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UNDERSTANDING XENICAL
Discourses in a Fat-loss Medicating World

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ABSTRACT

The aim of this study was to gain insight into the different understandings and constructions of the weight-loss drug Xenical, including its various symbolic, social and cultural representations as a weight-loss pharmaceutical, for a range of players. Pharmaceuticals play a central role in contemporary life and we need to understand their function as objects with social and cultural meanings. Weight-loss drugs are particularly interesting as their production, dissemination and consumption are linked to cultural discourses surrounding fatness, body size and health, as well as processes such as medicalisation and pharmaceuticalisation. We sought insight into the meanings that the Xenical holds for various 'players' invested in different stages of its 'lifecycle'. A qualitative design was employed using an in-depth, critical analytical approach, focused on the network of relationships or players surrounding the lifecycle of Xenical. There were seven players of interest representing this network, including pharmacists, dietitians, Xenical forum-users, Xenical non-users, the Roche website for Xenical, Xenical advertisements and news articles on, or relating to, Xenical in some way. The pharmacists, dietitians and non-users were all interviewed about issues relating to weight, weight loss, body size, pharmaceuticals and Xenical, and the four other sites of analysis were analysed for how they constructed and positioned Xenical through language or symbolically. The various ways in which these players discursively represented the drug were identified. These encompassed a range of similar and contradictory meanings for Xenical, reflecting the diverse and competing interests that can arise around a medication, both between players and within individual players. Against a background of issues relating to health, weight, weight loss, safety, side effects and efficacy, as well as processes such as medicalisation and pharmaceuticalisation, our analysis also shed light on why this drug has fallen out of favour in recent years. Thus, this research highlights the transient nature of weight-loss drugs, a possible de-pharmaceuticalisation of fat, and the complex existence of pharmaceuticals as they are located within broader contexts of social understanding.

DEDICATION

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CHAPTER 1

INTRODUCTION AND LITERATURE REVIEW

1.1 Medicines and Medical Practices

“The history of medicine has thus been bound up with the history of the different ways in which human beings have tried to make ourselves better than we are” (Rose, 2007, p. 200).

Medicines and their associated practices have been central to controlling or managing health across different cultures and societies throughout human history (Rose, 2007; Whyte, van der Geest & Hardon, 2002). In contemporary society, these substances continue to play a central role in everyday life and healthcare (Rose, 2007; Whyte et al., 2002). Medication is used here as a term to broadly denote the many forms of treatment and care available today. Such forms range from the conventional to the complimentary, and may be classified as prescription, pharmacist-only, pharmacy-only, over-the-counter, or alternative, the latter including homeopathic products or dietary supplements accessible through health stores.

Medications have become integrated into mainstream society and health care (Fox & Ward, 2008). Chamberlain (2004) argues that medicine consumption has become almost as routine a practice as eating or drinking. Medicines interact with our lives and how we manage our health and illness, or that of others, on a daily basis (Fox & Ward, 2008). Rose (2007) contests that medicines and medical discourses have become influential to the point that they shape “our ethical regimes, our relations with ourselves, our judgements of the kinds of people we want to be, and the lives we want to lead” (p. 702). Taken for a variety of reasons, ranging from the treatment of pain to the prevention of disease, medicines are experienced in different ways by different users. They are both easily obtainable and widely consumed. For example, a report by PHARMAC (2007) showed the drug Paracetamol was prescribed over 1.4 million times in the year prior to June 2006. Despite being widely used and accepted as a part of mainstream health care, they are not without controversy. Almost daily the media brings out a new story of the latest and greatest cure, or tales and tribulations of medicine use and medical failures.

The power of medicine

““I die by the help of too many physicians” was supposed to have been the final sentiment on the lips of Alexander the Great in 323 BC” (Burch, 2009, p. 37).

Medicines have taken on varying forms and meanings throughout human history, constantly transforming both geographically and temporally to where they are today (Whyte et al., 2002). Tales of medicine use extend throughout human history back to the Ancient Greeks and Egyptians. For much of history, medicines were derived from plant or animal-based sources or minerals. At the time of the Sumerians, ‘potions’ may have contained medical elements including “the shells of turtles, skins of snakes, thyme and milk and figs and dates” (Burch, 2009, p. 12). Likewise, the Egyptians also

appeared to use ingredients derived from nature ranging from watermelon and almonds to dill and cinnamon.

Medicine has consistently been revered for its perceived powers (Burch, 2009), seen as both dangerous and potent, with the ability to transform bodies and alleviate human suffering (Whyte et al., 2002). Conversation regarding the ‘divine powers of medicine’ can be traced back to ancient civilisations, who wrote of life-saving potions and doctors who were able to prevent death and aid the process of giving birth (Burch, 2009). Such texts indicate that physicians themselves were central to the concept of medical power. The leading doctors reached their divine status through preaching the efficacy of their practice. For instance, in his book *Taking the Medicine* Burch (2009) highlights how Galen, one of history’s most influential doctors, claimed of one potion: “All who drink of this treatment recover in a short time, except those whom it does not help, who all die. It is obvious, therefore, that it fails only in incurable cases” (c.129-c.216). Thus, failure was not portrayed as resulting from a malfunctioning medicine or fault of the doctor, but rather, was positioned as being due to the individual themselves.

Despite the failures of practitioners and their knowledge of medicine’s failures, according to Burch, people still flocked to them in hope of a cure. In fact, people’s knowledge of the immense powers of medicines and their toxicity only appeared to draw them to them more, and served to increase the perceived power of physicians. Thus a paradox was apparent, where “if medicines were dangerous, that meant they were powerful – and even if the power to harm was what was seen, the power to help was imagined to accompany it” (Burch, 2009, p. 37). This perception of medications as powerful and transformational has transcended history. Medicine is still viewed this way, with its ability to change lives, alleviate human pain and suffering, and make us better. Presently, biomedicine, also known as mainstream medicine, is the ‘gold standard’ or most ‘powerful’ form of medicine or medical practice, to which all medical practices are compared and judged. Biomedical approaches currently dominate the majority of treatments in Western culture.

Contemporary medicine

From around the eighteenth century, a rise in iatrochemistry, a branch of chemistry and medicine seeking to offer chemical treatments for diseases and medical problems, and the introduction of new technology, saw changes to the way society approached health care, particularly in Europe (Whyte et al., 2002). In more developed countries, medicine became closely intertwined with science, and humans played a central role in the transformation of medicine to a discipline of expertise (Rose, 2007). Through becoming a scientific authority, medicine was linked to “new ways of governing people, individually and collectively, in which medical experts in alliance with political authorities tried to manage ways of living to minimise disease and promote individual and collective health” (Rose, 2007, p. 700). Rose argues that medicine was “perhaps the first scientific knowledge to become expertise, in which authority over human beings derived from claims of scientificity” (p. 701). However, it wasn’t until the nineteenth and twentieth centuries that society experienced a real transformation in medical treatment. France and Germany led this transition with significant advances in physiology, chemistry and pharmacy (Whyte et al., 2002). Pharmacology, in particular, became a

scientific discipline in its own right. During this time, drugs were beginning to be manufactured on a large scale as global commodities (Moldrup & Morgall, 2001). The production and consumption of these drugs rocketed during the First World War, however, it was not until after the Second World War that the mass production of antibiotics began. With the discovery of antibiotics such as penicillin, pharmaceuticals reached a new height; marketed and sold widely they became substances which entered into the everyday lives of humans and became part of mainstream culture (Whyte et al., 2002).

Over the years the nature of disease and our treatments for it have changed substantially. Historically, diseases were acute and treatments were reactionary. However, the rise of medical technology in the developed world, and the availability of antibiotics and vaccinations, has meant that these kinds of diseases are no longer the focus. Rather than treating the likes of cholera and smallpox, contemporary medical treatments are more likely to centre around ‘chronic diseases’, such as diabetes, heart disease and cancer. These diseases are often purported to be linked to ‘unhealthy’ or ‘irresponsible’ lifestyle practices, such as poor dietary habits, a lack of exercise or drinking excessively. Against this background, ‘prevention’ has become the newest key message promulgated by the health industry and public health officials, for instance, preventing melanoma through wearing sunscreen or osteoporosis through getting adequate calcium. Individuals are bombarded with ‘healthy-lifestyle’ messages, and media and public health campaigns, all targeted at encouraging people to become more responsible about their health and the wellbeing of their families. To not do so has therefore come to be viewed as a failure of the individual themselves.

In addition to health-related messaging, medical themes also saturate Western contemporary culture. We experience them in books, the arts, in films and on television where doctors and surgeons are often depicted as heroic and medicine as infallible and life-saving. As medicine has developed into more of a mainstream or familiar concept, medical language has also become intertwined with that of the layman, who uses “languages of health and illness” (p. 700) interchangeably in daily life (Rose, 2007). In this way, medicine has changed our sense of self, our identities, and the frameworks through which we understand ourselves (Stepnisky, 2007). Rose (2007) suggests that it has become influential to the point that it shapes “our ethical regimes, our relations with ourselves, our judgments of the kinds of people we want to be, and the lives we want to lead” (p. 702). Health and illness have become concepts by which individuals can measure their value or existence and self-worth, as well as compare themselves against constructs of what is denoted as normal or abnormal by medical authority. As Rose puts it:

We relate to ourselves and others, individually and collectively, through an ethic and in a form of life that is inextricably associated with medicine in all its incarnations. In this sense, medicine has done much more than define, diagnose, and treat disease – it has helped make us the kinds of living creatures that we are at the start of the twenty-first century. (p. 701)

Medications as cultural objects

“Our bodies are the bodies of the Egyptians that came before us, and the Sumerians that came before them. We have the same organs and the same construction. The cancers and infectious disease and

hazards of accidents and age have changed a little over the millennia, but not a great deal” (Burch, 2009, p.5).

Burch’s (2009) quote illustrates how as humans, we are almost physiologically identical to our predecessors, experiencing the same illness and disease. While our bodies haven’t changed, what *has* transformed is the way we understand and perceive medicine, and the kinds of treatments that we use. This is evidence that medicines and medical practices are culturally-constructed phenomena, with meanings that extend well beyond that of the chemical to the social and cultural (Cohen, McCubbin, Collin & Perodeau, 2001; van der Geest, Whyte & Hardon, 1996; Whyte et al., 2002). Some anthropologists contest that historians have failed to consider these social or symbolic properties of medicines, such as how they save lives, alleviate illness, or provide comfort to humans. They argue that while historians have long been interested in how medications have moved, changed, and been a part of different societies across time, anthropologists consider the meanings these drugs have that extend beyond their physical make up (Burch, 2009; Whyte et al., 2002). It was not until around the 1980s that those from social disciplines, such as anthropology, started to consider pharmaceuticals for their social and cultural properties and the meanings they held for people (Whyte et al., 2002; van der Geest et al., 1996). Whyte et al. (2002) contest that medications are valuable to anthropological research because of their tangible materiality. They are cultural commodities that morph, transform and hold different meanings from one context to the next, in the hands of different social actors (Cohen et al., 2001; Whyte et al., 2002). Martin (2006) even goes as far to say that psychotropic pills, for example, can be considered both as “a kind of living person and at the same time as an inanimate object” (p. 274).

Recent years have seen social researchers begin to consider issues such as the metaphorical nature of medicines (Montagne, 1998), what makes them so appealing to people, how various people use it in different ways, and how medicines shape and are shaped by different actors (Whyte et al., 2002). A number of researchers in this discipline suggest that medicines have social and pharmacological ‘lives’, also referred to as ‘biographies’ and ‘lifecycles’ (Cohen et al., 2001; Whyte et al., 2002; van der Geest et al., 1996). These ‘lives’ progress through different stages, for example, from production and marketing to consumption. Van der Geest et al. (1996) documented the generic meanings and practices around medications for each of these stages. They suggest that medications experience different trajectories throughout their life cycle; some may experience a significant rise or fall in use which can often be linked to media controversies around the safety of the drug, or the introduction or cessation of marketing or branding campaigns. Cohen et al. (2001) used psychoactive medications as an example of how drugs have social lives with “diverse actors, social systems, and institutions determining who uses what medications, how, when and why” (p.441). Similarly to van der Geest et al., they contest that changes in the environment or the systems in which medications are embedded, which may be due to marketing or knowledge around medicines, alter the lifecycles of medications, constantly evolving and changing them. Research such as this helps add to our understandings of medications and how they interact with people and environment. However, there is

still room for further research which adds to this knowledge-base, particularly around the meanings of medications to the various different groups involved in their lifecycle stages.

The social meanings of medications

Van der Geest and Hardon (2006) state that “things acquire meaning when they enter into the life of people” (p. 1). It is only in the last ten to twenty years that researchers have started to consider drugs in such a way, focusing on the lived experience and practices of different users in greater depth. This body of research indicates that the experience of the user isn’t just limited to the very experience of taking the medicine itself, but also to the process of seeking it out, storing it, physically consuming it and the after-effects of that consumption. Further, medicines may be experienced diversely according to the purpose for which they are intended, such as to control illness, cure problems and provide relief from pain (Shoemaker & Ramalho de Oliveira, 2008). When considering medicine for its social properties or meanings to users, most studies to date have focused on decision-making or compliance around medications (Britten, Riley & Morgan, 2010; Pound et al., 2005; Shoemaker & Ramalho de Oliveira, 2008). Conrad (1985) was one of the first to consider medication practices and compliance. Through his research with epileptics, he discovered that patients interpret what they have been prescribed by health professionals in their own unique way, taking on different regimens and practices that diverge from instructions. He suggested that this could apply across diseases and medications. Since Conrad’s research, others have investigated the meanings of medications to users with conditions ranging from inflammatory bowel disease (Hall, Rubin, Hungin & Dougall, 2007) and epilepsy (Conrad, 1985), to depression (Cohen et al., 2001; Helman, 1981; Malpass et al., 2009). In a synthesis of qualitative studies relating to lay experiences of medicine, Pound et al. (2005) found that the majority concentrated on non-compliance or diverging from prescribed instructions, and a few focused on those who either reject medications or accept them without question.

While this body of research is useful to understanding practices around medication use, there is a growing field which investigates how medicines are understood or identified with by the individuals connected to them. Helman (1981) was one of the earlier researchers to consider medications for their symbolic meanings to users. Through surveying long-term users of psychotropic drugs, he found that users generally classified them into three categories according to what they symbolised, namely, ‘tonic’, ‘fuel’ and ‘food’. Metasyntheses have also been used to examine the meanings of medications to consumers. For example, in a metasynthesis of three qualitative studies, Shoemaker and Ramalho (2008) found four themes of medication experience emerged including: a meaningful encounter, bodily effects, unremitting nature, and exerting control. They argue that understanding the subjective experiences of medication use is fundamental to meeting consumers’ health needs, particularly in relation to healthcare practitioners, and treatment and care. Other common themes arising out of medication users’ experiences often centre around safety and risk (Moldrup & Morgall, 2001; Pound et al., 2005), side effects (Hall et al., 2007; Pound et al., 2005) and efficacy (van der Geest & Hardon, 2006). Risk has continuously been a theme integral to discussions around medication use, including the paradox of the ability of medications to help versus harm (Moldrup & Morgall, 2001). The concept of risk or safety appears to be central to consumers’

acceptance or rejection of medicines (Fox & Ward, 2006). For instance, in a study on 'health identities', Fox and Ward (2006) found that medication users were able to be classed as 'expert patients' and 'resisting consumers' according to the level and nature of interaction with the drugs they were using. Resistance to medications was often based around perceived risk. Moldrup and Morgall (2001) contest that the concept of risk and the risks associated with modern drugs is central to decisions around drug use.

Caution around medicine-taking was also central in Pound et al.'s (2005) synthesis. Issues relating to the safety and side effects of medications were a common theme. Similarly to Fox and Ward's (2006) findings, generally people were found to be either passive or active accepters of medication, or rejecters. Active accepters often modified or changed their regimen, regularly adjusting recommended doses to reduce unwanted side effects. Pound et al. suggest that such modifications reflected a want to reduce their intake of medications in general, and they often supplemented their pharmacological treatment with alternative treatments for this reason. People resisted complying with medical instructions around medication use because of their own beliefs or concerns, rather than the actions or failings of health professionals. These studies highlight how consumers are 'active decision makers' (Stevenson & Knudsen, 2008) when seeking out and consuming medicines; they have their own beliefs around medicines and their uses (Conrad, 1985) which are not necessarily determined by a blind acceptance of biomedical thought or dominance. Some people reject medications entirely, and others accept them uncritically (Pound et al., 2005). Pound et al. suggest that rejection of medicine taking, and the increasing preference for complementary methods that seems to accompany it, is an area that may require further inquiry as it has implications for the nature of health care in contemporary society. Stevenson and Knudsen (2008) found that users' perceived control over their health and sense of self was also fundamental in to their medicine-taking behaviours. In an analysis of two qualitative studies from the UK and Denmark focusing on users of mood-modifying medicines, they discovered that people saw their active role in medicine taking and help seeking as fundamental to their recovery and their re-discovering their sense of self (Stevenson & Knudsen, 2008). This concept of self could be considered to be central to medicine-taking behaviours. As Giddens (1982, 1984) highlights, the sense of self can be linked to how in control people feel of themselves and their situation. It is possible that medicine taking could potentially interfere or change the sense of self experienced by the user, particularly when it comes to issues such as control over their mind or bodies.

Not only are our understandings of medicine distinct due to individual differences in experiences or attitudes, but also because of the social context in which we live. Friends and family play a key role in the exchange of knowledge and information about drugs. Such environmental factors are likely to have an effect on how the drug is experienced by the user (Helman, 1981). Further, the way medicines are marketed to us, what the internet (Cohen et al., 2001; Fox & Ward, 2006) and mass media tells us (Coveney, Nerlich & Martin, 2009; Fox & Ward, 2006; Woloshin & Schwartz, 2006), as well as public health messages, all influence our medical worlds. Some studies have concentrated on the influence of the media as a site which constantly circulates discourses, debates and discussions regarding lifestyles, health and illness (see Coveney et al., 2009; Williams,

Seale, Boden, Lowe & Steinberg, 2008b). For instance, UK media coverage of the sleep drug Modafinal was shown to encompass a number of discourses relating to sleep and health, body and technology (Coveney et al., 2009; Williams et al., 2008b).

Despite their centrality to our daily lives and experiences, relatively little is yet known about the influence of the media, technology such as the internet, advertisements and public health messages on people's decisions around medication use. There is room for further research on these topics, as well as how medications function for people other than users themselves, or in settings outside of the home. The symbolic meanings of medications for groups such as manufacturers or distributors, as well the views expressed by the media, would add depth to the current research around users. Approaches to investigating these issues, Cohen (2001) argues, should account for the complexity of medications, their social construction, the influence of human belief and interaction, and the paradoxes involved in their existence (Cohen, 2001).

Medicines in a New Zealand context

New Zealand has a unique context when it comes to medications. Nationally, they are often at the centre of much discussion and debate, not only amongst PHARMAC officials but also between health professionals, drug companies and consumers. Common issues raised concern drug controversies, subsidies and access to healthcare. New Zealand is also only one of two developed countries that allow direct-to-consumer advertising (DTCA) of prescription drugs (Norris et al., 2005). Many groups and individuals argue that the opportunity to promote medications through such widely-accessed avenues, such as television and print media, allows the pharmaceutical industry to engage in disease-mongering and scare tactics in order to convince the public they are unwell (Gilbody, Wilson & Watt, 2005; Jardine, 2004). These advertisements are often misleading and fail to fully inform consumers of the negative side effects of drugs. They may also have negative consequences for healthcare and doctor-patient relationships (Gilbody et al., 2005; Norris et al., 2005). Through drug promotion and advertising, pharmaceutical companies are able to create a social context which plays to their advantage economically (Jardine, 2004; Toop & Mangin, 2007). Given our unique setting, there is an opportunity for further investigation surrounding the meaning of drugs to those in a New Zealand context. Focusing on those involved in the marketing, distribution and consumption of drugs would help our understanding of how medications are socially framed and understood within a local context, according to local processes of commoditisation and consumption.

1.2 Medicalisation and Pharmaceuticalisation

“Critiques of the ways in which doctors have extended their empire have become part of everyday and professional debate. Such critiques have contributed to the part deprofessionalisation of medicine” (Rose, 2007, p. 700).

Medicalisation

The term 'medicalisation' denotes the social process whereby everyday problems or behaviours come to be recognised as medical and dealt with through medical means (Conrad, 1992; Conrad, Mackie & Mehrotra, 2010). It is generally understood as the widening of medical influence over traditionally non-medical areas of practice, and the infiltration of medicine and medical discourse throughout contemporary culture. What was once normal or natural has become increasingly framed as abnormal or dysfunctional (Conrad, 2005; Rose 2007). Medicalisation may include the use of medical language to refer to problems, implementing a medical framework in order to interpret a problem, or using medical strategies to alleviate an issue (Conrad, 1992). Jardine (2004) argues that DTCA is central to the medicalisation of conditions through the ideas it promotes about health and illness. A wide range of phenomena can be considered to fall under the 'medicalised' umbrella ranging from sleep (Coveney et al., 2009) and hair loss (Moynihan, Heath & Henry, 2002), to jiggling ones knees (Woloshin & Schwartz, 2006). Rose (2007) suggests penetration of all things medical into all forms of daily life has "made us what we are" (p. 700) and transformed our lives.

Researchers have been debating and attempting to define medicalisation from as early as the 1970s. Illich (1975) criticised biomedicine for over-extending its arm to areas of health which should have remained out of reach, and, in so doing, altering the very concept of health in Western society. Conrad (2005) refers to this as medical imperialism. While Illich recognised the value of medical technology, he claimed that it had reached an extreme where it was attempting to tackle issues central to humanity such as dying, illness and experiencing pain. This in turn, Illich contests, transforms living, breathing humans into machines, robot-like consumers, or objects, thus eliminating their capacity for health. Illich's controversial account initiated a number of critical studies relating to medicalisation and the "overconsumption of medical services" (p. 154, van der Geest et al., 1996; Whyte et al., 2002). Conrad (2005) argues that these accounts, mainly from sociologists, revolved around three primary 'drivers' of medicalisation, namely "the medical profession, interprofessional or organizational contest, or social movements and interest groups" (Conrad, 2005, p.3). However, as more studies on medicalisation ensued in the following decades (see Conrad, 1992; Conrad & Potter, 2000) further complexity was revealed. Illich's 'medical imperialism' no longer sufficed on its own, nor did a focus on psychiatry as a driver of medicalisation, which was popular with critics earlier on (Szasz, 2007). Rather, medicalisation appeared to be the result of a range of different drivers at work (Conrad, 2005), none which could be reduced to a single explanation, and each of which should be considered in its own unique context. Further, each case of medicalisation is different from the next; some may be incomplete (Conrad, 2005; Rose, 2007) and others may either benefit or harm different groups (Williams, Gabe & Davis, 2008). It may be a useful term for people who want to contest medicine's role, however, each case should be considered distinct and any enquiry should be tailored to the individual case in question (Rose, 2007). Some analysts even caution that we should be wary of how we use the term medicalisation itself. They suggest that it be considered 'value-neutral', used only to describe how something has been transformed into medical matter (Williams et al., 2008; Rose, 2007) rather than to describe the process or explain why it has transpired.

One of the main criticisms around medicalisation as a process is how it loosens the boundaries of what is abnormal and pathological, classing more and more perfectly healthy people as

diseased (Nye, 2003). Medicalisation of everyday issues, such as a lack of sleep, may lead to social or psychological issues being overlooked or ignored once a medical label is attached. Further concerns include the possibility of psychological dependence on drugs after long-term use (Helman, 1981) and people seeking out their own treatments unmonitored by medical professionals (Carpiano, 2001; Gabe & Lipschitz Phillips, 1984). More recently, concerns with medicalisation have extended to its relationship with the pharmaceutical industry (Rose, 2007; Williams et al., 2008). These criticisms suggest that the expansion of the medical realm is predominantly profit-driven and has negative implications for costs associated with health care (Conrad et al., 2010; Lexchin, 2001; Moynihan & Cassels, 2005). According to Conrad (2005), the interrelationship between medicalisation and the corporate world was not considered predominant in earlier critiques, and may have been overshadowed by the prominence that was given to other players, namely medical professionals. However, the 1980s saw changes in medicine which resulted in doctors losing their power, whilst the patient gained empowerment and transformed into a more informed consumer with greater autonomy. With such changes and developments, Conrad (1992) argues that the key drivers of medicalisation now concern factors such as consumerism and advancements in biotechnology, especially within the pharmaceutical industry.

Pharmaceuticalisation

“As powerful technical devices and cultural symbols, medicines acquire a status and force in society. As medical technology, pharmaceuticals are not only products of human culture, but producers of it. As vehicles of ideology, facilitators of self-care, and perceived sources of efficacy, they direct people’s thoughts and actions and influence their social life” (van der Geest et al., 1996, pp. 156-7)

While related to medicalisation, pharmaceuticalisation is itself a distinct phenomenon. Where medicalisation expands the market for pharmaceutical companies to develop, produce, promote and sell profitable drugs (Lexchin, 2001), pharmaceuticalisation relates to the expansion of the pharmaceutical industry and its treatments to numerous everyday problems or lifestyle issues (Lexchin, 2001). Often this leads to an “overconsumption of medical services, including pharmaceuticals” (pp. 154-155) for increasingly non health-related issues (van der Geest et al., 1996). During the middle of the twentieth century, the pharmaceutical industry was responsible for the creation of numerous drugs that altered lives and “reduced human suffering” (Moynihan & Cassels, 2005, p. x). These drugs were largely accountable for a reduction in disease and played a significant role in saving lives (Williams et al., 2008b). However, in the latter part of the century, we started to see the concept of what were promoted by the industry as ‘essential’ drugs gain momentum. These were marketed and taken up as low-cost and safe pharmaceuticals for widespread diseases, largely under the influence of the World Health Organisation (see Kanji, Hardon, Harnmeijer, Mamdani & Walt, 1992; Mamdani & Walker, 1985). The use of pharmaceuticals has become so normalised that they are considered by many to be a ‘quick fix’ option or a ‘magic bullet’ (Fox & Ward, 2008) cure for everyday problems. Often they are chosen over alternative treatment options (Lexchin, 2001). This quick-fix mentality extends to every aspect of making ourselves better than we are. Monaghan (1999)

highlights: “The body is less and less an extrinsic ‘given’, that we perceive them to be more pliable, and are actively seeking to alter, improve and refine them” (p. 708). The pharmaceutical industry is quick to promote this view of the body as malleable and transformable, as well as take advantage of it through the sale of countless medications. Considered by business analysts to be the “most profitable sector of commerce” (p. 861), the pharmaceutical industry is a competitive field relying on both “existing business and development of new products” (p. 861) for their revenue (Fox & Ward, 2008). Approximately twenty per cent of their income is put towards research and development, whereas forty per cent is dedicated to marketing. In the year 2000, around \$320 billion was spent on prescription drugs globally, and this number appears to be rising at a rate of around ten per cent each year (Henry and Lexchin, 2002).

Lifestyle drugs

‘Lifestyle drugs’ have been important contributors to industry profits in recent years (Fox & Ward, 2008; Lexchin, 2001). Some critics have used the term ‘a pill for every ill’ (Chamberlain, 2004) to describe how these drugs have become available for every common issue. Moynihan and Cassels (2005) provide a compelling discussion in their book *Selling Sickness: How the World’s Biggest Pharmaceutical Companies are Turning us all into Patients*, about how normal or natural life processes have been pharmaceuticalised and marketed at great profit to the industry. They focus on ten different ‘diseases’ that have been marketed and sold by the pharmaceutical industry and have resulted in major profit, including high cholesterol, depression, menopause, attention deficit disorder, high blood pressure, premenstrual dysmorphic disorder, social anxiety disorder, osteoporosis, irritable bowel syndrome and, most recently, female sexual dysfunction. While there are countless drugs available to treat diseases like these, the industry appears to have little interest in treating rarer conditions or ‘neglected diseases’, often those affecting Third World countries (Busfield, 2010). Instead, they direct their campaigns at promoting ‘lifestyle illnesses’ and treatments that may appeal to large sections of the population, thus guaranteeing a significant market for the pills they produce (Lexchin, 2001; Moynihan et al., 2002).

Disease mongering and immoral practices

As well as neglecting or targeting certain groups in their enterprise, other controversial and immoral practices of the pharmaceutical industry include “bribery, fraud in safety testing, dumping, and misinformation” (van der Geest et al., 1996, p. 157). In addition to manufacturing pills for diseases, some argue the industry also actively promotes diseases (Applbaum, 2006; Moynihan et al., 2002; Woloshin & Schwartz, 2006) in order to sell drugs. In other words, the industry is not only creating drugs to manage ‘diseases’ but is paradoxically creating and marketing diseases (Moynihan et al., 2002). ‘Disease awareness’ campaigns are often introduced to publicise new illnesses, and these are linked to drug companies’ marketing strategies. Moynihan (Moynihan 2002; Moynihan et al., 2002; Moynihan & Henry, 2006) has, through various case studies, drawn attention to the ‘disease-mongering’ practices used by companies to frame ordinary issues as medical problems. For example, Moynihan et al. (2002) argued that the extension of the boundaries of illness and disease can happen

in five ways: transforming everyday issues into medical problems; overstating minor symptoms as serious; classing personal experiences or issues as medical; framing risks as diseases; and overstating prevalence rates to capitalise on possible markets. In this sense, pharmaceutical companies are trying to extend use of their products to as large an audience as possible, and “well beyond the meeting of health needs” (Busfield, 2010, p. 935).

Key players

Conrad (2005) suggests that pharmaceutical companies have become “active agents of social control” (p. 11) and key players in defining the margins of normality. The immense size and power of this multinational industry is crucial to its enterprise (Applbaum, 2009), however the expansion of business also requires the engagement of other groups, in order to promote and encourage use of their products (Busfield, 2010). In particular, doctors have a central role to play in the prescription of pharmaceuticals and their support is fundamental to the sale of medicine (Busfield, 2010; Campbell, 2007). According to Busfield, the industry has been “active in securing this support” (p. 935). Evidence of this can be seen in a survey of physicians conducted by Campbell, Gruen, Mountford, Miller, Clearly and Blumenthal (2007) which found that 94% of those surveyed had some kind of relationship with the industry. Common practices included receiving food and drink in the workplace (83%) and being provided drug samples by company representatives (78%). Perhaps more controversially, more than a quarter (28%) received monetary payment for consulting, speaking or enrolling patients in trials. Other groups central to the equation include public health officials, interest groups, researchers and the health industry.

Negative impacts

The negative implications of these processes were stated years ago by Warburton (1978) who suggested society was at risk of becoming a ‘pharmacotopia’, where drugs are the principal method of coping. While some problems may benefit from a disease label or medical treatment, critics suggests that much of pharmaceutical enterprise is now directed at “the healthy and the well” (Moynihan & Cassels, 2005, p. ix). Moynihan and Cassels raise concerns about the morality of these practices, which appear to be driven more by commercial gain than the desire the help truly ‘sick’ people get better. It may also change how doctors and patients weigh up the risks and benefits of pharmacological treatment (Lexchin, 2001). By extending the boundaries of pathology, Lexchin (2001) argues, the perceived danger of side effects may be mitigated and they may be seen as more acceptable. Over-prescribing has also been identified as a problem (Helman, 1981). There is evidence to suggest that when a drug is available as a treatment for a problem, general practitioners may be less inclined to consider non-pharmacological options, even where there is a lack of evidence suggesting drug-treatments are better (Everitt, Avorn & Baker, 1990). Greater numbers of people are also turning to the internet as a site to find out about and purchase drugs (Spain, Siegel & Ramsey, 2001; Fox & Ward, 2008). This allows for instant gratification and access at any hour of the day and the purchase of drugs online without regulation. It also provides an opportunity for the industry to exploit further

the daily lives of individuals, through interacting with them in their own home or personal space (Fox & Ward, 2008).

1.3 The Medicalisation of Fat

“Whereas once fat was seen in a positive light as a token of social, economic and sexual well-being, now the reverse is true. Present cultural preferences make thinness the ideal of beauty and discriminate against fat” (Pieterman, 2007, p. 319)

The concept of normality or pathology in health, is not only tied up with how we feel, how sick or well we are, or if we are free from disease, but also extends to normative appearance (Jutel, 2006). It could be argued, in fact, that normative appearance is where the health industries stand to profit most, as how we appear to others is often directly linked to how we are judged as individuals. Billions of dollars are spent each year on improving our appearance and trying to fit in through hair, makeup, surgery and other beauty products. However, in the twenty-first century there is one fundamental factor that is central to how others perceive us and we perceive others on a daily basis, and that is body size. We live in a society that is obsessed with weight, dieting, body size, fatness, thinness, food, exercise and everything in between.

The medicalisation of body weight

The preoccupation of Western contemporary society with body size and weight has partially stemmed from the medicalisation of fat. Historically, excess weight or corpulence was considered to be a status symbol (Pieterman, 2007) and a sign of health (Gracia-Arnaiz, 2010; Flandrin & Montanari, 1996), particularly in Western European societies. Being heavier was revered whereas scrawniness was perceived as unattractive and denoted poor nutrition or malnourishment. According to Gracia-Arnaiz (2010), gluttony was an accepted social practice, particularly in pre-industrial societies where food was scarce and poverty and hunger were common. People desired to be fat, yet it was a condition that only the wealthy could accomplish. These attitudes largely remained the norm until the twentieth century where fatness was transformed by biomedicine into something to be avoided and even feared. Through medicine’s influence over the body, fatness went from being celebrated to pathologised in the context of an ‘obesity epidemic’, where it is currently purported to be directly linked to poorer health outcomes and mortality (Gracia-Arnaiz, 2010; Oliver, 2006). Fatness has reached ‘disease’ status, with obesity now officially considered a disease by the World Health Organisation.

These changes in perception of fatness across time suggest that, like medications, body fat can be considered to be socially and culturally constructed. The body is positioned according to the dominant discourses at the time; it is constructed and expected to conform to that construct, particularly female bodies (Bell & McNaughton, 2007). Views about the causes of and solutions to obesity vary from one context to the next, and even between individuals such as the layperson and the medical expert (see Ogden & Flanagan, 2008). Despite some differences in opinions, the dominant discourse portrayed by medical authority is one that constructs fatness as unhealthy, and thinness as

better for health (Pieterman, 2007). In this sense, “cultural discourses in contemporary western society encourage weight loss” (Kwan, 2009, p. 1223). The medicalisation of obesity has also increased medicine’s specific control over the obese body. Jutel (2006) suggests that there are two possible explanations for this transformation of excess weight into a disease: “The first is the belief in the neutrality of quantification, and the objectivity that measurement brings to qualitative description. The second is the importance attributed to normative appearance in health” (p. 2268). These both have significant implications for individuals, health policy, and the treatment and care surrounding weight-related issues.

The ‘obesity crisis’

“The idea that a certain body weight should be classified as a ‘disease’ is not driven by any clear medical facts; rather, the pressure to label obesity as a ‘disease’ comes from a range of interests, from high-to low-minded, across the healthcare spectrum” (Oliver, 2006, p. 47)

Body fat and body size have gained increased attention in recent decades, largely due to the moral panic surrounding the ‘obesity crisis’, as it is often termed by the World Health Organisation and other institutions. The ‘obesity epidemic’ and the disease status of obesity have arguably been both drivers and consequences of the medicalisation of fatness. In New Zealand, the Ministry of Health classes a quarter of the adult population as obese and a third as overweight. This is a large disease category, pathologising a significant proportion of our population as ‘abnormal’ and therefore worthy of treatment. While there is no denying we are getting heavier, challenges to the obesity epidemic suggest that it is not as widespread as is made out, nor are the health implications so serious (see Oliver, 2006). Critics of the epidemic argue that it is used as a trademark or slogan to justify a ‘war on fat’. Classing obesity as a disease just serves to heighten angst, public concern and dissatisfaction with our bodies, generating fear and unease (Boero, 2007). The term ‘obesity epidemic’ itself has also been heavily contested. ‘Epidemic’ has traditionally been used to denote epidemics such as the Plague, HIV/AIDS and other scenarios involving communicable diseases. Referring to an epidemic of fatness is considered to be misleading, not only because it is impossible to transfer fatness from one individual to the next, but also as it promotes idea that we are all at risk of becoming part of this epidemic unless we keep a watchful eye on our waists. It generates fears about becoming overweight, discriminates against those who become so and promotes an unhealthy preoccupation with weight, body size and measurement.

Challenges to the construction of the fat body and the obesity epidemic have come respectively from feminist (see Bordo, 2003; Yancey, Leslie & Abel, 2006) and critical obesity researchers. In fact, ‘critical obesity research’ or ‘fat studies’ (see Campos, Saguy, Ernsberger, Oliver & Gaesser, 2006) is beginning to form its own field of inquiry. The majority of this research has stemmed from the USA, Australia and New Zealand, but is growing elsewhere in the world including in the United Kingdom (Colls & Evans, 2009). Research in this field criticises the dominant discourses present in Western society relating to fatness. It uses critical methods of inquiry to understand how these discourses are produced, understood and re-presented within mainstream

mediums such as “dominant media and policy representations of obesity” (Colls & Evans, 2009, p. 1013). Some of the key areas of focus include the medicalisation and pharmaceuticalisation of fatness; the labelling of fatness or obesity as a ‘disease’ (Jutel, 2006); the construction of the fat body in the media and public discourse; the political and economic motivations for the obesity epidemic, including the role of the pharmaceutical and weight loss industries; the overstatement of the connection between fatness and poor health issues; and the language used to refer to overweight individuals.

Measuring fatness: tools, scales and guidelines

Numbers, statistics and measurements have become central means to justifying the obesity epidemic and the ‘war on fat’ (Oliver, 2006). Not just at a population level to determine prevalence and incidence, but also at an individual level to track weight and body measurements. The Body Mass Index (BMI) has become the preferred measurement tool for both medical professionals and laymen to determine whether one sits in a ‘healthy’ weight range or is ‘too fat’ or ‘too thin’ (Gracia-Arnaiz, 2010). Despite its popularity, it has been widely criticised as a tool and is considered by many to be fundamentally flawed. Criticisms centre around the arbitrary nature of its categories, the fact that it was originally designed for population studies but is being used at an individual level, and its inability to take into account different bodily compositions such as muscle, fat and water (see Oliver, 2006). These kinds of faults are concerning given that BMI is used to inform population statistics such as those used by Statistics New Zealand that class a third of our population as overweight. Gracia-Arnaiz (2010) argues that explanations which account for the rise in obesity, and the approaches put forward to reduce its incidence and prevalence, are therefore justified on questionable scientific grounds and populist arguments about causality and correlation.

Not just are numbers central to the justification of an epidemic but so are guidelines, regulations and recommendations. It has been suggested that the “formulation of dietary recommendations has run parallel to the progressive medicalization and commercialization of body weight” (Gracia-Arnaiz, 2010, p. 220). The combination of BMI, numbers and statistics claiming that a significant portion of the population is overweight could be viewed as scare-mongering. Not only does it frighten the public but it may lead them to embark on intense diet or exercise regimes, or lifestyle changes in order to lose weight. Jutel (2006) suggests that through the fixation on measuring our bodies, body weight has become both the ‘diagnosing tool’ and the rationale for a “pseudo-disease in and of itself” (p. 2270) placing it as an “object of epidemiological study” (p. 2270). These kinds of measurements and guidelines are used to quantify or denote normality, and how ‘at risk’ one is of certain health issues that are considered to be weight-related. While there are a few people that may benefit from a disease label or diagnosis, the problem with measurement and the tools used to determine whether one is in a ‘normal’ weight range, is that the disease category is too wide and classes too many healthy people as obese or overweight. This obsession with quantifying health and measurement is also unhealthy as it promotes an unrealistic expectation of what one’s body should conform to. Failure to achieve ‘normality’ is often equated to failure as an individual. Falling outside the ‘normal’ weight range may be seen as bad, irresponsible and unhealthy. In this way, fatness is both

an aesthetic and moral issue (Yancey et al., 2006). Normality is closely linked to issues relating to risk, health and hierarchy, where those who are thin are considered superior and healthy and fat people are seen as abnormal, inferior and unhealthy.

Fatness and risk

Closely related to the concept of normality in weight, is the notion of 'risk'. Pieterman (2007) contests that it is social and cultural issues relating to "power, blame and control" (p. 310), rather than health issues, that drive this discourse. He suggests: "Just like other risk discourses, the one on obesity revolves around power and control relationships between different social interests. Risk and blame, power and morality are intimately linked" (p. 319). At a societal level, obesity is repeatedly emphasised as a major health issue which poses a great 'risk' to society (Campos, 2004; Gracia-Arnaiz, 2010). We are constantly receiving information about the 'dangers' or 'risks' of being overweight. If one falls outside the 'normal' weight range, then they are automatically classed as 'at risk'. Even if one is not currently classified as overweight or obese, they are still 'at risk' of becoming overweight and guidelines and precautions are recommended to avoid this. Thus, essentially everyone falls into this 'at risk' category and remains there for life.

Claims about the health risks of being overweight are widespread. Reports claiming that obesity 'causes' heart disease, diabetes, early death and various cancers are rife. However, other research suggests that the relationship between fatness and death or disease is grossly over-exaggerated (Campos et al., 2006). In fact, moderate fatness can actually be beneficial and may increase life expectancy (Campos et al., 2006). For instance, those classified as underweight by BMI standards are more 'at risk' of early death than those in the overweight category (Flegal, Graubard, Williamson & Gail, 2005). What *has* been established as a more crucial factor in disease is level of fitness, or, conversely, inactivity. Unfortunately, inactivity is often inextricably linked to fatness and many consider it one and the same. This leads people to assume that it is the fatness that is causing the diseases and early death rather than the inactivity.

Marginalisation and individual blame

Fatness has become both a political and a social issue (Colls and Evans, 2009; Campos et al., 2006; Gracia-Arnaiz, 2010 & Pieterman, 2007). Being overweight and therefore 'at risk' of health problems is purported to be "socially and economically irresponsible" (Pieterman, 2007, p. 319) as well as an individual failure (Colls & Evans, 2009; Elliot, 2008). Overweight individuals are seen as failed citizens (Elliot, 2007), a tax on the health system, as costing the economy and even contributing to global warming in one media report in a UK newspaper. We are even starting to see discussion around public policies, such as increasing the cost of 'junk foods', designed to prevent fat people from engaging in 'unhealthy' practices, in order to limit their causing further damage to themselves and society through their behaviours (Pieterman, 2007). This "blame-the-victim" (p. 1012) approach permeates cultural discourse relating to weight, and often goes hand-in-hand with moral judgements regarding the character of fat people (Colls & Evans, 2009). For example, Western society depicts a

typical obese individual as one who is generally morally irresponsible, lazy, weak, unhealthy, unattractive, and requiring a change to their own personal habits or lifestyle to de-size, lose weight and gain health (Boero, 2007; Colls & Evans, 2009; Evans, 2006; Jutel, 2005; Oliver, 2006). Through daily reports relating to fatness, the media is largely responsible for the reproduction of negative discourses and stereotypes that encourage discrimination (Boero, 2007; Lawrence, 2004). Colls and Evans (2009) suggest that “The politicisation of body size in this way is resulting in, and reflects, a widespread fear of fatness and prejudice against those deemed ‘fat’ or ‘obese’” (p. 1012). To illustrate this they draw attention to a 2004 UK government report (House of Commons Health Select Committee) that suggested attaching a stigma to obesity could be useful in encouraging people to try harder to lose weight.

Weight-loss methods in contemporary society

The medicalisation of obesity brings enormous commercial gains or opportunities for a number of groups, including, but not limited to, the medical profession, academic researchers, public health communities, government, and pharmaceutical and weight loss industries (Pieterman, 2007; Oliver, 2006). Critical researchers suggest that these industries and groups are also drivers of the epidemic, fuelled by self-gain or political motivations, allowing them to extend their power or empire (Pieterman, 2007). Obesity’s disease status means that a number of “diagnostic, curative and preventive strategies...fall into place, conveying both legitimacy to, and structure for the patient’s complaint” (Jutel, 2006, p. 2268). Like other medicalised conditions, obesity requires the ‘sufferer’ to carefully consider their health and potential treatment options, as these might provide a ‘cure’ or help them on their pathway to getting well (Jutel, 2006). From the point of view of the health and fitness industry, the positioning of weight as pathological and unhealthy has been extremely beneficial. The stigma against fatness only increases the impetus for people to shed weight. As has already been stated, to be fat is considered unattractive and unhealthy. As health and beauty are simultaneous concepts in Western cultures, this provides a great backdrop for the pharmaceutical and weight loss industries to sell products targeting people who want to lose weight. Kwan (2009) conducted a qualitative study where she interviewed people who were trying to lose weight and looked at their motivations for doing so. Often these attempts were driven by wanting to ‘fit in’ with western cultural concepts of beauty and attractiveness and this connected to their desire to “be healthy and live long lives”. Kwan suggested that the concept of health was often linked to or equated to that of beauty so that they became one and the same. To improve our looks we must therefore improve our health and vice versa.

Western society encourages consumption in the attempt to make ourselves better than what we are (Vrecco, 2010). This extends to the consumption of weight loss products, such as diets, programmes and pills, or professional help for weight loss including the use of personal trainers, dietitians or other medical professionals. Many of these come at a great cost and their existence is short-lived until they are replaced by the newest fad product claiming to ‘fight the fat’ or cure obesity. They encourage a preoccupation with weight and food, unhappiness with our bodies and an obsession

with physical appearance. Further, often weight-loss products are used over and above more holistic options as they are seen as offering a ‘magic bullet’ solution (Fox & Ward, 2008). Their efficacy, however, is questionable. Often the individual loses weight to begin with, only to put it back on again in a short time period. In these cases, failure to shed weight and keep it off is viewed not as a result of a flawed or faulty product, but rather as a failure of the consumer themselves. ‘Failed dieters’ are often positioned as ‘not doing it properly’, lacking the motivation or persistence to stick to a diet, or ‘cheating’ and giving up. Despite their questionable efficacy, these commodities are heavily marketed and widely available through media ranging from the internet, health stores, supermarkets, pharmacies, medical professionals and by prescription. Given their widespread consumption and availability, further research is warranted into the contemporary meanings of weight-loss products or medications and their everyday dissemination and consumption.

1.4 Pharmaceuticals for Weight Loss: The Case of Xenical

As with other medicalised issues, the pharmaceutical industry has been swift to jump on the obesity bandwagon. Fox and Ward (2006, 2008) discuss how pharmaceuticals for ‘lifestyle conditions’ (Lexchin, 2001), including weight-loss drugs, have entered the daily lives of individuals, becoming domesticated and integrated into everyday routines and practices. Billions of dollars are spent yearly on weight-loss products. For example, Sanofi’s weight-loss drug Rimonabant (Acomplia), which claimed to have a ‘breakthrough chemical’, was predicted to net \$3 billion per year on release (Sargent, 2006). Roche’s blockbuster Xenical (Orlistat, Alli) for obesity proved to bring substantial profit, with global sales of just short of \$0.5 billion in 2005 (Fox & Ward, 2008). Xenical is a particularly interesting drug to research further, as it has been one of the most widely marketed and purchased weight-loss drugs to ever be produced (Lexchin, 2001). In New Zealand it attracted attention for both its extensive advertising campaign, and the controversy surrounding its negative side effects. This research aims to consider Xenical in more depth, against a background of a fat-medicating world. According to Jardine (2004), Xenical is a drug that “uses the body as a focus of disciplinary power for surveillance medicine” (p. 485). To date, researchers have used Xenical as an example of direct-to-consumer advertising of drugs (see Jardine, 2004) and have investigated consumers’ experiences of using Xenical for weight loss (Fox & Ward, 2006) but none have considered it for its social and cultural properties as a medication and how it is understood by different players connected to it. Xenical was launched by Roche Pharmaceuticals in New Zealand in 1998 at a time where international concern was mounting within the medical and health communities relating to perceived increase in the prevalence of obesity (Jardine, 2004). With obesity cited as being a serious medical issue in medical journals and reports, Xenical appeared to offer a perfect solution or ‘cure’ to the obesity problem. Not only did Roche offer Xenical as a pill, but consumers also had the opportunity to sign up to its Weight Management Programme. The average cost of Xenical in New Zealand currently sits at between \$165 and \$175 per month and Roche recommends people commit to it for between three to six months at least. According to Ballinger and Peikin (2002), Xenical works as a fat inhibitor by altering the action of pancreatic lipase to reduce fat absorption.

Roche spent in excess of \$75 million promoting Xenical to the public at the beginning of its campaign in the United States in 1999 (Lexchin, 2001). New Zealand began earlier with their DTCA in 1998 and was the first in the world to launch and market Xenical (TVNZ/Marketing Magazine Awards, 2000.). The opportunity to advertise Xenical directly to consumers was seen by the pharmaceutical industry as a chance to inform consumers of the health risks of being overweight and to encourage them to initiate a conversation with their doctor. Using the slogan '*Lose weight. Gain life.*', Roche's campaign depicted large-bodied individuals generally in a negative light as being unhappy and in need of help. According to Jardine (2004), it painted obesity as "a medical and social problem for which Xenical was offered as a medical solution" (p. 486). Despite receiving criticism, the advertising campaign appeared to be successful and Xenical saw huge popularity after its release. At the end of 1999, \$20.3 million had been spent on Xenical within the year. New Zealand led 29 other countries in terms of pill sales per capita of the obese (TVNZ Marketing Magazine Awards, 2000). In 1999, Xenical "became the number one Roche brand in terms of New Zealand \$ sales and by the end of 1999, Roche had risen from the 9th to the 2nd pharmaceutical company in New Zealand according to sales into retail pharmacies" (TVNZ Marketing Magazine Awards, 2000.). As the first prescription medicine to ever be marketed directly to consumers in New Zealand, by early 2005 Xenical was reclassified as a pharmacist-only medication. Some regulations around its sale remained in place with this change, including the recommendation that consultation take place on a face-to-face basis. Further, Xenical was recommended only as appropriate for people with a BMI of 30 or above.

Why study Xenical?

Preliminary investigations into Xenical as a possible medication of interest for this study revealed that it may have declined in popularity in New Zealand in recent years. While sales figures could not be accessed, anecdotal reports from pharmacists and dietitians suggested that people do not appear to be seeking it out as readily as a treatment for weight loss. This was intriguing, and raised a number of questions as to what might have happened to Xenical, why it was no longer popular and whether it had been replaced by other drugs or weight loss options. Xenical is well-known for having a wide range of adverse gastrointestinal side effects, including, but not limited to, faecal urgency, fatty/oily stools, faecal incontinence, flatus with discharge and oily spotting (Roche, 2012). These side effects are amplified with increased fat in the diet, thus the pill is said to work partially through users' avoiding fatty foods for their undesirable effects. However, it is unlikely that Xenical's side effects alone account for its decrease in popularity; it still appears to be widely consumed in other parts of the world. Therefore, this study was interested in uncovering more about the processes which may or may not have led to its demise as the favoured blockbuster that it once was in New Zealand.

Its direct-to-consumer advertising, changes in availability and numerous side effects, make Xenical a particularly complex, yet unique drug to use as a case study. Some researchers to date have considered users' experiences of Xenical (see Fox & Ward, 2006). For example, a large study on pharmaceutical consumption and role of the internet (Fox, Ward & O'Rourke, 2005a, 2005b; Fox & Ward 2006, Fox & Ward, 2008) considered the experiences of Xenical users through online forums

relating to the drug. The internet is emerging as a new medium to consider users' experiences with medication, particularly through their engagement with websites and discussion forums. These are sites where people discuss, interact, form identities, purchase medications and make decisions around medication use. With the exception of a few studies, the internet has been somewhat neglected in the literature around medicines, particularly weight-loss medications. The internet adds another dimension to our understanding of the use of drugs such as Xenical. Not just because it has emerged as a site through which users exchange information and experiences about weight-loss medications, but also because it opens up a space for researchers to consider how people present online themselves and their experiences of drugs. In particular, it offers a route through which information might be accessed from hard-to-reach groups (Fox & Ward, 2008), such as those who are looking for treatment for stigmatised conditions like obesity. It is possible that the anonymity of the online environment allows for the more open expression of weight-related concerns or issues to do with taking weight-loss drugs such as Xenical, such as embarrassing or undesirable side effects. In any case, the internet is changing the nature of health care (Spain et al., 2001), and is emerging as both a source of information for consumers and a space in which to recount their experiences. Therefore, this study will use both websites and online forums relating to Xenical as sources for analysis.

Though some researchers have considered users' experiences of Xenical (see Ogden & Sidhu, 2006; Psarou & Brown, 2010), none have considered critically how it is represented by different groups or players and tied to discourses surrounding weight and weight loss. Rather, they have focussed more on the side effects of Xenical or issues to do with efficacy. This fails to take into consideration how it might be positioned and constructed differently from one individual or group to the next, according to differing interests, values and positions. For example, Ogden & Flanagan (2008) have shown how beliefs about the causes of and solutions to obesity differ between general practitioners and lay people. Through questionnaires, they discovered that general practitioners shared the view that obesity was caused predominantly by psychological and behavioural factors, whereas lay people preferred a biological model of causality. This study can be used to demonstrate how, whilst drugs such as Xenical have meanings to those that consume them, they can hold diverse meanings to other groups who may position and construct them differently. Of interest in this study are the meanings to all the groups who have an interest in Xenical and what it represents, and how issues relating to fatness and weight are discursively produced and reproduced through these groups. In essence, this study uses Xenical as a centre-point to connect up the experiences of those connected to it, as well as analyse the central issues present surrounding weight loss in a fat-medicating world.

1.5 The Current Study

Xenical has been considered in relation to understanding the medicalisation and pharmaceuticalisation of fatness, but no research to date has examined its meanings to the different players connected to it. Medications have social lives and are constructed and understood differently by various social actors such including manufacturers, distributors, marketers, users and other individuals or groups linked to them. While van der Geest et al. (1996) have explored how pharmaceuticals are socially and culturally constructed through their 'lifecycle' stages, no studies have investigated a specific pharmaceutical in

depth, considering how it is constructed and positioned diversely by those linked to it. Thus, this research seeks insight into the various ways that different players connected to Xenical construct and position it. Therefore, the key objective is as follows:

- To gain insight into the different understandings and constructions of Xenical, including its various symbolic, social and cultural representations as a weight-loss pharmaceutical for a range of players

In this research, the players include pharmacists, dietitians, Xenical users, non-users, the Roche Xenical website, Xenical advertisements and news articles. Data from these different sources are useful as they provide contextual and symbolic understandings of the practices surrounding the production of Xenical and its uses. For instance, Roche's website and advertisements are linked to the production and marketing phase of Xenical, pharmacists to the distribution or dissemination stage, Xenical users to the consumption stage, and non-users, dietitians and news articles to the broader contexts of understanding that surround Xenical. This research will add to the knowledge-base around the medications and how they are represented across humans and settings, and advance understandings of the meanings of medications and the social practices surrounding them.

1.5.1 Context and theoretical framework

It has been well-established in the literature that medications are socially and culturally framed and understood. They have complex social lives (Cohen et al., 2001) and change meanings from one context to the next. Therefore it makes sense that the methods used to understand them, and how they function across settings and within the hands of different groups, are sensitive to their social complexity. The epistemological framework of constructivism (Gergen, 1985) sets a fitting background for the study of pharmaceuticals, as it recognises that both behaviour and thought are constructed between different settings, individuals and groups. This takes into account the fluid, changing and complex nature of pharmaceuticals, rather than simply focusing on their existence as medical technologies that are purchased and then consumed (Cohen et al., 2001). This study also comes from a critical analytical perspective, as it attempts to diverge from the traditional biomedical view of health and illness and medication-use, which have traditionally concentrated on the patient-professional relationship, whilst excluding the plethora of other players involved in the lifecycle of pharmaceuticals. The research also considers issues such as power, blame and control to be pertinent to the study of pharmaceuticals, obesity, weight and weight loss.

In order to fully understand Xenical and how it is socially constructed, framed and understood by different players, qualitative, social methods of inquiry were used. Similarly to van der Geest et al. (1996), Xenical was considered as an object that passes through different stages in its 'lifecycle'. In order to understand how these stages are produced through talk, text and other forms of symbolic communication, we focused on how a range of different players, including pharmacists, dietitians, Xenical users, non-users, Roche's Xenical website, Xenical advertisements and news articles positioned Xenical. Rather than trying to identify specific discourses in these forms of

communication, our key interest was how language was used discursively by the different players to construct Xenical and legitimise (or reject) its use. Informed loosely by positioning theory as a tool for understanding meaning making between different individuals, we wanted to find out how the players positioned Xenical use, or were positioned by Xenical use, according to their unique context or situation. We considered how each of the players in their respective positions as, for example, ‘experts’ or users, constructed their talk around weight issues, obesity and drug use. Through analysing this, we were able to investigate how the players were embedded in forms of talking or representing Xenical by their position relating to Xenical or their professional stance. This is why we decided use such a wide range of sources of information or forms of communication rather than solely focusing on one avenue. Understanding Xenical from a range of different perspectives and settings provided an in-depth analysis of the journey of one pharmaceutical, adding to the current knowledge-base around pharmaceuticals and the meanings people attach to them.

CHAPTER 2

METHODOLOGY AND METHODS

2.1 Players and Research Approach

This research diverges from more traditional studies in the sense that it does not simply use one group of homogeneous participants, for example Xenical users. Due to the wide range of sources of information accessed, some difficulty was experienced in deciding on a label to generically denote or refer to the groups in this research. The term ‘groups’ did not seem appropriate, given that it could only be applied to pharmacists, dietitians, users and non-users, and was not so fitting for the website, advertisements or news articles. Likewise, ‘participants’ also didn’t fit as a label for similar reasons. The term ‘players’ seemed more suitable as it covers all of the different sources of information, both human and non-human, or talk and text. It is also fitting as it denotes a sense of active involvement in the research, rather than passive participation. In this study the ‘players’ all formed part of a wider network of understandings, constantly morphing and changing according to societal norms and understandings around Xenical, pharmaceuticals and weight loss. Occasionally, the phrase ‘sources of information’ will be used interchangeably with ‘players’ to refer more generically to all the different data sources. Also in contrast to traditional research, the current study uses a relatively small number of players. This is not a concern as we only aimed to get a ‘snapshot’ of Xenical from each source. We did not intend to generalise the findings to any other groups, rather, we simply wanted an in-depth understanding of Xenical pieced together by a small but significant variety of players.

In addition to using differing players, this research also used diverse data-gathering techniques. Rather than relying solely on the face-to face interview, we also analysed online content and other media content, including Xenical forums, Roche’s website, advertisements and news article. This made for a very rich and unique data set using a range of procedures. The pharmacists, dietitians and non-users were identified and recruited through a range of means, from approaching them in person to emailing them. Of the interviews, all took place in settings at the players’ discretion; some at the workplace, and others within individuals’ homes. In each setting, the privacy and comfort of the players were taken into consideration and the interviews did not proceed until they had indicated they were comfortable. For the players that were interviewed, these took place in an informal, semi-structured style around loose questions. This was considered suitable for the context of the research and the research objectives as it elicited discussion that was in depth and allowed the participants to tell a story around Xenical and its uses. Data from the remaining players was taken from websites and other public material, detailed below. The data were analysed for overlapping networks of practice surrounding Xenical and how fatness, weight loss and Xenical, as the object of interest, are constructed and positioned within them.

2.1.1 Ethics

Ethical approval to conduct this research was granted by the Massey University Human Ethics Committee (Application 11/047) on the 8th August 2011. Ethical issues were considered when both

preparing for the research, and throughout the research process itself, particularly prior to the commencement of the interviews given the sensitive nature of some of the topics surrounding weight loss. Privacy issues were also considered in relation to data collection from online spaces and media sources, particularly in regarding the Xenical forums. However, it was decided that the information available online were all in public spaces and therefore open to use freely. Pseudonyms have been used throughout to preserve the identity of the pharmacists, dietitians, non-users and Xenical forum-users and place names and other identifying information has been disguised.

Pharmacists

Two currently practicing pharmacists were interviewed. Both were male, New Zealand European, and were aged 36 and 68. The pharmacists were selected via face-to-face interaction. Pharmacies in the Wellington region were visited and the shop assistants were asked if there was a pharmacist available. If a pharmacist was available, they were spoken to about the details of the project and asked whether they would be willing to participate in a short, informal interview. If they indicated they were willing to participate, then a suitable time was arranged for the interview and they were provided with an information sheet (see Appendix A) to read in detail before the interview. Interview prompts were used (see Appendix B) to guide the topics covered, but the conversation often diverged from these as they were in no way intended to be prescriptive. Of the three pharmacies visited, only one declined to be interviewed. The interviews with pharmacists were held at their place of work. Both of the pharmacists talked to me while they were on duty mixing creams or organising prescriptions. This gave a sense of reality and context to the interviews, which were often interrupted by store assistants or customers. Prior to the interviews, the pharmacists were asked to give verbal consent to be recorded after being asked if they understood the procedures and that they would remain anonymous. It was decided during the ethics process prior to data collection, that obtaining their written consent would be too formal given the casual context of the conversations within the pharmacies. Both interviews were recorded and transcribed soon after the interview.

Dietitians

All three dietitians were female and ranged in age from 34-59 and were New Zealand European. They were all New Zealand registered dietitians, currently based out of private practices. The dietitians were identified via the Dietitians New Zealand website and were emailed with a brief about the project and asked whether they might be interested in participating. Three responded with interest and this was followed up with a phone conversation about the project where a time and place were arranged for a face-to-face interview. They were also sent an information sheet to read prior to the interview (See Appendix C). Two interviews took place at the dietitians' private residences and one at her place of work. The project was discussed again and verbal consent to participate was given. Verbal consent was justified similarly to the pharmacist interviews, due to the informality of the situational context in which the interview was to take place. In fact, we wanted to present it less as an 'interview' and more as a discussion or conversation around the key issues. The interviews were all recorded and transcribed and interview prompts (see Appendix D) were again used to informally direct the conversation.

Xenical forum-users

There were ten forum-users, selected from two different forums relating to Xenical in order to find out about how Xenical was understood by people who were currently using Xenical, or had used it in the past. Online forums were chosen as they are becoming an increasingly popular space for people to share in depth stories of their experiences of the medication without fear of public embarrassment or humiliation. The information on the forums was publicly available and thus has been used openly for the purposes of this project, though names have been changed. The ages of these players were not available on the forums. The online forums used all had 'Xenical' as a keyword in a conversation thread. The forums were selected through a browser search of 'Xenical forums' and only forums based in New Zealand were used for the analysis. The written conversational text on these forums was analysed for its content relating to Xenical.

Non-users

There were three non-users, all of whom were female and ranged in age from 22-23. All three were of similar background and socio-economic status and were currently undertaking diet or exercise regimes that did not entail the use of Xenical. None of them had ever used Xenical in the past. Non-users were selected through word-of-mouth, generally via friends or acquaintances. Given the extensive number of people on some form of diet or exercise regime, it was not difficult to find participants for this group. The only selection criteria was that they had to currently be on some form of weight loss regime, as the study was interested in how these participants may construct it differently to those who are using Xenical or involved in promoting the use of Xenical. Potential players were told to make contact if they were interested in participating or wanted to find out more about the study. Once they had initiated contact, a phone conversation was held and a time and location arranged for the interviews. All the non-user participants chose to be interviewed at home. Two of the non-users who were friends asked to be interviewed together. This meant that it became more of a focus group than an interview which was deemed acceptable for the purposes of the research, as the participants' comfort was of primary importance. Prior to the interviews they were provided with an information sheet (See Appendix E) to read over and a consent form to sign (See Appendix F). Written consent was deemed necessary for this group given the longer duration of the conversations, the greater formality and the sensitivity of topics to be covered. Interview prompts were used as part of the process, though the dialogue diverged from these the majority of the time, as they were only intended to loosely direct the conversation (See Appendix G).

Roche Xenical website

The main Roche homepage for Xenical New Zealand (see Image 1) was used as a source to gain insight into the company's perspective and construction of Xenical locally. The homepage on the website features a picture of slightly heavy women coupled with a few short paragraphs relating to Xenical's effectiveness when used in conjunction with a low-fat diet, as well as how it works by blocking fat to the system. In very small text at the bottom of the page is information about Xenical, including its categorisation as a pharmacist-only medicine, its suitability for adults with a BMI greater than 30, and a list of side effects. To the left of the homepage is a list of tabs that direct the website

user through to other information pages including: ‘What is Xenical?’, ‘Is Xenical for me?’, ‘How do I get Xenical?’, ‘Nutrition and Activity Centre’, ‘Healthy Recipes’ and ‘Frequently Asked Questions’. All parts of the website were analysed for content relating to Xenical.



Image 1. Xenical website homepage (www.xenical.co.nz).

Xenical advertisements

Two television advertisements for Xenical were viewed, both of which were promoted in a New Zealand context since direct-to-consumer advertising for Xenical was introduced in 1998. The advertisements for Xenical were accessed via Youtube (www.youtube.com) through searching the term ‘Xenical advertisement New Zealand’. The first of the video clips, Advertisement 1, often referred to as ‘Mysterious Lady’, is 1m 03s and features a slim woman doing a range of unusual activities (see Image 2). Then it cuts back to an overweight woman sitting on a bed who says “but I can’t even tie my own shoelaces” (see Image 3). Advertisement 2 is 0.15s long and features a single shot of an overweight man sitting in a car looking exhausted and unhappy (see Image 4). Following this it switches to a screen with a description of Xenical and a number to call. This advertisement was aired when Xenical was still a prescription medication. Both were aired in New Zealand on television networks and use the Xenical slogan ‘Lose weight. Gain life’. These video clips were analysed for how they positioned Xenical and its market consumers.



Image 2. Advertisement 1, Xenical Mysterious Lady



Image 3. Advertisement 1, Xenical Mysterious Lady



New Zealand Advertisement Xenical Advertisement

Image 4. Advertisement 2

News articles

Four news articles were analysed for their written content relating to Xenical. One was accessed on the New Zealand Herald website (www.nzherald.co.nz) and the three others were accessed on Stuff news website (www.stuff.co.nz). All the articles were found through entering 'Xenical' into the search box on the news websites as a keyword. There was an initial pool of 15 articles with 'Xenical' in them in the Stuff search, and a plethora on the New Zealand Herald website. Most of these only touched on Xenical briefly. The news articles selected from this larger pool were chosen for their relevance to Xenical, weight and drug treatments, and all had some significant content concerning Xenical. The four selected articles were all reporting on it, or on issues linked to it, for different reasons ranging from changes from prescription-only to pharmacist-only, to controversies over its side effects, to people's experiences of using it. They were also all released in the last seven years, with a date range of 2005 to 2012. Their headlines were as follows: Article 1, 'Weight loss drug to be sold over the counter' (Walsh, 2005); Article 2, 'Medsafe alert on Xenical liver risk' (Newton, 2009); Article 3, 'Anti-obesity pill won't hit NZ yet' (Baines, 2012); Article 4, 'Pill isn't a fat lot of good' (Stuff, 2008).

2.2 Analysis

In total, there were seven transcripts to analyse in addition to the data from other sources. Whilst this analytic process followed the concept of a discursive research study, there were no specific procedural rules used during this stage of the analysis. The process followed the data rather than the reverse. Initially, the data were read for particularly outstanding or noticeable content. Following this they

were re-read and analysed for how key themes and ‘issues’ were constructed and discursively reproduced by the different players, looking for patterns, variation and detail (Potter & Wetherell, 1994) in how the text, talk and video content were understood or organised within and between the various players. The bodies of data were coded and summarised according to the main issues that came up relating to Xenical. This coding was guided by a number of assumptions. Specifically, language and symbolic communication was considered fundamental to this analysis, seen to be oriented and shaped specifically according to the different interpretative contexts or social realities of the players. For example, in relation to Xenical, pharmacists may orient their talk around mainstream biomedical facts that they have been taught in medical school about obesity, whereas the point of communication in the news articles is likely to be constructed in line with a populist or controversial stance on weight.

In addition to these theoretical underpinnings regarding language, questions such as whether the specific topics were avoided or emphasised, if there were contradictions, and how questions or issues were interpreted were kept in mind during the reading, viewing and coding of the data. The key research objective was also central to guiding this part of the analytic procedure. Key patterns and issues in the data were then grouped into their own separate but related components. These collections were pieces of text, talk or notes relating to the advertisement videos, which were all examined together and positioned against one another. The key issues were identified between players, within groups of players, and across the whole range of players and occurred multiple times for some players, whereas were only touched on by others. In drawing the central ‘issues’ from the data, we did not limit ourselves exclusively to focusing on Xenical itself, but also considered how it was linked to broader social and cultural understandings of weight, weight loss and pharmaceuticals. This helped to shed light on how certain stereotypes, beliefs and understandings were discursively formed through talk and text. These main issues appeared to divide themselves into two broader themes: 1) Weight and Weight Loss, and 2) Weight-loss Treatments and Technologies. The findings section is arranged in this way, with two sections relating to these overriding issues, with other topics under sub-headings for other issues. Quotes from the data sources were then used in the findings to illustrate and emphasise the central discursive constructions.

CHAPTER 3

FINDINGS AND DISCUSSION

3.1 Introduction to Findings

Distinctive ideas or ways of positioning Xenical, and the activities that take place around it, were expressed discursively by the players. Roche, through their website and advertisements, positioned and glamorised Xenical as an effective, relatively safe drug, with manageable side effects. Conversely, the dietitians and pharmacists were less accepting and more questioning, often positioning it as a ‘quick fix’ option that should only be used carefully or as a last resort. The Xenical forum-users, and the non-users, were somewhat in agreement with the health professionals. They were sceptical about drug treatment for weight loss and added their own personal stories or anecdotes into the dialogue, concentrating predominantly on issues to do with side-effects, efficacy and the differences between respective weight-loss options. In fact, the forum-users focussed almost solely on issues relating to side-effects and efficacy, and were largely redundant from any of the other discussions. Finally, news articles linked to Xenical concentrated primarily on issues to do with the global context of obesity, and its health effects. This fell largely in line with dominant medical discourses surrounding weight and weight loss in contemporary society. These constructions will be explored in greater depth throughout this chapter, concentrating on the issues they raise in relation to weight and weight loss, and drug treatments and technologies in contemporary society, and how Xenical is contextually framed within these broader themes. Throughout the chapter, Xenical is slowly uncovered as a complex drug that is positioned and constructed discursively by the different players connected to it. In this way, it is not just a chemical ‘pill’ but rather, a functioning and fluid cultural object that both constructs and is constructed by things or people around it. In line with van der Geest et al.’s (1996) ‘lifecycle’ or ‘biography’ of pharmaceuticals, Xenical emerges as a drug with a significant history, shaped around controversies, periods of popularity and times of redundancy, forming a unique trajectory to where it sits today. Positioned as a ‘quick fix’ or a ‘silver bullet’, constructed as a solution or a cure to weight problems, or viewed as a dangerous substance with negative side-effects, Xenical is socially framed and understood in diverse ways, as both an inanimate object and a ‘living thing’.

This chapter has been divided into two sections, namely ‘Xenical, Weight and Weight Loss’ and ‘Xenical, Weight-loss Treatments and Technologies’. The two broader sections correspond to the central issues that were raised around Xenical, where the players did not frame it in isolation, but rather in a broader context of weight and weight-loss treatments. It was impossible to concentrate solely on Xenical in isolation from these key issues raised by the players. Within these two sections, some of the issues covered relate more specifically to Xenical itself, but most concentrate on the cultural context in which Xenical sits. For instance, Xenical is treated in a context of health by many of the players, so therefore it raises issues relating to health, ill-health and the ways of achieving these states. In this sense, often Xenical itself fell out of view, while the discussions and language hovered around other related topics, including, but not limited to, weight, weight loss, health, safety, side-

effects and efficacy. Also central to the discussion are underlying themes or discourses linked to medicalisation and pharmaceuticalisation. To consider Xenical without exploring all these facets would be to strip the social context from the drug. It is also worth noting that these findings are not intended to be an exhaustive account of each and every player's view or construction, as this would be too extensive, but rather the intention is to provide a key analysis of the kinds of representations and main issues that arose within the players constructions, and how these issues were framed diversely between the different players.

3.2 Xenical, Weight and Weight Loss

3.2.1 Legitimising weight loss

As a weight-loss drug, Xenical was treated and framed by the different players in a context of weight. As a result, it naturally raised issues about weight and weight loss. Weight loss was often justified and rationalised by the players through references to the obesity epidemic, numbers or statistics, and health guidelines or standards relating to weight and health. A biomedical discourse seemed to underlie the discussion around these issues, where fatness was considered 'unhealthy' if it fell outside the 'normal' guidelines or numbers denoted by medical authority. This relates to Kwan's (2009) suggestion that cultural discourses in modern society promote weight loss. For instance, the players generally constructed weight or obesity in a pathological sense, as both a disease in its own right, and part of a worldwide epidemic. Through these frameworks, weight loss was deemed acceptable and was encouraged by all. In fact, the pharmacists, dietitians and Roche strongly promoted weight loss as a means to achieving better health and well-being. Roche in particular, on its website, positioned Xenical as an effective approach to losing weight and improving health. Conversely, failure to lose weight was often framed as a failure as a citizen and was linked to laziness and other negative qualities. In this sense, Xenical was positioned within a broader social and global context of weight, weight loss and references to the 'growing' obesity problem. This also raised and reflected a discourse around health, where health information, especially that distributed by governing or influential bodies such as the Ministry of Health or World Health Organisation, was positioned as being the 'gold standard'. The health professionals appeared to use reference to such standards, as well as numbers or statistics, when referring to Xenical and the obesity 'problem'. Such talk was constructed in a way that legitimated their position as professionals within the weight-loss industry. Both Roche and the news articles also used these numerical references in connection to Xenical and weight loss. Conversely, the non-users and Xenical forum-users steered away from these interpretative frameworks, instead focusing on their own experiences of Xenical, weight and weight treatments. Two of the non-users in the focus group interview spoke of numbers throughout their conversations, but this was only when they were alluding to numbers on a scale, for instance weight in kilograms.

Global context

The constructions of the players often turned to the global context of obesity and how Xenical and weight loss were positioned within that context. The pharmacists, dietitians and the news articles in

particular, made reference to the obesity ‘problem’ or the increase in obesity, thus relating back to the concept of the medicalisation of fatness raised in the introduction. For example, as Conrad (2005) and Nye (2003) have suggested, through such frameworks of understanding, the disease category is extended and the ‘normal’ becomes abnormal or dysfunctional. The frameworks used by most players in the current research suggested a need to reduce obesity or obesity levels through weight-loss interventions if we are to prevent the ‘epidemic’ from ‘spreading’ further. This creates a circumstance or environment for the introduction of treatments such as Xenical and legitimises weight loss. For example, Dietitian 1, Pharmacist 1 and Article 4 frame obesity as problematic and on the rise:

Dietitian 1: So I think I’ve seen over a period of time, we’ve seen a huge increase in obesity...um...when I first started out in the UK, sort of in the 1990s, we were talking at that time about trying to get obesity levels back to 1980 levels, which in the UK were 6 per cent of men and 8 per cent of women, so you’ll know the latest statistics in New Zealand came out the last couple of weeks in the latest national health and nutrition survey. And we now know that about ¾ of the population are overweight or obese, so there’s been a massive increase.

Pharmacist 1: I think New Zealand has as much of an obesity problem as any other first world country, like the same as when I was working in Ireland, and England, Scotland, and not quite as bad as America but heading that way.

Article 4: Health Ministry figures from 2004 estimate obesity costs the health sector about \$460m a year. More recently officials have said that between 1500 and 3000 people could die over the next five years from obesity related complications. Only 9 per cent of men and 11 per cent of women were considered obese in 1977, but by 2003 that figure has risen to 20 per cent and 22 per cent respectively.

While these excerpts do not specifically refer to Xenical, they highlight the international context in which Xenical is located, constructing obesity as problematic. Using a medical framework to interpret issues of weight, the players suggest obesity is a growing national and international trend. Dietitian 1 in particular emphasises the serious nature of the issue through her use of the words ‘huge’ and ‘massive increase’, whilst Pharmacist 1 suggests New Zealand’s ‘problem’ is ‘bad’, and is close on par with America’s. Likewise, Article 4 claims that large numbers of people could ‘die’ from obesity-related complications. These constructions of the obesity context all highlight danger, and could be considered to be scare-mongering. If obesity is publicised as being so highly problematic and on the increase, this rationalises and legitimises arguments for tackling obesity through Xenical or alternative weight-loss treatments, pills or programmes. Further, increasing numbers of people will be classed as unhealthy, and more money will be dedicated to the problem. The news media is particularly influential in this sense as they are a widely-accessed source of information, and, as Colls and Evans (2009) have stated, are central to the reproduction of dominant representations of obesity. For instance, the excerpt from Article 4 also demonstrates a discourse of individual blame, where

obesity is positioned as a “cost” to the health sector. This relates to Pieterman’s (2007) argument which suggests that overweight individuals are framed as socially and economically irresponsible. Reporting of this nature may encourage the marginalisation of larger people, and perpetuate discriminatory discourses which suggest that they are ‘responsible’ for costing our country. Also of concern is the fact that the above representations could be pushing ulterior motives, particularly in the case of the pharmacists and dietitians. These players are employed in professions that directly benefit from obesity being considered a medical problem which causes severe health and economic implications for society. In this sense, these players might be considered to be ‘driving’ medicalisation, as Conrad (2005) has suggested, through “interprofessional or organizational contest” (p.3). These constructions can also be linked to Williams et al.’s (2008) suggestion that some cases of medicalisation can simultaneously harm and benefit different groups. In the case of Xenical and obesity, the medicalisation of fatness is advantageous to those who will profit from its disease status and expansion, whilst being detrimental to the public. For instance, people may embark on regimes in order to prevent themselves from becoming another statistic in the epidemic, at great expense and harm to themselves.

Numbers and measurement

In the excerpts from Dietitian 1 and Article 4, numbers and statistics were used to emphasise the ‘growing’ problem of obesity. This use of numbers to legitimise weight-loss was a commonality between various different players, most notably the pharmacists, dietitians and Roche on their Xenical website. Statistical data were used to refer to obesity, and were often used as evidence to back up players’ claims relating to the obesity problem, or legitimate their relative positions, as, for example, Xenical distributors or producers. These references to numbers were expected, as, in line with Oliver’s (2006) argument, numbers are frequently used to justify arguments relating to obesity. Worrying however, is the fact that, as Gracia-Arnaiz (2010) has suggested, they are based on questionable scientific grounds and flawed arguments relating to causality and correlation. This raises concerns because, as evidenced in Article 4’s quote, mainstream news media often use statistics to highlight a problem. Moreover, Article 4 attempts to validate its use of statistics further by claiming they are ‘Health Ministry figures’ or sourced from ‘officials’.

These constructions all contribute to the transformation of fatness to a disease entity and form the broader context around Xenical, drawing attention to how this pill is linked not simply to issues of consumption but also wider arguments around medicalisation, weight and numbers. They also link to previous arguments regarding the centrality of measurement or numbers to issues of medicalisation. For instance, Moynihan et al. (2002) have contested that the overstating of prevalence rates extends the boundaries of illness and disease, allowing for the capitalisation of possible markets. A parallel can be drawn from this to the context of obesity and Xenical, where prevalence rates are often grossly exaggerated, playing to the interests of companies such as Roche and the weight-loss industry in general. For example, Dietitian 1 suggests that “three-quarters of the population” are overweight or obese. This is an enormous disease category. However, claims such as this are largely

taken for granted because, as Jutel (2006) has stated, quantification is deemed to be neutral, and measurement, objective.

As they were referred to in order to emphasise the ‘growing problem’, numbers were again used by many of the players to quantify normality and to determine how ‘at risk’ people were of obesity-related illnesses. BMI was consistently referred to in this sense, constructed as a central tool to determine weight-loss needs. For instance, on Roche’s Xenical website, it constructs measurement as fundamental in terms of legitimising the use of Xenical. As an example, on the webpage titled ‘Is Xenical for Me?’ it uses BMI as the determining tool, suggesting Xenical “is indicated for an initial BMI of 30 or more”. It even provides a link to a BMI calculator to determine where one sits on the scale and whether they might be suitable contender for Xenical. The page then continues on to discuss stomach fat, indicating that too much fat around the stomach may increase the ‘health risks’ associated with obesity, suggesting that one should “aim for a waist circumference of less than 102cm for men and less than 88cm for women”. At the bottom of the page, it states:

Xenical website: If you have a high BMI and high waist circumference measurement, then you are more likely to develop obesity-related illnesses. Xenical accompanied by healthy lifestyle habits such as healthy diet and regular physical activity will help you reduce your weight and the risks associated with excess body fat.

This use of BMI as a tool to determine whether one is suited to take a drug such as Xenical for weight loss is concerning given that evidence has repeatedly suggested that BMI is a faulty tool, and should be used cautiously in determining ‘normality’ or risk (Oliver, 2006). Roche’s positioning of BMI as the verifying tool for Xenical use may lead perfectly healthy people to inaccurately assume that they are overweight or ‘at risk’, and should attempt to lose weight through drugs. These kinds of measurement tools are not uncommon in the weight-loss industry, where they are often used as qualifiers or indicators to determine the level of ‘risk’ associated with weight. Therefore, it is somewhat unsurprising that the players’ representations of Xenical also centred around measurement. Further, the recommendation that potential consumers utilise BMI for diagnostic purposes could also be considered to be misinforming them, a practice that is not uncommon within the pharmaceutical industry as van der Geest et al. (1996) have previously stated. After all, positioned within the manufacturing mindset, it is in Roche’s interests to legitimise weight loss and emphasise the risks associated with a higher BMI in order to sell and profit from Xenical. Perhaps predictably, pharmacists, as the distributors of Xenical, also are required to frame it within a context of BMI, similarly to Roche, raising issues to do with measurement:

Pharmacist 1: Um, so basically, someone would come in and request it, um, they’d be referred to the pharmacist by the shop girls, or shop boys, and then...uhh...the requirements are that they need to have a BMI to, for it to suit them, above a certain range in the product guidelines, which is not written in stone...umm...like it’s not going to cause any harm if

someone's slightly below that BMI...but...and, yeah, then you'd discuss that, and if they didn't know what their BMI was or if it hadn't been recommended by a doctor or another professional, then you'd just ask them about their weight and height, obviously sometimes by looking at someone you can probably spot what their BMI is, like if someone is...uhhh... grossly obese their BMI is going to be high enough.

Pharmacist 2: Well, if we're selling Xenical we do measure BMI or know their BMI and it's gotta be above 30 for us to sell it.

In Pharmacist 1 and 2's talk, BMI was again used as the rationale for weight loss and, specifically, Xenical use. Conversely, in the following quote Dietitian 2 rejects BMI as a traditional form of measurement, thus constructing a different context for weight loss:

Lydia S: And, um, earlier you mentioned, kind of, people being above their healthy weight, what, how do you measure this healthy weight?

Dietitian 2: Um so, so there is the BMI but I'm not a big fan of it to be honest, I might get told off by other dietitians for saying that but I believe BMI was designed for population studies as opposed to individuals. I do use it for people with eating disorders because I do work quite a lot with that to give them a minimum, you know, you need to be at least this kind of thing, but for someone who's got a BMI of 30 I'm not going to try and get them under 25, I'm just trying to get 10.. 5.. 5.. per cent body loss weight.

This dietitian's rejection of BMI may illustrate that some people are gradually becoming more aware of its flaws or are using it with greater caution. This is interesting as this resistance to BMI was accompanied by a resistance to Xenical and other drugs as a means to losing weight. Such a resistance to Xenical will be explored in great depth in the second section. However, while all the dietitians shaped their language in a way that indicated a 'holistic' approach to weight loss, and steered away from focusing on BMI and measurement, they still all integrated some reference to numbers into their talk. Thus, their position as 'holistic' professionals who largely rejected Xenical in a measurement context, remained dominated by a measurement discourse around weight loss. This presented quite a contradiction in their discussions, where they appeared to try to conform to the 'typical' holistic notion of what a dietitian should say in relation to weight loss and Xenical, but still remained focused on the pathology and measurement of weight.

In contrast to the pharmacists and Roche, the non-users didn't share the same interest in BMI as a tool of measurement. Instead, weight was represented as a fundamental factor in decisions around weight loss. For instance, Non-user 1 also makes reference to weight, legitimising the use of the scale as a trustworthy tool that tells the 'truth':

Non-user 1: Um yup I spose I do, I've only just started to weigh myself now that I'm doing this. Prior to that, the scales were not a friend of mine.

Lydia S: Why, why do you say that?

Non-user 1: Because I blatantly know that, cos they tell the truth {laughter}. Cos I know that I weighed a lot more than I did two years ago.

Similarly, Non-user 3 also constructs weight as important:

Non-user 3: Like, three four months ago I guess, I jumped on the scales and I was at 69 again, it was soo weird, it's like 69's mine 'no that's not OK'.

Through these examples it is evident that numbers are understood at both a professional and more personal level, as central to legitimising weight loss. This is concerning given that the tools most commonly used are fallible, and therefore may place potential users and users in an 'at risk' category when they are actually completely healthy.

Standards and guidelines

Standards or guidelines, like numbers, were also central to the players' legitimisation of weight loss and shaping the context around Xenical and its use. The pharmacists and dietitians were largely unquestioning of the regulations or guidelines relating to weight and weight loss recommended by governing bodies and medical authority, positioning it as the gold standard to which health professionals such as themselves should adhere. This is not surprising as the health professionals are situated within positions or fields of practice that are heavily regulated and guided by rules and standards. These players often made mention and constructed their talk of Xenical around 'official' information or 'health guidelines' regarding weight, particularly using reference to the Ministry of Health. This is not surprising given that the status assigned by medical professionals to the Ministry as an authoritative, governing body when it comes to health information. For example, Dietitian 1 highlights:

Dietitian 1: Yes, yes, I base my approach very much on looking at food, activity and behaviour, so you're probably familiar with the clinical guidelines on weight management published in 2009 by the Ministry of Health, really looking at a very holistic view, so not just what people are eating but also what's their activity levels and what are their behaviours around food. And, I think as dietitians a lot of us are moving very much towards looking at behaviours, it's not just about handing out a diet sheet.

Guidelines are used in the above quote to promote or justify weight loss. This kind of emphasis on guidelines relates to Gracia-Arnaiz's (2010) claim that the development of dietary recommendations has been tantamount to the medicalisation and commercialisation of body weight. They are also, therefore, central to the legitimisation of weight loss and weight-loss pills, including Xenical. Interestingly, Dietitian 2 conversely positioned herself as resistant to these kinds of guidelines, just as she appeared resistant to the use of BMI:

Dietitian 2: I try and get away from rules and guidelines.

This particular dietitian positioned herself through her language around Xenical as more critical in her practice, trying to steer away from traditional approaches to weight loss. She made a point of emphasising how her practice was ‘different’ in that she tried to diverge from rules and prescriptive approaches. While she still conformed to some traditional views about weight and weight loss, she professed a way of practising as a dietitian that was more in line with critical obesity researchers’ views, attempting to deviate from traditional methods devised or recommended by medical authority.

Whilst statistics, rules and guidelines permeated the talk of many of the health professionals and were central on Roche’s website and the news articles, the non-users tended away from these kinds of constructions. Likewise, the forum users were exempt from the conversation altogether with no reference to these issues. Therefore, we can see how Xenical is shaped in a context dominated by numbers and official or medical language for the majority of the players, whereas these issues were less relevant to laypeople or consumers. This raises questions about the discordance between the professionals and laypersons, in their understandings, talk and language around Xenical and weight loss, which may have implications for treatment and healthcare. For example, the non-users positioned their weight loss journeys or justifications for losing weight relatively personally, within the context of their own lives, referring to their lived experiences, anecdotes and emotions associated with weight gain and loss. Often their justifications for wanting to lose weight revolved around ‘looking good’ or ‘feeling good’, which link to Kwan’s (2009) findings around people’s motivations for weight loss being related to appearance. As Kwan concluded, the concept of health is often linked to the concept of beauty. This was certainly the case with the non-users. Whilst they shaped their discussions around personal stories, they still used weight and numbers as determining tools for weight loss, similarly to the health professionals and Roche:

Lydia S: So you don’t usually weigh yourself, did you say?

Non-user 2: I do now, I never used to.

Lydia S: Why do you weigh yourself now?

Non-user 2: Um..because I know, cos, like, for me, weight is associated with body size quite a lot, cos if I’m like, I’ve got to like that 58 sort of region, when I’m looking and feeling good, I know I’m quite fit, and I’m eating healthily and all that kind of stuff, and, and I know as soon as I go over that 60 mark, that’s kind of like my shock point where I’m like, oh crap, you need to do something.

Non-user 3: It was really bizarre because like, when I was running my marathon and stuff, I was like 66, 67 and that was OK, for me. 66 67 is that’s my weight, and for me, it’s three kilos, whatever, you know, you fluctuate three kilos in a day, but for me being 69 and watching it tick over to 70 was just like arghhhhh panic, like what the hell is going on but, I,

you know, and so I started, that kickstarted me again to, to try get back into my running and I was more consistently going to the gym and I was starting to look at different, different ways of...I don't think, I dunno, it's hard to say losing weight is the goal, like for me right now losing weight is not the goal cos I've come to the conclusion that, I'm 69 kilos now, that's just my, that's me now.

Through this talk it is evident that numbers and measurement are also central to laypeople, though are used in their context to legitimise or justify their own personal need for weight loss rather than the weight loss of others as the health professionals use it. In this sense, the non-users could be seen to be personalising a wider medical discourse around measurement and understanding of weight to which they can compare themselves. These weight-centric constructions evidenced in the above quotes substantiate Jutel's (2006) claim that weight has become both a 'diagnosing tool' and a rationale for a "pseudo-disease in and of itself" (p. 2270). They also corroborate Rose's (2007) suggestion that we "relate to ourselves and others, individually and collectively, through an ethic and in a form of life that is inextricably associated with medicine in all its incarnations" (p. 701). The non-users appear to be conforming to the ideas and constructs about weight perpetuated by medical authority, the pharmaceutical industry, the media and health professionals, around what is normal and abnormal. They are questioning their weight, dissatisfied with their size, and punishing themselves if they fall outside an 'acceptable' range. If laypeople are positioning themselves and their language in such a way, seeing weightiness as unappealing, this can explain the popularity of weight-loss treatments such as Xenical. In this sense, medicine has changed, as Rose (2007) has claimed, the frameworks through which we understand ourselves, and has shaped our judgements of who we want to be.

3.2.2 Xenical and the weight-loss 'candidate'

As Xenical exists in an environment of weight, it naturally raises issues relating to 'who' should, or needs to, lose weight. In this sense, a metaphorical weight-loss or Xenical 'candidate' was discursively constructed by the different players. The weight-loss candidate is someone who is 'suitable' to use weight-loss methods because they are deemed heavy enough or at risk in some way of weight-related health issues. The candidate was not constructed as specifically using Xenical, though Xenical was constructed as being a part of the broader context of the candidate. The candidate was painted in various ways by the different players; however they shared in common a derogatory theme. The language used to describe the candidate was negative, marginalising and positioned it as inferior. The issues that were raised to build the candidate generally fell into three categories, including: physical traits, aspects of their character and lifestyle, and readiness to change. Roche tended to construct the candidate physically through their advertisements and websites, whereas the dietitians, news media and pharmacists constructed it predominantly through references to poor choices, lifestyle, and occasionally, appearance. Once again, the users and non-users were more inclined to steer away from these kinds of discussions, focusing again on themselves and their own experiences. In addition to the weight-loss candidate, different ideas emerged as to the central

'qualifiers' for weight loss. These qualifiers were the mechanisms through which the weight-loss candidate was identified and constructed, as a potential consumer of products like Xenical. These fell into three categories, namely: measurement, health issues and feelings, all issues that were also central to descriptions of Xenical.

Appearance

The Xenical advertisements construct the weight-loss candidate through symbolically communicating aspects of physical appearance. For example, Advertisement 1 shows an attractive, thin, angelic-looking woman participating in a range of bizarre, exciting and glamorous activities. These are meant to be the activities that she wishes she could do, those that she *could* do if she had a thin body. The thin woman then looks in the mirror and the reflection staring back at her is one of a very large, morbid looking woman, sitting alone on her bed with a miserable expression, who then says "but I can't even tie my own shoelaces". The image this constructs is a negative one, where fatness becomes, as Yancey et al. (2006) have stated, an aesthetic issue, linked to physical attributes and abilities. Xenical is positioned as the saviour to the fat person's problems and the thin body as something that can be obtained through Xenical use. The advertisement also arguably discriminates against people who are physically heavier, through framing their weight as something that prevents them from participating in the same activities that a thin person could. This raises contextual issues around Xenical, and may serve to perpetuate negative attitudes relating to weight and physical appearance. Likewise, Advertisement 2, which was relatively short in comparison, presented a similar picture, of an unhappy, extremely large man, struggling to fit into a car, where he sits looking very uncomfortable and unhappy. Both advertisements were concluded with Roche's Xenical slogan, 'Lose weight. Gain life'. These representations relate to both Jardine's (2004), and Toop and Mangin's (2007) arguments, that drug promotion and advertising allows the industry to create social contexts or frameworks that work to their economical advantage. Further, as Jardine has stated previously in relation to the Xenical campaign, it paints obesity as a "medical and social problem for which Xenical [is] offered as medical solution" (p. 486). Raising issues about weight and body size, this framing of larger people as unattractive, unhappy and unable to participate in life's most mundane, simple tasks, such as tying one's shoelaces, encourages marginalisation of larger people. It could almost be said to be placing them in their own category of 'non-people', incapable of achieving success or leading fulfilling or exciting lives. This is typical of how Xenical was constructed across most of the players, within a Western society that positions fat people as 'failed citizens', as Elliot (2007) has suggested. Further, they are positioned as not only failing themselves, but also as failing society.

Interestingly, Roche's website for Xenical appeared to construct the Xenical in a dissimilar way to the advertisements, in relation to who the weight-loss candidate should be. The images presented on the homepage were of larger-bodied women who have happy expressions and look liberated. This portrayal is a good marketing strategy, as it suggests that if you take Xenical, you *too* will be happy and look like this. In this sense, through the use of both the advertisements and the website, Roche is respectively positioning the potential candidate or Xenical user as being unhappy and depressed, and then contented once they receive the product, thus implicitly insinuating that

slimness equates to happiness. This is a portrayal of Xenical and a context that works to the economic advantage of the company.

Like Roche, the dietitians also linked weight to appearance through their talk surrounding Xenical, equating weight to attractiveness when discussing people's motivations to lose weight:

Dietitian 3: The young ones certainly, want to look good. They wanna look good.

In discussing the context around weight loss, the dietitian here is suggesting that losing weight makes people 'look good'. This is unsurprising given that dominant discourses in Western society depict overweight people distastefully. It also relates to Jutel's (2006) suggestion that ideas about normality and pathology in health are linked to normative appearance. In the context of body size, anything which falls outside society's construction of normal is considered unattractive. This idea was pertinent to the formation of the context around Xenical. As Bell and McNaughton (2007) have stated, the body is constructed and expected to conform to that construct at any cost, including through the use of pharmaceuticals. In the current study, both Roche and the dietitians have constructed the body and a weight-loss candidate, linking weight to appearance or attractiveness.

Character and lifestyle

In addition to their physical traits, aspects of the candidate's character or lifestyle were also constructed. In general, they were positioned as inferior, unmotivated, irresponsible, and weak or lacking perseverance. Their lifestyles were described as busy, stressed, time scarce and unhealthy, where being overweight was framed as being due to poor choices, bad decision-making, or an inability to control one's appetite. Bad decision-making, practices or behaviours were particularly pertinent to the discussions, where it was suggested that weightiness was a result of choosing, for example, takeaways over a home cooked meal, fries instead of a salad, or a night in front of the television instead of a gym session. This reiterates the individual blame discourse prevalent in Western constructions of obesity and larger people, where society frames weight as an individual choice and a person's own responsibility. In this sense, the weight-loss candidate is positioned as a 'poor chooser', and thus is framed as weak and irresponsible. This is in line with Evans' (2006) claim that fatness is depicted as morally irresponsible and lazy. Thus, Xenical is situated as part of a symbolic framework of understanding that links weight and weight loss to moral and social issues, such as judgements about character, lifestyle, motivation and more. The pharmacists, dietitians, website and advertisements were particularly central in shaping it in this way. The following quotes exemplify the discursive issues the talk raised in relation to bad decision-making, poor control and poor choices around food:

Dietitian 3: They want more energy. Often people are too tired...um...carrying extra weight does make them tired so they want to feel more energetic. Um and eating poorly, they feel, you know that they're probably having a full bloated stomach a lot of the time.

Pharmacist 1: Um, I mean Xenical's more indicated in people where, um, they might tend to eat food they shouldn't. You know, probably control issues with food.

Dietitian 2: You get the best results from people if you don't um, focus on their weight, you actually focus on their relationship with food and tell them that their weight is a symptom of their relationship with food.

Dietitian 1: People know they shouldn't be going out and eating McDonalds and KFC every night and they shouldn't be having supersized portions, but putting it into practice is what's difficult...it's literally portion control, so they're not losing weight, they're eating too much. It's that simple.

Also relating to control issues around food, Pharmacist 2 refers to reducing one's 'appetite' as central to weight loss. This is in reference to a weight-loss pharmaceutical called Duramine that was raised in their talk around Xenical:

Pharmacist 2: Is a total, total appetite suppressant, it's a strong stimulant, related to 'P', works very well from the point of view of cutting down your appetite, getting the housework done twice as quick {laughter}.

Similarly, the media also taps into this discourse around food choices, suggesting:

Article 3: While some people would benefit from such a medication, there was more to be gained from putting recourses into changing lifestyles and creating an environment which encouraged people to make healthy choices.

In the following quote, Dietitian 1 refers to the lifestyle factors of the weight-loss candidate, discussing the changes she's seen in people's eating and exercise habits over time. Her talk depicts it as once again the fault of the person:

Dietitian 1: Yeah, you might put that down to, I dunno, umm factors such as TV or lack of exercise.

Likewise, Pharmacist 1 claims:

Pharmacist 1: Umm, well I just think with you know, lifestyle getting more and more sedentary and junk food being more prevalent, and, a lot of people who could use healthy eating, healthy cooking, have the least education about how to eat healthy and how to cook, um, so it is becoming, more and more people are becoming obese and they're not willing to, or sort of able to, they don't have the tools to manage it through exercise, lifestyle and

healthy eating, so then they're basically looking for a...umm... silver bullet, you know, magic answer.

These constructions of lifestyle issues and poor choices have implications that relate to Evans' (2006) and Colls and Evans' (2009) respective arguments surrounding the politicisation of body weight. For instance, where obesity is positioned as being due to bad decisions or choices, as in the above examples, public policy interventions or initiatives to reduce obesity may be introduced, targeting the environment, through, for example, restricting access to junk foods or increasing their price. Thus, more hype is generated around weight, greater numbers of people attempt to lose weight, and society becomes increasingly weight-obsessed. Xenical sits at the centre of this politicisation and individual blame, as a pill linked to social and political change and attitudes.

Readiness to change

Finally, the weight-loss candidate was constructed through a discourse of 'readiness to change'. This primarily emerged in the talk of the dietitians, who suggested that the candidate had to be fully accepting of their need to lose weight, and desire it for themselves. Only once they were 'ready to change' could they be assisted with, or successful in, their weight loss journey. This is another link between weight, individual responsibility and motivation, where the candidate who wasn't ready to change was almost deemed a lost cause. For example, in the following excerpt Dietitian 1 describes the weight-loss candidate:

Dietitian 1: Well, the incentive might just be that they want to look good and they want to get back into all their old clothes and stop wearing all the frumpy, you know, oversized clothes that they've got hanging in their wardrobe so, the incentives are really varied, you know, it might be that, you know, because they want to feel good, they want to look better, it might be a health reason, umm it might be wanting to have a baby, you know, there's a whole range of reasons, but I think that people do need to be motivated and they need to be ready to change.

Those who are 'unmotivated' or 'not ready to change' were constructed as inferior lazy, weak or irresponsible and appeared to generate the least respect. As well as displaying the readiness to change discourse, this quote also highlights, again, how weight is linked to appearance. As with similar excerpts in this section, reference is made to wanting to 'look good', and negative words such as 'frumpy' and 'oversized' construct the candidate and paint a picture of an unattractive person.

Through each of these key issues raised in discussions around Xenical it becomes clear that, as Colls and Evans (2009) have stated, a widespread fear of fatness and a prejudice against those deemed overweight exists. This prejudice was used to construct the candidate through physical or character-related descriptions that stigmatised them and their behaviours or lifestyles, suggesting that they need to lose weight to become attractive, happy and contributing citizens. Interestingly, the users' and non-users' constructions of the candidate were virtually non-existent. They didn't construct a character in such an extreme way as Roche, the dietitians and the pharmacists. Rather, they spoke of

why they themselves needed to lose weight, positioning themselves as the weight-loss candidate. For example, Non-user 2 discusses why she gained weight and her desire to lose it:

Non-user 2: Oh I think also because I've put on...last year due to...problems I have with contraception, that's what has made me, majority of weight gain. That's what I'm trying to lose, is the weight that I've put on, from, from that.

In this sense she is embodying the role of the weight-loss candidate; someone who has gained weight, is unhappy with that weight gain, and therefore wants to lose it. While it is not negative or derogatory and doesn't make assumptions about other peoples' weight, it still relates to the discourse that weight gain and fatness is not acceptable and extra weight must be lost. This kind of context is significant to the existence and consumption of drugs such as Xenical.

3.2.3 *Qualifying for weight loss*

As the character of the weight-loss candidate emerged, strategies were raised for identifying them. As it was central in discussions around legitimising weight loss, again measurement was central here, where it was understood as the diagnosing or qualifying tool for the weight-loss candidate by pharmacists, Roche, dietitians and non-users. Secondly, references to health or health effects were fundamental to justifying the need to lose weight in the eyes of the dietitians, pharmacists and non-users, where poor health outcomes were positioned as a legitimate reason or driver for weight loss, and Xenical use. Finally, the 'feeling' of being overweight and its personal impact was rationalised by non-users as a central issue to their weight-loss journey.

Measurement

Measurement also arose within this context of understanding as a way to determine or identify those who need or don't need to lose weight through use of numbers, scales, measuring tapes and tools. The references to measurement came across as an impersonal or detached way of framing those who are eligible to lose weight. In particular, the BMI was again raised as a tool, and spoken of by pharmacists and dietitians as a way to justify treating people with 'weight issues'. It was generally taken for granted as an effective tool to determine weight loss needs. The following excerpt demonstrates how it was framed by pharmacists as a tool for identifying the weight-loss candidate, in reference to Xenical:

Pharmacist 1: You did used to get people coming in for Xenical whose BMI wasn't actually that high and when you discussed how it worked, they'd think 'well maybe I don't want this script after all'.

Health

Similarly to measurement, health reasons were constructed as a legitimate reason to qualify a person to lose weight or use Xenical. A recurrent theme, skinniness was equated to good health whereas fatness was positioned as being unhealthy and therefore inferior. There were numerous references to

the co-morbidities deemed to be connected to fatness, and these were represented as key reasons for people to lose weight by all players, with the exception of the forum users and advertisements who only implicitly suggested them. If a person suffered at all from issues such as diabetes or heart disease, it was automatically assumed that they were related to their weight rather than an alternative health problem. Therefore, they were automatically placed in a category of needing to lose weight to preserve their health, through Xenical or other approaches. For example, Non-user 1 discusses why she wouldn't try medical treatment for her weight, though suggests that it might be necessary for certain people whose health she perceives to be at risk:

Non-user 1: I just don't think it's necessary...I think, it's a different situation for somebody who is...like, I know, we've got family friends who have had gastric bypasses because they're just to the point where they could drop dead and die. I think that's a different situation, but I think, for someone like me, who's not necessarily crazy huge fat, but I'm still not comfortable.

Dietitian 3 also talks about health issues and how they act as catalysts for people to lose weight:

Dietitian 3: I did see young ones in [place name] but often it was an event that was the catalyst for action so it might be a um, either, a, some, maybe a death in the family, or sudden realization that they were the only surviving sibling out of six and they were only forty-five...um...lots of...very young, grandparents often at a very young age so it might be concerned about their health to be able to be there for their grandchildren...or it might be a personal health event, it might be, ummm... you know, they had uhh...diabetes diagnosed.

Dietitian 3: Older one's it will be about perhaps diabetes, diabetes in the family, umm, hyperlipodemia, those sorts of things, so there'll be health indicators, that they've got, which are poor and they want to improve those.

Similarly, Dietitian 1 discusses the health issues she considers related to obesity and how they are used to justify weight loss:

Dietitian 1: Umm quite often people will come in because something else has happened and there's a lot of co-morbidities associated with obesity, so it might be that someone's been diagnosed with Type 2 diabetes or they've got high cholesterol or high blood pressure or they've got a bad back or bad knees.

These excerpts show how, as Campos (2004) has suggested, size is largely understood as an indicator of health. It is unsurprising that Xenical raises issues to do with health, as pills are inextricably connected to health and ill-health or disease. In the above excerpts, size and health are

used simultaneously as drivers for weight loss and legitimate reasons to lose weight. This is concerning as the connection between size and co-morbidities, and even death (Flegal et al., 2005), has been shown to be overstated. As both Jutel (2005) and Campos (2004) have argued, weight or size is not necessarily an indicator of health. These constructions are also evidence of how fatness is socially constructed and understood. For example, as Gracia-Arnaiz (2010) has stated, being overweight was historically deemed a sign of health, but now is constructed as a sign of pathology or ill-health. In the players' representations of health issues, health and ill-health were generally positioned as opposing and mutually exclusive constructs. One could not have health and ill-health at the same time, or be 'partially' healthy. The problem with this is that our concept of what is a healthy weight or size is driven by unrealistic expectations relating to appearance or body size, fallible tools of measurement, and extremely wide disease-categories. Further, marketing campaigns, public health messages and academic literature, all emphasise the relationship between weight and health, and convince us that the heavier we are, the more likely we are to experience poor health outcomes.

Lived Experience

The non-users again position themselves within more of a personal or emotion-driven discourse when it comes to identifying why they are a weight-loss candidate or trying to lose weight. Here again lies a dichotomy between the constructions of the health professionals and the non-users, where pharmacists and dietitians favour measurement and health issues, both relatively impersonal, and fail to recognise how the candidate 'feels' or the importance of emotion. This fits with their positions as respective players with different vested interests. The non-users focused on the feeling of being overweight and the sentiment associated with that. For instance, if one felt unhappy, distressed or discontent enough with their weight, then that led them to pursue weight loss. Often personal anecdotes were expressed about certain experiences of being overweight, such as other people's responses to their weight. Feelings of inadequacy about their size were often increased by the reactions of others, particularly loved ones. For example, discussing her mother's struggles with weight issues and her own justifications for losing weight, Non-user 1:

Non-user 1: She didn't bother losing the weight when she was at a, young [age] and now she can't get it off...I don't wanna be like that because I know the older you get, the harder it is to lose weight.

Non-user 1 also shared a personal story relating to her boyfriend's perception of her weight gain, which was part of the reason she decided to pursue a diet:

Non-user 1: It's just um, recently with, my boyfriend, he decided to tell me what his perception of weight-gain was, I guess. And, we came back from holiday, uhh, a couple of weeks ago, and we had this fight on the way home...and he decided to tell me that I'm not as skinny as my friends, it was real stink, I got so fucken angry...and that I was embarrassing, um...from my understanding there's never been a problem...but yeah...he just decided to, to, you're not as skinny as your friends, they're so skinny compared to you.

Non-user 2 also used a story to justify why losing weight was important to her, and why she thought she needed to lose weight:

Non-user 2: I used to be extremely fit when I was at school and I never had problems with my weight, everything like that, and I could eat whatever I liked and I never felt guilty about it, and it was great...but then I got to university and like, kind of, you know, you got the fresher five but it kinda like, times two for me {laughter}...I just wanna get back to...like I'm at a really comfortable stage, like, my weight and how I look and how I feel as stuff, like I feel fine, but I, it's not because I'm quite fit, and I, I always think it's better to, if you can have both, like if you're feeling good and looking good, and you're fit and healthy. Cos I think fit and healthy is like, a, really important part.

Like Bell and McNaughton (2007) have stated, bodies, particularly female bodies, are expected to conform to society's construction of the ideal body. The non-users appeared to be particularly aware of what the ideal body was and felt inadequate if they did not meet those expectations or requirements. Non-user 1 in particular, also highlights how others' perceptions of fatness can be influential in feelings and decisions around weight and weight loss. This kind of talk constructs the wider setting surrounding Xenical, as a drug which does not exist in isolation, but is tied to meanings that extend past its physical use, to issues of emotion, feeling, health and appearance, all of which are intertwined and linked together by the discursive constructions of the players.

3.3 Xenical, Weight-loss Treatments and Technologies

The previous section painted a picture of Xenical and the connected issues of weight loss and the weight-loss candidate, which emerged diversely through the constructions of the different players. Weight loss was legitimated through various means, ranging from the global context of obesity, to measurement and guidelines, and the weight-loss candidate was constructed physically and socially through reference to their traits and aspects of their character. This creates a background through which Xenical can be socially understood as a political and social drug, linked to physical and health outcomes and expectations, with symbolic meanings displayed by the different players. Now that we know who the weight-loss candidate is and how they are identified, the focus turns to issues that position and connect Xenical within a context of other weight-loss treatments and technologies. Here, Xenical raises issues surrounding how weight can be 'treated', the safety and side effects associated with treatments, and treatment efficacy. The Xenical users finally emerge in this section as part of the wider conversation around drug treatments and technologies for weight loss, particularly in relation to their experiences of Xenical.

Returning to Jutel's (2006) statement regarding obesity, its disease status means that a number of "diagnostic, curative and preventative strategies...fall into place" (p. 2268). This was certainly the case in the current research, where a plethora of treatment options were raised, as part of the discussions around Xenical, and ordered, rated, judged and rejected, or accepted, by the different

players. Despite the different positions and interests of the players, there were many similarities in the ways they constructed weight-loss treatments. Most represented Xenical sceptically, and pills and diets as generally fallible, suggesting they were unrealistic fads that rise and fall in popularity. Xenical in particular was denoted in such a way, as a treatment that was once sold in excess, and then rapidly fell in popularity before becoming largely redundant today. Rather than supporting drug treatments, the players appeared to be more wholly supportive or embracing of lifestyle changes or holistic options including diet and exercise approaches. Such approaches were rated and compared in relation to Xenical. On its website and in its advertisements, Roche was the only one that stood out from other players in this sense, constructing Xenical as a suitable, effective and safe approach to losing weight.

Interestingly, the approaches to losing weight often fitted appropriately with the respective players' positions and constructions of the modalities of weight gain or obesity, though sometimes they did not fall in line. For instance, if fatness was framed or understood as a predominantly biomedical problem, as described in the previous section, then the treatments for it were also likely to be constructed as biomedical. This was the case for Roche who, through their advertisements and website, emphasise the health co-morbidities of obesity, constructing it pathologically and able to be 'fixed' through using Xenical as a medical solution. The pharmacists also positioned weight loss biomedically, as a medical problem for which a medical solution could be offered or acceptable, though were less accepting of medical options in comparison to Roche. The dietitians also set Xenical and weight issues within a broader biomedical framework, though diverged in the fact that they also often raised psychological and environmental issues as being central to weight gain, and therefore necessary to target for weight loss. Whilst the news media positioned weight as a medical problem in their news articles, a medical solution was often resisted, with drugs positioned by one article as a 'quick fix' approach to weight concerns. Though the players constructed treatments and technologies in diverse ways, they also often fell into a general ranking system. For instance, certain treatments were favoured over others, or represented as superior. In this way, a hierarchy of weight-loss options was established where treatments were ordered as falling into three categories, namely: 1) Drugs, 2) Weight-loss programmes and diets, and 3) The 'natural' way. Situated within the 'Drug' category, Xenical is located at the bottom of this hierarchy by most players. This raises issues about the popularity of drugs and other treatments, as well as highlighting the approaches that tend to be preferred currently, and the reasons for people's acceptance or resistance to certain weight-loss options. These three groups will be explored in depth below:

3.3.1 Drugs

As Vrecko (2010) has contested, Western society encourages the consumption of products, technologies and procedures in order make us better than what we are. Drugs such as Xenical are offered as technologies for weight loss, providing a route for individuals to 'improve themselves' and fit in with cultural ideals of slimness. However, interestingly, drugs were largely rejected by all except Roche. Falling into the 'drug' category, Xenical was not a preferred method of treatment, positioned negatively in comparison to other options and framed as unpopular. Most of the players were condescending about drugs, seeing them as a 'quick fix' or lazy option, to be used as a 'last resort' or

only in conjunction with other holistic options, as one dietitian put it. Although pharmacists appeared to generally accept a medical solution to weight issues, and favour it to some extent, they were also slightly resistant to drugs as weight-loss technologies. They demonstrated a reluctance to prescribe weight-loss drugs, instead tending towards other options before turning to drugs as a last resort. Pharmacists and dietitians both also framed caution as being central to the use of Xenical and other drugs, only to be used under guidance or in certain circumstances with strict guidelines. The following three respective excerpts from Pharmacist 1 demonstrate how Xenical is constructed consecutively as a last resort, something that doesn't necessarily work, and a 'silver bullet':

Lydia S: And do people, do you see many people coming in for Xenical?

Pharmacist 1: Uhhh, not many these days...it's more people who have heard about it, tried other things and, um, you know, want to use it.

Pharmacist 1: I think people have probably become more aware of that it's a problem with diet and lifestyle, and it's um, not going to help them.

Pharmacist 1: Ummm, well I just think with you know, lifestyle getting more and more sedentary and junk food being more prevalent...more and more people are becoming obese and they're not willing to, or sort of able to...manage it through exercise, lifestyle and healthy eating, so then they're basically looking for a...silver bullet, you know, magic answer.

The news articles also largely positioned Xenical and other drugs as quick fixes to weight concerns. At the same time, however, they also seemed to frame them as a necessary part of health care to tackle the obesity 'problem'. Depending on the topic of the news article, some glamorised drugs and constructed them as an effective weight-loss technology, whereas others questioned their efficacy altogether. For instance, Article 3 below discusses a new weight-loss pill that was proposed for introduction in New Zealand, and also refers to Xenical. It appears to reject drugs, suggesting:

There was more to be gained from putting resources into changing lifestyles and creating an environment which encouraged people to make healthy choices. "We've got to get past 'let's take a pill and solve all our problems'. It's not the answer," [PHARMAC official] said.

Non-users, and Xenical forum-users to some extent, were highly resistant to drugs as a means to lose weight. Again, Xenical is framed as a last resort, or not the primary option, by two of the forum-users:

Forum-user 3: I am not allowed Duromine due to having a pacemaker and heart condition, and I wouldn't take it anyways, just not for me. I have tried diet and exercise hence the Xenical just need a helping kick start!!!

Forum-user 6: Hubby has been prescribed it, but has no intention of changing his eating and drinking habits which has led to significant weight gain. He seems to think all he has to do is take this drug and hey presto he'll be back in shape forever.

In the following examples, Non-user 1 is also highly opposed to pills, framing them as an 'easy option', taken by people lacking in motivation. She also displays a preference for approaching weight loss the 'natural way':

Non-user 1: I don't think that those things should be, you know, sort of pissed around with until you've tried the normal way. Because I, it's, it's also because people take the easy way out. Instead of, it's a lack of motivation. So instead of actually exercising and making changes in lifestyle and nutrition and stuff, taking a pill is so much easier than that. And, you know, there's results that are promised, it's so much easier than going to the gym or, you know, not eating McDonalds.

Non-user 1: But I have never done pills or any of that kind of stuff, I don't, I really want to try and do it, actually, I don't think I'll ever take diet pills.

Lydia S: Why is that?

Non-user 1: I dunno, I've done a bit of googling and research and other people that have taken them and (1) I think I'd rather just do it the good ole natural way =

Lydia S: =Yup=

Non-user 1: = Before trying to, you know, put medicine into your body that isn't necessarily gonna even work =

Lydia S: = Sure =

Non-user 1: = And has all the rubbish side effects to it.

As previously stated, Roche's website and advertisements were the sole groups that glamorised Xenical and other drug treatments or technologies. The remaining players positioned Xenical and pills generally negatively, or as inferior in comparison to other more 'realistic' options such as programmes, or the 'natural way' through diet and exercise. As Helman (1981) has suggested, drugs can have diverse symbolic meanings for different people. In these constructions, there was a surprising consistency between the different players' representations of drugs. The pharmacists' constructions of Xenical in particular were surprising, as they appeared both supportive but also resistant to its use, favouring exercise or lifestyle changes. This contradicts their position as distributors of drugs, where they might be expected to fall into a medical framework, offering drugs as the solution to a range of health-related issues.

3.3.2 *Weight-loss programmes and diets*

Pound et al. (2005) have claimed that some people reject medications entirely and others accept them uncritically. Further, they have suggested that rejection of medicines might be accompanied by an increasing preference for complementary methods, though this is an area that, as they have highlighted, demands additional inquiry. The current research seems to affirm Pound et al.'s suggestions, where players that rejected Xenical and other weight-loss drugs generally displayed a preference for complimentary or alternative options. For instance, Pharmacist 2 emphasised the existence of clinics such as Kate Morgan, Weight Watchers and Jenny Craig as part of the reason for Xenical's reduced popularity, suggesting these alternative options were taking over the weight-loss market. The pharmacists in general seemed to accept these alternative programmes, and did not position them as an 'easy' solution to weight problems in the same way as Xenical and other drugs. Thus, Xenical's existence as the shining blockbuster it once was is shadowed by a growing market or preference for alternative options, which may have led to its decline in popularity and status. As an example, Pharmacist 2 discusses the changes he has seen in the preferred approaches to weight loss over the years:

Lydia S: Alright, so um, what kind of approaches do people seem to be coming in for now, like treatments for weight loss? Do you see people wanting to lose weight?

Pharmacist 2: Not as many as there used to be because there's the weight clinics and also perhaps Kate Morgan which is run in other pharmacies, I mean, I don't, I'm not a franchise holder for Unichem etcetera, so therefore, we don't see those, so perhaps we see less than what we did ten years ago.

Lydia S: Right, so how long have you been practising as a pharmacist?

Pharmacist 2: Forty years.

Lydia S: Right, wow, so have you seen many changes?

Pharmacist 2: Well, the usual clinics and weight watchers...what's the other one where you get your food?

Lydia S: Jenny Craig.

Pharmacist 2: Jenny Craig and those things, yeah, there was a market for them, pharmacy, I would say, had total market share, thirty years ago, and now, I don't know what market share we'd have, 10 per cent? I don't know...

In the following quote, Pharmacist 2 again emphasises the existence of other clinics as a reason for the relative unpopularity of pharmacological options such as Xenical:

Lydia S: Mmm, so OK, that's interesting. So nothing really, Xenical's just not really around anymore?

Pharmacist 2: Well, I've got one on the shelf.

Lydia S: Right, yeah.

Pharmacist 2: We sell, two or three weight-reducing things there but they're just herbal.

Lydia S: Right, and do people come in kind of asking for advice on weight loss?

Pharmacist 2: Mmmm, but, as I say, not to the level as before because of other clinics.

Pharmacist 2's talk shows how Xenical is linked to broader processes and popularities of other treatments and technologies, where alternative options are taking over the market. For instance, in the non-users' representations, they were still looking for a 'cure' or pathway to losing weight, as Jutel (2006) has previously suggested, though pharmacological solutions were not favoured as a method for doing so. Like the other players, weight-loss programmes and certain diets were deemed a more acceptable approach, possibly because they were seen to take more determination, persistence or will-power. For example, in the following four excerpts, Non-user 1 discusses her current diet, her reasons for choosing it, and why she preferred it over other options:

Non-user 1: Umm, no starch, no sugar, no... juice, drinking heaps of water. Umm, you're only allowed a number of eggs in the first cycle, two eggs a day. Drinking heaps of green tea, and then, in the second cycle, the menu expands and you can have um...you can bring like bread into it, uhh, red meat, and starch. And uhhh, shellfish. And, then, there's another, another cycle, the menu expands again but I spose the point is that it kind of like trains your body, so...like it, so I think it like kick starts your metabolism kind of and trains, not trains your body, but it does something to, you know like, by doing the different three things? Ummm, what else about it..

Lydia S: How did you hear about it? What got you onto it initially?

Non-user 1: Umm, I did heaps of research, and looked at different diets and what was going to be the most...umm, I spose...what's the word, um, realistic.

Lydia S: Yup.

Non-user 1: Cos I looked at obviously stupid things like Lemon Detox and, um, Atkins and all that kind of stuff, and it was more just, yeah, just the fact that it's, um, easy. You don't have to, you know, there are not ridiculously, they're not stupid menus. And not stupid meal plans, they're, you know, you generally ate chicken and fish and vegetables anyway. So the fact that it was suited to what I eat anyway, I think was a big pulling card.

Non-user 1: Like the main thing for me is that it's, it's not stupid and unrealistic and one of those ridiculous diets that says don't eat for two days and eat for one, you know like, there's so many...different, you know, like stupid things like that that I just wouldn't be able to do.

Non-user 1: ummm...well like I said, I was just looking for something that was like, I dunno, like with the Lemon Detox and stuff, like, people rave on about it and blah blah blah blah but it's so unhealthy for your body. Like it's...you're effectively not eating and... I didn't want to do anything that was unrealistic cos if I do something like that, and I get to the second day, or the third day or whatever and it's horrible, then, then the risk of like bingeing, you know what I mean? Like it, and that's like the diet that I'm on now, you're not meant to

drink coke or lemonade or fizzy, but if I don't have like that, I spose one little vice, which I spose I've had to obviously compromise by having diet stuff, then it's so easy to... you know, get sick of all this and drink a whole bottle of coke. You know what I mean?

Lydia S: mmhmm, sure.

Non-user 1: Yip, so something that's not so strict that if you do one thing that's not in the book, everything just turns to, you know, shit.

Lydia S: Yup, yup. And so what =

Non-user 1: = and I didn't wanna be on a diet that you eat the same thing every single day...for, you know, x amount of time...and that's what's good about that is that it's different. And, um, it's also got, I spose like, handy hints, in it, just things like, um, like I've started drinking heaps of green tea which I don't usually drink. Um, I'm not drinking coffee, tea, I hate yoghurt but I've started eating yoghurt, and the biggest thing for me about this is breakfast. I never ever ever eat breakfast but I have to with that. And that's making a huge difference I think anyway, cos when I went to my, I did go to my doctor, cos I was sick of putting on weight =

Non-user 1: Yup. People saying, 'Oh my god, lemon detox is the best thing I've ever done', I remember people saying that they hadn't, didn't stop vomiting for two weeks.

Lydia S: Yeah, right. And so, did you find any forums on this diet, like about this diet?

Non-user 1: Um, yes. And it was good and bad. But when I read the doctor's review it was that it's, um, generally fairly healthy, because you're not depriving, you know, your body of food or nutrition or anything, it's just different, different food.

Non-user 1 suggests she chose her diet because it was “realistic” and “generally fairly healthy”, positioning it against other “stupid” or unrealistic diets that have stringent requirements and rules. This was interesting given that the diet she was on, the *17 Day Diet*, still appeared to have strict rules around eating and exercise, prescribing 17 minutes of exercise per day and specific phases where certain foods were ‘allowed’ or ‘not allowed’. In this sense, her diet was still a traditional diet in the sense that it was restrictive and prescribed, though she used language which indicated that she was resistant to falling into the ‘diet’ category, as diets, like drugs, also have a certain stigma attached to them. Though programmes and diets were certainly not wholly accepted by the non-users, they were still generally positioned as superior to drugs and preferred as a weight-loss method. This is slightly contrary to what was expected, as the literature around lifestyle drugs suggests that they are often preferred, or taken up over alternative options because of their ‘quick fix’ or magic bullet appeal (Fox & Ward, 2008; Lexchin, 2001). These findings may suggest that this mentality or appeal does not necessarily currently extend to weight-loss treatments in the same way that it might be relevant to lifestyle treatments for other medicalised ‘diseases’. They also could indicate a de-pharmaceuticalisation of fatness, where medical options, including Xenical, are no longer predominant or preferred.

3.3.3 The 'natural' way

Where Xenical and other drugs were framed as 'putting something into your body' and diets as 'unrealistic', doing it the 'healthy' way with food and exercise stood out as a preferred or superior approach. The dietitians, non-users and one of the forum users displayed the greatest support for this approach over and above the other categories, positioning it as 'realistic'. This weight-loss method was shaped as consisting of 'healthy' eating, calorie reduction and exercising or using personal trainers. Thus, it is positioned not so much as a 'diet', but more a lifestyle change. For instance, the two non-users in the following quotes discuss how it feels doing it the natural way. It is evident how more positive language is used to describe this approach in these excerpts, such as 'confident', 'attractive', 'fit', 'healthy' and 'exertion':

Non-user 3: I probably feel most confident about my body image when I've just come back from like a really big run, like I'm really sweaty...it's probably the most, like, where I feel most attractive.

Lydia S: And why do you think that is, is of you? Why do you feel the best after?

Non-user 2: {laughter} it's almost like you feel, all good about yourself because you have done something to, try and be fit, healthy and you know...

Non-user 3: Yeah, it's like, and you can like physically see it, I guess, I dunno, like see your exertion.

The following two quotes demonstrate Non-user 2's preference for the 'healthy' approach over diets:

Non-user 2: With me, me being the size that I wanna be is associated with fitness and healthy eating and stuff.

Non-user 2: Oh I don't really believe in dieting as such...they're all fad diets! Cos the, two years ago the lemon detox diet was like, the diet, and now you never hear about it. I don't know what the latest one is, cos I don't really tend to keep up with, but I mean at one stage it was like the Atkins diets, and...you know, I don't think diets keep weight off, and they're not, healthy, so I, I dunno I just think if you eat healthy food, and to me having smoothies and stuff is just a way for me to have, um, really healthy, quick, easy, and also like, you know, I'm not sure if this is true or not but I've got the whole thing that you actually like metabolise better if it's in liquid form.

In the following quote, Non-user 2 and 3 together discuss diets or programmes in comparison 'lifestyle' changes:

Lydia S: How about you? Have you ever been on a diet?

Non-user 3: Umm, I think...not really actively until recently and even then, like, I don't really like to call it a diet cos I associated diets with like, Kate Morgan meal replacements, Celebrity Slim, Jenny Craig.

Non-user 2: Calorie counting ay =

Non-user 3: = Yeah, I see people who have lost like ten, fifteen kilos and you're like, oh my god that's amazing, and then it's like, two months later it's back on, and so, I think, for me, it's more of a healthy lifestyle, I guess you would say.

Non-user 2: With food and exercise.

Non-user 3: Yeah, with food and exercise.

Likewise, a forum-user demonstrates a clear preference for doing it naturally through exercise and healthy eating:

Forum-user 9: The only good way to lose weight is by doing exactly what [another forum user] does walking and healthy meals, take from someone who knows. make this a family thing and all get fit at the same time as hubby is losing weight.

In contrast to the positive language used to describe lifestyle change approaches, words or phrases such as 'fad', 'unrealistic', 'stupid', 'magic answer', 'bingeing' and 'easy way out' were used to describe drugs, and, occasionally, diets or programmes. Through this comparison it is apparent that doing it the 'healthy' way is generally constructed as superior by most. In taking these different approaches together, and considering how they have been described, understood and positioned in comparison to one another, arguably they all share a similar theme in common. They all frame weight loss as central to fitting in, and making ourselves better, thinner, or 'healthier', and conforming to cultural constructions of the body. From this it appears that there will always be a market for weight-loss treatments and technologies. However, these findings do raise interesting questions about the future of drugs as weight-loss technologies, which appeared to be becoming somewhat redundant and unpopular as an approach. For example, where Xenical had sales of \$0.5 billion in 2005 in New Zealand (Fox & Ward, 2008), Pharmacist 1 reported having only one currently in stock. In this sense, Xenical, other drugs, and diets to some extent, were largely understood as being only temporary, and the future of weight loss instead seems to lie with the 'holistic' approaches. Also interesting was how the choice of treatment for weight loss appeared to be linked to motivation again, where those who were willing to put in the work, through exercise or sticking to a programme generated more respect, whilst those who took Xenical or other weight-loss drugs were considered inferior. In this way, the consumption of Xenical and other technologies and treatments was used by the players to construct moral judgments about the nature of the person or user, where a stigma was attached to certain treatments and the options chosen by consumers were linked to their character. This could explain why the non-users were so resistant to conforming to drugs such as Xenical and certain diets, and were more embracing of alternative options. They seemed to be aware of the stigma attached to taking a drug, as it was positioned as the 'easy' option. In any case, the representation of weight-loss

treatments and technologies was diverse, but still followed a similar theme between the players, of scepticism around Xenical and drug treatment and a preference for alternative options.

3.3.4 Safety and side effects

In the literature around medicine use, safety and side effects are issues that repeatedly arise for consumers, distributors, manufacturers, news media and the public. Often questions are raised about medicine's ability to help versus harm, where the risks associated with medicine use are weighed against its life-saving properties. With some widely-used medicines such as pain-killers, safety is often assumed, whereas others are seen as more risky. Risk is often also inherently linked to side effects and the seriousness of such effects. These issues were central to symbolic communication and understanding around Xenical and its use. As was discussed in Chapter 1, Xenical is well-known for its plethora of side-effects. These side-effects were covered in some detail by all of the players, who constructed them in diverse ways. For the forum users, the side-effects were particularly central to their experiences and often determined whether or not they would continue to use Xenical as a weight-loss method. While side-effects were also central to the representations of the other players, they were less directly or personally spoken of, and were even positioned as just being a natural or normal part of the drug-taking process, particularly in Roche's case. Roche did not frame Xenical so cautiously, instead emphasising the harm that could come from *not* losing weight, referring to the health effects and co-morbidities of fatness. This was the exception, however, as in most cases side-effects were framed as being a negative part of Xenical use and the use of other drug treatments, where the more serious the side-effects, the less safe the treatment was deemed. Xenical forum-users and non-users were the most cautious about safety concerns around Xenical and other weight-loss pills, but did not position programmes or diets as being risky or unsafe. There was also an air of caution in the news reports around Xenical use, with one referring to a controversy linking Xenical to a Medsafe alert of liver risk. This article drew attention to the possible dangers of Xenical. However, it also quoted a gastroenterologist as saying:

Article 2: If you're taking Xenical, you must be obese and obesity causes abnormal liver function on its own.

This quote links the risks allegedly associated with Xenical, to the risk of obesity itself, which in a sense mitigates or blurs the danger of the drug by suggesting obesity is just as bad or as likely to causes liver issues. This was similar to how Roche framed Xenical. A different article also touches on the safety issue, deeming it central to the loosening of restrictions around Xenical's proposed changes in classification:

Article 1: The Ministry of Health's Medicines Classification Committee, which had decided Xenical fitted the "safety profile" for over-the-counter sales, deferred its recommendation until a training programme for pharmacists was set up with the guarantee of face-to-face consultations.

In the following quote, which also relates to the issue of safety, Pharmacist 1 mentions how some weight-loss medications have been withdrawn due to safety concerns:

Pharmacist 1: They can get scripts from the doctor, or, although the number of products available on script has been reduced due to health concerns for, um, weight reduction drugs that work on the brain...um, there's pretty much only one left now, Duramine, which is quite an old one, and the um, other ones that were Reductil, first it was withdrawn in the UK and once that happens it takes about three months and gets withdrawn here. So that pretty much leaves people with Duramine, which is sort of an amphetamine-based old one, or Xenical, which is uh, you know, still available and also got the advantage of being available without a script.

The withdrawal of drugs from the market due to safety concerns is a common occurrence. Although Xenical itself has not been withdrawn, it still raises issues to do with safety. For example, one forum-user frames Xenical in relation to safety:

Forum-user 7: When I was very overweight and desperate for a quick fix I asked my doctor to prescribe it. He refused and then told me some horror stories about people soiling themselves in office meetings etc. etc.

In this sense, safety concerns can be considered to be central to Xenical and other weight-loss treatments and technologies. Safety is fundamental to decisions around whether or not people use them, their withdrawal from the market and their classification for distribution purposes. Closely linked to the issue of safety is the issue of treatment side-effects, which were repeatedly raised as being part of the process of taking Xenical and other medications. For instance, Pharmacist 1 discusses Xenical's effects below:

Pharmacist 1: Um, I mean, Xenical's more indicated in people where, um, they might tend to eat food they shouldn't. You know, and probably have control issues with food, um, if you did eat food that was high in fat and take your Xenical with it, um, you're going to have like bad gastric effects, or if you're really lucky you could have transient rectal incontinence, and if that happens to someone, it'll work so of like a, a, aversion therapy kind of, you know? If you have that enough times you'd probably stop eating the bad stuff.

Although the side-effects are constructed negatively here, they also seem to be framed as central to the effectiveness of Xenical's treatment. For instance, through saying 'you'd probably stop eating the bad stuff', Pharmacist 1 is suggesting that the side-effects are what make people avoid fatty food when using Xenical and therefore aid its effectiveness. Two of the news articles also refer to

Xenical's side effects. While Article 3 only mentions them briefly, Article 2 is based mainly around side effects, explicitly constructing them as potentially dangerous:

Article 3: Although Xenical is still on the US market, reported side effects have included flatulence, abdominal pain and liver injury.

Article 2: There had been no reports in New Zealand of serious liver injury linked to Orlistat, but Medsafe would "watch carefully" for the FDA investigation results and then evaluate the need for any safety action. However, anyone taking Xenical should get medical advice if they had symptoms associated with liver injury, such as fever, jaundice, dark brown urine, nausea, vomiting, itching, weakness or fatigue.

While Roche through its website positioned side-effects as non-serious and pharmacists appeared to represent them as a natural part of using drug treatments such as Xenical, the forum users constructed them as fundamental or central to their experiences of Xenical. Discussion of the side-effects dominated the forums. The following quotes demonstrate the centrality of side-effects in their representations of Xenical:

Forum-user 1: If you eat something that is very fatty (Hungry Jacks etc) you will definitely notice it next time you visit the loo. Extremely oily number 2s.

Forum-user 4: OMG xenical is the worst!!! I had fish and chips one night then took a t ablet and that didn't turn out to be very good LMAO!!!

Forum-user 5: I was on Xenical about 10yrs ago, and I think the gut problems now are as a result of it. I won't be taking it again.

Forum-user 8: I was offered by my doctor a choice of Xenical or reductil to lose weight. One thing with Xenical is that you can't eat much fat or else you will spend your life on the toilet!! The doctor said you would be too scared to eat fat after an episode like that! On the package one of the side effects is Anal leakage – I kid you not!

These examples show the significance of side-effects to the forum-users' experiences of Xenical and how usage is linked into everyday living, in contrast to the biomedical approach which is less personal. This relates to Shoemaker and Ramalho's (2008) findings from their metasynthesis, which showed that 'bodily effects' were a central theme in how medication was experienced by users. This also has implications for Spain et al.'s (2001) suggestion that the internet is changing the nature of health care. In these forums, side-effects were shared and recounted as a way to warn others of Xenical's effects. These anecdotes are un-mediated, 'real' stories, directly from users themselves. Unlike Roche's website, advertisements or even news articles, the forum discussions are also largely

unbiased, as the users construct Xenical in a very ‘real’ way. In this sense, the internet has created an open space through which people can share their stories and experiences of medications, in as much or as little depth as they desire. Therefore online forums might be seen as beneficial to health care or pharmaceutical consumers, providing a non-judgmental platform to discuss central issues such as side-effects, thus aiding others in their decisions around medicine use. Further, the side-effects were often framed by the forum-users as being so debilitating or demoralising that they were largely determinative of whether the users decided to continue taking Xenical. This finding in particular relates to Pound et al.’s (2005) synthesis of medication use, which showed that people are generally either passive or active ‘accepters’ of medication, or ‘rejecters’. In the case of Xenical, the previous quotes tend to indicate that the forum users largely rejected Xenical due to its side-effects. However, similar to what Pound et al. found, some were more inclined to keep taking the Xenical, but simply adjusted how they used it to reduce unwanted effects, thus falling into the category of ‘active accepters’, for example:

Forum-user 2: The side effects can be really bad but if you limit your fat intake to 20-30mg per day its not as bad. The number 2’s can get pretty oily but its something you get used to. The first month is the worst but after a while your body gets used to the tablet...I think after trying them it’s a personal thing to decide if you want to take it. Just warn your partner about the side effects!

Like Forum-user 2, Dietitian 1 also delves into this notion of active acceptance, discussing the side-effects and how it is possible to actively avoid or adjust Xenical consumption ahead of a high fat meal to evade the unwanted effects:

Dietitian 1: I remember talking to [Roche] and saying “well, you know, you’ve got to follow a low fat diet in order to manage on Xenical, why don’t you just not bother with the Xenical and follow a low-fat diet”... and their response was, “well, this acts as like an internal policeman, so, if you’re taking the Xenical and you decide to be naughty and go and have a high fat meal, then you’re going to know about it, you’re going to have all the adverse effects and that’ll stop you doing it”. But then...again...you know if you’re gonna start manipulating things like that and you’re gonna have a high fat meal then surely you’d just skip your Xenical and go and do it. You know, there’s all kinds of issues around that and people understanding how and the way things work and since it was launched we haven’t seen obesity disappear, it has increased dramatically.

In the following quote, Forum-user 10 diverged slightly from the group in that she claims side-effects didn’t put her off using Xenical. In this sense, she appears to be a passive acceptor, where she is aware of the side-effects yet deals with them and their consequences.

Forum-user 10: I have been taking Xenical for about five months. Even after the initial side effects such as those described, it didn't put me off. Its something you get used to. Just make sure you stock up on panty liners, and don't hold back if you need to go to the toilet, or else you will have a messy incident occurring...I think the reason I have managed to keep it up for so long is because i am currently single, thus not having to worry what my partner would say if he saw a messy toilet or underwear...

Overall, treatment safety and side-effects are central in discussions around medication use and were raised or communicated by all of the players in relation to Xenical. Some positioned them as a necessary part of medication use, whereas others rejected them entirely and used them as a justification for discontinuing Xenical. In general, weight-loss programmes and natural approaches were positioned as being free from side-effects and therefore more appealing options, except in Roche's case where Xenical was favoured.

3.3.5 Efficacy

Burch (2009) has argued that while drugs are seen as dangerous and linked to side-effects, they are simultaneously understood as powerful with the ability to transform bodies. However, this power is not taken for granted; they are also well-known as being fallible and faulty. Burch's argument appears to translate to weight-loss treatments and technologies and the case of Xenical, where efficacy was constructed as a central issue. Xenical was understood as being relatively ineffective by everyone except Roche and one of the dietitians. With drug technologies such as Xenical, efficacy might be generally understood as the ability of the drug to produce the desired effect, and the strength of that effect. In the case of Xenical, weight loss was generally framed as the key measure of efficacy, where the more weight that was lost, the more effective the drug was considered to be. Perceived efficacy was also a driver behind players' decisions to use Xenical or other weight-loss methods, where, if others had reported success stories, consumers were more inclined to use it themselves. For example, Non-user 1 discusses her justifications for choosing her diet based on perceived efficacy:

Non-user 1: And because I've heard from heaps of people that, it, works.

Lydia S: So you, you know people that have tried it before?

Non-user 1: Yup, yip.

Lydia S: Are they friends or...

Non-user 1: Ummm, my mum did it =

Lydia S: = Yup =

Non-user 1: = She lost like 8 kgs =

Lydia S: = Yup =

Non-user 1: = My aunty did it. She lost like 6 or 7. And I have a friend that did it, and she lost over eight. And, oh, I think, a point, a big part of this, of this diet as well, is that it (2) um, the point of it is to lose, in the first section, is to lose, I think it's like between one and

three kgs in that first 17 day block so that you (3) feel and see results so that you're then motivated, not, you know, motivated to continue doing it.

In this example it is evident that weight loss is the fundamental measure of efficacy to Non-user 1. Similarly, efficacy and “weight change” were also central to forum-users. Xenical was generally constructed as being ineffective by the forum-users, most of whom had tried it and were warning others about its lack of efficacy. The following quotes demonstrate these representations:

Forum-user 1: But I really didn't like it – so much so that I didn't even finish the 1st packet which is about 1 month I think. I had no weight change either.

Forum-user 3: I've been on Xenical for about three months or so now and haven't seen great results. I am seriously thinking about starting Tony Ferguson.

Forum-user 4: Tried both [Xenical and Duromine]and I'm still fat ...ohhh I KNOW that feeling hehee but no matter how much I try its not helping me loose weight mmm.

In this sense, the product was constructed as being flawed and faulty as it did not have the desired or expected results. In the following quotes, two different forum-users report a different, more positive experience with Xenical. However, like Forum-users 1 and 4, they both construct weight loss as the determining factor behind its efficacy or effectiveness:

Forum-user 2: Yep I've tried Xenical and it really worked for me...I'm going to go back on it after my pregnancy, definitely! I found it was the only thing that really worked. You still have to eat properly and exercise but I lost 25 kgs in 5 months!

Forum-user 10: And the results are amazing. I have lost everything i wanted to lose and more, and now i am my ideal weight, I carry on taking it for fear I will put it all back on, which WILL happen.

Surrounding Xenical itself, weight-loss methods in general were positioned with an air of scepticism when it came to effectiveness. For example, Non-user 3 discusses diets, suggesting:

Non-user 3: that's what I associate diets with. And I also associate them with not working.

The dietitians shared a similarly cynical attitude, resisting the efficacy of pharmacological treatments altogether, with one suggesting:

Dietitian 3: Well there's a lot of alternative things that they sell in health food stores for weight loss, for instance, you know there's pills and this sort of thing...pharmacists, I mean

pharmacists are as guilty as the next person for selling quack, quackery, um, in my, to be perfectly honest, you know, if it sells they'll sell it and sometimes don't seem to be too concerned about whether it works or not...um and you know, the placebo effect is alive and kicking.

Likewise, the pharmacists constructed Xenical as lacking effectiveness. However, instead of positioning the product as faulty, they frame the users as being to blame for not following instructions or using the product properly:

Pharmacist 2: They've tried it, yeah, and then they, most probably start putting weight on again when they go off it.

Lydia S: Right, yeah.

Pharmacist 2: Mmm, cos of their eating habits.

Pharmacist 1: Yeah, I just think it's, it's not hugely effective really, because a lot of people would probably be taking it, um, when they've got control issues around food and they're not doing the other things they could be doing. I mean, in conjunction with healthy eating and increased exercise it could, you know, boost up people's, you know, success and everything, um, but I think people have probably become more aware of that it's a problem with diet and lifestyle, and it's um, not going to help them.

The dietitians were partially similar in this respect, placing weight loss in the same category. For instance, Dietitian 1 below suggests that it's the individual that fails rather than the diet or the programme:

Dietitian 1: So for a lot of people they come along and they say 'I can't understand why I'm not losing weight, I'm eating all the right foods, I know I'm not doing anything wrong'...and it's literally portion control. So...they're not losing weight, they're eating too much. It's that simple.

On its website and in its Xenical advertisements, Roche also suggest that Xenical is effective if used in conjunction with a healthy diet and exercise. These constructions and examples demonstrate how failed dieters or users are often positioned as not 'doing it properly', rather than a failure of the product to produce expected results. The pharmacists, dietitians and Roche similarly framed Xenical and other treatments or technologies as effective in aiding weight loss, but the extent of the effectiveness was contingent upon the user's ability to stick to its guidelines of use. In the above examples, reference is made again to users 'eating' and 'lifestyle' habits, which were understood as being the reason why the drug is ineffective or fails to keep the weight off. Therefore, failure to achieve weight loss was not positioned as a failure of the drug itself but more as a failure of the individual to use it properly. In this way, the individual user is again being 'blamed' to an extent,

tying in with the popular discourses present in the media and public health linking individual blame and failure to being overweight.

In a separate quote, Dietitian 1 refers to Xenical, suggesting it might be effective but must be used carefully:

Dietitian 1: There is scientific evidence that shows that for some people it does seem to be in helping to get that weight off and keep it off, ummm...but it's not for everybody. So, I think there is a place for drugs but they need to be very carefully used, people need to be monitored, and it needs to be a very individual approach.

This quote also links back to the idea that drugs are dangerous and powerful, with the word 'carefully' being used and emphasised. In this sense, she constructs Xenical as potentially being an effective drug, but its effectiveness is linked to its potency, relating to Burch's (2009) claim that the perceived ability of medicines to help is accompanied by their understood ability to harm.

3.4 Summarising comments

These findings and the discussion surrounding them, highlight how there is no consensus of understanding around Xenical. It was shaped according to the positions and contexts of the different players, forming diverse constructions around its uses, and issues relating to safety and risk, side-effects and efficacy, all of which have been shown to be central to medications in previous literature. These issues were also situated in broader discourses or cultural understandings of weight, weight loss and drug use, as well as processes such as medicalisation and pharmaceuticalisation. Thus, the analysis provides a unique, in-depth, case investigation into the life of Xenical, raising notions around how those players that are linked to its existence are also linked to one another, in a nexus that connects the pharmaceutical industry, marketers and distributors, and consumers and health or medical professionals.

CHAPTER 4

CONCLUSION

In line with the primary research objective, I attempted to gain insight into how the weight-loss pharmaceutical Xenical was constructed, understood and symbolically represented by different players connected to it. The analysis resulted in two broader sections pertaining to the issues that arose in relation to Xenical: 1) Weight and Weight loss and 2) Weight-loss Treatments and Technologies. It became evident that the constructions were not uniform, but varied between players and even within groups of players. Xenical was positioned in a social context of issues including methods of treatment, safety, side-effects and efficacy. From this research, I have arrived at two key conclusions about Xenical:

Firstly, it was constructed as a ‘living thing’, and a social phenomenon as Cohen et al. (2001) suggested in reference to medications. It embodied social properties and was constructed much like a human, with significance to those around it and meanings embedded in its existence. Adding to this, it was also transient in nature, moving and morphing from one context to the next in the hands of different players, intimately linked to its social surroundings. Its meaning varied across settings and scenarios. For instance, in the hands of pharmacists it acted as a commodity, whereas to Xenical forum-users it was a personal object linked to them, their body and their feelings. Secondly, Xenical emerged as a medical technology that was redundant or no longer used. The general understanding appeared to be that it had dropped off the market almost entirely, largely replaced by weight-loss programmes and clinics such as Weight Watchers and more holistic programmes or options involving diet and exercise. What was intriguing however, was the fact that one dietitian reported Xenical as still being highly popular and widely used in the UK. This may indicate that the trend is limited to the New Zealand context. This has implications for the nature of health care, weight-loss and the pharmaceutical industry. The reports of redundancy appeared to be accompanied by a general resistance to Xenical and weight-loss drugs in general, by the majority of the players. Most positioned alternative means as being a ‘healthier’ or ‘more realistic’ route to losing weight. Further, in trying to account for Xenical’s disappearance one pharmacist stated, “people are always looking for the latest and greatest”. It seems that once people try one option and it doesn’t work, then they refrain from using it and move on to the next. This could account for why Xenical was exceedingly popular in its early years after release before its sales declined. These issues shed light on processes of pharmaceuticalisation, and how drugs rise and fall in popularity. They may also indicate a shift towards a de-pharmaceuticalisation of fatness whereby, not just Xenical, but all weight-loss drugs are no longer the preferred or desired route to slimness.

The findings were largely consistent with previous social research relating to medications, medicalisation, pharmaceuticalisation, weight and weight loss. However, some were unexpected. For example, not only was Xenical resisted as a drug treatment, but so were drug treatments in general, particularly by non-users. This seems to indicate a trend whereby people are becoming more aware of the controversies and dangers surrounding drugs, particularly for ‘lifestyle’ conditions or those that could be treated through alternative means to medication. Drugs were not framed as a necessary part

of health care by any of the players except Roche, but rather were positioned as more suitable for accompanying other treatments or being avoided altogether. For instance, the pharmacists' constructions of Xenical and weight-loss treatments diverged from what we expected them to be, where medications were actively dismissed several times throughout the interviews. This conception of medications was surprising as pharmaceutical sales figures still suggest that they are an exceedingly popular choice when it comes to managing health and illness.

4.1 Implications and Recommendations

This research has several implications and gives rise to a number of recommendations. Xenical itself provides a lesson in drug popularity and pharmaceutical fashion, risk and side effects. In particular it draws attention to the central matter of 'resistance', both to pharmaceuticals themselves, but also to the trends and transformations of everyday natural ailments or problems into medical issues. This supports previous research (see Williams, Martin & Gabe, 2011) which highlights resistance and de-pharmaceuticalisation as concepts to consider in research around drug use and technologies. It also emphasises the essential role that patients and consumers play in these processes, where for example, in the case of this research, the Xenical forum users were resistant to Xenical because of its side-effects, and the non-users were resistant to its potential dangers. In this sense resistance was 'situationally specific' (Chamberlain, Madden, Gabe, Dew & Norris, 2011), both linked to the nature of the medication being used, who was or wasn't using it, and reasons for its use. However, as Williams, Gabe and Martin (2012) have stated, it is important not to overplay the importance of consumers, as the "medical profession and the pharmaceutical industry are still the main locus for the growth in use of prescription drugs and remain central to any analysis of pharmaceuticalization" (p. 2130). In line with this statement, this research can be considered useful as it not only considers the experiences of consumers but also incorporates health professionals' and industry constructions, thus displaying the links between all the groups involved in the process of pharmaceuticalisation and drug use.

In addition, it highlights the need for a discussion around the tools used to measure fatness or obesity, most importantly the Body Mass Index. These faulty tools were framed as central in the players' discussions, and are currently being used by health professionals, officials and the weight-loss industry, to class a significant portion of our population as overweight or obese and therefore at 'risk'. This leads the public to become misinformed and concerned if their measurements do not fit in with official standards or guidelines. A specific recommendation from this is that the arbitrary nature and fallibility of BMI should be more highly publicised, with attention drawn to the fact that a higher BMI does not necessarily place an individual at greater risk of diseases such as heart disease or diabetes.

There was a general consensus or understanding between the players that fatness was unhealthy. Moreover, fitness was positioned as being separate from fatness, whereby one could not be fit and fat at the same time. There was an overwhelming focus on fatness, weight and their negative qualities, where marginalising language was used to refer to larger people. This creates a social context whereby fat people are discriminated against, and viewed as a 'cost' to society or the health

system. Seen in this way, it also has implications for public policy or health interventions targeting a reduction in obesity, which are often individualistic and blaming, aiming to restrict the environment to deter fat people from making ‘poor choices’. For example, recent discussions have circled around a tax on ‘junk foods’ and rules around where ‘bad’ foods are located in the supermarket. Further, if larger people are constructed in this way, it is unsurprising that they flock to pharmacists or diet programmes in order to lose weight and ‘fit in’ with cultural expectations around the body. Therefore, a re-direction in focus from fatness to focussing on fitness and nutrition is required, concentrating on establishing a healthy relationship with our bodies and our food, rather than a preoccupation with weight and body size. After all, fitness and diet have been found to be more determinative of health outcomes than weight or body size.

This research also highlights the important role that the media plays in constructing views or representations of fatness, obesity, and medications, and defining margins of normality or cultural definitions of attractiveness and health. The language used by the media is particularly influential in this respect. It can be largely emotive, playing up controversies and exaggerating disease or risk, yet often seems taken for granted as a source of credible information. While the media will always be interested in controversy, perhaps coverage should rather be re-directed at questioning the immoral or controversial practices of the pharmaceutical industry, particularly around misinformation or campaigns which could be considered to be ‘disease-mongering’. Also, further attention should be given presenting unbiased or critical media coverage of issues relating to obesity or weight, and to refrain from presenting information which is based on questionable scientific evidence or claims.

While some divergence between different players, such as laypeople, health professionals, consumers, or marketers is to be expected, this research has indicated that there needs to be a greater consensus of understanding when it comes to issues of health and health care. Xenical was naturally constructed in diverse ways given the different positions or understandings of the players; however, this also appeared to create a context of misunderstanding and misinformation. Each player was coming from their own unique history, context and place of understanding, which meant that often expectations of health and treatment did not match up. For instance, if they are rationalised and understood differently by different groups, it is difficult for the expectations of the patient or consumer regarding their health care to be sufficiently met or understood by the professionals that they are dealing with. This may indicate a need for a change in the educational practices of health professionals and the provision of more information for laypeople and consumers of medications. Perhaps health professionals need to be steering away from the biomedical view of health towards more user-centred approaches that are in tune with their wants and needs, rather than trying to meet the agendas of pharmaceutical companies or guidelines laid out by international and national governing bodies that may not have consumers’ best interests at heart.

4.2 Limitations and Future Research

By and large, the research objective for this study has been met, although further research could be useful for exploring this concept in more depth, across different players and groups of people, as well as other pharmaceuticals. What could be perceived as a limitation to this study was the fact that it only

used limited numbers of participants or sources, such as pharmacists, news articles or advertisements. However, this scope was intended as it allowed us to obtain a smaller, more focused data set from a range of players, concentrating in detail on each player to gain an understanding of their position and representations. The use of smaller, more targeted categories was pertinent to gaining this kind of insight, and resulted in a richer analysis.

A further limiting factor is that Xenical users were not directly spoken to as part of the research. In the early stages of planning the research we intended to interview Xenical users. However, this proved to be impossible as we could not make contact or find anyone who was using or had used Xenical, in spite of numerous attempts through advertising, and snowballing through non-users, pharmacists and dietitians. This was telling in itself as it indicated that Xenical had fallen in popularity. Instead we substituted users of Xenical online in forums as the next best option. If users can be located for future research, that may provide some different information about how they understood and experienced Xenical, as well as additional information including why they decided to use it.

Another group that was not spoken to were general practitioners. However, they were not considered to be as relevant as the other groups for the purposes of the study as they are no longer involved in the process of prescribing Xenical due to its reclassification from a prescription-only to pharmacist-only medication. While doctors were not relevant to this research because of Xenical's pharmacist-only status, further research could involve them to obtain their perspective on prescription drugs, as they are a group positioned very much within a biomedical framework, where prescribed drugs are likely to be seen as a solution to lifestyle problems. From this angle, they may offer some further perspective relating to pharmaceuticals and health care, as well as processes of medicalisation and pharmaceuticalisation.

This research only considered Xenical within a New Zealand context or setting. All of the forums, websites, advertisements and other players were locally-based. While this provides a very unique and specific case study of Xenical, it may be interesting to consider how it is understood in different contexts overseas, for instance in Europe or the United States, where it has been reported that Xenical remains largely popular and other weight-loss pills continue to be released regularly.

4.3 Concluding Statements

Overall, this study aimed to provide an in-depth case study of Xenical to understand the wider nature of pharmaceuticals and their social meanings, considering different facets of use and understanding, different motives and interests, gains and losses (Williams et al., 2012). This is a growing area of enquiry, particularly in relation to the critical obesity aspect, and it is hoped that this research has helped to contribute something novel to the current literature around fat studies and pharmaceuticals. In particular, it may help to shed light on the need to explore these widely used and accepted objects in more depth, as things that are tied to health, controversy, power, and political and social processes. In addition to drawing attention to these issues, the case of Xenical helps to challenge assumptions and constructions relating to both weight and pharmaceuticals. This is crucial given the emphasis

placed on being a 'healthy' weight or body type in modern Western society, and the great lengths that consumers may go to reach such a size or shape.

Despite its disappearance from the weight-loss market, Xenical still raises questions about the future of the weight-loss and pharmaceutical industry and where they are headed. Where Xenical leaves the market, the latest and greatest cure to fight the fat or cure obesity will be released, claiming to transform bodies, if not identities. Therefore, the pharmaceutical industry will still take part in the 'treatment of fat'. Despite their central role in saving lives and reducing pain or suffering (Williams et al., 2012), pills remain objects that are manipulated, driven by different interests, ulterior motives, misinformation and profit. In contemporary society where medicalised conditions are rife and a new drug is released every day, with claims to cure disease and fight illness, it is fundamental that we understand the nature of these cultural commodities, and how their existence shapes people's understandings and connects the economic or political process of producing and marketing medicines to people's everyday lives.

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APPENDICES

Appendix A: Pharmacist Information Sheet

Appendix B: Pharmacist Interview Prompts

Appendix C: Dietitian Information Sheet

Appendix D: Dietitian Interview Prompts

Appendix E: Non-user Information Sheet

Appendix F: Non-user Consent Form

Appendix G: Non-user Interview Prompts

Understanding Xenical

PHARMACIST INFORMATION SHEET

My name is Lydia Stallard and I am completing my Master of Science Psychology degree at Massey University, Wellington. I am specialising in Health Psychology and am interested in issues of weight and body size and the use of pharmaceutical drugs in everyday life. My research project is supervised by Professor Kerry Chamberlain, and it aims to gain insight into societal perceptions surrounding fatness and the use of weight-loss pharmaceuticals. My specific focus is the diverse meanings that Orlistat (Xenical) holds for different groups involved in its production, dissemination and consumption. I will be talking to two other groups about Xenical, including dietitians and people on weight-loss programmes, as well as analysing information from a range of other sources, including Xenical advertisements, Xenical users on internet forums, news articles on or related to Xenical and the Roche Xenical website.

Who can take part?

I would like to invite you to take part if you are employed as a pharmacist. Ideally, you will have heard of Orlistat (Xenical) and be familiar with its uses. I assure you that you do not have to discuss anything that you do not want to, and you can withdraw from the conversation at any time. I will also do everything I can to ensure that this experience is respectful and enjoyable.

What will be required of me if I agree to participate?

You will be asked to take part in an informal discussion with me, lasting approximately 10 to 20 minutes. I will ask you if you would be happy for me to record these discussions and use quotes from your speech in my analysis and research write up. If you agree to this, then I will ask you to formally verbally consent on audiotape before beginning the discussion. If you are not happy to be recorded, then I will ask you if I may take notes during the conversation to use later in my analysis. I would like to talk with you about topics such as the popularity of Xenical as a weight-loss medication, why you think people take it, whether there have been any changes over time since its release in the weight-loss market, and what other treatments are popular for weight-loss.

The location and time of the discussion will be decided in collaboration with you, and may be at work or somewhere nearby where you feel comfortable. At any stage you can ask questions and clarify issues about the project and you may withdraw your participation in the research up until one week

after the interview. During the interviews you do not need to talk about anything you don't want to. If you agree to our discussion being recorded then you can ask to have the tape recorder turned off at any time.

How will your information be used?

All the information you provide will be treated confidentially and only my supervisor and I will have access to it. The information will not be used for any purposes other than this study. If you agree to our discussion being recorded, the transcriptions of the discussions will have all identifying information deleted from them. Any contact details I have of yours will be kept in a different secure location to protect your confidentiality, and I will be the only person who knows who you are. Any transcripts and audiotapes from our discussions will be destroyed after the analysis and transcripts or written notes will be stored securely at Massey University for a period of five years before being disposed of in accordance with research protocols.

If you have any questions about any aspect of the project please do not hesitate to contact me, or my supervisor.

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This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 11/047. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 9570, email humanethicsnorth@massey.ac.nz

Appendix B

Pharmacist Interview Prompts:

- How long have you been practising as a pharmacist for?
- What are the main issues you see people coming in for? Do weight issues feature often?
- What kind of weight issues do people come into the pharmacy for?
- Do they often ask specifically for specific medications for weight-loss or do you recommend particular options? If so, what options do they want/do you recommend?
- What options do you tend to sell the majority of?
- What is your view on using pills for weight loss?
- How often does Xenical get requested and sold?
- Have you noticed any changes in Xenical's popularity over the years since it was released? If so, why do you think these changes have occurred?
- Do you think any of these approaches, including Xenical, can be effective in aiding weight loss? Why or why not?

Understanding Xenical

DIETITIAN INFORMATION SHEET

My name is Lydia Stallard and I am completing my Master of Science Psychology degree at Massey University, Wellington. I am specialising in Health Psychology and am interested in issues of weight and body size and the use of pharmaceutical drugs in everyday life. My research project is supervised by Professor Kerry Chamberlain, and it aims to gain insight into societal perceptions surrounding fatness and the use of weight-loss pharmaceuticals. My specific focus is the diverse meanings that Orlistat (Xenical) holds for different groups involved in its production, dissemination and consumption. I will be talking to two other groups about Xenical, including pharmacists and people on weight-loss programmes, as well as analysing information from a range of other sources, including Xenical advertisements, Xenical users on internet forums, news articles on or related to Xenical and the Roche Xenical website.

Who can take part?

I would like to invite you to take part if you are currently working as a registered private practice dietitian. Ideally, you will have heard of Orlistat (Xenical) and be familiar with its uses but this is not a requirement. I assure you that you do not have to discuss anything that you do not want to, and you can withdraw from the conversation at any time. I will also do everything I can to ensure that this experience is respectful and enjoyable.

What will be required of me if I agree to participate?

You will be asked to take part in an informal discussion with me, lasting approximately 20 to 30 minutes. I will ask you if you would be happy for me to record these discussions and use quotes from your speech in my analysis and research write up. If you agree to this, then I will ask you to formally verbally consent on audiotape before beginning the discussion. If you are not happy to be recorded, then I will ask you if I may take notes during the conversation to use later in my analysis. I would like to talk with you about topics surrounding weight, weight loss, the kinds of approaches that you recommend to people wishing to lose weight, whether you think there is a place for weight-loss pharmaceuticals such as Xenical, the popularity of different weight-loss approaches, and whether you have had any experiences relating to Xenical.

The location and time of the discussion will be decided in collaboration with you, and may be at work or somewhere nearby where you feel comfortable. At any stage you can ask questions and clarify issues about the project and you may withdraw your participation in the research up until one week after the interview. During the interviews you do not need to talk about anything you don't want to. If you agree to our discussion being recorded then you can ask to have the tape recorder turned off at any time.

How will your information be used?

All the information you provide will be treated confidentially and only my supervisor and I will have access to it. The information will not be used for any purposes other than this study. If you agree to our discussion being recorded, the transcriptions of the discussions will have all identifying information deleted from them. Any contact details I have of yours will be kept in a different secure location to protect your confidentiality, and I will be the only person who knows who you are. Any transcripts and audiotapes from our discussions will be destroyed after the analysis and transcripts or written notes will be stored securely at Massey University for a period of five years before being disposed of in accordance with research protocols.

If you have any questions about any aspect of the project please do not hesitate to contact me, or my supervisor.

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Appendix D

Dietitian Interview Prompts:

- How long have you been practising as a dietitian for?
- What kinds of issues do you come across most regularly in your practise?
- Do people often come to see you because of weight concerns or issues? If so, please explain what kind of concerns they seem to have?
- How do you work with people with weight concerns, for example, what kinds of processes, approaches or procedures do you use?
- Do you ever recommend diets, pills or other pharmacological medicines to clients in addition to or in conjunction with their programme with you? If so, what do you tend to recommend?
- Have you ever heard of or come into contact with Xenical? How?

Understanding Xenical

NON-USER INFORMATION SHEET

My name is Lydia Stallard and I am completing my Master of Science Psychology degree at Massey University, Wellington. I am specialising in Health Psychology and am interested in issues of weight and body size and the use of pharmaceutical drugs in everyday life. My research project is supervised by Professor Kerry Chamberlain, and it aims to gain insight into societal perceptions surrounding fatness and the use of weight-loss pharmaceuticals. My specific focus is the diverse meanings that Orlistat (Xenical) holds for different groups involved in its production, dissemination and consumption. I will be talking to two other groups about Xenical, including dietitians and pharmacists, as well as analysing information from a range of other sources, including Xenical advertisements, Xenical users on internet forums, news articles on or related to Xenical and the Roche Xenical website.

Who can take part?

I would like to invite you to take part if you are over 18 years of age, are **not** using Xenical, and are following some form of weight loss programme with the intention of losing weight. Suitable programmes could include using weight-loss pharmaceuticals, diet drugs, natural remedies, exercise, meal replacement programmes, weight watchers, or something of the like. The length of time you have been on this programme is not an issue, nor is whether you have tried it more than once.

I am aware that discussing issues surrounding weight may be an uncomfortable or embarrassing experience at times. I assure you that you do not have to discuss anything that you do not want to, and you can withdraw from the interview at any time. I will also do everything I can to ensure that this experience is safe and respectful. You will be provided with a \$30.00 supermarket, petrol or movie voucher to cover your time.

If you think you may know someone else who might be interested in taking part in this study, feel free to discuss it with them and pass on my contact details so I can send them an information sheet. Please note that by contacting me you are not agreeing to participate but simply showing interest.

What will be required of me if I agree to participate?

You will be asked to take part in one informal interview with me, lasting up to hour, discussing topics relating to weight, weight-loss and the programme you are currently on. I will record and transcribe these interviews following obtaining your written consent. The location and time of the interviews will be decided in collaboration with you, and may be in your own home or at another location where you feel comfortable. At any stage you can ask questions and clarify issues about the project and you may withdraw your participation in the research up until one week after the interview. During the interviews you do not need to talk about anything you don't want to, and you can ask to have the tape recorder turned off at any time. You will be given a summary of my findings at the end of the project.

How will your information be used?

All the information you provide, including transcripts and consent forms, will be treated confidentially and only my supervisor and I will have access to them. The information you provide will not be used for any purposes other than this study. The transcriptions of the interviews will have all identifying information deleted from them, and your consent form and contact details will be kept in a different secure location to protect your confidentiality, and I will be the only person who knows who you are. As soon as the transcripts have been analysed the audiotapes will be destroyed and the transcripts and consent forms will be stored securely at Massey University for a period of five years before being disposed of in accordance with research protocols.

If you have any questions about any aspect of the project please do not hesitate to contact me, or my supervisor.

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Appendix F



Understanding Xenical

NON-USER PARTICIPANT CONSENT FORM

I have read the INFORMATION SHEET and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I would like to take part in this project and be interviewed about my experiences of fatness and *weight loss*. I agree to participate under the conditions set out in the INFORMATION SHEET.

Signature: **Date:**

Full Name (printed).....

Appendix G

Non-user Interview Prompts:

- Are you on some form of diet, exercise or weight-loss programme?
- How long have you been on it for?
- What contributed to your decision to begin this programme?
- How do you perceive your body?
- How do you perceive others bodies?
- Has your view of yourself or your feeling about yourself changed at all since you have been on your programme?
- What was the process like of seeking out the programme? For example, how did you find out about it or where did you get it from?
- What kinds of expectations did you have of the programme? What or who led you to have these expectations?
- What is involved in the programme? E.g. can you describe the process?
- Did you share your decision to go on this programme with anyone? Why or why not?
- Have you ever tried any other weight loss programmes, diets or pills in the past? Why or why not?
- Would you consider taking weight-loss pills? Why or why not?
- Have you heard of Xenical? If so, in what context?