularly pervasive forms such as television, are very influential in influencing societal views. Take for example a news story in the New York Times reporting on a study by Tiggemann and Rothblum (1998, cited in Gapinski, Schwartz, & Brownell, 2006) which found that when students were polled they would rather marry an embezzler, a cocaine addict or a criminal than marry an obese person. On the surface this is just a newspaper reporting what is being said in a 'scientific' study, but in choosing that study to report to its readers about obesity adds to the construction of obesity as a completely undesirable state. In Western society mass media are thought to play a big part in not only circulating preferred body images but also in some way shaping what is popular. Media is so prevalent these days (television, internet and so on, are in more homes than ever), and that makes the pervasiveness of media more unique and relevant than in the past (Derenne & Beresin, 2006).

In this chapter I will discuss the three dominant ways in which obesity has been constructed in Western society. As well as looking at how obesity is constructed in society in general, there will be a focus on the influence of scientific studies and mass media. There will be a particular focus on medicalisation as it is has become such a dominant way in which discussion about obesity is framed.

The Moral View (it is just wrong)

> **The highly publicized war against fat is about moral judgements and panic (manufactured fear and loathing). It is about social inequality (class, gender, generational and racial bias), political expediency and organizational and economic interests. For many everyday people, including men and boys (but more often women), it is about striving to be considered good or just plain acceptable in a body oriented culture (Monaghan, 2005, p. 309)**

The morality associated with obesity, in large part, is based around the fact that excess weight is thought by many to be self-inflicted and caused by overeating and laziness (Dorfman & Wallack, 2007). Therefore obesity gets related to the age-old sins of gluttony and sloth (Gard & Wright, 2005). This is demonstrated by Quinn and Crocker (1999) who discuss the link between the centuries old Protestant work ethic and body weight. This ideology equates hard work with success and therefore a lack of success equals a lack of self-discipline and other moral failings. Therefore, being overweight means a person lacks the self-discipline to control their weight and so deserve any negative outcome related to that weight. Furthermore the person is considered to be a moral failure.

Aside from this influential Protestant ideology, Christianity in general has been influential in the association between morality and beauty and for a majority of people, fat is not considered beautiful. For centuries Christianity has made a connection between excess weight and morality. It has always been that beauty is associated with goodness and ugliness with sin (Jutel, 2005) and obesity is considered unsightly by most in Western society. The religious undertones in obesity and morality exist because of the assumption that obesity is the fault of the individual, and within their power to change. Simply put, obese individuals are seen as being to blame for their 'condition': if obesity is caused because of the (bad) behaviour of the individual then like other bad behaviours, the person should be able to stop them.

The current dominant representations about obesity, that it is caused by overeating and a lack of exercise, are both considered to be related to an individual's lack of control (Le Besco, 2004). This assumption appears to be the basis behind the New Zealand Ministry of Health initiative and their attempts to deal with obesity. The New Zealand Ministry of Health developed the Healthy Eating: Healthy Action (HEHA) plan which focuses on individual behaviour, education and action rather than environmental factors (Hock & Glendall, 2006). In other words, the New Zealand Ministry of Health perceives the individual as being responsible for becoming obese, for preventing it, and therefore for changing it.

Of course there are some obese individuals that are not considered to be at fault for their weight, namely children. The moral failings usually associated with obese adults get assigned to the obese child's parents or caregivers instead. Coveney (2006) discusses how it is commonly seen to be bad enough to neglect your own body, but to neglect a child's health is of much greater magnitude. In comparison to adults, children can be positioned as innocent in their own obesity, as parents are often perceived as remiss in letting their child get this way. Also, children are positioned as being vulnerable and working mothers are often seen as to blame for letting children watch too much television and not monitoring their children's eating habits enough (Boero, 2007).

However, for adults who are supposed to know better about nutrition, moral judgements get made about the obese person's ability to understand the reasons for their excess weight and how they can control it. A common theme in public discourse is that overweight people in the general public must be uneducated or ignorant about proper nutrition (Le Besco, 2004), and if obese people do understand nutrition then it must be their low socioeconomic status (SES) that makes them too poor to afford healthy food (Le Besco, 2004). This assumed connection between obesity and low SES and lack of education leads to the assumption by the general public that the majority of obese people must be poor minorities.

Campos (2004) states that the focus on obesity as a threat to health enables the white middle classes to legitimately discriminate against people in lower socioeconomic groups and minorities because of this assumption that they have the highest rates of obesity. There is evidence that negative attitudes towards the obese correlate with negative attitudes towards the poor and minority groups, with both being seen as lazy and lacking self control (Campos, Saguy, Ernsberger, Oliver, & Gaessar, 2006). In the United States, the blaming of minority groups for having high rates of obesity is rife. Groups which are already marginalised have one more stigma to add, obesity (Herndon, 2005). News reports name particular groups (for example, non-white, immigrants, lower SES) as the fattest people in the United States (Herndon, 2005), perhaps adding to the demoralisation that these groups may already feel.

The morality that surrounds obesity is so embedded in Western society that many people would not be consciously aware that they were drawing on these moral discourses when discussing the issue of obesity. However it is the underlying morality that leads to judgement of the obese body and in turn serves as a foundation for the desired aesthetic of the thin body.

The Aesthetic View (it just looks bad)

The social construction of the female body is based on a thin ideal, which has become the symbol of youth, beauty, vitality, success and health- representing the social pressure to discipline the surface body, where 'fat' is perceived as unfeminine, unattractive, and a sign of a body 'out of control'
(Germov and Williams, 1999, p. 119)

In Western society the common construction of attractiveness is the slim body, especially in women. The increasing concern about obesity is tied up with this idealisation of the thin figure and the eternal quest for slenderness. Why slenderness is considered the ideal can be associated with the traits that are associated with thinness, Campos (2004) believes that bodies have replaced clothes 'as the most visible markers of social class' (p. 225). Others have said that being thin is perceived as a sign of status and education (Le Besco, 2004), whereas obesity is often associated with lower socioeconomic position (Herndon, 2005, Averett & Korenman, 1999). How body shape is seen and judged is a product of the 'historical, geographical, social, cultural, political and economic ideologies' (Longhurst, 2005, p. 250) that exist within society. This means that in each historical period, country, and culture, those in the society will value a particular body shape at any given moment dependant on those in power and what agendas they may have.

An illustration of the way in which the ideal body shape has changed in modern times is the example of the 1960's model Twiggy. Before her the slim body had always been attractive, but more curvaceous bodies such as Marilyn Monroe were also seen as beautiful. Twiggy almost single-handedly started the trend for the stick thin model that is popular today (Tebbel, 2000). This is a good example of how society changes in what is considered attractive. Before the 1960's it is very likely that the exceptionally thin models of today would have been considered too skinny and ~~perhaps unattrac~~tive, yet today they are the gold standard of ultimate thinness and

attractiveness. The impact of Twiggy and others who contributed to the stick-thin model craze was that this rising desire for slenderness led 'fat' bodies to increasingly be labelled as deviant, leading to prejudice and discrimination (Sobal, 2003) and adding to obese people as being considered 'abnormal' and unacceptable.

The Medical View (it will kill you)

Overweight is not a disease any more than slenderness is an indication of health. Like cellulite, or baldness it is simply the way some people are (Jutel, 2005, p. 123)

Medicalisation of obesity means the change from 'observable dimensions of 'fat' to the measurable phenomenon of weight' (Gard & Wright, 2005, p. 179). So to become 'obese' rather than just 'fat' an individual generally gets categorised by their weight but also by a height/weight ratio calculated using the Body Mass Index (BMI). Obesity is predominately defined as having a Body Mass Index (BMI) of 30 or higher (James, 1996). Those who come above the predetermined range are considered to be obese, and therefore 'unhealthy' and in need of medical intervention. However the BMI is not just used to assess someone's excess body weight for categorical reasons, but is often used as a direct measure of health (Evans, 2006), making the assumption that as an individual's BMI increases their health must worsen.

The premise of excess body weight as health problem is not a new concept; it has been around for many years. In fact centuries ago Hippocrates noted that fat people were more likely to die suddenly than thin people (Jutel, 2005). As early as 1908 doctors began weighing people as part of their medical examination (Austin, 1999) and the medicalisation of obesity intensified after World War One (Boero, 2007). By the 1930's the medical profession accepted that fat was a health risk, and over a 10 year period obesity went from something that was inconsequential for most

doctors to an important medical issue (Pool, 2001). The debates around this time as to what caused excess weight focused on a few areas such as slow metabolism or genetic issues (Saukko, 1999).

A key event in the 1930's that contributed to obesity being seen as a major health risk was a study published by Louis Dublin of insurance company Metropolitan Life which consisted of details about the perils of obesity and associated health problems. From the late 1800's insurance companies started studying mortality rates amongst different populations, and associated health problems. This was undertaken in an effort to decide who was a greater risk and therefore would be charged a higher premium (Pool, 2001). Even though the study had serious flaws and showed higher mortality rates in both the over-tall and the underweight, it was the overweight that were singled out (Pool, 2001). Furthermore, the Dublin study led to a huge amount of research in the area of obesity as a health problem, and for decades the study was perceived as proof that obesity was a serious health risk (Pool, 2001).

The major turning point from obesity as a health problem to obesity as a health problem of epidemic proportions came in 1994 when obesity was declared as a national health crisis in the United States. The push came from a coalition led by the then United States Surgeon General C. Everett Koop, who requested that President Clinton form a President's Council on Diet and Health (Le Besco, 2004). Before Koop gave his speech about the obesity crisis at a prestigious White House function, the term epidemic was not one that was commonly used to describe obesity, but became one that was increasingly popular after this event (Coveney, 2006). Furthermore, the label of epidemic did not just suggest an increased prevalence of obesity, but also meant that obesity went from a somewhat minor risk factor for disease to a full blown disease in its own right and a serious one at that (Coveney, 2006).

Further adding to the growing health concerns surrounding excess weight following the declaration of obesity's epidemic status, in 1998 the National Institute

of Health (NIH) lowered the threshold for the BMI overweight category from 27 to 25, meaning that 50 million more people were suddenly considered overweight. Yet when media picked up on this, no mention was made of this changing guideline but a good deal was made of the vast increase in overweight people (Boero, 2007).

The increased medicalisation of obesity is illustrated in a study by Chang and Christakis (2002) who conducted a content analysis of the *Cecil Textbook of Medicine* from 1927 to 2000. The study examined how obesity was conceptualised and how this view had changed over the years. In relation to responsibility for obesity, they found the obese went from 'societal parasites' to 'societal victims' (p.151). In 1927 obesity was seen as the result of individual behaviour and by the year 2000 had progressed to the recent model of obesity, which blamed it on genetic factors and the Western lifestyle, rather than personal actions.

Obesity as a disease

As mentioned previously, the label of epidemic in the 1990's turned obesity from a risk factor for disease to a disease in its own right (Coveney, 2006). However there are debates in academic circles as to whether 'disease' is the correct term (Heshka & Allison, 2001). There have been different theories as to the reason for this shift. One theory holds that this functioned to remove blame from the obese individual (Saguy & Riley, 2005). If obesity is a disease, then people are less likely to blame it on individuals because of their perceived poor behaviour (Evans, 2006). Another theory is that if obesity is officially named as a disease then it will be fully covered by health insurance (Ernsberger, 2007). Although the 'disease' label in some way absolves the overweight person from being at fault, it also means that they are expected to get treatment for this 'condition' as one would with other diseases (Heshka & Allison, 2001). Ernsberger (2007) states that obesity can not be considered a disease because of the protective factors that obesity provides, as diseases do not have health benefits. Also, Heshka and Allison (2001) assert that

obesity does not hold the traditional characteristics that constitute a disease and there is no 'sound scientific basis' for labelling it as such.

However obesity has been labelled as disease by many and this fits with medicalisation being used as a form of social control by the medical profession; when something is labelled as a disease it then gives doctors the right to make judgements about a person. Medicalisation, in general, requires 'experts' to diagnose and treat the 'diseased' which is the role of the doctor and other health professionals. Doctors do this via the 'authoritative gaze' that gives them the power to decide what represents symptom and what represents disease (Austin, 1999). For obese people their supposed 'disease' is only too evident to health professionals, as their body size is something that cannot be hidden.

The medicalisation of obesity has its own set of discourses that serve to explain, define, and also help to legitimate the medicalisation process. These discourses help to maintain the concept of obesity as a health problem (Burns & Gavey, 2004). The medical profession gains control through medicalising everyday existence, by creating labels such as 'healthy' and 'ill', and making them such a feature of every day life (Jutel, 2005). The medical discourse allows experts to judge the obese as morally wanting and gives permission for medical intervention and the right to publicly monitor people's body shapes (Gard & Wright, 2005).

Unfortunately, the medicalisation of obesity labels an obese person as 'sick', and in the process the body is categorized as abnormal or deviant, thereby not only defining the person as sick and needing treatment but also stigmatizing those with excess weight (Evans, 2006). Even the term 'overweight' means falling outside the 'normal' standards of weight, just like many terms in medicine, which refer to illness as a deviation from the norm, for example, renal 'insufficiency', thyroid 'dysfunction', cardiac 'failure' (Jutel, 2005).

The increased spotlight on obesity as a disease aligns with an increasing focus in public health on non-communicable diseases, which shifts the focus from diseases outside the body to those located within the person (Evans, 2006). Because there are less communicable diseases than in the past, public health now focuses on lifestyle diseases, meaning the diseases that are caused through lifestyle choices. Of course one of the most visible of these is obesity. Rogge, Greenwald and Golden (2004) compare the construction of obesity as being the fault of the individual, to diseases such as lung cancer or sexually transmitted diseases, which are also commonly blamed on the individual.

The increased attention on obesity as a serious health problem also means that concern about weight and health is spilling over onto anyone who is deemed overweight, where once there was a difference in how the terms overweight and obese were used. Obesity has chiefly come to be seen as a medical issue, and overweight as predominantly an aesthetic issue (Jutel, 2005). However, as media exposure about obesity grows, these two terms are often confused, with the so-called health risks attributed to obesity being ascribed to those who are evenly slightly overweight (Burns & Gavey, 2004). This results in a large majority of Western society being pathologised because of their weight (Evans, Evans, Evans & Evans, 2002).

Furthermore, significant contribution to the construction of obesity as a disease comes from health professionals and organizations. In the United States organizations such as the National Institute of Health, the Center for Disease Control and Prevention (CDC), the American Heart Association and the American Diabetes Association, are big contributors to the social construction of obesity, particularly obesity leading to poor health and/or premature death (Rogee, et al., 2004).

Health problems commonly associated with obesity

The years of research on obesity and its associated health problems has led to obesity being named as the cause of numerous health and social problems, and as a risk factor for cardiovascular disease, diabetes, gall bladder disease, and some cancers (McNeil, 1996). It also supposedly exacerbates health problems such as respiratory illness and osteoarthritis (Kopelman, 2000). Doctor Swinburn from the New Zealand National Heart Foundation states that overweight people are 60 times more likely to develop diabetes and also 60 times more likely to develop heart disease (McNeil, 1996).

However, there are an increasing number who disagree with obesity being blamed for all these diseases. Of all the health problems blamed on obesity, predominately it is named as a risk factor for three major diseases, heart disease, diabetes, and cancer. However, there is no strong evidence to support these claims (Campos, 2004). In fact, there is some evidence to suggest that obesity could actually be a *symptom* of diabetes rather than a cause (Campos et al., 2006). In addition, with all that has been written about obesity causing numerous health problems, virtually nothing has been written about *how* it causes these diseases (Campos et al., 2006). Furthermore, obesity has been named as a protective factor in some health issues, such as chronic lung disease, hip fracture, anaemia, and peptic ulcer, amongst others (Campos, 2004). Obesity can also protect against infectious diseases and suicide (Ernsberger, 2007).

Another area where some alarming statistics have been produced is the higher mortality rates associated with obesity. Although many studies have found higher mortality rates in obese individuals (Flegal, Graubard, Williamson, & Gail, 2005; Fontaine, Redden, Wong, Westfall, & Allison, 2003), others argue that although obesity does increase the risk of many diseases, it generally applies only to those considered morbidly obese, meaning those with a BMI over 40 (Gibbs, 2005). Furthermore, Gorman and Masters (2005) state that overweight people are at no greater risk of premature death than those of average weight. In fact active obese

people have lower mortality and morbidity rates than sedentary average weight people (Blair & Brodney, 1999, cited in Monaghan, 2005). In addition, although BMI is increasing in the United States so too is life expectancy, and obese people today do not show the same cardiovascular risk profiles as they did 20-30 years ago (Gregg, et al., 2005 cited in Monaghan, 2005).

Actual mortality rates attributed to obesity have been difficult to calculate. Allison, Fontaine, Manson, Stevens, & Vanitallie (1999) suggest that 280,000 excess deaths are attributable to obesity in the United States, but that figure dropped to 26,000 in a study by Flegal et al. (2005). Manson, Bassuk, Hu, Stammpfer, Colditz, and Willet (2007) say this may be explained by difficulty in accurately measuring obesity and mortality. These include problems such as reverse causation (thinness can result from illness rather than cause it), failure to control for smoking and failure to control for co-morbid factors (which may or may not be directly caused by obesity).

The costs attributed to obesity are not only limited to poor health. Rissanen (1996) talks of economic and psychosocial consequences such as medical costs due to treatment and diagnosis of obesity-related disease and lost productivity from obese workers. A New Zealand study speaks of obesity costing the New Zealand taxpayer $130 million each year (McNeil, 1996). The discourse around the healthcare costs attributed to obesity is tied up with healthcare finances being limited, and arguments about who is more deserving (Herndon, 2005).

Proponents of the 'obesity kills' argument suggest weight loss as a treatment for the 'disease'. However there is compelling evidence that lifestyle changes that result in no long term weight loss, or only minimal weight loss, are extremely beneficial to health (Campos et al, 2006), suggesting that weight itself is not the issue. This supports the viewpoint of the Health at Every Size (HAES) organisation, which states that you can be fat and healthy; that fitness is the key, not weight and that fat people can be fit (Dorfman & Wallack, 2007).

A classic example of the commonly held beliefs about the health risks of obesity is illustrated in a comment made by Julie L. Gerberding, director of the CDC, who was quoted as saying "if you looked at any epidemic- whether it is influenza or plague from the Middle Ages- they are not as serious as the epidemic of obesity in terms of the health impact on our country and our society" (Gibbs, 2005, p. 70) This an extreme claim considering that between 1918 to 1919 the influenza epidemic killed 40 million people (Gibbs, 2005).

The Obesity 'Epidemic'

Aside from the many claims about poor health allegedly caused by obesity there is the assertion that it has reached epidemic proportions. Many articles have been written about the increasing prevalence of obesity (for example, Baskin, Ard, Franklin & Allison, 2005: Flegal, Carroll, Kuezmarski, & Johnson, 1998: Ogden, Carroll, Curtin, McDowell, Tabak, & Flegal, 2006). The Ogden et al. (2006) study reports the significant increase in obesity over the years 1999-2004, a rise in prevalence which has been reported in most epidemiological studies in the last 10 years. Brownell (2005) states that obesity is 'out of control' and though it is receiving much attention, not much is being done about it, and that it poses serious risk to children, the economy and the food industry.

As mentioned earlier, obesity has been referred to as an epidemic since the 1990s, thanks to Surgeon General Koop. This representation of obesity as an epidemic was taken up by mass media; however, although the term was initially used metaphorically by early academic studies, it was soon taken and used literally by media (Saguy & Riley, 2005). Mass media reports on obesity often construct it as "a looming global health catastrophe" (Gard & Wright, 2005, p. 17). Media representations of obesity as an epidemic have become so familiar that this way of thinking about obesity has become part of the everyday talk of the general public (Gard & Wright, 2005). Boero (2007) describes obesity as a 'post-modern' epidemic,

one without clear pathological basis, and differing from more traditional epidemics in that we are all at risk for obesity, the only variation is how big each persons risk is.

New Zealand is no different to other Western countries in that it too is supposedly facing an obesity crisis (McNeil, 1996). A Ministry of Health study (Ministry of Health, 2004) reported that BMI and obesity is increasing in New Zealand although less rapidly than in the 1990s. Their results 'confirmed' an obesity epidemic in New Zealand over the last 25 years. Origins of the 'epidemic' were considered to precede 1977, but accelerated in the 1980s and 1990s. Diet and lack of exercise were listed as the blame for the obesity epidemic in New Zealand.

However, there are an increasing number of people who are starting to accuse the obesity 'experts' of exaggerating the health problems associated with excess weight (Gibbs, 2005). There is reason to suspect that studies reported in the predominant obesity literature were not at all statistically sound and that results were, in many cases, overstated (Gibbs, 2005).'Body Weight and Mortality Among Women' (Allison et al., 1999), is probably the most cited article when proposing that excess weight is a health risk. However, what it actually showed is that those women with the lowest death risk were heavier than the average on the BMI (Campos, 2004).

The article 'Annual Deaths Attributable to Obesity in the United States' has possibly been the most (mis)quoted article in media, reporting that 280,000 excess deaths each year are caused by obesity (Monaghan, 2005). This article was cited more than 1700 times over a two year period (Campos, 2004). Yet this statistic was later found to be inaccurate (that the results did not show a marked increase of mortality for those in the obese range), with the studies authors even feeling the need to write to the medical journals to correct those who wrongly quote their study (Monaghan, 2005). Furthermore, although studies have stated that obesity is increasing to epidemic levels, the data do not prove this. In the United States the average weight has moved slightly right on the distribution curve, with an 3-5 kg in increase over the last generation (Campos et al., 2006).