(D)-graded female bodies and the emergence of weight-loss surgery: A discourse analysis of narratives relating a precarious moment in the medicalisation of women's weight

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Abstract

Within the last century, as large bodies came to be regarded as unattractive and deviant, the project of appearance has become entangled in projects of health. In the assumed legitimacy of discourses linking overweight with ill health, alternative understandings of large body size and the possibilities for large-body health have been effectively silenced. Within New Zealand's gendered social order, women in particular experience and enact surveillance and criticism of their bodies from an early age. Those whose bodies do not fit within prescribed norms for health and beauty become (D)-graded large bodies, especially vulnerable to discriminatory practices within consultations and legitimate objects for practice, treatment and experimentation. In the failure of diets and pharmaceuticals to produce 'normal' weight over the long term, some women considered weight-loss surgery (WLS) options.

This thesis traced the spread of WLS within New Zealand and the conspicuous creep of cultural prescription, morality and trade - including Direct-to-Consumer advertising - driving that proliferation. In this thesis, I attend to the problematics of surgeons trading in and promoting experimental and new procedures, especially where these were performed as early-on procedures in private medical arenas. A range of narratives in this account record some of the unexpected, unpredictable, and often adverse outcomes experienced by some WLS patients: Elective weight-loss surgeries were risky procedures and accompanied by significant iatrogenic injuries when surgeons had minimal experience, training and proctoring. WLS patients experienced technically induced eating disorders and multiple surgical and medical interventions, often for little or no long-term weight loss. Informed consent was a legalised ritual that did not protect patients.

In this reflexive, qualitative research project, reports, case material, emails and interviews with 14 doctors and 22 patients were analysed with respect to the power/knowledge relations implicit in them. This critical-health analysis challenges any inevitability of benefits in the wider application of WLS. WLS consultation and practice requires attention to the cultural and trade insistences that limit the parameters

of weight/health and, secondly, to the development of respectful practices of communication and consultation based within a relational ethics of care.

Acknowledgements

This project is significant for the relationships that built for me in and around this research and I dedicate this research to these important and wonderful people who have sustained me through this long and complex project. I acknowledge the significance of Narrative Therapy to this project and within my life and work; the intellectual and emotional sustenance provided over many years by Johnella Bird, David Epston and my wonderful case consultation groups in Auckland and Wellington – they continue to warm, encourage and sustain me.

I have experienced marked periods of transition in the matter and materials of this research and running alongside these were powerful feelings of connection with, and learning through, a series of significant relationships with supervisors and academics. Professor Jenny Carryer made available her deep insights into weightfull women's experiences of health and well-being and provided overall guidance throughout this project. Doctor Mandy Morgan applied a critical psychological lens to the philosophical foundations of my work. Doctor Kevin Dew and Doctor Suzanne Phibbs contributed a strong, questioning and disciplined sociological lens - Kevin with whom I began this project and Suzanne who sustained me in its later stages. I recall the collegiality of the attendees at my first international conference, the *Talk-in-Interaction on Health*, Perth.

I am humbled by the persistence of important others. My husband updated my technology, wrote poems about my health encounters and encouraged me at breakfasts on Saturday mornings to discuss the thesis. My sister Sylvia introduced me to ABC Health Reports and conversed with me long into the night. Jennifer and George, who breakfasted with me most mornings in the beginnings of this thesis, and have continued to value my work, and encouraged me to persist. My children, Haidee and Logan, their partners, Gregor and Jo, and my grandson, Jamin, have so heartened me through this process with their enthusiasm for life, learning and relationships. I recall the support of the wise women in the Victoria University-based discourse group and some very special mates: Anne, who read and connected with this thesis or sat in my office as quiet company; Jeanie, who shared her own work and knowledge with such generosity over coffee and talk.

I also would like to thank a number of other people: Doctor Michael Humble for his chirpy chivvying and UOW who paid my fees; Sarah and Jacquie who shared the task of transcription with such generosity; and especially, the participants as I interviewed them and who continued to support the research with tidbits of information, connections, great cartoons, and prompted me on occasion to consider my own health.

To all, I say a heartfelt thank-you and go well! Kia ora. Ka kite ano.

Special dedication

This thesis is dedicated to the memory of my firstborn grandson

Dann

Godspeed, little man
Sweet dreams, little man
Oh my love will fly to you each night on angels' wings
Godspeed
Sweet dreams
(Lyrics by the Dixie Chicks)

"The frontiers of a book are never clear-cut: beyond the title, the first lines, and the last full stop, beyond its internal configuration and its autonomous form, it is caught up in a system of references to other books, other texts, other sentences: it is a node within a network" (Foucault, 2002, p.25).

Foreword: "Warming the teapot"

"There are times in life when the question of knowing if one can think differently than one thinks, and perceive differently than one sees, is absolutely necessary" (Foucault, 1990, p.8).

Throughout this project, I expected at least a minimum level of good enough practice both of medicine and of medical ethics and I make no apology for refusing the invitation to applaud practitioners who practised at that level. The weight-loss surgery decisions of participants were made at a time when these technologies were beginning to proliferate in New Zealand. This thesis unintentionally traced the history of these experimental procedures performed as early-on procedures by practitioners with minimal training and proctoring. WLS[1] procedures are radical treatment options: They require best practice in relation to surgery consultation and an assiduous commitment to ethics.

But I am getting to the end before I have begun. This thesis is a project that has taken some years, (and many warming cuppas with my generous colleagues and mates), to reach this point in its production. So much so, that Mansfield's comment on Forster induced that dreaded second fear "What if" (to an anxiety always present in such a long-term project) "this work never gets finished?" Clearly, it will never be 'finished' but it is warmed enough to present without being a 'finished off', closed-in project with nothing more to say. As a reader, you may have much to add and I write this introduction in some anticipation of that. I also hope that in letting you know a little about me as the author/researcher, you will view my work as informed by a myriad of positionings open to me as a Foucauldian, feminist, patient, ethicist, parent, citizen… As I raise questions about some of the problematic processes and relationships, I trust

[1] Weight loss surgery.

that my account is sufficiently provoking to interest you as reader in some of the questions that surround these modern medical technologies of the self. I ask you to bear with the close attention I pay to focal case material through the data chapters: These were narratives that traced the multiple problems that occurred when radical new technologies were being introduced.

In this introduction, I hope to make you familiar with my style of writing in which my reading/speaking/reflecting are intimately connected. From years of learning and practising as a narrative therapist, I am aware that my choices in speaking and writing are intimately bound within those experiences. As female sexuality is bound with touch, so too do I seek to touch others through the medium of words (Freeman, 1988; Irigaray, 2005). I write to connect with readers; I reach out to make contact with you in ways that establish who I am and where I am from. Through my words, I bridge from what is familiar and local to position this work within its academic heritages. I gather strength through these processes and return to ground the work in ways that provide a useful basis for decision-making in WLS - and any one of the multitude of health projects being made available to patient/citizens in this twenty first century.

In the analysis stages of this thesis, I began for the first time to read material surrounding Carcinoma in situ patients at National Women's Hospital in Auckland, New Zealand. These were sobering readings. New Zealand required a new legislative framework and one eventuated. If New Zealand patients and doctors were applying the lessons from that inquiry, WLS practice would have been exemplary. This was not the case.

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