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**(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.

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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. WLS¹ 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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“Stories about *health* are, sooner or later, stories about the contemporary shaping of that particular human aspiration, being a healthy self” (Frank, 2006, p.434).

CHAPTER ONE

Introduction and overview: Weight-loss surgery decision-making as a modern medical dilemma

“Obesity experts are predicting tens of thousands of premature deaths, hospital admissions and billions of dollars in extra health costs and say a ticking fat bomb is hanging over Australia” (Jennings, 3TV New Zealand, 2008).

1.1 Introduction

Geoffrey Rose (1992) argued that public health strategising needed to focus on changing group norms of behaviour in order to influence the health decision-making of individuals. Included in his statement, “We¹ already know what is desirable” (Rose, p.105), Rose signalled the need for significant weight reduction in the general population. Within New Zealand and other, mainly Western, countries, extensive governmental campaigns are waged against obesity (Ministry of Health, 2003; The National Task Force on Prevention and Treatment of Obesity, 2000). As well, large corporate companies target the general population with advertising that promotes weight-loss interventions. Normalised body weight and a widespread acceptance of the links between overweight with disease and increased mortality has entered common parlance.

This thesis connects with a critical health movement in which robust critique of the statistical claims behind the health/weight conundrum² has been developed. This includes significant concerns about big pharma³ paying medical scientists to promote “shaky evidence” (Oliver, 2002, p.x) about weight/health. My attention was drawn to the persuasive effects of the weight/health discourse and the operation of expertise in the derivation of profit for weight loss surgery (WLS) technology companies, surgeons

¹“We” appears to suggest some idea of health experts.

²For example, Oliver (2002) and Campos (2004) were also engaged in such critique.

³This a nomenclature applied to large pharmaceutical companies.

and private clinics. Already interested in the operation of power within practices of consultation, I began to focus on the problems for patients when surgeons traded in these radical and experimental procedures.

1.2 Thesis question

My thesis question asks: How is WLS consultation and decision-making for women impacted by the mediated modern emphasis on intervention for prevention in health and medicine? Unexpectedly, this question allowed me to trace the dispersion of WLS technologies through the period in which they gained unprecedented acceptance in New Zealand. Indeed, WLS are presently considered legitimate, desirable, remedial-health technologies. By analysing some dominating societal and medical discourses in the narratives of patients and doctors, I came to reflect on WLS decision-making as a precarious moment in the medicalisation of women's weight. This thesis is situated critically at the point where radical⁴ procedures were being advertised, recommended and performed with minimum attention to ethical practices of consultation and informing for consent.

1.3 Thesis argument

I argue that the uptake of medical technologies in the form of WLS is a radical response to a modern problem of large body size. The current and powerful messages surrounding ideal weight in a mediated,⁵ medicalised, progressive science context have acted to constrain a fully informed view of individual health, and the seriousness of WLS options. Based on an analysis of the narratives of women who undertook WLS and the surgeons who traded in it, I argue that although WLS is a set of surgical technologies of possible medical value to some patients, it is also a trade. There are ethical implications in offering and performing WLS when the recommendations to perform it are conflicted by commercial considerations and practices. This thesis references a range of historical, cultural, financial and reputational factors that impact the ability of women who take up WLS options to consent to these procedures. In the current environment, WLS consultations in particular and decision-making for WLS in general are indeed problematic.

⁴“Radical” denotes treatment that is extreme, drastic, or innovative (medilexicon.com).

⁵I used this term as shorthand for the significant impact of media reporting in the proliferation of new treatments and medical technologies, translating medical science into personal responsibility messages: Saguy and Almeling (2008, p.74) give the example that “[...] almost all press reports in 2003 blamed weight on individual factors.” I have since found this term used in a similar sense and refer the reader to *Mediated: How the Media Shapes your World and the Way you Live in it*, by Thomas de Zengotita (2005).

1.4 Developing the thesis focus

The stories of women and doctor participants traced the impact of various discourses of body size within medical consultations particularly if weightfullness⁶ was considered to be an issue. While most WLS participants in this study experienced some weight loss, alongside this loss perplexing questions arose about the side effects of WLS and decision-making for these procedures. From an initial, generalised focus on the permeation of problematic-weight discourse into the arena of medical consultation, I chose to foreground WLS decision-making for three main reasons. Firstly, there was the immense significance of WLS for women who chose it; secondly, the current and heavy promotion of WLS options by technology companies and some surgeons; and thirdly, the anomalous results of these surgeries.

Over the last century, trade interests in diets and weight-loss pharmaceuticals have contributed to making diverse body shapes problematic. Meantime, the health/weight conundrum for individuals remains unresolved. In the arrival of WLS, weightfull health consumers have been offered the seeming possibility of choosing their preferred body size alongside possible benefits to their health. At the turn of the twenty-first century, the cultural and health stigma of living as a large person has been escalating. Choosing WLS options is increasingly accepted as reasonable and valid, even while such a choice involves radical interventions and rearrangements of complex body organs. It was clear in interviews with some doctors and patients for this research that the side effects of these surgeries were being shaped as reasonable risks against the alternative of continuing to live weightfull.

Early in the twenty-first century, medical technologies such as WLS have been heavily promoted through an extensive and highly active Direct to Consumer Advertising (DTCA) environment in New Zealand and the United States. What became interesting to me then was how this mediated, medical-commercial environment impacted individual consultations and decision-making. The trade environment of WLS technologies presents significant challenges to existing professional – clinical and surgical – practices of medicine. As well, when all has been said – the participants, media, medical authorities and government agencies have had their say – and done – the

⁶There was no attempt in the advertising for participants for this study to specify parameters for overweight preferring that perceptions of problem weight be a matter for discussion in the interviews. I coined the term “weightfull” within the thesis in preference to terms such as fat, overweight or morbidly obese given that these terms were medically connoted or overlaid with stigma.

medical-technology companies, surgeons and clinics had rolled out their technologies and patients have had their surgeries – what have been the costs and the benefits of these radical interventions for women patients who were interviewed? Specifically, WLS consultations began to intrigue me. I became interested in the way in which participants sought referrals, became eligible for surgery, the types of surgery offered, surgery outcomes and of course, the processes of information-giving and consent.

This thesis and my personal health decisions bear the marks of grappling with my own capture by ideal⁷ size, the health benefits of a thinned body and the possibilities of cures through modern medicine.⁸ The medical technology trades and WLS surgeons have positioned WLS as an (the) answer to a constructed problem of epidemic proportions. WLS has profited by being ever more closely aligned with medical technologies for chronic or severe disease states. In a mediated–health environment, modern medical science is headlined and its technologies in relation to surgical and drug cures for a range of conditions proliferate. The modern citizen is exhorted to lose weight for health (Caterson, 1999; FOE, 2006). When WLS is promoted as the intervention, the riskiness of these surgeries is so easily tempered by stressing a greater riskiness in living large (Dowling, 2008). In accepting a health intervention, the modern patient faces uncertainty of outcome. While benefits may accrue, the intervention carries the potential for additional “loss and burden” (McTigue et al, 2003, p.947). The pull to surgery as a technological fix for a social problem is enticing when large body size is considered defective, abhorrent, or even immoral (Bruere, 1999; Corbin, 2003; Crandall & Martinez, 1996; Hammond, 1996; Hughes & Degher, 1993). The risk of intervening comes to be preferred over living large.

1.5 Thesis outline

My aim through this thesis is to present a complex multiplicity of positionings through which to unsettle firmly-held, modernist, mediated or medical-science views of weight in general and WLS in particular. This thesis is not a search for a truth position about weight, WLS, or even medical consultation: Truth is a rather “[...] dubious enterprise [...] because it isn't clear that it's a good idea for us to try and live with it, and because the very notion of finding truth is in itself suspect” (Nietzsche, 1998, p.15).

This thesis is broadly divided into three major sections.

⁷A body mass index (BMI) between 18.5-24.9.

⁸By inference, any critiques of WLS apply in a range of ways to any modern day medical technology.

1.5.1 Introducing chapters 1 to 5: Developing a critical context. In these five chapters, I develop a critical context from diverse literature to support a feminist, genealogical analysis of the research narratives. This initial section of the thesis builds a theoretical framework within which to view the powerful macro environment of medicalisation. In expanding a view of the health/appearance project through recording its connections with governmentality and trade, the micro-practices of consultation may be viewed in relation to the uptake of WLS in the modern, mediated, clinic environment.

In chapter two, *The context and significance of science, medicine and law for WLS decision-making*, I point to a history of medicine as an experimental science. I refer to a range of legal and ethical frameworks that have been constructed to protect citizen/consumers and practitioners of medicine. This section also indicates how protections for patients have been constrained by the pull to progress in medicine as a science. This chapter makes specific reference to the current development of law and constraints on medical practice within the New Zealand health context.

In chapter three, *Weighty Discourses*, I sketch the movement of body-size preferences as a cultural construction when weight and health are conflated. I am interested in the development of epidemiology and governmentality in relation to weight and health. I suggest that weightfull women's bodies are spoiled (Goffman, 1963) bodies, and ripe for commodification. My thesis engages with the current interest in techno/medical innovations and their potential to improve lived-health. I avoid as simplistic any interpretation which seeks to disqualify body-modification projects out of hand as over-determined by patriarchy, although I was initially drawn to a radical feminist reading which eschews practices of bodily transformation in the interests of appearance (Bartky, 1990). When cosmetic procedures require "[...] cutting, the shedding of blood and the placing of foreign objects under the flesh and skin" (Jeffreys, 2005, p.149) they evoke radical WLS projects. WLS though is most often presented as a health project, with aspects of appearance and identity becoming secondary projects. In choosing to avoid an analysis which leads to a limiting portrayal of women who undertake body reconstruction surgeries⁹ as cultural dupes, I position this aspect of the analysis within what has been termed a third wave of feminism, cultured by both-and (Bordo, 1993) analyses. Chancer (2000) has pointed to the cultural primacy of

⁹I have chosen to use this term, body reconstruction surgery, as a nominal category to include cosmetic and WLS options.

dualisms, body/mind, nature/nurture, and masculine/feminine. While questioning body modification remains a collective feminist practice, there is a need to remain open to the diversity of possibilities for expressing agency in response to that question.

According to Nikolas Rose (1999a; 2001), the benefits of biotechnology were being anticipated by the end of the twentieth century: Decreased morbidity of body and spirit and increased control of mortality were seen to lie in new genomic understandings. Medical technologies would reach further into lives, screening for deficiencies and diseases, and designing improvements on the given body, creating an ever more desirable body, as nature might have intended. While debate around the use and implications of medical technologies has tended to centre on the manipulation of human embryos, there appears to be a less-troubled acceptance of new technologies to produce desirable bodies, especially for those bodies that are out-of-cultural step such as overweight or fat bodies. As I listened to the stories of women who have contemplated or undertaken WLS, the dilemmas posed by these body-modification projects indicated a fertile ground in adding to this analysis by tracing women's weight-loss surgery decision-making.

I then turn to look at medical consultation relationships. The previous section indicated some of the ways in which the knowledge-base underlying decision-making for weight-loss surgery is limited. In this section I suggest that the state of ethical practice in medicine is also and likewise problematic, uncertain and not to be taken on trust. WLS is but one of many medical technologies or interventions in which the nexus of governmentality, commercialisation and encultured health coalesce. In this section, I reference material, often written by physicians concerned about the ethics of practice in medicine, as a tool through which to filter and trace the state of current practice around weight and surgical experimentation. This provides a context within which to view the reports of consultations by doctors and patients.

In a thesis that began as one in which to examine the state-of-play in the doctor/patient relationship using weight as the focus of consultation, I have come to read these relationships as largely modernist, potentially archaic projects within postmodern contexts. These readings disturb notions of trust, trusting and trust-worthy resting on beneficence or moral obligation as the ultimate condition for a constructive doctor-patient relationship. While it may be a more convenient truth to understand beneficence as a good that existed and has survived intact into the postmodern era, this

research has indicated areas of significant limitations in the history, practice and modern utility of such a notion.

In chapters four and five, *Methodology* and *Methods*, I speak about my qualitative research methodology. My analysis concentrates on deconstructing power relations – within the context of the genealogies of medicine produced in the initial chapters – in ways developed and practiced within narrative approaches to therapy (Bird, 2000; 2001; Dulwich Centre, 2003; Epston, White & Murray, 1992; Riessman & Speedy, 2007; Waldegrave, Tamasesse, Tuhaka & Campbell, 2003; Weingarten, 2001; White, 1991; 1995; White & Epston, 1990).

The methods chapter develops and adapts these ideas from philosophical commitment and practices of consultation to a research orientation. I utilise feminist-foucauldian discourse analysis to study the proliferation of trading in WLS within a context where overweight and obesity are proposed as health problems of epidemic proportions. I introduce the participants and clarify my own ethical commitments. I use practical examples of the research processes to make transparent the conduct of this thesis.

1.5.2 Introducing data chapters 6 to 7: Analysing narratives of weight and weight-loss surgery options. Chapters six and seven relate experiences and ideas about weight and surgery options. I problematise these accounts in relation to the restricted notions of health and weight on which surgery decisions are made and ongoing care is organised. I use the narratives of participants and written documentation to explore a trading account of surgery in which progressive and scientific discourses of medicine dominate interpretations of weight, health and surgery. In viewing the problematics surrounding weight and WLS fixes through the juxtaposition of words and ideas of women patients and doctor participants, I analyse these stories in relation to the context in which they were spoken and are spoken about. In consultation, these participants were deciding about aspects of communication in relation to forthrightness, the honesty of the speaker, trustworthiness in the advice and level of expertise. When these encounters were spoken about in research interviews, I raised questions about the nature of medical consultation as a professional practice that patients may routinely take on trust.

In chapter 6, *Narrating Embodied Weight*, participants spoke of living weightfull in a culture dominated by statistical weight as the major measure of health when female body size is uniformly promoted and idealised as thinned. This chapter reflects a

cultural framing of weight based on the narratives of all women who participated in the study, those who undertook surgery and those who didn't, alongside women doctors. This research was explicitly "[...] a political act that challenges and intentionally confuses social theory, method and politics" (Fine & Gordon, 1992, p.14) by including the narratives of doctors within my analysis of an encultured-slimmed female body. Women's stories of weight and size materialised a discourse set that was fragmented, diffident and ambivalent: It stood stark in its subjectivity, weight-as-appearance inextricably merged within the epidemiology of weight. The stories of participants resonated with a wealth of complex and intense experiences around our bodies: From the transmission of culture within families, sometimes living large, weighing and being weighed in medical consultations, women participants were always and already alarmed and alerted about weight, knowledgeable about dieting options and ultimately despairing about any ready fix for weighty bodies.

In this thesis narrative I refer to the multiplicity of weightfullness, as women described living weightfull moving within, producing and re-produced by, the socio-cultural medicalised environment. Norms for healthy weight have been determined and overweight has come to be synonymous with the presence of a number of diseases. As weight-for-height has come to reflect the culturally-prescribed female body, such measurement is interpolated into women's lives, complicating their relationships with themselves, with their families, with their doctors and with other health care providers. Participants' varied interpretations of the statistical storying of weight and health flow through this chapter. In narratives of choice, desire, risk and resistance within lived habitus, participants spoke of the private and public rituals of weighing in stories of attempting to manage their weight by taking action. These stories reverberate with the dilemmas and contradictions of living weightfull in our society and influenced participants who considered WLS options.

Chapter 7, *Narrating weight-loss surgery decisions*, traces the context of decision-making over WLS options. In the pressure placed on women to achieve an ideal slimmed body for health, and in the strength of their desire to be slim, WLS options were considered. In this study, the narratives of women participants detail the commodified female bodies of women in the late twentieth and early twenty-first centuries. I argue that in relation to health and norms of size and appearance, the women in this study and the surgeon-traders who attended them, were encouraged to entertain even the riskiest forms of WLS in the ongoing search for slimmed-weight

health and acceptable appearance. These participants chose between two major procedures (Appendix 1), a gastric lapband or a gastric bypass. This chapter presents the narratives of patients, doctors, specialists and WLS surgeons reporting weight and WLS consultations. The rhetoric supporting these surgeries within pre-surgery consultations compelled a closer look at the processes around informing consent. What encouraged women to proceed to these surgeries? Would they have chosen to proceed if surgeons had not been proponents of these procedures? Would their lives have been any less healthy?

Whether WLS surgery is notionally cosmetic or conceivably health-based, if these surgeries are indeed life-enhancing/health-improving activities, then modern technologised medicine proffers the fulfillment of the modern fairy tale. As women described their decisions for and against surgery, having weight-loss surgery appeared often to be in conflict with their personal ethic or philosophy of living. That conflict resulted in narratives of explanation as participants sought to re-establish a sense of integrity through a series of rationalisations and adaptations to personal philosophy to incorporate these choices.

While women may choose surgery for body reconstruction, this does not obviate either the necessity or desirability of “[...] challenging institutionally based power and raising questions of political economy [...] (or) transforming a media industry that still overvalues young, thin, and often white women’s bodies” (Chancer, 2000, p.86). To understand women’s decision-making over surgery options, I drew on feminist analyses of cosmetic-surgery materials, specifically working with and developing the ideas of Balsamo (1992; 1996), Davis (1991; 1996), Gimlin (2002), Heyes (2000; 2007; 2007a; 2007b), Jeffreys (2005), Morgan (1991; 2003) and Pitts-Taylor (2007). I extend this work on cosmetic surgery by focusing on the work of Nikolas Rose (2007) to understand the press of medicalisation in provoking dilemmas for largely-well women who consider and undertake WLS projects.

1.5.3 Introducing data chapters 8 to 10: Analysing practice in the wake of weight-loss surgery. In these chapters, I trace the post-operative experiences of WLS participants before moving to focus on aspects of ethical practice. Specifically, participants speak about WLS lifestyles and consultation following these surgeries. These patients were unprepared for the immediate impact of the surgery and ongoing side effects were unexpected and, at times, devastating. Through these three chapters, I question the quality of some devices and suggest that, given the radical nature of these

interventions, surgeons needed to undertake appropriate and adequate training and proctoring in these procedures. Overall, this section reflects the experimental nature of these surgeries, wider systemic issues, and, a lack of commitment to informing consent as a process.

In chapter 8, *Living the surgery fix*, the significance of weight-loss surgery for these participants was evidenced in their preoccupation with their surgeries in the aftermath. It was the largely unexpected experience of pronounced and debilitating side effects following these surgeries that brought notions of effectiveness into play within the analysis. Even as WLS was clearly about losing weight, could it, for instance, be called effective in the presence of significant side effects? My discussion expands notions of effectiveness beyond limited notions of weight loss as signifying health, and notions of health beyond its limited appearance as a thinned body.

Having related some of the problematic outcomes for women from WLS, in Chapter 9, *The Questioning Patient*, I am particularly interested in reports of the micro practices of professional relationships in WLS consultation. Essentially, relationships within this modernist surgery-for-weight-and-appearance project showed evidence of considerable strain when problems occurred. In the later stages of the thesis project, in the interests of brevity, I even considered omitting chapter nine from the thesis. However, this chapter provides an intensive analysis about what happened when WLS patients questioned even limited aspects of practice. It remains integral to the thesis providing an essential link between patients' physical experiences of WLS (chapter eight) with the problematics of being caught within inadequate processes of informing consent (chapter ten).

It is important to reiterate that this thesis relates specifically to the experiences of some women in New Zealand during approximately a ten-year period from the late 1990s through the early 2000s, a period dominated by the proliferation of DTCA advertising and panic about an obesity epidemic. During this period, the transected, open, gastric bypass procedure grew in popularity and new and putatively less radical laparoscopic procedures such as gastric bypass and gastric bandings began to gain market share. However, the numbers of surgeons and WLS clinics were extremely limited both in numbers and in geographical location.

In chapter 10, I trace the failure of informing consent in WLS consultation relationships. My analysis relies on materials from all the preceding chapters, from methodology and methods, through the texts of media and medicine, as the experiences

of doctors-in-consultation and women-as-patients converge. In examining the application of the rules surrounding informed consent as a minimum requirement for surgical consultation, I looked for signs that these relationships could be categorised as both relational and ethical. In narrating informing consent, the relational activity of caring-for the patient and keeping them informed in an ongoing way appeared to be routinely and negatively impacted by surgeon agendas. The presumption of deviance in the fat body, perceived as a fatal flaw by surgeon and patient alike, opened up these weightfull, largely-well bodies to radical surgery solutions. In this chapter I seek to understand some women's acceptance of poor outcomes and unsatisfactory consultation relationships. In this chapter, I examine the potential for moral and legal violation of informing consent by deliberate or thoughtless acts in the achievement of a variety of personal/cultural agendas.

1.5.4 Introducing chapter 11: In discussion and reflection. Two particular happenings caught my attention as I set about writing this final chapter:

1. I read in my local paper that a pilot study is being carried out in Counties-Manakau, New Zealand, to test the efficacy of WLS operations for 60 obese citizens with diabetes (Hill & Palmer, 2008). This is a radical move of uncertain outcome in the longer term.

2. What does it mean that a fourteen-year-old girl, slightly over-average weight, with Type 2 diabetes, has been encouraged to apply for WLS by her GP.¹⁰

If the human body is a “[...] text, a sign, not just a piece of fleshy matter” (Dallery, 1990, p.54) then the present focus on slimmed weight is a cultural and commercial artefact that has come to dominate practices of consultation for health. In the presence of an alternative framing of health-at-any-size, greater acceptance of a diversity of bodies – sizes, weights and shapes – within society would be reflected in less radical projects on the self than presently evidenced in anorexia, unhealthy yoyo dieting, drug treatments and WLS.

This thesis presents a challenge to the halo effect of techno/pharma solutions in constructed-medical problems. Although WLS is often spoken of as ‘successful,’ I have questioned the efficacy and acceptance of considerable iatrogenic effects from these procedures, especially during the period in which new forms of WLS were introduced into New Zealand. In problematising success focused on weight-loss, I have

¹⁰This is a personal story from a grandmother who sought my advice.

critiqued the ethical environments in which decisions to undergo surgeries were made by these participants. Throughout this thesis, I ask whether the riskiness of weight loss per se and surgery for weight loss in particular is to be preferred over living weightfull. This chapter brings together a wide range of narratives to specify consultations, operative procedures and lived-patient-lives.

1.6 Restating the thesis argument

Weight Loss Surgery (WLS) is a radical response to a problem surrounding large body size. This thesis inadvertently traced the dispersion of WLS in New Zealand alongside current and powerful messages surrounding ideal weight within a moralistic, mediated, medicalised, progressive science environment. The clinic environment has presented limited options to largely-well women in relation to their individual health: WLS options may be promoted without full information on their seriousness; the problematic standing of BMI is not acknowledged; the concept of health at any weight is not emphasised. In a mediated health environment, surgical consultation was a precarious environment for decision-making over WLS options for these participants. While WLS may medically benefit some patients, it remains both an extremely risky and radical procedure. WLS is a burgeoning surgical trade. Even when WLS decisions are separated out from practices of trade, reputational and/or cultural commitments to current ideal weights will continue to impact provision of radical surgery options and patient decision-making.

Fully informed consent for WLS requires a deep commitment to the welfare of the patient from within a relational ethic of care. The current legalistic interpretation of consent has privileged the ethos of progressive medical science at some considerable cost to fully informing citizen-patients. In chapter two, I introduce a genealogy of medicine as science and profession and comment on the growth of legal protections for patients and doctors.

“It is precisely this spontaneity without consciousness or will which requires philosophical analysis, not least because of its pervasive and largely unquestioned influence on the conduct of our lives” (Gatens, 1996, p.xii).

CHAPTER TWO

The context and significance of science, medicine and law for WLS decision-making

“Critical reflection on history may thus contribute to the effort to think ourselves differently” (Heyes, 2007, p.58)

2.1 Introduction

WLS is a modern medical technology. The development of WLS and the practices that have built around it, reflect a widespread belief in medicine as a progressive science. Finding ways to evaluate technologies in general, but WLS in particular, is difficult. In the face of hegemonic beliefs about weight and health, I rely on Foucauldian discourse analysis to “[...] loosen the embrace” between words and the things they are made to signify (Foucault, 1972/2002, p.54). From within a more general critique of medical science and its structures of civil support, I point to the contingent and historically determined development of medicine-as-a-science (Velardo, 1956) that prompts modern citizens to look rather uncritically to medicine for cures to whatever ails them.

Clearly, practices of best care and informed consent have been interrupted by the pressure-to-progress, a dominating discourse in the history of the profession of medicine-as-science. A complementary pull to law-as-a-science has ensured increasing legal protection for professional physicians, furthering the sovereignty of the medico. Arguably, this has been at the expense of primacy of protection for the patient body. While the relationship between patient and doctor is considered to be primary, exploitation of citizen/patients has been a consistent factor in healthcare and medical science research. Some areas for potential conflicts of interest have involved unnecessary procedures; inducements to participate in new treatments and research; the

use and abuse of vulnerable populations in treatment protocols and research; and, the manipulation of patient trust from a position of dominance to meet physician/researcher goals. I specifically relate to some recent history around medical care and informed consent for women patients in New Zealand. I specify how factors that brought about the original cervical cancer enquiry remain essentially unresolved and I demonstrate this in relation to informing consent for WLS treatments.

Armed with new ‘truths’ about bodies emerging from the laboratories, medicine has placed itself in the service of emerging and governing a new normality in human vital processes (Rose, 1999a; 2001).¹ This is nowhere more evident than in disciplines and interventions regarding body size. Within medical science, WLS is promulgated as another modern miracle, the cure for a disease of (now) epidemic proportions, obesity. Analysis of some latent aspects of this promotion provides a necessary backdrop for later data chapters in which these issues may be seen to play through the micro-practices of consultation for radical WLS options.

2.2 Governmentality and medicalisation

Healthiness creates a “governable space” (Rose, 1999a, p.31) in which governmental objectives and the encultured desires of its citizens coalesce. These are locations in which citizen/patients are drawn to consult with experts and “authorities of all types exercise their powers over the conduct of others” (Rose, p.36). In this chapter, I consider weightfullness as a virtual governable space within the medicalisation-as-governmentality project. When a physical sign such as weightfullness becomes subject to clinical diagnosis, a particular structure is imposed unproblematically on a form of cultural deviance (Rosenberg, 2002). In the promotion of overweight as a disease, WLS may be promoted as a reasonable intervention. Within the medicalisation of weight as a governable space, particular “translation(s)” (Rose, p.48) occur between government funded bodies and a variety of local agencies that support the application of trade in medical technologies to the clinical management of weightfull citizen patients. Within this space, weightfull citizens are encouraged to consider that weight is a clinical sign of disease that medical science has the potential to cure.

In the aftermath of the Second World War, the purview of medical science expanded as the surveilling gaze of governments concentrated on their problem-based populations

¹ The per capita expenditure to produce health care reflects a Western belief in the centrality of health care (Evans & Stoddart, 1990). Yet discrepancies exist in, for example, the United States, where vast expenditure has not brought about the concomitant improvement in health status when compared with other nations who allocate lesser amounts (Barr, 2008).

(Wailoo, 2004). Scientific understandings have become foundational to a risk model of modern life. “(R)isk thinking brought the future into the present and made it calculable” (Rose, 1999a, p.247). With the emergence of surveillance medicine (Armstrong, 1995), the normal body became problematised as pre-diseased, always holding within itself the seeds of potential illness. With the gradual advent of “biopower” (Foucault, 1990a, p.139) the normal body became an object for problematisation, intervention and modification through treatment. Biopower is enacted on the basis of truth discourses about the essential nature of living human beings through the mediation of anointed professionals: These professionals promote interventions of supposed benefit to the wider society and individuals are encouraged to perform these tasks for themselves and for others (Rabinow & Rose, 2006). In the existence of weight/height tables, for example, research into deviations from average weight held promise in explaining disease; in manipulating the weight of populations, disease potential might then be ameliorated. The onus was placed on individual citizens to choose weight-for-health interventions.

Large corporations, governmental agencies, hospitals, clinics, unions, national (and international) politics (Klein, 2004) grasped the wealth of opportunities made available by the increasing individualisation of risk and its intensification through media presentations (Rose, 1999a,). This focus on citizen health has spawned a vast medical industry (Starr, 1982). As well, citizens have progressively internalised the statistical basis of intervention-for-prevention in modern medicine. This ensures that the rationality of modern medicine is less available for questioning (Stewart, 2001). From praying to God for eternal life in the hereafter, the modern citizen requests and awaits the promise of a longer, ‘natural’ ideal of life. This is a life potentially free of pain, disease and abnormality through the application of medical science and technology mediated by Spratling’s priest-physicians (Rosenbaum, 2003). Holding the answers to bodily and mental ills, the medical practitioner is positioned at the interface between the fragility of the patient-body and the promised sturdiness of pharmaceutical and technological interventions. Physicians have become the “[...] guardians and gatekeepers of a technological fountain whose elixir grants eternal health” according to one editorial in *The Lancet* (Anonymous, 1995, p.1126). Our personal problems have been opened to interpretation within the abstracted language of science (Starr, 1982) for which interpretation by an expert is required.

Western science, technology and medicine are culture (Casper & Koenig, 1996; Franklin, 1995) acting in, acting on and acting through the neo-liberal citizen/patient. The basic modus operandi of the conduct of health-conduct in Western democracies - or medicalisation as a specified operation of governmentalisation - signals a hegemonic neo-liberal positioning. Individual citizens as agents need, and are encouraged to want, to take care of themselves in relation to accessible projects of health and norms of health-related behaviours. The web of governmental control over the health of its citizens is increasingly at a distance but clearly directive. The devolution of responsibility for fulfilling governmental agendas in relation to health is evident in the purposeful development of a variety of agencies funded or contracted to provide health-related services.² The proliferation of professionals and experts, and risk thinking as an individual and societal concern, are central in the bio-political era (Rose, 2001). With the ability to surveil-by-surveying, proportionate risks are assigned to groups of citizens (Czerniawski, 2007). The reasons for doing this have moved from the security of the nation to the domains of the economic in the “rising costs of health care,” and the moral such as inequalities in health care provision vis-à-vis a nation’s relative reputational standing to other countries as in the WHO Report (2000). Still, these phenomena eventually track back onto individual citizens who are exhorted to care for themselves. Neither governmentality in regards to health nor risk thinking have abated through the bio-political era. Medicalisation, though, has become increasingly connected with new concerns.

The notable success of pathological medicine (Armstrong, 1995) brought with it an increasing demand for, and possibility of, new cures and preventative measures. Experimentation for innovation could be justified within largely utilitarian notions of ‘the greater good’ of the population as a whole. Medical research as treatment was increasingly tied to its social outcome,³ and the means, including the use of human subjects,⁴ justified by the ends.⁵ In its seeming inviolability, medicine remained

²For example, in New Zealand, District Health Boards are accountable to Government for meeting agreed health targets through the Sector Accountability and Funding Directorate (<http://www.moh.govt.nz/dhbf>)

³The public health observational study, known as the Tuskegee syphilis project, followed without treating, the natural history of the disease in 400 black subjects in rural Alabama (Fried, 1974; Katz, 1996; Hornblum, 1999).

⁴Although Ackerknecht (1982) correctly attributed the importance of Paris as the centre for the anatomico-clinical method to the “critical shift in power in Revolutionary Paris” (Weiner & Sauter, 2003, p.41), the right to health care entailed the “[...] use of their living bodies and their cadavers for study.

connected with science in a way that has allowed it to remain largely immune to critique (Casper & Koenig, 1996). The assumption is that, as an established Western, scientific practice, medical science is answerable only to rationality and knowledge. Medical professionalism came to be based on the association between “scientific values, morality and democracy” (Casper & Koenig, p.12). In this “dream of reason” (Starr, 1982, p.3), power needed to be accounted for. While Starr was specifically – and some would say rather short sightedly (Wailoo, 2004; Warner, 2004) – referring to the power of medical practitioners, this insight lingers.

Medicine has maintained its authority by linking judiciously with big pharma, the large technology companies and governments, those forces determining the focus of medical research and development. In connecting with power bases in science and technology, modern medicine emerged, established itself and proliferated even as its commitments and practices changed to maintain these connections. While modernist medical science has continued to hold sway, a powerful postmodernist critique has emerged. Modern scientific medicine has a range of effects: It may be either “the knight in shining armour or a new body snatcher” (Porter, 1997, p.669).

From a concentration on the public infrastructure, state interventions in health activities were initially focussed on the elimination or control of epidemics, and the provision of public health programmes in Western nations.⁶ By the late 19th century and early 20th century, governmental interventions and concerns had shifted focus from the physical conditions in which citizens en masse lived their lives onto individual citizen-lives. In the next section, I trace the emergence of conducting the conduct of the body, enumerated and individualised, as it moved to embrace the freedom to choose health within the rules of a self disciplining, docile citizenship.

2.3 Weaving the threads of the Psy⁷ through medicine and trade: Surfacing biopolitics

The docile citizen-patient sits at the nexus of what constitutes public and private behaviours: Western law enacts individual responsibility and purposefulness; Western

This concept entailed their ready availability in multiple stages of disease and in death, making Paris a magnet for medical men, native and foreign.”

⁵The moral rationales advanced by Nazi physicians at the Nuremberg trials were grounded in these very same utilitarian principles (Caplan, 1989). Only those believed at risk of death were sacrificed in the most lethal, experimental research.

⁶Medical research supported the colonial discourse in the 19th and 20th centuries (Anderson, 1992a).

⁷Nikolas Rose (1998, p. 13) uses the term ‘Psy’ to refer to those disciplines such as psychology, psychiatry and psychotherapy that have assisted citizens to reinvent themselves, acting on themselves and being simultaneously acted upon.

morality presupposes a feeling and genuine individual who may instinctively discern right from wrong; and, Western politics produces an individual with the freedom to enact its own freedom (MacIntyre, 1984; Rose, 1991). As particular aspects of individual behaviour intersect at a communal interface, as in the provision of welfare and health services, the individual becomes increasingly available to scrutiny and problematised in relation to the proliferation of expertise. The rise of and dependence on “professionals of the social” (Miller & Rose, 2008, p.18), prepared the way for a complex form of liberalist citizenship in the second half of the 20th century. This is enacted in the dispersal of professional networks, infused and supported by social activity, notably education and medicine. Governing or “action at a distance” (Miller & Rose, p.26) rests on a regulatory framework. This governance is supported within the hegemonic ideation of individuals enacting their habituated freedoms as they consult a range of experts in the running of their daily lives.

In the post World War II era, Western citizens have been exposed to increasingly complex technologies and projects of the self. Constructed and translated through the language of “psy” (Rose, 1991, p.13) as self-fulfilment, self-actualisation or enacting the ‘true’ self (Maslow, 1971; Rogers, 1961; 1969; 1980), this has provoked dilemmas and choices for individuals who have little information about the effects of complex population-targeted interventions (Miller & Rose, 2008). Medicalisation is based within statistical processes of body classification that create institutional structures for the purposes of intervention (de Ras & Grace, 1997). Problematising deviance as a disease, diagnosing the individual or group with the new disease, and promoting interventions for cure (Miller & Rose, 1994; 2008) are inextricably linked. The problems of modern living are overlaid with psy-pathology. This has opened individuals and communities to the promise of possibilities for individual consumers through the modern “therapeutic machine” (Miller & Rose, 2008, p.143). Effects may only be evidenced at a population level.

The historical and political roots of social agendas, implicit in the ethos of professional consultation, remain shrouded by their ability to produce effects that are desired. But still, citizens are encouraged and expected to choose to consult experts in life, living and health. This is not to suggest a façade of freedom but more a limiting of choice and a cultivation of desires within the culture. In regards to health, the psy disciplines (Rose, 1999a; 2001) and medical sociology (Turner, 1997) have aligned with the truths of science. Professional interest is focussed on proliferating benefits to the

health of individuals and community, from the application of, and compliance with, science-based, medical directives. Yet medical directives about health have tended to reflect popular cultural enactments in which looking good is the picture of health. Performing a cultural aesthetic in the standard of visual presentation as health, especially for women, has become a moral responsibility. Women are required to actualise a best-looking self. The modern citizen faces ever more choices to conform with, or to choose to enact, a quantified and qualified picture of health as developed within medicine (Jutel, 2000).

By the late 20th century, a complex relationship was developing between visual, moral and health projects for the 'reasonable' citizen. In the pull of progressive science lay an urgent and enticing possibility for techno/pharma projects on the self. In regard to the specifics of weight, appearance and health, there are some rather obvious repressions that problematise the possibility of absolute agency in this regard for any citizen-patient. These are evident in the way that risk is delineated and desire is shaped. Questioning the delineation of health risks points towards understanding the kinds of risks that may be talked about and by whom, the nature of these risks, degrees of risk, who is made risky, what follows on from being constructed as a risky individual and who has the power to conjure risk, let alone risky people. Similarly in the shaping of desire lies the picture of a desirable body conflated as encasing a desirable soul. But how did ideal size become so narrowed and so normalised? How did diversity of lived bodies being celebrated and desired miss out on cultural valency? Who benefits when the outer look of perfection in the body is converted into a virtual performance of a display of health? Clearly concepts of the desirable and the desired body have resoundingly infiltrated, and been infiltrated by, health practices and the operationalisation of risk.

The modern citizen is schooled and inured in risk thinking about weight but believes that desiring to be thin is agentic. The context in which risk and desire coalesce evades the possibility of working out how citizens came to read themselves into ideas that living overweight was risky. Overall, risk tends not to be connected in everyday thinking to the cultural commitments involved in constructions of desire. And, attempting to hold such mappings still enough in the moment to read the tracings of their history is indeed a difficult task. Medicalisation has shifted the focus from healing a patient to gaining control of lives through pre-empting or ameliorating the disease potential of always pre-diseased citizens. This has stimulated, and been simultaneously

stimulated by, the rise of biotechnology, pharmaceutical and medical device industries, and significant mutations in bio-power. These shifts have particular consequences in the modelling of subjectivity and the shaping of desire. Any “[...] technology⁸ represents a cultural invention, in the sense that it brings forth a world; it emerges out of particular cultural conditions and in turn helps to create new ones” (Escobar, 1994, p.211).

The micro-environment of medical consultation in which individual citizen patients make medical-intervention decisions in Western medicine has been impacted by its links with commerce. This has given rise to significant conflicts of interest at the interface of medicine as trade and commerce in all levels of health provision. In the following section, I argue that the complex interweaving of commercial concerns into the practice of medicine create a risky environment for decision-making over health. To understand the contextual space within which WLS decision-making occurs, I trace the influence on prescribing habits of weight-loss companies, the diet-food industry and big Pharma. In the manipulation of constructions of health and weight through the use and abuse of BMI, overweight and obesity have been constructed as a health catastrophe of epidemic proportions. This has borne fruit in relation to research funding, and a range of radical, expensive and often hazardous drug, surgical and dietary treatments promoted to and for patients.

2.4 Medicine as commerce

When “[...] a great profession and the forces of capitalism interact, drama is likely to result” (Blumenthal, 2004, p.1885). Modern medicine is a fee-for-service occupation and doctors require payment for their services either in the private sector of health and/or through government-funded health services that disperse medicine in most Western health systems. As well, some patients are able to purchase more immediate care and an alternative range of medical interventions available only to private or insurance-sponsored citizen/patients.⁹ At the macro level, commercial concerns have intruded into the medical enterprise (Breen, 2007; Campbell et al, 2007; Christian, Pitt, Bond, Davison & Gomes, 2008; Dean, 1998; Jonsen, 2007; Kassirer, 2007; 2005; Wynia, Latham, Kao, Berg & Emanuel, 1999). In relation to the specific concerns raised in this thesis, I suggest that big pharma promoted the definition of obesity as a

⁸Escobar was speaking here of cyberculture.

⁹WLS has had limited application in the New Zealand’s publicly funded hospital system. Participants self-funded WLS or received some assistance from group insurance schemes.

disease in its push to promote pharmaceutical and technological cures.

2.4.1 Constructing obesity: Health, trade and governmentality. There have been significant challenges to the thesis that a BMI rating between 18.5 - 24.9 ensures better health than that experienced by persons in higher weight categories¹⁰ (Campos, 2004; Campos, Saguy, Ernsberger, Oliver & Gaesser, 2006; Ernsberger & Koletsky, 1999; Gard & Wright, 2005; Gaesser, 2002; Kassirer & Angell, 1998; Oliver, 2005). In fact, relative mortality has been described as a U curve with persons at both the higher and lower edges of the curve having a greater risk of dying earlier than those towards the centre (Oliver, 2006). Much of what passes as scientific commentary on the obesity epidemic are “speculations delivered with an air of certainty” (Gard & Wright, p.5).

With obesity constructed as a major disease of the modern lifestyle with health effects that may exceed those of smoking (Marshall, 2004; Mokdad, Marks, Stroup & Gerberding, 2004; Ogilvie & Hamlet, 2005) intervention and treatment are validated. This has ensured the acceptability of surgical interventions (Dowling, 2008; He & Stubbs, 2004; Livingston, 2007; Mitka, 2003). The rhetoric of causal connections between weight and health are caught within a complexity of structures that layer society. But the lay public depend on professional medical interpretation of signs and symptoms including the weight/health equation. Sweeping statements are made about the problems caused by weight gain in relation to mortality or morbidity, and much is made of the economic, social and personal costs of gaining weight. This is rhetorical shorthand, assuming and subsuming (Fontana, 2000) the complexity of issues and problems surrounding social problems. As long as connections between obesity and disease appear substantiated, then the entitlement of researchers (or journalists, fellow citizens or medical professionals) to make social commentary or moral judgements remains virtually unquestioned, indeed unquestionable (Gard & Wright, 2005). In the history of the institutions, in the growth of practices and especially in changed beliefs about weight lie contributions to a layering of hegemony (Fontana, 2000) through which commonsense accounts develop. Such accounts lose sight of the myriad of forces that have coalesced in the evolution of those beliefs and practices. Such accounts affect any citizen’s ability to access or contribute to a counter-hegemony, specifically here in relation to weight and health.

¹⁰Internal critique of CDC research into obesity-associated mortality was described by Marshall (2004) as, “loosey goosey” (p. 804).

BMI constitutes a central mathematical equation in the determination of the health status of individuals and populations. An astronomer in the 1800's, Quetelet, developed the BMI as an application of statistical laws to predict human behaviour (Campos, 2006; Czerniawski, 2007; Oliver, 2006). It has become the most frequently cited and common method for classifying human weight. Quetelet plotted height and weight along a normal distribution curve, the Bell curve, with the weight of those closest to the middle being proportional to their height squared (Oliver). Employing the existing practice of political arithmetic, Quetelet delineated a social system based around the ideal of the average man: Thus, "[...] the "social" acquired a statistical backbone; as a "system," it also achieved an historical character and political force of its own, separate from anyone's knowing or habitual allegiance" (Schwartz, 1997, p.277).

When average weight, or the middle of the distribution, was conflated with ideal weight, a pseudoscientific step was imbued with political ramifications (Oliver, 2006). The history of this measure has thence been one of differentiation of a normal population from an abnormal, deviant or delinquent population. Dublin, a statistician at MetLife Insurance, constructed insurance actuary tables based on Quetelet's work and the burgeoning insurance industry focused on risky persons. If insurers could determine which citizens were most likely to die early, they could limit cover thereby protecting their business and maximising their profits (Czerniawski, 2007; Oliver). Dublin promoted the descriptive connection between overweight and mortality, and that connection was eventually conflated with causality: "Ultimately, the most influential factor in determining what Americans considered to be overweight was not based on criteria of health but criteria of profit and measurement within the insurance industry" (Oliver, p.19-20).

BMI as a measure of health lacks sturdy criteria by which to determine either the parameters of health or unhealthy weight. In 1998, for example, the National Institutes of Health (NIH)¹¹ revised BMI in line with a prior determination by the World Health Organization (WHO). This resulted in the weight status of millions of Americans being moved from normal weight to overweight (Basham, 2007). The major problem with the WHO document was that it was drafted and written by the International Association for the study of Obesity (IOTF) directly funded by Hoffman-La Roche (maker of the weight loss drug, *Xenical*) and Abbott (maker of the weight loss drug, *Meridia*). As

¹¹ Appendix 2 refers to abbreviations and country of origin for some large organisations.

well, the NIH panel experts were linked with major diet and drug companies (Oliver, 2006). This panel misinterpreted the review on which their report relied as supportive of a link between a BMI of 27+ and mortality from all causes whereas no such association was found (Troiano, Frongillo, Sobal & Levitsky, 1996).

There is increasingly sturdy data that opens current weight/health constructions to considerable debate. As well there is conflicting evidence surrounding WLS options. Failure to clarify either or both of these issues in the clinic makes the operationalisation of fully informed consent for WLS consultation problematic. For instance, physicians are bound to current knowledge and practices even when these may have detrimental effects for patients. In the competitive and politicised environment of medical research, researchers may negatively critique the work of others to support their own (Pearce, 2008). In the clinic, physicians have difficulty relating to alternative information about treatments when these threaten their learned world-view (Pearce). In the medical-science environment, the trade agendas of the large pharmaceutical and medical-technology firms have a strong presence within individual consultation. This influence is demonstrated at all levels of the health system from financial support of academic and research organisations, detailing in the clinics, traders shadowing surgeons in hospital theatres, to participation on national and international boards that determine the health status of populations.

In this next section, I show how the trade in WLS has been built within the direct-to-consumer advertising (DTCA) environment that exists in both New Zealand and the United States. The tactics involved in pharmaceutical marketing¹² have provided a blueprint for medical technology companies, such as Lapband SYS,¹³ to promote WLS in the interests of commerce.

2.4.2 Marketing Weight Loss Surgery in a DTCA environment. By the late 1980s, pharmaceutical companies were exploiting loopholes in the legislation that allowed DTCA advertising of prescription medicines in New Zealand. The regulatory environment was set in place by the 1981 Medicines Act (No. 118) and the 1984 Medicines Regulations (SR 1984/143), though neither the Act nor the regulations stipulated the legality of such advertising (Coney, 2002). Nonetheless, New Zealand became one of only two countries in the Western world that directly (USA) or indirectly

¹² Ethical issues in regard to technologies such as implants are only just beginning to receive attention (Abelson, 2005; Armour et al, 2001; Jones & McCullough, 2002; Jones, McCullough & Richman, 2006; Meier, 2005; Wenger & Lieberman, 2000).

¹³This is the major company promoting lapbands in New Zealand.

(NZ) permitted advertising drugs directly to consumers. The initial use of this loophole by the large international drug companies was a calculated experiment, demonstrating both the profit incentives and the level of sophistication in research that informed new marketing ploys and strategies. This is about “bottom lines,” “market share,” “brand loyalty,” and, “disease creation” (Toop & Richards, 2003, para. 5).

WLS has been marketed on the tail of significant campaigns for selling weight-loss medications. As with WLS, women were targeted in the promotion of weight-loss medications. This has been at considerable cost to women’s health. For instance, one of the longest careers for a weight loss medication was with *Ponderax*, widely available in New Zealand for over thirty years, 1966 - 1997. *Ponderax (Fenfluramine)* was withdrawn from use in the late 1990s on the basis of significant concerns that it was implicated in heart disease. A more modern drug, *Xenical*, was direct-to-consumer advertised in New Zealand as reducing dietary fat absorption by up to 30 percent. This drug continued to be widely marketed as effective even while weight loss with the drug was negligible.

Through the 20th century and into the 21st century, pharmaceutical companies aggressively marketed their products to physicians (Bowman & Pearle, 1988). Leading drug companies have spent more on marketing their products than on research and development (Applbaum, 2006). Physicians have been the traditional target of these endeavours. For instance, access to the AMA database allowed large companies to link in with pharmacy information to determine the prescribing habits of physicians (Fugh-Berman & Ahari, 2007).¹⁴ The AMA profited by 44.5 million dollars in 2006 from on-selling its database. Generosity has been carefully gauged to impact prescribing:

Ahari: "It's my job to figure out what a physician's price is. For some it's dinner at the finest restaurants, for others it's enough convincing data to let them prescribe confidently and for others it's my attention and friendship...but at the most basic level, everything is for sale and everything is an exchange" (Fugh-Berman & Ahari, e 150).¹⁵

Drug and prescription promotion by US pharmaceutical companies in 2000 reached between 16 billion dollars and 25 million dollars (Mizik & Jacobson, 2004; Rosenthal, Berndt, Donohue, Epstein & Frank, 2003).

¹⁴A current and related issue is being followed in Australia (Dearne, 2009).

¹⁵Ahari was a former drug company sales representative.

Individual surgeons, often supported by technology companies, now promote WLS direct to potential consumers. Surgeons have developed glossy websites promoting their surgeries and minimising the experimental aspects and significant downsides of these radical projects. Surgeons trading in WLS are using all of the techniques developed by pharmaceutical companies to promote their practices. The rhetoric that autonomous patients would end up demanding potentially futile treatments and physicians would be unable to deny them (Brody, 1992) promotes the positioning of doctors as professionals with the mandate to interpret and prescribe. What Brody could not have foretold and what is lost sight of in the current concentration on DTCA, is that WLS practitioners in the 21st century successfully use these practices of trading themselves. While DTCA may assist patients to be more informed about treatment and practitioner options, it is also clear that the move to DTCA has been covered over by a layering of rhetorical guises. This includes manifest appeals to the rather compelling notion that such advertising promotes freedom of choice for consumers. What it fails to make clear is that DTCA is advertising to increase profits and market share.

WLS has a significant presence in the media within New Zealand. It has the potential to financially reward large corporations, surgeons and private hospitals. As well, medical researchers in academic environments and other organisations continue to seek funding for themselves, their research and their institutions. This may well lead to significant advancements in health-related research. But when researchers and physicians have complied with corporate demands for publishing only the positive findings for a range of research, efficacy and side effects of particular treatments are suppressed (Dickersin & Rennie, 2003; Dobbs, 2004) with direct effects on patient health.

Underlying experimentation or research is the drafting or coercing of vulnerable populations into medical experiments (Ryan, 1979). This is so even while rates of iatrogenic injury have been noted as a cause for alarm¹⁶ (Australian Patient Safety Foundation, 2000; National Health Epidemiology and Quality Assurance Advisory

¹⁶An adverse event refers to "[...] injury resulting from a medical intervention, not the underlying condition of the patient" (Kohn, Corrigan & Donaldson, 1999, p.4) and an iatrogenic injury in which "[...] unintended or unnecessary harm or suffering arising from any aspect of health care management" (Australian Patient Safety Foundation, 2000, p.32). Wachter and Shojania (2004, p.53) have indicated the rates of iatrogenic injury in medicine: "Although our medical system kills tens of thousands of people each year, we register these deaths one at a time, not by the hundreds, as in airline disasters; and behind closed doors in hospital rooms, not on national television, as when a shuttle orbiter explodes."

Committee, 2006/2007; Runciman et al, 2000). When large drug or medical technology companies provide a high percentage of Continuing Medical Education (CME) packages, often at no charge, then the adequacy of that education is questionable (Blumenthal, 2004; Campbell et al, 2007; Chimonas, Brennan & Rothman, 2007; Kassirer, 2007). A recent trend is to upskill in new technologies through short courses provided by the technology companies. This has given rise to a “[...] drive-through training – the medical version of the “weekend warrior” – for new and complex procedures” (Wachter & Shojanian, 2004, p.151). This is hardly a practice that befits serious surgery.

The contemporary scientific and medical research enterprise has been described as “a technologically muscular medical science” that “possesses on its own no wisdom about when and how it should be deployed” (Bosk, 1999, p.48). Medical experimentation and medical science in the service of trade have been opened-to-view through medicine’s outliers in many fields, particularly philosophy, medical sociology and the media. Harrington (2002, p.215) has referred to this as a “coalition of the laity.” As well, an increasingly public voice from within medicine has begun to question the operation of commercial practices within medicine and advocated breaking the bonds between academic medicine and commercial concerns (Brennan et al, 2006). Brennan and Mello (2008) have described the failure of self-regulation by large companies in relation to payments to physicians. Medical writers have indicated the ubiquity and diversity of these financial associations (Angell, 2000) and called for mandatory reporting in relation to medical research. The safety of patients and the reasonableness of patient trust in ethical doctor/patient relationships are at issue.

2.5 Moving to protect the patient.

In the 21st century, commerce and media impact health decisions, particularly in relation to weight reduction diets, drugs and surgeries. When patients attend a consultation in relation to their weight, they rely on the physician or surgeon to be professional – competent, up-to-date, and ethically motivated. But this is a complex environment in which medical decisions are made. Patients require more than reliance on the professional ethos of medicine: Regulatory requirements, formal consent processes and codes of ethics may assist in bringing about a safer practice environment and ensure informed decision-making for health by patients who seek or require medical interventions. However it is the construction and targeting of the risky self (Lupton, 1999; Nettleton, 1997) that requires attention when the ‘risky’ self promotes

acceptance of risky interventions. Even the training aspects¹⁷ of, and individual reactions to, new interventions, have their own history of considerable risk.

In following sections, I trace the emergence of certain protections in law and codes of professional practice developed to cover the inevitable downsides of research on, and new interventions with, citizen/patients. I reflect on the significance of the inquiry into care for cervical cancer patients at National Women's Hospital in Auckland, New Zealand, (Cartwright, 1993; Coney, 1988; 2003) for the development of codes of practice for New Zealand doctors and the protection of New Zealand citizen/patients.

2.5.1 The science of law and the science of medicine. In New Zealand, a *Public Health Amendment Bill* (Ministry of Health, 2007) was proposed that included the potential for a Director-General of Health to issue codes of practice in regards to causes of non-communicable disease such as diabetes and then to regulate if the code did not appear to be achieving its goals. In describing public risk trumping individual freedoms (Bailey, 2008), this proposed Act was described as ushering in “the supermarket strategy” (Bailey, B3) of government. For example, certain food items could be deemed sufficiently risky for control by ministerial decree. While the modern citizen/patient retains its neo-liberalist definition as one with agency over their life and health, governmental surveillance and the threat of legal intervention run alongside, all the while proclaiming the hegemony of the individual citizen as agent. It raises the spectre that the very availability of WLS surgery for patients within the New Zealand public hospital system may lead to the requirement for specified patients to undergo these procedures. Failure to comply may risk denial of access to a range of health or other public goods. New technologies such as WLS create new enactments of moral responsibilities. As Ettore (2002, p.83) wrote of reproductive genetics, “In the feminised regimen of reproductive genetics, women enact a morality of the body which upholds the external population's standard.”

A range of legal apparati provide a regulatory framework within which modern medicine retains the power to contain (as in compulsory care orders for psychiatric patients), to restrain, or to treat. A conference in 2006, entitled *Obesity: Should there be a law against it*, explored possibilities for regulation to intervene in the obesity of individuals and the obesogenic environment (Magnusson, 2008c). In the acceptance of the epidemic nature of obesity, public health law emerges as a tool to manage lifestyle

¹⁷The problems of learning new procedures and applying WLS procedures after very short introductions will be referred to in the data chapters six to ten.

(Gostin, 2007) and to intervene in disease prevention (Magnusson, 2008a; 2008b; 2008c). Gostin's model delineates eight areas for possible legal interventions. These include: tort liabilities; taxing and expenditure on health, including forms of surveillance; mediated information campaigns; designing and altering the built environment; and, responding to health inequalities by legislating to ameliorate socio-economic disparities.

In a societal commitment to medicine-as-science, experimental and radical treatments have been progressively normalised. From the study of cadavers to the study of living bodies, medical objects have been surrounded by scientific rules to determine their correct perception (Foucault, 1975; 1988). The call for medical treatments to be available for all French citizens was made in the wake of the French Revolution in a move to democratise medical treatment. This move was accompanied by the rather less well-known corollary that citizens would make their bodies freely available for experimentation in life and dissection after death (Weiner & Sauter, 2003). This early influence from Paris in relation to accessible bodies for anatomo-clinical experimentation and surveillance of the course of a disease has lingered. While codes of ethics are based within law, the interpretation of ethics and medical law has traditionally supported the professional medical view. The pull to progress of medical science has historically diminished rather than promoted the essential primacy of the *relational structures* of the doctor/patient relationship. This is evident in practices of informing consent that have faltered even in the presence of significant legal regulations.

A myriad of attempts to delimit medical practice and control experimentation by producing codes and standards of care and responsibility, both from within and outside of medicine, have proliferated. Significantly, the Nuremberg Code,¹⁸ the Declaration of Geneva,¹⁹ the Helsinki Declaration,²⁰ and the Belmont Report²¹ have provided an

¹⁸The "Nuremberg Code" of 1947 stated 10 principles to govern the ethical practice of research on humans, insisting on strict conditions of consent (Anonymous, BMJ, Nuremberg, 1996, p.1448).

¹⁹The "Declaration of Geneva" in 1948 set out the requirements of ethical conduct of a medical practitioner's duties to their patients (WHO, 1948/2002).

²⁰The "Declaration of Helsinki" was produced in 1964 by *The World Medical Association*. It softened the requirement for consent to one of obtaining it "if at all possible." This declaration has been revised and clarified on a number of occasions with the primacy of duty centred on the individual rather than on goods pertaining for society as a whole, with best care taking precedence over potential gains from experimental practice. This was published again in 1996 by *The World Medical Association* (Anonymous, BMJ, 1996, 1448-49).

²¹The "Belmont Report" was entitled the "Ethical Principles and Guidelines for the Protection of Human Subjects of Research." Produced by the United States Department of Health, Education, and

international backdrop to the practice of medicine as a science in the second half of the 20th century. Such delimiting has met with strong resistance on two particular accounts from within medicine: The erosion of medical professionalism based on strong ties with scientific methods; and, the requirement for willing bodies for experimentation in the interests of progressing the health of humankind.

The latest patient/body is that of the WLS patient. Having been encouraged to participate in WLS projects, citizen/patients are subjected to the vagaries of uncertain outcomes, bodies ripe for experiment and training. In preparation for concerns raised in the data chapters about informing consent for experimental WLS procedures, I turn now to discuss the practices of informing, and obtaining consent from, patients and subjects to participate in medical trials and new or experimental treatments.

2.6 Coding professionalism: Ethics and consent

Medicine has a limited ability to cure. Hippocrates, focussed on the health of the patient in front of him, admonished his peers not to experiment or resort to heroic medicine (Lloyd, 1978). A declaratory statement by Hippocrates remains foundational to codes of medical practice: that is, that the duty of the physician lay in treating the patient by helping and doing no harm (Katz, 1996). While experimentation was acceptable to Hippocrates, experimental practice was to be focussed on curing or ameliorating the condition of the particular patient. There was no suggestion that a patient should be called on to sacrifice their body or health for the sake of others. Modern professional ethics, distinguished by Percival from the narrower medical ethics, were conceived in response to the outrage when the Manchester Infirmary refused entry to patients in the midst of an epidemic in 1792 because its staff members were in dispute (Baker & Emanuel, 2000).²² John Gregory and Thomas Percival were physician-ethicists who, in the 18th century, envisaged medicine as a profession vested with the moral duty of caring for the sick, a caring invested in the profession as a whole rather than in its individual practitioners. As the fiduciaries of their patients (McCullough, 1998), medical professionals were required to be competent and willing to challenge their own beliefs; to serve their patients,²³ setting aside self-interest with

Welfare in 1979, it iterated the need for respect for persons, beneficence which maximised research benefits while minimising harm to people and ensuring non-exploitative and reasonable procedures.

²²A colour etching entitled *Doctors Differ and their Patients Die* recorded this event (Baker & Emanuel, 2000, p. S15).

²³Patients include the “sick poor” treated in hospitals (Baker & Emanuel, 2000).

responsibility to peers²⁴ taking a very secondary place; and, medicine was to be practiced as a public trust (McCullough, 2004). The American Medical Association (AMA) adapted aspects of this code in 1847 (Baker & Emanuel; Rothman, 1991).

The legal delineation of “informed consent” appeared in 1957 in an *amicus curiae*²⁵ brief filed by the American College of Surgeons in *Salgo v Leland Stanford University*. The law drew on exemplary cases to contribute to the development of common law practices around consent in the US (Faden, Beauchamp & King, 1986). The history of informed consent refers to medical experimentation in Nazi Germany, a range of deceptive and harmful experiments, legal cases questioning interventions, the history of paternalism in medicine and the growing emphasis on the enactment of autonomy. While there is a history of academic attention to obtaining consent from patients within medical practice, the clinic and the laboratory, the reasonable achievement of informed consent has been affected by the narrow contexts of its practice. Although the citizen/patient should not experience unwanted contact (Faden, Beauchamp & King), the practice of consent relied on a set of physician behaviours in which material risks and benefits would be disclosed. Patient consent has tended to be limited because physicians determined the extent of disclosure (Katz, 1984). The relative value of patient autonomy has been restricted by culturally supported medical paternalism in a range of epithets such as “the doctor knows best.”

In the 20th and early 21st centuries, attempts to delimit medical practice by producing codes and standards of care and responsibility both from within and outside of medicine have proliferated. The *Nuremberg Code* is often discussed as the first document to set out explicit rules around clinical practice, human experimentation and the gathering of consent to participate (Vollmann & Winau, 1996). But a Prussian directive in 1900 had expressly prohibited non-therapeutic research without unequivocal consent with a second set of guidelines published in 1931. In the 1931 version of regulations on new therapies and experimentation, the Reich Health Council demanded that clear, unambiguous consent be obtained for all therapeutic and non-therapeutic research in human subjects. Both sets of regulations owed more to “critical public discussion and political debate” (Vollmann & Winau, p.1447) than to concerns about patient rights or safety expressed by medical professionals. The *Nuremberg Code* was “buried soon

²⁴Any priority formerly given to peers became secondary to practitioners’ duties to their patients thus “[...] inverting the tradition, set by the Hippocratic Oath” (Baker & Emanuel, 2000, p. S.14).

²⁵*Amicus curiae* briefs may be filed when matters of public interest are at stake.

after its birth" by American doctors who were considered to be deserving of "deference and encouragement, not oversight and outside management" (Hornblum, 1999, p.235). The *Declaration of Geneva*, the *Helsinki Declaration*, and the *Belmont Report* have provided an international backdrop to the practice of medicine as a science in the second half of the 20th century. As with the *Nuremberg Code*, these codes and practices were considered both unnecessary and too restrictive in relation to progressing medical science.²⁶

Bioethicists have suggested that there was a paucity of standards surrounding human experimentation until this was rectified in the mid-1960s (Martensen, 2001). An alternative account is at least as viable. In the presence of considerable standards for ethical practice, if physician/experimenters then chose to behave poorly, this was due, not to the lack of ethical standards but to the personal decisions of physician experimenters to disregard those standards, in the knowledge that they would evade sanctions. The privacy and professional privilege operating in experimental arenas and clinical practice have allowed the obligations imposed by an international regulatory environment to be disregarded. In New Zealand, for instance, these regulations did not avert significant harm to women as demonstrated by experiments with carcinoma in situ, beginning in 1955 at National Women's Hospital in Auckland (Anonymous [TV3 News], 2008; Bunkle & Coney, 1987; Cartwright, 1988; Coney, 1988; Jones & Fitzgerald, 2004; Phibbs, 2000).

Rather than doctors needing to prove themselves worthy of trust, patients have long been required to trust their doctors (Katz, 1996).²⁷ Persuaded by their trust in medical professionals and belief in medical science, patients may make personal sacrifices in the name of scientific progress. Yet medical progress appears often to be valued over the safety of patients. This was demonstrated, rather ironically, on the fiftieth anniversary of the doctor's trial at Nuremberg. Katz (para. 7) recalled one "distinguished" surgeon as saying: "[Conducting] controlled studies may well sacrifice a generation of women, but scientifically they have merit." It is the duty of the practitioner to have a "[...] responsible, non-experimental, definitive dealing with the subject himself [and that] not even the noblest purpose abrogates the obligations this involves" (Jonas, 1969, p.219).

²⁶ In 2008, the FDA decided that research studies submitted to it for review would not need to meet the standards set by the Declaration of Helsinki: "They must only follow the industry-sponsored Guidelines for Good Clinical Practice outlined by the International Conference on Harmonisation (Annas, 2009, p.2050).

²⁷ Hence the softening in consent requirements for the *Declaration of Geneva* in 1964.

The bedrock principle of medical ethics is the promotion of the wellbeing of the individual patient.

A major obstacle to the achievement of best interests of patients lies at the interface of medical science with agendas of trade. While it may be argued that the best interests of patients lie in progressing medical science, the complex relationships of medicine with commerce complicate this relationship. The primacy of respect for persons, as subjects and patients, has been breached in the interests of advancing scientific medical knowledge (Katz, 1996) and in the service of a variety of political, social and personal agendas. When Kligman entered Holmesburg prison for the first time, he did so as a physician to attend to prisoners who were suffering from athlete's foot (Hornblum, 1999). As he walked through the gates of the prison, he recalled this experience: "All I saw before me were acres of skin. It was like a farmer seeing a fertile field for the first time" (Hornblum, p.37). This was the beginning of over twenty years of experimentation in this Pennsylvania prison using a vulnerable population.

Practices in the clinic have been co-opted in the service of medical science, individual cases enumerated and eviscerated for their clinical material, 'interesting' cases in the service of knowledge, politics or reputation (Harrington, 2002; Rothman, 1993/2003). While some patients have been encouraged to make sacrifices in the service of scientific knowledge and the 'interests of mankind,' others have been coopted without their knowledge or consent. Notwithstanding codes of ethics nor the experiments which occasioned Nuremberg, the search for warm bodies (Shah, 2006; 2006a) has continued in Western countries: The Tuskegee syphilis study (Beecher, 1966; Bosk, 1999; Hornblum, 1999; 2007; Katz, 1996; Ryan et al, 1979; Sharav, 2001; Shah); the intradermal injections of live human cancer cells into 22 chronically ill, debilitated non-cancer patients in 1963 at the Jewish Chronic Disease Hospital (Beecher; Lerner, 2004; Standler, 1997); between 1963 and 1966, healthy retarded child residents of Willowbrook were intentionally inoculated, orally and by injection, with hepatitis and monitored to gauge the effects of gamma globulin in combating it (Beecher; Bosk; Sharav); the failure to treat carcinoma in situ in the National Women's Hospital inquiry (Cartwright, 1988; Coney, 1988); the 1996 medical experiment conducted by Pfizer researchers in Kano, Nigeria, during a major meningitis epidemic,

in which physicians followed the research protocol rather than vary treatment to treat and prevent death (Annas, 2009).²⁸

Kligman was quoted as saying, “I damned near killed people [before] I could see a real benefit [...]. Everyone of them got sick” (Hornblum, 1999, p.214). When scientific falsification is the paradigm, mishaps and trials may be accepted as reasonable in the development of skills, knowledge, cures and trade. But I problematise benefit when it accrues mainly to large corporations, academic institutions and a variety of other individuals.

2.7 The autonomous patient as a limited conception

The modern conception of the autonomous, agentic patient impels notions of equality in relationships of consultation. Yet the category of patients-as-agents is always destabilised by the vulnerability inherent in being sick. The sick person becomes a supplicant, seeking help or access to information, drugs or technologies. Patients seek well-informed advice on appropriate interventions believing that doctors act out of best knowledge, best practice and especially out of the best interests of the patient. Patients’ beliefs are evident in the implicit value questions: “What should we do?/What would you do?” (Baylis & Downie, 2001, p.20). Women constitute, in medical terms, a self-evident vulnerability, signalling dependency in the relationship. In turn, dependency may be used to justify paternalistic intervention (Shildrick, 2000). Gendered bodies remain subject to discrimination in consultation even in the face of strong challenges to such practices (Bunton, 1992; Hyde, 1999; Murray, 2005; 2005a; 2005b; Norsigian, 2005; Sherwin, 2007).

Until the 1970s, healthcare ethics were predicated on maximising the benefits to patients (beneficence) and the minimisation of harm (non-maleficence) (Beauchamp, 2007). Bioethics developed in response to issues of morality related to a dramatic rise in pharmacological and technological intervention for the improvement and extension of lived lives. Promulgated in the media, medical miracles brought “costs, pain and disappointment” (Jonsen, 2007a, p.51) and moral discussion centred around difficult cases such as Karen Quinlan²⁹ (Jonsen). In the following ten years, bioethics developed a formulaic morality taking medical ethics from its base in beneficence to a nesting

²⁸Kligman was recently applauded for his contributions to dermatology research and patient care (Stanley, 2006). Goldfarb (2006, p.3) used the celebration of Kligman’s career to argue the need for “[...] clearer guidelines on authors with unethical track records.”

²⁹Considerable debate and the intervention of the US courts surrounded the case of Quinlan who remained in a permanent vegetative state for about ten years. The arguments surrounded who had decision-making authority over such patients.

within autonomy and social justice (Beauchamp & Childress, 1979). Acceptable, 'lawful' behaviour in medical practice is now framed by four main principles: Autonomy with its respect for individual decision-making; non-maleficence with the avoidance of harm; beneficence based on a judicious balancing of risks with benefits; and, the appropriate social distribution of the benefits of medical science (Beauchamp, 2007).

The essential moral enterprise of medicine is about caring for the patient. When an intervention such as WLS is being considered, doctors must clearly advocate for interventions with an absence of net harm, because harm vacates beneficence (Cullity, 2007). Beneficence is the active promotion of the welfare of the patient and the furthering of a patient's medical interests in relation to their overall interests. Even when patients may "press forward to the edge of [...] imprudence" (Sidgwick, 1907, as cited in Tyler, 2007, p.36) in relation to their health, the medical practitioner needs not to assert what the overall interests of any patient might be (Cullity).

Patient rights are increasingly predicated on neo-liberalist understandings of the doctor and patient: These are seen to be free and autonomous individuals choosing to participate in a scientific-medical endeavour with largely unquestioned benefits for patients. Patients-as-agents are required to make choices about lifestyle and medical interventions. A paternalist underpinning and the unequal positionings of doctor and patient tend to be lost from view. The doctor provides a service for which s(he) is qualified by dint of specialised training; medical service gains financial recompense (public or private); the service is contractual on the provider. While doctors prefer well patients (Stimson, 1976), patients tend to present in the belief that they are unwell or require medical attention, prevention, or intervention.

The neo-liberalist conception of patients as autonomous agents promotes an expanded vision of citizens' freedom to choose. Any restriction imposed by the practitioner becomes a violation of the obligation to respect a patient's autonomy (Pellegrino, 2004). Doctors have long argued that there is a difference between outright lying to their patients and deception (Benn, 2001). Deception includes the manipulative effect of withholding access to appropriate technologies until the patient has complied (Daly & Willis, 1987; Hyde, 1999). The potential for manipulation lies also at the base

of the argument over the use of the placebo effect.³⁰ Deception speaks to the unequal relationship between the doctor and patient and violates the moral basis of the relationship. Consultation under optimal conditions ensures that patients may choose, or decide against, medical interventions (Brazier, 2003). Autonomy as a principle within healthcare ethics requires the securing of fullest, voluntary and informed consent to a procedure or treatment (Stoljar, 2007).

2.8 Problematising informed consent

Informed consent is foundational to best practice in health care and underscores the importance of enabling "a reasoned decision about his or her treatment" (Gillett, 2004, p.72). It is not a fixed doctrine. The modern practice of health care – clinical and research – raises questions about the primacy of informed consent, how it functions in practice, whose interests are served by it, with significant implications for patient trust in medical professionals.

The hegemony of medicine as science has been accompanied by support from the courts. In English law, medicine has historically been treated as scientific, "dynamic" and "experimental" (Harrington, 2002, p.217). Judges accede to medical authority in legal decision-making (Hurwitz, 2004; Montgomery, 1989; Samanta & Samanta, 2003). In medical negligence trials, for example, judges were loath to disturb such notions as doctors having access to specialised knowledge that neither they nor patients could be expected to understand; that physicians were altruistic professionals deserving of trust; and that citizens might well be expected to pay a price in the service of progress (Montgomery; Rothman, 1991/2003). Withholding information from patients to gain their consent has at times been described as a beneficent act in the patient's interests (Manson, 2007). Arguments continue to surround how much information and the nature of the information that patients require in relation to their medical condition, proposed interventions or the quality and experience of the practitioner. For instance, in this present research, I have already indicated that informed consent processes could be compromised by failing to discuss the tenuous weight/health connection; the experimental nature of WLS; the significant side effects of such surgeries including, for

³⁰“The mystery of the “placebo effect” is dispelled by calling the placebo by its rightful name – a lie” (Szasz, 2008, 0). Excluding the patient from information regarding treatment carries elements of deceit and paternalism, whether or not the patient may be considered likely to gain benefit. There is a clear “risk and burden” that accompanies placebo interventions especially in relation to sham surgeries (Biller-Andorno, 2004, p.48).

example, some substantially negative effects on glucose tolerance (Roslin et al, 2009); and, the trade and collegial interests involved in relation to it.

Clearly current practice in relation to informing consent and best care is framed by legal judgements. However, when a clinical practice such as WLS becomes the subject of complaint,³¹ breaches may be decided on the basis of opinions provided by medical peers. In *Common Law*, the Bolam test (*Bolam v Friern Hospital Management Committee*, 1957) set the standard of care as a matter of medical judgement based on the principle “that a doctor does not breach the legal standard of care, and is therefore not negligent, if the practice is supported by a responsible body of similar professionals” (Samanta & Samanta, 2003, p.433). Recent cases have relied on two often-cited cases. In *Bolitho*, it was argued that healthcare professionals could not be held to have been negligent if medical peers supported the approach in question (Elliston, 2006). The Australian case of *Rogers v Whitaker* (1992) demonstrated a shift in emphasis. The practitioner needed to warn the patient of any material risks inherent to the proposed treatment (Marks, 2003), having “a fair dinkum duty of disclosure” (Chalmers & Schwartz, 1993, p.139). While expert evidence remains crucial in relation to medical negligence, it cannot be the law that even if “all or most of the medical practitioners in Sydney habitually fail to take an available precaution to avoid foreseeable risk of injury to the patients, that none can be found guilty of negligence” (*Albrighton v Royal Alfred Hospital*, 1980, in Hurwitz, 2004, p.1025).

Medicine has promoted its science, defined by an aggressive approach to the control of disease and disability under the rubric of progress. Although medical knowledge has developed practices verified by biomedical research (Malterud, 2001), such research is not routinely credible and reliable (Hurwitz, 2004). Evidence-based practices may be “Bolam defensible,” though not enforceable (Hurwitz, p.1024). Practising outside of best-practice guidelines could therefore result in censure just as the “slavish” use of such guidelines could amount to poor practice if patients were harmed (Hurwitz, p.1024).

Choices operate within the limits of what is available (Bourdieu, 1990). The protection and benefit of the quasi-autonomous patient relates to choices that are influenced, shaped and steered, even while those choices may not appear to be limited or coerced (Sunstein & Thaler, 2003). Childress (2007) has advocated for a weak form

³¹The reader is referred here to a complaint about research on nips of liver detailed in chapter 10.

of paternalism meaning that doctors would be protected for promoting drug treatment or WLS for weight-related issues. While coercion requires ethical justification, beneficence-based actions are not seen as coercively persuasive and therefore breaching patient autonomy.

Such a weakening of the concept of patient autonomy paves an opening for paternalistic promotion of a variety of clinical interventions. Consent would require a patient's trust in the relationship rather than the fullest information on a proposed procedure; patients may not be encouraged to gather information by questioning; procedures may be promoted even when they are not medically indicated; exploitation of patients may result. For instance, the price paid for an intervention may be incommensurate with any advantage accruing to the patient; vulnerable groups may be subject to manipulation; a characteristic of a patient may be used for profit, even in the presence of consent and where no harm has occurred; and, the exploited party receives less benefit than that accruing to the user (Wertheimer, 2007).

Financial incentives are inducements that detract from autonomous consent-giving. In the United Kingdom, the General Medical Council (GMC) advised against offering incentives to induce experimental research risk-taking that potential participants otherwise would not take (GMC, 2002, S14). When the bodies or body parts of citizen/patients are used as a basis of trade, the value of that body becomes instrumental rather than intrinsic. The person is objectivised, instrumentalised and interchangeable with any other person. Using people in such ways influences the very construction of what is a reasonable intervention.

The ethics of professional practice around the trade in WLS requires investigation. In particular, this is about the quality of consent, the degree of harm occasioned even in the presence of consent, and the effect of these interventions on the overall health and welfare of individual WLS patients. This present research reflects on care and informed consent for yet another set of women patients in New Zealand. The Cartwright Inquiry, and ongoing activities to improve the positioning of patients vis-à-vis practitioners, provides an important context for this present study.

2.9 The provision of patient care in New Zealand: The Cartwright Enquiry

The current legislative environment for medicine in New Zealand was instituted in the wake of what is referred to as *The Cartwright Enquiry*. This inquiry investigated allegations regarding the treatment of cervical cancer patients at the National Women's Hospital in Auckland (Cartwright, 1988). These allegations first appeared in an article

in *Metro* (Bunkle & Coney, 1987). The article related to inadequate treatment and experimentation with or without the consent of informed patients (Skegg & Paterson, 2006). Judge Cartwright's report in 1988 indicated the urgent need for specific legislation to protect patients and to restrain medical practice: Following the issuing of this report, Common Law was interpreted for the protection of New Zealand patients, the "consumers"³² of health care. Protections for patients have been disseminated in *The Code of Patient Rights*.³³

In New Zealand, the public was alerted to the operation of medical experimentation and its primacy over the care of some patients:

One woman had 44 smears taken over 22 years, 24 of which showed malignancy. She had fifteen biopsies and eleven general anaesthetics during this period without being told that there was anything wrong (MacDonald, 2006, p.266).

Within New Zealand, the Cartwright Inquiry and *The Cartwright Report* (1988) were perceived as a threat to the traditional hegemony of medicine. Professor Green (1970) clearly understood that leaving Carcinoma in Situ (CIS) untreated was potentially harmful to his patients but he continued to do so for research purposes. Indeed, a classic study by Petersen (1955) in which 33 per cent of 127 women with abnormal cervical cells developed invasive cancer was basic to international practice during the period of Green's research (Cartwright). Significantly, Green's clinical freedom was protected by many of his peers who preferenced their professional duty to one another over care for these patients (Cartwright; Coney, 1988; MacDonald, 2006; Phibbs, 2000). Some medical professionals supported an inquiry and were prepared to speak against the practices at National Women's Hospital (McIndoe, McLean, Jones & Mullins, 1984; Jones & McLean, 1986). Experts at the Inquiry referred to 21 years of experimentation on one patient as "terrifying mismanagement" (Matheson, 1989, p.185; Cartwright, p.90). Kolstad commented, "Dr Green has certainly proved that his fanatic belief that CIS is a harmless disease is a severe mistake" (Cartwright, p.89). The Head of

³²A health consumer is referred to in *The Health and Disability Commissioner Act* (Crown Entities, 1994, p.7) as "any person in respect of whom any health care procedure is carried out." A health care procedure is then defined as "any health treatment, health examination, health teaching, or health research administered or carried out on or in respect of any person by any health care provider; and includes any provision of health care services to any person by any health care provider."

³³The Code of Health and Disability Services Consumers' Rights became law on 1 July 1996 under the Health and Disability Commissioner Act (Health and Disability Commissioner, 1996). It confers rights for all consumers of health and disability services in New Zealand and obligations on providers for those services. The Code has been reviewed twice (in 1999 and 2004), and one change was made in June 2004, to substitute a new version of Right 7(10), re consents relating to the use of human tissue.

Department and Chairman of the Ethical Committee at Auckland Women's Hospital, Professor Bonham, attempted to prevent the review of CIS patients at National Women's Hospital (McIndoe, McLean, Jones & Mullins). This was the paper that informed the *Metro* article (Bunkle & Coney, 1987) leading to the Inquiry (Cartwright, 1988).

Hostility by some doctors acted to prevent some patients and doctors from speaking about what had happened. Some doctors showed little respect for the inquiry on the basis that it was instigated by women and headed by a woman judge:

How the strident claims from a couple of feminists, and the findings of a woman judge, can warrant the replies we have seen in the press and television, I do not know. Who is going to have the decency to defend those under attack (Anonymous, NZMA, 1988, Letter to the Editor)?

And:

The Cartwright Report was the end result of a pre-determined witch-hunt, a collusion of two well-known feminists of the 'take the power from the docs' (Anonymous, NZMA, 1988, Letter to the Editor).

Professor Green refused initially to participate in what he termed a "witch hunt" led by women (Matheson, 1989, p.142).

In order to frame the discussion of informed consent and medical care in relation to WLS in New Zealand, I introduce the structure of the New Zealand health system. I indicate legislation that interprets common law for the protection of New Zealand patients, as consumers of health care.

2.10 A legislative framework for medical care in New Zealand: After Cartwright

Through this thesis, I refer to the legislation and codes that were occasioned in New Zealand by Green's cervical cancer experimentation. I depend for some interpretation on Skegg and Paterson's (2006) *Medical Law in New Zealand*. Whether patients consult medical practitioners in the public or the private health systems, they may expect treatment that meets the standards of care developed in *The Code of Health and Disability Consumers' Rights 1996* (HDC, 1996), based at common law, and *The New Zealand Bill of Rights 1990* (Crown Entities, 1990). While *The Code* clearly sets out patient rights to best care and informed-consent processes, I briefly point to some areas of potential slippage between the legislative framework and the day-to-day practices of quality of care and fully-informed-consent processes. Legislation and codes may act to encourage meeting some minimum standards. However, I suggest that best care standards will more likely emerge in an environment in which ethical practitioners

absorb and act out of relational values. Specifically, informed consent is based on concerns about the autonomous patient who may be assisted to make a rational choice from available options with adequate information and a lack of coercion. While attention to ethical principles may ensure some basic approximation of informing consent as an ongoing process, it does not attend to the oppressive context in which the consent is procured nor does it attend to important relational aspects of women's decision-making. Consequently, when advice is sought about undergoing any procedure, the effacement of the practitioner lends an air of objectivity in which the basic questions women are asking such as "what do I need to do?" and "What do you recommend?" are never attended to. These are relational aspects of decision-making that would clarify the context in which these decisions are being made and insist on real engagement for practitioners with the lived experience of their patients in ways that benefitted both.

Health service provision in New Zealand is funded within a tax-based system framed by *The New Zealand Health and Disability Act 1994*. The public health system delivers 120,000 elective surgeries and this is supplemented by an expanding provision of care through private hospitals and clinics that perform 150,000 elective procedures each year.³⁴ The private health system is supported by fee-paying individuals, by patients with private medical insurance³⁵ and by public funding of elective procedures in the private system. There is some division between the public and private systems, with the provision of emergency care and some treatments being provided solely through the public system. As well, though, surgeon and specialists often operate within both systems; patients may choose to consult a specialist in the private sector but then choose to have their procedure, via a waiting list, in the public system; public funding may be made available for surgeries in the private system as in some WLS (Ryall, 2009); and, treatments for some patients have been accepted for cover under ACC regulations.

New Zealand citizens access their health care in an environment of government compensation for injuries sustained in treatment environments without regard to gravity, rarity or fault needing to be proven. ACC is New Zealand's no-fault accident compensation scheme that came into being on the 1st April, 1974. This is presented as a "social contract" between the state and New Zealand citizens to compensate them for

³⁴The present government in New Zealand is moving towards contracting for more publically funded elective procedures in the private sector of medicine (Ryall, 2009).

³⁵Patients holding private medical insurance in New Zealand decreased from about 40% of men and women in 1996/1997, to just over 37% in 2006/2007 (Ministry of Health, 2007a).

injuries sustained as the result of accidents and includes iatrogenic injuries: It “[...] boldly extinguished the right of New Zealanders to bring civil claims for damages for personal injury against wrongdoers” (Manning, 2006b, p.680). In 2005, medical misadventure,³⁶ which included medical error, was replaced with a category called treatment injury. Given that this category includes both serious and minor iatrogenic injuries, an increase in claims was expected because the patient no longer had to prove rarity and severity (Braddell, 2005) as required under the former provisions.³⁷ Given some reported levels of iatrogenic injuries elsewhere³⁸, it is difficult to understand why medical misadventure claims comprised only 0.05 percent of all injuries accepted under the scheme in New Zealand.

The legislative environment in New Zealand provides a regulatory framework for the safety and quality of health care provision: The Health and Disability Commissioner has become “the one stop shop” (Paterson, 2006, p.22) for complaints about patient care. Legislation includes *The Health and Disability Commissioner Act 1994* and its associated code of patient rights; *The Health and Disability Services (Safety) Act 2001*, that seeks to ensure reasonable and consistent standards of safety amongst providers of care. This act specifies the requirement to report to the Director-General of Health sentinel events that place the health or safety of a consumer at risk, including any police investigation into service provision or any death reportable under *The Coroner’s Act 1988*; the *Health Practitioners’ Competence Assurance Act 2003* provides the mechanisms for ensuring fitness to practice including methods for making health professionals accountable for that practice (Paterson, 2006b).

Medical encounters are clearly risk-infused environments. Patients depend on professional standards in relation to care and the provision of quality information in consent processes. As well, practitioners risk a prima facie assault on a patient unless consent is obtained for medical and surgical procedures (Earle, 1999). Under common law a technical assault occurs when any test or procedure involving physical contact is not expressly consented to. *The New Zealand Bill of Rights 1990*, Section 10 (Crown Entities, 1990) prohibits medical or scientific experimentation that is not patient-sanctioned, and does not limit such experimentation to that involving physical contact.

³⁶For a history of Medical Misadventure/Medical Injury provisions under the Accident Compensation Acts beginning in 1972, the reader is referred to *Medical Law In New Zealand* (2006).

³⁷ This provision is again under threat in 2009 with the change to a National government in New Zealand.

³⁸ For instance, a minimum of 44,000 deaths per year is reported in the United States annually to result from medical error (Edmonds, 2004).

The Code of Health and Disability Consumers' Rights 1996 (HDC, 1996) has a crucial role in many areas of New Zealand Medical Law (Paterson & Skeggs, 2002). This code exists under the parentage of *The Health and Disability Commissioner Act 1994* that was itself enacted in response to *The Cartwright Report* (1988).³⁹

2.11 Some critical commentary on legislation for protection of patients in New Zealand

Under *The Code of Patient Rights* a consumer may report a concern about a practitioner though mandatory reporting of competence concerns about professional colleagues was removed from *The Health Practitioners' bill* following representations from professional bodies⁴⁰ (Paterson, 2006). While this omission does not absolve a clinical team member from responsibility for reporting suboptimal patient care, the failure to include mandatory reporting in the legislation demonstrated the power of this medical profession to influence such legislation.

The current legislative framework has sought greater accountability of this professional group to its patients. The practice of accountability is compromised when patients remain vulnerable within the vagaries of a very private, professional practice. It maintains the illusion that doctors are not a group who trade and that they are deemed capable of managing the discipline of their peers, are unlikely to make mistakes, and will not take advantage of patients. Patients trust doctors and believe that 'the' doctor-patient relationship is a good to hold on to. This is a strange notion that doctor/patient relationships have somehow transcended the imperfections and shortcomings of other important relationships in a person's life (Bury, 2004).

It is possible that the doctor-patient relationship has become a rhetorical device that encourages patients to open their bodies in intimate and intrusive ways, and to engage readily and speedily with medical directives. Medicine is based within the superior knowledge base of a trained professional, with power at the heart of medicine's moral discourse (Brody, 1992). Ethical and responsible practice – in relation to informed consent, telling the truth, confidentiality and physician's virtues – are impacted by the way in which this power/knowledge is invoked. A "veil of secrecy" (Paterson, 2006, p.22) surrounds procedures in which practitioners report, review, or carry out remedial activities for poor or detrimental outcomes of interventions. The public do not know

³⁹For a detailed account of the inquiry into allegations concerning the treatment of cervical cancer at National Women's Hospital in 1987, I refer the reader to *The Unfortunate Experiment* (Coney, 1988).

⁴⁰Concerns were expressed by the Association of Salaried Medical Professionals and the NZMA (Paterson, 2002).

which practitioners or what procedures are being investigated or the grounds for such investigations. Practitioners have wished to retain name suppression in disciplinary cases, and historically this has largely been the case. Holt, a former crown prosecutor, has suggested that this has diminished the New Zealand public's right to know in favour of a practitioner's right to privacy (Hayman, 2007). It is clear from the HDC website that a number of complaints concerning WLS have been made. It is not made clear to patients or referring practitioners what procedures and practitioners might need to be avoided.

The HDC has begun to move towards greater transparency in relation to naming health professionals who might present a risk to the public, those who refused to comply with his recommendations, and repeat offenders (Hayman, 2007). This is clearly resisted by some doctors (Frizzelle, 2004). For example, the Anaesthetic Mortality Assessment Committee ceased to function when it was forced to provide information in relation to a manslaughter investigation (Paterson, 2006). The professional argument is progressed that freedom from recrimination promotes openness. This suggests a number of corollaries: For instance, truth-telling is not incumbent on professionals; the protection of medical professionals is more important than protection of patients; professional privilege is a special case, deserving of protections not available to the lay public; and, open processes may lead to truth-telling rather than being essentially face-saving. Given the one stop shop⁴¹ for patient complaints, the public depends on the findings of the HDC. Under section 7 of the Crown Entities Act (2004), the Commissioner is independent of government policy (Health and Disability Commissioner, 2006/2007) though he is clearly responsible to the New Zealand public for the quality of the service he provides. However good the rules and regulations, "the relative coarseness of those rules cannot reflect the subtlety of practice" (Jacob, 1999, p.11). When recourse for advice in complaints depends on professional peers, the status of lay submissions remains problematic.

2.12 In reflection and moving on

In this chapter, I have woven the threads of governmentality, science, commerce, law and the psy-disciplines through the practice of modern medicine in the emergence of biopolitics. I have placed the risky body as being targeted in the name of health and the practice of trade. Medical practice remains enmeshed within practices of

⁴¹In the 2006/2007 year, an associated advocacy service handled over 8,000 enquiries, 4,000 complaints of which 88% were fully or partially resolved (HDC website: Advocacy).

experimentation and the progressive thrust of medical science for the greater good of the society as a whole. In referring to a particular set of experiments that took place at National Women's Hospital in Auckland over twenty years ago, I have demonstrated that rules and regulations have not protected patients from experimental treatments with or without consent.

Weight and obesity have become the focus of highly commercialised practices within medicine. What I indicate through this thesis is the way in which the stigmatised body is used to carry out the trade agendas of corporations and individual practitioners when the weight/health relationship remains unclear and while WLS brings considerable iatrogenic events and side effects. In relation to ongoing experimental treatments such as WLS, I have invoked the legal context within which new legislation was sought and enacted in New Zealand to protect patients. In setting the scene for data chapters seven to ten specifically relating to WLS, the Cartwright enquiry and the enactment of legal protections are clearly pertinent. WLS companies and practitioners target women even while WLS remains a radical, experimental procedure in which there are uncertain outcomes for individual patients and society as a whole.

“Investment in the look is not as privileged in women as in men. More than any other senses, the eye objectifies and masters. It sets at a distance, and maintains a distance. In our culture the predominance of the look over smell, taste, touch and hearing has brought about an impoverishment of bodily relations. The moment the look dominates, the body loses its materiality” (Irigaray, 1978, as cited in Jay, 1994, p.493).

CHAPTER THREE

Weight(y) Discourses

“The discourses of science and medicine are a powerful influence – some would say the most powerful influence – on constructions of the female body, and on what it is to be a woman” (Shildrick & Price, 1999, p.145).

3.1 Introduction

In chapter three I examine literature surrounding encultured weight, health and appearance projects thereby extending the basis for critiquing the gendered uptake and ethical practice of WLS technologies considered in later data chapters. The biomedical model has normalised a singularity in thinking about weight/health: Weight is considered to be a disease and patients need to access cures. However, multiple readings of weight, health and appearance indicate a distinct lack of consensus. This is a sufficient critique in itself to unsettle the unproblematic promotion of radical WLS options for weight reduction.

Agendas of government and trade have coalesced in the increasing commodification of individual health choices around weight and health. The biotechnological age of the 21st century has long held the promise of decreased morbidity of body and spirit and staving off mortality (Rose, 1999a; 2001). This includes increased screening of the population for deficiencies and diseases and supports designing-for-improvement an ever more desirable citizen-body. While there is considerable debate around the use and implications of medical technologies in the manipulation of human embryos, there appears to be a less-troubled acceptance of new technologies to shape acceptable bodies. Although WLS patients may experience some weight loss, this is against a background of significant mortality and morbidity. To paraphrase Pellegrino (2004), is

WLS a truly healing enterprise or a happiness nostrum with surface benefits undermined by its potentially lethal side effects?

It is of particular concern that WLS has been overwhelmingly targeted at and taken up by women. WLS is normalised as a modern health technology but it is clearly problematic if a cultural preference for slim female bodies is gendering clinical decision-making for WLS. What is enhancing and what is therapeutic are complicated.

Essentially, such critiques identify a clear ethical predicament for practitioners who continue to facilitate or recommend extreme projects such as WLS without fully informing consent for these procedures. I begin by examining some key documents promoting the weight/health discourse in New Zealand.

3.2 Discoursing weight for health in New Zealand

By the late 20th century, significant advocacy from national and international medical, media and commercial sectors was promoting the dire effects of overweight according to population health parameters and the urgent need for intervention at a government level. The Agencies for Nutrition Action (ANA)¹ was one such advocacy group. The ANA report (Tustin & Zimmerman, 2001), *Healthy Weight New Zealand, Taumaha Tika Aotearoa*, emphasised the role of poor diet and nutritional status in obesity and co-morbid disease amongst New Zealanders. ANA was an advocacy group, formed in 1996 specifically to promote awareness of obesity and to give guidance in relation to weight reduction and control. Their report was aimed at informing a range of governmental and non-governmental agencies, industry, media and health consumers. Based on analysis of the Ministry of Health's 1997 *National Nutrition Survey* (Russell, Parnell & Wilson, 1999), the executive summary to the ANA report compiled a compelling case about the extent and impact of obesity for New Zealanders. The evidence, historically accumulated from a number of studies of the New Zealand population, was interpreted as a crisis for New Zealand in relation to rates of obesity: This crisis was seen to have originated in the 1970s and was currently described as an epidemic. While the ANA report indicated that the impact of obesity on individuals was negligible, it estimated the cost to the nation as being \$130 million (Tustin & Zimmerman).

¹I have limited my discussion to what I considered some key documents written or funded by New Zealand's Ministry of Health. ANA was a strong advocacy group representing major health societies in New Zealand and in receipt of government funding.

Some key statistics in that report contextualised New Zealand's involvement in a worldwide problem in obesity (Tustin & Zimmerman, 2001). These referred to the alarming 55% increase in obesity among New Zealanders between 1989-1997: One in every two adult New Zealanders was considered to be overweight or obese, with higher rates for males, and the socioeconomically disadvantaged. Being overweight (BMI>25) or obese (BMI>29.9) was considered to carry significant risk factors in co-morbid cardiovascular disease, Type 2 diabetes and some cancers. The report assessed deaths from obesity to be about 1,000, twice New Zealand's road toll.

Obesity prevention and weight reduction were the focus of ANA's efforts based on restricting dietary fats and correcting overall energy intake in relation to levels of sedentary living especially for those susceptible to gaining weight. The report supported intensive monitoring of exercise and restricted food intake to ensure compliance with the goal of losing weight for health. It indicated that environmental factors were acting as disincentives to exercise and promoting obesity. Based on the statistic that 15% of New Zealand adults had a BMI of >30 and that such a BMI was predictive of individuals likely to be "[...] severely affected by their weight" (Tustin & Zimmerman, 2001, p.15), the ANA report directed its focus back on the significant personal and social costs associated with obesity.

In 2004, a report was produced by the Ministry of Health in New Zealand, compiling and comparing the findings of four national health and nutrition studies in an attempt to produce a definitive portrayal of the emergence and persistence of an obesity epidemic² over a thirty-year period. This report, the *Public Health Intelligence Occasional Bulletin No 24, Tracking the Obesity Epidemic: New Zealand 1977-2003* (Tobias, Paul & Turley, 2004) referenced increased weight amongst New Zealanders as a major public health issue connected to "3,200 deaths per year in New Zealand through Type 2 diabetes, ischemic heart disease and stroke" (p.iii). This report supported the concept of an obesity epidemic beginning in the 1970s, with BMI and obesity increasing slowly but showing a sharp rise in the 1990s, and a slowing in the 2000s. While the statistics revealed that rates of obesity were decelerating, the persistence of the epidemic was suggested. The slowing was dismissed as artefactual, possibly reflecting technical

²Gerberding of the CDC in US was reported: "If you looked at any epidemic - whether it's influenza or plague from the Middle Ages - they are not as serious as the epidemic of obesity in the terms of the health impact on our country and our society" (Gibbs, 2005, p.1).

differences between the surveys. New Zealanders still had “[...] no reason for complacency” (Tobias, Paul & Turley, p.xi).

Key results of the 1997 *National Nutrition Survey* were published in a report entitled *NZ Food: NZ People* (Russell, Parnell & Wilson, 1999). Alongside specific diet-related questions, the original study produced BMI scores for all participants, measured blood pressure as the indicator for cardiovascular disease, calculated waist to hip ratios to indicate metabolic disease, and performed blood assays to indicate iron and cholesterol levels. There were some interesting and anomalous findings in this report. For instance, mean body weight increased by 3.2 kg between 1989 and 1997, and the number of citizens classified as obese had risen from 11% to 17%. On the other hand, levels of fat in the diet had decreased by almost two percentage points; more people were reported to be consuming healthy food; mean serum cholesterol levels had fallen, and 7% fewer New Zealanders maintained a total cholesterol level greater than 6.5 mmol/l (Russell, Parnell & Wilson).

The Ministry of Health adopted a strategic approach to improving the health of New Zealanders by reducing obesity. This strategy, called *Healthy Eating-Healthy Action* (HEHA, 2002) focused on nutrition and promoting participation in physical activities. This strategy was accompanied by associated television advertising, newspaper and magazine publicity, and website updates. New Zealanders have been informed that two out of every five deaths each year, or approximately 11,000 annually, are due to nutrition-related risk factors. These include high cholesterol, high blood pressure, overweight/obesity, and, inadequate vegetable and fruit intake (HEHA Newsletter, 2007). Government investment in reports, staffing, websites and other initiatives framed the widespread acceptance within New Zealand that obesity constitutes a major health issue. Reducing obesity has become a major population health objective in New Zealand. In the apparent failure of drugs and diets, WLS began to emerge as an intervention of possibility.

3.3 The WLS experiment: Modern miracle or incipient calamity? The concentration on obesity as a major health issue spawned an associated epidemic in obesity surgery (Steinbrook, 2004; Tessier & Eagon, 2008). For example, in the United States, the number of WLS procedures being performed annually rose from about 16,000 in the 1990s to over 100,000 in 2003; the number of registered

practitioners offering these surgeries increased fourfold (Steinbrook).³ Rates of WLS interventions continue to rise with about 75% of WLS procedures being performed on women (Maggard et al, 2005). I suggest that there is a third epidemic, a bandwagon, ‘me-too’ propagation of obesity-surgery research by surgeons and companies trading in these procedures.

Evidence-based medicine in relation to weight/health remains in question (Cundiff, 2007; Tanne, 2005). Ties to the industry amongst doctors who write treatment guidelines or carry out research affect the quality of medical advice and decision-making within the clinic (Tanne). For instance, the proliferation of WLS series research, supported by technology companies and conflicted by other aspects of trade such as surgeon reputation, impacts understanding of WLS outcomes. It has been suggested that the benefits of WLS have been exaggerated (Mitka, 2003): While the merit of WLS interventions requires quantitative investigations with subject controls and statistical measurements, even so, quantitative research will contribute only limited clinical understanding (Malterud, 2001).

Research into WLS is beset with potential conflicts of interests. This is demonstrated in practitioner/experimenter projects confounding current Australasian work (Dixon et al, 2008;⁴ He & Stubbs, 2004). For instance, some patients who undergo WLS show remission of Type 2 diabetes. But these findings are confounded when they result from uncontrolled surgical series, participant/patients are not randomised, or, the control groups do not receive appropriate interventions (Pinkney & Kerrigan, 2004). One gastric banding study (Dixon et al), contained many of the elements of the ethically compromised pharmaceutical studies. While surgery intervention was shown to be associated with metabolic improvements, this was with a very small group of patients who had early Type 2 diabetes. As in an earlier study out of Monash (O’Brien et al, 2006), qualifying BMI for the surgery and therefore into the study is disputed (Padwal, 2006; 2008). *Allergan Health* made an unrestricted grant available to Monash University and provided the gastric bands free for Dixon’s (2008) research. *Applied Medical* provided the laparoscopic instruments. *INAMED Health*, *Novartis* and the *US Surgical Corp*⁵ supported the Melbourne study (O’Brien et al).

³New Zealand statistics are inaccurate in relation to private WLS uptake (personal communication, NZHIS).

⁴It is unclear what was involved in conventional treatment for the non-surgical group.

⁵Stating potential conflicts does not eradicate bias. Besides the Australian Lap-Band studies (O’Brien et al, 2006) there is also a coordinated series of LAGB studies emanating out of Italy (Angrisani, Favretti,

When a surgery group is compared with a conventional therapy group, it is clearly troublesome if conventional treatment differed in any way between the two groups. Overall, better non-surgical interventions might need to be attempted rather than moving to the surgery option (Padwal, 2006). When conventional treatment is the non-operative comparison, the Hawthorne effect (Mayo, 1975) may be operating. This raises concerns that if any intervention brings some positive effect, then the surgery group could have improved with appropriate and intense non-surgical intervention. Questions remain about the influence of these researchers on the participants and how numbers in non-operative control groups came to languish. In the latest Swedish obesity study, conventional treatment ranged from advanced lifestyle interventions including behaviour modification to no treatment at all (Sjöström et al, 2007). Both the Monash studies had short term follow-up and when meta-analysis is limited to studies of two years or less of follow-up, this clearly limits the quality of the evidence (Buchwald et al, 2004).

WLS research abounds but its calibre is questionable. Consequently, rigorous commentary constitutes an important function in relation to publication of research about radical treatments. Reviews and studies require stringent peer review. When Padwal (2008), for example, reviewed Australasian research he showed a clear bias in favour of surgical interventions for obesity. In suggesting surgery for teenagers with diabetes, Padwal failed to consider that diabetes recurs in 50% of surgery patients. This statistic alone should have alerted Padwal to take a more conservative position for young patients: For instance, achievable exercise programmes might have proved the much superior intervention without initiating young patients into a career of yoyo weight loss and regain, noted even in the longer-term Swedish obesity studies (Sjöström et al, 2007). Such weight regain following gastric bypass may well lie in the contradictory finding around glucose tolerance (Roslin, 2009): Rather than curing diabetes, many patients who undergo gastric bypass surgery begin to exhibit abnormal glucose tolerance.

Renewed concerns are emerging about the connection between thinning bones and WLS. A Mayo clinic study has demonstrated that WLS participants were twice as likely as other Minnesotan residents to suffer at least one fracture in years following WLS with an inexplicable preponderance of hand and foot injuries (Neergaard, 2009).

Furbetta & Iuppa, 2004; Angrisani, Lorenzo & Borrelli, 2007). Clearly, LAGB is routinely carried out in sufficient numbers that off label use could be studied for effectiveness.

Decreased hip-bone density is related to the amount of weight lost through WLS (Fleischer et al, 2008). These are problematic findings particularly when these technologies are sold to teenagers who are still developing bone mass and to older patients who may be at risk of hip-bone fracture. A loss of 10 per cent density in hip-bone in the year following WLS is a significant loss with long-term effects for morbidity and mortality. While there is some novelty in these findings, clearly this is not news. Metabolic bone disease is “a well-documented long-term complication of obesity surgery” (Goldner, O’Dorisio, Dillon & Mason, 2002, p.685) and this raises questions about whether patients are routinely told about these effects before they choose WLS. As well, a number of studies have tied cardiovascular and other health effects to weight loss (Berg, 1999; Cogan, 1999; Miller, 1999; Stunkard, 1958; Wadden, 1993). Patently, WLS remains an experimental treatment:

The number of patients who undergo Roux-en-Y gastric bypass (RYGB) and gastric banding (GB) surgeries has increased dramatically over the past decade, yet the long-term impact of these surgeries on body weight, co-morbidities, and nutritional status remains unclear, as do the mechanisms of weight regain (Shah, Simha & Garg, 2006, p.4223).

While the success of WLS has been widely proclaimed, I suggest that success requires efficacy and a lack of side effects. For instance, there is variable weight loss with significant weight regain for some patients (Livingston, 2005; Tessier & Eagon, 2008). The safety of WLS remains unclear particularly for younger and older patients (Barlow, 2004; Jan, Hong, July, Pereira & Patterson, 2005; Holtermann, Browne & Holtermann, 2008). Nutritional problems following surgery are impacted by surgical decisions into, for example, the optimal length of the roux limb (Sanchez, Schneider & Mun, 2006). While particular surgeries may reduce some co-morbid disease in some patients for some period of time (He & Stubbs, 2004; Pories et al, 1995; Sjöström et al, 2004), this is not without significant iatrogenic side effects (Mizón et al, 2003; Livingston; Tessier & Eagon; Sanchez, Schneider & Mun).⁶ Questions of patient

⁶The very public WLS in February 1982 of a former leader of the Opposition and then Prime Minister of New Zealand is recorded in *Working with David: Inside the Lange Cabinet* (Bassett, 2008). For instance, Lange “would stare at a poached egg and have to make a decision as to whether he wanted the yolk or the white” (p.65); He experienced “‘dumping syndrome.’ Lange would break into sweats and would push his fingers into his eye sockets to gain relief” (p.66); Lange’s surgeon “used the term ‘failure’ when “his patient began to put on weight” within a year of the surgery; by the end of 1984, only two years out from this life changing surgery, Lange is described as “sicker than even his closest friends realized” (p.137) and almost six years later Lange’s health was said to be “hovering between good days and not so good. He was still prone to sweating a lot, [...] dumping syndrome kept recurring [...] his

preferences for different surgeries have not been resolved (Ternovits, Tichansky & Madan, 2005; Shayani, 2004). The need for patients to manage a very restricted diet over a lifetime may affect success (Livingston). Death may result from the surgery (Flum et al, 2005; Steinbrook, 2004; Tessier & Eagon), or following WLS surgery, WLS participants may experience “a substantial excess of deaths owing to suicide and coronary heart disease (Omalu et al, 2007). The long-term prognosis for patients who lose large amounts of weight and/or regain weight is unknown (Berg, 1999; Kassirer and Angell, 1998). For instance, a recent Finnish twin study showed that losing weight was associated with higher mortality for those who were otherwise healthy and moderately overweight (Sørensen, Rissanen, Korkeila, & Kaprio, 2005).

In questioning both the effectiveness of WLS and its safety into the future, McCullough (Mitka, 2003, p.1762) commented on the “[...] the classic problem in surgery - innovation without the research to guide it.” He called for WLS to be brought within experimental protocols, with informed consent based on advising the patient that the procedures are in trial format with unknown long-term outcomes. In all the concentration on whether or not WLS works, the question that has too little purchase is whether WLS should be performed at all. At the very least, there needs to be a whole-of-life perspective in relation to WLS interventions:

I am concerned about the goals of surgeons and patients and their level of interest in what really goes on inside the body after alterations of the anatomy. I am concerned about the focus on the superficial and results from the first year with a lack of concern about how life will be affected when patients are 10 and 20 years older (Mason, 1999, p.3).

The medicalisation of weight has been associated with an expanding presence of advertising for bariatric surgery on the Internet (Salant & Santry, 2006) and television, often accompanied by celebrity endorsement (Mitka, 2003; Steinbrook, 2004). With the evidence of weight loss for some patients who qualified under the NIH guidelines for surgery (1991), there have more recently been calls to promote surgery for those who are overweight and obese⁷ rather than limiting surgery to the morbidly obese group; there are instances of deliberate weight gain by some patients to increase their chances of surgery (Smith, 2008). Thin may be preferred at any cost: WLS patients who have lost weight but incurred serious side effects have been unwilling to consider reversal

heart was also starting to cause trouble” (p.287). “The speech was delivered [...]by a leader (who said) ‘he hadn’t felt sicker in 30 years’” (p. 399).

⁷ Why was a particular Australasian study approved as a randomized trial (O’Brien et al, 2006) of surgery for the treatment of mild to moderate obesity?

procedures (Gallagher, Sarr & Murr, 2005; Ravitch & Brolin, 1979). The conflation of health and appearance ushers in a culture of greater tolerance for experimental health interventions at both an individual and societal level. This is particularly an issue for women who are targeted by and attracted to thinned body projects, including radical WLS options,

3.4 Insalubrious weightfull women bodies. Eurocentric society over the last 100 years has lauded slim and female bodies, while considering fat women to be in excess of their appropriate boundaries. Large women have become a caricature of the feminine, abnormal, unhealthy, abhorrent and immoral, tarnishing the visual landscape and appropriating the proximal physical space and entitlements of others. “Unsurprisingly,” says Braziel (2001a, p.243) “[...] one of the most pervasive representations of fat in contemporary culture is as ‘diseased’ material – bilious, humorous, gelatinous, lethargic, insalubriously salacious, markedly asexual, if not utterly revolting.” The public display of the polluting body is transgressive both in the body and in its display, signalling the inappropriate crossing of a cultural boundary (Douglas, 1966), enfreaking a corporeal extreme (Shildrick, 2000). Hegemonic discourses crowd out alternative understandings of weight and health.

In *Purity and Danger*, Douglas (1966) extended the possibilities for understanding the wider social systems by studying its effects within the individual:

We cannot possibly interpret rituals concerning excreta, breast milk, saliva and the rest unless we are prepared to see in the body a symbol of society, and to see the powers and dangers credited to social structure reproduced in small on the human body [...] (Douglas, p.115).

In extension, social control is evidenced in physically restrained bodies visually apparent, the inner/outer eye of the body-look. The thinned individual may pass as fitting, disciplined, normal, and within bounds. Shoveller and Johnson (2006) have pointed to the way in which ‘youth’ is a complex term that has been used without specificity. So too has weight in general and overweight in particular suffered from its incorporation in the encultured proliferation of weighty bodies’ discourses. Certain forms of talk are sanctioned in public discourse, silencing or excluding others (Foucault, 1983/1985; Shoveller & Johnson).

As norms of acceptability around size and shape have decreased, large women have faced increasing physical and psychological strictures within society as they move about their lives, often as visible outcasts. The obsession with thinned-female bodies may be

described as the anorexic aesthetic of modern culture (Heywood, 1996). Nevertheless the thinned body is viewed as the disciplined body, lauded in public and in private. Appearance appears to count over skills or abilities (Manore, 1996). MacKinnon (1987, p.122) wrote that the good, strong, female body displayed an unbecoming physical strength “[...] threatening to one’s takeability, one’s rapeability, one’s femininity.” The social response to weightfull bodies has been one of marginalisation in which femininity may be questioned, morality and sanity attacked (Bovey, 1989). Bartky (1988) emphasised the gendering of differential effects that urge women to constantly self-surveil and discipline their bodies; Seid (1989, p.9) deplored appearance norms which insisted that women be “painfully thin, but muscular and buxom – qualities that can occur together only if women spend vast amounts of time on exercise, money on cosmetic surgery and emotional energy on diet.”

When a woman loses weight, approbation is pronounced and some women describe being viewed differently. For instance, Piercy (1988) decried the adulation accorded the loss of 20lbs by a female dinner guest, while her current exhibition of paintings and Piercy’s own recently completed novel were ignored. Kean (2005) wrote of being treated differently following her significant weight loss. Different treatment enters medical arenas: A nurse-participant spoke of treating a large woman with advanced multiple sclerosis less gently than a slimmer patient because “heavy seemed to mean lumpy, sack of spuds, no need to take care, solid” (Carrier, 1997, p.127). When losing weight is equated with having become a better person, losing weight becomes the moral condition of acceptance. In Western culture, people are larger but thinness especially for women is prized. Seid (1989, p.83) has suggested that this was largely the result of an ideology of efficiency in which technology and economics have worked “[...] to reinforce the slenderised ideal.” In this context, being overweight or obese attracts stigma and discrimination (Tustin & Zimmerman, 2001) while a lower body weight than average is accepted as normal and may well be prized. Even being as far from average as a thinner person, a larger person attracts a marginalisation and discrimination not meted out to the thinner person (Sobal, 1999).

In relation to the very enduring discrimination and self-condemnation that exists within society for being weightfull and female, there appears to have been little if any respite. Repeated entreaties for weight to be reduced in the name of health, seemliness, or being a properly “cautious person,” reflects findings in relation to AIDS patients (Douglas, 1992, p.103). Lupton (1994, p.4) comments that healthiness appears to have

replaced godliness as “[...] the yardstick of accomplishment and proper living. And, as with any religion, sinners can expect to be punished.”

This punishment in modern terms according to Foucault (1979) rests within the proliferation of disciplinary power to the edges of society, operating within and between individuals. Slim appearance and the disciplines of slimming are lauded and applauded. Changing lives in ways that give the appearance of the healthy mind/body claims a moral high ground that further condemns the weightfull body as transgressive. In stepping out-of-line, the weightfull woman remains always in the line of sight, separated out from her slim peers. These constitute types of dividing practices, a subset of practices that lie at the centre of social exclusion activities (Foucault, 1983/1985).

As the norms of any correct behaviour, such as being of normal weight, are spread and established, behaviours that do not reach that standard are subjected to a variety of punishments exemplified in La Salle’s construction of punishment:

Everything that is capable of making children feel the offence they have committed, everything that is capable of humiliating them, of confusing them: a certain coldness, a certain indifference, a question of humiliation, a removal from the office (Foucault, 1977, p.178).

The threat of being designated an outsider is of immense social significance. Individuals yearn to belong and to participate fully in the material and emotional benefits of society. Emotional dimensions of being shunned consist of “anger, anxiety, frustration, hatred, rage, fear [...] (alongside) the conflicting emotions and feelings, such as fascination, excitement and desire” (Lupton, 1999, p.45). Indeed, as this present research will show, participant narratives were peppered with low affect, self-recrimination, inability to participate, and punishment alongside stories of hope and possibilities for living an improved/approved life. When being weightfull is considered an avoidable choice, it is accompanied by appropriate disincentives. For instance, women may be denied access to adoption (Hinde, 2007), have limited access to reproductive technologies (Gillett, Putt & Farquar, 2006), or be described as poor mothers (Owen, 2007).

Within Western cultural contexts, women’s bodies have been subjected to more intense medical surveillance and intervention than men’s bodies since the 19th century: “Having babies and trying not to have babies makes women sicker than men in terms of use of hospital and other medical services” (Oakley, 1993, p.12). The medicalisation of women’s experiences is significant. While women have actively sought access to the

benefits of medicine (Bartky, 1988) this has been with somewhat mixed effects (Riessman, 1998). For instance, a male-dominated medical community gradually assumed control of pregnancy and birth by portraying their methods as scientific, painless and safer than midwifery (Mitchinson, 1993). In her 1980's analysis, Leavitt's portrayal of women as agentic minimises the significance of the social context in which women came to choose painless childbirth. In their visibility through pregnancy and childbirth, women as the potential mothers of the nation were poked, prodded, and explored, and repetitive internal examinations became the norm. The habits of women through the period of gestation were open to surveillance through "[...] the ritual laying-on of hands by a succession of different doctors, none of them especially trained in the art of talking to the face beyond abdomens" (Oakley, p.13). Weighing and measuring as examination led through to judgement and intervention, with the regularity and medicalisation of childbirth ensuring medical oversight for women in New Zealand choosing to bear children. Indeed, women accessed more medical interventions than men even when the effect of chronic conditions was allowed for and pregnancy and births were excluded (Statistics Canada, 2007). In a study by the National Center for Health Statistics (NCHS), (2001), women were 33 percent more likely than men to visit a doctor; attendance for annual examinations and preventive services was 100 percent higher for women than for men; women were dramatically more likely to have an antidepressant prescribed or receive hormone treatment.

In the contingency that has continued to attend women's position within society, women are continually caught within the cultural paradoxes that define the good life and the good person. The embodiment of preferred femininity lies in the outward sign as inward grace, disciplined and penitent. Foucault did not write a history of women's bodies, though he had intended to include a volume within the *History of Sexuality* called *Woman, Mother and Hysterical* (Sawicki, 1991), locating the control of women's bodies within the various discourses and practices of biopower. In Foucauldian terms, power is evidenced in the way the soul may be viewed through its representation in the body (Grosz, 1994). Within the contexts of health, the medical professional's lens has moved from women's mindlessness to their sightliness: A good-woman body demonstrates inner cleanliness and discipline through her beauty in the eye of the beholder. In self-surveilling their embodied presence within the normative surveillance of others, women seek to manage their presentation, somewhat-docile bodies "subjected, used, transformed and improved" (Foucault, 1984, p.180).

3.5 Women, weight and health projects

Overweight and fat bodies are positioned for medical and pseudo-medical interventions in the form of diets, maxillomandibular fixation (or jaw-wiring),⁸ drugs and bariatric surgeries. As the anti-obesity climate was building through the 1980s, Schwartz (1988) for example found that 75% of women between the ages of 24 and 54, who attempted weight loss, did so for reasons of appearance not health. More recently, that anti-obesity climate has been evidenced in distorted body image (Gruber, Pope, Lalonde & Hudson, 2001), low self esteem (Furnham, Badmin & Sneade, 2002), and deliberate choice of sports that promote leanness (in itself associated with eating disorders) (Sundgot-Borgen, 1994). Slimness has cultural valence and the aim is to achieve an ideal body shape (Davies & Furnham, 2006).

Contradictory discourses like self-acceptance and self-improvement tend to be promoted simultaneously, while being essentially mutually exclusive. This is symptomatic of the double bind in which modern women attempt to pursue an adult relationship to their bodies. A further and major discursive double bind for modern women rests in a Rousseauian insistence on the rediscovery of, and return to, the natural self, “[...] the sanctity and promise of the individuality with which they were born” (Mansfield, 2000, p.18). The larger body is denatured and the thinned body is accepted as the natural birthright of most women.

The persistence of thinned female bodies discourse as being “[...] natural and medically well grounded in the face of its health consequences is a testament to the strength and pervasiveness of this ideal” (Bartlett, 1994, p.109). In a modern “[...] hymn to the natural human self” (Mansfield, 2000, p.18), radical or unnatural interventions are required to emerge this putative natural self. In the next section I consider some of these paradoxical positionings for those who choose WLS.

3.5.1 Women and WLS projects. After successive and unsuccessful diets, rather than accepting their failure to become thin, women continue to request treatment. When drug treatments do not produce weight loss or the side effects are pronounced, surgery options become the site of the new potential, modern-day miracle. The weightfull women’s body of the late 20th and early 21st centuries is a body ripe for commodification and WLS is developing as a treatment of possibility. Almost eight out of ten WLS patients are women (Bariatric Surgery.Info, 2004; Hitti, 2004).

⁸The Wise medical group (2007) are currently promoting this as a new weight loss option for people with a BMI between 29 and 40.

This gendering of WLS interventions is at issue as WLS marches towards the centre of medicine. The increasing acceptance of this radical technology is manifest in the proliferation of WLS material in mainstream journals (De Maria, 2007; Dixon et al, 2008; He & Stubbs, 2004; O'Brien et al, 2006; Sjöström et al, 2007), the growth of WLS (Mitka, 2003; Salant & Santry, 2006; Spurgeon, 2005) and the increasingly public face of practitioners happy to be associated with it.⁹ But whether it is clothes, make-up, diets, cosmetic and weight-loss surgeries, or slimform bras, women's bodies are targeted:

Why is it never said that the really crucial function that women serve as aspiring beauties is *to buy more things for the body?*¹⁰ Somehow, somewhere, someone must have figured out that they will buy more things if they are kept in the self-hating, ever-failing, hungry, and sexually insecure state of being aspiring 'beauties' (Wolf, 1990, p.66).

It is difficult to analyse the uptake and proliferation of health/appearance surgery within feminist research practices of inclusiveness (Better, 2006), encouraging new perspectives (DeVault, 1990), rather than merely designating women who choose these options as cultural dupes (Gimlin, 2002; Hanigsberg, 1997; Pitts-Taylor, 2007). Choosing breast reductions or liposuction have even been considered as agental modernist projects of identity through self-transformation rather than appearance projects: This has allowed such projects to be theorised as eluding the project of normalisation (Davis 1991, 1995, 1996, 2003). While women may enact degrees of choice in relation to taking up degrees of appearance or identity projects, this is always constrained by what is possible and what is predicated as normal. Radical elective WLS has moved alongside its more researched counterpart, elective cosmetic surgeries, "out of the sleazy, the suspicious, the secretively deviant, or the pathologically narcissistic, it is becoming the norm [...] leading to a predictable inversion of the domains of the deviant" (Morgan, 1991, p.165). WLS is promoted as both less radical and more safe than any previously available. As WLS progresses further along the trajectory towards acceptance within mainstream medicine, there is an associated pull for potential patients in general and women in particular to consider these surgeries as agental. Choosing WLS becomes rather unproblematically a health project as though these technologies have no connection with normalising weight and appearance.

⁹This is clearly demonstrated by more recently entering the search term "obesity surgery surgeons" in Google that refers to numerous New Zealand surgeons now practising forms of WLS.

¹⁰Italics are Wolf's own.

The spread and availability of these technologies engage the attention of the targeted citizen: A potential patient is encouraged to consider the benefits to themselves and others of such a progressive technological cure. The paradoxes of choosing WLS interventions are those of its cousin, cosmetic surgery: This choice of surgery to merge, conform or to transcend presumed natural limitations in the achievement of a more natural, small-sized self, demonstrates some level of buying into a current cultural representation of ideal size.

Women's decision-making over WLS is thickly encultured, with the internalisation of ideal weight/health/appearance evidenced through a lifetime of dieting or restriction, and angst about the body - look, size or taking up space. While holding a distorted impression of the body is common amongst women, the most pronounced manifestations of encultured disciplinary practices on the self are currently evidenced in anorexia, anorexia athletica and bulimia. But the body modifications in WLS are extreme: WLS readily displays dedication to an agental project of health/appearance transformation than to "[...] the less visible labour of becoming happy in one's skin, a project that surely also requires risk, discipline, tactics, and perseverance" (Heyes, 2007, p.67). Indeed, seeking to perfect bodies through radical surgery options could be described as the latest grotesque crystallisation of encultured femininity.

In the scientifically predicated imperative to lose weight for health and the apparent impossibility of losing weight by other means, WLS is proposed. As in cosmetic surgeries, and whether WLS is more about weight than appearance, women's bodies are assessed for intervention within a masculinist-medical consultation. In the end, WLS decision-making is sanctioned and actioned within the clinic.

3.6 Encultured medical consultations

When surgery for weight loss is contemplated, this is a significant decision. Patients have traditionally consulted their primary care physicians for referral-on to a surgeon. Implicit trust in the physician's advice lubricates assent to medical interventions. The need for patients to rely to some extent on practitioner advice demands a transparency about any potential conflicts involved in the trade in medical technologies.

WLS consultation demonstrates many of the flaws that pervade modern practices of trade and the evidence base of modern medicine. As well, WLS is a medical speciality supported by an historical and cultural preference for slimmed body size and a contemporary conflation of slim and healthy. Given that medical consultations are entrenched in culture, this limits diversity of practice in relation to health and well-

being. Limited notions of weight and health influence surgeons' promotion of radical WLS. For instance, if the objective in consultation surrounds not whether this body requires to be thinned but how to thin a patient's body as an essential project, then the promotion of WLS technologies is clearly problematic. This is demonstrated in a televised interview following the very public gastric bypass of Carnie Wilson¹¹ who asked the surgeon about her future health prospects.

Question: Dr. Wittgrove, I really need to know about how this surgery will affect me when I am old.

Dr. Wittgrove: Hopefully you will live that long [...] People who are morbidly obese don't have long life spans (Obesity Surgery Information Center, 2008).

Rather than reflecting on any health effects from WLS, the surgeon deflected it by focusing on fat bodies discourse.

Weightfull female bodies have been subjected to increased scrutiny through the years, a scrutiny that has been normalised and attached to individuals as agents-of-their-own-health. Distanced from its origins as a cultural artefact for women, weightfull women's bodies are targeted for health interventions. In *The Forbidden Body* (1989), Bovey's doctor-participants admitted that the existing climate of fat prejudice had influenced them to label women as fat and unhealthy. These doctors could still discern the links between fatness and cultural perceptions.¹² In the present, weightfullness is attached so firmly to poor choices in lifestyle (BBC News, 2004; Hall, 2008; Miller, 1999; Ministry of Health, 2003; Prentice, 1995) that there is little opportunity to espy the influence of culture, commodification and governmentality even in the evident cracks in this incorporation.

Doctors are deferred to in medical matters, and enjoy a privileged position with patients and government. The medical profession actively pursues the maintenance of their authority as demonstrated in the mediated coverage of medical issues (Willis, 2006) and consequently have continued to experience "significant cultural and social authority" (Lupton & McLean, 1998, p.957). As well, medical relationships of consultation have been attended to in a range of creative endeavours such as Cronin's *The Citadel*, Edson's play, *Wit*¹³ (Edson, 2000), and television programmes from *Medic*

¹¹ Carnie Wilson is a high profile music star in the US whose gastric bypass was followed in the media.

¹² Lyons (2000) also notes how mediated images and words influence lay and professionals alike.

¹³ Also an excellent film starring Emma Thompson (Nichols, 2001).

(Moser, 1954) which was the first to premiere in 1954 to the BAFTA-nominated British television medical drama in 2004, *Bodies* (Mercurio, 2004). In these arenas, physicians have been variously portrayed as brusque, aloof, inconsiderate, grasping, narcissistic, arrogant, insensitive and incompetent. Balance is provided in the film and television arena: *Patch Adams* (Shadyac, 1999) a film starring Robin Williams; television series such as *Chicago Hope* (Kelley, 1994) or *Gray's Anatomy* (Rhimes, 2005) and reality TV series in which surgeons perform modern day miracles. It is intriguing that these latter programmes have relied on the medical establishment for authentic locations and expertise to be convincing. The cultural price paid has been in the power of the AMA and other medical establishments to shape that material and to sustain particular doctor and patient stereotypes (Turow, 1989).

TV reality shows, fronted by an array of surgeons and specialists, appear to be contributing to the increased uptake of cosmetic and WLS procedures. Many patients who underwent cosmetic procedures for the first time revealed that they were regular viewers of appearance medicine shows and four out of five patients said that their decisions were influenced by reality television (Petrie, Faasse & Fuhrmann, 2008). Surgeons fronting these reality shows were chosen for their appearance and ability to attract ratings and their medical credentials were considered much less important (Roan, 2007).

Commentary abounds in a variety of Western cultural mediums indicating the significance of medical relationships of consultation. In the current proliferation of academic and media portrayals of problematic decisions and medical misadventures, something is clearly amiss. Modern patients look to doctors to facilitate access to modern day medical miracles and rely on the beneficence of their doctor for diagnosis, explanation and discussion of options. While the partnership model of consultation is much discussed, its advent has coalesced with a proliferation of commercialised materials from pharmaceutical, technological and medical businesses on the Internet and Television. Increased access to these materials has produced an increasingly medicalised patient rather than an essentially critical or discerning one.

In a medical context that increasingly asserts the autonomy of the patient rather than the beneficence of the doctor, the modern neo-liberal patient is described in agental terms, the autonomous citizen patient exercising choice. Clearly this begs the question of whether this is a newly liberated patient or still a scarcely-liberated patient who gives the appearance of exercising choice. Agency exists within “the messiness [...] of the

ambiguity of language and cultural practice” (St Pierre, 1997, p.176) but is enacted within the discursive frames that dominate the lived lives of Western women. Agency takes place in the recognition of the potential for, or actual entrapment within, discourses, especially when these are represented as the reality of lived lives. In this thesis, agency lurks in the encouragement of questioning the discourses without ever needing to set up an alternative orthodoxy by which to “capture and control one’s identity” (Davies, 2004, p.4). While women patients may resist and subvert less-preferred cultural prescriptions of sanctioned and normalised behaviours, the impact of systemic oppression, negative stereotyping of women as patients or cultural perceptions about acceptable body size impact patients’ choices in relation to size and health. Choosing to disregard certain medically prescribed and culturally promoted interventions may encounter considerable criticism. In the next section, I problematise issues relating to the micro practices of power within consultation.

3.6.1 The exercise of power in clinical encounters. Within modern societies, it is possible to discern the proliferation of power effects through “progressively finer channels, gaining access to individuals themselves, to their bodies, their gestures and all their daily actions” (Foucault, 1980, p.151). The juxtaposition of health, wealth, appearance and well-being are nowhere more apparent than in the clinical encounter: “Overall,” according to Malterud (2001a, p.397) “[...] clinical practice is, at its worst, a private enterprise shut off from outside assessment, where pitfalls and fallacies are reproduced by dangerous and irrational subjectivism.”

In 1904, Sir William Osler advised doctors to listen to their patients as they were “telling you the diagnosis” (Osler, 1904, as cited in Appleby, 1996). However, in the exercise of power-as-authority in medical settings (Ainsworth-Vaughn, 1998), doctors do not routinely value patient perspectives. Doctors tend to control the consultation, interrupting patient narratives within 18 seconds of the patient beginning to speak (Beckman, Markakis, Suchman & Frankel, 1994; Groopman, 2007; Groopman, Miller & Fins, 2007; Schofield, 2005). Such interruptions resulted in less than a quarter of patients ever being able to complete their opening statement; doctors dealt with the first complaint rather than the presenting complaint and made unilateral closings.¹⁴ Consultations in which patients attempted to express their views have been associated

¹⁴It is often suggested that interruptions by doctors are time saving in constricted consultation time slots, though given the opportunity to continue their opening statement, patients rarely took more than two minutes overall when they were encouraged to continue (Schofield, 2005).

with considerable tension (Tuckett, 1985; 1985a). Practitioners may deliberately use technical language to limit patient questions (Lipton & Svarstad, 1974; Lyons & Chamberlain, 2006); when patients do not admit that they did not understand, then a virtual “communication conspiracy” is set in motion (Svarstad, 1974, as cited in Roter & Hall, 2006, p.128). This may be a face-saving manoeuvre when, for example, doctors express amusement at patients’ mistakes (Ainsworth-Vaughan).

Poor medical outcomes have been linked to cascades of problems resulting from constricted thinking (Groopman, 2007), or, a medical dictum that “the newest and most technological care” is the best care (Deyo & Patrick, 2005, p.16). The patient’s knowledge of their own body and disease processes are presumed by doctors to be limited (Tuckett, Boulton, Olson & Williams, 1985). Patient concerns may be disregarded and the possibilities of correcting errors in a doctor’s thinking or prescribing go unchecked even as they are developing (Groopman). In a reliance on evidence external to the interaction of the doctor and patient, a veritable “medicine by the numbers” (Schneider & Lane, 2005, p.xi), what is lost is the patient’s experience of his world and body. Formulaic diagnosis and intervention, that which Rosenfeld (2004, pp.153-155) has referred to variously as “dogma,” “religion” and “the codification of daily practice,” have distanced the patient (Leder, 1990) even as the partnership model¹⁵ is being promoted as the preferred relationship model for consultation.

Attempts are being made to include aspects of obesity as a brain disorder within the DSM V¹⁶ allowing obesity to be promoted as a disease based on an excessive drive for food. Any such inclusion raises the potential for an increase in discriminatory practices within consultations that already target the mental component of obesity to promote diet compliance and prevent relapse (Volkow & O’Brien, 2007). The over-reliance on pattern recognition or visual presentation to make diagnoses, snap judgments, and a failure to recognise alternative explanations, will likely be exacerbated with the ready availability of a new DSM categorisation. The opportunity for patients’ views to be

¹⁵I refer to a definition of partnership model as one that addresses the “incompleteness” of the expert’s vantage point with knowledge being “an interweaving of multiple perspectives (with) different kinds of expertise” (Hatgis, Dillon & Bibace, 1999, p.22).

¹⁶The Diagnostic and Statistical Manual (DSM) (American Psychiatric Association, 1994) is a handbook that categorizes or constructs mental disorders alongside the criteria for diagnosis. It is published by the American Psychiatric Association and includes reviews of the categories allowing new constructions in and others to be eliminated. Homosexuality was dropped from the seventh revision of the DSM-II, in 1974.

explored within a consultation will be further eroded by the potential to apply yet another diagnostic label.

Specialness in the relationship between doctors and patients may be seen as an ideological device rooted within medical paternalism (Bury, 2004). In such a relationship, “coercion and domination” (Morgan, 2003, p.168) take on the appearance of benevolence and choice (Wear & Aultman, 2007) by physicians who lay claim to “[...] certain kinds of legal and professional privileges – largely to autonomy over practice and dominance over other professions” (Bury, p.48). In his study of the medical profession, Brody (1992) discovered a myriad of allusions to the superiority of doctors’ professional power with little discussion of it. When power is placed at the heart of the moral discourse of medicine, it is possible to see how ethically responsible practice, in relation to informed consent, truth-telling, confidentiality and physicians’ virtues, are impacted by the way in which power/knowledge was invoked (Brody).

The Parsonian view of medical knowledge points to a knowledge and practice gap in which medical knowledge is earned, owned and may be passed on reluctantly. Patients have needed to rely on the physician to make best use of that information for them as individuals and have therefore tended to comply with instructions. When patients resist instructions or the condition does not respond to treatment, they may earn a malingerer’s status: “[...] no patient can truly want to get well if he or she does not cooperate with a doctor” (Roter & Hall, 2006, p.24). Patently, overweight physical appearance may signify a lack of compliance, an undersocialized (Granovetter, 1985) citizen whose appearance suggests a patient unlikely to comply in the future with medical instructions (Brownell & Puhl, 2003; Bruere & O’Connor, 1999; Eisenberg, 1979; Kristeller & Hoerr, 1997).

Good outcomes from medical consultation rest on the ability of a physician to critique medical research (Allen, 2004; Godlee, 2008). Physicians need to be committed to lifelong learning (Allen, 2004) and to be highly reflexive in relation to their practice (Malterud, 2001; Teunissen & Dornan, 2008). But “(e)ven at its scientific best, medicine is always a social act” (Elwyn & Gwyn, 1999, p.186). A holistic approach to medicine in the context of the patients’ beliefs, values and culture is required, while also “considering a range of therapies based on the evidence of their benefits and cost” (Pietroni, 1987, p. 1387).

Medical decision-making is never free from subjective influence (Allen, 2004). The schema formulated by Parsons (1964) in relation to doctor and patient roles has received

much criticism (Freidson, 1975) and the role of the doctor is more complex than Parsons acknowledged. Still, when patients conform to Parsons' ideal patient type, the patient who seeks professional advice, adheres to treatments, and (preferably) recovers, is evaluated positively (Millward & Kelly, 2005). Healthy patients are preferred (Stimson, 1975; Roter & Hall, 2006). Preferred patients are also those who consult a doctor only when they need to, do not take up the physician's time, exhibit specific organic symptoms, are easy to diagnose, and require little in the way of ongoing management (Stimson).

3.6.2 Discrimination in the clinic. The term heartsink is regularly applied to patients (Millward & Kelly, 2005; O'Dowd, 1988) and this records negative stereotyping by doctors. In such cases, causality for a range of medical problems may be easily assigned to deviant behaviours, and/or issues related to medical compliance (Najman, Klein & Munro, 1982). A survey of parents found that one in ten would abort a child if they knew it had a genetic tendency to be fat (Fraser, 1997) and health professionals have been shown to share culturally imbued, anti-fat attitudes (Puhl & Brownell, 2001; Mason & Ghamar, 2002; Vallis, Currie, Lawlor & Ransom, 2007). In an early study, obese patients were described as unintelligent, unsuccessful, inactive and weak-willed (Maddox, Black & Liederman, 1968). When the *Implicit Attitudes Test* (IAT) has more recently been used with health professionals, they remained significantly pro-thin/anti-fat and endorsed the implicit fat-stereotypes of lazy, stupid, and worthless (Schwartz, Chambliss, Brownell, Blair & Billington, 2003; Teachman & Brownell, 2001). Women are more likely to be infantilised, requiring care, psychiatric evaluation or intervention (Oakley, 1993). This is more likely when their bodies are negatively connoted. In the presence of stereotyping, decisions about WLS may be shaped to promote these interventions for women, by specifically tailoring information to increase the likelihood of agreement, and/or a rushed decision-making process may be entered into. Pearn (2000) has referred to such activities as being both unethical and unacceptably paternalistic.

In all the talk of remedying bias against obese patients, the possibility is that changing only the veneer of bias increases risk in consultation relationships. For instance, if doctors choose not to discuss weight with their patients or to suppress negative affect, patients may not perceive the implicit bias underlying either a proposed remedy (Brownell, Puhl, Schwartz & Rudd, 2005) or the lack of an appropriate referral. Some authors accept, for example, the common construction that overweight is

unhealthy (Brownell, Puhl, Schwartz & Rudd). While a respectful attitude to weighty patients may be advocated, the message to health professionals is that displays of respect avoid arousing defensive reactions that might impede the message that patients need to control or lose weight. Another author in this book also promotes WLS in glowing terms as “the most powerful intervention in modern medicine” (Downey, 2005). Eliminating bias could thus be read as relying more on slimming fat patients than addressing fat bias (McKinley, 2007), but being nice about it.

“It takes power to stigmatize” (Link & Phelan, 2001, p.375). The physician’s positioning in society is based on aesculapian knowledge, the knowledge of medicine, charismatic personal qualities, and social positioning derived from physicians’ current status in society (Brody, 1992). Patients are brought face-to-face with their lack of professional knowledge as well as their undesirable bodies in the consultation environment. Whether or not the physician wears a face of beneficence, as research into racial attitudes has demonstrated, unconscious biases determine actions even while the spoken word does not appear to endorse them (Goode, 2002). As well, harsh talk does not “guarantee its rejection, for hardships can be endured if they are thought to be necessary or inevitable” (Bartky, 1988, p.43). Stigmatisation of obesity within western society is severe and more pronounced than for eating disorders (Sobal, 1999). This is so even as emaciated models, *Fashion’s famished slaves* (Robb, 1989) continue to hold sway in media images of women. Given the Western standard of thinness for women, with discriminatory attitudes towards women noticeable at a BMI of 27 (Puhl, Andreyeva & Brownell, 2008),¹⁷ being obese engenders acceptable discrimination (Puhl & Brownell, 2001; Stunkard & Sobal, 1995). Discrimination within the clinic disenfranchises patients (Weiss, Ramakrishna & Somma, 2006).

Stigma is currently being studied as a variable within relations of deviance (Scrambler, 2006). If persons are considered to have engaged in guilt-related behaviours (Hebl, Mason & Xu, 2003), those stigma-bearing people may be held “morally responsible for their defects” (Scrambler, p.293). Parker and Aggleton (2003) have suggested that fear of stigma-related diseases such as AIDS, is acted out as defensive social control – stigma – with the boundaries being drawn between the normal and the outsiders in a them-and-us mentality (Link & Phelan, 2001; 2001a). The medical profession has been deeply implicated as instigators of stigma with calls for

¹⁷ In contrast, stigmatised weight began at a BMI of about 33 for males (Puhl, Andreyeva & Brownell, 2008).

action to reduce discriminatory treatment of the large-sized patients by their physicians (Stunkard & Sorensen, 1993).

When value systems including stereotypic attitudes towards the obese are inculcated throughout childhood, medical training at undergraduate or postgraduate level fails to mitigate that early cultural indoctrination (Cowan et al, 1991). It may be inferred from the findings for discrimination against large people, specifically in the studies of medical students, that it has much to do with their early enculturation (Blumberg & Mellis, 1985; Price, Desmond, Krol, Snyder & O'Connell, 1987; Sobal, 1999; Stunkard & Sorensen, 1993). As younger health professionals exhibit more bias, this may be related to the increasing societal pressure to be thin (Schwartz, Chambliss, Brownell, Blair & Billington, 2003). While social attitudes affect health professionals, current preferred treatment paradigms have the potential to reinforce and maintain any negative stereotypes when weight loss fails (Bruere & O'Connor, 1999). A questionnaire study of obese women did not discover 'routine' disrespect amongst their physicians though patients rated both medical interventions and advice about weight as poor (Wadden et al., 2000).

Even while there is an increasing emphasis on a shared decision-making model in consultation, the operation of discriminatory practices in consultation may affect access to health care (Sobal, 1999) and diagnosis and treatment (Adams, Smith, Wilbur & Grady, 1993). In a recent study, participants cited doctors as a major source of weight bias (Puhl & Brownell, 2006). This is a significant finding given that bias against obese patients may create barriers to the achievement of health projects such as weight management in diabetic patients (Vallis, Currie, Lawlor & Ransom, 2007). While medical students were more likely to believe that obesity was functional in their large patients, it may result in different treatment, with large patients being referred routinely for specialist assessment, and more interventions (Wigton & McGaghie, 2001).

A partnership model in medicine relies on a respectful relationship and the provision of the fullest information on the illness, the proposed treatment and the potential for detrimental outcomes from any intervention (General Medical Council (GMC), 2008). The duty to inform compels doctors to advise their patients. In the move towards the construction of the medical consultation as a partnership, the patient may well exercise power in relation to attendance, withdrawal, compliance with directions or greater reliance on a variety of health options from Internet websites or friends. The emergence of the British patient as an 'expert' (Department of Health, 2001) has become pivotal to

British government plans to modernise the health system linking patient expertise to ideas of 'empowerment', 'a better quality of life,' 'self-esteem' and a 'user-led NHS' (Department of Health; Fox, Ward & O'Rourke, 2004).

The growth of the Internet has contributed to an era of consumer health informatics (Eysenbach, 2000; Eysenbach & Jadad, 2001) in which "the public will have an unprecedented ability to access information and to participate actively in evidence-based health care" (Eysenbach & Jadad, e19). In the United Kingdom, the GMC has emphasised the duties of doctors to work in partnership with their patients. Doctors are required to listen to patient concerns and preferences, to provide patients with information that they require and to ensure their understanding of it. This is to take place in a context in which they respect patients' rights to participate in decision-making and to support them in care, maintenance and improvement of their health (GMC, 2008).

Weight consultation is mediated by a cultural preference for slimmed body size and a burgeoning literature support the contemporary conflation of slim with healthy. This means that the current paradigm of weight/health and its corresponding knowledge base are limited. Such limitations impact all consultations about weight and health, and are especially egregious where radical WLS options are being considered. As well, enhancement medicine is moving towards increased acceptability in the "confluence of an ego-oriented culture sustained by social approval, peer example, and clever advertising (to) produce a cascade of demand" (Pellegrino, 2004, para. 13). In the current proliferation of body modification technologies, there is an associated call for practitioners to practice within best evidence guidelines. This is especially so in the presence of compelling arguments supporting the social construction of disease and associated concerns about the evidence connecting overweight/obesity with ill health.

3.7 In reflection and moving on

In this third chapter I have sketched a picture of the cultural and medical project that has so deftly linked overweight with ill health, legitimating the modern call for weight loss at any cost. As the cultural preference for slimmed body size has been conflated with a healthful body and commercial interests have infiltrated medical consultation, then the epistemic standing of medical practitioners as authorised knowers is more problematic. Clearly patients rely on their doctors as if they are people close to them. Patients believe that doctors act only in the patient's best interest. But the biotech age has increased the precariousness of modern medicine. The impact of the trade component

in the practice of medicine, whether that consists of selling medical technologies, earning a living, learning (upskilling) while you earn, or using patients for harvesting work product, these impact medicine's moral enterprise and its caring trustworthiness. When an adult citizen/patient seeks medical care, they do so in the expectation of caring, never to be confused with sentimentality in the guise of caring. When the belief that 'overweight causes ill health' is connected with a largely unquestioned assumption that 'doctors have my best interests at heart' this may translate into the automatic action of filling the script or accepting radical surgery options. In consultations, patient compliance is swayed by the encultured prestige of, and trust in, medical practitioners. When the patient meets a physician or surgeon primarily acting out of unrefined and fixed ideas of a good person or an ideal body, or is intent on his/her own self interests, then the stage is set for inadequate consultation processes leading into unexpected, inadequate or poor outcomes.

WLS procedures have been problematised as an effective technology for health through weight loss by further exploring the connections between culture, weight and medicine. In developing a genealogy of medicalisation, this present research has attended to the shaky grounds on which new technologies for managing modern health have emerged. The worth of WLS interventions depends on the reliability of the evidence that being overweight is indeed risky and that a serious surgical manipulation is not only productive of increased life years but is exponentially of more value than merely increasing lifestyle-associated activity. While radical surgeries may slim some bodies or reduce some co-morbid disease or improve confidence in some-selves, it does so at a cost. Doctors who recommend, and patients who consider, these new technologies need to comprehend the seriousness of these interventions and their potential to produce iatrogenic injury. In chapters four and five, I discuss the methodological implications of such a diverse accounting and show how that was attended to through an explication of my research methods.

“The search for one’s own voice. To be embodied, to become more clearly defined, to become less, to become more limited, more stupid. Not to remain tangential, to burst into the circle of life, to become one among other people” (Bakhtin, 1984, p.147).

CHAPTER FOUR

Methodology

“Whenever we engage in research, we are offering a first person narrative. Even our most traditional work is somebody's story” (Pelias, 2004, p.7).

4.1 Introduction to methodology

Methodology is an ethical commitment to showing how one stands in life (Van Manen, 1997). In this chapter, I relate the philosophical foundations of my methodology within which my thesis is situated. I began this thesis examining the fields of weight and weight consultation at a time when WLS began to assume an unprecedented legitimacy. It is a period in which encultured medicalisation has encouraged citizens-as-patients to embrace mind-body projects as routine and ethical. Narrative therapy (section 4.3.4), based within the “tradition of poststructuralist thought” (White, 1997, p.217), provided a research orientation that developed the work as it also developed alongside this work. Based largely on Foucauldian critique, narrative therapists encouraged a reflexive analysis of power within current structures and institutions. Power relations were seen to restrain stories within a cultural embrace of familiarity and seeming neutrality.

Since beginning this thesis, I have been perplexed about what compels patients such as myself to seek out and accept referrals for radical health projects. To answer this question, I turned to understand the forceful fabric of histories, communities and politics (Plummer, 1995) that produced progressive medical science. Thus, in the initial chapters, I have focused on developing several elements of Foucault’s (1977) methodological apparatus. In chapters two and three, I develop a genealogical analysis of a range of discourses, institutions, regulations, scientific statements and ethical propositions, making visible some aspects of modern, medical projects. These are aspects that are unstated or taken-for-granted within largely utilitarian, neo-liberal

medicine. Specifically, dominating discourses influence the nature of decision-making for health. This then is the socio-political backdrop against which participant stories could be foregrounded.

In threading the history of medicine-as-a-science through a viewing of the modern fixation with weight in a range of research narratives, I set out to personalise the material, complicate the issues and to both involve and intrigue readers. For these are all absorbing narratives. In a genealogical approach to the research question, I waft the layers of cultural and gendered material in which WLS consultation lies. Such an approach identifies the elusio, the taken-for-granted and the hidden-from-view. This supports the Foucauldian analysis of discourses through data chapters six to ten allowing some challenge to the dominant discourse that progressive, modern technologies are always and essentially about health. The complexity of the patient/doctor narratives is opened-to-view. In expanding on a diversity of ways for comprehending the world around us (Rodriguez, 2002), weight and WLS consultation become examples of how particular discourses encourage citizen/patients, such as myself, to understand and work on our bodies in particular ways. Available discourses promote possibilities for individual health projects without acknowledging the histories, limits and effects of making such choices.

Uncertainty surrounds weight in relation to health. The value or desirability of medical or technological interventions has complicated the decision-making faced by citizens who inhabit the field¹ of weight and weight consultation. Through my own years of immersion in reading, writing, and experiencing weight and surgery projects, any certainty about the progressive promise of these medical-technology projects has dissipated. WLS projects cannot be reduced to any harm versus benefit analysis and readers of this critique will in the end choose amongst possible endings to a postmodern mystery that remains unsettled by the discovery of the body (Frank, 2004).

4.2 Research orientation

This research rests on a validity evidenced in the compelling nature of diverse narratives. Trustworthy narrative accounts do not come with ready-made structures, or any one right way to use or interpret them (Riessman, 2003). “Goodness” criteria (Smith, 1990, p.168) arise and are legitimated within their own paradigm. This research

¹The concept of field is explained in relation to the companion concept of habitus as “a set of objective, historical relations between positions anchored in certain forms of power (or capital), while habitus consists of a set of historical relations “deposited” within individual bodies in the form of mental and corporeal schemata of perception, appreciation, and action” (Wacquant, 1992, p. 16).

works with the narratives of decision-making that surround issues of body size for women and the ethical practice of the body projects that they have invoked. Such projects - diets, weight loss pharmaceuticals, jaw wiring and WLS - have appeared variously through the years as the newest cusp of a beneficent, progressive medical science. In monological research, the newest technologies, or, the relationships of consultation, or, the experience of WLS, become single entities subject to analysis. All the while, however, the progressive thrust of modern, medical science, its cultural determination, ideological implications and connections remain immeasurably significant but largely unchallenged. Hence the importance of a Foucauldian research bricolage in which a multiplicity of discursive analyses of the literature allows for a compelling and expansive opening up of the background against which the substantive data chapters, six to ten, make their appearance.

4.2.1 Bricolage. Bricolage (Denzin & Lincoln, 1994; Kincheloe, 2001; 2004) has provided a place to move within this research, framing a layering of narratives emerging from the complex interrelationships of the various elements encountered in, and engendered by, acts of researching and experiencing. Lévi-Strauss (1962) originated the idea of bricoleurs, veritable “Jills of all trades” (Gatens, 2007, p.25). Denzin and Lincoln (p.693) suggested that a more apt description might lay in “Mad Max's car parts and pieces assembled from scrap, from what comes to hand, which nevertheless runs across inhospitable and dangerous terrain.” Essentially, bricolage is praxis-based with an essential criticality dependent on a researcher who brings together a lifetime of experiences and learnings in the assessment of emerging problems (Kincheloe, 2001).

Plurality of methods is a distinguishing feature of bricolage. This encourages a move away from the limits to understanding imposed by disciplinary reductionism and an encouragement of multiple understandings of what researchers are seeing (Kellner, 1995). Feminist researchers have been described as “theoretically promiscuous, or pluralist” by Middleton (1992, p.42) who pointed to the somewhat edgy and risky underhandedness of transdisciplinarity² within much feminist research. Indeed, “true

² While Kincheloe frequently refers to interdisciplinarity in these texts, his development of bricolage clearly sits within feminist understandings of transdisciplinary work. Nicolescu (2005) has defined the differences between multidisciplinary, interdisciplinary and transdisciplinary approaches: Multidisciplinarity involves researching one object simultaneously within a number of disciplines; interdisciplinarity involves the transfer of methods between disciplines, and transdisciplinarity “[...] concerns that which is at once between the disciplines, across the different disciplines and beyond all disciplines. Its goal is understanding of the present world” (p.2 of 12).

transdisciplinarity is characterized by a continual examination of artificially drawn and contingent boundaries and that which they exclude” (Dolling & Hark, 2000, p.1178). Transdisciplinarity focuses on explicating the problem at hand transcending the limits imposed on knowledge production by uni-disciplinary, multi-disciplinary and interdisciplinary approaches: I see these approaches as remaining essentially disciplinary-based (Nicolescu, 2005). Transdisciplinary approaches are critical in intent and include local and formerly subjugated knowledges to stand alongside expert knowledges. The objective in transdisciplinary research is to “preserve the different realities and to confront them” (Ramadier, 2004, p.433). In this research, while I report some statistical aspects of WLS, refer to medical research supporting WLS options and listen for dissident voices in academia about the weight for health discourse, this research underlines the value of hearing the voices of patients in health research.

The edginess of bricolage emerges as the bricoleur-researcher weaves a story from seemingly disparate knowledges (Lincoln, 2001) within a critical-research orientation (Kincheloe, 2001). In my research, the weaving of stories and methods requires a strong, critical edge in the face of a hegemonic discourse such as medical knowledge. Medicine’s dominating positioning essentially devalues stories from lay and alternative professional sources. My research storyings are conducted at the margins of gendered-medical knowledge, that knowledge in which women are objects rather than subjects (Fine, 1992).

Challenging the current promotion of thinned weight-as-health including the construction of WLS as an appropriate technology for health, involves running over inhospitable ground. By employing multiple skills, being resourceful in creating ways to shed light through the research on weight/health decision-making, I seek to avoid both a reductionist methodology and any parochial bias of interpretation. Researchers-as-bricoleurs are open to using and developing a range of research methods. This is about foraging for the useful (Frank, 2004) to manage complexity in the field and expanding techniques rather than resolving them within the comfortable confines of disciplinary assumptions.

The bricolage is a wellspring for a less settled yet more satisfying understanding of the diverse circumstances that surround lived lives. While Geertz (1973) has suggested that such eclecticism could be self-defeating, Kincheloe (2001) has specified that

bricolage within method and theory is so crucial to rigour in qualitative research that rigour demands a bricolage. From the time when researchers began to question the limits of objectivity and the conditions of knowledge production, knowledge had spilled out of disciplinary drawers. Old certainties and stabilities in disciplinary methods and knowledge have increasingly less purchase (Kincheloe).

Bricolage requires the researcher to be as responsive to what is not there as to what is (Berry, 2004). This notion of rigour in the absence signifies peripheral knowledge from the boundaries as imperative to understanding³ in the bricolage. Disciplinary research disregards peripheral knowledges in a preference for seemingly detached, expert and central-facing processes. Seeking to identify what is absent in particular or taken-for-granted situations, researchers may trace complexity of notions about the social world. This invokes the research poetic: “To imagine things that never were; to see the world as it could be;” the social action: “To develop alternatives to oppressive existing conditions;” and the promotion of agency: “To discern what is lacking in a way that promotes the will to act” (Kincheloe, 2008, e16). In a bricolage, disparate knowledges of lived-lives are gathered and woven with formal knowledges to create new possibilities for viewing and acting in our worlds (Lincoln, 2001).

In the bricoleur’s attention to transdisciplinarity, methods, epistemologies and social-theoretical assumptions jostle for attention. Research orientations are about ways of constructing knowledge rather than paradigms for revealing truth (Kincheloe, 2004). Wide ranging knowledges and the use of diverse research strategies encourage exploration of a multiplicity of relationships connecting the research issue or problem to the contexts of its occurrence, thickening and texturing the issues under discussion. Thick description supports the wider applications of studies such as this present one on WLS decision-making, to relate with consulting over a range of health technologies within the medicalisation project (Wainwright, 1997).

Any research enterprise that sets out to reflect ourselves within culture is always assuming some degree of power in relation to the researched - object or person. There is no “[...] unmediated photograph or passive camera obscura in scientific accounts of bodies and machines” wrote Haraway (2003, p.29). Meaningful theoretical outcomes for the researcher-as-bricoleur lie in avoiding the trap of using data to get at truth, while acknowledging the significant impact of what happens to people. Essentially though,

³This is not to suggest an alternative of a feminist standpoint epistemology, that one set of knowers be substituted for an alternative or preferred set.

within bricolage, the emphasis is on the clarification of the researcher's positioning relative to their particular project (Kincheloe, 2005), making clear that all researchers from a variety of social locations shape their research product. Theory, after all, is not "[...] an explanation of nature - it is more an explanation of our relation to nature" (Kincheloe, p.324).

In this thesis, I attend to the development of a modern patient as schooled for experimentation in relation to new technologies, specifically WLS. The genealogical approach to medical science is a significant critique of the progressive thrust of modern medical projects. In understanding the history of medicine as a science based on experimentation, I address concerns surrounding the practice of ethics in medical projects. Such concerns are as much a part of this thesis as are the substantive data chapters in which these discourses play out. I acknowledge that this bricolage is a complex research orientation. The criticality of bricolage has enabled the evidence of historical forces around weight and medical consultation to be highlighted in their current context within the texts of interviews and emails that form the essential database in this research.

How researchers choose to approach these tasks resonates with the philosophical background and commitments of each person. The adoption of the paradigm becomes the critical factor in determining decision-making within the research (Lincoln, 1990). It calls for consistency to a worldview throughout the research with a clear articulation of the researcher's philosophical perspective and positionings. Having acknowledged a philosophical position, the research paradigm, methods and conclusions may then be assessed in relation to this position.

4.2.2 Transdisciplinary research into WLS decision-making. Lived-lives are embedded within a complexity of multiple intersecting stories (Rodriguez, 2002) and such storytelling inherently moves within and between disciplines (Reissman, 1993). Richardson (1991) referred to a discursive move in which no particular discourse in the present may lay claim to an authoritative version of the truth. Mixed methods⁴ are "[...] a paradigm whose time has come" (Johnson, 2004, p.14). In mixing methods, a researcher encompasses patterns in ways that open up the field of study reducing the possibility for limiting interpretation and discussion. The adoption of a particular

⁴Mixed methods study may be based on a variety of qualitative methods. In this study, I concentrated on a deconstructive approach to conversational interviewing, a reflecting team process and Foucauldian discourse analysis of a variety of related texts from a wide range of disciplines.

tradition extends to claims for authenticity of that prescription and, in extension, the deprecation of alternative approaches (Atkinson, 1995). This creates an “other” in the field of research paradigms (Denzin, 1994). Given the call for consistency to a worldview, the personal philosophy of the researcher and the paradigm and methods chosen, this present research is based on an inclusive approach to experiences from within and outside of dominating paradigms. These ways of working are valued within narrative therapy and feminist approaches to living and to research.

In adopting an open bricolage, I choose ways and means to explicate my topic. This has prompted me to nest together a set of practices that works through the problems in the field. Surrounded by a plethora of philosophical and paradigmatic positions open for me to take up, I have increasingly moved towards those philosophies and ideas that embrace attachment, subjectivity and critical interrogation of what is most often taken for granted (Lincoln, Pinar & McLaren, 2001). In relation to weight and health, I am particularly drawn to surfacing unspoken or subjugated elements in available discourses. In moving away from ideas of detachment and objectivity, I have worked to deconstruct the hierarchical positioning of the power to speak implied in paradigms of objectivity. I value speaking-out-with and eschew speaking-down-to with all its associated connotations of power-over and expertise-in. I view these as bringing into play the oppositional preference for professional over lay understandings in modern medicine.

Habiti or early predispositions, reinforced by the civilising influences of society (Bourdieu, 1972; Bourdieu, 1980/1995), are the major arbiters of when, if and how we speak. Even while opportunities to speak may be thwarted in medical consultations by the dominance of professional over lay understandings, a relation of power is present in many forms of resistance.⁵ In the absence of speaking-out, holding fast to old ideas, mulling over ideas, playing with and developing ideas preserve and mature ideas and keep resistant ideas alive. Even taking the opportunity to speak “[...] under one's breath, one negotiates the space between silence and freedom [...] to speak and to keep on living” (Pelias, 2004, p.32).

The object under scrutiny exists within a “[...] network or configuration, of objective relations between positions [...]” (Bourdieu, 1992, pp.96-97). By attending to this field

⁵I merely note here Bordo’s powerful opposition to the Foucauldian notion of resistance as signifying the presence of a relation of power. Bordo (1988, p.246) uses media representations to argue that “the rhetoric of resistance has itself been pressed into the service of such normalization.”

it is possible to understand more about the nature of an object, its relational activity, the historicity of its appearance and the means of its maintenance and visibility. The thinkable, internally consistent object reflects of commonsense and discourages heterodoxy, those ideas that do not reflect orthodoxy (Bourdieu, 1988). For instance, in the acceptance that overweight is indisputably unhealthy, a number of other possibilities are not opened for discussion: health is possible, or even preferable to dieting, at any weight; that a thin-at-any-cost understanding of weight affects consultations from ingrown toenails to heart failure; epidemiology is an appropriate resource within the clinic; WLS is the answer to overweight; or, surgeons are appropriately involved in trading health technologies.

The complexity of weight and its resolution is constructed within the mutually dependent activities of media-ated culture, govern-mentality, and health-as-trade. The compulsion of the weight/health message lies in its weaving through the fabric of our lives like dog's hair through a sofa. Bourdieu (1988) insisted that social scientists should access an intellectual toolkit which included the social history of science exemplified by the French theorists, Foucault, Bachelard and Canguilhem and I have taken such an historical approach to be highly significant in this study. I have looked for creative methods to encompass the fields of consultation in which weight is subject to intervention. In the end I have chosen to notice-but-stray from the arbitrary bounds of medical science, in the interests of producing a more complex story about weight, medicine and WLS consultation. Within a critique of the orthodoxy of weight and health, I suggest that the proliferation of weight technologies gathers momentum when the connections between weight and the cultural context of its occurrence are largely ignored. I have chosen to “[...] live in the middle of things, in the tension of conflict, confusion and possibility [...]” (St Pierre, 1997, p.176) without determining acceptable weight for health. After all, it is in the act of abstracting ideal weight by doctors, scientists, insurance and technology companies, and by citizen/patients⁶ as well, that much of what is termed overweight or obesity has been created as unacceptable. WLS emerges as a legitimised and compelling technical option against the terrifying picture of its culturally produced, risky, and insalubrious alternative, living life as a fat person.

4.3 Introducing the elements of my purposeful bricolage

⁶Health research is permeated by evidence-based medicine for clinicians. The ‘general public’ is accustomed to patterns, averages and other measures based on normative data. Drawn to wider numerical findings, citizen patients may not understand the subtlety of quantitative inference reflected in numerical pictures.

As author/researcher, my concentration in this thesis focuses on the moral dimensions of responsiveness in professional relationships. While I was, from my thesis beginnings, interested in the play of weight in relationships of consultation, what I did not anticipate was that weight technologies could become, so rapidly, a significant and contestable medical speciality through my years of exploring it. Nor did I grasp initially, the significance nor value the potential to such a project of my personal, academic and professional history as transdisciplinary. In reading Kincheloe (2001, 2002, 2004, 2005), I came to relate to methodology as a bricolage but one that was framed, for me, within narrative therapy foundations.

Through the stories of participants, I have watched these narratives played out in our lived lives. In a series of moves in this and the following chapters, I introduce myself into the text as clarification and evidence of my philosophical positioning.

4.3.1 Introducing the author in the text: An interested objectivity. The personal is political, intellectual, theoretical and always significant in the research process (Deutsch, 2004). According to Donna Haraway (2003) objectivity rests within the embodiment of knowledges. Embodying methodology calls for conscious attention to reflexivity on the part of the researcher bringing light to the various structures that shape academic research narratives; it highlights “[...] the relationship between a researcher's ways of seeing and the social location of his or her personal history” (Kincheloe, 2005, p.324). Riessman (1993) pointed out that writing carries the author’s signature embedded within its text specifying their location within a network of relations and ideas. To trace the idiosyncratic strands which weft this particular project as feminist and ethical, I embody each area of the project, writing myself in and giving voice to my body (Cixous, 1981).

In thinking through, resourcing and proceeding with this particular project, I mark it by my locations within preferred and acquired habiti (Bourdieu, 1990; Wacquant, 1992), a spontaneity of instinct (born) and intuition (bred) internalised in the body and acting out of it almost as second nature. Reflexivity adds validity through transparency to the research manoeuvres and the written text that emerges. Primarily, though, in this project, reflexivity guides research and researcher integrity. The ethics of relating with participants through this research and beyond, required a critical openness of the self that encourages a “[...] coherent and illuminating description of and perspective on a situation that is based on and consistent with detailed study of the situation” (Wainwright, 1997, p.202).

It is in the activities of a scientist, according to Geertz (1973), that we may best understand what a science is. In choosing to map within this thesis some of the major theoretical and personal influences on myself, I make myself “[...] answerable for what we learn how we see” (Haraway, 2003, p.28) avoiding the “god trick” (Haraway, 1988, p.584). My choice of topic, the methods with which I explore it and the variety of ways in which this research is recorded reflect my early casuistic socialisation. I read catholic philosophy, argued states of grace, examined my conscience from the age of seven and thought about veniality and mortality of sinfulness. As students, we were encouraged to concern ourselves with ethics in relation to birth control and abortion, all the while absorbing art history in the form of ‘holy pictures.’ An early move away from Catholicism that had impressed my early life at home and at school led to an immersion within a diversity of life’s experiences and academic traditions. Education, sociology, psychology, psychodynamic therapies, ethics, poststructuralist Foucauldian philosophy and narrative therapy are also traditions and experiences which are disciplined but not constrained within this research: I encourage their habit of peeking through the texts. This is a personal bricolage that has taken time to develop: “[...] ideas that originate rather than replicate established [...] practices have a long germination process” (Bird, 2000, p.xv).

4.3.2 Post-structuralist feminist research: Our bodies. I rely on a number of interrelated aspects for a post-structuralist feminist approach to research. This thesis rests on notions of the materiality of the body, the opportunity to speak the body through and beyond cultural bounds within a familiarity of relationship forged between participant and interviewer where this was possible.

In moving away from notions of the immateriality of the body, I acknowledge the importance of the body as a lived entity. This notion embeds the experiencing body within its languaging (Butler, 1993) with which it is inescapably intertwined; it avoids any normative bounds to its constitution. In response to the former marginalisation of the female body as “[...] intrinsically unpredictable, leaky and disruptive” (Shildrick & Price, 1999, pp.2-3), the body remains of central concern in feminist research. In the move to praxis, feminist researchers have embraced matter-as-mattering. In the feminist appropriation and development of Merleau-Ponty’s (1962) understanding of embodiment emerges the notion that our body provides a “[...] general medium for having a world” (p.146). In extension of this idea, those worlds can only be interpreted

by connection with, rather than separation from, the objects and practices of the female body that require description:

For each object, as for each picture in an art gallery, there is an optimum distance from which it requires to be seen, a direction viewed from which it vouchsafes most of itself: at a shorter or greater distance we have merely a perception blurred through excess or deficiency (Merleau-Ponty, p.302).

Talking about our bodies is limited by the presentation of female bodies as deficient and to be discussed in ways that show evidence of the uptake of expert accounts of those deficiencies. This is clearly the case in relation to weightfull women's bodies' discourses where medical science has exerted considerable influence on how the weightfull female body is viewed as a display of deviant excess (Shildrick & Price, 1995). Expert discourses around weight encourage a 'good' patient/participant to discuss body reduction and health as a confessional discourse. Trying and failing is the culturally preferred account and women may be less likely to discuss with their doctors a choice of not dieting.

The crisis of representation, the responsibility for representing 'the other' in ethical feminist research is addressed in this research. In the sense that individual accounts of experiences (Marshall, 1999) are bound with hegemonic accounts from the culture, no text of participant or researcher/writer can know and say the truth of the stories that participants tell (Weatherall, Gavey & Potts, 2002). It is important in feminist accounts of health to consider "[...] the voices of women who have lived the paradoxes in the domain of women's health" (Spitzack, 1990, p.4) even while such a consideration may break with the tenets of post-structuralist philosophy. Recognising the everyday lives of women as they go about their business - how they manage their bodies, how they talk about them and to whom they may say what - relates to the historical location and cultural production of these lives-as-lived. Encouraging women to speak about their experiences within a feminist research interview is at least as important as any eventual findings from the overall study (Campbell & Wasco, 2000). A feminist methodology encourages women's voices to be heard without the reader, listener or researcher succumbing to the notion that these words deliver a full account from a preferred or alternative standpoint. This is particularly at issue in research (such as this thesis) that acts to interrupt (Fine, 1992) current understandings of weight and surgery for weight loss as inevitably an intervention for health.

A further aspect of post-structuralist, feminist research on which this thesis relied was a relational emphasis in the interviewing. Maintaining an appropriate distance between researcher and participant in quantitative research is seen to promote the validity of the data collection. In qualitative research the emphasis is on gaining rapport through relative degrees of closeness promoting access to sensitive information that affects the quality of qualitative data (Wainwright, 1997). In feminist research, the emphasis is on the genuineness of the relationship that may develop. Using or faking a relationship for the purposes of, for example, lending a veneer of plausibility (Fielding, 1993) to the analysis may result from a researcher's over commitment to a particular analytic thread. Personal experience of the phenomenon under study may aid the relationship to develop and provide a source of insider information (Stanley, 1990). The emphasis in a feminist research relationship needs to be on fostering genuineness in the relationship and a genuine wanting to know.

Single interviews do not preclude the development of a significant relationship just as lengthy participant observation in the field does not lead necessarily to the closeness suggested by Wainwright (1997). One of the ways of ascertaining the development of the research relationship in ethical feminist research is on the alternation of speaking and hearing evidenced through the research record. While there is often a main hearer, a major questioner, one who will eventually record the words and ideas constructed within the interview for an audience (Plummer, 1995) the transcripts and the written record should reflect some of the natural sharing in the to and fro of conversations between women. While the researcher is committed to her study, the study is also related to some aspect of the experiences of the participants:

It is the interviewer's investment in finding answers, her own concern with the questions she asks and her ability to show that concern, that serves to recruit her respondents as partners in the search: the things said are responses to these words of this particular researcher. The researcher is actively involved with respondents, so that together they are constructing fuller answers to questions that cannot always be asked in simple, straightforward ways (DeVault, 1990, p.100).

This then is about the stories that are told within these relationships. In these stories, lives are re-membered, choices are re-counted, and emotions are re-enacted. Pathways of storytelling meander, backwards and forwards, future, present, past and back again.⁷

⁷This wording works with Bateson's (1989, p.34) notion of the construction of a quilt. While I use the idea of pathways I dislike the necessarily progressive imagery invoked: This is not about stages in a progression but meanderings back and through and round again.

4.3.3 Speaking our stories. Personal narrative is both “fundamental” and “universal” (Ochs & Capps, 1996, p.19). The term ‘narrative’ has become the veritable catch-all for stories, utterings, discourses and the like.⁸ According to Hardy (1968, p.5), “We dream in narrative, daydream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticise, construct, gossip, learn, hate, and love by narrative.” Indeed, writers such as Riessman (2007, p.428) have come to refer to narrative as a veritable “tyranny.”

In the uptake and proliferation of narratives, narrative has named the empty signifier through which the disparate and the ubiquitous are spoken of as though they share meaning. But meaning is constructed, contingent (the gap between causes and results), and political (Groppo, 2004). As the narrative label has gained currency, as it gathers such a multiplicity of understandings and meanings, to use the term “narrative” as though it stands for something is increasingly less informative. Jonathan Swift's 18th century satirical account of the fictional academicians of Lagago would trouble any commonsense notion that words are representational, that signs may ever stand easily for things.

Stories people tell have gained epistemic standing through numerous disciplines. This has both initiated and responded to “the breakdown of transcendental truth-claims, to various overturnings or assaults on formerly hegemonic logico-deductive and patriarchal models of reason and knowledge” (Kreiwirth, 1994, p.63). The narrative tradition in which I place myself is essential to this project. Narrative therapy rests within the social constructionist domain of social psychology (White, 1997) and my decision-making within the project reflects my longstanding association with the complexity of ideas and practice with which narrative therapy is associated. Personal narrative is focal: After all, storying provides a way to bring coherence and meaning to our lives and allows us to reach out and touch others. However, I also understand stories as significant for what is missing as from what is present in them. Thus the deconstructive aspect of my discourse analysis attends to the dominating influence of hegemonic discourses appearing in and affecting the research narratives. In particular, I trace the operation of power through the narratives of all research participants. In the analysis, I reflect on the limiting nature of what is available to be storied by participants and the impact of those limits on the outcomes of WLS consultation.

⁸For a review of personal narratives, refer to Ochs and Capps (1996).

While narrative research has proliferated within the field of medicine/health, medical knowledge is itself a powerful narrative: Supported by a hegemonic discourse, it resists being woven into ever-larger stories. When Michelle Fine (1992, p.1) wrote that the field of psychology “[...] has long enjoyed an internal debate about women [...] traditionally, we have been the objects of these conversations, however, and not their subjects,” she could just as easily have been speaking of the related professional field of medicine.

This thesis is framed through a weaving of alternative knowledges from lay and professional sources within a bricolage resting on narrative therapy foundations. These foundations embrace feminist principles of inclusiveness and evade the artificial structuring and othering of dominating, uni-disciplinary shaping. In encouraging reflexivity, this research is based on narratives clearly marked by personal “[...] sensibility, inhibitions, language, history, intelligence, inclinations to wish, hope and dream” (Hardy, 1968, p.9). It is always also a cultural narrative. In pointing to a story’s ubiquitous nature, Richardson (1990) promotes an agental understanding of story as a positive means through which people may access and enact new lives. In mapping intentionality and making lives understandable within their cultural contexts, narrative allows us “[...] to contemplate the effects of our actions, and to alter the directions of our lives” (Richardson, p.117).

My particular bricolage-as-methodology rests within and around narrative therapy opening my positioning as researcher to processes of reflexivity.

4.3.4 A genealogy of narrative therapy in the development of a research approach. As a result of social, historical and economic contingencies (Foucault 1975; 1977; 1980), medico-therapeutic endeavours have proliferated. Secondary professions such as psychotherapy and counselling, the “psy” disciplines (Rose, 1989; 1999), came to share in the ‘professional gaze’ (Foucault 1975). Aligned with the medical model, these disciplines protected the right and ability of their professional groups to interpret problems as deficits, and individuals as deficient or deviant. Labelled as deviant, individuals became ripe for analysis within medical discourse and diagnosed according to specialised language.⁹

⁹Sexual abuse practitioners in New Zealand, very few of whom were psychiatrists or psychologists, have been required to categorize their clients according to the DSM in order to have their work with clients funded.

Positions of authority in society call for ‘others’ to comply with directives. In the failure of citizen¹⁰ clients or patients to do so, they could be diagnosed as resistant and blame attributed. The objectified languaging of deficit was available in various editions of the Diagnostic and Statistical Manual (DSM). From 1980, DSM-III was built on a medical model that clearly differentiated normal from abnormal behaviours. This was a time marked by the proliferation of mental health diagnoses using the DSM. This has been described by Tomm (1989, p.6) as “collapsing problematic descriptions onto people.” Problems were related to individuals within a political ethos of a free, neo-liberal citizen who would accept responsibility for acting within uni-dimensional cultural strictures. The move from the external imposition of discipline to self-discipline came with rules and patterning of normalised behaviours delineated in the psy-sciences from the 1950s in versions of the DSM. These labels generalised into the wider practice of medicine and into lay languaging of deficit.

When narrative, social constructionist foundations appeared in the world of therapy, they did so into a wider world that aspired to largely middle-class values and which encouraged the imposition of socio/cultural norms for living a good life predicated on a transcultural, monolithic self with shared values. Narrative therapy was part of a notable political movement based within a deconstructionist move. It emerged at a time when expertise was invested in therapists who assumed the right, conferred by professional memberships and appropriate trainings, to diagnose problems and to treat (Freedman & Coombs, 1996, p.16). Foucault’s analysis of power/knowledge allowed a tracing of the socio-political context in which therapy was being conceived and practised.

The originating narrative therapists (Bird, 2000; White, 1995; White & Epston, 1990) looked outside of existing therapy traditions to find new metaphors to challenge current practices in family therapy and the culture of deficit that dominated the psy-disciplines (Rose, 1999; White). The development of narrative therapy is described in two major texts: *Literate Means to Therapeutic Ends* (White & Epston, 1989) and *Narrative Means to Therapeutic Ends* (White & Epston, 1990). These texts reference eight selections from Foucault’s work. Specifically, they worked initially with Foucault’s genealogical texts of *Discipline and Punish* (1977), *Power/Knowledge: Selected Interviews and Other Writings* (1980); *The History of Sexuality, Vol. I* (1978);

¹⁰I deliberately employ this term to refer the reader to the idea that the medical profession has increasingly been caught up with a “govern-mentality.”

and *Space, knowledge and power* (1984a). By 1990, they were referencing *Madness and Civilization* (1988a); *The Birth of the Clinic* (1975); *The subject and power* (1982); and *Nietzsche, genealogy, history* (1984d). Narrative therapy drew as well on a wide range of other academic and literary resources including family therapy, anthropology, psychology, ethnography and sociology.

My choice to develop a bricolage that owed much to my immersion in narrative therapy was about encouraging multiple perspectives within the data and the analysis. Narrative therapy developed on the basis of diverse influences that encouraged richness in storying experiences and contextualising stories within deconstructive framings. My thesis project is likewise embedded in a rich complexity of description as I considered, up-front and personal, the breadth of narratives that surround and determine the field of WLS decision-making.

The narrative therapy foundations of this bricolage emphasised a reflexive ethics of relating within the embrace of critical-narrative, feminist principles of transdisciplinarity.¹¹ From its beginnings, therapists working with narrative ideas sought to be respectful and non-blaming in working with communities, families and individuals, interested in people as experts in their own lives. Clients were resourced to work with the problem, using expertise and resilience garnered from their own preferred stories. Rather than asking questions that might imply right ways of thinking and being, therapists working with narrative ideas are curious and expectant of Goffman's (1961) development of "unique outcomes" (White, 1995, p.26) in clients' responses. This opens up an array of stories by which clients make sense of lives and choices. Working with unique outcomes encourages a sense of agency and opportunities to choose from a less limited range of options (White and Epston, 1990). This forms an essential bridge to ethical decision-making for WLS options on which this thesis relies: For instance, if medicalised notions of weight did not confine decision-making for WLS, what other choices might have been available?

When I inscribe others in my thesis writing process, this carries strong ethical commitments to acknowledge that my writing is not neutral (Van Maanen, 1988). Narrative therapy is both my philosophical commitment and a political project that concerns itself with respectful and inclusive practices of speaking and listening. Within narrative therapy approaches, the emphasis on respectful and reflective practice thickens

¹¹While the artificial structuring and othering implicit in uni-disciplinary shaping is voided, transdisciplinarity is not itself closed to critique as yet another form of social construction.

the description of the person rather than thinning or essentialising (Freedman & Coombs, 1996). Resilience in the face of life's difficulties rather than deficits open to definition and resolution by professional others, created a philosophy of practice within narrative traditions that challenged modernist professional production of meta-narratives and practices of expertise (White, 1997, p.222).

This thesis is grounded in narrative therapy methodology and my use of genealogy as a form of social criticism is informed by narrative therapy's appropriation of Foucault's concept of genealogy (Foucault, 1985, p.116). The benefits of working with the research narratives through such a developed methodology were immeasurable as I traced the history and arrival of current cultural practices around weight/health and intervention as practices of expertise. I was engaged in working with the narratives of weightfull women and doctors to understand the effects of power in decision-making for health, specifically WLS technologies. As Foucault argued:

The real political task in a society such as ours is to criticise the workings of institutions, which appear to be both neutral and independent; to criticise and attack them in such a manner that the political violence which has always exercised itself obscurely through them will be unmasked, so that one can fight against them (Rabinow, 1984, p.6).

Participants were clearly making decisions about WLS on the basis of meaning constructed on deep cultural commitments (Wittgenstein, 1953) and narrative therapists reflect on the limits imposed by culture on life stories and decision-making. In this research, I seek absences in available discourses and subjugated knowledges to re-incorporate "[...] vital and previously neglected aspects of lived experience" (White & Epston, 1990, p.31).¹² While narrative therapy is concerned with critiquing Western psychology and humanism, I work within this research on women, weight and health to apply these ideas to the associated humanistic traditions within the application of medical science to modern problems of living.

In standing up to labelling and notions of deficit as a practice of narrative therapy (Bird, 2000; Monk, Drewery & Winslade, 1997), my analysis of the storytelling rights of health professionals required respect for their diverse values and commitments. As well, my interviews with weightfull women required a respectful approach marked by an active curiosity about their decision-making within medical consultations and

¹² This deconstructive aspect of narrative therapy owes much to Derrida's (1982): "DifferAnce is the hidden way of seeing things that is deferred out of awareness by our distraction with the imagery that captures our attention" (Derrida, 1982, p.22).

choices of radical WLS technologies. Within my work and in that of participants, I have attended to the “[...] magic power that comes with the use and misuse of language in social and political life” (Bruyn, 1986, p.125).

4.4 Engaging with transitions and disconnections: Writing and research

In my engagement with the topic of consultative medical relationships, I have experienced marked periods of transition in the research from powerful feelings of connecting with the participants as I interviewed them to total immersion in the data as I attempted to understand these stories. I noticed times of marked unwillingness to disconnect from each stage of the thesis process and at other times a burgeoning excitement for moving through to setting yet another scene, sometimes precipitately.

These transitions have been marked in my life around the research by absorption with my fabrics and patchwork projects. There have been significant parallels between these patchwork projects and the research. The excitement of putting together colours and fabrics, trying out new combinations of weights and grades, the new and the old, the bought and the received, integrating an embroidered piece in the body of the quilt, placing fan blocks in the bottom corners... These are activities that clarify for me how the research is also coming together: Full and rich, layer-upon-layer, a sense of unsettled integration to be artificially ended when the thesis has sufficient complexity to provide an entrée into the material and ideas that surround weight and WLS consultation for reader-participants.

At times in between, I stand back and appraise my project and the connections and disconnections inherent in it. As one piece of the project seizes my attention, I notice that other layers become temporarily lost from view or are even deliberately backgrounded. This thesis project has persisted in layering itself, a process that all the time invites further layering, and which will require to be brought together in some more formal sense. I begin to talk about analysis-as-re-search (it is my search and it is a re-searching of the searching of others); it is authoring and also co-authoring (this text contains my writing about all-of-us who are involved in the processes that this re-search text brings into life); it is about being gifted stories and passing them on (being fed and finding a way to feed). It is about finding ways to acknowledge the author-ity of participants as they relate their lives within this project and it is about seeking ways to re-produce these stories-of-lives-as-lived in a text that reaches into the hearts and minds of reader-participants. I trust that this will encourage a re-remembering and re-contextualising of readers’ own stories and lives. My research process is about finding

and developing new ways for re-researching within a philosophical ethic of inclusiveness: I embrace what lies between the new and the old, this challenge to accepted uni-theoretical practices and methods of research and findings.

4.5 In reflection and moving on

While exposure to and practice within a diverse exploration of models and paradigms are made available within the academy, it is obvious that ways of working academically have a great deal to do with experiencing and managing these-ourselves within many spheres of lived-lives. Theories inform the very practices of personal lives as they do academic lives. However, consciousness of the theories we live our lives by are not usually so available to scrutiny nor so apparent as those within academic pursuits. As in the sociological practices of Frank (1993; 1995; 1998) personal experiences of illness promoted new understandings of his worlds and work, my research is informed by my experiences of weight and WLS to find ways of understanding how other people experienced WLS, living weightfull, and, choosing WLS.

Academia provides access to practitioners, methods, methodologies, philosophies and exemplars of practice that fit along methodological and disciplinary axes of intersection. These underpin the diversity of possibilities for research practice. Traditionally, the emphasis has been on choosing methods, materials and texts from within particular disciplines. Critical transdisciplinary bricolage is practiced naturally within feminist Foucauldian environments and may be considered a crucial approach in the 21st century (Dolling & Hark, 2000; Wear & Aultman, 2007). I use these ways to trace the artificiality and contingency of progressive medical paradigms that encourage citizen/patients to undertake radical WLS technologies,

In the following chapter, I work from methodology as a philosophy of self and practice to engage with lived experience in this thesis project. I will talk about research as a practice of ethics. I will show how I appropriated and developed tools of analysis in the service of viewing the weightfull-female-body-in-the-world and as an appropriate target for surgery intervention.

“A plurality of independent and unmerged voices and consciousnesses, a genuine polyphony of fully valid voices [...] a plurality of consciousnesses, with equal rights and each with his own world, combine but are not merged in the unity of the events”
(Bakhtin, 1984, p.6).

CHAPTER FIVE

Methods: Extending methodology

“Many personal narratives hence remain in the private sphere of dim inarticulateness, having no group to sustain and strengthen them. For stories to flourish there must be social worlds waiting to hear” (Plummer, 1995, p.121).

5.1 Introduction

Methods are research activities that bring methodology into play. This chapter deals specifically with particular research methods I used to research weight and WLS consultations. In this chapter I work through various aspects of a research project based within an analysis of narratives: participant selection; working with the data; the use of technologies; interviews reporting participant experiences; processes of analysis; the use of diverse narratives to aid the textured complexity of the final accounts. In recognition of the complications of the research endeavour, I discuss some of the conundrums in this research and show how I moved to resolve them.

5.2 Ethics

WLS may or may not produce weight loss in the shorter term; many patients have rebound weight regain; there appears to be little consideration of the long-term consequences of WLS on specific bodies or for the population as a whole. My investigation of WLS underlined my belief that social science research should use methodologies to promote wise choices of action and that this was itself a form of applied ethics (Flyvbjerg, 1993). This thesis came to reflect on ethical concerns surrounding radical surgical technologies.

Narrative and its construction are deeply personal and relational. Yet my attempt to explore and map lived experiences of participants and to produce some meaningful meta-text has deeply ethical constraints. My ability, let alone right to engage in

interpretation at all, is dependent on the existence of a sufficient basis of shared cultural identity and a heartfelt attempt to avoid the production of “the other”. I have continued through the project to ask myself the question that is often placed around Foucauldian projects: What are the ethics of opening up the research domain to find that “there are no definitive answers?” I have had other questions too: How do I form research relationships in which the questions I ask, the responses that are made, the way I work with the data and my final writing of the report may open into a darker picture of these procedures and medical relationships of consultation? What are participants and readers expecting and wanting? Could this work inadvertently to produce a new or established right response?

A relational ethics of care operates within a reflective practice of respect for clients (Bird, 2000). In bringing this orientation to my research, I encountered a number of tensions in this work. Many of these tensions were ethical in origin and involved some inevitability of exploitation in any research process. In this regard, the exotic nature of some stories about WLS, as when women talk about vomiting as an everyday experience following WLS, could be exploited to add drama to my research or presentations. Undoubtedly, such stories affect audiences in different ways: For some there is horror and disbelief; for others, there is an acceptance of the side effects produced by a lifesaving intervention. How do I co-produce such stories? How do I position myself in relation to the trade potential of body-normalisation projects? How will my personal experience of living as a weightfull woman be reflected in the questions I ask and the documents I produce? How do I relate with women who have chosen surgery and with the surgeons who normalise these surgeries as part of their business portfolios? I remind myself both during the interviews and in the writing that follows them, that I am encouraging or at the very least making use of the contemporary obsession with confessional dialogues, in particular the requirement for a woman to “declare her deviance” (Spitzack, 1990, p.58). In defence of this method, I suggest that these research conversations aimed at promoting reflective discussion on weightfull women’s presence within weight and WLS consultations.

Reflexive positionings have become an accepted part of feminist methodologies, allowing and requiring researchers to discuss their multiple positionings in relation to their research (Cook & Fonow, 1990). My interest in the ethical aspects of WLS consultations arose out of practising as a narrative therapist for over twenty years; my questioning of processes of consultation around weight arose out of my experiences

with living large and participating in WLS. These experiences informed my positioning in the research as both a participant and a researcher. My experience of WLS was complex, with positive and negative effects. For instance, I lost weight with WLS but I had also laid a complaint with the Health and Disability Commissioner (HDC) about some aspects of my WLS treatment. This was discussed fully with my original thesis supervisor and we presented it jointly as an issue to the Wellington Ethics Committee in October 2002 (Appendix 3) before applying for full ethics approval. I also approached the HDC for his opinion on the study: He indicated that any complaints he received about WLS following on from my research would be regarded individually and would have no effect on my own complaints' process (Appendix 4). Final approval for the study was granted, initially by the Wellington and Northland to Frankton ethics committees as a Multicentre study – Wellington lead – on December 20, 2002. Subsequently two further centres were contacted, Blenheim and Manawatu, who also granted the limited approval I had requested. Ethics oversight transferred to the Health and Disability Multi-centre Ethics Committees on June 5, 2005.

Several issues emerged from the ethics approval. Firstly, I was asked not to advertise the fact that I had had WLS in talking to participants; I was required to say merely that I had a personal interest in the field of weightfulness. This in a sense placed me in a double bind. While the committee underlined my thinking that the research needed to be fully transparent, I was concerned about how to be transparent when I could not say that I had also had WLS. In the research interviews, I took the position that if a participant asked me if I had had surgery, I would answer them honestly but briefly. What I had not prepared myself for was the time when a participant discussed her decision not to proceed with a particular form of surgery. At this point in the interview, we were discussing the impact on Meryl's decision-making when a friend chose WLS:

Meryl:

She had the gastric stapling but she didn't have the bypass. So I went on to the computer and did a search, and the first thing I came up with was a Health and Disability hearing result which would have been Dr Z. There was some problem there, so I thought, "Oh, I don't want to go..." and then I read some more about him, and thought, "Oh this is no good."

participantR:¹ *(Absolute silence, then) Even though he got only one finding against him and four findings for him?*

Meryl: *Yeah, toys for the boys I think.*

I recall the shock I felt, and the struggle to speak. I later wrote about it in my reflecting diary that accompanied me on these research journeys: Meryl was referring to my complaint documented on the HDC website. Following the completion of the interview, I informed Meryl briefly that this related to a complaint I had taken.

Having experienced WLS, I was able to ask technical questions and to understand the differences between certain types of surgery. I knew of its availability in the different centres. I recognised the practices, such as lapbanding inflations, laparoscopic versus open procedures, and the variety and particularity of side effects often associated with certain procedures for some patients.

Access to counselling for myself and for participants was recommended by the Wellington Ethics Committee. As a counsellor, I continued to receive supervision in which my progress in the thesis and research became a significant focus. The Northern Ethics committee requested that I have cultural supervision available and my consultant for cultural supervision was a very experienced Maori researcher in the Eru Pomare Research Centre at Wellington Medical School, Otago University of Wellington. She was supportive of the research and actively recruited two Maori participants for the research.

The participants were also given contact details of my academic supervisors at the time of interviewing and they were encouraged to make contact if required. I made myself available to assist participants with any difficulties within or following the interviews. I installed a free-calling 0800 number in my home so that contact could be made free of charge at any time. Participants were also given my email address. I approached a number of my counselling colleagues in the various geographical regions to be available if they were required, for ongoing work with participants. This was not needed. One participant, who did not know that I had taken a complaint, asked me about proceeding to a complaint, and I gave her the contact details of the HDC. Participants are less identifiable because some time has passed, allowing these stories to

¹What could I call myself? I settled for participantR to reflect my positioning as both a participant in the research and the researcher.

merge with other stories. Since the time of the original interviews, WLS patients and surgeons have become part of a burgeoning field of surgical enterprise.

New Zealand has a very small population of approximately 4,000,000 people. Correspondingly, there are few surgeons and this may have been a limiting factor in relation to being identifiable. For instance, as Meryl's narrative indicated, she was readily able to identify the surgeon on the HDC website. That some time has passed may assist in protecting the identity of doctors who agreed or asked to be interviewed. However, I assigned pseudonyms for all the doctors even when they saw no need for confidentiality. Two doctors I interviewed acknowledged their very public views on weight and WLS and did not wish for pseudonyms.

Bearing in mind that this was a reflexive document and that I expected the participants to tell me their stories, I counted myself as always in rather than outside the research. I referred to aspects of my own experience, as did Pitts-Taylor (2007). She researched cosmetic surgery while also being a cosmetic-surgery patient. My research was about voiding the possibility of a "God's-eye view, the view from nowhere" (Bordo, 1993, p.39), the narrative of the expert (Plummer, 1995). While it was important to include aspects of my own story, I did not wish my story to take over any aspect of the research. Initially, I believed that it was both an important story and somewhat unusual. In the end my story took its place almost unnoticed amongst others. However, what happened in relation to my experience of surgery stimulated and assisted my analysis of modern medical technologies and processes of consultation. I chose the PhD thesis as a format for that research. Overall, I believed that it would be ethically compromising of the research and incompatible with its reflexive commitment if my own story faded into any "dim inarticulateness" (Plummer, p.121).

My methodology-as-process has challenged the idea of researcher as univocal expert. I do not sample to completeness and I "use (my)self to get to culture" (Pelias, 2004, p.149). I turned to texts as scenes of narrative display in the interaction of alternating and alternative perspectives. This thesis is about presenting complex material, sufficiently rich to survive multiple reinterpretations within multiple readings. These stories produce weight-full women's life courses as precarious and slippery, beset with medical sign postings and cultural laws.

5.3 Data and technologies of recording and transcribing

There were multiple sources of data. One participant provided access to all her emails sent to a support group about the time of her first WLS. These emails continued until

the point of reinterview in the study after she had elected a further procedure, almost five years later. Another participant whom I was able to interview before her surgery and reinterviewed a year later, had maintained an online diary and also recorded her experiences in emails to a support group. I was allowed access to both of these. I had access to a completed WLS complaints process, and accessed the HDC website for further complaints' processes as well as media portrayals of two specific HDC processes in which the media coverage for one participant was considerable. Two women provided access to notes from their operations and a range of clinical letters.

Although this research began as a study based on interviews with doctors and patients, it was initially designed to include a series of reflecting team processes.² I did not proceed with this interactive section of the research when only one doctor expressed any interest in participating. A reflecting team process, with four of the women participants, did proceed. On reflection, the sheer weight of the qualitative data might well have made this larger project unworkable for me as a single researcher who was self-funding this research.

All interviews were fully transcribed, by the researcher, or by one of two transcribers who were paid³ for some work. All the interviews, including the reflecting team process and reinterviews, were recorded on the researcher's own digital recorder. This technology produced extremely clear sound on mini-disc technology (including chewing and sipping during interviews conducted at meal times) and was not frustrated by the need to change tapes at the end of each half hour. The disc recorded about three hours of transcript at one time and did not require the researcher to be present. At one point during the reflecting team process, I needed to leave the room: I alerted the participants to the tape continuing to run and the discussion continued and was fully recorded. These discs have been retained in secure storage. The transcripts are available in electronic and hard format in a locked cabinet. This cabinet also houses the downloaded emails,⁴ personal documents including case notes, and the downloaded electronic diary. Although several presentations I have made included sound files, the words are those of the participants but actors were used for voice-overs.

²Appendix 5.

³One grant of \$500 for transcriptions paid for the initial 3 interviews to be transcribed.

⁴While these were online forms of data I chose to download them for coding. This was a fortuitous decision as the server experienced a problem and all the original three years of data were erased from the website.

5.4 Who were the participants?⁵

Thirty-eight participants were interviewed for this study.

1. Twenty-two women participants: Two women identified themselves as Maori and a third acknowledged her Maori heritage on re-interview. Participants were recruited for the research from three main sources:

(a) An advertisement (Appendix 6) was placed on the New Zealand weight-loss surgery support site and 16 women were recruited, of whom one was Maori. Of these women, all but four had undertaken a form of WLS by the end of the data collection phase.

(b) A Maori health researcher took the advertisement (Appendix 6) and the information sheet (Appendix 7) about my study to a meeting at a local Primary Health Organisation (PHO)⁶ with a predominantly Maori population: Two Maori women volunteered to participate, neither of whom had WLS.

(c) Janice, Phoebe and Em heard about my research and asked to be included in the study. Of these participants, only Janice had had WLS.

2. ParticipantR was included in relation to case notes and other written materials.

3. One woman, recruited through a contact on the website, was also a doctor initially recruited as a weight full woman participant. She was interviewed in both capacities.

4. Sixteen doctors, including the weightfull woman participant/doctor, were eventually interviewed for the study.

5.4.1 Recruiting the women participants. I chose the WLS support website in order to attract a group of women who had an extensive history of grappling with issues around weight and were investigating WLS as a possibility. Out of respect for the privacy of website users, who do not expect to become potential research participants (Eysenbach & Till, 2001), I emailed the coordinator to discuss the research in a preliminary way and to seek her permission to place such an advertisement. Email contact was initiated before phoning participants to arrange times to meet. This selection process might be seen to have in a sense narrowed the range of experiences

⁵A full listing of the participants by pseudonym are in Appendix 8.

⁶New Zealand Health Care strategy aims to provide access to healthcare services that will improve and maintain health within a coordinated care process. For more information, the reader is directed to documentation about the implementation of this strategy (Ministry of Health, 2001).

and histories of the participants: For instance, participants required access to the Internet and would probably be considering WLS as an option. The women participants were self-selecting and all the women who offered to participate in the study were interviewed. One woman originally asked to be interviewed but declined two invitations to meet, proceeded to WLS, and was continuing to experience a number of problems at last contact.

5.4.2 Recruiting the doctor participants. After an initial mail-out to 35 doctors (Appendix 9) in my local urban area failed to attract any participants, I used three contacts within a university followed by a mini snowball resulting in six doctors being interviewed. One participant recruited from the website asked her friend, a doctor, to participate; three women asked their General Practitioners to participate; one WLS surgeon asked to be interviewed and another WLS surgeon was approached and agreed to participate. I approached three doctors in weight-related specialities, who also agreed to be interviewed. One doctor, introduced by another doctor, initially agreed to an interview but refused when I did not offer a consultation fee. Surgeons on occasion alluded to personal information about their respective patients and I deliberately avoided such openings. I held the ethical position that my contract with the participants did not and could not include subjective comments by these doctors concerning their patients: This was in the interests of patients maintaining ongoing relationships of consultation.

5.5 Data gathering

5.5.1 The first stage of data gathering. This consisted of individual interviews with 21 women, a group reflection process with four of these same women, and reinterviews with another four women over the next few years as they made new and major decisions about their weight.

(a) The individual interviews with women lasted at least one hour, with most of these interviews being up to two hours in duration. The interviews generally took place in the participant's home or workplace; two participants were interviewed in rooms offered by the interviewer. In the interviews, I asked the participants to sign the consent forms (Appendix 10) and left them with a sheet of information about the research (Appendix 7).⁷ Participants

⁷The information sheet showed an ongoing reflecting team process as part of the original format for the study. The sheer volume of information made this part of the research untenable but is being considered as part of an ongoing research process. Only one of the doctors offered to participate.

were encouraged to talk about those things that were important to them in their history with weight issues. Women reflected on how they considered weight had been dealt with in their consultations with doctors.

(b) A reflecting team of four women out of the original eight who had been interviewed in one geographical area, agreed to meet and talk. This group meeting lasted for three hours and was fully transcribed. Two further women were unable to attend at the last minute, one through advanced pregnancy and another through illness.

(c) In the course of these interviews, a number of participants referred to website emails and these two participants allowed me access to retrieve them. Another participant gave me the first chapter of her book detailing her experiences of being a weightfull woman; another photocopied and forwarded medical case-notes including operation notes; a further participant referred me to an article she had written. Where I have used this material in the data chapters, I have noted their provenance separately to any interview materials. The email material in particular added a valuable insight into the history of the participant's decision-making process. Shona's diary entries were a painstaking record of her daily food and weight and followed her post-surgery progress for almost a year. This written material added considerable depth to the descriptive and analytic processes as found data rather than data produced for a particular piece of research. It also raised ethical issues about the use of the Internet as a public/private space for research. Specifically, I asked for permission to access and required the provision of passwords in one instance. These were readily given. On the other hand, these communications were being accessed, referred and responded to by other people with whom I did not have a confidentiality agreement. While I was also an accredited member on the website, and while I appreciated the richness of this form of data (Eysenbach & Till, 2001), I needed to respect the privacy of others on these websites. Thus I did not refer explicitly to any postings outside of those I had agreed access to.

5.5.2 The second stage of data gathering. This consisted of individual interviews with fifteen doctors. Doctors were interviewed in their workplaces apart from two doctors whom I met at home. While doctors were asked specific questions about the nature of their consultations around weight, they were encouraged to situate

their practice within examples of their practice and to reflect on their own history of weight.

5.6 Conversational interviewing in the gathering of stories

Interviews with participants followed a semi-structured style of in-depth interviewing (Wainwright, 1997). I took with me to each interview and to the reflecting team a skeleton list of questions (Appendix 11). Towards the end of the interview, I asked participants to think about anything that they considered important that had not been covered. I left my contact details including email address and 0800 number for participants to contact me if they had anything further to add or if they wished to view the transcript.

As a therapist I regarded myself as skilled in interviewing, understanding the interview as a medium for understanding a problem rather than as a site for intervention by an expert. This was built on the personal and client-centred approach of Carl Rogers (1961; 1969; 1980). I prefer an interested and informal, as opposed to a disinterested, style of consultation and this promoted an ease-full bridge into the research interviews. My interviewing style reflected the narrative therapy style of interviewing based on the deconstruction of professional expertise (Bird, 2000; Epston & White, 1992; Epston, White & Murray, 1992; Gilligan & Price, 1993; Monk, Winslade, Crocket & Epston, 1997; White, 1991; White & Epston, 1989). Essentially, my research orientation reflected my acknowledgement of participants' expertise and understandings of their lives and their decision-making as integral to that.

Within these research interviews, I worked naturally with a reflexive approach to questioning. As a practitioner and as a researcher, I work from a Feminist Foucauldian perspective, dialoguing through narratives, a process in which the deconstruction of power/knowledge in consultation is fundamental to my thinking and openly played through this narrative-based research (Besley, 2002; Riessman & Speedy, 2007). Deconstruction resided within questions that are creative in their use of language: Micro questioning carries through a curiosity that works against the power of preconceptions to impose meaning; social, political and cultural assumptions are traced within persons' experiences and this facilitates co-authoring aspects of the research narrative. For instance, in the interviews with weightfull women, my questions related to how women understood the effect of living weightfull, and, for those who opted for WLS, how they storied that decision:

- participantR: *You thought it (WLS) was to get you away from dieting per se?*
- Michelle: *Well I had already gone away from dieting*
- participantR: *because you*
- Michelle: *had fat acceptance and that kind of stuff*
- participantR: *Imm*
- Michelle: *So I was really in quite a good place and all it was for me was reducing the physicality of my size and unfortunately, what it seems to me happened, it shifted me back into that horrible diet crap and I was still there and only just now, five years - four and a half years later- still climbing out from underneath that again*
- participantR: *from whatever it was*
- Michelle: *The blame and judgement and its all fault and rules and regulations.*

An empathic style of interviewing paid attention to material relating to the operation of power in processes of consultation between women and their doctors. Michelle discussed a problem she had experienced in a recent WLS consultation, and this clearly contributed to the research. That discussion appeared to have positive flow-on effects for Michelle as well. Following this interview, Michelle emailed: *“After six months of some pretty rough stuff and I think in part due to the time we spent together during our (second) interview, I’ve finally reached that nice, calm place”* (email 139, 24 June, 2004).

I encouraged the use of anecdotal information. Such information has many functions. It promotes access to material that is yet to be reflected upon or is difficult to describe. Van Manen (1990) promotes attention to anecdote in its ability to access pre-reflective, concrete experience while prompting reflection. When that process of reflection is stimulated in the research interview, participants are present in the analysis rather than only in the mode of a ‘voice-over’ by the researcher. Voice-overs by the researcher tend to show that they “[...] know us better than we know ourselves” (hooks, 1990, p.48): This constructs an anonymised document in which the expert is the only producer of knowledge. The passive languaging of psychological reports provides just such an exemplar:

The authority of the absent investigator lies behind every passive textual construction. It is he or she who decides hypotheses and methods, and draws conclusions from results. The investigation tries to increase scientific order and truth at the expense of the chaos and errors in the field (Burr, 1995, p.165).

Anecdotes act as a grounding mechanism for ensuring that participant voices are not lost in the researcher's analysis and reflection. The text becomes inclusive of the many voices and experiences on which the research is based. Opie (1992), in her study of the community care of older people, positioned herself clearly in the feminist and post-structuralist traditions. She relied on participants' knowing, in the face of a sociological tradition that has tended to privilege the anonymised voice of the researcher, while silencing or suppressing the voices of the researched.

At the conclusion of each contact, the possibility for ongoing discussion was made available to each participant, though I viewed each interview or contact as complete in itself. Each of these research interviews recorded a moment in time within the negotiated space of an interview. Interviews were sought and agreed to, for the purposes of understanding the research questions. Issues to do with interviewing were dealt with as they arose such as one participant who needed to discuss the effect that being taped might have on her ability to be open (Sheree).

I remained aware through these interviews that in the research stories we construct and put out into the world, our personal experiences are implicit in the questions we ask, the responses we make, the dialogues in which we are willing to engage and the analysis we undertake (Gentry, 1989). But then, what do we do with the stories that participants tell us, which in our view may possibly relate to inadequate or discriminatory care that is ongoing. Do we, as Fine and Gordon (1992) suggested just ask nice questions in a tame manner? What would be the effect of that on our research? This was a research dilemma. For instance, in Figure 1, I have transcribed part of the interview with SusieB and described in "*Deliberation and process*" my reflections on difficulties she had encountered around a WLS procedure. This section recalls my feeling of concern even while I recognised that this treatment-related issue might not be of concern to SusieB.

Transcript from interview	Deliberation and process
<p>1. participantR: <i>There are some issues that if somebody from outside came to you, like I know a bit of your story already and I know a lot about the various doctors and patients and things like that, and what's involved, I think questions might be asked around informed consent</i> SusieB: <i>Imm!!</i></p> <p>2. participantR: <i>And where you feel that's been a bit borderline?</i> SusieB: <i>Yeah!!</i></p> <p>3. participantR: <i>Umm, but you may not feel like that.</i> SusieB: <i>I was very angry.. I was very angry after the op</i></p> <p>4. participantR: <i>Was that a bit of an indication that things weren't right?</i> SusieB: <i>For one, this doesn't go any further because I don't want this going back to him, at all. I was very angry</i> participantR: <i>Can it be hidden in the research?</i> SusieB: <i>Yes, as long as it doesn't come through me although, I don't think there would have been too many people that would have had that operation done though.</i> participantR: <i>I can change your name?</i> SusieB: <i>Yeah! I feel that, I feel that I should have been forewarned prior to getting into surgery, that that could happen. And it didn't happen.</i></p>	<p>I have picked up on SusieB's concern about what has happened to her and I seek clarification @ question 1. Clearly SusieB answers my probe with a marked affirmative. I continue on as delicately as possible, with a further probe @ question 2. SusieB is showing in her demeanour that she is distressed by what has happened. I draw back a little to allow her more of a way out @ question 3. Again though the reply is affirmative and this time very definite! Question 4 aims at further clarification and could be called more of a counselling question though really significant in this research: while my concern might have been about her safety in the WLS consultation, SusieB wonders about any compromise of the consultation relationship. I ask for permission to include the information in the thesis: I offer to change her name as even her number plate carried her chosen pseudonym! Once she had expressed concern, there is a sense of acceptance that her story is a fairly particular one and that she is prepared to accept a name change. She doesn't hesitate then to move forward with her story. I substitute "that operation" for the specific procedure she had to further confuse her identity.</p>

Figure 1: Transcript from interview with SusieB, including reflection.

My questions were based on concern for SusieB though a critique of expert power was implicit in the questions I asked. The opening question carried to the heart of what I considered disquieting in SusieB's story. My question disquieted SusieB. She wondered how she could protect her relationship with her surgeon while contributing her experiences to the research. Question 1 was a risky question but added depth to my

own and SusieB's reflections. This excerpt and this final research interview added considerably to understanding how patients may become stuck in conflicted relationships of consultation.

I noticed a similar disquiet amongst almost all the doctors in the research when I asked them to personalise weight as something they not only experienced with patients but lived for themselves. I moved doctors from a familiar perch in which they tended to speak about weight in abstracted, professional words. On the one hand, weight-full women such as Michelle, spoke about weight in highly emotional terms as impacting their lives, "*It's a visible, horrible thing to deal with,*" (Michelle); doctors tended to frame weight-talk in pseudo-scientific, generalised notions as in "*I guess if we're trying to get scientific about it and we measure their height and weigh them*" (Dr George). Their talk was focused on solution-based concerns about knowledge of, and treatment options for, the medical disease of "obesity." Nonetheless Dr George articulated the uncomfortable positioning of most practitioners in this study. "*I don't have any special knowledge in it,*" or Dr M1, "*I only have the operation.*"

How participants spoke about weight, the actions taken in regards to personal weight and how weight was approached in consultation, sprang from embedded, encultured beliefs, richly imbued with personal anecdote and private action. In explicitly asking each participant to speak personally about weight, I sought to bring into view some of the opinions, ideas and actions that were less available to consciousness. With doctors, this replaced the neutralised and somewhat jaded languaging, from which personal framings had been expunged. In the following example Dr Gabrielle is talking about her mother:

Dr Gabrielle: *Strong bones! Yeah, yes, but that she's got, very little wrists, French wrists and ankles (laughs) as we say. She always used to say she noticed that New Zealand women have very big arms*

Participant-R: *So you haven't got the French wrists?*

Dr Gabrielle: *Imm. I've got the French wrists.*

Gabrielle's languaging resonated with the richness of this personal anecdote.

Research tracing the operation of stigma in relationships of consultation has often relied on the application of scales such as the Implicit Attitude Test (IAT) (Schwartz, Chambliss, Brownell, Blair & Billington, 2003). Reports of individuals' beliefs about obese patients might otherwise be confounded by the bias of socially acceptable

responses (Teachman & Brownell, 2001). Yet in interviews for this research, doctor-participants entered freely into conversations about weight and consultations in which I asked for a reflected and situated response. In the interviews with medical practitioners, surgeons and specialists, the right to speak was asserted, and this allowed doctors to speak from a privileged and moral positioning in relation to their weightfull patients. Having asked me if I wanted “total honesty?” Dr M2 reflected on the ugliness of some of his patients; Dr Daisy commented on wanting to sack her housekeeper for making “the most disgusting smells” in the bathroom following her WLS; Dr Maurie laughed and slurped his way through an anecdote on the sexual proclivities of a very large woman patient; Dr Mary spoke of motivating patients to lose weight while she had no expectation that they would be able to do so. I have juxtaposed the explanatories of doctors and patients from these research interviews. This allows the reader to reflect, for instance, that although patients believed they were viewed positively by their WLS surgeons, surgeons in this research did not express positive acceptance of WLS patients. By providing an opportunity for reflection on, and contextualisation of, positionings assumed in regards to weight, I based the research move of reflexivity on the premise that we-participants shared an encultured habitus. Through the interviews, I sought to develop a picture of the culturally rich environment in which consultations occur. The dialogue that ensued was “[...] a serious play of questions and answers, in the work of reciprocal elucidation” (Foucault, 1984, para. 3). In his interview with Rabinow, Foucault (1984) emphasised the present nature of the interview: Questioning and answering, querying and postulating, suggesting contradiction or faulty reasoning, are all part of the accepted plays through dialogue.

5.7 Complexities in narrative tellings

There are more than the words of a story in any telling (Cortazze, 2007) and the style of interviewing in this research allowed a complex research narrative to emerge. Such complexity was encouraged within this research in numerous ways. Firstly, I had a personal experience of WLS and laying a complaint with the HDC (refer paragraph on ethical research earlier in this chapter). Secondly, doctors were asked to reflect on their personal histories of weight and weight within their families. This encouraged doctors to consider weight outside of their clinical expertise and in relation to their practice. This complexity was gendered by women-as-doctors who recognised themselves, and are recognised, as women first. This material gave rise to the first data chapter in the thesis, “Narrating Embodied Weight.” Thirdly, as the stories about a particular form of

WLS had become less positive than I had anticipated, I used a media story of Jane to present a somewhat different picture. Similarly, when another form of surgery appeared to be positive for weight loss and women were minimising the negative effects of their surgeries, I looked at an early complaint to the HDC in order to understand what happened when surgery has negative outcomes. As well, the gendered nature of the struggle to obtain or maintain a trim body emerged graphically in these stories told by women and doctors. This material was textured by reference to media presentations in stories and advertising. These are our stories. In this research, they enrich the polyvalence (Foucault, 2003; Lather, 1991) of the story base for this thesis narrative.

5.8 The analysis

The tapes were transcribed and then corrected on at least two occasions. I returned to the original recordings as I wrote to listen to tone. I completed an “Analysis Mapping”⁸ of all data to improve access to the material. Figure 2 is an example of one entry into the analysis mapping of 150 emails from Michelle.

Thematic material	Contextualising quote	Email number; Subject line? Date?	Positionings, power, discourses	Conundrums, nuances, contradictions
Practices of restriction	<p>“food diaries and Smoothies: “I wish I had been a good lapbander, clever to make do with the smaller portions that are recommended by the surgeon”(65)</p> <p>“I’ll work on trying not to get too obsessed with the process, keep the faith that this is going to work and focus on looking after myself”(131).</p>	<p>32</p> <p>65 (13/9/02: “Update on Slippage”</p> <p>131(12/2/04: re: 8 week blues”</p>	<ul style="list-style-type: none"> •Good/bad food •good/bad patient •keeping faith with surgeon/ process versus acknowledging what is happening •compliance/non compliance •clever/stupid 	<p>Told that this new surgery will ensure weight loss occurs no matter what she does, M is obsessed with her slow loss and attributing it to what she herself is doing. Has she forgotten that he gave her a different size pouch?? Follow up on reinterview.</p>

Figure 2: Example from analysis mapping for Michelle’s emails

While transcripts could be accessed in a Microsoft Word “find” command, the analysis mappings gave me access to an abbreviated form of each data set particularly in the early stages of the analysis.

⁸Opie (1995, p.38) spoke of the need “[...] to attend to the positioning of the speaker and to the nuances, contradictions and recursiveness within each text and across texts, being aware of what is not said and also the implications of brevity, and attending to the discursive and power implications informing the text.”

The early analysis mappings were written up as stories. This processing enabled me to understand the material as it was developing and to find ways to encompass the wealth of experiences of each participant (Appendix 8). These processes all enabled me to become familiar with the data at increasing levels of abstraction without losing connections with the original material. More importantly, through this time it became apparent that the material relating to consultation and WLS decision-making would need to be described and analysed. Significant research has already been published in relation to women and weight (Blood, 1998; Bordo, 1993; Burns, 2004; Burns & Gavey, 2004; Carryer, 1997; 2001; Halbert-Crowe, 1998; Jutel, 2000; Spitzack, 1990; Stinson, 2001).⁹ However, the increasing promotion of WLS over the period of the research and the minimisation of its significant side effects highlighted the importance of critical-health research dealing with WLS options.

5.9 Critique through the Foucauldian analysis of discourses

Since I began this project, I have been asked, “Does WLS work?” Following up on this query has added useful information to this study. However, a variety of supplementary questions have the potential to add more value in responding to the overall thesis question, that is, how are WLS consultation and decision-making for women impacted by the modern preventative approach to medicine. Supplementary questions access different kind of knowledges, such as where does WLS come from? How is WLS receiving so much attention in the media and in the professional journals? What will be the effect of this on overweight teenagers or women or men? What is the influence of trade in WLS consultation? Does WLS open up or close down a diversity of ways of belonging in the world? In asking these types of questions, a different kind of thinking is set in motion (Visweswaran, 1994), promoting a more diverse response-set in relation to the basic thesis question.

Foucauldian discourse analysis has been questioned in relation to work on female¹⁰ bodies because Foucault did not specifically address the gendering of political technologies of the body. While we do not have a specific body of work from Foucault related to the sexualised pathology of the female body,¹¹ nonetheless, feminists are able to use his “[...] insights to develop a specifically feminist analysis of disciplinary

⁹I have been particularly interested in including New Zealand-based research, especially since my research relates to the introduction of a range of alternative WLS technologies into New Zealand.

¹⁰I use this qualifier of ‘female’ bodies for ease of reading the text though I am interested in the philosophical debate that surrounds the production of male/female.

¹¹Foucault was to have produced a volume in the *History of Sexuality* entitled *Woman, Mother and Hysteria*.

technologies investing women's bodies" (Sawicki 1991, p.71). Michel Foucault's historical analysis provides tools for feminist critique and research around the medicalisation of the female body.

In analysing story-texts, I am curious about the appearance of similarities and differences in these texts. These story-texts are part life histories that will give participants an opportunity to engage in storying their weight, decision-making around weight and the processes of medical-consultation relationships. Chase (1995) explored life stories when she realised that understanding any aspect of a life required that it be contextualised within a wider life history.

I adapted deconstructive interviewing developed within narrative therapy to trace the effects of dominant stories within clients' lives. In narrative therapy, the aim is to assist clients to view their stories within the wider understandings of social life and to choose those stories they prefer to live by. My practice within this research differed to the extent that, while my questions and pattern of interviewing continued to be deconstructive in intent, I focused on hearing how participants negotiated alternative positionings and referenced a range of often conflicting preferred and less useful stories. Experiences for participants are linked through time and plots, a landscape of action, and this emerges a sense of the activities that participants were involved with. In asking participants to reflect on the meaning of these events for them, participants traced what Bruner (1986) called a landscape of consciousness. In these ways I could begin to understand what a series of events, decisions, and activities might say about the desires, preferences, beliefs, and commitments of participants (White, 1995). This surfaced a thickened description of participants. Thin description (Geertz, 1973) results in thin conclusions about people hiding within the broader relations of power. The individual merges within the group designated by the label attached to that group and particular skills, abilities and competencies may be erased. Such descriptions serve a modernist project in which the problem is the person, a person is the problem, or there is an essential knowing about people. Knowings become vested in practices of professionalisation and statistical measurement. Within medical-based practice, thin description rests in the determination, for instance, that a weight-full woman has poor health and a lack of self-discipline. Thick description (Geertz) on the other hand opens up the uncertain nature of all choices, actions and possibilities and increases the likelihood that weight/health will be considered within a broader array of available discourses.

It is critical to this research that alternative knowledges surface and be reflected upon. Licensed practitioners dispense expert medical knowledge: Post-structuralist critique challenges the dominance of these ideas especially by asserting a place for local (what people know for themselves) or previously marginalised wisdom. My reading of these events is neither final nor absolute, but

[...] a selecting out, among the many readings and possibilities present in a concrete instance, of those characteristics and aspects that will promote the goals of the individual or group doing the selecting [...] (in the end) knowledge comes to shape the world it describes (Ransom, 1997, p.19).

Juxtaposing data from a variety of sources within the analysis, triangulation (Chenail, 1997; Denzin, 1978), opened out the complexity of working with diverse perspectives from lay, medical and ethical viewpoints. For instance in chapter nine, I realised that the mechanism and the intervention of post-surgical inflations were being conflated in the surgeon's statement, "*If the band is in place, then it works.*" I elaborated on that statement because, if a band wasn't inflated with saline, then why did patients undergo this major surgery? Consequently, material from an HDC complaint's procedure, a bypass surgeon, patients and doctors added considerably to understanding this process. As well, I sought to include material from multiple perspectives of women participants, doctor participants and researcher in all aspects of the analysis.

5.10 Framing the analysis of my thesis argument

Decision-making for WLS is a precarious moment in the medicalisation of women's weight. I was interested in the early stages of the analysis by the similarities in how all women interviewed for this research spoke of weight and weight in their families. Consequently in writing chapter 6, I brought together the stories about encultured weight of both doctors and patients. Clearly, cultural attitudes towards eating and body size were being transmitted between mothers and daughters in this group,¹² began very early, and lasted a lifetime. This supports the argument that encultured attitudes towards weight impacted doctors in their practice and significantly impelled women towards accepting radical WLS interventions. In Chapter 7, WLS decisions reflected this pressure on women to produce a meaningful look of weight-as-health according to current specifications. It reflects the currency of newer forms of WLS as commodities designed and mediated as reasonable interventions. But WLS decisions in this account

¹²Where indicated, I include material related to fathers in this study, given the research that suggests that fathers contribute to children's concerns about their bodies (Keery, Boutelle, van den Berg & Thompson, 2005).

reflected a significant relational basis. Even while women sought advice from families, friends and the Internet, they relied on the surgeons they consulted to advise them personally about the risks and benefits. My analysis indicated that a range of systemic interests significantly impacted WLS decision-making in consultation: These trumped the necessary focus on the individual patients.

Through Chapter 8, participants discuss the physical problems they are experiencing as a result of WLS. I argue, based on the emergence of considerable side effects and iatrogenic injury, that WLS was not an effective intervention for reducing weight-for-health nor did it bring about the overall improvements in health that had been promised. Chapter 9 analyses communicatory problems that occurred when some participants began to question surgeons about the problems they were experiencing. Essentially, women encountered a range of unhelpful, conservative or discriminatory attitudes that impacted any potential for improving health outcomes through processes of consultation. In this chapter I argue that the precariousness of WLS decision-making was affected not just by problematic technologies but also by asymmetric power relationships demonstrated in these WLS consultation styles (Chapter 9). In Chapter 10 I trace the tension between informed consent focused on the individual doctor/patient relationship and the wider systemic issues that pervade the clinic but which patients have limited knowledge of, or control over. Such systemic issues make informed consent for experimental WLS procedures problematic. This thesis shows how the advent of the WLS surgeon-trader resulted in patients' health goals being at least partially subsumed under those of medical commerce and professional self-interests.

5.11 Reflexivity

Reflexivity marked all stages of the research. I reflected on my practice as a researcher, at times with participants and at times within my reflecting diary. My ethical commitments reached through my lives as a therapist to interviewing as a researcher and as a writer recording and creating a new text from the texts which I had been gifted. My style of interviewing encouraged a practice of reflection for participants within these interviews.

In this research project, I wished to avoid the subject-object trap (Boucher, 1994), and remained ready to acknowledge how my own experiences have influenced this research. I use researcher reflexivity to surface my understandings and subject my own experiences to the same processes as the data from other participants. From the beginning of the research, I sought ways to reflect my personal journey with

weightfulness within the research and I have continued to experiment with reflexivity in my writing, speaking and presentations (Appendix 5).

Participants were valued as reflexive subjects. The call for reflection influenced the nature of these research conversations and was commented on by a number of participants. Phoebe talked about her first experience of being considered overweight.

participantR: *What understanding did you have, then, of yourself as a person of substance or a person with weight. Did it change your perception at all?*

Phoebe: *It didn't! That's the first incident that ever made me think that other people might perceive that I was carrying more weight than I should, (pauses, then adds,) "Hell, that's interesting isn't it."*

I encouraged doctors to reflect on their practice by situating their thinking more personally. For example, I asked Doctor Henry about wearing a pedometer as "walking the talk:"

Dr Henry: *It's a coach*

participantR: *If we read that now...*

Dr Henry: *It's a coach.*

participantR: *We'd know how much you'd done today*

Dr Henry: *Not very much today! (uncomfortable) Not yet!*

While Dr Henry espoused the notion of "walking the talk," I was interested in whether he used his pedometer as merely a visual aid for teaching his patients. Dr George talked about a male patient who had maintained a large body weight for ten years:

Dr George: *I've never said to my guy, if you don't do something you could be dead in a week you know. And I think some people, I don't know if some people still say things like that.*

participantR: *You don't really believe it after 10 years?*

Dr George: *No, because he's been around for ten years. So lucky I didn't say it (laughs).*

While we shared a laugh, this constituted a significant reflection in relation to medicalised thinking about the correlation between weight and mortality. My question promoted a deconstruction of these ideas that Dr George continued to hold without ever

stopping to consider what it meant that his patient had lived at the same degree of overweight for so many years.

5.12 Grappling with methodological issues

5.12.1 Naming weight without defining or stigmatising overweight. Many of the terms used to refer to overweight appear to have very fixed meanings e.g., to be obese is to have a BMI of over 30. Some terms are, or have taken on, derogatory connotations, or have been used in the past to shame or humiliate a person with issues around weight, or have had that effect. In the use of the descriptor, weightfull, I found a term that did not have fixed meanings. While it has continued to satisfy my criteria, it met with some derision in the medical school environment: “Why don’t you just call fat, fat?” I was asked.

5.12.2 Relating with participants. Overall I encouraged participation and acknowledged a diversity of views about weight and WLS. Increasingly through the research, my understanding of weightfullness, my analysis of medical interventions and my concerns about the practices of weight consultation were growing. At times during interviews with doctors or WLS participants, I was called on to express agreement with certain hegemonic views. Years of experience in working with mediation clients in my counselling practice allowed me to steer a path which neither agreed with nor denied these ideas. Overall, my response was to respond with interest in the expression of a diversity of experiences throughout the process.

The unsettled nature of participant/researcher relationships in the field (Bateson, 1989; Fielding, 1993; Wainwright, 1997) has been written about a great deal. Particularly with the women in this research, I puzzled as Bateson (p.101) did, about how to understand these relationships:

[...] these women are not "interviewees", not "subjects" in an experiment, not "respondents" to a questionnaire. There is a symmetry in our mutual recognition but there is asymmetry in that I am the one who goes off and weaves separate skeins of memory into a single fabric. But they weave me into their projects as well.

Although each interview was a discrete event, the connections with participants began well before I met them and continue to this day with some intermittent contact. This has taken a number of forms. One example was when a participant asked me at her reinterview about the potential side effects of gastric bypass. When she then discussed those experiences with her surgeon, Michelle was told to advise me to seek a consultation. Another participant sent me a variety of cartoons in which weight was the

issue. One of the boundaries that I set myself in counselling was to engage with clients only on work-related matters while they were free to continue to contact me. I used this same standard in relation to the research: Consequently I turned down the opportunity to work with and have a friendship with one of the doctors on an ongoing basis; I did not make another appointment to consult a specialist who gave me advice about Lipedema when I met him in a research capacity. I was encouraged by one surgeon to discuss a personal issue with another surgeon in the research but I chose not to.

My familiarity with the surgeons and the area of WLS was a factor that I needed to bear in mind constantly. In the first interview with Michelle, we discussed the referral by her surgeon back to the local surgeon. We both interpreted his motivation as caring and distinctly lacking in self-interest:

participantR: *Yeah, so he wasn't out there saying you know, "Come on, come on!"*

Michelle: *But yeah, seemed genuine. That is the thing I appreciate about him (her surgeon).*

What is interesting was this acceptance by both Michelle and participantR of the altruistic motives of her surgeon. While as participant-R, I asked: "What did you think about him saying that?" as being also his patient, I was clearly disposed to accept this surgeon's motives as straightforward. Later in the research, it became evident that a business pact existed between the surgeons. Such a relationship made it difficult for the more experienced surgeon to accept patients from outside his own immediate area without placing pressure on that relationship. The interviews with Michelle pointed to one of the difficulties that is also a benefit in research, when a researcher who is engaged in and familiar with the research area and participants.

5.12.3 Representation and the use of key participants.

Altheide and Johnson(1994, p.489) wrote of the need for researchers "to substantiate their interpretations and findings with a reflexive account of themselves and the processes of their research." In this methods section I have discussed how I worked in the interviews. I have done so in the interests of thickening the research foundations as well as to bring these interviews alive. The aim of transparency can be somewhat frustrated in qualitative research by the sheer weight of words required to do that. I have chosen representative excerpts to add texture both in this chapter and in the substantive data chapters but I acknowledge that choosing has been a challenge. In the methods section, I have quoted from SusieB, Michelle, Rosie, Shona and Marjorie:

These participants were interviewed twice because, through the time of the research, they underwent a further WLS project. As well, the first four participants occupied key positionings within the WLS community. These participants appear frequently within the data chapters because the decisions they took and their multiple experiences were seminal to the development of the thesis argument.

5.12.4 Resisting a takeover by the dominant voice. I began this project in a Medical School Department focusing on Public Health and completed it in a Health Sciences faculty at a different university. Within a public health department, as within the media and in the mainstream medical journals, the current anti-fat focus of research relates disease as correlated with fatness. This brought with it a sense of closure and determination that being overweight as defined by the BMI was connected unproblematically to definitive and negative disease outcomes.

While I continue to work with medical students in a Medical School, my choice was to move my thesis between institutions: This reflected a choice for feminist input into a feminist project. I have wished to open up the project to diverse understandings of the potential relationships between weight and health.

5.12.5 Focus and title for the research. This research and thesis process began life as a discourse analysis of weight in consultation. Once in the field, the significance of WLS became apparent. The reader might well ask what did she expect if she interviewed people from a WLS support group website. As I have written elsewhere, I could not have foretold the explosion of materials that entered the media, including real life stories on television and in magazines in the form of sensational or pseudo documentary style programmes and articles. It was clear to me from the first interview in which WLS was discussed, that all other experiences of weight faded in comparison with the intensity of contemplation and results of WLS. Thus, following the first four interviews with women, I became particularly interested in WLS options particularly as these related to practices of consultation. From a working title of *A Matter of Fat: Power Relations, Doctors and Weight-Full Woman Patients*, this thesis is entitled: *(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.*

5.13 Consulting the texts and writing-up the thesis

Originally, my literature search sought out qualitative methodologies through a range of disciplines especially where narrative was mentioned. Over time, I came to understand that the critical-narrative orientation with which I was familiar through association with

narrative therapy approaches have received little attention in health research though they have been suggested more recently in relation to research in psychotherapy (Riessman & Speedy, 2007). In the initial stages, I called my research orientation Foucauldian-feminist discourse analysis emphasising a transdisciplinary approach. While I have since related the specifics of a bricolage based on narrative therapy philosophy and modes of enquiry, this thesis has always been about tracing the operation of power through the range of narratives in which these occur. This methodological focus meant that the research moved from being limited to obesity, weight interventions and the influence of medical consultations on decision-making over weight and health. These were the original foci for extensive literature reviews, and I needed to return to the literature to carry out an extensive review of the history of medical/surgical interventions, trading in health, and the ethics of medical practice. This has allowed a context of understanding and reflection on the very problematic aspects of WLS practices.

5.14 In reflection and moving on

My research text became a gathering place for narratives of women's lives as they lived with and managed weightfulness. However, within the context of the over-arching shaping of lives by hegemonic cultural and moral norms within Western society, I became focused in on two specific areas: Expert processes of consultation and the reach of medical technology, specifically WLS, into women's lives. These areas remain both significantly unquestioned and convincingly inevitable within the rhetoric of medical technology as progress and the hegemonic weight/health connection.

Following an introduction to the history of medicine as a science, its encultured biases and the increasing reliance on expertise in modern medicine, I moved in chapter four to introduce the specifics of my methodology as a transdisciplinary bricolage based within narrative therapy. In chapter five, I have shown how methodology was translated into the ways and means of working through this thesis. I have worked also through the various aspects of researching as an ethical form of critical narrative enquiry that suggested the need to consider ethical consultation practices in WLS later in the thesis. Having proceeded through participant selection, the use of data and technologies and the nature of interviewing, I have indicated a process of qualitative analysis without the use of data-technology programmes. The use of diverse narratives aids complexity, adding to the reliability and validity of my account. In the final

paragraphs I have spoken of some of the conundrums in this research and showed how I moved to resolve them.

Through each of the following data chapters six to ten, I build my thesis that WLS decision-making is a precarious moment in the medicalisation of women's weight. From being exposed to a lifetime engendering of slimmed weight for women (Chapter 6) to the commodification of health interventions targeting women (Chapter 7), WLS participants were primed and recruited into reducing weight through radical surgery options when these were promoted as medically indicated. But these surgeries were experimental and they came with a range of side effects that threatened ongoing life, health and well-being (Chapter 8). Professional practices of consultation were poor particularly in relation to what could be discussed and how ongoing problems could be understood or resolved (Chapter 9). In Chapter 10, I show how the relentless drive to trade in WLS promoted formulaic informed consent processes that lacked moral and relational commitments to the protection of WLS patients. These patients could not consent to these procedures because they were denied access to disconfirming information that would have precluded their involvement.

I begin in chapter six to understand through the narratives of women participants how the engendering of weight in Western society increases the likelihood of an uptake in risky WLS options.

“Being a problem is a strange experience [...] this double consciousness, this sense of always looking at one's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity”
(W. E. B. Dubois, 1903/2007, p.1).

CHAPTER SIX

Narrating embodied weight

“Though woman is identified with body she never can be confidently convinced she is mistress over it. Graying, wrinkling, gaining weight, all represent reminders that that one area of female identity and authority is only marginally governable”
(Chapkis, 1986, p.16).

6.1 Introduction

Culture grips our bodies (Jeffreys, 2005). Visibly thinned bodies people our lives, sell our papers and induce a fascination with celebrity. The dimensions of a woman's physical presence are in public view, standardising presence as a beauty in which no part of the body may be “[...] left untouched, unaltered. No feature or extremity is spared the art, or pain, of improvement” (Dworkin, 1974, p.112).

In this chapter I rely on narrative therapy's deconstructive interviewing to capture landscapes of action and consciousness (Bruner, 1986) to critique weight/health discourse. I map the practices and processes (landscape of action) and understandings (landscape of consciousness) of scaled weight for health. This allows me to trace the production of weightfull women's bodies through the cultural contexts within which our understandings of weight and appearance are formed. Weightfullness is, after all, a culture-bound disease (Contaldo & Pasanisi, 2005) and actual weight means little until it is sanctioned, positively or negatively (Jaffe & Worobey, 2006).

In a social-cultural environment that is invested in slimmed body size especially for women, early interpretation of the fears and anxieties about weight are internalised by children within their homes and amongst peers. Women live lives alongside the ideal of slimmed body size; they may have responsibility for the provision of food (Bryant & Zick, 1996) arousing considerable internalised conflict; children of weightfull appearance or partners who gain weight may induce a social attribution of unhealthy

food habits in the home for which responsibility devolves onto women. In worrying about weight, women may act out of their own fear of being fat or demonstrating poor parenting by consciously restricting their children's food (Jaffe & Worobey, 2006). In turn, children internalise parental attitudes and behaviours at a very early age and are particularly vulnerable to teasing and criticism about their bodies.

This chapter demonstrates how ideal-body discourse acts to restrict thinking about weight and health. This encultured thinking about weight for women participants, including doctors, is traced to show how hegemonic weight/health understandings provoke individualised practices and rituals of weight loss. Women participants found it difficult to resist the weight/health connection and their acceptance of this understanding was instrumental in their consideration of WLS options. In an analytic manoeuvre to demonstrate that personal values and encultured attitudes enter the substance of medical consultations (Katz, 1984/2002), I asked doctors to personalise their understandings of weight and health. This interrupts any notion that encultured, feminine body discourse does not affect consultation or that medical consultation is "objective." In this chapter, doctors were heavily influenced by hegemonic, commonsense understandings of the weight/health relation and this affected their practice.

6.2 Engendered-slender, female bodies

The template of a good and/or perfect body evolves within the culture. Women through the last 100 years have been progressively stimulated by cultural symbols of wealth and the good life. Exemplars of the aspirational body have been internalised, "[...] geared into the world when my perception presents me with a spectacle as varied and as clearly articulated as possible" (Merleau-Ponty, 1962, p.250). This body has moved from the wealthily plumped body of the 1800s, through the rounded¹ screen-star body of Marilyn Munroe, the thin, waif-like figure of Twiggy in the 1960s to the toned, slim, long-legged models, Elle and Rachel, of the late 20th century. As our fascination with thinned bodies has grown, ideals of female body size have dwindled. Women's competence and achievement of success is presented alongside visibly slim bodies: "[...] slenderness is equated with competence, self control and intelligence" (Sanz & Burkitt, 2001, p.44). For instance, the BMI of celebrities in many areas of accomplishment are significantly below average BMI: Kate Moss, model (5'7, 107

¹I replaced my original word, curvaceous, with rounded, avoiding the sexualisation implicit in curvaceous.

pounds, BMI 17.3); Gwyneth Paltrow, film star (5"9, 112 pounds, BMI 16.5); TV's Jennifer Aniston (5"6, 110 pounds, BMI 17.8); tennis star, Anna Kournikova (5"8, 113 pounds, BMI 17.2).² These women portray a limited version of female beauty based on slender youthfulness or boyish athleticism, an imagining of a woman forever captured by "[...] the ideal image of a woman in which she is not yet a woman" (Bordo, 1988; Sanz & Burkitt, 2001). The expressed desire of many women is to be thinner (Tiggemann & Lynch, 2001): Having a normal BMI did not prevent further dieting (Better Health Channel, 2007; Kenardy, Brown & Vogt, 2001).

In this current research, awareness of the media pressure on women to weigh less and diet more, had one doctor moderating his advice about weight, to "*be a wee bit more umm, gentle about it*" (Dr Craig). Even while Craig accepted that his daughter was "*never going to be a Twiggy,*" he believed that she "*feels better when she's thinner.*" What he does not comment on is whether "*better*" relates to his daughter feeling healthier or looking better, closer to looking more like her peers. Dr Maurie also made connections to media presentations of the ideal female body being "*influenced by the way, the perception of the female body is, you know, it should be, what you see in the magazines.*" In referring to the play of women's bodies against a societal backdrop in which sexualised bodies sell sexualised foods, Dr Daisy pointed to the highly visible double standards of food promotion. Advertisements often related to nutritionally poor foods by slimly perfect models whose body shape was both unrealistic and unhealthy for most women to attain. These exemplars unsettled any complacency about a less ideal body as they carried within them the resolution of the angst they fomented (Bordo, 1997). Clover, for instance, was a large-chested young woman. She grew up in the 1960s surrounded by images and imaginaries of the flat-chested, thin, boy-like figure of Twiggy. Not surprisingly, Clover's first surgery to correct her flawed body was breast reduction.

In the 1990's Elle's presence dominated body ideals and Michelle connected gym membership with the possibility of attaining her ideal shape. After losing substantial amounts of weight, Michelle became a trainer. She informed her clients: "*Well, I can't guarantee that you are going to lose weight or that you are going to become Elle McPherson. But no one wants to hear a trainer say that. They want to hear that you can achieve those things.*" As a trainer whose shape was far from model proportions,

²Celebrity statistics at www.freewebs.com.

Michelle's body could not counterbalance the pessimism of the message implicit in it, nor proffer living proof in the face of the message. Michelle's body confirmed that exercise, diet and surgery for weight loss do not achieve ideal bodies. Dr M2 also worked to an image of Elle:

participantR reflects

I interviewed Dr M2 today. As I arrive in the room, he asks to see my Elle McPherson figure. I write in my research diary: "I do not take off my coat but do a twirl and sit abruptly down. He seemed disappointed." (Reflecting Diary, 15 July, 2004).

Phoebe recalled her growing body as tall, slim and strong. In her late 20s, Phoebe pulled a muscle in her groin while she was out tramping and consulted a local Sri Lankan doctor. He shook his head: "*You big man. You big man.*" Initially, Phoebe was amused by this comment and related it to the doctor's own small physical stature and his recent arrival into New Zealand. On recounting the story to friends, she encountered hilarity that shocked her, initiating a reinterpretation of her story. At the age of thirty, she perceived that other people negatively connoted her size: "*It was like a little shift in, a little glimpse of other people's perception. It wasn't the doctor so much as my friends' perception of my being overweight. It was extraordinary for me. I felt incredibly insulted.*" The original stimulus for the story, and the laughter with which it was greeted, manifested the 'normal-female-body' discourse that is continually being reproduced in what people think but often do not say. At times, this discourse is prompted or surprised into awareness. Initially astonished, then mortified, by her friends' reaction to her story, she realised that her friends did not challenge the doctor's assumption of her large size but were entertained by his use of the word "*man.*" For the first time, Phoebe confronted the experience of being considered large in a world that is less accepting of women of larger stature.

For a number of the participants, slender-gendered bodies had emerged within their family of origin. Margaret, a teenager in the sixties, grew up in a family with a father whom she described as "*loving,*" but "*tactless*" about her size. Her memory of making a dress and trying it on in front of him was seminal in her continued discomfort of living large as a woman. Her father's words were recalled with some emotion in the telling: "*Its lovely. Pity about the shape inside.*" Such early grooming and socialisation influenced the lives of a number of participants. As Michelle, now in her thirties, spoke

of her father, there was a glimpse of a man captured by ideas of how a woman should look:

(...) in a very old fashioned, sexist kind of way, that we're to look good all the time and we're like little accessories and he loves women who wear lots of eye make-up and are always well presented and you are not large.

Michelle emphasised, “*You are not large.*” She has struggled to comprehend her father’s outdated ideas, especially in the light of a thirty-year marriage to her mother who, like Michelle, has also struggled with weight. Accustomed to believing that weight is something that can and should be controlled, Michelle has sought counselling: “*I think I am still under the spell of what a woman is supposed to look like.*”

Women access a variety of discourses in living their lives (Weedon, 1987) but these discourses have different degrees of influence (Blood, 1998). For instance, various fat acceptance values may or may not support the feasibility or desirability of interventions in relation to weight (NAAFA, 2008; Saguy & Riley, 2005; Samuel, 2007) while still supporting equal rights and opportunities for persons regardless of size. Thinned body ideals have tended to be articulated through an analysis of power relations: Women may choose a form of size acceptance as a lifestyle choice in the acknowledgement that losing weight is unhealthy or impossible (Orbach, 1984), undesirable, or in resistance to widely disseminated norms of thinned weight (Germov & Williams, 1999). The activity of choosing, whether that choice is about losing or not losing weight, may be interpreted as agency within feminist theorising on embodiment. When Michelle’s counselling focused on size acceptance and health, she described a sense of personal peace but her size acceptance ideals were complicated by a lack of support for those ideas within her world. Michelle’s mother also vacillated between an espoused position of size acceptance to one of great distress about her “*bulk.*” Her attempts to adopt moral high ground of size acceptance – “*Fuck you, this is how I am!*” – this appeared more to be a display of painful bravado in the face of perceived personal failure.

In Em’s family, gender was played out in relation to weight as Em’s doctor/dad³ pressured Em and her mother to lose weight, “*the whole appearance thing.*” Meanwhile, her brother’s weight gain was accepted and normalised, related only to drinking a little too much beer. From the time she was explicitly described as a “*chubby*” 9 year old, Em described how her “*weight was watched quite a lot.*”

³I coined the term doctor/dad when it became impossible to delineate the tasks of father from those of the doctor. Em’s father took care of all her medical requirements until she was in her late teens.

Family, friends, teachers and doctors have all referred to Marjorie as “a big girl,” a notion of herself that is embedded as though “stuck on my forehead.” Connection between body shape and acceptability began in her early teens. Marjorie remembered playing around the family pool when a friend of her mother’s sneered at her body:

She said “ Oh my God.” She was German, “You have stretch marks.” And I had stretch marks on my thigh. Well I was so embarrassed I nearly died and she said, “What are you doing? Why are you so fat?” (Marjorie laughed defiantly in the interview) And I wasn’t!

The implicit obligation on a mother galvanised Marjorie’s mother: Marjorie was denied treats, though her brother continued to receive them. Although Marjorie acknowledged her distress at the incident, and continued to recount it, she did not connect this to subsequently “cutting down” on her food intake. In debunking the influence of this interpellation,⁴ she chose a normalised accounting of an adolescent choosing to diet:

This was the thing to do. It got into the thing of boyfriends and then so you want to look nice and nobody else eats, because of, you know you really should watch what you’re eating so I would cut down what I was eating and ... it was never an active, “Oh, I’m going to diet.” It never put me off having boyfriends or them off me.

Marjorie’s husband has referred to “veiled comments” about her weight by work colleagues including suggestions that they “would leave my wife if she was that size.” She rationalised that in certain societies her husband would be considered wealthy, as owning “many cattle.” Even while she reports a long and happy marriage, this pressure on her partner from his colleagues has tended to unsettle her.

Concern about size at the point of marriage was a common thread: Margaret was advised to lose weight before the ceremony by her mother-in-law and Dr M2 spoke of about his fiancée’s wish to lose weight before the wedding. Rosie told of her sister’s struggle to maintain a good weight because being married to a GP she was “not allowed to be fat.” Pammy believed that her weight might affect her partner’s attraction to her:

I suppose when I went over the 10 stone and you’ve got to buy bigger clothes; things don’t fit any more and girls start looking at your husband and he starts looking back, although he said it never bothered him because he’d put weight on as well. But I was always aware that I’d got to keep myself trim.

She wanted to remain sexually attractive, and “just didn’t like being fat. I hated it. I hated myself being fat.” Having lost “the huge weight mass on my backside” following

⁴Interpellation refers to the ideological process through which the individual is summoned to take up its subject-positions (Althusser, 1998).

WLS, she visited her daughter in Dubai. Describing herself as no longer “*the twelve/thirteen stone Michelin Man*,” Pammy’s pleasure at viewing herself in a shop window wearing her daughter’s clothes was palpable: “*I go past a reflection and I go, ‘Oh! Is that me?’*” Hine also panicked that her husband might leave their marriage if she remains large even while he has refused to support her running home from work in relation to safety: “*I mean*,” she said hesitantly, reflecting these conflicting positionings, “*my husband says these days he’d love for me to get back to a 14 or 16. He has this thing about, ‘I don’t want a stick thin person; I want someone of substance.’*”

Janice, now in her forties with an adult diagnosis of type 2 diabetes, feels unattractive and believes that others view her as unattractive:

Cos you feel ugly. You know? Nobody likes being overweight; you feel insecure, you feel that you’re not as attractive to your husband or whatever. I don’t know, for all those reasons, the insecurities of being overweight, you hide behind things.

The ongoing effect of being large and feeling unattractive led to Janice “*hiding out at home*.” Yet even losing weight following a gastric bypass has not substantially improved this tendency.

The urge to fit-in, physically and psychologically, materialised as an important cultural notion, enacted in diverse contexts within the everyday lives of participants. The intractability of problem weight was evidenced on a daily basis. Women dressed their large frames to reflect appropriate style for age; they minimised bulky appearance; they worried about how they might be viewed in their friendship and professional networks; the size of theatre and transport seating or having to request extender belts on airplanes were frequently voiced concerns; being given “*the big size nighties (with) a blue thing*” (Dr Kim) for radiology; not wanting “*to be the person sitting on the bus that never had anyone sit beside them because they didn’t want to sludge up against you*” (Shona). These were sites of conflict between inner comfort and the outer constraints of living as a large woman day-by-day. Reference was also made to having refused help in risky situations where derision or further embarrassment might result: Kim, on a marathon swim, compromised her safety by refusing to be pulled into the companion boat. She spent an additional 90 minutes in the freezing water, resulting in hypothermia.

Dr Kim and Dr Jennifer recalled the sexualised environment of their medical schools in which their bodies were “*always on the line*” (Jennifer). Kim related a number of

incidents in which a male student had “*made some very disparaging comment to my face about my weight.*” By her fourth year in Medical School, Kim had resorted to bulimia that she described as “*convenient (...) an easy way out (...) illusion of control and then it takes control of you and that’s the seductive thing with all these things.*” Jennifer spoke of the harassment from male students, “*ribbing*” female students about their bodies, and female students consciously dieting. At a recent Medical School reunion for her class from the late 60s and early 70s, an incident occurred which reminded Jennifer of the pressures on her as a student:

(O)ne of them said something, about my breasts actually. They were drunk at the time and it made me think, “Fuck, I think these innuendos were probably going on when I was there.” But I would have kind of not, I’d have to switch off to them.

Dr Jennifer reflected that sexually harassing behaviours by students were common, difficult to manage and with no formal supports in place to manage them.

In whatever terms women explained their current weight and size, when their bodies did not meet everyday notions of reasonable body size and medical dicta about weight and health, women felt the need to minimise their high visibility. In attempts to look “*relatively normal*” (SusieB), women covered up, making “*a lot of effort in looking slim*” (Pinky) or hiding out in the back row for photos (Shona). With the objective of passing unremarked, and needing eventually to exit the cover of the water, SusieB’s heartfelt plea as she crossed the swimming pool complex was: “*Oh God, please don’t let anyone look at me!*”

6.3 Mothers and daughters

Janice has two daughters, one of whom she described as “*very slim and gorgeous*” while her second teenage daughter was a size 14. Janice has worried about how best to help this youngest daughter and tries to modify her daughter’s diet without encouraging anorexic thinking. This conflict was evident in her concern following reading an entry in her daughter’s diary describing the use of laxatives to lose weight, and bulimia amongst her schoolfriends.

Dr Lesley’s anecdotes about her mother’s diet reflected her belief in the connection between eating and weight. She detailed her mother’s breakfasts and her sister’s restrictive and overly careful patterns with food, while positioning herself as making good, “*normal*” choices about food. Her husband and two daughters believe she has “*issues about weight.*”

My children would say that. They say “You never let us have milo when we want to have it, and you only have one when we want to have two chocolates,” and things like that. But I think that’s just because I don’t want it. (pause) So maybe I’ve got more of an issue than I think.

Doctor Jennifer worried that her body did not match the ideal shape for a young, athletic, female. Her body shape was likened to that of an unfavoured relative:

I think mum might have said something about her having enormous thighs and I think when I got to puberty I gained a lot of weight. I never had a weight issue until puberty when I put on a lot of weight and ah and it would have been commented on that I had the same sort of body type as this grandmother and my thighs in particular.

With her body shape negatively connoted at home, she was highly embarrassed at needing to change into shorts and togs at school. At age 16, she was one of two women in this study who had their first experience with *Weightwatchers* in the company of their mothers. Michelle at age 14 and Doctor Jennifer both recalled a mix of embarrassment and relief at doing something about their weight.

Sheree grew up being groomed to be thin within a society that expected mothers in families to ensure that children’s weight conformed to standards normalised by Plunket.⁵ Scrapper’s mother continues to suggest weight loss, mostly covertly: “‘You could do with a little bit of weight lost.’ Sometimes it would be straight-out comments, other times it would be sly comments.” Scrapper experienced this advice as “needling,” and counterproductive while also understanding that it was based on her mother’s own discomfort of living weightfull. Dr Tricia commented that both her girls had been “a little bit tubby and got teased about it by us.” Her concern about having weightfull children was captured in a discussion of one son becoming “a wee bit tubby and I started to think: “Oh well, I’ll have to watch this! I don’t want a fat boy.” Doctor Gabrielle’s eleven-year old daughter recently announced that she was “fat:”

Gabrielle: *You know, they start getting a bit thingy about all that stuff. She’s very slim, but you know.*
participantR: *Does she worry about weight?*
Gabrielle: *No I don’t think worry, but you know, they’re all watching each other; you can see that. They’re all thinking about weight.*

Gabrielle has chosen to remove scales from her home.

⁵Plunket is the name commonly applied to a New Zealand organisation caring for maternal and baby health from the early 1900s.

Dr Kim recounted a family history of disordered eating related to perceptions of, and distress about, their bodies. At the age of nine, Kim lived in America with her doctor/parents. She described her peers as “*weight-conscious, American, pre-adolescent girls.*” Her mother related being fat to being “*ugly,*” chronically restricted her own eating and engaged in large amounts of exercise to be thin. She called Kim “*my lovely big girl’ and apologised to me for having inherited my father’s genes.*” Kim recalled mowing lawns furiously at the age of nine “*to use up calories.*” Kim’s daughter, aged nine, was described as “*certainly not skinny, she’s chunky,*” with a brother who “*is remorselessly horrible to her about her weight.*” While characterising this behaviour as sibling rivalry, Kim’s daughter was also experiencing teasing about her weight within her wider peer group. Kim described her daughter as being unfortunate enough to have her build and liking to eat. Clearly in response to some chiding, Kim’s daughter has recently told the family: “*Oh, I’ll go and be anorexic then!*”

Feeling the responsibility for bearing a child who wasn’t a “*normal kid,*” Sheree’s mother consulted an array of doctors and alternative practitioners though Sheree’s weight was most often labelled as “*piggy eating.*” Sheree expressed considerable frustration with the way in which the discourse “*You are what you eat*” has received such universal acclaim, commenting on how doctors “*generalise*” around big people. Clearly acting within socio-cultural ideals, Sheree’s mother believed that girls needed to be slim to attract friends and partners and that it was a parent’s responsibility to ensure that “*someone’s going to want to be with her, and things like that.*” Dr Nicky connected overweight with the social effects of being unable to attract a mate :

We’re biologically programmed to try and choose good looking mates and its probably (...) to generally keep people to choose people who are generally healthy, and the ones that have got very even features and nothing too extreme in looks is appealing to us. And being overweight is not in that category.

Sheree maintains a watchful eye over her daughter’s diet and limits her attendance at birthday parties: “*I think if I just teach her that, and then don’t take away everything else.*” Dr Nicky has limited her children’s access to certain types of food: In subscribing to the idea that “*Sugars are not what’s making us overweight. It really is the fat,*” Nicky allows her children to eat gummy sweets but not ice creams. This is also the advice that she gives to parents who consult her. Shona, who described her mother as complacent about carrying extra weight, asked her father how he could possibly love

her large mother. Shona herself wished to be like her grandmother, a slim, beautiful woman, once a model. Following WLS, Shona's new creed has become: "*Nothing tastes as good as thin feels*" and she recalled her grandmother's advice: " '*Just have a small piece of it, Dear. You don't have to have the whole thing. And that's what she did and (who) she is.*'" Shona has moderated her daughter's diet. In the interview I assumed this meant that her daughter was overweight.

- participantR: *Has she got a weight issue?*
Shona: *No, not at all. She's just gorgeous. Eats like a horse.*
participantR: *By gorgeous, do we mean tall and thin?*
Shona: *Yeah, we do, but she is gorgeous as well, to be fair.*

In a later description of her daughter as a "*twig insect type of thing*," it became even less clear why Shona would want to limit her daughter's food. While she took pleasure in her daughter's fit within current cultural requirements for weight and appearance, chagrin and worry about her own shape and size was evidenced in this watchful brief over her daughter's body. Before her surgery, Shona expressed disgust with her mother's body and her own inability to achieve desired weight and shape. This was evident in a semi-serious envy of her daughter's body expressed as humorous:

You asked me about my daughter and she is a shameless hussy as I refer to her. She has this most gorgeous body. She is model material. We're getting her into modelling this year we... I use the royal we! Me!

Keeping watch over her daughter's food intake and in her goal that her daughter should become a model like her great-grandmother, reflected acceptance of current cultural norms. Although Shona described her daughter as having "*an exceptionally healthy self-image*," that image of self was strongly connected to having an ideal body. In the suggestion that her daughter has a "*real issue with needing to look good*," Shona's daughter appeared just as conflicted about herself and her body as her mother. While Shona acknowledged this ambivalence, she also commented how hard she had tried "*not to put my mental head stuff onto her*." On reinterview, after losing 50 kilos with WLS, Shona emphasised the connection between thinned weight and an attractive female body: "*You can lie all you like and say, "Oh you're very attractive." Overweight is not attractive. You might have beautiful features but overweight is never attractive. I was never attractive when I was overweight.*"

Doctor Mary carried strong personal views about weight and the connections she made between attractiveness and weight were clarified in describing her daughter: "*She*

had rolls of fat around her and she was fat (laughs) and now she's thin (...) She looks gorgeous, really." Her 15 year old daughter attended a school where "*the girls are completely obsessed*" with weight, and have "*very bad eating behaviours.*" Mary's patients include eating-disordered patients, and Mary reflected on some of the health ramifications of being underweight. I used this opportunity to ask, in the interview, whether her daughter's recent weight loss was an early sign of anorexic-type behaviours. Mary considered the question but preferred her stated view that thinned weight was both attractive and healthy.

1. Dr Mary: *She's really got very thin and you know and every now and then I think, "Oh god, jeepers, I hope there's not." She doesn't look like someone with anorexia, she just looks, she looks gorgeous really.*
2. participantR: *Do you think there's still an equation between the young woman who looks slim, **and** gorgeous?*
3. Dr Mary: *Yes, I do, unquestionably, unquestionably. It just so happens that it's also very healthy as well. So my push is not on the thin and gorgeous but it's the thin and healthy.*
4. participantR: *Do you think it's a complicating factor, thin **and** gorgeous?*
5. Dr Mary: *Um well it is if you're not thin.*

In Mary's speech at 1, it is clear that Mary's daughter has lost a great deal of weight and is in fact now "*very thin.*" But Mary approved her daughter's current thinned appearance, and references a standard of attractiveness to which thinned weight is basic. My question at 2 stimulated Mary to consider that her response may have shown an overvaluing of thinness (Wiseman, Gray, Mosimann & Ahrens, 1992) in 1. In moving to modify her initial response to be more socially acceptable (Schwartz, Chambliss, Brownell, Blair & Billington, 2003; Teachman & Brownell, 2001), Mary promoted thinned weight as healthy, in 3. Building on that answer with my question at 4, I asked Mary to reflect on the incidence of anorexia and bulimia rising in relation to thinned-down normative body size especially for young women (Pritts & Susman, 2003). In 5, Mary re-emphasised the connections between size and female attractiveness. What was missing from Mary's response was any reference to the marginality of a low 'normal' BMI leading into underweight, the need for vigilance at her daughter's current age, such as that shown by Dr Gabrielle, to ensure that, if an eating disorder is beginning to be manifest, immediate intervention may prevent that disease from becoming chronic (The British Dietetic Association, 2008). After all, there is a significant rate of mortality and morbidity associated with these eating disorders (Birmingham, Su, Hiynsky, Goldner & Gao, 2005; Herzog et al, 2000).

Weightfullness is a health risk that has been overvalued (Cogan, 2000). The alternative and more pressing health risks may lie in chronic restricted eating amongst women. In this section, food was restricted, different foods assumed normative values and women as mums reflected the attitudes and behaviors of their mothers in their parenting around food and body size. Restricting food and describing food choices as being good or bad manifests the morality of food choices and eating behaviours (Lupton, 1996), norms inextricably relating to both health and size.

These narratives related the considerable concern, criticism and teasing in these families about weight and appearance, inheriting ‘bad’ genes, and disturbing life chances. Body-related teasing in families is significantly related to body-image dissatisfaction and the development of eating disorders (Keery, Boutelle, van den Berg & Thompson, 2005). As well, when mothers encouraged their daughters to lose weight, restricted access to foods or criticised their daughters’ size and appearance, these were associated with more intense fat stereotypes amongst their daughters (Davison & Birch, 2004). These issues played out as multi generational in their effects.

6.4 Reading the population story and living the risky life

participantR reflects

On August 13, 1948, three years after the end of the Second World War, I come into the world already female, child, bigger than average, 10lbs 5oz. In the delivery room, I am often told later, the talk is: “Pity she’s a girl – she’d make a great All Black.

Beginning in the early 20th century in New Zealand, a baby health monitoring and support system, Plunket, has mapped weight in relation to height as a measurement of health. The ‘Plunket Book’ became a personal document attached to those New Zealand children who have accessed the services of Plunket. Clover referred to that document in explaining her lifetime of struggling with weight:

Well, if you go right back to my Plunket books, it shows, at the point where I actually went above the average on the line, and the Plunket Nurse has written in the book, umm, something about no need to force-feed.

The terminology ‘force-feed’ evoked the historical context into which most participants in this study were born, post-Second World War New Zealand. It also suggested that Clover’s mother, in the pressure to ensure that her children survived into adulthood, following the loss of a child, “*had an issue over children not eating*” (Clover laughed). Clover indicated that early over-feeding had led to her lifetime issues with weight.

Clover's family was one of the many New Zealand families affected by an economic depression in the 1930s and the Second World War in the 1940s. In her extended family, young members had succumbed to tuberculosis or died on the battlefield. These families were targeted in the political push to improve the health of the population. Governmentality in regards to the health of young people coalesced with progress in medical science bringing with it oversight of citizens as patients and access into private homes for issues not formerly considered to be health related.

Epidemiology permeated participants' lives, placing population norms as ideal and achievable weight-for-health equations. Overweight was evidenced in these narratives as synonymous with the risky lifestyle, disease and early death. Habituated responses to findings in medical science were evident in the acceptance of the weight/health equation by these participants. Meryl read an excerpt from her current writing: "*I realised what I was, an obese woman who was unlikely to live to see her children grow up.*" Within the interview, she spoke of her panic about her weight/health:

But I knew, I knew then I was waiting to get sick basically. I was just waiting to get diabetes or a heart attack or – I was waiting for something to happen – sleep apnoea – heart – uterus hanging down.

Living with the risks of being overweight and diabetic within a statistical representation of the relationship between diabetes, weight and early death was clear for Janice as well:

I felt like, I felt like I was a walking heart attack. I felt, I don't know if that was the weight thing or the diabetes thing, I knew that if I didn't do something I would be in an early grave. Yeah.

One participant, who had adopted a child when she was in her forties, spoke of her alarm when she noticed back and knee pain. Niggling pain connected SusieB, not to the possibility of arthritis, but to a precarious connection between obesity and early death. Her catastrophic interpretation of minor pain in connection with overweight illustrates the powerful pull of the epidemiological story. In her work as a dietician, Pinky discusses, interprets and communicates statistical risk factors of weight for clients. She assessed her personal health risk status within the interview: "*And my blood pressure's fine, all my health risks are minimal – um, but inside yourself you're saying, 'Yes. I'm a time bomb,' because in both generations, I'm waiting for my gall bladder to explode.*"

'Time bomb' is a compelling metaphor used by a number of participants to describe their panic around weight. This is a metaphor highly redolent of the war-like discourse

that surrounds weight (Komesaroff & Thomas, 2007). Such metaphors add to the panic and psychological suffering surrounding weight (Lupton, 2004) where there is little reprieve from worry and risk thinking. The early twenty first century has been characterised by a proliferation of research from private and governmental sources relating the epidemiology of weight/health (Ministry of Health, 1999; 2001; 2003; 2004; 2007; FOE, 2006). In this research women faced pressure from family members about their risk of developing health problems. Janice's husband was concerned that she will end up "*legless in a wheelchair*;" Margaret's younger partner "*doesn't want me to kark it and leave him alone*." Janice believed that her father died from the co-morbidities of weight though her mum is resistant to that idea. While this may suggest a lesser exposure to statistical measures of weight/health amongst her mother's generation, it might well be related to the implication that she is at fault in her role as her husband's meal provider. Dr Mary believed that if she could get men thinking about what they ate, she could encourage changes in eating and weight. By implication, their current diets lacked the critical awareness and insight needed for the provision of healthy food based on the supposition that men were not preparers of food for families.

Even where women sought to distance themselves from being uni-dimensionally portrayed as statistically overweight or obese, their narratives reverberated with references to the population story and its impact in their lives. In working for an insurance company, Clover recalled their differential weightings and penalties for overweight clients:

I think it was life insurance for a mortgage and there was a 50% weighting put on it for a BMI of 35. Well, a BMI of 35 is a rugby playing weight...so okay, a weight problem but not necessarily a problem depending on the person's lifestyle.

Clover critiqued the weight/health correlation and called upon a culturally resonant argument within New Zealand society. Acceptance criteria for insurance has impacted her attempts to access health and employment insurance. Clover's frustration was palpable: "*I think BMI is just a load of rubbish*." Her text was redolent with a preferred discourse, relating exercise with health regardless of size:

It's just that small mindedness again, that size is everything, or your weight is everything. No one asks you how much you exercise; no one asks any of the important questions. No one! It's all too complicated. That stuff is all too complicated. Let's just get to the numbers on the scales.

The pull of habituated weight/health ideas was evident:

(A)ll that old stuff, all those old diet things that were so comfortable just kind of clicked in. Yeah all that stuff from... You know, like that you can do it, and that you should be doing it. You know, you should be doing it.

Michelle reflected on the ease with which she took up dieting again following WLS. She described this as a return to a well-practiced discipline, a spontaneous response to being overweight. She spoke the highly moralised discourse around dieting as needing to be self-imposed while it was also externally sanctioned. The call to self-actualisation was elicited in the phrase, “*You can do it;*” the words of guilty remorse for being overweight and the need to act morally: “*You should be doing it. You know, you should be doing it.*” Her text demonstrated the embedded nature of social stories of weight and health and the call for individuals to accept personal responsibility for, and agency over, weight. In a critique of normed weights as “*a load of rubbish,*” Kim pointed out how easily some people pass relatively unremarked while they weigh 100 kilos or wear a size 16. She also pointed out the significance of visual appraisal within medical consultation: If she is weighed and measured before a consultation by ancillary staff, then the doctor “*would expect this very fat person to come in.*”

It is a common adage in Western society that a book may not be judged by its cover, yet the body is visually infused by cultural preference and this is supported by epidemiology. Judgements are made about the relationship between a healthy body and a correspondingly good character (Jutel, 2000; 2005) with trust in visual perception having precedence over all other senses (Jutel, 2005). For Kim, 100 kilos is a weight at which she “*looks quite good, fine,*” while achieving a size 16 would be at the risk of becoming “*too thin for me.*” While she asserted a somewhat critical attitude towards accepted weight/health equations, Kim’s activities belie that essentially cognitive analysis. She asserts that “*fat is a jolly risk factor in everything,*” and seeks out lurking disease processes through constant and anxious blood testing to discover something that might “*frighten me into losing weight!*”

Epidemiological arguments are compelling. They rest in scientific research knowledges that feed the drive for certainty in the achievement of a long and healthy life. While weight/health correlations are produced as facts within epidemiology, the statistics become fashioned into codes of ideal behaviour. Alongside a patterning of aspirational lifestyles, ‘modern’ citizens are encouraged to live their lives with agency, making choices associated with requisite penalties and rewards. For a society highly alerted to risky bodies’ discourses, scientific findings in relation to health become the

key to unlocking the secret to immortality. A post-modern critique reflects on the epidemiological association of weight and health as something more akin to a scientific manoeuvre. This disrupts, intellectually speaking, the notion of the absolute truth of scientific facts. It also troubles what is taken-for-granted when inconsistencies and alternating logics of modern weight/health/diet are in question. Nonetheless, these connections are basic to habituated actions, even while they are clearly open to debate. And, it doesn't stop women dieting (Germov & Williams, 1996; Kenardy & Ball, 1998; Kenardy, Brown & Vogt, 2001; Tiggemann & Lynch, 2001).

6.5 Rituals of weight loss

Female participants and some male doctors had participated in weight-loss schemes. Despite the fact that a number of the male doctors commented on their own weight gains and losses, their overall positioning in relation to personal weight was generally pragmatic: Dr Henry was using his pedometer to raise his exercise levels and lose 10 kilos; Dr Maurie used *Weightwatchers* to lose 20 kilos; and, Dr M1 preferred to ignore his weight gain. Most of the women doctors were pursuing restricted eating or diet-exercise regimes to manage or reduce their weight. Dr Kim, who self-selected for the study as a weightfull person,⁶ viewed her weight as “noticeably over the ton,” and was dieting with the assistance of *Reductil*.

Women and doctors referred to the cyclical nature of the processes by which people initially lose weight by dieting, followed by weight regain, consistently regaining more than they lost. SusieB was first prescribed weight-loss pills in her early twenties before resorting to a range of diet and exercise programmes including alternative therapies, sessions with dieticians, *Weightwatchers*, *Jenny Craig* and WLS. Significant long-term weight loss has eluded her. Meryl had read many books on how to lose weight though their inspiration was short lived. *Weightwatchers*, point plans, gym attendance and long walks, have also resulted in only temporary losses of weight. Overweight throughout thirty years of marriage, Pansy has been prescribed two drugs for weight loss and participated in a drug trial for a weight loss medication. She attended *Weightwatchers* and was so successful that she became a lecturer for a short time. This weight has all been regained. Phoebe, in her fifties, was for the first time in her life monitoring her food intake within a low carbohydrate diet. As a young woman, Clover was prescribed

⁶While the reader might be intrigued to know the degree to which each of the participants was overweight, some information about weight is provided in Appendix 12. However, I chose not to reproduce weight as clinical data in this thesis to avoid defining women by their weight.

drugs for weight loss and normalised this as “*one of those addictive things that they use to prescribe back then.*” Having gained weight as a teenager, Clover began dieting at the age of eighteen, also losing and gaining: “*You know. Subject to the normal diets. Go on a diet and then lose three stone, slip up, go off the diet for a short while, you gain the weight back, and more with it.*” Pammmy had also tried dieting “*every trick in the book,*” but was unable to achieve lasting weight loss. Janice enrolled in *Weightwatchers* and *Jenny Craig*, but always regained any weight lost. Her endocrinologist had suggested she try the Milk diet: “*I said I don’t think I like milk that much that I could do a milk diet. It was just milk for 5 or 6 weeks or something, milk. Breakfast, Lunch and dinner! Milk!*”

When Rosie’s first pregnancy left her with a large stomach, she was prescribed pills that “*kept her up all night.*” She lost about 8 kilos but regained even more weight with ensuing pregnancies and her life has been punctuated by constant dieting with *Jenny Craig* and *Weightwatchers*:

I went up and down and up and down. Kept going back to Weightwatchers. I’d get up to 70, then I’d get up to 80 and I’d get back down to 70 and I was always dieting. It was just a nightmare but I never, if I had known then I’d get to 135 kilos. When I’m trying to not have this and that and the other, I think about food all the time. When I don’t do anything, I don’t even think about food and I actually don’t eat as much.

Shona has also tried *Weightwatchers* on a number of occasions and experimented with the *Hip and Thigh Diet*, *Atkins*, the bread diet and the cabbage diet. Feeling “*good*” while she was dieting because she felt “*in control,*” she would lose weight but always regained it. These diets were all or none affairs in which she would completely empty her cupboards of any foods proscribed in a particular diet and, in zealous anticipation, would fill her pantry with the most recent “*right*” food. As a young woman, Topsy consciously tried to lose weight by “*smoking and not having lunch.*” Later, she began taking over-the-counter drugs to promote weight loss. Her use of *Tenuate*, which later became a prescription-only drug, was spasmodic and finally ceased when she found herself bursting into tears, clenching her teeth and feeling racy.

Women felt impelled at certain periods, or for certain events, in their life to slim their bodies, the “*thin and gorgeous*” (Dr Mary) standard on show. Topsy gained weight while on an overseas tour of duty, she lost weight following her return to civilian life and prior to getting married. Marjorie joined *Weightwatchers* before she married so that she might “*look spectacular as a bride,*” and Dr M2 referred to his fiancée who “*would*

like to be a whole lot thinner by the time we get married (laughs). So she's still a woman as well." Margaret diets as she changes jobs or enters a new relationship though she has had no permanent weight loss from diets, including *Weightwatchers*, *Jenny Craig* and a counselling course.

The ritual involved in weight loss was played through in families who found faith in particular methods of weight loss, becoming adherents for one method or company.

participantR reflects:

The similarity between being brought up Catholic was not lost on this researcher. Being in a state of grace, sinning, confessing, returning to a state of grace, straying from the faith and checking out other denominations, the prodigal son/daughter welcomed back into the fold.

Sheree in her twenties, on the other hand, was an experienced dieter. Exposed to agitation around her weight, and lacking the acceptance she desired, Sheree recalled suggesting weight loss options to her mother at an early age. She was allowed to attend a very expensive programme: *"It was the wealthier that got to do it, or people that had paranoid parents."* *Jenny Craig* is the diet organisation of choice in her family: *"We all belong to Jenny Craig, indefinitely, you know, life members (laughs)."* *Weightwatchers* was the dieting organisation that Scrapper, her sister, and her mother all looked to for expertise in dieting. Scrapper has weighed in again recently and her sister is also currently registered. Scrapper joked that there should be a *"family discount."*

Four women doctors spoke of restricting their eating and dieting to lose weight. Doctor Mary actively encouraged patients to attend *Weightwatchers* because they *"have the psychology of it worked out."* She herself has recently taken up running and lost 10 kilos. As a medical student, Mary had told her friends: *"I'm going to start exercising when I'm 40 years old because I'll just stop if I do it before."* Enjoying her current thinned weight, Mary was hopeful that she herself would not succumb to the *"inevitability that people would end up being back where they were."* With a mother who was *"overweight,"* and clear that she did not want to end up like her, Doctor Lesley experimented with diets as a teenager, not *"the extreme type,"* she *"would just cut out after school snacks for a little while and feel terribly virtuous."* As a teenager, Dr Moyra went on a diet when her gym instructor told her that she was getting fat. She stopped dieting only when her mother threatened to stop her taking up the offer of an overseas scholarship. During her overseas studentship to Japan at the age of 15, Nicky *"stashed on heaps of weight."* Blaming this on the Americanised diet fed to her by her

host family, and feeling as if she was “*busting out of her clothes*,” Nicky began dieting for the first time by

(...) eating one meal a night and having some apples on the other day. So every second night I'd have a meal and a few, low fat milk drinks and things like that and took myself off walking around the neighbourhood.

While she described her weight gain at this age as “*accidental*,” Nicky normalised dieting amongst teenagers using figures such as 75% of normal weight girls and 95% of overweight girls diet, talk about and read magazine articles about dieting. Conscious of her choice to work mainly with women who have issues with their weight, Doctor Nicky has settled into a personal regimen of “*a rather low fat, high fruit and veggie type diet which I like and I do my exercise with my dogs*.”

Pinky, a dietician, referred to the “*yoyo dieting*,” effect on metabolism when dieting is attempted and abandoned: “*Even then they would tell you it wasn't a good idea to yoyo diet all the time. Nothing's really much changed. I knew not to Yoyo diet. You're better to hold onto what you've got.*”

6.6 Weight and consultation

The construction that overweight causes disease and early mortality is reinforced within medical consultations. I recalled an occasion when our family doctor was called to the family home. He told my mother that she would die very early unless she lost weight. My mother lived into her eighties, but this doctor's words produced an obsession with weight that permeated the life of our family.

participantR reflects

The bathroom scales were always in evidence. She tried the bread diet and Weightwatchers'. She lost weight, gained weight and lost it again. The scales never tipped below 14 stone until her weight plummeted towards the end of her life. By then her legs were like sticks (Reflecting diary).

Scale readings provide ammunition in a doctor's battle against obesity. As a twenty year old, SusieB was warned to lose weight or she would “*end up with eczema like old ladies get*.” She recalled another occasion when a doctor reported her cholesterol reading as being “*up a little bit*,” though he later admitted having said it “*hoping that it might have boosted me into losing weight*.”

Visual assessment of weight and the imposition of ideal weights featured in consultations. Dr Moyra believed that her visual assessments of weight have been reasonably exact though some patients may appear lighter than they are. Being labelled as overweight often conflicted with a patient's idea of their health: “*This doctor said I*

was quite physically overweight and that was kind of a bit of a shock to me but I didn't feel it was relevant to my health because I didn't feel like I was" (Em). Even while Em's lifestyle was healthy, her overweight was the focus of consultation: *"Did she just look at me from the outside and say what you are and whether it was just her judgement looking at me from the outside?"* This visual construction of being overweight became, through the sovereignty of medical positioning, a written, objective assessment. Sheree recalled the time when her operation was held up while her 'normal' blood pressure readings in relation to her weight were rechecked: *"They didn't believe that the readings they had on my records were mine and could we check that we had the right ones. It's a huge prejudice. You're overweight that's the first thing they look at."* Hine was the only participant who was placed on a programme of regular weighing by her family doctor. She assumed that this related in some way to her early menstruation. She was one of three New Zealand Maori women who participated in the study. The way in which she was weighed through her teenage years raised a question about whether women of different ethnic backgrounds or attendance at different practices might bring different levels of scrutiny. For instance, Margaret, who attends a medical practice in a culturally diverse area, believed that the lack of comment on her weight reflected the greater percentage of that practice population being weightfull.

On occasion women participants, rather than their doctors, expressed their desperation to lose weight. SusieB was recently told by her GP that her weight was acceptable though she was adamant about her continued need to lose weight: *"It is not what I want. I'm not ok because I'm not where I want to be."* Motivated by appearance and weight, SusieB and her WLS surgeon pursue further loss of weight even though reflux brought on by the lapband could result in aspiration pneumonia. Clover was continually told by doctors to lose weight: *"You do know you need to lose weight."* On one occasion, following WLS, she consulted her local GP and was concerned that her doctor's advice was influenced by his religious beliefs (refer also to 7.3.2):

I said "I can eat things that I didn't used be able to eat" and he said, "Well, you know, it's a temptation like any other to be resisted." Of course it didn't help that he had a New Testament sitting on his desk either.

Growing up in medical families, practising as doctors or working in medical environments heightened the day-to-day visibility of weight, complicated medical care and raised several ethical issues. Em grew up with her doctor/dad who dealt with the family's medical needs, including restricting her access to dairy products from the age

of 9. Em's father continues to comment on how Em is looking. Today, "looking healthy," "a picture of health," "a healthy glow" and, conversely, "she doesn't look well" suggest that health is treated as a visual condition, one that is easily assessed by the size of the body" (Jutel, 2005, p.120). Em's weightfull appearance has continued to be a source of conflict between herself and her father into adulthood. Kim's parents are both doctors and she recalled her mother, a GP, prescribing *Ponderax* for her specialist husband. Kim's mother has always self-medicated and Kim has prescribed *Xenical* for herself, using it after a fatty meal. She has used *Reductil* that, while "not useful as an anti depressant was very good for the metabolism." She has refused a script for speed: "Freaked-out" on *Adipex*, she felt "naughty" taking it, and eventually stopped using it when she realised its potential to cause heart problems. Pansy stopped taking *Ponderax* prescribed by her gynaecologist/employer when she became "racy." Another doctor/friend prescribed *Xenical*, but Pansy "cheated" by establishing how much fat she could safely eat, without succumbing to *Xenical's* most pronounced side effect: "I farted from here to Africa."

Dr Maurie recently lost weight on a *Weightwatchers'* programme. In the following excerpt from an interview⁷ with Dr Maurie we reflected on this experience in relation to his medical practice with patients. Dr Maurie was a large-bodied student who was ribbed about his weight in Medical School. Very pleased with his weight loss, he described himself as a successful *Weightwatcher*.

- participantR: *So up until that time you would have been quite happy with your weight, felt it was pretty normal?*
- Dr Maurie: *Nah! I was always porky.*
- participantR: *Always porky? (laughs). So, grew up porky?*
- Dr Maurie: *Yeah. Yeah. Born porky, grew up porky, always porky.*
- participantR: *Does it make a difference?*
- Dr Maurie: *Well I have patients come and see me about my... their weight because they heard I lost it.*
- participantR: *Ah really? What did you lose? To be personal – put it on tape!*
- Dr Maurie: *20 kilos.*
- participantR: *Yeah?*
- Dr Maurie: *Something like that!*
- participantR: *So that's a nice amount?*
- Dr Maurie: *Imm. Yeah I no, no, I did it with Weightwatchers, that's good. I like Weight watchers because I did it and it's easy.*
- participantR: *You find it quite a straight forward kind of?*

⁷ This excerpt demonstrates the deconstructive/narrative style of interviewing. What the personal nature of questions displays is the bridging of personal and cultural contexts within consultations.

Dr Maurie: *Yeah. It's easy, it's very easy.*
 participantR: *Is it something you suggest to your patients because of that – I did it, you can do it?*
 Dr Maurie: *Of course. I tell em, I did it, you do it!*
 participantR: *Is that true?*
 Dr Maurie: *That it works?*
 participantR: *That everybody can do it?*
 Dr Maurie: *Nah, nah!*
 participantR: *No?*
 Dr Maurie: *No, people – Because it requires a bit of looking and being in detail about what you're eating and always thinking about it.*
 participantR: *So being a bit of a scientist can help?*
 Dr Maurie: *Yeah, I think so.*
 participantR: *Yeah? and exercise? You haven't mentioned exercise.*
 Dr Maurie: *Oh yeah, yeah but I'd been doing that for years.*

participantR: *So it didn't actually help you not to put on weight?*
 Dr Maurie: *Not at all!*

Maurie considered that his weight loss was a personal feat that his patients were intrigued by. In suggesting that it was easy for him to lose weight and that *Weightwatchers* was an easy programme to follow, he assumed a moral high ground that justified his asserting to patients “*I did it. You do it!*” His single experience of dieting has confirmed the belief of many medical practitioners that diets work (Thomas, Hyde, Karunaratne, Kausman & Komesaroff, 2008). Maurie does not believe that overweight patients can comply with dietary instructions, crediting himself as having greater ability to use the programme than his patients.

A similar pessimism emanated from Dr Mary's text: Patients “*generally fail.*” Mary has always been slim, and has recently lost more weight by taking up running: “*It's easy for me. It's easy.*” For her patients, however, it would be “*ridiculous for me to suggest that most of my patients take up running because they're far too heavy.*” What are the ethical implications of promoting weight-loss fixes in the absence of any belief that they will work? Clearly it would impact on trust in a relationship in which overweight patients feel overwhelmed, disrespected and misunderstood (Thomas, Hyde, Karunaratne, Kausman & Komesaroff, 2008). In her early career, Mary pursued and promoted weight loss vigorously, before succumbing to the belief that asking her patients to lose weight was “*a burden that was too great to add.*” She now believes that this position is “*irresponsible*” and she is again informing her patients about the influence of excess weight on their health:

I do preface the conversation with “I do realise this is as helpful to you as da de da, but you need to understand what the role that excess weight has on your health. You need to understand that you increase your risk of diabetes 80 fold if you go from healthy weight to having a body mass index of 35 if you’re a woman. You need to understand how it works. You need to understand how fat accumulation within the visceral cavity drives insulin resistance and diabetes. You need to understand how the guidelines for healthy weight according to body mass index were derived” and you know all that sort of thing. So I do now make a lot of effort to inform people about the effect of weight, but hopefully try not to make them feel that this is, you know, a mandatory part of the relationship that they have with me as a doctor, there to look after them. That’s something they have as an option possibly to them (Mary).

In employing the epidemiology card, Mary delivers the message at a distance, an objective appraisal of the statistical burden of being overweight. Meanwhile, her pessimism about patients being able to effect any real change in that position influences the tone of her message.

Overall, participants disliked being weighed or being told to lose weight. Participants had been advised, on numerous occasions, of their need to lose weight. Dr Maurie told one of his patients: *“I told her. I said, ‘Look, y’know, you’re gonna die. (laughs) This is just terrible.’ She was just grossly obese.”* Dr George had thought about saying that to a patient but chose not to. George’s practice partner, Dr X, has no fat patients in his practice: *“I tell them, ‘You’re fat,’ and they leave.”* Shona disliked being weighed given the lack of support for losing weight: *“He would have said to me as all doctors do, ‘You need to lose weight if it affects your asthma.’ ‘Sure, thanks for that. I’ll just go away and lose 20 kilos tomorrow.”*

Women doctors discussed extensive histories of personal weight management and believed that compliance was the major issue if patients failed to lose weight. Medical consultations around weight have tended to concentrate on weight as a disease rather than on the social ramifications of living weightfull (Komesaroff & Thomas, 2007); consultations may be abbreviated, and expressive of bias (Schwartz, Chambliss, Brownell, Blair & Billington, 2003). While patients have been found to experience doctors as more negative in their practice than doctors believe themselves to be, it is clear that patients also hold very negative attitudes towards obesity (Brandsma, 2005). Long histories of living weightfull, trying to lose weight and maintain weight loss in the longer term, and maybe the failure to have these experiences acknowledged in medical consultations, led to expressions of frustration such as that expressed above by Shona.

6.7 Discussion

Whether we understand dieting agentally or as the coercion of women within a complex interweaving of beauty/health/trade (Bartky, 1990; Jeffreys, 2005) may be of little relevance. If being weightfull is synonymous with being considered ugly in our society, then the pressure on women to normalise their weight is immense. In the societal abhorrence of overweight, reinforced within families and infusing women's lives both within and outside of medical consultations, women managed their lives attempting to bring their bodies within norms of weight/appearance. Participants believed that a better life depended on achieving a body close to the ideal parameters. Whether or not participants achieved a semblance of the ideal, these participants expressed living much of their lives dissociated from their bodies, a virtual hiding from the world as limits were placed on participation in-group and ritual activities.

Taking responsibility for being overweight occurs even in the absence of weight/health issues. In the cultural assumption that thinned weight requires disciplined eating and exercise, a confessional discourse is normalised. Even when women became interested in new ideas about health/weight, such as being fit at any size, or size acceptance, women in this study were careful to show knowledge of the medical discourse that weight in excess of normal is synonymous with poor health.

Women participants were distressed at being weightfull and being called obese. In WLS consultations, they learned to accept this term realising that access to WLS might depend on acknowledging their fault in having gained weight. Participants began to call themselves obese and labelled their weight as obesity. Even while these participants expressed strong resistance to socio-cultural medicalised practices around weight, they spoke confessional discourses – comfort eating, lapsing in their exercise routines, regaining weight after losing it at *Weightwatchers* or on *Jenny Craig*.

At times, participants challenged the practice of doctors and 'the media' as imposing generalised epidemiological norms on individual bodies. Although participants clearly held diverse understandings about weight and their bodies, these remained largely private views, marginalised, suppressed within both their day-to-day lives and medical consultations. The effect of early socialisation around weight, with a plethora of experiences of being watched, criticised and denied food, promoted a pronounced discourse of shame about their weightfull bodies. Understandings about health and weight reflected the powerful discourse of epidemiology, reinforced by discriminatory practices targeting weightfull appearance. Flanking the requisite catechism of health

understandings around weight, women's talk acknowledged their transgression within a medical discourse. Through participants' stories emerged the strength of normalised practices around weight that deflated women's understandings of their own health and of more recently acquired ideas of what worked best for them.

With scales readily available, epidemiology supports the medical discourse connecting overweight with co-morbid disease. Scales have assumed the mantle of arbiter in matters of weight. Norms for healthy weight have been produced and overweight has become synonymous with the presence of a number of diseases. Scaled weight reflects the culturally prescribed female body interpolated into women's lives, complicating their relationships with themselves, with their families, with their doctors and with other health care providers.

In this chapter, I merged all narratives of practices and understandings about weight of doctors and patients. This material demonstrated how cultural attitudes towards eating and body size are being transmitted between mothers and daughters,⁸ begin very early, and last a lifetime. I argue that these encultured attitudes impact parenting of children, were evident in doctors' narratives of medical practice around weight, and, significantly within this research, impelled a number of participants to consider radical WLS interventions.

In chapter seven, I move on to look at WLS decision-making. In the light of the interwoven pressures of appearance and health being dependent on slimmed body size, WLS became an option, even a condition of survival, for some women in this study.

⁸Where indicated, I include material related to fathers in this study given the research that suggests that fathers contribute to children's concerns about their bodies (Keery, Boutelle, van den Berg & Thompson, 2005).

“Medicine’s job became correcting the appearance of illness as well as its pathology”
(Gilman, 1999, p.16).

CHAPTER SEVEN

Narratives of weight-loss surgery decision-making

“The bodies of women in a postsurgical culture are all compromised regardless of whether we choose or refuse surgical interventions... we are inevitably in a relationship to surgery regardless of whether we actually become surgical... we are hailed by cosmetic surgery as a practice to which we must respond (in one way or another) ”
(Blum, 2003, p.44).

7.1 Introduction

This chapter reflects the mediated, medical-trading environment in which WLS decision-making occurs. In Chapter six, participants spoke about living weightfull in a culture dominated by statistical weight/health and idealised-thinned female body size. In the pressure to be slim and in the strength of their personal desire to achieve a thin body, WLS options were considered. Narratives of women participants detailed the lives of commodified female bodies of women in the late twentieth and early twenty-first centuries. In relation to health and norms of size and appearance, I argue that women in this study and surgeon-traders who attended them, were willing to entertain even the riskiest forms of WLS in the ongoing search for slimmed-weight health and acceptable appearance.

While aspects such as the geographical location of the WLS trade influenced decision-making, it was in discussing participants’ pre-surgery appointments that I began to focus on their problematic nature. Participants researched WLS options before meeting with surgeons but approached these pre-surgery consultations with considerable fear about the proposed procedures. Yet WLS patients tended to embrace radical surgery options during a single pre-surgery consultation. I began to ask myself about how encultured weight biases of doctors and patients were at work within these processes of consultation. How aware were surgeons of alternative weight and health

ideas and did these form a major element in the advice given? How was the radical nature of these surgeries being clarified in pre-surgery consultations?

Participants' texts may be read in diverse ways, as narratives of choice, deficit, or even just as stories of or for the researcher. Readers may engage these stories with pity or opprobrium, and miss the nuanced inflections that waft through the layers of women and doctors' narratives. For instance, women-participants' stories may readily be attended to as narratives of agency and resistance, reaching out with hope, staving off despair. Davis (2003, p.66) spoke with compassion of women who undertook cosmetic surgery as agentially seeking to resolve their "problems of suffering in special cases." This does not constitute a complete answer to the readily available and culturally validated trade in either cosmetic or WLS procedures. This chapter reflects on the discourses of the 'open2view,' flesh-bound, modernist project in which 'good' women must strive to be the best that they can be or, even, just to fit in. WLS became the last resort for some participants and the Holy Grail for others.

WLS decisions were encultured decisions that reflected the pressure on women to produce a meaningful look of weight-as-health according to current specifications. The newer forms of WLS were commodities designed to meet that need. But, WLS decisions were not isolated decisions made by atomistic, neo-liberal citizens. In this chapter, these decision-making processes reflect significant relational basis. Participants discussed WLS documentaries and Internet information with trusted family members and friends. Bonds were formed via Internet websites and WLS decision-making was clearly influenced by advice and personal anecdotes. Consultations with doctors demonstrated that these professionals were a significant and trusted element in women's relational decision-making processes.

In opening this chapter with the narratives of doctors and two WLS surgeons, I add a further layering of complexity to the narratives of women in this research. Of particular interest in the doctors' narratives was the persistence of medical thinking reflecting Parson's (1978) conception of the sick role with its underlying thrust towards the need for patients' compliance with medical directives. The doctor's narratives reflected the morality implications of patients' lifestyle choices.

7.2 Chance and variability in WLS decisions

Few GPs discussed WLS with their patients though Dr George, formerly a surgical registrar, and the specialists interviewed, had both referred patients to surgery. Two specialists in one centre were convinced that WLS had a major place in interrupting the

life course of disease. Henry believed that “*an expensive operation like that is the cheapest way of doing the whole thing. Because otherwise you will be treating them all their life for some other problems.*” Notably, Henry and Mary were colleagues of a WLS specialist and Henry was in awe of his colleagues’ procedure and dramatic research: “*I would take (his) word for that!*” On ward rounds, Dr Mary alerted students to patients hospitalised for the “*comorbidities of weight*” and was adamant about the benefits of gastric bypass surgery:

You’ve only got to look at, you know, those patients that come in and out and in and out of hospital are now you know with cellulitis from obesity for example, not to mention the huge amount going into diabetes, to realise that gastric bypass surgery would be a tremendously valuable thing for lots of patients (Mary).

Mary’s response promoted WLS as valuable for many patients, and her speech tied an individual’s obesity to co-morbid disease. This argument rested within a health-economics argument that obesity is a burden on the state (Allender & Rayner, 2007; Hughes & McGuire, 1997; World Health Organisation (WHO), 2002; 2004; 2009): Large patients get sick and tie up valuable health resources. Both Mary and Henry recommended surgery at least in part out of their concern for the economic implications of obesity. Dr Craig conceded that radical WLS might be useful for those who “*get to the extreme obese state*” to “*save their lives sometimes*” and this echoed George’s reluctance to “*rush anybody into surgery,*” while on the other hand repeating the medical refrain that “*weight loss surgery is surgery that is maybe saving a life cos otherwise they maybe are going to perish from their osteoarthritis of their hips or their heart attack or whatever.*”

Dr Nicky had set up a weight-based practice. In her dislike for the “*the old malabsorptive operations*” with their adverse implications for health, she avoided discussing gastric bypass with her patients. She remained unconvinced about the efficacy of lapbanding having worked with lapbanding patients, few of whom had achieved normal weight. George expressed being “*comfortable*” with the processes of lapbanding surgery even though only one of three referrals lost weight with that procedure. He laughingly referred to its lack of success and deftly minimised his role in his patients’ choices of lapbanding. Dr Moyra expressed a lack of interest in weight and WLS preferring to concentrate on “*more important practice issues.*”

The influence of lifestyle theory (Hansen & Easthope, 2007) permeated participant-doctor interviews.¹ For instance, patients would lose weight if they could “*resolve their issues*” (Nicky) or “*control the lifestyle factors of their own lives*” (Craig). Dr Lesley’s reference to one female patient who had “*lost an incredible amount of weight,*” indicated her belief that with the right motivation, WLS was unnecessary as “*diets do work.*” Dr Mimi also encouraged patients “*to gain control in their own lives: ‘It’s your car. You’re driving it.’*”

Overall, general practitioners and specialists in private practice were reluctant to tell patients that they might qualify for radical surgery. Henry believed that patients would have been told the health consequences of being overweight before they reached him, and his style was to “*get on phase so we can discuss it.*” He tells patients that their muscles are not strong enough to support their own weight: “*You’d be great in the front row of the scrum, if you were strong enough.*” Henry has moved from a consultation style he described as more appropriate to the “*factory atmosphere*” of the public health system. He described having sat behind his desk, in his white coat, “*tell(ing) people off,*” ordering them “*to go and lose weight,*” and generally “*bully them.*” As a specialist in private practice, he has shown a more sensitive attitude to discussing weight or, “*you won’t see them again probably.*”

A number of practitioners referred to WLS patients. Lesley recalled two open-procedure gastric bypass patients² in which diabetes for one patient remitted, while the second patient had such significant side effects that she required a bypass reversal. Dr Craig referred to a notional “*one or two people in the practice*” who had undergone WLS. After some reflection, he recalled that one had died since her very successful procedure. Neither Lesley nor Craig’s narratives are straightforward accounts. They suggested that these practitioners had limited and secondary knowledge of WLS procedures. The rhetorical neatness of positioning two patients, side by side, raised the possibility that these were figurative creations rather than literal renditions, in the tradition of objectivity. This was clearly an issue in Craig’s production of surgery success. Following the interview with Dr Craig, I reflected on whether the WLS patient’s death might have been related to that surgery (Thesis reflecting diary, July 2004). Craig neatly disqualified the two for whom it had been successful by also referring to a “*couple for whom it’s not successful.*” The original one or two became at

¹Refer to sections 1.5, 1.7, 2.6, and, 3.3.1.

²This was the only procedure available in the local area.

least four in the space of a sentence. While Craig is referencing case narratives, with the ability to recall and relate clinical case histories foundational in clinical decision making (Montgomery, 2006), the inexactness of his recall demonstrated a “cognitive cherry picking” (Groopman, 2007, p.65) from anecdotal information – the antithesis of scientific thinking (Montgomery) – and the uncertain nature of WLS outcomes.

The riskiness of surgery for large patients (Craig) and the steep prices charged in the private hospital arena were also reasons for avoiding discussing WLS (Lesley; Maurie; Moyra; Tricia). WLS patients were “*already compromised physically and you’re putting them through big surgery*” and the risks for surgery complications made it an “*extreme*” solution (Craig). Kim’s understanding that WLS patients risked extensive complications led her to dismiss WLS as a personal option. While it resolved her dissonance in choosing against surgery, Kim referred to clinical case material as if these had been her actual patients. Her rhetorical statement, “*I have seen people,*” appeared frequently in doctor-talk. Tricia and Craig chose not to inform patients about surgery based on their assessment of a patient’s ability to pay because it was “*almost cruel to raise it*” (Craig), while Tricia reflected during the interview on at least one “*problematic lady*” with whom she might now consider raising it.

participantR reflects

I am alerted here to interviewing as an intervention. The ethical dilemma for doctors of choosing whether or not to inform their patients of possible surgical solutions, based on subjective assessments of their ability to pay for procedures, intermingles with concern that my research questions might open up possibilities for patients to have procedures offered to them did not exist before this research.

To briefly summarise this section, doctor-participants did not routinely consider referrals for WLS and they had limited knowledge of these procedures and surgeons performing it. As well, some surgeries were not available within their areas and they were therefore uninformed about those procedures. WLS was essentially unavailable through the public hospital system and doctors privately decided not to raise WLS options believing that it would be beyond the reach of many patients. As well, a lack of knowledge was evidenced in espoused notions and sweeping statements that were intricately interwoven into GP talk about WLS outcomes. Stories so neatly fitted-in with a proverbially ‘balanced view’ that they reflected rhetorical positionings rather than experience. In research interviews, GPs spoke in generalities and expressed a general lack of comfort in discussing or recommending WLS procedures. There was scepticism about any need for such radical procedures. Poor knowledge and limited

experience were covered by generalised statements as conscience-salving and face-saving manoeuvres.

GPs displayed the resistance to WLS displayed by the general public, a veritable “*last resort*” (George). As well, GPs limited reading medical articles to “*practice-based*” materials (George and Moyra): For instance, neither Moyra nor George considered weight to be a practice-based issue in which they wished or needed to keep up-to-date. News of treatments was percolated to GPs from surgeons and this resulted in recommendations for new surgeries as medical progress, “*the cutting edge*” (George). Following referral of a patient to a surgeon, GPs awaited results with a degree of vicarious interest and little or no responsibility was assumed when these surgeries failed to perform to expectation.

7.3 Surgeon traders

Both weight-loss surgeons referred to “obesity surgery” distancing WLS from ‘cosmetic’ procedures in the service of abnormal self-absorption or vanity (Caplan, 2004). Enhancement surgeries – and participants in this study were clearly influenced to change their appearance by WLS procedures – emerged out of the successful application of therapeutic technologies (Ter Meulen, Neilsen, & Landeweerd, 2007). The more closely WLS could be tied to healing a disease and the restoration of health (Balsamo, 1996), the greater the spread of these technologies and the expansion of rewards for WLS surgeons. This included greater acceptance within the surgical fraternity.

In this research, two major WLS were being promoted: Gastric bypass (Figure 3, Appendix 1), performed as an open or laparoscopic procedure, and a gastric banding or lapbanding procedure (Figure 4, Appendix 1). At the time of the initial research interviews, three New Zealand surgeons were offering lapbandings, one of whom was also offering laparoscopic bypasses; open bypasses were available in limited numbers publicly and were available as privately funded procedures.

7.3.1 Dr M1. As a young doctor, Dr M1 believed that WLS was inappropriate and unnecessary if patients exercised self-discipline. He believed that “*(d)octors are serious people, surgeons are serious people. We’re interested in serious conditions and serious illness.*” Recruited by an experienced surgeon developing obesity surgery³

³Refer to the discussion section for comment on the inter-changeability of obesity surgery with weight-loss surgery.

within the public sector, Dr M1 took over the programme and introduced the Fobi Pouch gastric bypass, “*a winner.*”

Dr M1 described WLS as complex, requiring high levels of skill and miraculous in relation to its results:

We cure diabetes, we cure hypertension, we thereby, we cure high cholesterol. We get people off a dozen drugs. They go out of hospital on none, substituted with our multi-vitamins. Their profile for heart disease totally changes. Instead of looking, staring at death before the age of 60, they can reasonably expect to get into their 70s and even 80s. They can enjoy their grandchildren, they can enjoy their children, they can mix properly, and they can enjoy the benefits of ah of employment and socialising in a way that they were beginning to be precluded from (Dr M1).

Gastric bypass patients do tend to lose weight and some experience amelioration of co-morbid disease. But this speech advances WLS as heroic, definitively curative technology. The tone, reminiscent of Banja’s (2005, p.54) “unadulterated omnipotence fantasy,” calls for caution around the procedure being promoted, the practitioner and these results: In psy traditions, the omnipotent clinician presents a known risk for iatrogenesis (Pepper, 1996, p.287). Dr M1’s bypass surgery has become the ultimate weight-fix for private-sector patients who have the financial and personal resources to proceed to surgery. His patients were asked to pay a premium for his experience. These patients were described as a “*robust group*” because they were able to fund WLS. Robustness was stated to be the basis for ignoring best-practice in relation to multidisciplinary, pre-surgery assessments. This notion was reinforced in his expressed assumption that public sector patients would require selection based on “*sieving*” and ongoing “*support.*”

From 2000 until about 2004, the surgeon compared his open bypass operation only with that of gastric lapbanding. In so doing, he avoided losing patients to laparoscopic bypass procedures. Although this website now refers to the laparoscopic bypass procedure, the information suggests that the open bypass procedure is safer with less complications. By first ignoring or diminishing lapbanding then promoting the open gastric bypass as the operation of choice in the United States, Dr M1 placed trade above providing full information for potential patients who might consider a laparoscopic bypass.

While describing himself as “*the principal guy who wages war against lapbands.*” Dr M1 expressed some reservations about the long-term viability and efficacy of lapbanding. For instance, he described the long-term sustainability of the lapband as

“the daftest thing I know;” Given the requirement for lapband patients to be on a diet for life, patients faced the uncertainty of weight loss, the possible need to convert to a bypass, multiple replacements of the bandings, and the possibility of *“dropping off the edge and regaining weight.”*

In crediting his operation with the ability to cure many of the diseases of the Western World, Dr M1 believed that 200,000 New Zealanders with a BMI over 35 would benefit from his procedure. Dr M1 located himself as the central force in determining the greater acceptability of WLS through his ability to play a political game of guile. Although pressure from the health lobby had positioned obesity as a threat to public health, according to Dr M1, surgery would be acknowledged as its cure only when obesity’s genetic base⁴ was finally acknowledged.

Dr M1 referred to his international reputation as based on a procedure that *“always works,”* with *“only delighted”* patients, yet it was clear that he had experienced some disappointing outcomes and associated complaints. Thus he spoke of a need to *“protect”* himself around vulnerable or marginally acceptable patient groups. In such instances, he involves the patients’ family and friends in the decision making to ensure that they would not be *“unduly critical”* if problems developed.

Everybody loves a good outcome. It is when you get a disappointing outcome or a problem is when you see people taking sides and saying: “I never thought that was a good idea; he shouldn’t have done that; he’s a menace really; that man will operate on anybody.”

Dr M1 believed strongly that the code of patient rights⁵ needed to be balanced by a code of rights for practitioners and a code of patient responsibilities emanating from his experiences with patients who had complained. He called for patients to

“Accept complications as stated.”

“Tell the truth.”

Do not *“withhold information.”*

“Accept medical treatment as a partnership.”

Accept that *“the problem is the patient’s.”*

⁴This idea traces a model of medicine in which the body displays symptoms that are biologically determined and opened to cure by progressive modern medicine (Hansen & Easthope, 2007).

⁵Refer section 2.9 for a fuller discussion of the NZ Code of Patients Rights (1996/2004).

Understand that “*Doctors seek solutions*” and the “*patient must share in the responsibility for the outcome.*”

Give doctors “*a chance to refine what his thinking was*” rather than “*go off for a second opinion.*”

Individual patients needed to “*seek out reputable practitioners*” rather than “*hunt for the cheap option.*”

M1’s rules for patients promote moralistic, normative claims to the authority of medical practitioners (Giddens, 1984) in which respect for surgeons is inalienable beyond demonstration within elements of practice. Patients were required to demonstrate respect for his authority and knowledge as “earned” and “owned” (Roter & Hall, 2006, p.24). Under medical (especially hospital-based) care, patients accept the need to relinquish control to practitioners who agree to access and utilise procedures and resources on behalf of the patient. Ceding authority to the provider of care is unavoidable in surgery or extreme illness and this vulnerability needs to be managed by strict and moral attention to ethics of practice. Patients are routinely expected, and wish, to cooperate with medical-care injunctions in anticipation of the protections offered by a doctor, framed within a code of practice (Roter & Hall). Patients acting independently are seen to threaten the “rhythms and routines of the organisation and the clinical and administrative order” (Irvine, 2002, p.41). While agency lies in questioning aspects of care, such questioning remains problematic even while patients are being adjured to do so in the interests of improving safety (Agency for Healthcare Research and Quality, 2009).

This is not a simple matter. Questioning doctors about practice requires patients to assert their position within a relational space in which doctors, notably in this case Dr M1, access considerable symbolic capital, “the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition” (Bourdieu & Wacquant, 1992, p.119). In the acceptance of medical competencies and qualifications, questioning threatens the status quo and leaves women patients particularly vulnerable to legitimated forms of symbolic violence (Bourdieu & Wacquant) including threats to withdrawal of care or disparagement.

7.3.2 Dr M2. Most participants believed that their surgeons performed WLS out of concern for weightfull patients. Dr M2 explained that he had no such “feeling for overweight people.” Having performed obesity surgery in the public hospital system,

WLS became part of his trading portfolio in the private sector, “another string to the surgical bow (...) part of a financial programme, I guess, and that was the only motivation.”

For Dr M2, a weightfull patient was essentially an unattractive person:

Umm, I mean, I can tell you, you get some people in here, (draws in breath), that you think they would probably become, might qualify for the, ah, top of the, the ugliest person in New Zealand category, but, they're still loved by somebody.

Being perceived as physically attractive comes with “profound social effects” (Olson & Marshuetz, 2005, p.498). Physical attractiveness has been associated with economic benefits referred to as the “beauty premium” (Hamermesh & Biddle, 1994, p.1174) bringing quality of care research into play through this analysis. For instance, studies demonstrate being considered unattractive is associated with absence issues in health care: lack of care; delays in seeking treatment; and, less interventions (Friedman, 2008; Puhl, 2008). In extension, the perception that a patient is unattractive may facilitate, without adequate reflection, the rapid, unquestioned promotion and adoption of radical interventions in pre-surgery consultations.⁶

Dr M2 connected obesity with personality deficits. Because “*changing plumbing doesn't make someone a better person,*” Dr M2 has extended his WLS agenda beyond performing the procedures in which he is credentialed. Convinced that “*nothing works like surgery,*” WLS has become the first step within a new vision for his obesity surgery practice: “*As people shrink, they grow.*” Having asked himself, “*What do I actually want for that person when I do an operation on them,*” he is committed to a project of improving his patients from surgery and beyond. This paternalistic intervention was directly tied to his wish to do “*God's work.*”⁷

Some physicians seek emotional support through expressions of gratefulness by their patients (Gabbard & Menninger, 1988). In the development of his WLS practice, Dr M2 enjoyed “*incredibly grateful patients.*” While Dr M2 prided himself on providing a safe, personal and value-for-money approach to WLS, this had brought substantial personal rewards.

There's not a lot of times in surgery that you necessarily get a lot of warm fuzzies from your surgery, especially when you're dealing with cancer surgery and

⁶ This is not to suggest that Dr M2 gave less time to his particular patients. However, short consultations were considered an issue in the Medical Disciplinary Tribunal decision (Fookes, 2000).

⁷ I was presented with a copy of the text that Dr M2 presents to some of his patients, a religious edition of *The Purpose-Driven Life: What on Earth am I Here For*.

things like that but when it comes to the weight surgery, as long as you're getting good results, umm, it is very rewarding.

This surgeon's first obesity surgery was a vertical banded gastroplasty. He converted to offering laparoscopic gastric bandings because of the control he could exert through manipulating the lapbanding mechanism. Lapbanding had proved unsatisfactory for many of his patients. He ascribed the failure to achieve good long-term weight loss with lapbandings as patient-failure. For instance, patients were described as having demanded inappropriate inflations and he had needed to accede to the emotional blackmail by patients to keep them onside. This was described as making "*commercial sense*" in the arena of private medicine. Clearly Dr M2 relied on an excuse account (Monaghan, 2006) to deflect personal responsibility for failed lapbandings. This surgeon introduced and performed costly procedures that produced meagre weight loss in the longer term, no weight loss at all for some patients, and brought considerable and debilitating iatrogenic side effects. By a process of error rationalisation and blame shifting from procedure to patient, both common responses to problematic medical outcomes (Banja & Porto, 2005; Gunderman, 2000), Dr M2 excused these failures. In developing a laparoscopic gastric bypass, Dr M2 offered an alternative procedure that was described as less radical than an open bypass to produce better results for patients than lapbanding.

During the period of the research, Dr M2 moved from enthusiasm about gastric banding, then declining to offer it routinely for some period of time, to again offering and actively promoting this surgery. In his rationalisation that the original procedure failed through patient-induced effects (HDC, 2003), Dr M2's new vision has included a return to offering lapband surgeries, convinced to do so by a close friend who "*used to sell the bands in Australia.*" His lapbanding practice is advertised in at least one large city newspaper in New Zealand and this advertising is funded by a health technology company in Australia.

7.4 Agency: Responding to WLS options⁸.

Mediated health and appearance projects for women had resulted in numerous attempts by these participants to lose weight by dieting or drugs. Largely unaware of being shaped by mediated weight and surgery presentations, participants were being required once again to respond to yet another form of medically sanctioned weight-loss

⁸Appendix 12 provides a breakdown by procedures for the participants who chose surgery.

interventions (Blum, 2003). While some participants decided against WLS, others chose lapbanding or gastric bypass.

7.4.1 Forgoing WLS. Four participants did not consider WLS. A further four, including Dr Kim, considered it but did not proceed. Pansy sought a definitive and acceptable “*best way*” to lose weight. Although a specialist physician suggested gastric lapbanding Pansy was ostensibly turned down for this procedure on the basis of a psychological report required before WLS.⁹ Her interview with the psychologist followed, and was impacted by, her prior consultation with the surgeon. Pansy appeared to have decided against WLS during a pre-surgery consultation in which the surgeon failed to respond to her either as a fellow professional (Morgan, 2003) or as a mutual participant in the consultation (NHS, 1996). Pansy reported:

He sat me down and patronised me and gave me the lecture about people, you know, hunters and gatherers and things like that. And I actually wanted to ask him questions. I actually wanted to say, you know, “What happens with the lap band? The incidence of infection? What are the incidences of it slipping? I believe there’s an awful lot of epi-gastric discomfort. What would happen if by chance I got an enormous dose of diarrhoea and vomiting and, you know, because I’m going to be losing fluid very quickly, and if I’ve got a lapband, will I be able to drink enough?” He didn’t answer any of my questions.

Pansy’s account of her pre-surgery consultation indicated that the surgeon routinely included a discussion about the body, complete with pull down charts. With a registrar sitting-in on the consultation, Dr Z may have been more likely to exert control over what could be attended to within the consultation. Pansy described a number of attempts within the consultation when she attempted to negotiate a more equal footing for herself with the surgeon. She placed knowledgeable questions but these were ignored. She tried to involve the young registrar. She assumed her right to participate in both the process and outcome of the consultation (Morgan, 2003).

Pansy addressed questions as tools for learning, obliquely, by addressing the visiting doctor. In this way she asserted some control while avoiding a direct confrontation with the surgeon. In a medical talk-style described as “the voice of medicine” (Mishler, 1984, as cited in Gill & Maynard, 2006, p.115), the surgeon performed his medical task,¹⁰ demonstrating his learned consultation style that tends to remain constant over

⁹A psychological profile, compiled at the same time, gained her acceptance into Christian Ministry.

¹⁰This is a style of communication that evokes Freire’s (1970) banking model of education (Roter & Hall, 2006, p.13): The perceived empty vessel or passive recipient is given the facts: “Knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing” (Freire, 1970, p.72).

time (Scrambler, 2003). For Pansy, the surgeon's failure to respond discredited both practitioner and procedure. Pansy was irritated by the encounter. The lack of patient-centred information-giving reflected the centrality of this surgeon's priorities (Morgan, 2003). Even while the surgeon provided information, his failure to answer questions meant that informed consent requirements could not have been fulfilled. In the event, Pansy decided against surgery and laughingly referred to it as being turned down. This was a major reframing to one of patient control. It followed one of Carlson's "moments of truth" (Gabbott & Hogg, 1994, p.16) in which Pansy's minimum expectations of having her questions answered were not fulfilled.

Following that consultation, Pansy described becoming perturbed about the potential iatrogenic effects on the body of the lapbanding procedure. For instance, Pansy recalled a website posting discussing problems with regurgitation following lapbanding: "*The thought of me going around with little snap lock bags in my handbag, so I could throw up into them! It was just too awful.*" Negative reports of WLS were invoked in support of Pansy's decision in a process of cognitive dissonance (Festinger, 1957)¹¹

Hine's current male GP continued to recommend WLS: "*He's always going on to me about, you know, 'You do realise there's stomach stapling options available'.* She considers that her GP holds a very limited view of his patient, tied to her overweight appearance: "*He has only ever seen me large.*" Identifying herself as Maori, Hine believes that surface appearance is not important (Halbert-Crowe, 1998): "*Maori do not assess people in terms of what is on the outside of their body, but rather what's on the inside of their body. It's a whole different way of looking at things*" (Durie, 1994, p.19).

Her GP engages with the patient removed from the context of her daily lived-life. Her weightfull appearance prompts a solution focus even while the appearance of body fat does not equate with an unhealthy lifestyle (Jutel, 2000). Meanwhile, Hine's knowledge of what has worked for her in the past is not accepted by the GP who has continued to promote WLS. Her protestations of being able to lose weight may even have reinforced his suspicion that the patient lacks self-control, is lazy or ill disciplined (Bruere, 1999; Brownell & Puhl, 2003; Puhl & Brownell, 2001; Schwartz, Chambliss,

¹¹Individuals are motivated to avoid inconsistency in their cognitions - beliefs and attitudes. They do so by reducing the importance of the dissonant beliefs, or adding more weight to those consonant beliefs or behaviours so that they outweigh the dissonant or, they may adopt a changed belief. (Festinger, 1957).

Brownell, Blair & Billington, 2003). Silent in these consultations, Hine has maintained agency by rejecting a WLS referral.

Hine's continued refusal to consider WLS was, like Pansy's, maintained by a process of cognitive dissonance. Her Grandfather had become "*hooked on pure oxygen*" following an asthma drug trial. These concerns linked into the experimental and radical nature of WLS. When Hine felt tired or down, she would revisit her commitment to not having surgery: "*I think, "Oh bugger it, maybe I should just ring him up and have this operation and stuff."* But then I sort of slap myself into submission. I think, "*No, you're just tired. Go back to bed.*" Hine's GP was promoting only the locally available, open gastric-bypass procedure. In the pressure to have WLS, Hine may be influenced to take up less radical procedures if they become available in her local area.

The idea that surgery would remove her incessant worry about food and dieting, brought WLS within Dr Kim's horizon: "*The thought is so tempting, it is really tempting. On the one hand to have an operation and not worry about it but of course you can't eat, and I love eating. I mean I do like eating.*" Kim could not imagine only ever being able to eat "*tiny little bits.*" In the flickering possibility that surgery might act like *Reductil* when eating "*just doesn't occur to one,*" she believed that WLS seemed "*almost too good to be true.*" Having decided against surgery, Kim, like Pansy, supported her position with accounts of WLS complications referring to "*...people who have ended up with brain damage... Her stomach necrosed and she ended up nearly dying.*"

7.4.2 Choosing WLS. Fourteen participants chose an initial WLS before participating in this research and I frame their decision-making processes in the following section. While there were clear elements of Blum's (2003, p.66) "becoming surgical" in participants' narratives of excitement and anticipation about changing appearance, participants were also careful to speak of elective WLS as required, an essential intervention for their health. This befitted WLS's radical nature. I begin by tracing WLS decision-making as essentially mediated and relational, supported by prevention and intervention narratives of doctors and surgeons. These were all persuasive elements that allowed WLS participants to engage in WLS options.

7.4.2.1 Media presentations. For WLS participants, aged from early twenties to mid fifties, mediated presentations of weight and health provided the vicarious standard by which they measured themselves and were measured by others. Articles depicting weight and health, imbued with deeply held cultural preferences for slimmed

appearance, acted as the surface manifestation of standards women were urged, and in turn desired, to achieve. The visibility of this standard unsettled their acceptance of body-size and self and troubled any complacency about their current weight. This position was clearly articulated by Michelle as she reflected on her decision to have lapband surgery:

There's that kind of balance isn't there of the physical implications of your weight and the self acceptance stuff like the stuff about, well, I know that I can't change my body as much as the media thinks I can and I know that it's a destructive thing to think that I need to. But balancing that against the fact that I did need to do something about it and that balance tipped towards having to do something.

This text traced a myriad of positionings and crosscutting discourses affecting women's WLS decision-making. Unsettled by mediated images of desirable bodies, the lack of public support for living weightfull and the widely broadcast call to reduce size for health reduced participants' ability to resist WLS. Overall, Michelle and other weightfull participants were subjects - like Hay's (1994) juvenile delinquents - swept up in a moral panic fanned by media presentations.

The earliest memories of reading about WLS options were described by Topsy and Clover. Topsy was a nurse whose GP laughed off her original request for an intestinal bypass. Clover chose breast reduction to adapt her body to the slimmed, boy-shaped female body of the late '60s. A number of other participants including Ms AR ¹² viewed an advertising documentary (Unichem Medical File, July 1999) in which lapbanding was advanced as the alternative to radical "stomach-stapling" procedures. This programme exemplified clever DTCA. Marketing targeted both patients and their doctors who were resistant to current gastric bypass procedures. It was aimed at the modern sovereign consumer (Woodward, Goldblatt, & McFall, 2004) as an individual rightfully demanding particular services from a company and a profession duty-bound to respond. Lapband advertising created demand by distinguishing lapbanding as the new form of WLS in contrast to old, radical gastric bypass surgeries. For instance, the advertising documentary introduced laparoscopic procedures as minimally invasive; procedures were shown to have the restrictive benefits of the bypass surgery without the nutritional side effects; it was reversible; it was fronted by a New Zealand surgeon-trader as a third-party expert. The programme was presented as public information.

¹²Ms AR's information is based mainly on information involved in an HDC complaint's process (HDC, 2003).

The use of a local surgeon was a tactic of persuasion: This expert was shown as the expert, able to perform the miracle that diet had not afforded these participants, weight loss. Rampton and Stauber (2001, p.29) referred to the “media stage” on which modern public life unfolds. There are two kinds of experts, “the spin doctors behind the scenes, and the visible experts that they select, cultivate, and offer up for public consumption” (Rampton & Stauber, pp.29-30). The trade-for-profit and reputation goals of the surgeon and the lapband technology company were obscured within a pseudo-documentary format.

Ms AR’s decision to have surgery was markedly influenced by this one television programme:

In mid 1999 Ms AR saw a television programme during which [...] a general and laparoscopic surgeon, discussed laparoscopic gastric banding (“lap banding”). She telephoned Dr Z’s rooms and asked for information to be sent to her. (HDC, 2003)

Until her brother-in-law/GP¹³ recommended the procedure, Rosie had not considered it for herself:

Yeah and then I think Zed¹⁴ must have done a mail-out to the GPs and he said, “Look, I really think you should look at this.” He said, “Think about it, because I think it would really help you.” And I said, “No, I can’t. I can’t have another operation,” and I just put it out of my mind. Then he sent me this stuff.

These surgery procedures were marketed simultaneously, within New Zealand’s DTCA¹⁵ environment, in magazines and on television to the general population. As well, lapbanding was introduced to doctors, in three geographic areas during the late 1990s. Specialist colleagues were major information gateways and rated highly by doctors as sources of up-to-date medical information. When Topsy consulted a GP following an episode of atrial fibrillation, his recent attendance at a colleague’s presentation on WLS resulted in her immediate referral to a local surgeon and her operation took place within weeks.

Media stories of WLS sensationalise both the original weight and the radical surgery to engage their readers. Sensational titles accompanied graphic photos of women in large size dresses extending them in elated demonstration of the changes wrought by

¹³This recommendation is discussed more fully in section 7.4.2.2.

¹⁴Rosie unselfconsciously uses the surgeon’s first name.

¹⁵ In Direct to Consumer Advertising, the emphasis is on selling a brand in a way that essentially promotes radical and new technologies and drugs in ways that minimise their side effects, push efficacy and rarely mention the costs (Toop & Richards, 2003).

surgery, as in “Stomaching the Staples” (Dekker, January 22, 2003). In another article, “Fat Chance” (Richardson, 2005), the reporter developed a story of an author who “lost half her body weight and regained her health after stomach stapling.” A plethora of newsprint articles (Dekker, 25 January, 2003; NZPA, 11 May, 2005) followed the sensationalised fraud case of a New Zealand parliamentarian. Her misuse of public funds funded her bypass surgery. Coverage of the court proceedings included photos of the former Member of Parliament (NZPA, 2004) and discussion of WLS, raising the profile of the operation and of the surgeon who performed it.

Significantly, participants who chose surgery preferred stories of positive outcomes. Indeed participants ascribed WLS failures to the personal characteristics of that person. For instance, participants did not refer to the first transected gastric bypass in Australasia. Yet media coverage was extensive in relation to a Medical Disciplinary Tribunal (Fookes, 2000), and referred to extensive complications from one patient’s bypass surgery that had necessitated an extended stay in hospital, ongoing ill health, and, changed life circumstances. This case was covered in the New Zealand media, and surfaced on Internet sites, predating the Awatere-Huata media frenzy by only a couple of years.

7.4.2.2 Family, friends and the Internet. WLS decisions reflected relational decision-making processes for women. Friends or family of most participants had suggested a variety of weight loss solutions including WLS options. Rosie recalled her brother-in-law’s promptings:

I’ve got this choice. Shall I have this or not?” And he said to me, “Rosie, you haven’t got a choice.” And I said, “Why do you say that for?” And he said... “If you don’t do something about your weight now, by the time you’re 60 you won’t only have diabetes and heart problems, but no one in the medical profession will want to touch you because you’ll have this myriad of medical problems which are all connected to each other caused one way or another through weight.

The fact that her brother-in-law, a doctor, recommended the surgeon, “*made me feel I can trust the guy. He’s a good surgeon...He wouldn’t put me crook.*”

Rosie’s medical “at risk” status was used to support WLS in a persuasive, clearly rhetorical and generalised medical language. As her brother-in-law and friend, his advice was ethically compromised. The surgeon was recommended on the basis of a successful appendix operation for his son, an operation he had been invited to attend. The invitation had raised the surgeon’s standing with Rosie’s brother-in-law and may have blurred his vision in relation to the greater complexity of the surgery he was

recommending for Rosie. Rosie was not encouraged to consider aspects of new surgeries such as the surgeon's experience or success rates. Her brother-in-law focused on Rosie's weight.

Scrapper and her friend chose WLS and had surgery on the same day. Pinky's mother attended a WLS lecture, informed Pinky about the surgery and paid for her lapbanding. SusieB's sister-in-law suggested lapbanding following a cousin's procedure. Meryl's friend advised her about surgery following another friend's WLS in Australia.

Lapbanding came to the market as the use of the Internet for research purposes by the general public was burgeoning. Pinky accessed academic databases available within her institution; Karlie had become used to researching her health options and had access to medical researchers employed by her brother, a breast cancer specialist. Karlie and her doctor/daughter researched options for weight control to assist her continued mobility:

I went to Dr M2 and he said that because I wasn't obese enough, it wasn't something that he would just do and also because I had cancer and MS I had to prove to him that it would be worthwhile to do. So then we got on and my brother found a surgeon that had done it, in America, for someone with MS and it had made a big difference to their lifestyle.

Michelle used her Internet research skills to investigate lapbanding: *"I didn't need a doctor to tell me whether it was good bad or indifferent. I wasn't looking to a doctor for that."* Michelle's research included contacting the company producing the lapbands. When a friend suggested WLS to Meryl, she investigated the New Zealand Health and Disability Commissioner's website. Although one complaint was essentially anonymous, Meryl referred to the surgeon by name: *"(He) was very dismissive of her and I got the sense that he was really derogatory to her."* Meryl decided against the surgeon and the lapband. She then discovered the New Zealand bypassers' website, read the postings and placed her own question: *"How could it be that a woman who's been so successful in all these other areas of her life can fail so spectacularly at weight-loss?"*

WLS for Shona began on Atkins-diet Internet sites which led her to "before and after" photos of people on WLS support-group websites. Shona discussed potential operations in the quasi-anonymous environment of support group websites. After all, *"Weight is one of those private things people don't talk about."* Shona represented talking online as keeping her surgery private. The boundaries between what is private

and what is public have been obscured in this Internet environment (Eysenbach & Till, 2001). Sharing the bond of being involved in WLS allowed intensely meaningful relationships to develop and decisions about proceeding to WLS were influenced within this environment. Their significance was underlined by the presence on these sites of company representatives who might act to “*cut off any problems as soon as someone posts a problem*” (Michelle, email). Surgery practices/doctors’ receptionists were also tracing the postings. “*We are not alone*” (Michelle, email) and “*We need a place to vent and be open*” (Michelle, email).

Three participants developed websites referencing information amassed in their own searching. Information on these websites ranged from personal experiences of WLS, societal attitudes to thinness and weight-loss, dieting, comparisons between different surgical procedures, information about surgeons, and the geographical availability of particular surgeries. Michelle also summarised the FDA transcripts involved in the application for registration of gastric lapbanding procedures in the United States.

These were resourceful women, attempting to improve their lives. They developed relationships that supported their choices and most did considerable research into the proposed WLS. Davis (2003) has argued that choosing cosmetic surgery procedures may be both agental and reasonable options for women who wish to improve their lives. I suggest that WLS choices may be described as agental within the limits of choices shaped by the type of information that participants were able to access and the cultural lure for thinned bodies that was difficult to resist (Bourdieu, 1984; Fields, 2004). The internalisation of thinned body norms, the assumption of personal responsibility for weightfulness and the medical sanctioning of WLS impelled participation in these radical procedures.

7.4.2.3 The “hailed” WLS patient.¹⁶ Some participants were introduced to WLS in a medical consultation. In her late twenties, Michelle consulted an endocrinologist about her weight and gastric bypass was recommended. Initially grief-stricken and overwhelmed by this medical opinion, Michelle recalled asking herself, “*Why do I have to? I really felt sorry for myself then*” (laugh). The laugh contained her grief at living large for much of her adult life and the possibility that radical interventions would be required to control her weight. Having dismissed the open gastric bypass in the early

¹⁶This refers to Bourdieu’s conception of citizens being interpellated or hailed into subject positions which we are already primed to accept through their availability within the ideology or belief systems in which we are absorbed (Butler, 1999a).

1990s, she was primed for less radical surgery options: “*It softened me towards the idea*” (Michelle). Her concerns were ostensibly addressed by this new WLS:

(The endocrinologist) kind of opened the door in a way and then this one seemed that that cost-benefit analysis worked a bit better for me... the fact that it wasn't permanent, the fact that it didn't interfere with my normal, the way things worked, and that kind of stuff that yeah.

The endocrinologist's opinion acted as the proverbial thin end of the wedge for Michelle. Already interpellated through the myriad of ways in which modern citizen/patients may be hailed, in the absence of words or alongside the words without conscious awareness of being continuously hailed, Michelle consults the designated expert. Citizens enact patienthood in seeking consultations. Within consultations, patients are exposed to medical dicta reinforced by the intimidatory power of non-verbal cues (Bourdieu, 1991). Michelle, patient-ed¹⁷ in relation to weight, accepted that WLS options were medically indicated for her. As a rational consumer, Michelle determined that she was making the best decision possible.

Patients are continually hailed into their patient-hood: The person called from the waiting room responds, more or less, as a patient, an “enabling vulnerability” (Butler, 1997, p.2) in a process of interpellation. The patient/doctor consultation opens up possibilities for positive health interventions as it also opens patients to the subtle coercions implied in the symbolic positioning of the doctor as expert. When gastric bypass was first suggested to Susie B by her GP, she turned it down because, “*I'm not ready to die (and) because I didn't know enough about it.*” When an apparently safer, less radical option of lapbanding became available, she approached her GP for a referral even though she was “*terrified at the thought of surgery, because everything I've ever had done in my life has always gone wrong and this terrified me.*”

Doctors and specialists suggested WLS both in reaction to their own concerns about risky weight and to those of their patients, alerted to new technologies by surgeons and technology companies. Doctors described such ‘suggestions’ as casual or reactive but participants interpreted them as serious medical pronouncements about their health. The objectivity of these opinions tended not to be questioned. Even when suggestions were “*lightly given*” (SusieB), they were taken seriously. Encultured thinned weight preferences and weightfull-body discourses interspersed with injunctions to lose weight by medical practitioners primed these patients to accept radical WLS. Doctors' words

¹⁷This draws on Butler's discussion of being “girded” (Butler, 1999, p. 120).

within consultations are framed as the words of an expert. They are uttered when people are vulnerable in being a patient (Roter & Hall, 2006). Even seemingly insignificant but persistent persuasions, such as those being experienced by Hine, may eventually lead to WLS. When women had been advised to consider WLS, choosing not to have such a surgery became less possible.

7.4.2.4 Framing slim as healthy. Most participants just wanted to be slim. This was clearly expressed by the youngest participant, Sheree: *“I always had this thing that I really wanted to be slim and, and I wanted it now!”* As hope faded that diet and exercise would achieve a slimmed body, women turned to surgery as a last resort. Meryl believed that to be successful as an educator and writer, she would need to project a slim, controlled image. Her goal of being slim by forty appeared achievable only with surgery. Janice acknowledged that stress was the major reason for her diabetes being out of control, yet it was diabetes that brought WLS into play. The surgeon approved her decision as otherwise *“You won’t live to see 50.”* Her major motivation for surgery lay in feeling fat and therefore *“ugly.”* Looking good was important for Michelle though dealing with the problems of everyday living were uppermost: *“I’m not some pathetic woman that thinks that it’s just because I look bad. It was actually interfering with my life so I did have to do something. The balance tipped towards having to do something.”* Adamant that appearance was not a major issue, she spoke of needing to look good and to dress well. Being both large and tall compromised Michelle’s comfort in cinemas, restaurants and travelling, *“an added level of complication that was really interfering with my quality of life.”*

The goal of becoming slim tended to be obscured in participants’ talk as they engaged with the urgency of potential health concerns. Interviewed prior to her surgery, Shona, clearly repulsed by her mother’s body, remarked: *“Now I look worse than my mother.”* In comparison, her grandmother was described as *“a gorgeous woman, slim, beautiful,”* a model. On reinterview following her WLS, the appearance story continued to dominate.

I used to dwarf photographs. You do when you’re a big person, and I would look at photos and I would cringe because you know the chins would be bulging and the eyes would be shut if you’re smiling, the fat would push them shut, and you look, by comparison, repulsive against a size 12 body, when you’re a size 28 body.

However, a health explanation had gained prominence:

I was afraid that I was going to be 40 and be crippled in a wheel chair um eating tim tams out of milo (laughs). That was the path I was convinced I was heading down. I would have ended up with diabetes. I would have ended up with munted knees or hips, and I would have been crippled. I also, I mean, I also – I have a... Maori blood in me. My mother is half Maori so I've got a lot of Maori blood in me. My mother has type 2 diabetes.

Health concerns dominated Karlie's process. Nonetheless, Karlie's desire not to be "a big fat person in a wheelchair" related to potential stigmatised appearance of being large and having multiple sclerosis. Pammy was horrified at being large: "Well I just didn't like being fat! I hated it! I hated myself being fat!" While WLS was approved on the grounds of a back injury, she had continued to perform active security work even before her surgery. With her weight at about 75 kilos, measuring 5 feet 2 inches, she was accepted for WLS.

In the reflecting team process, Michelle and Scrapper discussed the tendency for surgeons to frame WLS decisions within pre-disease states:

Michelle: *(T)he surgeon is marking everyone as pre-diabetes when they go to see him. It seems interesting to me the number of people he's told are pre-diabetes and I'm thinking "Oh? I suspect it might be like (one surgeon) where it's like "It's good that we're getting in now, you know, since you're morbidly obese when you're not, or since you're pre diabetic when you're not, you know?" All of his patients seem to be quite close to diabetes.*

Scrapper: *But don't you think that they just hook on to something, though?*

The existence of co-morbid disease processes lowered the accepted threshold for WLS according to the US National Institutes of Health Consensus Development Conference on obesity surgery in 1991. This conference recommended that WLS should be considered for those with a body-mass index (BMI) over 40, or over 35 if there were coexisting co-morbidities (De Maria, 2007; National Institutes of Health, 1991; 1998).¹⁸ The presence or potential for co-morbid disease added credibility to, and was persuasive in, WLS decision-making. WLS is being advocated for patients with a BMI of 30+ if they are at risk of cardiovascular disease (Livingston, Chandalia & Abate, 2007). The

¹⁸ According to clinical practice guidelines developed by the American College of Physicians (Snow, Barry, Fitterman, Qaseem & Weiss, 2005) patients with a BMI over 40 who fail to lose weight following non-surgical interventions and who develop obesity-related complications, may be referred for bariatric surgery. There has even been a call to lower BMI criteria for obesity surgery to 30+ BMI if patients have risk factors for cardiovascular disease given that high BMI is not consistently associated with a poorer CVD profile than patients with a lower BMI (Livingston, Chandalia & Abate, 2007).

idea of marketing health to potential patients rests on the notion that diseases are preventable and that it is possible to pre-empt them. In the reflecting team Ms AR discussed how, in her pre-surgery consultation, she had realised that expressing the co-morbidity presumption would increase her likelihood of being accepted for surgery:

I went to the psychologist! When I look back, I started saying things like, “Oh well, of course, I’m obese, and all this stuff from the surgeon, “I’m worried about diabetes.” And I knew that I had to say certain things in order to get the operation.

While these moves by the patient promoted the patient’s chances of receiving WLS, Ms AR and Pammy were acting on promptings by their respective surgeons. The expression of health concerns provided the justification and assurances on which their surgery appeared to depend;¹⁹ the patient could acknowledge the seriousness of their predicament and this reassured surgeons that the patient would be compliant; and, the request for surgery could be considered as about health rather than merely appearance.

7.5 Choosing the procedure

The type of surgery²⁰ was significantly determined by geographical availability, costs, and, notions of relative radicalism.

7.5.1 Availability. WLS was chosen largely on the basis of its geographical availability. While most of the women and all of the doctors knew of gastric bypass surgery through the 1990s, much of that surgery was performed as private surgery in only one major New Zealand city. From the late 1990s, GPs and specialists who did not practice in the upper North Island²¹ were unaware of lapbanding procedures and did not suggest them to their patients (Doctors’ research transcripts). Although lapbanding received television and magazine coverage throughout New Zealand in the late 1990s, only surgeons in the northern New Zealand cities actively promoted it. Clover, Pammy and Janice opted for bypass, a decision framed by personal referral and geographical availability.

For Scrapper, Susie B and Michelle, lapbanding was their preferred surgery and it was available locally. They chose between two surgeons within a two-hour radius of their homes. Scrapper and her friend were patients 5 and 6 to have their lapbanding

¹⁹Pammy’s BMI was significantly lower than that usually required for acceptance.

²⁰The research period was extended when it became obvious that WLS for these participants was not a one-off definitive cure for weight loss. At a number of junctures during their WLS journeys, participants faced deteriorating health, poor weight loss or regained weight and these required new decisions to be made about WLS.

²¹Lapbanding is also available now in the South Island.

operations: They both had young families and wished to avoid travel for surgery and follow-up appointments. Susie B was originally referred to a surgeon over two hours away: Unable to be fitted in for a surgery consultation “*because it was Christmas time,*” she was referred back to a less experienced, local surgeon. Michelle was also encouraged to use her local though relatively inexperienced surgeon. The referring surgeon suggested that this was about the risks of travelling to appointments.

Shona chose lapbanding with a surgeon who was operating in the town closest to her home. Turned down for the procedure, she was referred on for a laparoscopic gastric bypass in a city some hours away: “*I’d proven by going to Pitona that I’d had no problem with travelling for the surgery. So he sort of said to me “Well, Pauataha is not that terrible a deal.”* She had shown that she was prepared to travel for a form of WLS acceptable to her.

7.5.2 Intrusiveness, reversibility and costs. Shona was initially upset and rather shocked that “*a surgeon would turn somebody away who was obviously quite desperate to seek that sort of help.*” She refused to consider an open bypass in her local area because of its costs and long recuperation period. She spoke of “*really hurt(ing) financially*” in choosing WLS. Funding for these operations came from a variety of personal resources: Participants had increased mortgages on their homes, relied on some funding from medical insurance,²² sold property, or borrowed from friends and family. As Michelle wrote: “*I had to decide whether I was happy continuing life as a larger person or trying a fairly non-invasive and reversible procedure which had the potential to free me from all that* (Michelle, email). Clover’s original WLS cost her “*an enormous amount of money*” and she borrowed money for the second operation. In the revision consultation she focused on costs and negotiated a flat rate for her surgery to include any complications.

There were certainly people working in the aircraft industry, that knew I was having it done, suggested that it should be a warranty claim, because it would have been subject to a warranty claim if it had been a plane.

Clover paid \$15,000 for her first bypass and her revision operation, by the same surgeon, was \$21,000 at a time when first procedures were being charged at \$18,000.²³

WLS tended to be described on a continuum from more to less radical. Open bypass surgery was considered to be both radical and risky, a laparoscopic bypass was

²²Medical insurance companies deemed WLS ‘cosmetic’ and declined or paid out less for WLS.

²³The charges for this operation rose to \$20,000 and are presently set at about \$28,000.

considered less radical compared to an open bypass though more invasive than a lapband. Karlie's previous cancer ruled out an invasive open procedure and she chose a laparoscopic bypass. Topsy described the bypass as "*invasive.*" Scrapper who originally investigated the Gastric Bypass decided that it was "*just too invasive, you know, total open-up.*" When Michelle's lapband failed to produce long-term weight loss, she researched laparoscopic bypass as a "*crappy option.*" Its potential rested on the fact that she had not "*heard of anyone not losing weight after the more invasive surgery*"(Michelle, email). Michelle was lured to more radical bypass options by her knowledge and experience of the appearance and reported weight loss of those patients (cf. Blum, 2005).

Describing the open bypass operation as "*the big cut,*" Shona chose the laparoscopic version. She placed the surgeon "*under orders not to go open. If he can't do it, he'll just close me up on the spot.*" Her surgeon had described open bypass procedures as "*basically butchery versus very, very technical surgery.*" Shona pointed to the longer and more painful recovery times involved in open bypass as a major reason for choosing laparoscopy: As a single mother, she needed to be return to work as quickly as possible. Having originally sought the lapband for its reversibility, Shona resolved the dissonance of choosing bypass because of its laparoscopic method. She wondered aloud why she would have opted for reversibility if she were serious about weight loss: "*Now that's an interesting thing isn't it? Why on earth would you want to reverse it?*" What are discounted here are the very serious side effects that involve reversal of any form of WLS.

7.6 Pre-operative consultations in decision-making

Discussions in pre-surgery consultations with WLS surgeons were scenes of searching for and discovering the Holy Grail. This was the opportunity to change bodies (Frost, 1999). The pre-consultation period was reminiscent of Philip Larkin's²⁴ description of the holiday atmosphere amongst men queuing to enlist at to go to the First World War when the direness of war has yet to penetrate. Women sought the ultimate fix for weight and surgeons promised the cure.

partipantR reflects

I transferred to another surgeon after my first surgery failed. He says: "I've got a procedure that will work for you." Even after my first surgery has failed, I am tantalised. Yet again the holy grail! The ultimate fix. When he eventually

²⁴ Philip Larkin's 'MCMXIV'.

introduces me to the laparoscopic bypass, I no longer recognise it as stomach stapling: My fears and concerns about radical surgery have been vanished.

Notwithstanding their research, participants consented to procedures when they lacked significant understanding of WLS realities. In their pre-surgery consultation, Scrapper and Rosie were classified as morbidly obese and this supported their acceptance for the surgery.²⁵ While Rosie recalled her lapband surgeon's disclaimer that, "*It doesn't work for everybody,*" she also described how this opening gambit was qualified positively and personally. Rosie clearly recalled his words delivered alongside a range of powerful, encouraging interpersonal gestures that informed her decisions. Roter and Hall (2006) have pointed to the presence and critical nature of non-verbal behaviour within doctor/patient consultation. Rosie wanted to know whether this procedure was safe for her. In looking for "information behind the information" (Roter & Hall, p.17), the obvious enthusiasm of her surgeon for the procedure and his approval of it as a procedure for herself was convincing: "*I've got a good feeling about you. I don't know why, but I think it will work for you.*" This acted to minimise any formal disclaimer. When the surgeon dispelled Rosie's fears about surgery, "*all my fears straight away,*" the road to WLS was begun. The surgeon's personal disclaimer shaped Rosie's decision to opt for surgery.

When tests confirmed that Marjorie's gall bladder needed to be removed, she was referred by her GP for a cholecystectomy and lapbanding. She was impressed with the surgeon whom she described as "*the first surgeon I had come across that didn't actually put himself on a pedestal, and think that he was God, a regular guy, really nice.*" This promoted her confidence in the surgeon and the procedure when he said to her:

"There's no way that this cannot work. Simply what you are doing is that once you have this band put on, it restricts how much you can eat so you have to lose weight. ... Hunger disappears." Now this for me was amazing: your hunger would disappear! Yes, this was now finally the last resort. I thought, "Great. OK."

Marjorie was advised formally that there are "*significant risks*" with WLS. But persuasive elements within the consultation convinced her of the appropriateness of this procedure for her: the logical simplicity of the mechanism; a good presentation of the process; the potential to resolve her issues with weight and hunger; the standing of this

²⁵In the United States, where parameters around weight appeared to be more strictly adhered to, patients placed stones around their bodies to increase their possibility of being accepted.

surgeon to whom she had been referred; the surgeon's demeanour and affability; and her surgeon's enthusiastic support of his skills and procedure.

Meryl approved her surgeon's clarity in describing the WLS procedure even while commenting that he seemed to "*kind of tick off the boxes.*" She was accepted for surgery without being required to meet with a dietician or have a psychological assessment. Patients such as Meryl responded with relief as though they had been "*let off the hook*" when surgeons validated their new patients' long run, physical and mental struggle to lose weight. Although Meryl emphasised technical competence as being paramount in a surgeon, she did not question him about his surgery statistics. She did not attach significance to choosing a surgeon experienced in laparoscopic WLS procedures and there was no discussion of significant complications with WLS procedures performed by surgeons learning these techniques.²⁶

Shona's pre-surgery consultation for a laparoscopic bypass was described as "*a very entertaining forty minutes.*" Having "*clicked*" with the surgeon, she characterised the length of the consultation as "*quite a long time with a specialist.*" Her wish for an equal and satisfying relationship was begun. Two moments in this pre-surgery consultation threatened the beginning relationship. When the surgeon told Shona that he had done his first laparoscopic bypass on his local pastor, she felt uneasy because she believed that the surgeon was breaching medical privilege, and, because "*I don't like religious people!*" A second moment arose when Shona joked as she stepped onto the scales, and the surgeon interpreted her joke as being typical for large persons to hide their hurt with humour. She was impressed by the surgeon's ability to "*switch immediately*" when she disputed this psychodynamic interpretation. As well, she interrupted his "*spiel,*" complete with the operation video on the screen, several times; she demonstrated her own competency by fixing his computer. Paying for WLS gave Shona a feeling of power over the surgeon because unless he answered her questions, "*I don't give you my money basically.*"

Shona emphasised her "*right to ask*" questions. In indicating that interrupting a surgeon was neither common practice nor had any certainty of being accepted, she approved his accommodation of her interruptions. She displayed confidence and made a number of attempts to establish her equality. The power of the surgeon was

²⁶In one review, a New Zealand surgeon wrote: "In (a particular) series of patients, 81% of the deaths occurred in patients operated upon in the surgeon's first 19 cases, emphasising that this is technically demanding surgery requiring a skilled and experienced surgeon and a team for optimal outcomes" ((Martin, 2004, p. 1207).

minimised as she described participation in this relationship as satisfying the social needs of both participants: *“We had a lot of fun. We laughed and carried on and it was completely unprofessional, I’m sure. I made him run late actually, we ended up yacking so long.”*

Michelle recalled a strongly negative reaction to Dr Z at her first consultation, and a very positive response to Dr M2. Dr Z was described as *“obvious about his god complex,”* and pushing his procedure as *“a magic bullet.”* Alerted to the availability of an improved lapband, Michelle requested the improved version:

He didn’t do a bloody thing about it. I gave him ten days and he gave me some patronising bloody phone call about “Are you sure?” I thought well that doesn’t bode well. He made me feel stupid, like I didn’t know what I was talking about, and it seemed completely unprofessional to me, that if there was a vague possibility that there was a new band and he was using the old one. He just completely dismissed it and I knew at that point that there was no way that I wanted to proceed with surgery.

She rebooked her surgery with Dr M2, the surgeon who had *“not talked down to me.”* This surgeon’s greater experience with the procedure and his ready agreement to source the new band made him a safer choice. She described him as being more forthcoming about the procedure, providing her with a more balanced view than Dr Z.

Having had the lapbanding procedure explained to her in her pre-surgery consultation, Susie B told the surgeon: *“I want this done now!”* The surgeon laughingly reminded her of his mandatory one-month stand down period. SusieB’ was committed to lapbanding following this initial consultation: *“I never ever wanted another Monday morning. I wanted to have the surgery and say, ‘Right, this is the start of my life.’”* Her assessments with the dietician and psychologist did not occur until a few days before her first lapbanding. Most participants became confident that they would be accepted for surgery during the initial consultation. Indeed, they booked surgery before any discussion took place between the surgeon and the ancillary professionals. Ancillary referrals were referred to as a waste of money, a *“rubber-stamping”* of the surgeon’s opinion, and a money-spinner for the professionals involved. Acceptance for surgery was less certain for two patients: Pammy’s surgeon *“didn’t really think I was heavy enough for it”* and Karlie was considered *“barely obese enough.”* Karlie’s surgeon asked her *“Why would you want to take this drastic step?”* and I said *“Well, wouldn’t you want to walk?”* She was irritated at needing to follow the surgeon’s usual assessment protocol believing that her *“trade-off”* was so different to other patients.

The only operation that Janice considered was the locally available, open gastric bypass, “*the 20 thousand dollars operation.*” Although Janice was informed that the surgery was major, the surgeon focused on WLS as the cure for her diabetes. Sheree was assured that she would lose weight with lapbanding. When the surgeon diagnosed her longstanding issue with abdominal pain as gallstones, Sheree articulated absolute trust in her surgeon. Her surgeon’s word had become “*gospel.*”

7.7 Discussion

Participants portrayed WLS as an intrepid last stand in a gruelling, lifelong battle, against overweight. At a point when participants were almost surprised to find themselves heavy enough to consider radical interventions, the search for the definitive solution to weight loss and weight control over a lifetime was embarked upon. The contemplation of weight spiralling out of control and the need to deal with intractable weight on a long-term basis increased the possibility that participants would take up radical WLS options.

These participants viewed themselves as autonomous in relation to choosing medical care even while they were clearly the target of medical device and pharmaceutical marketing (Andereck, 2007; Ryan & Carryer, 2000). Participants and doctors learned about WLS from media sources and people in their wider networks. The media, whether in the form of newspapers, magazines, radio and, more latterly, television and Internet, played a cogent role in the formation of public opinion about weight, based on the words of “[...] experts who decide you need to shed pounds (but) work for the industry that profits from their declarations” (MacPherson & Silverman, 2008, p.1). Participants were exposed to selective, often salacious, cultural commentary about weight presented in the guise of news,²⁷ and medical documentaries and reality television focus on making over and reforming the erring weightfull citizens. The growth in articles and programmes beckoning readers and watchers to medical and surgical interventions has grown apace. For instance, in New Zealand during July/August, 2008, TV One showed *Real Life: Eating Themselves to Death* and TV3 showed *Half Ton Mum*, while Prime was due to give the viewers “a fatty-a-week on the upcoming British series, *Fat Doctor*” (Hunkin, 2008). Sensationalised personal narratives and reality television series formed the backdrop against which these participants opted for WLS.

²⁷As an example, one has only to follow the news items surrounding the trial for fraud by a Member of New Zealand’s Parliament, who used part of the money to pay for weight-loss surgery.

In advertising and public interest programmes, friendly, approachable non-blaming doctors assert the connections between weight and health and the potential of WLS interventions (Inside New Zealand, 2008; Unichem Medical File, 1999). Most lapband participants in this study viewed the Unichem Medical File programme. This programme stimulated desire for these surgeries and featured a local surgeon. DTCA for WLS options has highlighted the underbelly of drug and medical technology promotion to doctors (Rampton & Stauber, 2001). Overall, the trade in health technologies has stimulated and confirmed, pictorially and verbally, the riskiness of living overweight by employing starkly vivid images of unhappy, weighty persons. The science of medicine and the selling of news have coalesced to frame obesity as a social problem (Saguy & Almeling, 2008). News items, advertising, pseudo-documentaries and the Internet (Salant & Santry, 2006) have blurred the lines of demarcation surrounding BMI and WLS technologies. WLS has captured the interest of women living around the edges of overweight through DTCA advertising.

WLS is an elective surgery based on weight-loss for health but compellingly described as a life-saving procedure by WLS patients. Surgeons in the private sector of New Zealand medicine who wished to perform these surgeries and companies who profit by on-selling technologies have driven the discovery and promotion of surgical cures (Inside New Zealand, 2008; Unichem Medical File, 1999). Significantly, surgeons interviewed for the study²⁸ were adamant about the benefits to patients of their particular WLS options. On interview and in pre-surgery consultations, surgeons made persuasive cases for their surgeries. While weight-loss surgery was the term in common use, the use of the term obesity surgery in interviews with surgeons reflected a desire to recast these surgeries as the surgical treatment of choice for a disease. This raised the profile of the procedure and the practitioner who performed it. Naming the disease differentiated it from its body-enhancing qualities as a form of cosmetic procedure. It also fostered its links within the tradition of heroic cures for disease. The epidemiology of weight and co-morbidities has presented the population and its individual citizens as being at grave risk from obesity. Supply-sensitive medical services guarantee the call for, and use of, medical technologies, less because they are needed and more because they are available (Abramson, 2005).

²⁸At the time of the initial research, only three surgeons were performing Lapband surgery, one of whom also performed gastric bypass surgeries; another surgeon was performing open bypass surgeries.

While the conundrums of what is a healthy weight for individuals and whether large citizens should concentrate on maintaining weight or gaining fitness at any weight, WLS is being promoted as the solution. While the efficacy of these surgeries remains in question, the legitimacy of claims that WLS is the ultimate fix for weight let alone for health remains debateable. Women were told that these surgeries were both viable and healthy cures and they were not informed of their experimental nature. This forms part of a deliberate move to position WLS as the exceptional weight-loss intervention, clearly promoting its commercial success. When making money is a primary goal in the performance of medical care, patient safety is patently at risk (Andereck, 2007). The period in which this research took place surfaced a proliferation of trade in lapbandings. Lynn McAfee, Council on Size and Weight Discrimination predicted that this would bring WLS into the realm of possibility as an appearance tool for an essentially healthy population (Gastroenterology and Urology Devices Advisory Panel, 2000).

In chapter seven, I argue that, if participants were being fully informed about the seriousness of choosing WLS, then pre-surgery consultations would have been described and enacted as sobering experiences. This was not the case and consultations for WLS echoed culturally-driven imperatives about reducing weight for health and the benefits of improved appearance. Participants who attended WLS consultations, with the exception of Pansy in this study, became eager for the duly promoted fix.

This research traces a ten-year development of WLS when participants undertook their procedures. In chapter eight, WLS participants have moved from contemplation into surgery and are beginning to live WLS lives. Some of the problems with WLS have begun to emerge. Recognition of the immensity, even horror, of the WLS undertaking has begun to emerge. Through chapter eight, I progress the argument that if the side effects and downsides of these procedures were being appropriately addressed in pre-surgery consultations, a number of participants would not have chosen surgery.

“The procedure was humane and daring – the spirit of benevolence enlivened by the boldness of a high-wire circus act” (McEwen, 2006, pp.44-5).

CHAPTER EIGHT

Living the surgery fix

“However much the particulars of the beauty package may change from decade to decade – curves in or out, skin delicate or ruddy, figures fragile or fit – the basic principles remain the same. The body beautiful is women’s responsibility and authority. She will be valued and rewarded on the basis of how close she comes to embodying the ideal” (Chapkis, 1986, p.14).

8.1 Introduction

The requirement for citizen-patients to reduce weight for health rests on the assertion that obesity is a leading cause of preventable deaths (Allender & Rayner, 2007; Khaodhiar, McCowen & Blackburn, 1999; Komesaroff & Thomas, 2007; McTigue et al, 2003; Mokdad, Marks, Stroup & Gerberding, 2004; The National Task Force on Prevention and Treatment of Obesity, 2000). Weight loss is considered so significant that even radical interventions¹ are prescribed. At present WLS is gaining momentum as the treatment of choice for morbidly obese persons (Benotti & Martin, Kolanowski, 1997). Surgical options are considered by some as the most likely intervention to produce long-term weight reduction (Adams et al, 2007; McTigue et al.; Sjöström et al, 2007).

In this chapter, and in the thesis overall, I am interested in the effectiveness of WLS procedures. I expand notions of effectiveness beyond its limited appearance as weight loss. Reasonableness and effectiveness of surgeries may be determined also in relation to other factors such as cost effectiveness and especially long-term benefits to lived health. In this chapter, I concentrate on the lived experience of WLS participants following their procedures. For some participants, any loss of weight was deemed beneficial regardless of WLS side effects. While losing weight was a benefit

¹ For instance, deep brain stimulation is a new area of obesity treatment currently being trialled (Halpern et al, 2008).

experienced by some WLS patients, significant side effects accompanied these surgeries, whether or not weight was lost. If effectiveness relates to a ratio of benefits over side effects, then patients would experience improvements in symptom or disease-free days (Hughes & McGuire, 1997). These researchers indicated the need to base the utility of any intervention in alignment with patient values. Some WLS participants settled for WLS procedures against their philosophical preferences or even their ‘better’ judgement.

In the aftermath of surgery, ongoing side effects were significant and harmful for most participants in this study. Procedures did not uniformly produce expected benefits; they caused significant side effects. While patients fully expected to lose weight and gain considerable health advantages with WLS, they were not prepared for the negative side effects. Extreme pain and incapacity followed some procedures. Poor nutrition, reflux and vomiting, failed procedures and multiple surgeries for related conditions were just some of the negative outcomes from these procedures.

Chapter eight analyses the experiences of post-operative consultations and complications. It also provides background for chapter nine in which in-depth analysis of four examples highlights the complexity of problematic surgical procedures if patients began to question the quality of their care.

8.2 The early post surgery patient

8.2.1 Understanding the significance of WLS. In comparison to Shona’s “throbbing” pain, Janice described pain following her open bypass as excruciating. She questioned the information given in her pre-operative consultation: “*I should have said to him. “Why are you going to have an epidural in for 5 days?”*” Janice had not understood the gravity of the intended procedure:

Tell somebody what a major operation is. In your words, you have to say to somebody what a major operation is. Ok, you’re going to be cut from your breastbone down to your stomach, but that’s not the major bit. It’s the insides that are going to be cut, and they’re going to be cut a lot. Even if you see it on paper, it doesn’t make sense to you. I’d never experienced pain like it, and I didn’t for one minute understand that it was going to be like that.

Reassured that both laparoscopy and banding were minimally invasive, it was only in the postoperative pain that followed her procedure that SusieB reflected on her failure to consider just “*how severe, how painful the surgery was going to be.*” The severity of post-operative pain and the potential for complications were minimised by the surgeon in relation to more radical surgeries and in the promise of a slimmed body.

Extensive haematoma, intense pain, inflammation, and wound dehiscence (HDC Opinions, 2001; 2003) indicated that lapbanding was a serious intervention with potential for multiple problems: “The inflammation and weeping at the port site is an uncommon but recognised complication and entirely within the normal scope of the procedure” (Expert, HDC, 2001, p.27). I suggest that, if at least two procedures by one practitioner were being investigated within a close timeframe,² haematomas and dehiscence were not uncommon within that surgeon’s practice. The expert opinion (HDC Opinion, 2003) reproduced the prevailing framing of these procedures in pre-surgery consultations: Lapbanding procedures are minimal interventions and postoperative problems uncommon.³ Wilmshurst (1997, p.567) wrote that “[...] those who should uphold the ethics of medicine and medical research tolerate and help to conceal dishonesty,” and I would add poor practice. In HDC complaints processes (2001; 2003) the surgeon/expert framed his opinion carefully so as to support both the practice of a colleague and the particular benefits to health of laparoscopic procedures. He employed two common rationalisations that conceal medical error - euphemisms and distortions (Banja & Porto, 2004). The use of “*uncommon*” supported the safety of the procedure. But, the perplexing suggestion in this context was that while problems were uncommon, they were also within the “*normal*” range. Having supported his colleague and the procedure, the surgeon then trivialised (Tsang, 2002) negative consequences for particular patients by espousing overall benefits to ‘most’ patients.

8.2.2 Focus on food and weight loss. Concerns in the immediate post-surgery were about eating and weight loss. Following her conversion to bypass, Ms AR maintained a food diary for two years. She recorded how her restricted diet meant she could eat only the liquid from a vacuum-packed soup: she served the chicken and vegetables as a stew with rice for her partner. From weighing herself each day, she gradually moved to weighing once per week as weight loss slowed. Shona maintained an Internet diary in which she painstakingly recorded what she was eating and body measurements. A friend became so concerned at her constant weighing that she removed Shona’s scales. Michelle expected significant weight loss following her conversion to bypass and her Internet correspondence displayed disappointment at the slowness of her losses:

²While HDC opinions are made anonymous, both complaints, for instance, carried the same information sheets and were clearly from the same surgeon.

³Refer to Appendix 1 in which lapband surgery failed to meet safety, effectiveness and overall improvement in health outcomes in the CTAF technical assessment.

“Losses positively glacial over the last two months.”

“Unlike most of you, the slow patches are not followed by grand losses.”

“Imagine my shock, amazement and disappointment when the scales just refused to move as quickly as I had expected them to” (Michelle, emails).

Panicked at going *“from losing teeny amounts to actually gaining this week”* (email), Michelle referred to her recovery following bypass as a *“roller coaster ride:”* *“4 months and basically I’ve stopped feeling crazy, frantic and out-of-control and moved towards a much calmer place”* (email).

8.2.3 Medical care in the community. Patients faced a lack of knowledge in their local health communities about these procedures. They were concerned about the functioning of their technologies. In the experience of post-operative problems, their medical care was clearly compromised. For instance, post-operative care might be assigned to surgeons in other cities (Marjorie), or to surgeons unfamiliar with the procedure (HDC Opinion, 2003); GPs and emergency room doctors were faced with ongoing post-operative infections (Janice, Ms AR), staple-line breakdown (Clover) and over-inflated bands (Sheree). Doctors consulted post-operatively in General Practice or in the hospital did not understand transected bypasses and had never heard of lapbands.

Surgeons expected other doctors to manage any problems that developed. In the tradition of medical training based on experiential learning, patient safety is routinely placed at risk when excessive responsibilities fall on inexperienced or new practitioners (Banja, 2004; Duncan, 1996;). Participants were alarmed to learn that doctors and hospital emergency staff did not understand these procedures. Pinky collapsed with shock from constipation five days after her lapband surgery and discovered that the GP had not heard about lapbanding. Sheree required an urgent deflation at a local hospital that staff refused initially to perform. The surgeon informed the staff by phone, and advised them to rely on the patient to guide them through the procedure. Sheree signed paperwork *“to say how they weren’t liable,”* before talking the registrar through the process. Ms AR required emergency room attention on two occasions following her banding, with severe bleeding from her wound one week after the surgery and wound dehiscence two weeks after the surgery. On both occasions she insisted that the staff phone the surgeon. When SusieB’s asthma was exacerbated by reflux as a side effect of lapbanding, she consulted the locum. Clearly fascinated by the procedure, he did not understand the processes of inflation that were exacerbating SusieB’s symptoms. Participants faced problems within a wider medical community that were unfamiliar

with these technologies. This promoted anxiety for participants about their long-term safety with these technologies. But did participants lose weight and gain associated benefits?

8.3 Gastric laparoscopic banding⁴

Some lapbanders experienced and maintained weight loss. Nonetheless, within three years of their surgery, the success stories of lapbanders in this research⁵ were beginning to evaporate. Participants became clear that the band had not fulfilled its original promise: Banding was not diet-free, minimally invasive nor the vanguard surgical cure for weight loss they had expected. In the failure of the band to deliver them lasting weight loss, some women managed the consequent dissonance by focusing on the band as gaining some degree of control over their weight.

8.3.1 Gains and losses.⁶ Scrapper, aged 36 on interview in 2003, and four years out from her banding, lost 38 kilos initially but had regained more than 10 kilos on interview. Ms AR lost ten kilos preoperatively but did not lose weight following lapbanding (HDC Opinion, 2003). SusieB insisted that her reduction from “125 kilos to about 95” was life enhancing, even in the presence of pronounced asthma-inducing reflux and persistent vomiting. She remained enrolled at *Weightwatchers* with a weight of 107 kilos in 2007 following a second band placement.

Marjorie failed to lose weight with the lapband and her Internet research revealed that only about “20% of people who have the operation are really successful and lose weight.” By contrast, one of three surgeons performing lapbandings recorded that “70% of those who have the operation achieve the dramatic weight loss” (Michelle, email). Michelle’s pleasure at losing 45 kilos with lapbanding was tinged with envy for appearance and losses of bypass patients: She was “a long way from thin and gorgeous... size XXL (like myself) depressingly **after** my weight loss!” (email). Michelle’s emails to the support group over a six year period, recorded her personal journey from being an optimistic “convert to weight loss surgery” (email) to believing that lapbanding was successful for a few “lucky ones.” She contrasted her experience with the success of lapbander Jane (Colville, 2003), whose “body responded well to the

⁴Refer Appendix 1 for technical information on this surgery and a diagrammatic representation.

⁵Refer to Tables 3 and 4, Appendices 12 and 13, for a summary of surgeries, weight loss and side effects by participants.

⁶Refer to Tables 3 and 4, Appendices 12 and 13, for weight loss and symptoms.

lapband and she has the combined benefits of reduced hunger and portion control” (Michelle, email).⁷

8.3.2 Pre-surgery and early post-surgery weight loss. Patients were required to lose weight on a liquid diet for up to three weeks prior to surgery to “*shrink the liver*” (Unichem Medical File, 1999). However, the pre-surgery diet acted as a covert test of compliance: In one HDC Opinion (2003, p.6), the psychologist wrote how the patient “[...] *could be a good candidate for surgery, pre-operative weight loss being predictive, as the liquid only diet will trigger now any negative behaviors that will ankle tap her success down track.*” Lapbanders were told that preoperative weight loss was essential and worried about losing sufficient weight for the surgery to proceed (Unichem Medical File).

In the preoperative and early postoperative period, liquid and ‘mushy’ diets were mandatory and all participants reported losing weight. Preoperative weight loss ranged between 7 to 15 kilos, and was a significant portion of the loss actually attributed to bandings. For example, Pinky’s entire weight loss resulted from the liquid diet: She lost 10 kilos prior to her lapband procedure and a further five following it; Topsy lost 12 kilos prior to the operation and 15 kilos on the “mushy diet” immediately following it. These losses correspond with the research of Wadden (1993) who found that when patients were fed a very-low-calorie diet (400 to 800 kcal/d) they lost approximately 20 kg in 12 to 16 weeks, maintained some loss for about a year, but tended to gain weight back over time.

So how did this procedure work in practice?

8.3.3 Tethered: Inflating and deflating. From a positioning critical of lapbands, one bypass-only surgeon pointed out the risks inherent in placing a device, which at the very least would require replacements:

The problem also is that you’re putting a little technical device in that you think is going to last and not cause problems for the rest of their life. This is just the daftest thing I know! You know, that you put a little device around the stomach and you constrict it, and you think that that’s not going to slip, erode through, cause ulceration, do this and that, over 30, 40, 50 years! (Sounds incredulous). “Christ,” (he muttered softly), “it’s crazy stuff” (Dr M1).

For women who chose lapbanding, the surgeon implanted a silicone banding with associated port and tubing for ongoing physical control of stomach size to induce weight loss. Concerns about silicone were allayed by professional assertions in

⁷Clearly Jane’s story may well have changed over time as well.

information materials as to its safety: “*The band is made of solid silicon as opposed to that used in breast prostheses, and therefore cannot leak*” (Fris, 1999, p.2). In labelling the silicone as “solid” it was differentiated from the silicone implicated in breast implant failures (Jeffreys, 2005; Rowsell, Norris, Ryan & Weenink, 2000). Issues related to the life of the banding and its potential need for replacement in the longer term were not referred to nor did most patients consider these.

8.3.3.1 Early inflations. Lapbanders were preoccupied⁸ with adjustments – ports, inflations, deflations, level of fills and expected weight loss. Levels of fill appeared to be highly individual. But these participants did not lose weight when there were negligible levels of saline in their band and quickly regained weight when they were deflated (Michelle; SusieB; Rosie). Most participants required sustained fills of close to 4mls (with the LAGB) to lose weight though this did not ensure either loss of weight or maintenance of loss.

Submissions as to the best practice of saline restriction arose in Hearings relating to lapbanding (Center for Devices and Radiological Health, 2001; Hearing into Lapbanding, FDA, 2004) and included the following clinical proposition:

[...] constricting the lumen by adding saline to the band is a key factor in slippage. Slippage did not generally occur until you started narrowing down that stoma size. We didn't usually start adjusting until 4-6 weeks after surgery to allow some scarring in to prevent that.

One of the three surgeons placing lapbands in New Zealand during the research period followed this conservative approach. After the first six weeks, American doctors were cautiously inflating the band to find an appropriate level of fill (Hearing into Lapbanding). The fill level for LAGB was placed at 3.5-4 mls for producing weight loss without distressing symptoms. By 2004, FDA hearings into the efficacy of the band and investigations into its mechanisms were ongoing. Levels of fill remained experimental and confusion surrounded whether bands should or did require a small inflation at the conclusion of the operating procedure. The recommendations provided by LAGB manufacturers for fluid left in the band was clarified in Dr MacDonald's evidence (Hearing into Lapbanding) and included advice that there be no inflation for seven weeks to allow the band to scar in. At least one of two New Zealand lapbanding surgeons was placing saline in the band during the operation: “*The access port was then*

⁸During one well-attended support group meeting, at least fifteen minutes was devoted to discussing timing and rates of fills.

sutured to a pocket over the rectus sheath, tested, and then left inflated with 2.0ccs” (Operation Report, HDC, 2003). Inflating the band appeared to breach the protocol or recommendations. Failing to inflate bands (Topsy) following the surgery led to scarring over the port that impeded inflations and necessitated port replacements. There was marked variability in restrictions from inflations: European evidence indicated that best practice was to vary inflations according to the thickness of the stomach with frequent small inflations as the optimal management style (Hearing into Lapbanding). While some early lapbanders reported losses from pre-surgery to their point of highest loss as 30 to 50 kilos, rapid inflations tended to deliver maximum weight loss within a year from surgery with a tendency for weight regain even while high levels of inflation appeared to be in place.

8.3.3.2 Timing of inflations. SusieB was first banded in 1999 and described the progress of inflations: *“You’d have a fill of 2mls in the band and then they would go to 3, 4, bang, bang, bang, up like that!”* After initial clinical enthusiasm for rapid inflations, at least one of the three surgeons experimented with inflating more slowly to prevent rapid regain of weight. However, by 2007, when SusieB was rebanded with a 9 mls capacity *“vanguard”*⁹ band, her surgeon had reverted to rapid fills for speedy weight loss within the minimum time period. The possibility was that this afforded better statistics in the first year following these operations as slow or poor overall weight loss impacted on patient confidence in banding.

In New Zealand, weight loss with lapbandings was compared unfavourably with consistently higher weight loss following gastric bypass procedures. The benefit to reputation of both procedure and surgeon was served by rapid inflations with associated rapid weight loss even while experience showed that much of that weight would be regained. However weight regain could be ascribed as patient failure. Using rhetorical injunctions such as, *“We have given you a tool,”* the lapband surgeons blamed their patients who did not lose large amounts of weight – a common rationalisation technique when procedures failed¹⁰ (Banja & Porto, 2004). For instance, one surgeon-advisor ascribed failure to *“tolerate the fluid in the band,”* and *“difficulty swallowing”* (HDC

⁹A 9mls band had been used from the beginning of lapband surgeries by one of the three surgeons.

¹⁰Failure is routinely ascribed to patients rather than to the therapy or the practitioner in modern health scenarios. For instance, Gunderman (2000) described a patient for whom chemotherapy had not worked: “Mrs Jones is a 37 year old mother of three who failed the standard breast cancer chemotherapy protocol, subsequently failed our newest investigational protocol, most recently failed autologous bone marrow transplantation, and now presents for palliative care with widely metastatic disease.”

Opinion, 2003) as patient failure rather than to concern with the operation of the banding mechanism.

In the Reflecting Team Process,¹¹ Michelle expressed relief that she had chosen not to proceed with the local surgeon. When he disparaged her research on the revised band, *“I thought that’s not the good basis for an inflation relationship (Laugh). Not at all!”* (Laughed again). But what was an inflation relationship? Pre-surgery, inflations were promoted as a readily accessible process: *“[...] instead of having people either with a fixed outlook that they’re going to vomit with or find it too easy to eat, I was going to be able to adjust them and it would be great”* (surgeon). The practice of inflations within individual accounts was marked by uncertainty and diversity of practices. Such diversity, given that these accounts related to three surgeons performing this form of surgery in New Zealand at that time, highlighted the experimental nature of this procedure.

8.3.3.3 Problems with the mechanism. Participants in this study experienced significant problems with the banding mechanism. Michelle’s research in 1999 alerted¹² her to leaking and difficulty in filling some bands. Early bands were connected with stories of leaking and lack of saline in the band amongst these participants even while an improved version appeared to be available. From 1999–2002, the possibility is that faulty mechanisms were bought in bulk and on-sold to patients for about \$3,000 per mechanism who then paid for installation during WLS.

The problems with inflating and deflating flowed through the support group website and within the interviews for this study. Where the surgeon chose to position the port, for instance, affected access for inflations and caused considerable discomfort. Marjorie’s band was placed uncomfortably on her waistline. Inflations were not the simple process women had been promised. Surgeons found ports difficult to locate and could not access them. Women reported over 20 needle insertions by the surgeon, the surgical assistant and sometimes both in a relay, attempting to access their ports for a single inflation (Rosie, SusieB, Ms AR). When participants discovered they could eat more rather than less following inflations, this signaled a failed inflation. That failure needed to alert surgeons that the saline was not progressing through the tubing and into the band. After one particularly gruelling inflation consultation, Rosie described the

¹¹ Refer to Appendix 5.

¹²Michelle was alerted to a new band by one of two surgeons she consulted. This surgeon eventually accessed a new band when she requested it while the second surgeon disparaged her research.

eventual level of fill as unknown. The surgeon said, “*There’s something in there but I don’t know how much’ because there was all this. So I think I probably I had less than 2mls in and of course it didn’t do anything.*”

Even where these inflations were later done under radiology, problems persisted. Following an unsuccessful inflation, Rosie was directed to have her inflations under x-ray. The patient was charged even when an indeterminate inflation was achieved or another attempt was required. Each consultation charge included the surgeon’s time, the radiologist’s fee, and even an extra \$50.00 for the “big” needle.

But it was so expensive, I mean I’m talking you know \$200... Coz he couldn’t do it! And I thought none of that was my fault! ... Back I went in to have another inflation. Well this time it was 55 minutes under x-ray and I still got the holes, 21 holes.

Rosie recalled the disquiet of the radiologist and another person present who became distressed during the procedure. At this appointment, the surgeon promoted port replacement. Rosie recalled his words: “*Because,*” he said, “*If you put it between the breast bone you can feel it with your hands. You don’t have so much fat there.*” The patient’s fat was the cause of the surgeon failing to inflate the band rather than poor positioning of the port, problems following a complete deflation, or a faulty mechanism. Rosie was wary about committing more money and time to have the port replaced as it required “*time off work*” and “*going under the knife again.*”

The potential for leakage of saline from the band was never discussed with participants who discussed occasions when there was less fluid in their bands than specified. For instance, following a barium swallow, Michelle’s surgeon was unable to locate any level of inflation in her band:

He said that it didn’t look like I had any fluid in there. Interesting!?! Looks like somehow, 3.2 mls may have “leaked” out over the past eight months. Guess that might explain the 25-30 kg weight gain, which seemed excessive for the 0.5 ml deflation I had back in January (Michelle, email).

Surgeons withhold information from their patients by a judicious choice of words (Gallagher, Studdert & Levinson, 2007; Gallagher, Waterman, Ebers, Fraser & Levinson, 2003). Although banding mechanisms appeared to be failing, surgeons deftly directed patient’s attention onto areas of patient responsibility. For instance, surgeons blamed a patient’s deposits of fat even when these patients had lost weight since the bands were placed. Surgeons decided placement but problems with placements became patient issues related to their fat deposits. Significantly, the costs of inflations were

highly impacted by surgeons' surgical decision-making and variable skill levels. In fact, WLS patients also blamed themselves when surgeons were unable to access their ports for inflations. This was unsurprising given the pressure on patients to accept blame for requiring radical interventions. Michelle spoke with embarrassment about the surgeon having a "*dreadful time finding the port through all that fat,*" even though she had lost 20 kilos following WLS. Given that port access would have been a significant issue in the original operation, the taking of blame by the patient in this context issued from both a shame-based bias against her own body mingled with her need to continually "acknowledge her deviance" (Spitzack, 1990, p.58). This involved patients having to accept the uncertain outcomes of WLS interventions.

The ease with which blame could be attributed to these patients lay in their already spoiled identities (Goffman, 1963). As in some other disease experiences,¹³ overweight women are considered responsible for their large size (Sherwin, 1992) and the first order of compliance rests within their acknowledgement and acceptance of responsibility. This confessional discourse is heard by the one who also judges it (Lakoff, 1996). Following WLS, the possibility for care to be withdrawn, disparagement of weight and projection of responsibility were forms of symbolic violence performed by surgeons (Bourdieu & Wacquant, 1992). Women's acceptance of these conditions was not absolute though WLS patients were relatively powerless within asymmetrical relationships of consultation given the lack of alternative surgeons, degrees of learned docility as women-patients and the installation of this technology.

8.3.4 Reflux and the spectre of slippage. Common side effects of the bandings were regurgitation, food sticking in the gullet, vomiting and reflux. Michelle fielded website enquiries to which she responded carefully:

You just have to keep working with your surgeon to find that sweet spot where you are able to eat fairly good healthy meals but in a small enough volume so that you can lose/maintain your weight WITHOUT reflux (Michelle, email).

SusieB was fully deflated twice. With each following inflation, she vomited for two weeks after each meal, even after being fitted with a new band: "*I mean I had this inflation two weeks ago and today I haven't thrown up. Nearly everyday afterwards, I've been sick*" (interview, 2007). A friend has asked her: "*Oh, god, how the hell do you put up with that? I couldn't put up with it?*" (2007). In the cheerful way in which SusieB reported the consternation of her friend, the significance of vomiting and

¹³For example, lung cancer (Chapple, Ziebland & McPherson, 2004; Mitchell, Street & Love, 2005).

regurgitating for over six years was minimised. In the interview, she assured me that it was “ok” because she had learned to do it quietly. To her friend, she said: *“I have lived with this for too long to worry”* (2007). SusieB vomits or regurgitates foods such as sushi, chicken, bread and fruit.

In a support-group posting entitled *“Stuck, stuck, stuck!”*, Michelle described her *“intense pain”* when a piece of chicken roll lodged in her gullet. She dislodged it by making herself sick. Her following postings described *“getting food down the oesophagus”* becoming such an issue such that *“every meal felt like a battle”* as she dealt with *“regurgitation,” “dislodging,” “barfing,”* losing *“three dinners in a row,”* and spoke of the *“productive burp”* (emails). On one occasion she chose *“scrambled egg on toasted pita bread:”* After two trips to the restaurant bathroom, the food was still lodged fast. On her way home, she was unable to prevent a *“serious regurgitation “* in her friend’s car. Having described this as her *“most hideous lapband experience to date,”* she advised lapbanders:

“If the menu seems lapband-unfriendly, then the safest option is just to order the soup!”

“If usual methods for regurgitation fail, one might have to consider resorting to putting one’s fingers down one’s throat to force the issue. I swore I would never do this.”

“Never, never, never go anywhere without either a zip-lock bag or, (my preference), an airsick bag” (Michelle, emails).

Reflux and persistent regurgitation indicated the clinical requirement for some level of deflation or band revisions (Rosie, SusieB, Michelle). For Rosie, minor deflations did not reduce reflux and Michelle’s reflux abated only when she was fully deflated before her gastric bypass. In particular, reflux alerted surgeons and patients to the possibility that the band had slipped out of position on the stomach. Michelle described a lapbander experiencing *“terrible problems with repeated excessive vomiting (several episodes a day) and reflux over the last six months which have damaged her oesophagus and caused the band to slip”* (Michelle, email). The potential for slippage came to loom large in the lives of women who had been banded.

This occasioned a renewed call for vigilance through the banding network. Lapbanders were advised to show respect for their bands by *“restricting portion size”* and bringing pain, regurgitation and reflux to the notice of their surgeon; they were to avoid *“nausea-induced excessive vomiting”* (Michelle, emails). A surgeon advised website members:

“(The lapband) is great for those it’s great for, but 3 in 130 don’t seem able to tolerate restriction. Gullets lose the ability to push through the band, so stuff sticks and irritates or straightforward slippage” (Surgeon, email to website).

While these figures were cited incidentally, they were accepted as authoritative even though they did not refer to published research nor were they statistics related to his practice as this surgeon advised that he had not performed that number of lapbands (surgeon, HDC Opinion, 2003). Figures of 3 in 130 did not relate to the actual occurrence of problems for lapbanders in this research.

The surprisingly low estimate for problematic eating following restriction was followed by the surgeon’s quizzical message emphasising the need for patients to consult their surgeons, not **if** “vomiting or reflux” occurred but “*if it becomes a problem*” (Surgeon, email). Regurgitation and vomiting in lapbanding appeared to be tolerated as aids to the development of compliance and the promotion of weight loss. This echoed the toleration of dumping¹⁴ as a positive side effect following gastric bypass being reframed as promoting patient compliance with very restricted diets (Marcus, Karlarchian & Courcoulas, 2009). In a *Next* magazine article, Colville (2003) indicated Jane’s inability to tolerate many foods following her banding. For example, eating meat was difficult and she ate very little, very slowly. Even so, she experienced vomiting, regurgitation and chronic restricted eating. For instance, “*I say it’s like draining a sink – if a piece of food blocks the sink, then there’s nowhere for it to go, so you have to excuse yourself, go to the bathroom and throw up*” (Jane, in Colville).

While the surgeons admonished patients publicly not to “*sit there enjoying the unhealthy weight loss of technical bulimia,*” the use of the word “*enjoying*” spoke to an unhealthy tolerance of these symptoms by surgeons and patients alike. The problem for patients was that if they reported these symptoms, surgeons might completely deflate the banding on account of “*the dreaded slippage,*” (Michelle, email); this was followed by renewed testing, weight regain, and, an expensive programme of reinflation. Anxiety about being completely deflated caused patients to delay reporting their symptoms:

I knew that he would completely deflate me and I couldn’t bear the thought of being completely deflated. I’d rather have been sick (Rosie).

¹⁴ Refer Section 8.4.2.

I have been deflated twice. I knew then that I was faced with two weeks with nothing in the band and what was going to happen. Now I tried to be as careful as I could but I still put on 2.8 kilos in two weeks (SusieB).

Recognising her own symptoms as reflux, Michelle adjusted her diet but her symptoms were so pronounced that she was unable to sleep. Her surgeon, “*to get a clear idea of EXACTLY what is going on,*” advised endoscopy or fluoroscopy. In another forum, this surgeon had indicated reduced confidence in such investigations: “*The problem is that slippage may not show up all the time and barium studies and endoscopies have deceived me before*” (surgeon’s email to Support Group). When Rosie requested a small deflation, the surgeon replied: “*I think your band has slipped. We’ll completely deflate you. I want you to have an x-ray, barium swallow and, if it’s fine, we’ll reinflate you slowly [...]*” A barium swallow and everything is perfectly fine.” Following a complete deflation, Michelle was gradually reinflated, continued to gain weight and suffered “*hideous reflux at night.*” (Michelle, email). The surgeon promoted a laparoscopic gastric bypass rather than merely repositioning her port: “*If we are going in there, we need to fix the problems.*” Coughing, with pronounced reflux, on losec for heartburn caused by the positioning of the band, gurgling during her sleep, and having difficulty swallowing saliva, Michelle slept upright in a Laz-y-Boy chair for months.

Michelle lost confidence in banding, describing it as a fairly “*lightweight, non robust device.*” “*As soon as it reaches a certain pressure on it, then the body doesn’t seem to cope well and the issues with reflux and heartburn start*” (Michelle, email). Finding a good level of inflation “*WITHOUT being restricted to mush forever!*” indicated the “*rough time of it*” (Michelle, email) experienced by some patients. Some participants spent extended periods on liquidised diets, sitting upright to achieve sleep, in pain, embarrassed by regurgitation, and experiencing difficulty eating ‘healthy’ foods. Tests were ordered and took place within the private sector of medicine, a further cost on these patients. Tests are a practice of medicine that is minimally studied and poorly understood (Moynihan, 1998). The relative ease with which these particular procedures were ordered and carried out within days, spoke much about the ease of access for patients within private medicine and less about their clear clinical necessity.

8.3.5 The new diet imperative: Healthy options or manageability. Lapband surgery was to produce restriction to suppress appetite, allowing patients “to achieve a healthy diet and lifestyle” (Fris, 1999). But the reality of restriction meant that

lapbanders were unable to tolerate many ‘healthy’ foods: “*One of the greatest ironies of the lapband is that something that is supposed to make you healthier makes it harder to eat healthy (usually fibrous) foods*” (Michelle, email). Following their liquid or mushy diets, fibrous foods were reintroduced. Most fruit, vegetables, breads, rice and a variety of meats and fish, were all reported as obstructive for most lapbanders in the study:

And the other day I was able to eat half an apple and I haven't eaten an apple in four or five years. I was able to eat a piece of bread. You just could not eat those foods with the lapband (Rosie, following removal of her lapband).

This was the “*trap*” that lapbanders spoke of when the only food that “*stays down is bad for you*” (Rosie). Jane (Colville, 2003) described her post-lapband diet:

I found a smoothie could keep me going half a day. I remember cooking lamb chops for my family and just gnawing on a bone – that was all I wanted. Now I sometimes have to remind myself to eat something.

I now live on three small meals a day” – and she does mean small. “For dinner I might make a chicken casserole and have a large spoonful of that, with a couple of teaspoons of vegetables and a couple of teaspoons of rice. My meal usually fits on a side-plate.

The stories of lapbanders were littered with references to food and dieting. Food diaries were published on websites, with other lapbanders eager to know what others were eating. There were concepts such as ‘plateaux’ when weight loss stalled, and advice was given on how best to break through them. Weight loss was to be maximised within ‘windows of opportunity’ and ‘periods of grace’. These were variously placed at between nine months and two years following lapbanding.

Post-surgery, proprietary dieting continued to feature. Within a few weeks of her lapbanding surgery, weight loss stopped for Marjorie. Following her description of a grating feeling of hunger, the surgeon prescribed weight-loss drugs and the nurse recommended *Weightwatchers*.

I froze. I thought, “I’ve had this operation so I don’t have to go down that path anymore. No more dieting. (I’d) said I’ll never go another diet because I know they don’t work. And here’s she’s saying to me try Weightwatchers.” I thought, “What have I done?”

On reinterview, SusieB was attending *Weightwatchers* following her second lapband.

The following discussion centred on a cost-benefit analysis:

participantR: *It’s hard isn’t it, because how do you do the cost-benefit analysis?*

SusieB: *I don’t even go down that track because if I did, I’d get depressed!*

participantR: *You don't do it with, "That would paint the house," or*
 SusieB: *I don't ever.*
 participantR: *Buy a new car or*
 SusieB: *There's no point in doing that, because at the end of the day, I*
feel whatever I've done, I've done with the last straw in mind.
Thinking that this is going to be the last time to think about it,
you know?
 participantR: *How is that to look back? Over six or seven years?*
 SusieB: *You don't look back. There's no point to it like life itself,*
there's no point to it. The only thing you can do is learn from it
really.

Clearly disappointed with the reality of her lapbanding experiences, SusieB was managing the dissonance by dissociating the significant physical, emotional and financial costs from her everyday awareness. The new banding had not brought further weight loss, nor cured her reflux and regurgitation. SusieB was living the reality of failed expectations from two costly WLS procedures.

8.3.6. Patients: Changing cognitions in adapting to disappointing outcomes.

In this study, gastric bypass patients lost more weight than lapbanders and sustained it over time. For the lapbanders in this study, however, the dissonance between their goals for weight loss and the reality of failed expectations required resolution. Lapbanders came to accept over time that they would not achieve a normal BMI. In a cognitive sleight of hand, the focus shifted from losing weight to gaining some control of even small losses. This was a significant cognitive journey for some women, who moved from an expectation of reasonable weight loss to a nadir of maintaining little more than, or sometimes less than, the weight lost on liquid or mushy diets. Pinky's "three appointment relationship" with the WLS surgeon cost \$12,000 and she maintained the weight lost on the liquid diet. Bombarded by multiple discourses around weight and weight loss in her profession, Pinky has sought to resolve that dissonance:

That's why I think the lapband really does work because what it has done, it's given me control. Whereas before I'd lose my 10 kilos but over two or three years, I'd gain it all again.

She appealed to participantR: "Does that make sense?"

participantR reflects

"Not much," I wanted to say, but didn't.

Her failed expectations were acted out in a display of anger in our interview. She recalled not handing over her 'before' photos to her surgeon as requested: "He's not bloody having them!" SusieB also referred to maintaining a small loss. She compared

herself, as did Scrapper, to others on the website who had regained weight: *“Like Michelle, gone back to where they were and more. I hadn’t. I’d still kept within about 8 kilos under.”*

Through time, success came to be redefined as control, or being more successful than less lucky ‘others,’ “the Other woman, the yardstick for our imperfection” (Blum, 2005, p.104). Ten kilo weight losses equalled the amount lost on their pre-surgery fluid diets, and did not approach the promised loss of from 50% to 75% of excess weight. With an eight-kilo weight loss for SusieB following two \$10,000 - \$12,000 procedures, the weight-for-dollar ratio was well over \$2,000 per 1 kilo of weight. Prior to her WLS, SusieB would not have considered this to be value for money.

8.3.7 Surgeons: Changing cognitions in adapting to poor outcomes. In numerous forums, complaints processes, clinical letters and speeches to scientific meetings, surgeons’ talk and documentation emerged a compliance discourse. Patients who did not lose weight on WLS or regained it, proved their inability to comply with medical direction. This rhetoric of blame was clearly evident in a radio interview following the deaths from biliopancreatic diversion, a form of WLS being used in Queensland, Australia: “Had Mrs M. adhered directly to my instructions, without deviation, she would still be here today and successfully, too” (Willacy, 2007). The surgeon in this case blamed the patient for taking a supplement that may have led to rapid emptying of her bowel and a severe loss of nutrients. However, other patients also died following this procedure. It was unclear how WLS patients were informed about managing their everyday exposure to gastric upsets and the rapid loss of essential nutrients. For instance, Ms AR required rehydration as an outpatient following a bout of vomiting and diarrhoea.

By blaming patients, surgeons could act to protect their reputations and the reputation of their procedures. While some patients in this present study reported being berated or put down by their surgeons, other patients described a less obtrusive mechanism of persuasion: Misleading information, espoused notions, gentle-seeming but compelling repetition of truisms and other persuasive statements provided an underbelly of pressure within consultation processes. Significantly, these participants – patients and surgeons – repeated them in emails, interviews and consultations:

“You need to work with the band.”

“We can only do so much.”

“It’s up to the patient.”

“If the band is in place, then the band is working.”

Patients were encouraged to believe that if they had followed instructions, they would have lost weight successfully. When these instructions were analysed, compliance rested on attending follow-up consultations for inflations, adhering to a very strict diet, taking supplements and exercising. Following these instructions did not ensure weight loss or freedom from side effects.

Complicit in attributing blame to their post-surgery diets, patients avoided criticism for choosing an expensive WLS option that did not work. Compliant dieting may well have been an issue with lapbanding: Being on a diet for life or being unable to eat satisfying or healthy food were not the outcomes lapband participants desired when they bought into the WLS remedy. But these patients were already discredited by their inability to lose weight: Attributing failure to patients concealed very significant issues with the banding mechanism and practices of inflations.

8.3.8 Consulting disappointing outcomes. Small losses, or large losses followed by significant regain, could not meet pre-lapbanding expectations and short-term surgery consultation relationships turned into long-standing consultation sagas for lapband patients. Surgeons were required to manage the complexity of care following iatrogenic effects and failed expectations. One surgeon stopped performing lapband surgery because of the variability in results.¹⁵ Another surgeon suggested that 70% of his patients achieved good weight loss, a figure commented on by Michelle: *“I guess the success is helped by making sure you only operate on people that have a relatively small amount to lose and making sure that you offer good post-op support”*(email). While good post-operative support might result in improved outcomes, one doctor participant suggested that that post-operative support consisted of harassing behaviours:

He’s got strong views about what women should do to get their weight down (laugh). Yeah! So he uses words like ‘compliance.’ He does tell people didactically to get their act together and stop eating, that sort of thing.

Follow-ups were devolved onto a variety of ancillary staff, including research assistants and surgeons’ spouses; patients were exposed to the vagaries of surgical practices as when a surgeon’s marriage broke down, rapid staff turnovers in another clinic, and, medical trade-barriers.¹⁶ The single WLS procedure evolved into complex requirements for revisions, alternate procedures, enhancement procedures to excise

¹⁵ Refer 7.3.2.

¹⁶When one doctor left a WLS practice, the surgeon refused to provide surgical oversight for her to continue to provide inflations, a technique she had mastered (Rosie and SusieB).

excess skin, and, a variety of operative and medical procedures to restore or optimise health following these operations.

Given that, on the whole, these were otherwise healthy, weight-full patients, the problems and side effects of the surgeries evidenced amongst this group of participants was unexpected. For instance,

- Information on the procedures was contradictory, untimely or omitted significant information about the variability of loss.¹⁷
- The practice of inflations and the resilience of the banding technology were misrepresented prior to the operations and poorly handled following them.
- Surgery statistics were distorted. They included pre-surgery losses on fluid diets in overall figures; minimised or neglected the side effects of the banding surgery; neglected to include the use of weight-loss drugs and concurrent membership in dietary organisations in any losses experienced.
- Lapbanders' diets were suboptimal in relation to good nourishment: The picture of Jane “gnawing on a bone,” (Colville 2003, p.149) and forgetting to eat at all; Pinky's choice of calorie-dense milkshakes to supplement her otherwise meagre and restricted diet; the necessity for WLS patients to eat ‘easy’ foods when in public; the carrying of receptacles to manage regurgitation and vomiting in public arenas.
- Weight regain was significant for most lapbanders interviewed: Michelle's weight cycled from a high of 149 in 1999, to a low of 96 but returned to 133kgs with severe reflux in 2003. In facing the reality of band failure, Michelle wrote: “*I'm just starting to understand the sense of betrayal at being given much promise and so little delivery*” (email).

8.3.9 Discussion. Lapbandings were expensive surgeries that achieved markedly less sustained weight loss than expected. Women incurred significant side effects that interfered with their lives on a daily basis and they continued to need drugs for weight loss and enrolment with proprietary diet programmes. In fact, diets were promoted by surgeons and practised by patients following their lapbandings: *Atkins* (Marjorie), *Weightwatchers* (SusieB), and *Jenny Craig* (Scrapper). Chronic restricted eating was a dieting formula that could produce weight loss following these procedures especially

¹⁷A surgeon offering gastric bypass procedures compared lapband losses with bypass losses: “The average weight loss after lapband is about two thirds of the average weight loss after what I do. But the spread (for lapband) is from very good to nothing. So, you see, if you have a lapband, you don't know if you're going to have a great weight loss, or no weight loss. Now that's terrible. 10 % of lapbanders effectively lose nothing really at all” (Dr M1).

when accompanied by large amounts of exercise. This entailed exposure to a range of deficiencies in participants' diets and degrees of starvation. The erratic eating behaviour of lapband patients appeared akin to the eating behaviours of patients with anorexia and bulimia.

Rhetorical concealment, edited accounts and physician projection were significant in interviews with women. As well, in media articles and reports of surgical and scientific meetings, the failed WLS patient was one who was, (benevolently) 'unable' but (essentially) 'unwilling' to cooperate.¹⁸ Variation in results from laparoscopic gastric banding were rationalised as poor compliance. Surgeons were advised that successful procedures depended on differentiating the "compliant" patient from the "teenage personality" (Royal Australasian College of Surgeons (RACS), 2003). Salant and Santry (2006) carried out an investigation of bariatric websites and Internet marketing of WLS procedures. Surgeons relied on genetic or environmental, essentially non-blaming,¹⁹ discourses in their promotion of surgical intervention but blamed individual behaviors of patients when surgery failed (Salant & Santry).

The HDC relies on evidence and comment from surgeon-advisors who have significant conflicts of interest. In two cases (HDC Opinions, 2001; 2003) one expert indicated a couple of minor, negative aspects of banding faced by a few patients, but did not discuss his reservations about the intervention overall. This was a tactic of omission (Finkelstein, Wu, Holtzman & Smith, 1997) that supported both his introduction of the technology and his colleague whom he had trained in the procedure. Yet on interview for this research the surgeon expressed concern that he had promoted lapbandings that did not deliver "*a guaranteed result*" (Dr M2) for patients who "*invested their life savings*" (Dr M2) but experienced suboptimal results and persistent side effects. He continued to rationalise²⁰ this as being about a patient's inability to comply. Denial – "[the] psychological analogue of the endorphin attentional tune-out" (Goleman, 1996, p.43) – allowed this surgeon to believe in himself as a healer if patients followed his direction. In foregrounding patients as the problem in getting the band to work, faults with the mechanism, the operator, or the lack of inflations, did not get addressed.

¹⁸ In a Medical Disciplinary Tribunal reported on in 2000 (Langdon, 2000a; 2000b; NZPA, 2000) the surgeon's reliance on espoused statements in contrast to the straightforward statements of the patient was suggested as a major reason to prefer the statements of the patient.

¹⁹ These were discourses in which the potential patient was the victim of obesity.

²⁰ Banja (2004) describes rationalization as a "[...] kind of moral counterfeit, such that a moral lapse, which in this case is error concealment, becomes morally acceptable" (p. 37).

8.4 Gastric bypass²¹

Nine participants eventually had gastric-bypass operations. For five women, this was their only WLS, three converted from lapbanding and one required a revision of her original bypass. Bypass participants experienced significant weight loss. The transected bypass was positioned as the gold standard WLS and “(e)ven the most disappointing result is probably nearly as good as the average of the lapband” (Dr M1). As with lapbanding though, the physical costs of living with the band were both pronounced and minimised.

8.4.1 Gains and losses. Clover and Janice lost weight following open Fobi pouch procedures and their diabetes was controlled without medication. Clover required a bypass revision following staple-line disruption, and reported a reduced weight from her highest weight before her first surgery of 140 kilos down to 70 kilos with weight loss following her second WLS considerably less than after her first surgery. With the same operation, Janice went from 100 kilos to 64 kilos within ten months of her surgery. Pammy also had open-procedure gastric bypass and her weight reduced from over “11stone to 7stone 4lb,” regaining six pounds but revelling in wearing a small size 8 dress size.

Following laparoscopic bypass operations, Meryl reduced from a high of 116 kilos to her lowest of about 58 kilos. Karlie reduced from 100 kilos to 64 kilos. Michelle expected to lose at least 50 kilos following her conversion to bypass, and described her loss of about two kilos a month as “glacial:” “*This reality is bitterly disappointing. I really thought I deserved to get down to ‘normal’ weight after taking a more radical step than the lapband!!*” (email). Yet Michelle knew that Clover’s revision bypass did not produce as much weight loss as her first operation:

“Shame that you have been losing weight far slower than you would like. I’ve always thought that the least your body could do after having to go back for revisionary surgery is to reward you with weight losses approaching those that you experienced the first time around, but it sounds like it just doesn’t work that way!?”(email)

Michelle’s expectations for good loss were encouraged by the surgeon’s assurance that all his bypass conversions achieved normal BMI. After two weight-loss surgeries, Michelle lost 45 kilos with the lapband, regained almost 40 kilos and was approaching a 35-kilo loss following her conversion to bypass. Rosie lost 20 kilos following her

²¹Refer to Appendix 1.

conversion to bypass, though “*It's still not worth what I've been through*”²² (reinterview).

Weight regain was evident with earlier bypass patients such as Clover and Ms AR. However, most of the gastric bypass patients interviewed for this study were interviewed early in their experience of bypass. The need for conscious attention to dieting has only more recently been highlighted. The malabsorptive elements of bypass cannot be depended on for maintenance of loss. Most patients will need to restrict themselves to about 1000-1200 calories (Brigham and Women's Hospital, 2007).

8.4.2 Chucking, dumping²³ and shedding. One drawback with gastric bypass surgery is “the lifelong difficulty with eating that they produce” and one third of patients experience “regular vomiting and regurgitation of some food” (Stubbs, 2000). Surgically induced bulimia following WLS was both expected and acceptable to the surgeon who developed the Fobi pouch bypass (Widemark, 2005). Silastic rings placed during their transected bypasses exacerbated difficulty in eating some foods:

I had an apple the other day and it was the first one I'd had for about three years and I just brought it back up again (Pammy).

Pammy and Janice experienced high levels of regurgitation and Janice was vomiting seriously and regularly: “*I just vomit and vomit and vomit, like 12, 15 times, until I can't vomit. You can even see the lining of my stomach in the toilet.*” Both these participants worried about their vitamin and mineral levels and Janice noted how she tired easily.

Dumping was a food-aversive side effect of bypass procedures and suggested as a reason for preferring bypass over lapbanding (Stubbs, 2000). Even so, dumping is not correlated with weight loss following gastric bypass (Cowan, 2005). To avoid dumping, patients needed to ingest low fibre, low calorie foods and eliminate fat or simple sugars. Patients would experience feeling “nauseated, bloated, faint, sweaty and develop palpitations. They usually have to lie down for 20-30 minutes after which time the symptoms pass” (Stubbs, p.25). In fact, foods that induced dumping were varied and, for instance, Shona dumped after three teaspoons of apple juice: “*Holy shit, I can't tolerate the sugar in apple juice!*” (diary). Her second dump occurred after a low sugar, low fat mocchachino: “*I spent two and a half hours in agony, stomach cramps, nausea,*

²² Case-study of a consultation following a near-fatal gastric bypass procedure, section 9.5.

²³ Dumping results from easily absorbed food particles entering the digestive system. WLS patients experience a range of symptoms such as feeling cold, clammy sweating, pallor, feelings of anxiety and rapid heart-beats. Cramps and diarrhea may follow with a dump lasting from 30-60 minutes.

and just dumping my little heart out” (diary). Shona believed that sugar had caused her to dump, though the possibility is that milk was the real issue (Balsiger et al, 2000). Rosie experienced difficulty in eating food prepared by others: *“Gripey pains in my stomach and wanting to be sick. I hadn't over-eaten, but then you don't know what's in food that you get in a place like that.”* She reported significant diarrhoea to her specialist:

I said to him, “I've got, you know, frequent loose bowel motions and sometimes really bad diarrhoea.” And he said, “Are you dumping?” And I said, “Well it doesn't matter what I eat, whether it's low fat, low sugar, whatever it is, some days I'm just really bad.” And he said, “Well be grateful, because most people are constipated.”

The surgeon's initial question implied that Rosie was not eating correctly; Rosie's reported response clarified that she had picked up that suggestion and signified her understanding that the surgeon's first resort would be to focus on his patient's choice of foods.

Michelle researched the experience of dumping prior to her gastric bypass. One website participant replied and forwarded an e-medicine article to explain the difference between dumping and dumping syndrome:

Food is a serious issue and, although I had been told that I would dump if I ate too much sugar or fat (my fault!), I had no idea about dumping syndrome that is a completely different beast. When I read the article I sent on to you, I realised why I was fighting going to sleep over the wheel after a sandwich for lunch and some of the myriad of symptoms that are part of my life. I am in the early stages of adapting to dropping as much carbo as possible from my diet and I am experiencing some control over my symptoms (Ms AR, email to Michelle).

Information about dumping syndrome or late-onset dumping was not uniformly given to participants. Michelle discussed the e-medicine article with her WLS surgeon:

The 'dumping syndrome' occurs in response to the presence of undigested food in the jejunum. When this occurs, plasma fluids shift into the intestine area to equalize osmotic pressure, causing a drop in blood volume. Symptoms vary among individuals and may consist of the following: abdominal bloating, nausea, cramps, diarrhoea, weakness, diaphoresis and tachycardia. In most instances, symptoms appear within 15 to 30 minutes after a meal. The secretion of gastrointestinal hormones has also been implicated in causing hypotension and palpitations. Some postgastrectomy patients experience "late postprandial dumping syndrome" characterized by hypotension 1 to 2 hours after a meal (Morrison Management Specialists, 2002, B-8).

Only then did the surgeon discuss with Michelle the possibility of persistent and debilitating symptoms as a recognised complication for some bypass patients.

One participant received glucose tolerance and insulin resistance testing and her three-hour glucose tolerance test report recorded the following:

A normal fasting glucose of 4.5 with a corresponding insulin level 47pmols/L normal range being 40-80. This is not in keeping with insulin resistance. With her oral glucose tolerance test, she developed hypoglycaemia after 2¹/₄ hours with the blood glucose going down to 2.2. Her corresponding insulin at that time was 17 mols/L. However the insulin peaked at 45 minutes following the oral glucose load to 426 with a corresponding glucose of 10. This represents a somewhat exaggerated insulin response and shows the typical prolonged insulin effect causing subsequent hypoglycaemia (clinical letter, endocrinologist to GP).

In 2006, this patient discovered research (Service et al, 2005) relating to the overproduction of insulin-producing cells in post-gastrectomy patients. She wrote to the endocrinologist:

Does the newish research around the overproduction of insulin-producing cells apply to me? Can the original information and test results inform us about this possibility?"

The endocrinologist wrote to the GP:

I caught up briefly with Ms AR in the Endocrine Clinic today. She has found information regarding the possibility of pancreatic islet cell hyperplasia following gastric bypass surgery being related to late onset post-prandial hypoglycaemia. This would certainly sound biologically plausible.

The patient was awaiting an intra-arterial calcium stimulation test for islet cell hyperplasia indicating the possibility of treatment by partial pancreatic resection.²⁴ These were serious symptoms minimised by Ms AR's specialist in relation to the alternative risks of living large. His concern was focused on the benefits to the majority of WLS patients with diabetes who did not suffer such complications. An editorial in the NEJM demonstrated this position when it posed the seemingly rhetorical question:

Finally, should reports of Roux-en-Y gastric bypass-associated nesidioblastosis²⁵ be considered worrisome or promising? Nesidioblastosis probably represents the pathologic extreme of a phenomenon that would benefit the vast majority of obese patients with diabetes (Cummings, 2005, p.302).²⁶

8.4.3 The post-bypass surgery diet. So what were the day-to-day food experiences like following gastric bypass? Karlie's job and lifestyle were devoted to

²⁴One study suggests that restoring gastric restriction might treat such severe, recurrent hypoglycemia with pancreatic resection as a second-level treatment (Z'graggen et al, 2008).

²⁵The pathologic overgrowth of pancreatic beta cells (nesidioblastosis) following gastric bypass procedures may result in life-threatening hyperinsulinemic hypoglycemia.

²⁶A more recent scientific presentation has suggested that gastric bypass is causing glucose abnormalities: One practice indicated that 80% of their GB patients might be affected (Roslin et al, 2009).

her café, writing cookbooks and a cooking school. She has resorted to eating crackers because they dissolve more quickly than bread and do not get stuck in her gullet. Crackers are a mainstay for Janice as well: She has tried to retrain her eating but finds it difficult to restrict her diet to drinking fluids or eating “*baby food*.” Meryl declared that she hadn’t had surgery to “*spend the rest of her life dieting*.” In fact, her food and drink choices were limited and her meals required strict planning: Wine with salad-based meals or filling-up with water prior to a more substantial meal of one “*lamb chop*.” Ms AR could not eat sugars, fats, cereals, dried fruits, potatoes, breads, pastas, rice, wine, fruit juices and carbonated waters. Even small amounts of meat, fish, raw vegetables and fruits tended to get stuck.

8.4.3.1 Shona: Disordered eating following gastric bypass. Always ashamed of her weight, Shona’s dissociation from her body was apparent in the early postoperative period. Following her laparoscopic gastric bypass, Shona maintained a food diary on the Internet. She felt comfortable exposing her weight statistics to an Internet audience because “*I feel strangely removed from my body as though this isn’t “mine” anymore. I don’t want this one anymore!*” (diary). Her diary demonstrated her fixation with weight loss and bowel movements:

I haven’t eaten much lately (I am guessing that’s why it’s been 11 days since I last did #2’s) so I have decided I am going to have breakfast rather than dinner...if I am still hungry at night, I’ll have a few ice cubes of soup. If I am hungry.

She described freezing quantities of soup in ice cube trays, meal size: “*I now have (in the freezer) 112 meals of liquid broth (6tsp per meal = 1 ice cube). I won’t need to cook for myself for 78 days*” (diary). One day’s food was listed and commented on by Shona:

*4 tsps veges with cheese for brekkie
Small carrot, apple and lemon juice thru the day
4 tsps veges with cheese for late lunch at 2pm
4 tsps the same for dinner at 7!
And I just ate a 1/5 of a ripe kiwifruit mashed up, now – 8.17 pm.
Oinkitty oink! Now today I am feeling pretty low. So is this extra food a reaction to that?*

Having enacted a critical surveillance of each teaspoon of food consumed during one day, Shona described one bite of kiwifruit, one hour after her dinner meal, as piggish behaviour. Examining her conscience, through a virtual card-sort of culturally available excuse accounts (Monaghan, 2006), Shona assigned the transgression label of inappropriate self-soothing behaviour.

Shona referred continually to the bypass as “*the tool*” she had been given. She described her need to use it well by dieting and seemed excited by the possibility that she could be one of those patients who lost “*too much weight.*” Still “*on Atkins,*” Shona, a vegetarian, described her diet as an extremely sensible one. Even following pronounced weight loss, Shona was prepared to “*cut out that one meal a day and get down to 67 kilos.*” While eating just an extra small bite of fruit worried her, being able to eat a toasted sandwich “*without crusts*” had panicked Shona that it signified a return to former “*bad habits*” (diary entries).

Shona’s critical and anxious surveillance of her post-surgery diet was pervaded by a strong sense of morality and perfectionism. She believed that she was being “*a lot more vigilant*” in her eating than other WLS patients. In her determination to keep her weight loss trending down and her “*bowel moving,*” Shona resorted to taking 9 *coloxyl* (laxatives) in a three-day period:

I can’t swallow the capsules tho’ cos they’re too big and am scared it’ll get stuck so I poured its contents onto a tiny sliver of toast with vegemite and ate it... have never gagged so much in all my life lol. Now to hope it doesn’t kick in while I’m on the train.”

Shona sometimes forgot to take her iron tablet or was unable to swallow it: “*It’s either iron pill or dinner!*” (email). Thrilled with her weight loss, Shona rationalised that the loss of vitamins and minerals was a simple equation of a jab a month against continuing to be “*(...) obese. I know which I prefer!*” (email).

Shona’s weight-loss success prompted Dr M2 to use his patient as a contact for other women considering WLS. On interview for this study, Shona believed that she was different to other WLS patients:

I don’t think there was deep underlying psychological issues there, as would be evidenced by this dramatic change now that I’ve had my appetite cut off basically. Umm, but you have got people who have got mental issues around food and they’re struggling even after they’ve had the surgery.

In fact, three elements of Shona’s post-gastric bypass regime indicated that WLS had initiated anorexic behaviours: Extreme restriction of her food, the use of non-prescription laxatives as an aid to purging, and excessive exercise. Losing weight was triggering the desire to apply even stricter controls around eating: It seemed that the more Shona was losing, the more in control she felt and the more weight she wished to lose. The chronic restricted eating pattern of Jane (8.3.4) following lapbanding and Meryl (8.4.1) following gastric bypass would also raise concerns of disordered eating

responses triggered by pleasure in the control that losing weight was affording them (Fredrickson & Roberts, 1997; Tyrer & Burns, 2008). When patients lose weight following WLS “[...] problems tend to be glossed over by the patient. The ultimate outcome is still unknown, but it seems clear that many of the patients are in a state of controlled malnutrition, which may lead to progressive penalties” (Ravitch & Brolin, 1979, p.382).²⁷

One surgeon in the study referred to the induction of technical bulimia with WLS, though in Shona’s case, the indications point to the induction of anorexia/anorexia athletica. Shona was last interviewed within a year of her WLS when she was experiencing some dumping and required Vitamin B injections but her long-term prognosis is unknown. With her highly restrictive diet, the use of laxatives and her haphazard use of supplementary vitamin and iron, there lies the possibility for significant pathology akin to that suffered by other eating-disordered patients. Such long term effects have been suggested as atrophy of the brain, significant cognitive impairment, cardiac arrhythmias, infertility, osteopenia/osteoporosis, impairment of renal and hepatic functions and neurogenic bowel with subsequent rectal prolapse (Central Region Eating Disorder Service [CREDS], 2008). Openly critical of Shona’s limited diet, though also envious of the amount and speed of her weight loss, Michelle has followed a more diverse diet in the wake of her malabsorptive procedure. Nonetheless, she is displeased with her moderate weight loss given her significant financial investment and the radical nature of the procedure.

8.5 Discussion

A variety of WLS interventions have been promoted and performed within the private sector of medical care in New Zealand especially through the last ten years. The safety and efficacy of these procedures has been assessed in research that is conflicted by relationships with technology companies and surgical-series’ statistics that are confounded by considerations of trade and reputation. The effectiveness of WLS has tended to be focused on loss of weight and the appearance of health. Little attention is paid to the overall impact of radical WLS interventions. When type 2 diabetes remitted following gastric bypass, this remission occurred almost immediately following the surgery and was not dependent on diet and weight loss. Yet these patients were exposed to a major WLS procedure with ongoing and significant side effects. This

²⁷This related to an early form of WLS but is included here in relation to patients’ positive responses to losing weight despite ongoing side effects and the potential for long-term negative effects.

suggests that a full and radical gastric bypass procedure to control diabetes will prove to be as avoidable as they were for stomach ulcers.

From the moment of waking following their procedures, WLS patients entered a WLS lifestyle. A significant range of side effects impacted lifestyle. Food was clearly restricted with restrictions ranging from being unable to eat healthy foods and problems absorbing essential vitamins and minerals. WLS induced eating-disordered behaviours from chronic restricted eating through technical bulimia to manifest anorexia in which the physical control of food became associated with the cognitive and emotional aspects that control of food alerted or heightened. Researchers (Guisado et al, 2001) have indicated the tendency for some obese patients who lose weight to develop an intense fear of regaining weight resulting in anorexic-like symptoms following rigid diets or WLS procedures. In another study, narcissistic personality factors were predictive of high levels of compliance, and, therefore, of weight loss, at least in the short term (Pontiroli et al. 2008). This is a complicated scenario in relation to compliance. If compliance with WLS advice is correlated with higher levels of personality disorder and/or is more likely to result in significant eating disorders, these are themselves associated with noted increased morbidity and mortality. Such increases in mortality and morbidity relate to findings in a recent study (Adams et al, 2007) in which death from accidents and suicide were 58% higher for the WLS group than the control group.

WLS participants set out to find a way out of their dieting bind. Prior to their surgeries, participants were assured that the WLS technology would control appetite: The small pouch would limit food intake and patients would feel full on very small amounts of food. The pouch would function as the inbuilt will-power mechanism to controlling the amount of food that could be consumed.

However, conscious and stringent dieting was a striking feature of the post-surgery narratives of research participants. Worn down by years of living overweight and worried by the mediated morbidity, mortality and appearance issues that assailed them each day, these participants chose WLS to resolve their health/weight dilemmas. They undertook expensive surgeries to make proprietary diets and the need for ongoing conscious, burdensome restrictions on food intake redundant. Both bypass and lapbanding were restrictive procedures. Bypass was also malabsorptive. Surgeons assured patients that weight loss would occur – in the case of bypass, no matter what a patient ate (Dr M1) and in lapbanding, inflations would control the desire to eat and limit the amount that could be ingested (Dr Z). However, WLS participants continued

their pre-WLS struggle to lose weight and to maintain any loss they did achieve. Their talk featured significant WLS effects alongside conscious dieting discourse including continued enrolment with *Weightwatchers* or *Jenny Craig*²⁸ for some participants. This is a significant failure in informed consent: Had patients been informed of the ongoing need to struggle with weight and/or to be enrolled with proprietary diet companies, would they have considered the outlay for WLS to be of value?

Patently, financial advantages accrued to surgeon-traders,²⁹ who offered WLS, and to private hospitals that provided services to patients and surgeons. Participants accessed shares, family income, added to mortgages and borrowed from friends and families to finance these procedures. From no weight loss for a \$12,000 operation to 1 kilo per \$1,000 for a loss of 10 kilos, Shona achieved the best cost/weight ratio of these study participants at \$300 per kilo. The overall benefits to her health were uncertain given the side effects of her procedure and the possibility of disordered eating as a chronic condition. Even for two participants whose diabetes remitted, a better cost/benefit ratio may have been achieved by increased exercise and reduced stress with no surgical intervention. At a financial outlay of over \$40, 000 for one of these two participants, and over \$20,000 for the other, these radical surgeries have continued to cause them serious side effects.

When weight loss did not occur or there were problems with the procedure, blame was readily placed on patients with a history of failed weight-loss:

The major problem with the band has been the need for patients to co-operate. The successes are great for those who take ownership of their lives and work with the band, but in those who can't, weight loss can be minimal, or even non-existent (expert, HDC Opinion, 2003).

Medical professionals maintain negative beliefs about weightfull patients (Barclay, 2003; Brownell, Puhl, Schwartz & Rudd, 2005; Schwartz, 2003), and these stereotypes are alerted and confirmed when a weight loss intervention fails (Bruere & O'Connor, 1999). Such rationalisations are possible in the presence of widely held and negative stereotyping (Banja & Porto, 2004; Goleman, 1996).

In this chapter I have reflected on some side effects that accompany WLS. These challenge the ready promotion of technological fixes in the current trade environment of

²⁸ The fact that proprietary dieting was often an essential feature of post-WLS is also an issue in series-research promoting the efficacy of WLS. After all, what may weight loss reported in these studies be attributed to, the surgery or the proprietary diet?

²⁹For example, patients discussed their surgeon's ability to participate in expensive outdoor pursuits, to own very expensive cars, or to invest in or establish boutique hospitals.

WLS. WLS is neither a panacea for weight loss nor even a reasonable option for most overweight/obese citizens. WLS may prove to be more dangerous for the health of WLS patients than the obesity or diabetes they were intended to cure or control. WLS may need to be specified for particular patients.

In chapter six, I traced the cultural context of women and weight through the narratives of all women involved in this study. This provided some context for the choice of WLS options by some participants in this study. In chapter seven, I concentrated on narratives of decision-making for WLS before turning, in this current chapter, to critique WLS as a decision for health by exposing some significant side effects. A reasonable interpretation of informed consent provisions in New Zealand³⁰ is that patients should be fully involved in healthcare decisions. Such involvement has more recently been promoted as ameliorating the rates of iatrogenic injury (Davies & Ware, 1998; Groopman, 2001; 2007; Runciman & Moller, 2001). Yet some participants worried about raising issues with their surgeons and experienced considerable difficulty in so doing. In the following chapter, I use in-depth analysis of three narrative episodes in ongoing surgical-consultation relationships. These are brief but powerful expositions of attempts by some WLS participants to resolve issues related to their post-surgery care. In chapter ten, I relate the material in chapters seven to nine to the failure of informed consent processes in both the pre-surgery and post-WLS arenas.

³⁰In particular, I direct the reader to sections of chapter two of this thesis and in particular, 2.7.

"[...] if you want to understand what a science is, you should look in the first instance not at its theories or its findings, and certainly not at what its apologists say about it; you should look at what the practitioners of it do" (Geertz, 1973. p.4).

CHAPTER NINE

The questioning patient

“In fact, these rhetorical ruptures with rhetoric leave untouched and undiscussed most of what can be brought to light by a reflective return on scientific practice and its instruments that is not an end in itself but genuinely aims at improving this practice” (Bourdieu, 1988, p.775)

9.1 Introduction

The analyses in chapter nine highlight the relational micro-practices of WLS consultation when language is used to maintain and resist power. This reflects a Foucauldian notion of resistance as integral within relations of power (Foucault, 1977). It also relies on the notion of professional discourses as symbolic capital (Bourdieu, 1984) referred and deferred to within the consultation. When surgeons employed these practices in the aggrandisement of the self rather than in the interests of their patients, these were actions of symbolic violence (Bourdieu). Banja (2004) suggests that medical narcissism is at work when physicians relate to uncertainty in medical knowing and practice by rationalising or minimising errors and largely ignoring patients' needs and concerns. Medical narcissism is enacted when firstly, empathy for the patient is essentially vacated allowing (secondly) a “compulsive and insistent treatment-oriented focus that winds up “subtracting” the patient from his or her disease, and (thirdly) a communication/relational style that seeks to control the patient's beliefs, feelings and actions” (Banja, p.48).

As much as patients are encouraged to consider themselves experts or are handed the responsibility for questioning their practitioners, the expert patient arouses for medical practitioners an “unappealing stereotype of the dissatisfied, middle class consumer” (Shaw & Baker, 2004, p.723). Both doctors and patients experience questioning as potentially confrontational or even unpleasant. Better health outcomes are to be

experienced only by ‘good’ patients. For instance, patients may be preferred when they appear to be both “compliant and superficially cheerful. A patient who is openly distressed is as much a problem patient as one who is refusing to take her pills” (Oakley, 1993, p.40).

To this point in the thesis, relational aspects of participant narratives have remained constrained in the development of important and shared thematic threads. But these doctor/patient relationships of WLS consultation were complex, threaded by trade, culture, power/knowledge and framed within the modern context by ideas of the autonomous patient in partnership with a health practitioner. The model of the patient involved in partnership with their doctor has been developing alongside the increasing commodification of patients, the commercialisation of pharmacological and technological interventions, and serious conflicts of interest in the development of the science of weight and health. As well, the concept of ‘expert patients’ is being promoted (Department of Health, 2001; Robb & Seddon, 2006). Modern patients are spoken of as ‘empowered’ to make choices about their health; patients have access to considerable amounts of information to understand suggested health interventions; patients may become knowledgeable about or experts in their own conditions. Still, the more subtle operation of unchosen choices and the hegemonic operation of commodified and medicalised bodies underlie medical talk within doctor/patient consultations.

In chapter eight, WLS participants in this study talked about experiences of WLS including some significant side effects. Clearly, these women were highly motivated to resolve side effects and to achieve the best outcomes possible from these expensive and physically intrusive surgeries. But these were novel, functionally experimental procedures and little was known about them in the wider health community. Participants were highly dependent on relationships with surgeons that were trustworthy and functional.

I have chosen three episodes of communication for analysis¹ here and this is an analytic strategy to demonstrate the complexities in enacting consultation protocols when patients questioned aspects of their care. In essence, when patients indicated that a procedure had not worked, asked why they were not receiving promised treatments or requested an apology for a clinical mistake, this alerted “[...] narcissistic defences”

¹ I chose episodes that were supported by a range of materials in the interests of a complex account.

(Banja, 2004, p.48) prompting a surgeon to remove his ethical focus from the patient as self-protection. This chapter is based on a critical discourse analysis in which emancipatory elements suggests ways in which attending to consultation communication in new ways might have carried these relationships forward (Fairclough, 2001).

9.2 The telephone consultation and the question of recording²

Six months following her banding, a patient consulted the surgeon by telephone to discuss her failure to lose weight and the lack of inflations. She taped³ the consultation (HDC Opinion, 2003) preparatory to talking through her options with her partner. This patient was one of a number of women in the study who were hailed into the procedure by a documentary on New Zealand television (Unichem Medical File, July 1999). The surgeon fronting this advertising documentary had stated unequivocally: “*The patient can expect a slow, steady, weight loss over the two years following the operation.*”

The telephone consultation opened with a statement of failed expectation, “*Nothing is changed from what it was before*” (patient, TC).⁴ The patient has stated her failed expectations from an expensive surgery. When a patient adopts an active role in questioning the practitioner, that questioning “may be negotiated and accommodated or (the patient) may be perceived as confrontational and critical” (Roter & Hall, 2006, p.33). Physician response depends more on the physician’s personality and social characteristics than the presenting medical problem (Eisenberg, 1979). The patient expressed concern that she had lost no weight following her banding. The surgeon ignored the break in her voice, losing an opportunity to empathise with his patient (Levinson, Gorawara-Bhat & Lamb, 2000); he then dismissed her opening statement by defending his practice and procedure:

The thing is, from the start, we’ve always said it was going to be a long struggle. This is not a simple, straightforward way to go down where you are going to lose a steady weight loss all the way along, in that most people have problems here and there along the line (surgeon, TC).

²This information is based on the original recording of the telephone consultation (HDC Opinion, 2003).

³According to the Crimes Act, 1961 No 43 (as at 26 June, 2008), Public Act, 216B: Prohibition on use of interception devices

(1) Subject to subsections (2) to (5), every one is liable to imprisonment for a term not exceeding 2 years who intentionally intercepts any private communication by means of an interception device.

(2) Subsection (1) does not apply where the person intercepting the private communication—

(a) Is a party to that private communication [...]

⁴(TC) Telephone consultation, June 2000.

These statements contradicted those he himself had made as well as those made less than a year earlier in the television documentary (Unichem Medical File, July 1999). The surgeon ignores the fact that the patient has lost no weight. No loss is turned into the patient's unreasonable expectation of a "*steady weight loss all the way along.*" The patient asked the surgeon why he had decided not to inflate her band during one of her "*frequent visits to the clinic (as) necessary to adjust the diameter of the band*" (Information sheet, HDC Opinion, 2003).

Patient: *I'm perturbed by what I put into it and what I'm not getting out of it.*
Surgeon: *What we said at the beginning, it's up to the patient. We can only do so much (TC).*

The surgeon's rhetorical statements project failure onto the patient. Having given the patient only one minor inflation in six months, having installed a device for that reason alone, what was it that the surgeon was doing for the patient? This surgeon promoted, sold and installed a banding mechanism,⁵ for the sole purpose of inflations to produce weight loss by appetite suppression, an invasive⁶ operation. To withhold inflations was a significant clinical act. His suggestion that he had withheld the inflations "*because we thought you would rely too much on the band.*" (surgeon, TC), surfaced a bizarre illogicality: The surgeon appears to suggest that the mechanism be ignored and that the patient should lose weight by diet and exercise alone⁷ while receiving no assistance from inflations.

Inflations are produced here as an indulgence rather than an entitlement based on a clinical decision to proceed with the lapbanding operation. The patient questioned the overall worth of the procedure in a dollars-for-weight-loss equation, pursuing that element over which the surgeon maintained control: "*Why did you decide...?*" Such a question, while it opened possibilities for a wide-ranging set of medical explanations, constituted a challenge to the surgeon's control as evidenced in the patient's phrasing. The surgeon responded from within the discourse of risk in a powerful move to wrest back control over the patient and the consultation: "*You can actually cause problems by overinflating it, major problems and we've just had a near death from one. I think that*

⁵While the trade is more visible in private surgical practice, it is no less a trade in the public system and requires the similar levels of informed consent and ethical practice.

⁶Based on the physical presentation of these lapband patients following their surgery, the rhetoric that produced lapbands as minimally invasive surgery is questionable (CTAF, 2007).

⁷The surgeon had performed this procedure knowing that this client needed to lose weight to qualify for bilateral hip replacement surgery and could not exercise.

if we had inflated you, we could have made the problem worse (surgeon, TC). When this patient repeated the near-death story to a second surgeon, he had laughed dismissively (Patient's submission, HDC Opinion, 2003).

Urging his patient to comply with instructions was a rationalisation that acted also to discredit his patient: *"Do it our way! Because not doing it our way doesn't work"* (surgeon, TC). In ignoring the patient's question, *"What is your way?"* (surgeon, TC), the surgeon exerted control by refusing to acknowledge or respond to the patient's question. The focus was redirected away from the patient's concern with the failure of her procedure because of a lack of inflations and back onto her compliance.

Early in this taped consultation, the surgeon references three reasons for lapbanding not working: Band slippage, poor eating, or the attitude of the patient. In this telephone consultation, the patient is informed that inflations have been denied on the basis of the surgeon's preconceptions prior to the surgery: *"I think because of your attitude, right from the start with how we categorised you"* (surgeon, TC). This patient was accepted for surgery just a few months prior to this consultation following a selection process in which *"we spend a lot of time in selecting patients who might be suitable, and in preparing them for their surgery"* (clinical letter, surgeon to GP). A clinical letter written prior to the surgery, but only surfacing after it, suggested that the patient's occupation might prove to be an issue in relation to her compliance:

As she deals with stress counseling, and counseling of sexual abuse and marriage, she may find the programme a little of a problem... Sometimes there are many psychological problems unearthed, and in fact it would seem that some patients have just too many problems to be able to manage the compliance required by the lap band patients (clinical letter, surgeon to GP).

Here the surgeon relates the patient's occupation as based on a particular psychological profile. Such a use of "disparaging or stigmatising typifications [...] seems to represent the utmost abuse of the professional's power" (Atkinson, 1995, p.33). Banja (2004) refers to these behaviours as a form of medical narcissism: Based on the suspicion that the patient will not accommodate his needs, the patient becomes dismissible from the start. In referring to the possibility of psychological problems in this consultation, the surgeon applied them to the patient, even while he attempts to deflect that specificity: *"[...] they know what's really going on in their deepest hearts of course and of course there are often problems going on that they haven't told us about"* (surgeon, TC). In the rhetorical use of the third person plural, the surgeon articulated censure without

owning its effect on the person he is talking with. But he has not yet managed to stop her questions:

- Patient: *Like what? What are you wondering about?*
Surgeon: *Listen, (patient's first name), I'm just telling it the way I see it.*
Patient: *You sound like you are alluding to things. I'm not sure what you are meaning.*
Surgeon: *No, I'm not alluding to things. I'm just stating what we have analysed as evidence-based medicine (TC).*

In responding to an earlier complaint (HDC, 2001), this surgeon clarified his belief that his obesity patients had probably suffered sexual abuse.⁸

I did not delve into the psychological trauma that she has undergone, although she freely admitted that there was a problem that she had difficulty in facing. Statistically, I think the odds are high that this was sexual abuse as a child (HDC, 2001, p.11).

In the telephone consultation, the surgeon's failure to close the patient down is signified in the patient's request for clarification. He avoided answering her follow-up question but instead changed direction. By referencing "*evidence-based medicine*," he asserted medical privilege as giving him knowledge and authority to make clinical decisions about her. But what was the evidence-based finding that he was referencing: Was it that patients with "problems" need not apply for banding? Or that banding works without inflations? Or, that banding works if patients comply with instructions in the absence of inflations? The surgeon reiterated his conviction that the problem belonged to the patient and not to the band: "*If the band is in place, it's not the band's problem! It's the patient, the patient with a problem*" (surgeon, TC).

"We" was a confounding, rhetorical device that appeared in the surgeon's clinical letters, responses, and throughout the telephone consultation. While this patient's post-surgery consultations appeared to be with the surgeon alone, "we" conveyed the impression of a group of professionals who were continuing to consult with the patient and had reached a unanimous and objective medical opinion about her. The voice of the patient, already compromised by the implicit stigma of requiring WLS, then by failing to lose weight, was effectively silenced. The suggestion that the patient was "*going to rely on the band quite a bit*," (TC) was anomalous. Nonetheless, this suggestion was endemic in the language of lapbanders and appeared to emanate from their consultations with surgeons. Yet the lapband was promoted to patients as a freely

⁸For instance, an Australian study confirmed that neither past nor current sexual abuse was significant in the dieting or disordered eating behaviour in young to middle-aged women (Kenardy & Ball, 1998).

adjustable aid to weight loss such that, *“I was going to be able to adjust them and it would be great”* (Surgeon, HDC Opinion, 2003).

There is a point in the telephone consultation where two different conversations are taking place. The patient is asking about a clinical issue, but the surgeon is concentrating on the patient’s failure to lose weight:

Surgeon: *No, not at all. I would have put money on it.*

That his response referred to her failure to lose weight became clear:

Patient: *So you are not surprised that I haven’t lost weight on this?*

Surgeon: *I would have put money on it.*

Patient: *You would have put money on it? (TC)*

There was a clear disjunction in the recording here. The patient repeated what the surgeon had said in a stunned voice, paused, and as she spoke again, her concerns appear to have switched to her overall consultation history. The patient appears to have grasped the significance of the surgeon’s statement that he had never believed that lapbanding would work for her but she does not address this. The pause gives the surgeon an advantage that he uses to bring the consultation to an end: *“We need to find out what the cause is and we often play along with the patient, because they are really sort of part of the team as well”* (surgeon, TC).

What meaning can be attached to the idea of a surgeon *“playing along with”* a patient, who is only *“sort of part of a team?”* To play along with suggests not listening to the patient, or not taking the patient seriously, *“jollyng”* (Maguire & Pitceathly, 2002, p.698) a known blocking tactic. What does it mean to the patient who trusts that their doctor is attending to their care, seriously? In this extract the patient’s concerns were not being taken seriously: Her questions were overridden or answered generally; at no time does the surgeon pick up cues, paraphrase to ensure that he and the patient are talking about the same issue; he does not demonstrate that he has grasped her concerns and he does not acknowledge the patient’s concerns. Within this telephone consultation, the spectre of lapband slippage increased the patient’s uncertainty; the firmly stated belief that the surgeon never expected her to lose weight with the procedure eventually deflected the patient’s focus.

Significant in this consultation and in the HDC investigation (2003), both the patient and the Commissioner fail to pick up the dexterous conflation of banding with inflations. The patient failed to focus the telephone consultation on inflations and this

sustained the surgeon's ability to remain essentially unresponsive. Significantly, this is the first time that the surgeon tells his patient that lapbanding would be unlikely to resolve her weight.

9.2.1 Discussion: Telephone consultations and taping consultations. The taped telephone consultation between the surgeon and his patient was an important one for the patient, accepted by the surgeon, and carried out by telephone because of geographical distance, a major reason for such consultations to take place (Car & Sheikh). What happened in this consultation became evidence that was largely discounted in a complaints' process (HDC Opinion, 2003). There are two particular aspects of recorded and/or telephone consultations that are important here: Firstly, there are the legal and moral aspects of taping a consultation, and secondly the poor clinical quality of phone consultations.

New Zealand case law states that one of the parties to a conversation has the right to tape it, and, if the original recording is available, it can be treated as "real evidence" (Cross on Evidence, p.5056, Section 1.34). The independent expert, a surgeon, declined to review the taped consultation on the basis that "[...] *it was recorded without (the surgeon's) knowledge or consent*" and because "*I do not feel that such information would be legally admissible should any further action stem from this complaint*" (HDC Opinion, 2003). The surgeon-advisor's feeling rather than the law dictated what material he chose to consider in relation to this complaint; in the use of the word "*surreptitiously*" the HDC also rebuked the patient for taping the consultation: "*You have repeatedly referred to your surreptitiously taped telephone conversation*" (letter from HDC to patient). But this was not the tape of a "*conversation.*" When the patient sought medical advice by approaching the surgeon, it became a consultation (Usherwood, 1999). In this instance, she sought advice in relation to a failed surgical procedure; the consultation was requested by the patient and freely entered into by the surgeon; this was an ongoing medical relationship based on a surgical intervention; accountability lay with the surgeon for respectful practice; decisions should be based on clinical realities not a surgeon's "*gut*" feelings; decisions needed to be made with the patient, not for or about her; and, finally, any communication between patient and practitioner was protected within the bounds of the fiduciary⁹ relationship.

⁹Talcott Parsons (1978) referred to the fiduciary nature of the doctor-patient relationship indicating its essential 'trust' features.

When the subject was clinical concerns, how did taping or not taping the consultation change what was being asked and answered by patient and surgeon? Is the ‘Hawthorne effect’ (Mayo, 1975) disregarded in relation to medical consultations? If the worker (the surgeon), knew that he was being watched (taped) his rate of work (the tenor or quality of the consultation) improved. If openly taping a consultation about the failure of a procedure improved the surgeon’s impression management, then that would clearly bring into question the general standard of behaviour of doctors and the safety interests of patients within traditionally private, consultation relationships. In this instance, it would have added a further level of confusion to the complex layering of discourses evident through this consultation relationship. In the expectation of appropriate communication by most professionals, taping should be welcomed by a practitioner as a demonstration both of his competence and empathy, rather than feared and discounted.

Telephone consultations have been an essential tool in the delivery of health care from Alexander Graham Bell’s first recorded call for help after spilling sulphuric acid over himself (Car & Sheikh, 2003). Yet telephone consultations¹⁰ have been described as disturbingly inadequate (McKinstry & Sheikh, 2006). WLS is a procedure that is carried out in limited geographical locations in New Zealand. Consequently, telephone consultations are promised and relied on for continuity of care between face-to-face consultations in the clinic. The telephone is also an essential aid between providers when adverse events occur. The skills required for telephone consultation are generic to all medical consultations (Car & Sheikh): For example, the length of a telephone consultation should be of comparable length to a face-to-face consultation for the same problem, and active listening skills aid all aspects of any consultation (Maguire & Pitceathly, 2002). Any communication between a doctor and a patient contains elements of privilege; notions of the best interests of the patient dictate that communication between doctor and patient will meet basic professional standards in relation to care. As a consequence, any consultation needs to be of a standard that would tolerate the potential for it to be recorded, monitored or evaluated.

9.3 The voided contract

Scrapper and her surgeon signed a pre-surgery contract for lapbanding: Scrapper agreed to attend follow-up appointments and follow a dietary plan and the surgeon would

¹⁰This taped consultation constitutes valuable research data given the dearth of consultation data that arises naturally.

provide inflations and follow-up care. Scrapper described this contract as being unilaterally terminated when she asked the surgeon to acknowledge a faulty inflation.

Following an initial inflation at five weeks, Scrapper received two further inflations to reach a 4 mls inflation six months out from the surgery. At a point when her weight loss was described by the surgeon as “*tailing off*” with her BMI still in the “*risk range of 37*” (clinical letter to GP) Scrapper was given an inflation. She experienced no benefit from this inflation. Indeed, her eating was facilitated rather than diminished following the inflation: She requested, but was refused, a further inflation. Her failure to lose further weight following the inflation was assigned to psychological factors and she was directed by the surgeon to consult a psychologist.

The surgeon wrote to her GP: “*I do not think we should inflate the band at this stage. This leads to the danger of the patient relying too much on the band*” (clinical letter). In this same letter, the surgeon also criticised Scrapper’s diet, specifically referring to the patient as having only reduced from eating “*two sausages to one.*” The surgeon also wrote that Scrapper had been “*angry and seemingly a bit aggressive to the receptionist.*” In the reflecting team, Scrapper described her shock when the GP shared the contents of the clinical letter with her. She rang the receptionist, who said, “*I was actually mortified that I had to type that up and that I was being portrayed as saying that you were being aggressive to me.*” And she said, “*You never have been!*” This receptionist left the surgeon’s practice. Scrapper’s GP was asked to work with the patient on her diet and attitude:

Therefore can I ask you to become involved in this respect as well, or we are not looking at a good long-term result from the lap band and all has been wasted (clinical letter).

After consulting with Scrapper, the GP responded to the surgeon:

[...] lapses and comfort eating are the exception rather than the rule. She remains motivated, and I must say she looks stunning. I hope that you will be able to perform a further inflation for her (clinical letter, GP to surgeon).

The surgeon performed the inflation in which the existing level of fill was discovered to be markedly lower than the level indicated in the patient’s notes following the previous inflation. Concerned that she had been held responsible when it was the clinical inflation that had failed, Scrapper wrote to the surgeon:

I am writing to express my concern at the outcome of our last three meetings along with the content of the letters you have written to my general practitioner [...]. To me, with the band only having 3.5mls in it, clearly explained all the

symptoms that I had experienced and why my weight had plateaued. Since having the inflation to 4 mls, my weight has dropped steadily and my hunger has vanished. I feel upset that you have not acknowledged this to me personally or in your letter to my family doctor (letter to surgeon).

Scrapper's letter also acknowledged her former experience of the surgeon's caring and compassion; she spoke of her wish to rebuild the relationship and asked for their pre-operative contract to be realised. She then requested that the surgeon waive his fee for the failed inflation and acknowledge that the problems she had experienced were in fact related to faulty-fill levels rather than to psychological factors. In response, the surgeon returned her cheque and advised her to consult a surgeon in another city: "*The contract was made preoperatively and is not a unilateral decision*" (Surgeon's reply to Scrapper).

Scrapper was currently without a surgeon. In asserting her understanding that a clinical error had been made, Scrapper was dismissed from the practice. The reflecting team (RT) discussed what "*standing up to a surgeon*" entailed:

Scrapper: *I don't know but as much as everyone would say "Oh yes, he's being a bit of a pig, and he's this and he's that, they all kept going back. Nobody ever had the courage to stand up to him.*

Marjorie: *That's while they were still losing weight.*

Michelle: *Well there was so much to lose to stand up to him.*

Scrapper: *But I never really stood up to him. That was the thing; all I did was question the fact that I wasn't losing weight and he kept coming back and telling me it was all in my mind.*

In this discussion, power was a fact of consultation life that patients believed they needed to manage with some care. Resistance, in the form of questioning or speaking up, risked the refusal of inflations; the characterisation of being non-compliant or having a "teenage personality" (RACS, 2003) occasioned a psychological referral; telling the surgeon that it was possible to eat more following an inflation incurred a referral to the dietician (Reflecting team). Problems with inflations did not focus on the lapband, technique or technology.

Scrapper referred to patients who had written to the support group website complaining about not receiving inflations: "*Lording it over us. You know he's almost got, you know, "I've got this power. I've got the needle. I'll decide. Not you"* (Scrapper, RT). Uncertain about the safety of the band mechanism, unable to access inflations, concerned that in the event of a recall of any part of the technology she would not be contacted, Scrapper has considered making the surgeon "*accountable*" by

laying a complaint with the HDC.¹¹ By implanting this mechanism, Scrapper believed the surgeon had an ongoing obligation “*to see it through for the life of the band or the life of the patient.*”

9.3.1 Discussion: Termination of consultation relationships. Patients may choose to end a medical consultation relationship and doctors may choose whom they treat. A finding of legal liability for abandoning a patient is difficult to achieve (Menikoff, 2002). Bioethics suggests that a doctor needs to provide an opportunity for the patient to find another practitioner: The doctor is not bound to consider the patient’s circumstances such as travel or costs (Menikoff). However, there are several particular elements in Scrapper’s narrative that make abandonment in this instance problematic. In particular, the surgeon implanted an unfamiliar technology; the doctor and the patient had signed a contract for life; this surgeon was the only one available to inflate or deflate the banding without a four to six hour journey between cities.

Desertion is recognised as one of four major problems in communication that prompt patients to lay complaints (Beckman, Markakis, Suchman & Frankel, 1994). Desertion of patients may be considered professionally unethical in relation to the moral responsibilities inherent in medical relationships (Bismark & Paterson, 2005; Cunningham, 2005). Abandonment in clinical encounters is another aspect of medical narcissism such that when “health professionals whose sense of self is so fragile that when their need for narcissistic supplies is disappointed, they react in a markedly immature and non-therapeutic way” (Banja, 2004, p.58). Katz (1984/2002) interpreted this as a form of projection such that when a doctor felt pressured by uncertainty or challenged in relation to professionalism, fault could be projected back onto patients. When Scrapper questioned an aspect of her treatment, this triggered the surgeon’s heavy investment in his work as a source of respect and he acted to terminate the consultation relationship rather than work through the concerns expressed by both the patient and her GP. The physician exerted his authority (Roter & Hall, 2006) and withdrew medical oversight for this lapbanded patient.

Overall, the potential for finding a way to continue this relationship was present in this account: An acknowledgement by the surgeon of a problematic inflation, and a reworking with Scrapper of the parameters for giving and receiving inflations, could have reinvested this as a working consultation relationship.

¹¹Scrapper asked me about the technicalities of making a complaint: I referred her to the HDC website.

9.4 The meaning of tears in the consulting room¹²

When this research began, there had been no reports of early post-operative deaths following bypass procedures in New Zealand. Potential bypass patients such as Michelle were reassured by this statistic. However, Rosie almost died following her conversion to bypass and was experiencing long-term, adverse outcomes.

In the hospital, following her revision procedure, Rosie reported increasing levels of pain to her surgeon:¹³

He told me just to “Harden up,” because I’d had an anxiety problem and he thought it was that.

Having visited Rosie on the third evening out from her bypass conversion, Michelle recorded Rosie’s progress:

Went to visit that patient last night (surgeon’s first bypass/lapband conversion). Poor thing was in agony. Apparently he had read her the riot act and told her to stop dwelling on how much pain she was in and get up or she would definitely get a clot or pneumonia. Then he promptly told her she wasn’t allowed any more strong pain medication (email).

For patients, pain prompts the search for medical intervention; the practice of diagnosis, however, “largely precludes the actual expression of suffering by patients” (Heath, 1989, p.114). As well, pain may be interpreted as personal failure for some practitioners (Korsch & Harding, 1998); and, the more dramatic the representation of that pain, the more likely the practitioner is to discount it (Korsch & Harding). Rosie’s pain talk did not activate a diagnostic activity to establish its cause (Heath). While intra-abdominal sepsis may present somewhat subtly following gastric bypass, it needed to be actively investigated at least on a daily basis (Cowan, 2005); abdominal pain was a significant sign for sepsis (Thodiyil, Rogula, Mattar & Schauer, 2005). But the surgeon discounted Rosie’s pain talk; her expressed concerns of post-operative pain became a manifestation of her “mental weaknesses” (Jackson, 2005, p.339).

Four days after her bypass surgery, Rosie collapsed. Transferred to the local public hospital, Rosie spent two months in ICU:

That night, I almost died. They operated and apparently there was 2 litres of bowel contents emptied into my stomach. They told me that they smelt me before they saw me. They told my family that I probably wouldn’t make it

¹²This analysis is based mainly on the recall of the patient. Significantly, Rosie’s recall is conversation-based and there is some triangulation of Rosie’s concerns in an email to the support group, written prior to Rosie being admitted to public hospital. As well, Rosie accepts the surgeon’s approach overall.

¹³Rosie’s recall of the surgeon’s words

through the night... I was in an induced coma for two weeks... I almost died three or four times. I was on dialysis, and every organ just was closing down. I came out of ICU after two months. I'd had 8 operations and 16 procedures, and my husband said at one point I had 18 tubes coming out of me.

Three months after her bypass, Rosie returned home, having difficulty walking and with a nasal feeding tube: *"I remember so clearly thinking, nearly every day in that ICU unit, I'd rather be fat than go through this. It was hell, it was absolute hell."* On reinterview in 2005, Rosie was wearing a wig; she had lost her job; she was starting to walk but still counting the steps; she had been diagnosed with post traumatic stress disorder. She described herself as *"a walking miracle."*

Clearly agitated by the near death of his first bypass patient, the surgeon repeatedly requested Rosie and her husband to consult with him about the procedure. Believing that closure was possible, Rosie and her husband were persuaded to attend an appointment:

I walked in the door and he started crying. It just blew me away and he said, "You have no idea how good it feels for me to see you walk through that door," he said. "I just can't believe you're here." And then we sat, we sat there for an hour and it was so good.

The surgeon's tears impressed the patient. This was a powerful display in which the surgeon's concerns trumped the concentration on his patient (Banja & Amori, 2004). In the patient's report of this post-surgery consultation, the surgeon appeared to be acting to protect himself from a formal review. For instance, he aligned himself with Rosie's husband:

He told us how he would say to Craig, "How have you slept?" and Craig would say, "I've slept a couple of hours," and Zed would say he hadn't slept much more than Craig did, (that) he couldn't sleep at night, because of what had happened to me.

While concerns about his (by then former) patient would have been appropriately evidenced in checking on her progress, entering into the intimate circle around Rosie was "not about" Rosie but about the surgeon. In the event that the surgeon's sleep pattern was disordered, this needed to be discussed with the surgeon's advisors, not Rosie or her family. It is interesting to note here physicians do not routinely seek psychological help following an error (Gallagher, Waterman, Ebers, Fraser & Levinson, 2003). The surgeon's attention needed to be focused on increasing precautionary care for his existing patients, by, for instance, reducing or discontinuing surgical procedures in the meantime.

Patients have questions regarding the cause of error (Gallagher, Waterman, Ebers, Fraser & Levinson, 2003). In this post-surgery consultation, Rosie wanted to know why the surgeon had dismissed her pain with words like “*Harden up!*” The surgeon deflected her enquiry by querying her recall, then dismissing it: “*I don't remember that.*” The surgeon discouraged her attempts to voice her concerns (Brown, 2006; Byrne & Long, 1976). Rosie recalled having to repeat her assertion, “*I remember you telling me that.*” The surgeon responded by pointing out her tendency to anxiety: “*We didn't know whether the excruciating pain you were in was the anxiety or not.*” Patently if, as Rosie recalled, she had described her pain to the surgeon as “*excruciating,*” that was a significant account of pain to be dismissed as anxiety.

As this final consultation proceeded, the surgeon assured Rosie that he had been very careful with this first procedure; he repeatedly amplified his reputation and surgical performance by mentioning discussions with “*Mr Fobi himself, who he was friends with, in the States.*” Fobi was said to have agreed that the surgeon had done everything correctly. The surgeon indicated that “*the staples*” may have failed, even while the staple line company reported that their staples had never failed. In positioning staple breakdown as an accident, both the patient and the surgeon could be positioned together as victims of the technology: “*None of this was your fault,*” he said, “*It wasn't my fault either. It was just a staple breakdown.*” The surgeon also indicated that Rosie’s “*fat cells made it hard to get at things*” making it once again the patient’s fault.

Towards the end of the consultation, the surgeon attributed his survival during a marathon event, to Rosie’s bravery: “*He said my face kept appearing there in front of him and he'd think, “Rosie's not giving up, I'm not going to give up.”* In this representation, the surgeon took on victim status, another person who has fought to survive. Rosie was positioned as the surgeon’s saviour.

On reinterview for this research, Rosie continued to question why her operation had almost ended in her death. She recalled the immense effort it had taken to survive and recalled blaming her condition on the surgeon:

I remember thinking, blaming Zed and thinking I'm not going to let him, I'm not going to allow him to let me die. Yeah, I honestly thought, I'm not going to let him. He's not going to kill me. I'm not going to let him.

Although she now blamed herself for choosing an inexperienced laparoscopic bypass surgeon, Rosie emphasised that her clinical condition would not have deteriorated had the surgeon reacted appropriately by taking her reports of increasing pain seriously.

In this post surgery consultation, the original bypass surgeon dispersed and deflected blame. The surgeon attributed some blame for her present condition to “unnecessary” procedures carried out in the public hospital. This suggestion perturbed Rosie:

I thought to myself, “Well if I didn’t have to have all those operations, um it might have been better!” But then the thought came to me that “those operations also might have saved me!” How do you know? I’ll never know, because I mean you can’t undo what’s been done.

9.4.1 Discussion: Attending to needs in consultation. The pressure on Rosie to place her near-fatal operation in the past has been immense. The surgeon’s many efforts to delimit the fall-out and deflect the blame elsewhere was evidenced in visits, letters and within this final consultation; her brother-in-law/GP, who referred her to the surgeon, also encouraged her to move on from it. A review of Rosie’s experience would have been actioned in the event of her death or in the laying of a formal complaint. That this did not happen served only the interests of the surgeon. This was a series of events that required an extensive consideration of safe operating practices around WLS.

In a final move, at the end of the consultation, the surgeon called on Rosie to give him a hug:

But as we were leaving he said, “Can I please have a hug?” And I went “What?” I just couldn’t believe that ‘cos he is so not that kind of person. And he gave me this almighty hug, and he wouldn’t let me go, and he was crying almost again and um...I was just overcome, I didn’t know what, I just thought that he’s obviously ...it just softened my heart towards him because I thought well you can’t fake stuff like that. You know the tears and all that was not faked. And I said to my husband when we got in the car, “Do you think that all that was genuine?” And he said, “Absolutely.”

Rousseau (2003) has suggested that the profession and the public need to support the expression of emotions, including tears by physicians. Such tears, though, would be a show of empathy, “persons meeting other persons who suffer” (Rousseau, p.252). An emotionally mature person is one who can perceive and read emotions in oneself and in others; using emotions, they are able to adapt and facilitate modifying behaviors; they understand emotions and how these relate to particular experiences or life events; and, they manage emotions competently in self and others (Grewal & Davidson, 2008; Mayer & Salovey, 2003). In this narrative, from the initial tears of the surgeon through to his request for a hug, Rosie was prompted to look after the needs of the surgeon: “Can I please have a hug?” In her description of his “almighty hug,” and “He wouldn’t

let me go,” indeed, in the very request for a hug, this post-surgery consultation was about the surgeon and not about the patient. Rosie was bewildered by these displays of emotion, and her description of the interview as “*good,*” rested on ascribing the surgeon’s tears as a sign of empathy. But this final consultation did not focus on Rosie nor did it lay her concerns to rest. Tears and hugs were powerful physical deflections of the patient’s concerns to control the patient and manage any potential for an enquiry into this procedure. The surgeon did not take responsibility nor offer an apology. In this report of a consultation following a life threatening medical event, the surgeon remained unable to suspend his concerns in favour of his patient’s.

Rosie asked a major question in this post-surgery consultation, and continued to ask it on reinterview: Why did the surgeon not act following her reports of excruciating pain? The implication of her question remained: “If the surgeon had responded to my pain, I would not have almost died or been critically ill for so long that my future health has been so severely compromised.” While the surgeon’s stapling technique was one probable technical failure in this operation, increasing pain, expressed by the patient and largely ignored by the surgeon, was the clear manifestation of an incipient septicemia. An experienced gastric bypass surgeon has recommended that

[...] the best policy is to have a very low threshold to return a patient with a suspected leak to the operating room without delay. Failure to do so is the most common cause of preventable, major long-term disability or death in bariatric surgical patients (Livingston, 2005, p.855).

When the surgeon decided that Rosie’s pain was psychological, he had fallen into a cognitive trap (Groopman, 2007; Groopman, Miller & Fins, 2007). This was the surgeon’s first laparoscopic bypass. The surgeon’s lack of experience with open gastric bypass procedures and his failure to act on his patient’s pain for four days, precipitated a cascade of events that almost caused Rosie’s death and has resulted in ongoing morbidity.

9.5 Discussion

The scarcity of WLS procedures and experienced surgeons in New Zealand ensured that WLS patients were highly motivated to avoid relational problems in WLS consultations. Invested in these procedures, participants wished for weight loss with minimal negative impact on their lives. But WLS is a physically intrusive intervention with proliferating side effects and uncertain outcomes. Recovery and ongoing wellness are not always possible particularly with experimental procedures. However, honest and open

communication between patient and surgeons was obligatory. Patients need to question practice and discuss concerns whether that is about the intervention or the communication. They needed to be safe from any form of retribution when they did so.

Patient safety, physical and psychological, rests on improving systems within the medical environment in which care is accessed and delivered (Leape & Berwick, 2005). This present research traces problematic consultations both before and after WLS procedures. Bombarded by negative imagery and risky accounts of living large, women entered highly mediated surgical environments in which WLS was discussed as a reasonable surgical solution. Trusting medical advice to be disinterested and applicable to them as individuals, participants accessed these procedures. With the inexperience of some practitioners and the experimental nature of these surgeries, patients encountered a range of complications. Surgeons managed their patients in ways that avoided formal review. Even when a consultation, surgical blunder or other issue was considered by the HDC in New Zealand's no-fault health practice environment, these surgeons did not admit fault, reflect on their practice, or accept the few, mainly minor, findings against them (HDC 2001; 2003). In the complaint that included the telephone consultation, the patient's concerns and evidence were less preferred to those of the surgeon in that forum. Repeated complaints and patient deaths may encounter less resistance.¹⁴ Narratives of complaints' processes from the Medical Disciplinary Committee and the HDC Office were littered with displays of what has been referred to as medical narcissism (Banja, 2004; Banja & Porto, 2004). Such displays were evidenced in the talk and practice of some surgeons referred to in this research.

In 1984, Katz (1984/2002) made, what was then considered to be, a rather radical suggestion: Doctors and patients should talk with one another. Aspects of his analysis relating to problematic patterns of communication remain pertinent in this thesis even while his portrayal of patients as able to exercise only acquiescence or silent rebellion remain very limited notions. Degrees of speaking up, questioning or leaving a doctor's practice have long been part of patients' repertoires for dealing with unsatisfactory relationships, sustaining Foucault's thesis that resistance and power coexist in some degree of symbiosis (Foucault, 1982).

¹⁴During the editing process for this thesis, the apparent first death in 2006 resulting from WLS was subject to HDC (2008) review (Opinion Case 07HDC11318) and referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994. A report was also made to both the Medical Council of New Zealand and the Royal Australasian College of Surgeons.

Even so, conservative traditions in medicine and the maintenance of traditional aesculapian power profoundly affect the nature of what is spoken, what may be spoken about in consultation and the tenor of that communication. For instance, when patients asked questions or requested an explanation, this challenged the customary authority of a doctor. Indeed, it was interpreted as an attack on the basic legitimacy of the professional doctoring role (Millward & Kelly, 2005). In the codification of communication within a specialised languaging in which doctors are well versed and patients lack expertise, and, in doctors' failure to acknowledge areas of medical uncertainty specifically related to a patient's situation, communication broke down. Some patients read the uncertainty in their medical predicament but were unable to address it; others trusted some form of reassurance by their doctor when trust was unwarranted. Katz (1984/2002) suggested that doctors deal with uncertainty by a system of professional defences that projects the problem back onto their patients whom they describe as unable or unwilling to manage medical uncertainty. Trust however, rests in the "mutual recognition of the capacities and incapacities of both parties for coping with [...] vulnerabilities engendered by uncertainty" (Katz, p.563). Patients were confused and abandonment resulted when physicians failed to listen to patients or answer their questions meaningfully (Katz).

In Chapters 6 through 8, I traced the effects of women living encultured-thin lives. In particular, I showed how this influenced their decision-making for health. In Chapter 7, some women participants had been recruited into radical WLS options, and in Chapter 8, some of the side effects of choosing WLS were clearly evident. In this current chapter, women had consulted their surgeons about problems with their surgeries only to meet defensive, controlling styles of communication. This communication prevented any ready resolution of the clinical concerns for patients. In Chapter 10, I focus on the context of informing consent for WLS in New Zealand. Specifically experimental WLS procedures were being performed as standard care without sufficiently informing patients and without seeking consent in ways that promoted the overall benefit to patients above a variety of surgeon agendas.

“A liability of having a neocortex is that humans make errors”
(Banja, 2004, p.7).

CHAPTER 10

Weight-loss surgery consultations: The failure of informed consent¹

“Today we seem to believe that research is its own justification, that it is in itself a desirable pursuit. The research “status quo” needs to be relentlessly reexamined by all of its stakeholders: investigators, funders, patients, and anyone who might ever participate in, or benefit from, clinical trials – in short, all of us”
(Wolpe, 2003, p.vii).

10.1 Introduction

Performing WLS on largely-well women constitutes an imminent threat to their life and health. Fully informing consent for these radical surgeries constitutes both a legal and a moral obligation for doctors. However, as I demonstrate in this chapter, informed consent for WLS was ritualised as a technical and legal requirement. This was a consent-taking that prioritised the agendas and protection of surgeons above the health interests of these patients. Specifically in this chapter I trace the performance of WLS surgeon-traders and discuss the impact on patients’ health when the interests of patients became even partially subsumed to those of medical commerce and professional self-interests.

Discussing procedures and signing a consent form merely begin a process of informing consent. An ethical relationship of consultation for experimental WLS requires that consent to be based on fullest information and to be ongoing. Any form of persuasion to undergo these surgeries was inappropriate. Bombarded by their designation of being “at risk” of co-morbidities and early death through their weight, participants contemplated major surgery. For example, laparoscopic surgeries were

¹ Research note: In this chapter I have referred to material that was triangulated by being publicly aired in one or another forum and supported by documents in others.

promoted as less radical while clearly all WLS procedures were both invasive and risky. When surgeons promoted procedures in which the body is entered and reformed as minimal and non-invasive, they created a false impression for the patient. Essentially, preoperative consultations needed to be sites for beginning a process of informing consent. Consenting in WLS needs to continue through the surgery and follow-up into the longer term.

Gains and losses, serious operative and post operative problems, fills and spills, unfulfilled claims of dietless options and variations in the potential for healthy and sustained weight loss have highlighted the very real risks and disappointments to which some WLS participants were exposed. This chapter clarifies and specifies what has become apparent through Chapters 7 to 9 of my thesis: In the private sector of New Zealand medicine, a less regulated and visible practice environment than the public sector, patients were being recruited into WLS procedures without being informed of quality issues surrounding some devices; participants did not understand the very real and imminent threat to life that undergoing these procedures entailed; they were not informed of the lifetime of uncertain and proliferating effects following the implantation of these intrusive interventions; and, systemic problems with training, equipment and proctoring protocols were not discussed with patients before consent for these procedures was obtained. These factors vacated informed consent for these experimental WLS procedures. I suggest that these surgeries were in fact performed without the consent of patients.

Medical science cannot avoid philosophical questions (Thayer-Bacon, 2003), those questions that specifically relate to morality in the practice of medicine. In this thesis questions about the ethical basis of informed consent for WLS pervade the everyday contexts in which these procedures were discussed, offered, performed and supported. The modern ritual of informed consent in the clinic (Wolpe, 1998) based within autonomy essentialises fully informed decisions about health. However, concentration on its legal enactment avoids calling attention to the widespread systemic uncertainties in health interventions and the relational aspects of care required for the fullest accomplishment of consenting.

Surgeons distanced themselves from responsibility in WLS decision-making: This was evidenced in the way they spoke and the decided lack of accountability when procedures did not go well. But participants did not, indeed could not, proceed to surgery unless WLS was recommended to them and agreed on by the surgeon. There is

a chicken-and-egg argument here. Undoubtedly, patient eagerness for these surgeries was fuelled by a number of factors within and outside the pre-surgery consultation. These include cultural preference for thinned weight, DTCA advertising associated with WLS procedures, media presentations of public health issues, and, governmental support for the weight-health paradigm. Through a series of “action upon other actions” (Foucault, 1982, p.791), including the proverbial wink and a nod in WLS consultation, by surgeons enacting the privilege of their positioning and patients permitting it, ‘the sale’ of these procedures was clinched.

In this final data chapter, I am particularly interested in the operation of power in consultation and I employ a Foucauldian analysis of the discourses surfacing in participants’ accounts. The withholding of vital information from patients was a major exercise of power in the consultation. For instance, it became clear early on in the research process that WLS patients were never informed that their procedures remained experimental. As well, patients were unaware of the learning curve for early-on procedures with clear differences in mortality and morbidity statistics for an experienced over an inexperienced practitioner. Gaining informed consent to perform a surgery is one thing: Keeping patients informed and continuing to seek consent is essential in ongoing ethical relationships of consultation. Through this research, cursory attention was paid to informing consent throughout the process of WLS consultation.

In the first narrative, patient B suffered iatrogenic injuries from her transected bypass revision, the first of its kind in New Zealand.

10.2 The first Australasian transected bypass: Patient B.²

In a Medical Disciplinary Tribunal, a revision gastric-bypass patient alleged that the surgeon did not inform her of the possibility of serious harm from her revision procedure. The Tribunal agreed and imposed a substantial financial penalty. The surgeon proposed a radical new procedure to which the patient agreed within a twenty-minute consultation (Langdon 2000a). The surgeon was convinced about the potential benefits of transected bypass surgeries; he considered himself trained and experienced in related surgery; he wished to be in the vanguard of the new procedure. He proposed the new operation and “[...] wittingly or unwittingly, his enthusiasm about matters has

² This information is based on direct quotes from a medical disciplinary proceeding (Langdon, 2000a; 2000b). I use it to emphasize the problem with first procedures.

misled (his patient)” (Counsel to the Tribunal, in Langdon). While the surgeon expressed regret at the outcome for the patient, he argued generally “[...] patients should share the responsibility for discussing risks with their doctors” (surgeon, in Langdon).

The patient’s statement resonated with the cultural prescriptions that envelop the surgeon/patient relationship: “We put them on pedestals and maybe that’s our fault, but it’s a two-way thing” (patient B, in Langdon, 2000b). The metaphor of the pedestal indicates a trusting reverence accorded to medical professionals. Doctors believe themselves to be “prototypical professionals” (Kassirer, 2005, p.72) whose judgement needed to be trusted implicitly. In this instance, the patient understands from her medical predicament that she has overly trusted the surgeon. While she initially suggested that “maybe this is our fault,” patient B undermined this culturally appropriate, verbally-gendered responsibility by pointing out the brevity of the consultation and the tantalising of her agreement by the confident demeanour of the surgeon: “It never occurred to me to ask if I was going to die, which is what nearly happened” (patient B, in Langdon).

Brief consultation promoted the interests of the surgeon. It was economical in time and energy and he achieved agreement to perform the first transected bypass in Australasia. The patient could not be expected to grasp the implications of a radical new surgery within a twenty-minute consultation. While her symptoms increased the likelihood of securing the patient’s agreement, the brief consultation did not deal with the safety of first procedures, the complexity of revisions, the surgeon’s operating history, or the very brief history of transection. The patient could not give fully informed consent.

10.3 A surgeon’s first revision from banding to bypass: Rosie.

Rosie was recruited by her lapband surgeon for the performance of his first laparoscopic gastric bypass. Even though Rosie had experienced reflux, expensive and painful inflations, and her banding had largely failed, she trusted this surgeon because he had been recommended to her. She believed that his knowledge of “*my system*” would provide an elevated level of protection during the gastric bypass procedure.

The surgeon promoted his skills in laparoscopic bowel surgeries and offered Rosie financial and time-to-operation incentives to be his first bypass patient including a discount for the anaesthetist. He impressed Rosie with the credentials of his proposed training programme such that “*I thought, if he’d been trained by Fobi, he’d be alright to*

do the operation.” This training did not eventuate because, as he explained to Rosie, he had “*run out of time*” to train in the States. Instead, he seemed to have done a short course or observation in Australia.

Experience and practice do lead to improved safety and reduced operating times (Flum & Dellinger, 2004). Rosie’s surgeon was experienced in some laparoscopic procedures but lacked open bariatric surgery experience, a fact commented on by research participant, Dr M1:

A lot of the lapband people came to this as laparoscopic surgeons with very little experience of major gastric surgery and it’s not an easy thing to learn to do.

Although Rosie was reassured that the surgery was safe and that she would be well cared for, that “*they would hold my hand the whole way,*” this was a complex operation. The lapband required removal and the bypass instituted. Another participant, Marjorie, required a band removal and hernia repair that took longer than expected. “*He told me ‘It’s just as complicated to take it out, as it was to put it in, and there’d been scarring, and he needed to be careful.’*”³ This suggests that the complexity of removing the lapband, the least significant and most practiced part of the surgery carried out on Rosie, was in itself a complicated procedure.

The surgeon’s account of his prowess with bowel surgeries helped to convince Rosie:

I was a bit worried ‘cos I was his first one but then I thought “Well, he’s done hundreds and thousands of bowel surgeries!” which is basically what it is, and, ah, I thought, being the first one, he’ll be really, really careful.

Although Rosie knew that she was his first bypass, she was not informed of the very real risks of iatrogenic injury or death, particularly in procedures early on. In relation to early lapband procedures, Dr A (HDC Opinion, 2001, p.2) advised the Commissioner:

All the early patients⁴ were made aware that I had only just started doing the procedure. They were given the alternative of waiting until I had more experience, or to go to (another city) to see a colleague who had done many more cases.

This surgeon appeared to comply more with the form than the substance of informed consent. For instance, it is unclear at what point he considered his experience to be sufficient that he no longer informed patients about early procedures. It was in the

³A patient might well have expected carefulness to be factored into the original operating times.

⁴Ms AR, for instance, was not told that her procedure was an early one for her surgeon.

months following her gastric bypass procedure that Rosie learned that mortality following bypass surgery was about 2% and serious complications at 5%:

It was (him) that offered it to me that put the idea in my head.

Rosie's surgeon breached ethics when the very real risks of surgery were hidden or minimised by omissions, obfuscations, self-promotion, or deception (Assael, 2006). Gastric bypass surgery is a major procedure performed on a population already considered to be at risk of increased morbidity and early mortality. This was emphasised in an advisory issued by the Board of Registration in Medicine, Massachusetts, following the deaths of six patients within 30 days of their gastric bypass surgery at Massachusetts's hospitals (Hohler, 2007). A recent study by researchers at the University of Washington found that 1 in 50 people die within one month of having gastric bypass surgery. For inexperienced surgeons, those who have done fewer than 21 surgeries, the rate is 4.7 times higher than for more experienced practitioners (Flum et al, 2005). As well, mortality statistics following bariatric procedures are confounded. It has been pointed out that a patient with severe surgical complications might survive for several months, and that these deaths might not be counted as related to WLS (Clark, 2003).

Surgeons in this study had little experience and oversight for new procedures; one surgeon spoke of oversight for only his first two procedures (HDC Opinion, 2001). In regard to WLS, this was a risk that needed to be discussed openly with a patient, never camouflaged. This has been commented on in relation to other procedures. In a study of laparoscopic cholecystectomy, 55% of practising surgeons who undertook a weekend training – virtual “weekend warriors” (Wachter & Shojania, 2004, p.151) – felt inadequately trained yet 74% of these surgeons began performing the procedure immediately. The most commonly cited mortality rate for bariatric surgical operations across the United States is 0.5% suggesting that 1 in 200 patients will experience a fatal result (Clarke, 2003). In a study of Medicare beneficiaries, the risk of early death after bariatric surgery was considerably higher than previously thought particularly amongst older and/or male patients, especially where these surgeons had minimal experience (Flum et al, 2005; Martin, 2004).

Outside of New Zealand, there is a commitment to raising standards of training and experience for surgeons who wish to add WLS to their portfolio: Fellowship training, for instance, requires pre and peri-operative experiences, along with

- Participation in at least 100 WLS with the surgeon having assumed the primary role in at least 51% of those surgeries.
- Comprehensive fellowship required experience with a minimum of 50 stapling/anastomotic operations, 10 purely restrictive operations, and five open procedures (Ben-David & DeMaria, 2007).

Rosie's procedure was impacted by a number of systemic issues including inadequate regulation of upskilling for surgeons in private sector medicine. While these issues pervade the trade environment of WLS in New Zealand, they are not being publically audited in any meaningful or systematic way.

10.4 Switching or cancelling procedures: SusieB.

On reinterview in 2007, SusieB was exhausted "to-ing and fro-ing" with the band, its detrimental side effects and limited weight loss. She agreed to a new "vanguard" banding which her surgeon assured her would cure reflux and ensure a further 30 kilos of weight loss. This surgery was cancelled by the surgeon with little warning. Susie indicated that the operation was to have been funded by her medical insurance company. Given that insurance coverage for these surgeries was limited, and Susie had already received a partial payout for her previous surgery, this seemed unusual and I asked her about it.

participantR: *They were we going to pay the whole operation?*

SusieB: *Ummm (reflective) No.*

participantR: *A bit though? They were going to pay the first*

SusieB: *No, uh no, no. I won't go into that. No. We were doing it in another area. I was going to have a gall bladder done at the same time. And I think the whole thing was going to be put in somewhere along that.*

participantR: *With the gall bladder done, have the band?*

SusieB: *Put in, yeah, yep.*

participantR: *So you didn't even have the gall bladder done?*

SusieB: *No, No. It kind of was like a bit mickey mouse and the whole thing didn't happen.*

participantR: *How did you come to that decision, to do sort of a compound operation?*

SusieB: *Well, it wasn't going to be a compound operation. It was going to go in for one, but possibly work in the differences (embarrassed).*

The pain associated with a diseased gall bladder is significant and SusieB's narrative lacked any description of such symptoms. The failure to proceed with the gall-bladder surgery indicated that this was a strategy to obtain funding for an experimental WLS. The Disciplinary Tribunal Proceeding in 2000 referred to one surgeon as having

[...] described the surgery being for a gastric ulcer when it was really more involved than that. (Lawyer for surgeon) replied that as was common practice among surgeons, (the surgeon), in good faith, drew attention to the clinical rather than the cosmetic aspect of the operation (NZPA, 30 March, 2000).

The Disciplinary Tribunal deliberations in 2000 described these practices as signifying a lack of moral fibre on the part of the surgeon that undermined the credibility of that surgeon's testimony.

SusieB was eventually scheduled for a partial gastric bypass, *The Sleeve*, in the surgeon's private facility. "Gowned-up" and anxious, she was informed by the surgeon that he might perform a different WLS procedure:

SusieB: *Just ready to go into theatre (she speaks slowly and deliberately to provide emphasis) when he comes to me and says, "Now (SusieB), I just want you to know that I haven't been sleeping well last night and I want you to know that if this (The Sleeve) proves to be dangerous, we will go for the other band." (SusieB went completely silent.) This was like total panic. "This is not what I want. I don't want another band." And he said to me, "We can't muck around with your life," sort of thing. So I mean, what do you say? Do you say, "Well, leave it or whatever?" I was totally confused and I didn't know.*

While the surgeon was obliged to inform a patient if he could not perform a safe procedure, this needed to be accompanied by a cancellation of the procedure, not a unilateral decision to cancel a procedure as in the first instance or substitute one procedure for another as in the second instance. A process of consultation was required. The future possibility of procedures that he himself could safely offer and his reasons for suggesting that the procedure was not a safe option, were pertinent to this discussion. A suggested new date for the procedure could have been agreed or a different procedure proposed. At the very least, a laparoscopic gastric bypass with an experienced surgeon needed to be considered (Weber et al, 2003).

Five months elapsed between the surgeon recommending *The Sleeve* and SusieB's eventual presentation for this procedure. This was the second of two dates, five months

apart, given to SusieB for revision of her lapband. Susie had consulted the surgeon for almost seven years, “*three or four times a year,*” for inflations and deflations of her band; she had numerous contacts with the surgeon for reasons of his business, being his voice in the WLS community; and she had been in email contact with him about the cancellation of her original operation. All of these occasions and consultations presented opportunities to express and discuss any reservations the surgeon might have held about the procedure he had proposed.

In recovery, SusieB noticed that she did not have drains. This alerted her that she had received another band. She asked the nurse for a glass of water but was refused on the grounds that she had been given “*The Sleeve:*”

I just said to her, “Oh what, you reckon I’ve had the sleeve done?” And as I said that, this other woman said “No she hasn’t; she’s had a lapband done.” And the other one said, “But she came in for a sleeve!” and she said, “Yes, but the surgeon changed it at the last minute. She’s actually had a band done.” So that’s when I found out. And then, I went down like a ton of bricks because I did not want another band in. (She was speaking very firmly). That’s when I realised!

SusieB had her procedure in the surgeon’s boutique operating facility and this aided the last-minute switch in procedures. Within a larger hospital system, switched operations or surgical blunders might have been open to greater scrutiny. Potential problems for SusieB’s procedure were heralded only by the surgeon’s report of worry on the night prior to her operation:

participantR: *So everything seemed fine up until the surgery?*

SusieB: *Had he told me an hour before, I may have opted out completely. Had he have told me an hour before. Because I would have had time to*

participantR: *Or a day before?*

SusieB: *Or a day before!*

participantR: *Or a week before?*

SusieB: *Or a week before. Had I’ve known that that was a possibility, I may have turned round and, I don’t know. I may have turned round and said to him, “If you, if you go in and you can’t do the sleeve, then take the band out and that will be the end of it.” I may have done, I don’t know. Because I know leading up to having the sleeve, I had had a gutsful of the band. Because I was so sick all the time.*

Even after the surgeon spoke to her briefly and immediately prior to the surgery, SusieB went into theatre believing that she would be given *The Sleeve*. Any possibility of informed consent for this changed procedure was denied her.

SusieB used words like “*bitter*” and “*angry*.” The cancellation of her operation six months previously and the surgeon’s support for the formation of a new support group and spokesperson had been considerable blows to her self-esteem. Even so, SusieB continued to express “*faith*” in her surgeon, based on a weight-loss procedure in which she initially lost about 30 kilos, regained at least 20 kilos and needed to be enrolled with *Weightwatchers* to achieve or maintain any weight loss at all. She continued to assert: “*I’ve got a faith, a lot of faith in (him). Because at the end of the day, he still gave me back my life.*” As a support-group leader, with special access to the surgeon and ongoing involvement in a very supportive community of WLS patients, SusieB had found a secure place for herself in which her self-confidence had grown. While she was traumatised by the events described and expressed highly conflicted feelings about her experiences, she did not personalise her anger: “*I feel that, I feel that I should have been forewarned prior to getting into surgery, that that could happen. And that didn’t happen!*”

While SusieB believed that she should have been forewarned, she was fearful of discussing any concerns with the surgeon. SusieB did not like “*rocking the boat*,” and she has accepted the surgeon’s explanation that band slippage was the cause for the switch of procedures. This appeared to have been used as a rhetorical device to manage a distraught patient. If, for instance, slippage of the band was suspected, then a simple, inexpensive, radiological investigation, prior to the procedure, would have been not only sensible but also mandatory.

SusieB wished that she had questioned the surgeon more:

The only thing that bothers me, is that if he had done his research and looked on the website that I’d looked at, he would have realised. And if I had been strong enough, I could have queried him about it. But I thought, being a surgeon, they know it all.

Information available on Australian surgical websites indicated that lapband conversions to *The Sleeve* were being performed in two operations rather than one. The fact that SusieB did not question the surgeon about this procedure as requiring two operations speaks to her almost complete disempowerment in this relationship.

Quality of communication and clinical skills were important factors in determining whether patients remained with current practitioners (Mold, Fryer & Roberts, 2004). SusieB's relationship with the surgeon has survived serious and problematic clinical and personal issues. In remaining ostensibly trusting and compliant, SusieB has continued access to the surgeon for lapband interventions: She has no easy option to change surgeons given that she requires oversight following her second banding.

In two interviews for the research, which occurred over three years apart, this continued overt support for her surgeon was both striking and confusing. Even during her first interview, SusieB spoke about the failure of her first lapbanding:

Would I have it done again if I was faced with that? To be honest, I whispered to my husband, if I have to have it done again I'm going for the bypass. I would go for the bypass because then I've got no mucking around. Whatever I'm left with, I've got to just deal with it. That was my reasoning.

By the time of the second interview, SusieB had been promised a particular surgery that did not eventuate; she had been fitted with a second lapband that she did not agree to; her procedures have left her with significant health issues. SusieB's need to whisper to her husband and to the interviewer was a significant demonstration of her concern that she was being unfaithful to the surgeon. Whispering spoke about the seductive influence of powerful connection in this surgical-consultation relationship.

SusieB clearly enjoyed the attention afforded her by the surgeon and her self-confidence had grown in relation to her outreach within his support group: *"I've made a lot of lovely friends out of this. A common bond."* However, the exploitative nature of this relationship was reflected in the reinterview: *"I did a helluva lot of work for him, when I think about it!"* SusieB continued to praise the surgeon even while discussing treatment that did not eventuate, limited accounts of informed consent and her surgeon's apparent lack of concern about the health implications of the side effects of her lapbandings.

To friends who question her evident failure from two surgeries, she replies, *"I know. I should be Twiggy by now"* and *"I s'pose at the end of the day, whatever surgery I've had, I'm still alive, for which I'm grateful."* Her older daughter has questioned her financial commitment to these surgeries and told her mother that continued vomiting is irrational. Disconnected from the actuality of living with reflux and vomiting, SusieB replies: *"I have lived with this for too long to worry."*

At the end of this final interview for the research, SusieB revealed an emergent reassessment of her WLS experiences:

participantR: *You may not have had a chance to say what you think.*

SusieB: *I think, I think that it doesn't matter who it is in the medical profession, that at the end of the day, either a dollar or a number. We're just numbers. Just a job.*

participantR: *Part of their trade?*

SusieB: *Yeah, yeah.*

participantR: *Part of their way of earning money, being in the world?*

SusieB: *Yeah, no different to being a mechanic. I think where that hit me hardest, and this is so blasé of me: I'm driving along Park drive, Dr Zed goes past in his little Lamborghini or what ever it is, and I thought "That just speaks for it all!" One of his tyres, my inflations would have paid for it, probably. And that's how I looked at it!*

participantR: *Probably not.*

SusieB: *Probably not. (Chuckles). But that's how my mind went.*

SusieB referred to a new attendee attending a meeting of lapbanders, a "newbie," who decided after one meeting not to proceed with the lapband.

participantR: *So if you were Helen walking into that room, to hear lapbanders talking about some of the issues.*

SusieB: *Oh, I wouldn't do it either!*

10.4.1 Changing procedures: ParticipantR, "14 March, 2006."

I am in the operating theatre. I have had my premeds. "Do you know what you are having done today?" I say, "He is looking for an internal hernia from my gastric bypass and he is going to clear away scar tissue which he believes is causing my pain." The anaesthetist is waiting to begin the drip. I notice a shadow cross the nurse's face: "You do know that he's not doing the scar tissue?" I am bewildered. My agreement to looking for the internal hernia was supported by the idea that "We can, at the very least, make you more comfortable by clearing away some of the scar tissue." "Do you need to speak to him?" I have travelled for this operation. I have been told I need both parts of it. I think, "Talk with him tomorrow about why he chose not to do the scar tissue." I say to the nurse, "I guess not." I am plunged into whiteout. When the surgeon visits me the next morning, his story is based on having discovered too much scar tissue during the procedure: "You had too much scar tissue so we were unable to proceed with that. Well, at least I got to tennis"(laughs).

I leave the hospital within half an hour of his visit. I do not return to follow-up. This is not the first time that I have been spun by his stories (reflecting diary).

10.5 Telling stories or speaking rhetorically: Michelle.

Although surgeons, under informed consent provisions, were required to give accurate information to potential patients, success in previous procedures appeared often to be espoused, sometimes to the point of misrepresentation. For instance, Michelle recalled being told by her surgeon that all his bypass conversion patients reached a normal BMI and that two poor results with bypass related only to non-conversion operations. These poor results were attributed to the psychological problems of those patients. In an earlier research interview, the surgeon referred to these two patients:

Out of 150 bypasses, I've got two ladies, that haven't gained weight, but they certainly haven't lost what you'd expect, and both of them have got psychological issues, and both of them were revisions of one a band, one a gastroplasty that had failed (Dr M2).

In the research-based account, the “*problem*” patients were described as conversion patients; Michelle, however, was told that the surgeon had only encountered problems with two straight bypass patients. The essential story was recognisable, but elements surrounding conversion versus non-conversion were switched. Did the patient recall the story correctly or did the surgeon switch the conversion element to allay Michelle’s concerns? Both Michelle in her pre-surgery consultation and myself in the research interview were given an account of success rates in which failure was ascribed to the psychological profile of two patients. Michelle requested the success statistics of the surgeon’s conversion patients, and it was in her interests to hear that story correctly. The story was performed for clearly different purposes: In the interview, the surgeon promoted the positive aspects of laparoscopic bypass procedures; for Michelle, a potential bypass-conversion patient, the surgeon was buoying optimism in the new procedure to obtain consent to proceed. While the surgeon informed Michelle about some problem outcomes, his obfuscatory means of doing so impacted her ability to make a fully informed choice.

The question of rhetoric as an element within clinical encounters has a long history and ambivalence continues to surround its use and abuse. A positive view of medical rhetoric in the clinic is that the better the doctor is as a persuader, the more possibilities he has to engender confidence and promote healing. A contrary view suggests that when doctors use “ [...] eloquence to disguise their own defects and to blame the

disease [...]” then indeed “You are able to kill, and – mirabile dictu – to accuse those you kill” (Streuver, 1995, p.281). It has been suggested that such argumentation is of its nature not coercive. Indeed it has been seen to promote a critical approach towards an issue leading on to compliance within medical consultation relationships (Rubinelli & Schulz, 2006). Such a stance belies the significance of diverse factors that underlie medical advice. It suggests that medical advice is always in the best interests of the individual patient; that issues of trade do not impact surgical advice; or even, that professional power/knowledge does not exert undue influence within these relationships of consultation.

10.6 Problematising informed consent: The anaesthetised body

Vexing questions have been raised in relation to informed consent prior to the performance of these surgeries including timescales for making elective-procedure decisions, referrals-on, and the balancing of patient-interest with trade practices. In the pre-operative period, surgeons were skilled in achieving consent. This skill compromised informed consent for patients whose procedures were changed at the last minute or where information, which brought into question the appropriateness of the procedure, was thrust at a patient already under pre-medication (submission to the HDC, 2003). Clearly a patient was unable to give consent under anaesthetic. In this section, the concern has shifted into the theatre and recuperation periods. Much of what happens for the anaesthetised patient is not open for ready viewing and this discussion is based on clinical notes, excerpts from HDC Opinions, or constituted dilemmas raised by patients or doctors in this study.

10.6.1 In the case of Rosie’s bypass. Rosie’s revision of her Lapband and a laparoscopic conversion to Gastric Bypass placed her life in danger from septicaemia. Following the operation, the surgeon told Rosie that he had noted a problem with her tissue during her procedure. In this explanation, the state of Rosie’s tissue generated questions related to informed consent: “*He said when he, when he went in, then he noticed that my tissue wasn’t that good then, but they were already in, so. He said, “It held then!”*” In the septicaemia following the operation, Rosie’s tissue deteriorated. Yet the surgeon suggested to Rosie that the tissue was already compromised when he began the procedure and suggested that this had led to her complications.

Did the surgeon blame the patient’s poor tissue to deflect attention away from this being his first gastric bypass procedure, with the patient suffering significant iatrogenic injury more common in early-on procedures (Mason, 2007). If Rosie’s surgeon

continued a complex operation believing that the tissue was compromised, this was poor practice and the necessary consents to continue the procedure were no longer in place. For instance, the surgeon could have reverted to a two-step operation in which the lapband was removed and the problem of the tissue dealt with. After all, the bypass depended on the tissue being able to hold the staples. One surgeon (HDC Opinion, 2001) stopped a WLS operation when he was unable to proceed^{5 6} and completed the procedure some weeks later. Rosie's surgeon did not discuss any emerging problem with Rosie's husband; he did not convert to a two-stage procedure in which he removed the band, before coming back on another day to institute the bypass; he did not bring Rosie back to consciousness to inform her of any risks of continuing the bypass with compromised tissue. Either the tissue was not compromised or the surgeon proceeded with the operation notwithstanding any increased risk to his patient. This was his first bypass and a trade representative was invited into the theatre. These were pressures that may have encouraged him to progress this procedure even when he believed that Rosie's tissue was compromised.

10.6.2 Without incident: Questioning the objectivity of operation notes.

Patients do not have direct access to their operation notes and seldom request them. These are notes are written following the operation, filed, and may be requested by patients following an adverse event as occurred with Scrapper, Ms AR, and Patient A (HDC Opinion, 2001). The research narrative of Dr Henry's⁷ operation notes, which were requested in a complaints' procedure, raised questions about being able to routinely rely on the supposed objectivity of such materials:

The only complaint I've ever had against me is from somebody who I wrote in the notes was obese and that therefore this operation was difficult and too risky to do something I would like to have done. I just wrote it in the operation notes and she was so anxious and they got the notes out and made a complaint because I hadn't done exactly as she'd wanted.

The operation note referred to was for an arranged and agreed operation. When Henry decided not to complete the procedure, he recorded his choice as being a professional decision based on his patient's weight. Clearly, patient weight was a

⁵In one instance, the surgeon failed to ensure that he had the correct retractors for operating on a large patient laparoscopically.

⁶In a recent proceeding, the HDC breached a surgeon: "Although I accept that waking a patient from anaesthesia should not be undertaken lightly, in my view Dr E should have taken this action. Mr A was undergoing major elective surgery" (HDC Opinion, 2008, p.31).

⁷Henry was interviewed for the study as a specialist working with patients whose symptoms were believed to weight-related.

variable considered prior to the operation. Informed patients needed to give consent based on the possibility that weight in this instance, or other known variables, might specifically interfere in a procedure. In one Opinion (HDC, 2001, p.44) the Commissioner concurred with an expert who advised him: “It would have been advisable to have clearly spelled out to (patient) that the surgery might fail for technical reasons.” This suggests that blanket consents could be used routinely to conceal poor practice. This is demonstrated in the Banja and Porto’s (2004) work. They described the medical team’s response to the death of a patient following the application of an inappropriate technique by an inexperienced practitioner. The operating team chose to protect the practitioner by informing the family only that the patient had died of a haemorrhage. Because the possibility of haemorrhage was covered by informed consent, the concealment of the practitioner’s error could be rationalised.

When Henry’s decision-making was questioned, he moved to protect himself, his professional judgement and his overarching right to make medical decisions. He querulously blamed the patient’s obesity, although the procedure was presented as “*something I would like to have done*” prior to the operation when he was fully cognisant of his patient’s weight. In a milieu of discrimination and panic about obesity as an epidemic, the patient was easily positioned as blameworthy (Lupton, 1994/2003) taking the spotlight off the surgeon’s practice.

It was the failure of the patient and the complaints’ system to acknowledge his protected and privileged positioning in regards to decision-making that most provoked Henry’s frustration. The failed procedure was turned from being something the surgeon had agreed was necessary into something that the patient had wanted, (a suggestion here of *fancied, in contrast to required*). The complaint was twisted into the patient’s wish to control him and Henry’s failure to do “*exactly as she’d wanted.*” Henry did not change his practice apart from wording his operation reports more carefully, a tactic noted in other research (Gallagher, Waterman, Ebers, Fraser & Levinson, 2003). As Fred (2008, p.7) has pointed out, the core values of professional medicine are threatened by such “*dishonesty [...] in all shades.*” Henry has resorted to a number of subterfuges to protect himself from any future complaints even in New Zealand’s non-tort system.⁸ In the research interview, he recorded never again using the term obese in his notes,

⁸In “Tort does not affect medical injury,” Law (2003) expressed concern that medical injury rates noted in medical reports are minimum data. This suggests that whether or not decisions made by a surgeon, for example, are recorded, is a very subjective process of the surgeon.

scrawling to ensure that his notes were unintelligible and being selective about what he did record: “*I never write it in the notes now*” (Henry).

10.6.3 Open-to-view: Performing the anaesthetised body. Shona recalled lying on the operating table, the insertion of lures and monitoring devices, noting the number of people in the operating theatre with some amazement, as “*the mask descended on my face*” (Internet diary). Although surprised at the number of people in theatre, she questioned neither their right nor need to be there. In the wake of her agreement to have bypass surgery, Rosie was asked to allow a person to observe her surgery: “*And he also had, I had to sign permission, and he also had the lady there from the staple company, who wanted to be in there at the surgery.*” Rosie’s consent to the presence of a salesperson was confounded by the multifaceted nature of her commitment to this surgeon. This request was made in the wake of the surgeon’s assumed generosity in operating on her without fee⁹ prompting socially sanctioned reciprocity. Being both indebted to and reliant for care on the surgeon affected Rosie’s ability to consent freely. The issue would be further complicated by any gratuity or consideration that the surgeon received, free meals, reduced costs or free equipment, for allowing the salesperson to be present during this operation. In 2002, the morally dubious practice of “shadowing” for payment by pharmaceutical representatives came to light (Kassirer, 2005). Some patients were never informed of the presence of a visitor. Physician-shadowing by trade representatives has now been banned in some countries or states (Jones, 2007; Kassirer).

The purpose of, and responsibility for, the presence of persons in theatre became a source of concern to one patient. Her unease concerned whether a second surgeon had scrubbed, assisted or was being trained by the surgeon during her operation. When she queried why her consent was never sought for the presence of a professional visitor, her concern was noted in the HDC Opinion (2003) and the surgeon’s response was recorded:

(The patient) was concerned that another doctor may have participated in or observed her surgery, without her knowledge or consent. (The surgeon) advised me: “I don’t know who this other doctor is that she is alluding to. When I asked the hospital to look at their records, someone had written the presence of another surgeon, but this name is unknown to me. It might be the name of another general surgeon who used to work here, whose name is somewhat similar. It is routine around the world for surgeons to observe colleagues, sometimes to give a

⁹In speaking with Rosie, it became clear that this financial promise was honoured only in part, leaving Rosie in considerable debt.

second opinion about something unusual, and sometimes to pick up little techniques that improve their own surgery. When I have a request for another surgeon or medical professional to come into theatre, as the patient's advocate, I explain to the patient beforehand and obtain their permission. This is also the policy of the hospital. No such form is in the chart, so I'm not even sure if a surgeon was there or not, or why the name was on the operative form (p.8).

This excerpt displays elements of denial, obfuscation and projection in the surgeon's statement. The Commissioner agreed that the patient needed to be asked, acknowledged that she had not been asked, but did not hold the surgeon responsible:

(The patient) had surgery in a private hospital. The anaesthetic notes recorded that Dr H, a "professional visitor", was present. (She) had not been asked if he could observe her surgery. She was entitled to be asked, under Right 6(l)(d) of the Code. However, I have no reason not to believe (the surgeon's) assurance that he had no prior knowledge of a professional visitor and that he cannot recall an observer being present. In these circumstances, I am satisfied that (he) did not breach Right 6(l)(d) of the Code (HDC Opinion, 2003, p.30).¹⁰

This suggests that the evidence of the surgeon was preferred to triangulated evidence from the patient that included the written record of the surgery and confirmation by the second surgeon that he had attended Ms AR's procedure. It appears that viewing this patient's surgery was part of a courting process for partnership in a surgical practice. In denying the presence of a second surgeon in his theatre, the surgeon sort to undermine the credibility of the theatre form: "I'm not even sure if a surgeon was there or not, or why the name was on the operative form" (surgeon's evidence, HDC Opinion, 2003, p.10). In the subjunctive, the surgeon espoused knowledge of, and concern for, the rights of his patients: As "their advocate," he "would" have sought consent for any visitor to be present, and a form "would have recorded" this in the operation notes. The absence of a patient-signed consent form came to deny circuitously, not only his knowledge of the presence of the professional visitor but even his actual presence signified in the operation record.

In submissions relating to informed consent in a New Zealand Medical Disciplinary Tribunal (Langdon, 2000a; 2000b), one surgeon lost his case. In that case, the QC to the Medical Council's Complaints Assessment Committee cautioned against the inclination in disciplinary procedures to place more weight on the words of a medical professional than on that of the patient. In the HDC Opinion (2003), the patient's right

¹⁰A further complaint related to the same surgeon came to light in the later stages of this research process (HDC Opinion, 2001). Clearly the HDC had knowledge that this surgeon was highly motivated to avoid any findings against him given he was to be reported to his professional body on an informed consent violation in relation to the prior complaint.

to privacy was infringed, yet, on the basis of the surgeon's assurances and evasive replies, no breach was found. This reflected a cultural scaling of morality in which, to paraphrase a line from Mozart's *Don Giovanni*, "The Nobility (medical profession) has honesty painted in its eyes!" As a senior practitioner, this surgeon was highly motivated to avoid censure. For instance, Fred (2008) has suggested that the "fear of being found wrong" and "the need for aggrandizement" are clear reasons why physicians lie. In accepting that he was his patient's "advocate" in the theatre, the surgeon was bound to protect her privacy, which he did not do. While Rosie's consent was sought, the conditions of achieving it suggest that this was more about the form than the substance of consent. In Rosie's case, the trade relationship prevailed.

10.7 Surgeon agendas in weight-loss surgery

Although WLS was lucrative for surgeons involved in private sector health provision (Mitka, 2003), laparoscopic procedures required "demanding and prolonged" (Herron, 2005, p.23) upskilling even when surgeons already possessed advanced laparoscopic and bariatric skills. How then were patients apprised of their status as experiential training aids?

10.7.1 Fat bodies in the service of surgeon upskilling. By 2000, most bandings were completed within two hours, though technical experience allowed "[...] operation times to fall" (Chapman & Kiroff, 2000, p.31) below that. Ms AR's banding was booked and charged as a three hour operation, suggesting that, having offered these procedures for well over a year, her surgeon lacked familiarity with the procedure, his skills were deficient, or he chose to benefit by charging for three hours when he required less than two. Given that the operation took at least a third longer than the norm cited for surgeons lacking technical mastery of the procedure in the ASERNIP-s study, did the problem lie with the surgeon's technique? Given that he was instructing a visiting surgeon in the techniques, did this occur at the patient's expense? Was this a matter of trade in which the surgeon decided to charge all his lapbanding procedures at three hours, even when the procedural time fell well under that?

Timely and safe procedures, with minimum exposure to anaesthetic were important considerations. But most participants did not ask or were unaware of the "learning curve" phenomenon (Chapman et al, 2002, p.19) believing that surgeons were trained in surgery. This meant that they took on faith that surgeons had the requisite skills and most patients accepted the operating times quoted by their surgeons. Scrapper was banded in May, 1998 as the surgeon's 5th lapband: "*He stuffed, he took a lot longer*

over my operation.” By the time Scrapper participated in the reflecting team process, the relative inexperience of WLS surgeons was emerging as a source of concern for some participants in this study:

Michelle: *And I think, because we saw him when he was still only a year out. You were number something weren't you?*

Scrapper: *Fifth.*

Michelle: *Five! (sounds shocked). (Reflects quite slowly) See, he had no idea what he was getting into at that point did he?*

Scrapper: *(repeats) Barbara and I were no 5 and no 6.*

participantR: *Did he tell you that you were no 5 and no 6 at that time? Did you think, "Oh well that's fine or*

Scrapper: *Oh, we were a bit worried. I mean, he'd done it under Dr M2 first but he did take a long time to do my surgery. I think it was only supposed to be 2 hrs and he took 4 and a half and charged me for it!*

Marjorie: *Good grief!*

Michelle: *Ahhhhhhh.*

participantR: *Ouch! Charged you for four and a half hours. What did he tell you about why the surgery took so long?*

Scrapper: *Difficult. Difficult for him to get it into me apparently.*

participantR: *Difficult because he didn't have the skill at that time or difficult because of, you know, your body?*

Scrapper: *I actually requested a copy of the surgeon's notes of the surgery. I can't remember how he quite worded it. He was going on about this was wrong and he had trouble getting it in and around but I think it was because he was inexperienced.*

Group: *Imm immm.*

Scrapper: *Looking back at it, he just really didn't know. Blame the patient. Blame that my insides were all wrong but hello!!*

Michelle: *Blame the patient! (General laugh).*

Dark hilarity accompanied the expression of reservations in the reflecting team process, signifying a gradual loss of trust in their surgeons. In the safety of the reflecting team process, patients spoke freely and shared their concerns. Participants

were questioning the wisdom of being an early-on procedure and bearing the cost of a surgeon's upskilling. They deconstructed surgeon-talk such as when patients are blamed following difficulties in or following their procedures. Consumerist talk enters patient talk when there is a reason to question the competence of the physician or where medical error has occurred (Hibbard & Weeks, 1987; Roter & Hall, 2006). What these WLS patients do not reflect on is the failure to inform them about the iatrogenic effects of early and training procedures. Meryl paid \$20,000 for a laparoscopic gastric bypass.

participantR: *You paid how much for your operation?*

Meryl: *\$20,000.00*

participantR: *So that's quite a lot more than Dr M2.*

Meryl: *It is, but I was in, I was in surgery for a very long time.*

participantR: *How long?*

Meryl: *Nearly 6 hours.*

participantR: *Why?*

This length of time in surgery and related costs were explained to Meryl as, "*the intestine slipped off the clamp and they couldn't find it.*" This surgeon, new to laparoscopic bypass, appeared to have spent about two hours looking for her intestine. Meryl took this as a sign of his good practice and expressed her gratitude: "*So I was very, very grateful for Michael being very patient, methodical. He just said, "Yes. Kept calm. Yeah!"*" At a time when a surgeon, on interview for this research, noted performing the bypass laparoscopically in "*one hour and twelve minutes,*" Meryl's procedure took almost five hours longer to achieve! It is possible that the surgeon was motivated to ensure the success of this early-on laparoscopic procedure for his own experience or because of pressure from the patient "*not to go open.*" If patient safety is in danger of being compromised, the surgeon needed to clarify the conditions that could require conversion to an open procedure or refuse to perform the surgery.

The sheer length of this procedure indicated this surgeon's lack of experience with bariatric laparoscopy. While he reported the incident to his patient, he did so in a way that produced it as an act of resoluteness in the face of adversity; he emphasised his decision not to convert to an open procedure; he suppressed his lack of experience with laparoscopic procedures, "the lie of omission" (Assael, 2006, p.570). His narrative

enhanced his reputation with the patient. As Fred (2008, p.13) wrote, “Patients often foster our frailties by conferring God-like qualities on us. We, in turn, accommodate that perception in order to protect the image for them as well as for our colleagues and ourselves.” While the sheer length of her operation and the problem that occurred were indications that this surgeon was on a learning curve with this procedure, Meryl did not question his ability, his experience, nor why she should pay a premium for his upskilling.

The American Society of Bariatric Surgery (ASBS) and the Society of American Gastrointestinal Endoscopic Surgeons (SAGES) have produced a joint document specifying “global credentialing requirements” (Herron, 2005, p.23). To perform laparoscopic bariatric procedures, surgeons must hold privileges in open bariatric procedures and advanced laparoscopic surgery; they must be proctored for three cases and must document adequate outcomes in fifteen laparoscopic bariatric procedures (Herron). There appeared to be no experienced oversight required for these early New Zealand procedures¹¹ discussed here. For instance, one New Zealand surgeon did not inform his patients that he lacked experience in open bariatric procedures. A complaint was made against this surgeon when he was unable to complete a WLS procedure because he lacked “the correct retractor” (HDC Opinion, 2001), specifically required for laparoscopic WLS with many large patients. The independent expert’s testimony suppressed comment on the factors that had led the surgeon to abandon the original operation. He did so by concentrating on the surgeon’s decision to abandon the operation “[...] because of the risk to the patient, and instead come back at another day with better equipment, shows that he had her best interests at heart” (HDC Opinion, p.26). The expert neglected discussion of the factors that allowed the situation to develop in the first place. An expert’s opinion requires “[...] an honest evaluation of all the relevant facts” (Gutheil, Hauser, White, Spruiell & Strasburger, 2003, p.426), whether for an inquiry or in a court process. In her review of Banja’s (2004) *Medical Errors and Medical Narcissism*, Rosenthal (2005, p.234) commented:

It would also improve the understanding of patterns of error (and the language of full disclosure) if physicians would examine more closely what they call “unavoidable,” “anticipated,” or “known” adverse events. A close examination of empirical studies shows that many such events are more preventable than is commonly perceived.

¹¹The HDC Opinion (2001) discussed the first two lapbands placed by the surgeon under supervision of a more experienced colleague.

The Commissioner accepted that the surgeon's inability to retract the liver with the available instruments was not unusual. He did not indicate that the surgeon's failure to equip his theatre appropriately before offering surgeries designed for very large patients, led directly to the problems experienced by this patient. This surfaces a seeming irrationality in that a bariatric procedure could be offered to a large patient without the requisite equipment being available. In such a case, the surgeon needed only to cover the legalities of informing consent by telling his patients generally that the operation "may fail for technical reasons" (HDC Opinion, 2001, p.44). In fact, the special needs of the bariatric-surgery patient require "careful planning and organization" (Hamad, 2005, p.55) prior to offering these procedures, with particular attention to ensuring the availability of all appropriate equipment. Patients needed to be informed if a surgeon did not have available all the requisite equipment.

In this study, I have indicated the problems which developed with the first transected bypass in Australasia (Langdon, 2000a; 2000b); the very long operative procedure for the first revision from lapband to a laparoscopic transected bypass in Australasia (Dr M2); Dr Z's first laparoscopic bypass which included a revision from a lapband for Rosie; the length of Scrapper and Meryl's operations including the problems which developed during the latter procedure. These patients were not made aware of the very real risks of harm that might accompany these early forays into learning new techniques.

While "the risk of patronizing patients' decisions through argumentation is really low" (Rubinelli & Schulz, 2006, p.357), the effect of persuading by omission, deception or obfuscation (Assael, 2006) appeared endemic in these pre-surgery consultations. Surgeons who wished to learn and master new procedures, promoted their skills in so called 'related' surgeries and neglected their inexperience in respect to particular procedures. These surgeons clearly patronised the decision-making of their patients who shared surgeons' encultured bias about living weightfull.

There were primary gains for these surgeons in proceeding to develop new skills even at the risk of physical, emotional, and financial costs to their patients. In the words of the surgeons interviewed for this study, the decisions to perform a new procedure were not about the patient in front of them. It seemed to be more about the surgeon's wish to add a procedure to their portfolio: Dr M2 decided on a laparoscopic bypass "*for*

the next patient that needed a bypass” and Dr M1 chose to perform a transected bypass: “It seemed like a winner to me and I came back and started doing it.”

In no fault systems such as Sweden and New Zealand, patient safety and the reduction of medical error require the rigorous commitment of the medical profession (Rosenthal, 2005) to fully discuss adverse events in associated investigation processes. When an expert was asked to give independent¹² advice to the HDC (Opinion, 2001), he clearly acknowledged that being a colleague and trainer of the surgeon involved in the complaint, rendered his evidence partial. An overseas expert might have contributed some insight into the very real risks to patients from the proliferation of WLS and WLS centres in New Zealand during late 1990s/early 2000s.

10.7.2 Fat bodies in the service of medical trades. Following her bypass, Janice was attending three-monthly ‘follow-ups’ in her surgeon’s rooms. She believed that this was normal post-operative care, and was merely irritated that her visits were not with the surgeon himself: *“I saw him three times, the rest of the time he got his co-workers, his men, they weren’t a part of the surgery.”* Janice’s follow-up care within the surgeon’s practice provided data for the surgeon’s long-term research objectives. This material was being collated and turned into published papers and reports. Follow-up of patients over a 2.5 year period was clearly notated, and added validity to this research (Dhabuwala, Canaan & Stubbs, 2000).

Whether or not Janice originally agreed to be part of the research, and whether she derived any personal benefit from these check-ups, they were promoted as necessary for her health and were included in the original cost of the surgery. As these visits fulfilled research objectives, this needed to be overt, never camouflaged, emphasised before each visit, not regularised as either “normal,” “clinical” or “follow-up.” Had informed consent in relation to Janice’s follow-ups been sufficient, she would have identified them clearly as research. One patient complained (HDC Opinion, 2001) about being an unknowing participant in such a research programme. Mrs A commented on the checklist format of her follow-ups. If the check-ups were clinical, these would have been held in her clinical file and forwarded to her when she requested copies of her clinical notes. Inventories completed at her check-ups were not included in her clinical notes as they were part of an ongoing research project.

¹²The problem is amplified when expert evidence was requested from “(...) those who are already in lock-step agreement, reinforcing set beliefs and creating a situation ripe for miscalculation,” sometimes referred to as “... incestuous amplification” (Krugman, 2003, p.19).

Mrs A's complaint concerned liver biopsies being taken by Dr B without her consent during her gastric bypass in 1999 and her related cholecystectomy in 2000. The ethical basis for this complaint rests in the notions that "the research imperative has no moral status at all to coerce the unwilling competent person to take part in research" (Callaghan, 2003, p.154). In response to this complaint (HDC Opinion, 2002, pp.3-5), the surgeon minimised the risk to the patient as "trivial" in relation to the "important information about associated liver abnormalities, common in morbid obesity, (which) can be gained," a clearly stated research objective. He defended liver biopsy as "clinical" and suggested that it was a practice "shared by many undertaking gastric bypass surgery."¹³ However, Mrs A derived no clinical benefit. She did not give consent for the biopsy and she did not receive information related to her 'abnormal' results. The surgeon maintained that gastric-bypass patients did not need to be informed that a liver biopsy was being performed: "Any risk associated with this is tiny compared with the risk of the surgical procedure itself" (HDC Opinion, p.4).

Dr B's actions were characterised as "audit" rather than "research" by a medical ethicist and audit did not require the consent of the patient. This argument supported audits as "[...] an important contribution to the improvement in care for future patients" (HDC Opinion, 2002, p.13). This is a specious line of reasoning when only one New Zealand surgeon was routinely taking liver samples. In the inquiry, the focus on the concerns of the practitioner and the possible needs of future patients took precedence over the needs of a particular patient. How do "audit" and "the contribution to future patients" provide reasonable arguments in relation to the duty to care for a particular and anaesthetised patient? Essentially, these arguments rest on the utilitarian assumption that patients may be treated as a means of trade, even while the HDC Code (1994/2003) specifically refers to a patient's right to be "free from coercion" and "financial exploitation"(Section 2). Secondly, patients are presumed to have responsibility to future patients yet the HDC code specifically provides, under Section 4(4), that services be provided "[...] in a manner that minimises the potential harm to, and optimises the quality of life of, **that** (my emphasis) consumer." Thirdly, a surgeon asserts broad rights of intervention over the anaesthetised body yet under Section 7(1) "[...] services may be provided to a consumer only if that consumer makes an informed

¹³Clearly most patients undergoing Gastric Bypass have some degree of abnormal liver function, and, according to information available to the HDC, most surgeons do not routinely biopsy the liver (HDC, 2000).

choice and gives informed consent.” Fourthly, there is no concern about the benefit to work product derived by procedures classified as either audit or research while under Section 2, “financial exploitation” is specifically prohibited. Finally, if the nips of liver were about enhancing the care of future patients, audit in this instance equaled research and was simultaneously a function of ongoing surgical training. Clearly the biopsy and the use of the patient’s body was subject to formal processes of informed consent under Section 6(1)(d) of the HDC code: The patient needed to be fully informed of any participation in training or research and formally agree the parameters of that participation.

The equivocation that defined the nips of liver study as audit acted to privilege the power of the clinician/surgeon; it stripped body-rights from the patient. Even when the promise of research is great, it is also speculative and has only “a weak moral claim on us” (Callaghan, 2003, p.186). If the original wedge of liver was *clinical*, the patient would have been informed of both the procedure and the results. As well, the procedure would have been common to many practitioners rather than merely espoused as such by the surgeon. The independent advisor (HDC 2002, p.17) disagreed that it was common practice because “[...] most surgeons doing obesity surgery would not biopsy the liver, as such findings are common in obese patients and do not alter the management.”

In this complaint process (HDC 2002), both the surgeon and the medical ethicist raised the issue of harm to the patient only to rate it as minimal. This was not about the size of the intrusion but about the fact there was any intrusion at all. The notion “[...] that it cannot harm the patients whose information is used anonymously” was a highly contentious and sweeping statement that denied the intrusion into both Mrs. A’s physical body and her life. It failed to problematise Dr B’s assumed right to harvest work product while espousing spurious clinical ends for so doing. All the while, Dr B has been free to use the nips of liver for research purposes, by means of which he fully extended his WLS agenda, promoted his personal reputation as a surgeon, and, increased his financial rewards. Mrs A. paid a premium for her operation, bore the costs of extra time in surgery, experienced higher levels of pain and increased recovery times, and was required to attend research-based follow-ups. Yet Right 7(10) of the Code of Health and Disability Services Consumers’ Rights provides that “Any body parts or bodily substances removed or obtained in the course of a health care procedure may be stored, preserved, or utilised **only** with the informed consent of the consumer” (my emphasis).

Another US investigation evaluated changes in liver histology following Roux-en-Y gastric bypass surgery (Clark, 2005). These subjects were selected from 225 consecutive patients presenting for that procedure who were eligible according to National Institutes of Health (NIH) guidelines. All patients had an intra-operative wedge liver biopsy during their procedure. Following the surgery, 16 patients who required repair of incisional hernias became the study participants and underwent a repeat wedge liver biopsy. What appeared to be missing from this study was specific information given to participants that their livers were being used for research. I asked Clark about informed consent and she replied: “All patients were notified that a biopsy would be taken as part of the routine practice for that surgery group” but this did not mention the research aspects of the biopsies (personal correspondence, 24 September, 2008). Given the research imperative to perform repeat wedge biopsies, it raised the possibility of undue pressure on patients to have unnecessary laparotomies.

Although the HDC (Opinion, 2002) accepted an espousal of clinical grounds for Mrs A’s first biopsy, the surgeon was found in breach of two sections of the HDC code in relation to the second biopsy. Given the uncommon nature of liver biopsy in bypass procedures and the myriad of profits to Dr B, the constricted findings against him and the letter of limited apology to Mrs A were insignificant consequences and scarcely a deterrent and there was no requirement for the surgeon to ask Mrs A how her liver samples might be disposed of. Dr B has remained free to inform his patients that he collects liver samples as a routine measure in all bypass operations.

10.8 Discussion

However altruistic the goals of experimental and innovative medical treatments and research, the processes of informing consent have lagged in the shadows of heroic narratives of medical progress. Systemic issues pervade the clinics in the adoption and selling of new WLS technologies. In this chapter, I trace these issues through the failure of informed consent during a ten-year period in New Zealand. For all the attention that has been paid to ideas of an autonomous patient who requires fullest information in the choice of medical interventions, these WLS patients had minimum protections. On the other hand, attending to the legal format of informed consent protected the autonomy of the physician when interventions resulted in unexpected or unwanted outcomes. This was notable in some HDC Opinions (2001; 2003).

Participants worried about being denied access to the surgery and maximised efforts to ensure their acceptance (with the notable exception of Pansy). But in the end, their

weightfull bodies were coveted by these surgeons and associated medical technology companies, a fertile field for trading in WLS. When surgeons added WLS to their portfolios, motivations were clearly multiple with commercial self-interest and “*grateful patients*” appearing as important elements in that decision. But WLS patients were, and indeed referred to themselves as, “*guinea pigs*” (SusieB; Marjorie). Although all the participants gave some degree of consent to their WLS procedures, it is also clear that they were continually reinforced in the belief that they were more at risk from their weight than from these surgeries. A “drowning person does not ask too many questions about a life raft” (Hornblum 1999, p.241).

Doctors in this study spoke of professional responsibility for weight-in-their-practice as a duty of care in the current war on obesity. Their narratives demonstrated a reliance on medical rhetoric in ways that justified plying their trade in the battle against the ‘epidemic’ of obesity. This rhetoric is supported by complex complicities between medicine and industry. WLS is inappropriately promoted (although it could be appropriately discussed) when surgeons stand to gain financially and reputationally from recommending these radical interventions in the absence of fullest information and consent.

WLS in the private sector of medicine in New Zealand was a complicated consultation environment with little apparent or effective oversight. Patients were in awe of the knowledge/skills they perceived their surgeons to hold. Surgeons used their positioning to elevate their reputation, to influence outcomes, and to manage, control and cajole their patients. For instance, surgeons discussed in this chapter premeditated their offer of vanguard WLS procedures. They proceeded with new or new forms of older surgeries when they were inexperienced, had minimal training and lacked professional oversight for early-on procedures. These were systemic issues that led directly to problematic surgical outcomes.

Patently, WLS patients whose stories appear in this chapter were not kept fully informed. They needed to understand that WLS was investigational with uncertain long-term outcomes (Mitka, 2003). While life and death scenarios might require a surgeon to act promptly, the risk of iatrogenic injury from these elective procedures suggested that taking any surgical action needed to be tempered with sufficient reflection by patient and surgeon (Australian Patient Safety Foundation, 2000; Brennan et al, 1991; Edmonds, 2004; Leape, 1994; National Health Epidemiology and Quality Assurance Advisory Committee, 2006/7; Runciman et al, 2000). Groopman (2001,

p.214) suggested the maxim, “Don’t just do something, stand there!” ‘Doing something’ in medical terms does not mean doing harm. In a US study of malpractice claimants, women patients experienced greater marginalization in their treatment and more severe iatrogenic effects than male claimants (Fielding, 1999). It is critical to reflect on what it means when women are being targeted for WLS procedures in which so many iatrogenic effects arise.

Conflicts of interests for surgeons arose within with a very small group of participants. They became apparent only after I had remained some years in the field. As a patient and as a researcher, I expected that participants might experience some difficulties in relation to their care. On the other hand I could not have predicted that this research would relate to surgeons carrying out procedures they were not experienced in; that they might do so without the requisite equipment; that they might charge full rates for what were learning-curve procedures; and, particularly, that longer-term relationships of consultation might exhibit degrees of such poor ethical conduct around informing consent. Trust is fundamental to the practice of medicine and patients trust that doctors prioritise the welfare of their patients. Personal passion, convictions and trade compromised fully informing some patients. Indeed, the consultation arena and the operating theatre appeared through this research as locations of persuasion, serving decidedly personal and political agendas. Just as a “[...] good con man, after all, is very good at getting people to trust him” (Brody, 2007, p.6), medical practitioners also learn, practice and eventually master the skills of influencing their patients (O’Neill, 2003). Current informed consent processes conceal the nature of its acquisition by coding it within a tick box/sign off format.

The regulatory environment surrounding informed consent provides a basic framing for clinical standards of care that remain protected within the self-regulatory environment of medical practitioners. This is particularly so in the private arena of medical practice in New Zealand. Consenting to medical interventions requires reframing within a relational morality based on minimum standards of respect. Doctors could demonstrate respect by acknowledging uncertainty in the practice of medicine and by accessing the expertise of patients in their lives-as-lived. Medical consultations are problematic for accessing and privileging subjugated local knowledges partly because citizens, in the drive to consult experts, have become deskilled in relation to their own health. Respectful communication for doctors is about remaining open to learning from, and having opinions challenged by, patients.

It is significant that more women than men seek WLS so it is women once again who display and judge their bodies as deficient in the presence of a “panoptical male connoisseur” (Bartky, 2003, p.34) who gazes, evaluates and pronounces. In all the promotion of, and support for, weight for health initiatives including radical surgery options, what is not considered seriously in the clinic are “[...] the cultural and societal pressures that drive women to seek these interventions” in the first place (Latham, 2008, p.440). WLS presents an imminent threat to both life and health. The zeal with which WLS practitioners promote these surgeries demonstrates what Katz (2004/1984) was only too clear about over twenty years ago: “Optimism was fuelled, as it is today, by the belief (that) in the presence of a deadly disease it is the physician’s duty boldly to try everything” (p. 177). Whether the disease is breast cancer, carcinoma in situ or obesity, “single-mindedness” (Katz, p.174) displays attendance to personal and professional concerns that trump the required ethical focus on the patient. Practitioners have long tolerated mutilation, ongoing ill health or even the death of some patients in the pursuit of certainty in medical cures (Katz).

As this thesis demonstrates, such experimentation in WLS has once again placed women’s overall health in jeopardy. Failure to discuss these procedures openly with patients demonstrated disrespect and disregard for patients that ranged from dishonesty in communication through to deliberate deception. Banja (2004, p.152) proposes that “[...] overcoming narcissistically-based defences is key to encouraging the kind of morally appropriate feelings that health professionals should experience when they are tempted to offer the patient less than he or she is owed.” Fully informing consent is an onus that rests with medical practitioners. Informing consent consists of wide-ranging discussion through full and ongoing consultation. Only when consultation and informing consent for health interventions are based on relational respect for patients, will practitioners demonstrate that they are worthy of the trust patients currently continue to place in them.

“Recent transformations in the lives of women can often illustrate the way in which we, as human beings, change our interpretations of existing realities, give ourselves reasons to act differently than in the past, and think and feel and live differently than before.

We can understand how clumsily accounts of these changes fit into any familiar framework of causal explanation” (Held, 1993, p.11).

CHAPTER 11

Revisiting Weight-loss surgery Decision-making as a modern medical dilemma

“I believe that true scientific theory and practice must overcome this opposition by integrating into a single model the analysis of the experience of social agents and the analysis of the objective structures that make this experience possible”

(Bourdieu, 1988, p.782).

11.1 Introduction

In this final thesis chapter, I review some major understandings that have emerged in this research and revisit the arguments that these supported. In chapters 1 to 5, I built a critical context from diverse literature to support a feminist, Foucauldian discourse analysis of the research narratives related to WLS. I distilled views of a powerful macro environment of medicalisation that encourages patients towards adopting strategies of health intervention for prevention as a conservative position. Not intervening in health is fast becoming the exception. In chapter 6, participants spoke of living weightfull in a culture dominated by a female body size that is uniformly promoted and idealised as thinned. In the pressure placed on women to achieve an ideal slimmed body for health, and in the strength of their desire to be slim, WLS options were considered. In chapter 7, participants chose between two major procedures of a gastric lapband or a gastric bypass. Participants were often not aware of their options: They were unclear about referral processes; they learnt about procedures via magazines, pseudo documentaries on television, the Internet or from family, friends and doctors. Women and surgeons were encouraged to entertain these radical WLS procedures to achieve slimmed-weight health and acceptable appearance.

Chapter 8 traced the impact of these surgeries in which ongoing side effects were as unexpected as they were devastating. In the largely unexpected experience of pronounced and debilitating side effects following these surgeries, I questioned the effectiveness of these procedures. Side effects, including some patients' failure to lose weight, brought questioning into play within consultation. Given that patients are encouraged to question their practitioners in the interests of improving patient safety, chapter 9 provides an intensive analysis of what happened when some WLS patients did question aspects of practice. Essentially, relationships within this modernist surgery-for-weight-and-appearance project showed evidence of considerable strain when problems occurred. In chapter 10, I question the involvement of surgeons as they trade in these devices. Given the radical nature of these interventions, surgeons needed to undertake appropriate training and proctoring for early-on procedures: This did not occur. These were systemic issues that patients had little or no awareness of. WLS narratives in this research demonstrated both moral and legal violation of informing consent when personal/cultural/medical agendas trumped the essential focus on the patient.

The task of philosophy, according to Foucault, is to question domination in all its many forms (Foucault, 1977). In my analysis of taken-for-granted assumptions and the relative influence of evidences, I have been led to research in ways that "[...] shake up habitual ways of working and thinking, to dissipate conventional familiarities, to re-evaluate rules and institutions" (Rabinow, 1984, p.354). This thesis contributes to a critical health movement by challenging any ready acceptance of the body size protocols that emanate from weight/health research and the extreme body projects that are provoked in the name of health. I have engaged with forms of social criticism to explore WLS decision-making and in this final thesis chapter, I review some major understandings that have emerged in this research and revisit the arguments that these invoke.

The findings of this thesis are specific to WLS consultation and decision-making. Even so, the critical context adopted has indicated the advisability of resisting narrow and fixed ideas on what constitutes lived-body health. In particular, I challenge the inevitability of benefits in the wider application of radical health technologies such as WLS and suggest that medical consultation is itself hazardous. As such, WLS consultation requires attention to, firstly, the cultural and trade insistences that limit the

parameters of weight/health and, secondly, to relational aspects of consultation based on respect for patients' expertise in their own lived health.

11.2 Researching women, weight and health

If there is a major gap in the literature surrounding lived weightfullness, it lies in the absence of voices of those who live weightfull (Komesaroff, 2008). As a researcher and as a weightfull woman, I am therefore embedded in this text. From the beginning of the project, I sought to involve weightfull women's lived experience of consulting about weight. This decision emerged out of many years of attempting to deal with my own large-body size, culminating in a decision to have WLS. That I felt able to refer to my experience of decision-making around weight emerges out of a belief in the value of reflexivity as a life practice. Although, as a result, my writings are "[...] anything but a straightforward, unproblematic, descriptive or interpretive task based on any assumed Doctrine of Immaculate Perception" (Van Maanen, 1988, p.73), I make myself available in a number of ways through this text and allow myself to be read therein. I am especially grateful to the women participants who spoke movingly and often pragmatically about living weightfull-women lives and some decision-making junctures they encountered along the way.

This study came, in the end, to focus on the modern medical technology of WLS. It was not until I had interviewed the first participants that I chose to foreground this technology. I believe, now, that I needed to come to terms with my own decision to use these technologies before I could make it a central focus in, not so much speaking with participants, but in actually writing my decision into a public document. Given that my philosophical positioning relies on self-reflexive practices, the congruency of this thesis text depended on just that level of my participation. As well, I have contextualised WLS within, and challenged its ready acceptance on, some historical analysis of the development and acceptance of progressive medical science. I have embedded my study on weight and WLS options within an historical analysis of the development of modern medical authority. To have done otherwise would have constituted a glaring omission, akin to "[...] studying a heavenly body without considering its relations to other such bodies in the solar system" (Bourdieu, 1988, p.776).

Women's decisions were clearly embedded within mediated visions of ideal-feminine appearance. Much has been made in the literature of the need to construct women as agental in their decision-making as they negotiated a rewards-based existence concerned with conforming to ideals of the "body beautiful" (Chapkis, 1986, p.14).

Theorists such as Davis (1995) have struggled to produce accounts that balance a feminist critique of cosmetic procedures on highly visibilised ideals of femininity alongside a strong belief in women's right to choose. How do we maintain a strong "critical edge" as feminists (Bordo, 1993, p.32) while representing the complexities of living and choosing within the contemporary world? Extrapolating from various critical feminist accounts of cosmetic surgery practices, WLS comes even more immersed within a complex culture of possibilities. Potential weight/health manoeuvres proved a maelstrom for participants such as Michelle, who agonised: "*I can't change my body as much as they think I can.*"

One possibility was for me to take a non-blaming stand for women but against such practices. This remained problematic even while it provided some sense of a solution. It is, as Davis (1995) suggests, essentially an oppressive way out of a particular bind. WLS may be seen as analogous to cosmetic surgery procedures however much patients and surgeons prefer to push the potential benefits to health of WLS options. WLS is, like some forms of cosmetic surgeries, about achieving normalcy in weight and appearance. My response to this conundrum in the research has been to explore the options of WLS as a modern dilemma of health and beauty. I have done so within a wide exploration of the power relations inherent in having a settled, commonplace idea of what ideal weight for appearance and health is all about. What I did in the end was to adopt a "polyhedron of intelligibility" (Foucault, 1994/2000, p.227). In so doing, I regarded WLS from an array of multifaceted perspectives and did not settle,¹ for the purposes of this thesis, what is "a good" weight, "a good" appearance or even "a good" relationship of consultation.

11.3 Ethical practice and the trade in weight-loss surgery

Health sector relationships, and in particular, the doctor/patient relationship are unique. They rely on largely implicit permissions supported by a structure of explicit consent-taking to intrude on otherwise sacrosanct bodily processes and within a range of private and personal matters. As Bury (2004, p.49) has said, "a peculiar form of trust has to exist between doctor and patient to legitimate such taboo breaking." Consequently, patients or potential patients, and this includes myself, have needed to believe that medicine is on a higher plane, clearly above the hurly burly of the marketplace. The privilege extended in these forms of contact rests on a particular morality of protecting

¹ This refers to Bourdieu's notion of not trying to prematurely settle the uncertain by writing it down (Bourdieu, 1988)

the patient (Stauch, Wheat & Tingle, 2002). This applies within the diversity of essentially medical relationships that patients consult within a lifetime. More recently, headlines in the news or troubles in the surgery suggest that commerce and other forms of self-interest have intruded excessively in this unique and privileged consultation relationship.

In tracing a brief history of modern medicine in this thesis, I have highlighted how citizen/patients have been encouraged to place their bodies on the line in the search for cures. This rhetoric has fostered a second-order belief in the progressive nature of modern medical science. That belief rests firmly on a first-order belief in the objectivity of science. That objectivity has been dealt a considerable blow over the last few years when negative effects and disconfirming studies are found to have been suppressed by medical researchers; where high-level researchers at the United States based National Institutes of Health have received payments from industry that may have compromised their judgment; where confidential information from ongoing clinical trials has been leaked by researchers paid to talk to investors; when some doctors have accepted bribes in exchange for using devices or prescribing drugs; when patients may be unknowingly enrolled in clinical trials [...]. In the end, choices made in relation to making money reflect the values we hold (Kassirer, 2007). In respect to the practice of medicine, using patients for financial, personal or medical ends is reflected in a concomitant deterioration in patient trust and the authority of medicine. The prisoners experimented on at Holmesburg expressed considerable disdain and distrust in “the eminent men of medicine” when they were paid “money for a piece of their skin” (Hornblum, 1999, p.242).

I have argued that medical practice is based primarily on a morality underpinned and disconcertingly undermined by a legalist framing of rights and responsibilities.² Specifically, I have come through this research to understand that the welfare of the patient rests secondary to the maintenance of professional power, knowledge and performance. For instance, this thesis has dealt at some length with the operation of informing consent processes: When the professional emphasis within informed consent is concentrated on self-interest and self-protection, then patient-agency in relation to decision-making over choice and care is correspondingly vacated. I suggest that practices of consultation that emphasise meeting rules and regulations are consequently

²I refer the reader to chapter two in regards to the regulatory environment surrounding patient/doctor consultation in New Zealand.

and increasingly detaching practitioners from the very morality that might infuse these rules to make them work within practices of relating. Where the “[...] liberal individual has no motive – of empathy or caring – to concern himself with others” (Held, 2002, p.158), other than a contractual basis for the provision of a service, then professional relationships will disintegrate. This is about the trustworthiness that patients routinely relied on, considered integral to medical relationships and which was lacking. When caring relationships become signified as professional caring, they are increasingly notable for their “indifference or unconcern” (Gilligan, 1993, p.22). Professional medical consultations cannot be about an equality of rights for atomistic citizens: Patients have a justifiable moral claim on practitioners to attend to the relationship with at least an empathic attendance to the story of illness or dis-ease (Walker, 1989).

Good-enough care is the minimum standard of caring for a patient, but relying on such a minimum of care raises the potential for the inappropriate intrusion of alternative agendas into the medical consultation environment. When modernist doctors are captured by the cultural and commercial underpinnings of problematic weight, they substitute fully informing patients with espousing notions based on medical habitus, epidemiology and their own self-interest. From steering decisions in ways that were “gentle but firm” (Henley, 1977, p.149 in Bartky, 2003, p.31) to oppressive declarations of imminent mortality, women participants were provoked into undertaking WLS procedures: After all, “(p)ain and the threat of pain usually bring compliance with the dictates of a disciplinary regime; they render the subject obedient, docile” (McWhorter, 1999, p. 179).

The rules around informed consent procedures for radical, elective and costly procedures were, in this research, routines that in the end acted to protect the surgeon even while they were framed as protection for patients. Consultation relationships remain asymmetrical: Surgeons minimised the iatrogenic effects of their surgeries, chose to proceed with them on their own grounds, listened-for and spoke at patients rather than listening-to them, and relied on discrediting already discredited patients to void responsibility in the event of problems. They demonstrated little concern for maximising overall benefits for these patients.

Medical consultation would benefit from ceasing to rely on outdated and inappropriate forms of beneficence evidenced in the exertion of authority over patients for their own good. Doctors would need to change their practices of relating with patients and they would value informing consent as an ongoing process. Women who

consider radical technologies of the self also need to act as ethical agents in their own right. This is about reflecting on how we value ourselves within cultural processes of normalisation that determine cultural valency (Heyes, 2007; McLaren, 2002). Participants considered living large to be a painful experience: Still, there are many forms of physical and emotional suffering to which people adapt through a lifetime. Personal ethical questions abound: Which is preferable? Is it about living large but healthy, or transforming ourselves to meet current whimsy or presumed health benefits of slimmed body size? What are the immediate and ongoing dangers to health that WLS may bring? What is of most interest through this thesis is how each participant “acts upon himself” (Foucault, 1988, p.19).

11.4 Consulting weight-loss surgery

There has been increasing pressure to halt what is often referred to as the obesity epidemic (FOE, 2006; Haslam, 2006; Ministry of Health, 2004; WHO/FAO, 2003). In the failure of dieting to produce long term sustained weight loss and improved health outcomes (Mann et al, 2007) WLS entered the frame. If living healthy is indeed possible at any weight with exercise and quality food, those messages are difficult to deliver in a mediated environment redolent with bias against fat bodies. The visibility of WLS procedures has been ensured through DTCA in New Zealand’s trade environment. In mediated presentations, the connection is made between the technology and members of the trusted³ medical profession (Rampton & Stauber, 2001): This influenced participants who believed that they needed or wanted to reduce weight. They bought into WLS as the modern surgical answer to that problem.

Participants routinely turned to their ‘Internet’ and ‘media’ doctors. While this practice was informative, it did not offer alternatives to medicine but tended to redirect women back into mainstream medicine. Participants would have benefitted from discussion of internet and media material in an environment focused on living largely-well lives. Consultations for WLS brought together the pressure for medical science to produce new solutions and the commercial imperatives of technological companies to promote their particular items and procedures. In this study, there was a tendency for doctors to exaggerate their prowess in relation to these new technologies for

³**Gallup Poll. Dec. 8-10, 2006.** "Please tell me how you would rate the honesty and ethical standards of people in these different fields: very high, high, average, low, or very low? Nurses, 84; Pharmacists, 73; Veterinarians, 71; Doctors, 69. **The Harris Poll. July 7-10, 2006.** "Would you generally trust each of the following types of people to tell the truth...? Doctors, 85; Teachers, 83; Scientists, 77; Police 76; Clergyman, 74.

reputational and financial advantage. Particularly in early WLS procedures, surgeons in this study displayed significant difficulties in managing these new technologies and used patients in their own upskilling.

The WLS consultation emerged, during this research, as an intense moment in the lives of women who have grappled with living weightfull. Decision-making within these consultations was propelled by the coalescence of inextricably interwoven discourses. Essentially, the history of medical science has become woven through cultural notions of goodness, conflating sightliness with goodliness evidenced in a mediated-thinned-healthy, and preferred body. With WLS consultations mainly positioned within the domain of private medical practice, the major source of information prior to surgery occurred with surgeons in pre-surgery consultations.

When women entered these WLS consultations, they did so looking for the technological fix they have been sold via the internet, TV and media. Elective-surgery patients met surgeons who were clearly prejudiced against weighty bodies and excited by presentations of the newest medical cure, WLS. These doctors were at least as affected by media presentations of desirable bodies and thinned body size as their patients. As well, the healthy body in medical school and the clinic is a thinned body. WLS consultations have become risky, conflicted environments in which to make (w)holistic and well-informed choices about surgery for health and appearance.⁴ When women entered these consultations, they were vulnerable around their fit,⁵ appearance, and health. This vulnerability has increased over the last ten or so years with the proliferation of public discourses that make large bodies unacceptable in the marginalisation and vilification of overweight and obesity. That marginalisation has enhanced the potential for WLS to be promoted as a practice of trade. It has also increased the likelihood for premature and symptom-focused decisions within the 'regional' environment of WLS.

The inevitable reductionism of growing medical specialisation has exacerbated a tendency within medicine towards a perilous form of body regionality. The thigh-bone no longer feels so firmly connected to the hipbone. The proliferation of technologies

⁴Given the domination of medicalised weight, the public system appears marginally safer because there is a limit on the number of procedures that can be performed; a multidisciplinary team is involved in the decision-making; surgeons do not profit individually; they are accountable within the system for procedures performed.

⁵Fit is the term I apply to the range of problems women experience in their day-to-day life: Fitting into seats, clothes, medical technologies, toilets on airplanes and so on.

and pharmaceuticals, the expansionist,⁶ business-oriented thrust of pharmaceutical companies, medical technology companies and medical practice, alongside the development of new surgical techniques, has created a patient-base ready to respond to that very availability. The belief in, and dependency on, medical science to improve lived-lives has acted to produce a risky consultation environment within which patients and doctors make serious life decisions.⁷ This is not intended to be a critique of medical technologies per se: Rather, it problematises the essentialist rationality of specialisation within medicine that promotes a focus on specific areas, processes and practices of the body to the diminishment of the person-body as a lived totality. To the extent that symptom-focus acts to escalate the rift between the patient-as-body and the lived-person-life, the presumed rationality of medical injunctions and decision-making by doctors and patients takes on the appearance of an absurdity, which is both counterproductive and harm producing.

The general practitioner in New Zealand works at the interface with patients and referral into the wider health system. The ability of GPs to determine requirements for urgent referral-on to specialist or emergency care is not in question here: Their work is based within patients' everyday concerns and medical needs, issuing medications, monitoring, screening and advising. GPs in this study had neither the inclination nor the time to be current in all areas of patient need. The proliferating knowledge base and technologies within medicine are managed therefore with increased speciality.

The GP occupies a position within the medical hierarchy in which they may earn less than surgeons and specialists; they inhabit a practice environment which is involved in the intimate, day-to-day health experiences of patients; their status in relation to surgeon and specialist colleagues, may be negatively connoted by that positioning. General practitioners and specialists in this study practised at the medical interface with patients. Patients were referred back to GPs if issues relating to compliance arose or they were to receive ongoing care. Rudimentary and out-of-date information about weight and obesity surgery became apparent within the general practice environment and this did complicate everyday care and decision-making for patients. A lack of specific

⁶ The descriptor, cynical, might be employed in situations in which a company, Glaxosmithkline, which produce Ribena for toddlers with high levels of fructose and minimal amounts of vitamin C or real fruit also produce diabetes medications (Anonymous (NZ Herald), 2007).

⁷ My use of "life" in this context where I might normally have used "medical" is deliberate: While the decision to operate on an ankle and to place it in a cast, may fix the ankle, weighing up the effect of a heavy cast on a compromised back or hip pathology has overall effects on the lived body which need to be factored into that decision-making.

knowledge underlay an expressed reluctance by some practitioners to refer a patient on to weight-loss surgeries. As well, when some GPs accessed feed-downs of limited information about surgeries from surgeon-traders or when highly speculative findings were presented to them as shorthand facts, “informed” practitioners could become unsuitably eager to refer on. In turn, these GP consultations become subject to unexamined, encultured biases about weight and health in which even radical interventions began to seem reasonable.

Participant-patients recognised this lack of up-to-date, fully informed and individualised content in consultations, particularly when they noted their very real concerns being summarily dismissed. The medicalisation of Western culture has been fundamentally impelled by large corporate pharma: Their influence in New Zealand and the USA has been intensified by the legality of DTCA for drugs, medical procedures and equipment. Patients have been poorly served in relation to this perceived wealth of possibilities for weight and health: Citizens are inundated by advertising documentaries and reality television weight-loss programmes; daily living is accompanied by explicit fat bias in the media where reference to overweight may be pictorially represented by downloaded website photos of extreme forms of overweight; citizens access mainstream Internet information that focuses on the regurgitation of a core discourse of medicalised material in which weight-loss at any cost is deemed beneficial; patient-support networks discuss surgical options throughout the country rather than within the limits imposed by what is on offer in the local community; the current knowledge about procedures and drugs of participants in this research indicated that patients may be much more current about available options than their doctors.

While caution may well be the most appropriate advice within a GP consultation, when that cautionary advice is based on poor information, patients discount it. In this research, participants pursued surgery options in an environment in which lip service was paid to the formalised processes of referral: The letter of referral did not necessarily predate the pre-surgery consultation.⁸

11.5 Injury in the context of treatment

The HDC was created as an independent agency to “[...] facilitate the fair, simple, speedy, and efficient resolution of complaints about the quality of healthcare and disability services” (HDC, *Right 10*, 2004). When things go wrong within the present

⁸“In New Zealand, access to secondary care, except in an emergency, requires referral from a general practitioner” (Raymont et al, 2008).

environment of medicine, doctors and their organisations portray themselves as beleaguered and may threaten to withdraw services. Those threats, implied or explicit, may lead to the neglect of individual patient concerns. For instance, complaints against individual doctors may not be properly and in good time investigated; the focus in complaints' processes may be continually placed back on the patient or the more convenient empty signifier, system error, rather than the practitioner, the practice or the technology. As well, HDC processes in New Zealand allow doctors involved in similar practices to judge the actions of their peers; patients may be deemed capable of lying to gain their ends while doctors' mere assurances are accepted (HDC, 2003). My thesis research shows that doctors lied to their patients to gain compliance, to meet their own ends in research, and to cover their tracks when patient care was compromised.

This research also shows that patient-focused medicine remains illusive in the practice of WLS consultation, an empty signifier variously invoked and advanced as the element of practice that protects patients. It is in this context that rates of iatrogenic injury have proliferated. When things went wrong in these surgeries or when some patients questioned their doctors, practitioners routinely acted to protect themselves. As well, many of these events did not reach a public forum of any kind: Medical errors remain severely underreported (Lamb, Studdert, Bohmer, Berwick & Troyan, 2003).

As I have argued earlier, the various performances of medicine or surgery require the evocation of a patient's trust. Consultations and procedures are critical contexts in which patients wish to trust and need to be able to rely on doctors. For a medical professional to feign caring or concern is not difficult, yet consultation relationships that exploit the fiction of the caring professional create risky environments for patients. In even a small study such as this, which took place over a number of years, the number of women who were exploited, harmed by poor practice, and exposed to misinformation in so called consultative relationships, was as unexpected as it was alarming. The physical, emotional and financial health of a number of these participants was at the very least undermined: Some were irreparably harmed.

What is evident through this research is that reliance on legally sanctioned parameters of informed consent based within autonomy has failed to deliver a safe site for the practice of WLS consultation. There also appears little possibility of a change in the framing of ethics from those based on the notion of autonomy any time soon. Thus, in Chapter 10, I suggested a readily achievable degree of remedy lies in informing consent within a relational ethic of care based on respectful communication.

Calls to become surgical are based within ideas of an individuated, authentic self. Foucault referred to the modernist search for authenticity originating within the self as a virtual “Californian cult of the self” (Foucault, 1994a, p.271). Such a search belies the relational embeddedness in which lives are lived and decisions are made. The complexity of decision-making for WLS indicates a necessity for new ways of practicing caring (Ellis, 2003). A critical/reflective turn on choices and freedoms available within a modernist, consumerist cult of the self constitutes a powerful resistance to the domination of expert discourses in relation to health choices. For both consulter and consultant, taking care of self in Foucauldian terms is evidenced in self-care activities and in carefulness towards, and freedom from the exertion of control over, others.

11.6 Implications for the future: Focus on weight, health and intervention

Increasing medicalisation is a subject of sociological significance, “[...] an accelerating trend that has important implications for society” (Conrad, 2007, p.x). This has been demonstrated in the widespread acceptance that the slightest deviation over “normal” weight creates health deficits. This is an example of truths that are falsely obvious and hardly neutral constructions yet become accepted as commonsense (Bourdieu, 1988) in relation to weight and health. Commonsense and widely-held notions encourage a treatment perspective in which treating becomes the conservative position and not treating weight reverts to being a radical position (Foster & McGucken, 2004; Wooley & Garner, 1994). A lifetime of treatment for WLS participants in this research has been at considerable physical, financial and emotional expense.

In the specification of areas of concern for future research, the experiences and conversations with participants and doctors have pointed to the need for sensible precautions for patients considering any type of surgery. I have indicated the requirement for practical improvements in caring for and about patients who require or seek medical and surgical interventions. I repeat: Even while WLS may be of clinical value to some patients, WLS consultations are a risky environment in which to make radical surgery decisions. For example, if better overall-health outcomes are associated with weight parameters in the overweight categories of BMI, then this has serious implications for WLS decision-making. When notions of health and weight are culturally and commercially mediated for women within medical consultations, they are health limiting: When WLS is proposed as the answer to a spoiled body or identity, a certain aura of recklessness proliferates within a lucrative trade in weightfull bodies.

The context in which WLS decisions are made requires an improved and expanded view of health and weight. Decision-making about WLS needs to take place in an environment in which not treating rather than treating is the natural or fall-back position. From that point on, limited technological interventions may be made available in a regulated and highly ethical practice environment. Specifically, I suggest and comment on potential improvements in WLS consultation:

- Pre-surgery consultation needs to be separated out from the medicalised and mediated hysteria of encultured weight standards to allow for improved health at any size.
- We need to challenge the “fat” prejudice that continues to infiltrate medical consultations (Wooley & Garner, 1994) as demonstrated in this present WLS research. This lies in training the eye of the medical beholder to accommodate emerging notions of health at any weight rather than thin at any cost.
- WLS requires improved consultation processes prior to referral to a surgeon. While surgeons’ considerable finances, emotional needs and reputation are invested in these procedures, the ethics of weight-loss surgeons providing the preoperative assessments and postoperative care remain open to question. Pre-surgery consultation needs to be focused on explicit and individualised sharing of information between experts. In the current environment, GPs routinely rely on being handed information by surgeons: This is often partial, sketchy and trade-related. Patients need a tiered system of referral that includes referral to a specialist physician or other holistic practitioner before referral to a surgeon specialising in WLS. The findings of this research call for augmenting the category of specialist, patient-focused physicians to work the interface between medicine and surgery, specialists to whom patients with complex, chronic or specific needs may be referred or may self-refer. The surgeon’s specific job in relation to WLS options needs to be concentrated on the application of excellent bariatric techniques, safely practiced, in centres of excellence.
- Specifically, surgeons require ongoing oversight and learning from peers, patients and other professionals. Before undertaking radical procedures, maximum rather than minimum standards of training, proctoring and equipping need to have been fulfilled. These standards require professional ratification

and supervision by the profession in discussion with external agencies that remain steadfastly focused on safety and benefits to patients.

- The demand for treatment cannot be its justification. The possibility is that the lucrative trade in WLS needs to be sharply curtailed. This may deny access for some consumers who do not meet strictly enforced criteria for acceptance. This is too radical an area of health to allow the proliferation of off-label⁹ usage with patient groups such as young patients or those with diabetes or low BMI. Such increased constraints may force some specialists from the field. This is a reasonable outcome that requires consideration.
- There is a tendency within New Zealand to inertia in regards to poor medical practice. Concerns about certain practitioners are too often ignored, with the evidence that this has been to the detriment of numbers of patients through the years.¹⁰ When things go wrong in surgery, waiting for a patient to complain is an insufficient response: Improved practice relies on open inquiry automatically instigated by the professionals involved. When a patient expresses concerns or lays a complaint, thorough investigation of these concerns is a basic requirement for transparent processes in which all information to any enquiry is made available to the patient as well as to the practitioner. Patient information needs to be dealt with as valid, equal-but-different, to that of doctor evidence. The incorporation of all forms of consultation material into any investigation and the exposure of this information to positioning-analysis,¹¹ would ensure equitable and sufficient investigations of patient concerns, medical mishaps or medical misadventures.
- When treatments fail to produce expected results, or deliver unwanted or unexpected results, attention needs to be focused at least as much on the treatment and the provider of the treatment as on the traditional and easy target, the flawed patient.

⁹Off-label usage refers to the practice of medical practitioners to trial medications or technologies in novel ways that are not approved.

¹⁰Through the period of this research, it became apparent that complaints early on in a surgeon's career tended to be repeated. If this proved to be a significant issue, then dealing swiftly and decisively with poor processes of informed consent and poor technique on their first appearance in the complaints' arena has much to recommend it. In this research, the surgeon who operated on Rosie had already had a minimum of two significant complaints about his practice with minimal findings.

¹¹ I am suggesting here that complaints processes need to deliberate on complaints with specific attention to the operation of the invocation of power in relation to knowledge. It is this aspect of complaints procedures that neglects patient reports as equal but different.

- Professionals, including WLS practitioners, need to be open to accepting degrees of responsibility and be required to make reparation for deficient practice. There are clear societal rewards available to medical practitioners; on the other hand, being held responsible and being disciplined as individuals has become unfashionable under, for example, New Zealand's no fault compensation for medical injury legislation. Szasz (1974) suggests that this relates to preferring an amorphous collective guilt that disperses individual responsibility. Rewards and acceptance of responsibility belong together: The use of discipline in relation to medical error or poor practice is not about revenge but about improving practice and preferencing professionals who are prepared to take responsibility for their practice decisions. The jury is out on whether a no-fault system of recompensing patients¹² results in more open disclosure of medical errors or has even led to increased patient safety in hospitals (Davis, Lay-Yee, Briant & Scott, 2003; Gilbert, Cheung & Kerridge, 2009).¹³ Overall, this is an astonishing red herring: This suggests that when medical errors occur, protecting the practitioner is more important than the harm that has been occasioned to the patient. As Lamb (2004, p.3) has said, "[...] the open, honest, and timely disclosure of medical error to patients is indeed the right thing to do and should be the only approach to medical error." In this thesis, concerns have been raised about elective procedures in the private system: Patients paid large sums of money for procedures which were at times poorly performed, resulted in ongoing ill health, or did not even work. These New Zealand citizens had no way to receive recompense. The financial advantages that accrue to practitioners in these instances are never addressed.

 - Patients need to be encouraged to ask questions based on an expectation and experience of having their questions taken seriously. Answers need to be based on facts as the doctor knows them, never espoused, and always with an openness to critique and ongoing discussion.

¹² No-fault compensation in relation to adverse medical events has not righted "[...] a well documented shortcoming of the tort system — only a small proportion of patients eligible for compensation after an adverse event actually receive it, and vulnerable subgroups of patients are the most unlikely to claim" (Bismark, Brennan, Davis & Studdert, 2006).

¹³ In this very recent article from Australia, the simple act of handwashing by physicians is again under the spotlight. When non-compliance with hospital protocols was individually sanctioned, baseline compliance improved markedly (Gilbert, Cheung & Kerridge, 2009),

- The modern patient is produced as an autonomous health consumer. In fact, as this research has indicated, in the array of expectations about how citizen/patients will behave towards themselves (self disciplines) and to others (patients and providers of care), they remain subject to the authority of the health-care provider. It is the provider who determines patients' responsibilities and this curtails patients' rights to act independently (Irvine, 2002). Citizen/patients are considered in need of surveillance and corrective interventions by departments within Governments and medical organisations. In the end, notwithstanding potential benefits to some people, this opens citizenry to the potential for "unlimited exploitation" (Bourdieu, 1998, p.94). Patients need to be fully involved in their health care without the risks of too much service, poor service, no service or the withdrawal of services.

A major issue in relation to WLS, is that medical researchers and doctors are granted the implicit privilege to define what is right. To counter any unwarranted spread of radical WLS options, a critical approach to WLS is advocated. It is timely to suggest that the questions Oakley (1993, p.12) posed about women and reproduction could be adapted and applied now to weight and WLS options. For instance,

"Is there something genuinely sick-making about being fat?"

"How have treatment options contributed to the problem?"

"Whose idea was it to treat fat as an illness?"

"Was that a good idea?"

These questions are basic within a critical examination of modern health technologies. Increased scrutiny and scepticism of emergent technologies increases the possibility that patients and doctors will be alert to the risks and benefits of interventions in a context in which medical practice no longer screens off the uncertainties of medical practice: Patients need involve themselves only in "what is sensible, safe, and necessary" (Richards, 1999, p.268).

11.7 Highlighting opportunities, dilemmas and limitations in this research

This research relied on a wide analysis of the discourses around weight and WLS technologies especially as they were spoken about in clinical applications. To this end, I relied on interviews with fourteen WLS participants (Appendix 13) supported by

material from interviews with other weightfull women participants, a reflecting team process with four of the respondents already interviewed, fourteen doctor participants, material about WLS participants and providers in HDC Opinions, six years of emails to a support group for one participant and a diary from another, clinical notes and news items in which direct quotes were reported.

My thesis did not aim at any generalisable truth about medical consultation or WLS for that matter. I chose a convenience sample, based on a general request to members of easy-to-contact populations who were weightfull and/or had considered WLS options. Any person who responded was interviewed. This resulted in a wealth of data. One dilemma in relation to this amount of data is about whether a data-analysis technology might have sampled the data more rigorously than was possible for a single researcher. In the event, the system that I applied worked well for me and this is discussed in chapter five: It did not predetermine what could be gleaned from each set of data while I maintained ready access to the narratives and interviews.

Feminist research approaches emphasise the importance of collecting data that will be used. During the process of this thesis, I have made decisions about focusing and then refocusing on issues that were emerging as significant. Consequently, much material has been written up that has not appeared in this thesis manuscript. It is my intention to return to that material to write up this research for academic journals and conference presentations as well as in more readily accessible forums of public discussion and articles.

Readers may be perturbed about some of the negative accounts of this surgery. I must say that I also expected mainly positive accounts and these were apparent in some initial interviews. By remaining open to further interviews over an extended period and by applying an analysis of the discourses, I traced the breakdowns in technologies and consultation relationships through an intense period of experimentation in WLS technologies in New Zealand.

Clinicians who consult this research may be disappointed by the lack of definitive data about initial weights and measurements or clinical records related to weight loss and regain. I did not weigh participants, and asked only that participants discussed their weight in relation to pounds, kilos, clothing, fit or comfort as they wished. Most participants did make multiple references to their scaled weight and I have indicated the notional weights mentioned by these participants in relation to the surgery they chose (Appendix 13).

Qualitative data-gathering processes led to a critical reflection on the state of play within the largely hidden arena of WLS consultation. In this critical discourse analysis, I engaged with a humanistic portrayal of the participants while I strove to place the practices around WLS within their wider contexts. Practices and decisions in WLS are clearly limited by economic, political, and ideological forces that did not tend to be discussed in decision-making processes. This study has paid attention to how patients and doctors speak about and write those understandings into a diverse array of literatures. I believed that tying these events into the wider contexts of the history of medical science and progressive medicalisation, for instance, would add immeasurably to the richness, credibility and comprehension possible within what was a small, single researcher study.

My own experiences of consulting with clients for over twenty-five years, including work with medical students, and being a weightfull woman, prompted involvement in this research area. Having been exposed to a range of both reasonable and negative experiences with WLS was a dilemma, that in the end, was essential to understanding how these WLS technologies and processes of consultation worked in practice. In the early stages of the research, I was concerned that the less positive aspects of WLS experiences, resulting in my complaint to the HDC, would not be available to the research through the experiences of other participants. I responded to this dilemma by making my own experiences available in a range of ways on the understanding that qualitative research is about expanding on rare occurrences rather than on frequency of occurrence. As the research unfolded over six years, however, my experiences in fact merely foreshadowed those of other WLS participants.

Interviewing in a reflective style, with my ear attuned for the operation of power/knowledge/discourse, was second nature long before I began this research. This allowed me to take up opportunities as they presented themselves in the interviews. I did not routinely rely on listening later and returning to seek clarification, outside of the circumstances of the original interview itself. Observation and the co-production of meaning with participants (Kvale, 1996) required me to change tack and explore new ideas as they occurred. Interviewing was a powerful research strategy yielding rich and complex data. This kind of information, based on the narratives by and about participants, surfaced a graphic representation of how participants in this research thought, spoke and acted around WLS options.

Some triangulation of the data occurred naturally in this qualitative New Zealand research study, and was intended in the use of a reflecting team process. But, the researcher's account is always designed for a wider audience (Mays & Pope, 2000) and a critical discourse account of weight in the current health climate is neither widely held nor understood in the WLS community. I was influenced by a critical approach to these narrative accounts though the reader of this research is still able to trace the multiple positions held by research participants. Within these research interviews, I captured moments in time when meaning was being constructed: This research is based on what was happening at that moment though some participants chose to contact me in an ongoing way.

I could not have foretold just how relevant this research might become over its lifetime. During the course of the research, WLS uptake has increased markedly in the private sector of health in New Zealand and the New Zealand Government has become involved in limited provision of procedures out of public funding. The surgeons who were interviewed and some patients were adamant that these were successful procedures: Some patients lost weight. I have suggested some alternative views based within a critical-health approach that does not equate weight loss with better health. I believe that this approach contributes to the knowledge base (Mays & Pope, 2000) around WLS options and practices of surgical consultation and might provide more of a reality check for surgeons, doctors and patients who become involved in WLS.

11.8 Suggestions for further research

Significantly, communication was critical in WLS consultation. Patients and surgeons were intent on their own goals in pre-surgery consultations and did not appear to sufficiently question the impact of that difference. These differences surrounded what was happening and what the participants, doctor and patient, wished to achieve in the pre-surgery consultation. In the section on limitations of this study above, the study and development of a reflective practice tool in regards to WLS and other area of medical consultation was initially suggested. I suggest that this is critical in achieving greater correspondence between the goals of doctors and their patients.

I have commented on the fact that at least two practitioners mentioned by participants in this research were subjects of complaints to the HDC about informed consent. Further issues in relation to informed consent throughout this research indicated that this is an area that requires quite some concentration in qualitative research endeavours. As well, research into ongoing issues related to informed consent

throughout the practice life of a practitioner is indicated. For instance, I question whether Rosie's life would have been placed at risk had her original surgeon been firmly disciplined when complaints were pursued earlier in his career. The same question needs to be asked about the circumstances surrounding a complaint laid by the patient who appears to have been the first gastric bypass death in New Zealand.

I have suggested earlier that positioning¹⁴ analysis needs to be applied as a matter of course in HDC complaints procedures. An analysis of HDC Opinions in which the actual words of parties to the complaints, as well as those of expert advisors, could provide some indication of the relative value placed on narratives of doctors and patients who are parties to these proceedings. This might fruitfully be followed through in interviews with participants. While the former are often available in anonymised public records, it would not be possible to go from the opinions to the complainant or the medical professional involved. On the other hand, seeking interviews with those who have participated in complaints' procedures could include accessing anonymised public records.

This research traced WLS consultations through the private sector of New Zealand medicine over a ten-year period. Returning to speak to these particular participants or to those who lived with these technologies for fifteen to twenty years would provide some longer-term context. Also of interest for comparative research, is how these experiences of consultation might be supported by accounts from within other modern surgical and medical trades such as reproductive technologies or the spread of dementia pharmaceuticals. As well, research into the public versus private sectors of trading in WLS (or other technologies) might improve our understanding of aspects of trading in health/medicine and how that impacts medical consultation.

11.9 Moving on

This research into participants' stories of weight and weighing, surfaced a discourse set that was fragmented and ambivalent but also hopeful and enabling as participants strove to enact health and appearance from an array of treatment possibilities. Nonetheless, weight-as-appearance was inextricably merged with the epidemiology of weight. The stories of women participants reverberated with a wealth of complex and intense experiences around living large, weighing, and being weighed in medical consultations. In a meta-narrative which sought to touch upon this multiplicity of weightfulness(es),

¹⁴ Refer section 5.8.

there emerged stories of women living weight-full as they moved within, produced and were re-produced by, the socio-cultural medicalised environment.

Through this thesis, I have argued that the uptake of medical science technologies in the form of Weight Loss Surgery (WLS) is a highly intrusive response to a modern problem surrounding large body size. In the appearance of WLS within the micro practices of the clinic, the current and powerful messages surrounding ideal weight in a mediated, medicalised, progressive science environment have acted to limit a fully informed view of individual health, and the seriousness of WLS options. Based on the narratives of women who undertook WLS and the surgeons who offered it, this study has shown that surgical consultations constituted a risky environment for decision-making over WLS options. WLS is a set of surgical technologies, of possible medical value to some patients, but it is also a trade. This research has displayed, within the micropractice environment of WLS consultations, that benefits to patients from these new technologies may be eroded in the presence of too close an alliance between the medical profession and the large companies. The application of WLS is limited and its current proliferation needs to be controlled. Safe decisions for WLS would benefit from being separated out from practices of trade, where financial, reputational and/or cultural commitments to current ideal weights inappropriately impact patient decision-making.

I have sought to embody this thesis as a process of learning, contributing and becoming: “If everything is dangerous, then there is always something to do” (Foucault, 1982a, pp. 231-232). I used a discourse analysis from within a critical health perspective to examine the practice of care for WLS patients. Good-enough care may act as the minimum standard of caring for a patient, but such a minimum of care needs to be free from practices of trade that encourage selling a surgery or a device, promoting personal agendas of carers over the cared-for, and a concentration of care on the specific needs of the cared-for. When the medical practitioner meets only minimum standards, it is neither reasonable nor incumbent on the public to give praise or recognition. Citizen-patients should expect, as consumers of health care, that at least a minimum, preferably a reasonable, standard of care prevails in all medical consultations. That acceptance underlay the original thesis for this research. In the complacency about expecting or meeting only a minimum standard of caring-for, then the possibility for alternative agendas to intrude is ever present. In this thesis, I have indicated areas of concern for future research, sensible precautions for patients considering any type of

surgery, and practical issues for improving ongoing medical and surgical consultations around weight and health.

Charlton's (1995, p.610) warning is only too clear: "Human health is too complex, and ethical considerations too important, for social engineers safely to employ wholesale management of public lifestyle without secure knowledge of the mechanisms by which these interventions are supposed to operate." Opening up WLS options as a strategy for intervening in the weight of a proportion of the population has clearly uncertain, long-term outcomes for the physical and psychological health of individuals. In the presence of doubt about these technologies, concentrating on health at any weight may well be preferable.

I end this thesis in a much less settled place than when I began...

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APPENDIX 1

WLS procedures

The gastric bypass.

This procedure was developed by Mason and Ito (1969) in the 1960s based on the weight loss observed among patients who underwent such procedures for ulcer treatment. It was gradually modified into its current form based now on a Roux-en-Y limb of intestine (RYGBP). This bypass procedure for weight loss is the most commonly performed procedure in the United States with 140,000 gastric bypass procedures being performed in 2005 (ASMBS, 2005).

Often referred to colloquially as stomach stapling, the Roux-en-Y gastric bypass is performed as an open surgical procedure or laparoscopically using the keyhole approach to surgery with a telescope. In these procedures, the stomach is completely divided leaving a pouch that measures about 25mls. Once the small bowel is divided the divided end is joined to the small pouch. The small bowel end is joined back on to the small bowel about a metre down from the stomach, thus creating a bypass apart from a tiny pouch. The small pouch is created to promote a feeling of fullness. This in turn limits the amount of food that may be taken in at any one time. If high fat or high.

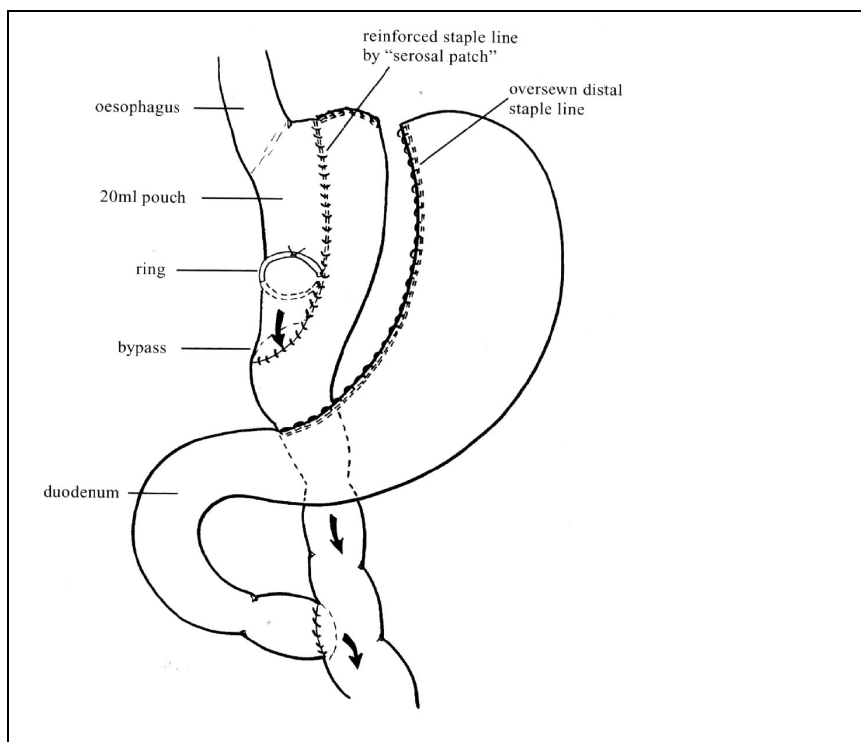


Figure 3: Transected silastic ring gastric bypass (Fobi Pouch).¹

¹Adapted from Stubbs (2000/2005).

sugar food passes quickly into the small bowel, symptoms of dumping such as nausea, sweating, clamminess and dizziness occur, often leading patients to avoid certain foods. Hospital stays are generally much shorter for laparoscopic procedures. Figure 1 above shows a fobi pouch that uses a silastic ring instead of staples, around the distal end of the pouch to prevent stretching of the opening between the pouch and the section of small bowel. A gastroenterostomy to a Roux-en-Y type limb of the jejunum completes the procedure.

The gastric lap band.²

The first adjustable silicone banding was developed by Kuzmak in 1983 and implanted in June, 1986; the first trial was approved by the FDA in 1990 and the lapband was approved by the FDA in June 2001. By January, 2008, the company selling lapbands worldwide had sold 350,000 bands (Allergan Inc, 2008). The bands placed by the three main lapband surgeons operating in New Zealand from the late 1990's were of two types: The Swedish Adjustable Gastric Band (SAGB) with a capacity of 9.0mls and the Bioenterics' Lapband (LAGB) with a capacity of 5.0mls. Lapbands were fitted in New Zealand from the late 1990s, though even conditional FDA approval was not given until 2001.

The lapband is produced as a minimally invasive procedure³ because it does not rely on rerouting, cutting and stapling procedures. Regurgitation, reflux, the inability to eat nutritionally sound food leading to a reliance on soft, readily chewable or liquid food sources were problematic with this technology. For instance, when the mechanism was reviewed on June 9, 2004, the California Technology Assessment Forum (CTAF) (2007) concluded that there was insufficient evidence to conclude that the benefits of LAGB outweighed its harms particularly when compared with the loss of weight possible with Roux-en-Y gastric bypass (RYGB). The CTAF (2007) recommendation⁴ read: “[...] the use of laparoscopic adjustable silicone gastric banding for the treatment of morbid obesity does not meet CTAF technology assessment criteria 4 for safety, effectiveness, and improvement in health outcomes” (p. 40).

³The need to adjust the band and monitor its placement and condition is scarcely mentioned. An LAGB is promoted as a less invasive and completely reversible alternative to RYGB (CTAF, 2007).

⁴This report referred to other organisations that had differing views about lapbanding (CTAF, 2007, p. 41).

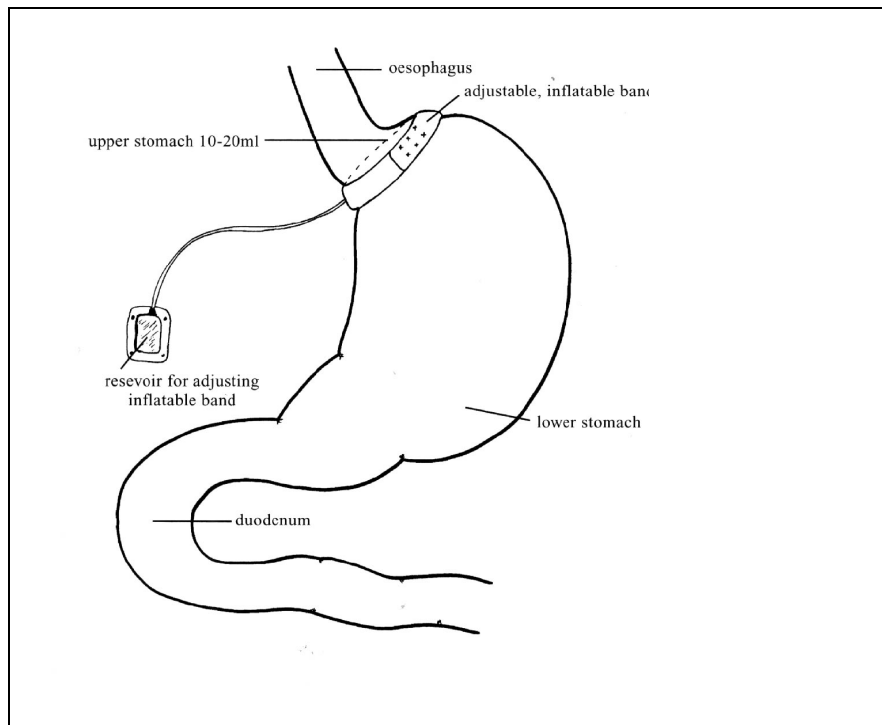


Figure 4: The gastric lapband.⁵

The device, demonstrated in Figure 4 above, shows the positioning of the inflatable silicone band when it is implanted into the patient's abdomen around the upper stomach. This is usually completed using laparoscopic techniques. Fullness in the stomach pouch is created by injecting saline into the reservoir (inflations), through a port that lies just under the skin on the abdomen; the saline travels through the tubing and into the band. Restricting the rate of emptying the small pouch aids satiety and limits food intake to induce weight loss. Inflations are integral to this treatment.⁶ When saline is introduced into the band, levels of restriction complete the treatment. Lapbands may need to be removed: In one study (Pontiroli et al, 2008),⁷ 10 of the 178 lapbands in their study required to be removed during the research period. Of particular concern related to the trade in Lapbanding is that the commercial sponsorship of LAGB has promoted its use over gastric bypass procedures that do not have that backing (CTAF, 2007).

⁵Adapted from diagram at <http://www.bariatric-surgery.info/lapband-gastric-banding.htm>

⁶Some patients were said to have lost weight without inflations, but most patients were given some inflation in New Zealand procedures at the time of the operation.

⁷It was not made clear whether this research was one of the Italian centres for research supported by Lapband Systems.

APPENDIX 2

Glossary of abbreviations

ABC	Australian Broadcasting Corporation
ACC	Accident Compensation Commission (New Zealand)
AMA	American Medical Association
ANA	Agencies for Nutrition Action (New Zealand)
AOA	American Obesity Association
AHRQ	Agency for Healthcare Research and Quality
BMI	Body Mass Index
CAST	Cardiac Arrhythmia Suppression Trial
CDC	Centre for Disease Control (United States)
CMAJ	Canadian Medical Association Journal
CNN	Cable News Network
DSM	Diagnostic and Statistical Manual
DTCA	Direct to Consumer Advertising
EBM	Evidence-based medicine
FDA	Food and Drug Administration (US)
FOE	Fight the Obesity Epidemic (New Zealand)
GB	Gastric banding
GMC	General Medical Council (UK)
GP	General practitioner
HDC	Health and Disability Commissioner (New Zealand)
HEHA	Healthy Eating, Healthy Action (New Zealand)
HRT	Hormone replacement therapy
JAMA	Journal of the American Medical Association
LAGB	Laparoscopic adjustable gastric banding
Medsafe	New Zealand medicines and medical devices safety authority
NHS	National Health Service (UK)
NIH	National Institutes of Health (US)
NZMA	New Zealand Medical Association
NZMJ	New Zealand Medical Journal
NEMJ	New England Journal of Medicine
Pharma	The phrase <i>Pharma</i> or <i>Big Pharma</i> are used to refer to the largest pharmaceutical companies
PHO	Primary Health Organisation (New Zealand)
PSY	Psy refers to disciplines such as psychology, psychiatry and psychotherapy
RCT	Randomised control trial
RYGB	Roux-en-Y gastric bypass
TVNZ	Television New Zealand
WLS	Weight-loss surgery
WHO	World Health Organization

APPENDIX 3

Correspondence: Ethics Committee

Letter 1: Request for Opinion from Wellington Ethics Committee¹

The Chairperson and Members,
Ethics Committee,
Wellington Area

14 August, 2002

Dear Members,

I ask that you form an opinion on the following ethical dilemma. My topic is "A Matter of Fat: Power Relations, Doctors and their Weight-full women patients.

Background:

- I myself have had weight-loss surgery within the last three years.
- One of the two operations was with one of three surgeons in New Zealand who carries out a particular form of weight-loss surgery which did not work for me: subsequent to the operation, I laid a complaint about certain aspects of the care that I received from this Doctor. The Health and Disability Commissioner's Office will eventually decide if any aspect of the complaint will be upheld.

My concerns are:

1. the doctor in question might object to the research and might try to prevent other clients of his from participating in the research;
2. as it is qualitative research, and includes my voice in a reflecting capacity, that any residual negativity might skew the research – this is a question about my ability to be fair;

¹ Printed on letterhead from Wellington School of Medicine

3. that some of his patients who I know, through participating in one support group meeting almost 30 months ago, are extremely positive about what this doctor achieved for them, might choose to be part of the research and be overly positive about him;
4. When the issue of researcher as complainant was taken to the Chairperson of your committee to informally discuss the issues, the potential for the researcher to use the research to garner support for her complaint, was raised. The question of how the researcher would respond to a participant, who raised the possibility of making a complaint, was also raised.

To counter these concerns:

1. As part of the informed consent letter, participants could be informed that I have undergone weight-loss surgery myself. In the follow-up to that letter, potential participants, who asked, could be told that I had experienced some problems, that I had tried to sort these out by making a complaint, that the process of the complaint is still ongoing and that I am unable to discuss the issues until after research is complete. Potential participants would then have the possibility of opting in or out of the research either at this point or after the individual interviews and before the Reflecting team/focus group processes were begun.
2. (a) the research is about the years of experience women with weight issues have had with their doctors rather than being concentrated on the weight-loss surgery experience;
 - (b) I realise that many women have had markedly good experiences with weight-loss surgery and found this particular doctor to have been very helpful to them;
 - (c) this research will be respectful and scrupulously transparent with all individual and group interviews being taped and transcripts being made available if participants wish to read them.
3. Again, see 2(a); also, there will be a variety of experiences and this research will succeed only if it is able to reflect a variety of experiences.
- 4(a). In consideration of the concerns raised by the Chairperson, I have spoken to an advisory officer at the Office of the Health and Disability Commissioner. She says that,

as the legislation calls for each and every complaint to be considered on its own merits, any further complaints would not add support for any particular complaint.

4(b). I would undertake not to speak about the matter of my complaint to any participants until the research interview were over. This would be in line with the Code of Ethics that I have abided by, as a counsellor, for about 20 years. If a participant were to ask me about the substance of the complaint, I would answer that I have an ethical commitment not to discuss the complaint. If I were asked how to go about making a complaint I would merely refer them to the 0800 number for the Office of the Health and Disability Commissioner.

4(c). I have had the opportunity over almost three years to use the lapband support group to gather support for my position. I have not done this on the grounds that what has occurred has been a problem for me and is not necessarily the experience of any other person. There have been two occasions on which the fact that I had experienced a problem was mentioned by me.

- On one occasion, approximately two years ago, I responded to a concern on the support group network. I did so individually and just suggested that the person go for a second opinion. The person did not do that and indeed proceeded with the surgery.

- On another occasion, I was asked why I was not contributing to the support group and I replied that my experience had not been as positive as others and that I had decided to run the issue past the HDC.

This person is a leader in a support group for those who have had a particular form of weight-loss surgery. She is positive about the research and keen to proceed.

I trust that this answers the concerns.

Margret Westwater

Letter 2: Response from Wellington Ethics Committee

16 October 2002

Wellington Committee Ref No:02/R-10

Please include the reference number and study title in all correspondence.

Margaret Westwater
C/- Kevin Dew
Dept of Public Health
Wellington School of Medicine

Dear Margaret

02/R-10 – A matter of fat power relations: Doctors and their weight-full women patients.

Thank you for attending the Ethics Committee meeting of 8 October with Kevin Dew. The Committee gave approval for you to submit a full application for your research project. The Committee made the following suggestions:

- 1 Research should be fully transparent.
- 2 Clear guidelines on the management of emotional distress should be set out. Researcher to give consideration to having counselling supervisor for debriefing.
- 3 Researcher to state that she has a personal interest in this area rather than the fact that she has had weight loss surgery.

Thank you for bringing this matter to the Ethics Committee we look forward to your application in due course.

Yours sincerely

Claire Lavakula
Co-Administrator

Letter 3: Original ethics approval

Wellington Ethics Committee

Room 425, Fourth Floor
Community & Support Services
Wellington Hospital
Private Bag 7902
Wellington South
Phone (04) 385 5999 ext. 5185
Fax (04) 385 5840
Email: claire.i@wec.org.nz

20 December 2002

Wellington Ethics Committee Ref No: 02/11/119
Please include the reference number and study title in all correspondence.

Margaret Westwater
59 Pharazyn Street
Lower Hutt

Dear Margaret

WGT/02/11/119 A matter of fat: Power relations, and weight-full women patients – Multicentre Wellington Lead

Auckland Ethics Committee Ref AKY/02/00/294

Thank you for your letter of 16 December 2002 responding to the points raised in my letter to you of 19 November 2002. As all ethical issues have now been addressed, the above study has been given ethical approval by the Wellington Ethics Committee.

Accreditation

This Committee is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

Progress Reports

The study is approved until September 2005. The Committee will review the approved application annually. A progress report is required for this study in December 2003. You will be sent a form requesting this information prior to the review date. Please note that failure to complete and return this form may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

Amendments

All amendments to the study must be advised to the Committee prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.


General

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Please quote the above reference number in all correspondence relating to this study.

Please note a new version of the application form (EA0502) is now available either by email from the Administrator or from the Health Research Council website, www.hrc.govt.nz. Form EA0699 will not be accepted after 31 December 2002.

Yours sincerely



Claire Lavakula
Co-Administrator

Letter 4: Final ethics approval

21 May 2009

Ms Margret Westwater
Wellington School of Medicine & Health Sciences
59 Pharazyn Street
Lower Hutt

Dear Margret,

WGT/02/11/119

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

Thank you for submitting the annual progress report for review. This document has been reviewed and approved by the Deputy Chairperson of the Multi-region Ethics Committee under delegated authority.

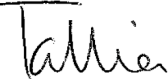
Approved documents

- Annual progress report dated 12 May 2009

Ongoing approval of the study is re-confirmed until 28 May 2010 by the Deputy Chairperson of the Multi-region Ethics Committee under delegated authority. We look forward to receiving your next annual progress report before this date.

Please do not hesitate to contact me if you have any queries.

Yours sincerely



Tallia Beri
Multi-region Administrator

APPENDIX 4

Correspondence: HDC



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

30 October 2002

Mrs Margret Westwater
PO Box 31 150
LOWER HUTT

Dear Mrs Westwater

Thank you for your fax, which I received on 3 October 2002.

If, upon receipt of a complaint, I decide to investigate the matter under the Health and Disability Commissioner Act 1994 my investigation process is impartial. At the end of the investigation I consider the facts and decide if there has been a breach of the Code of Rights.

I can assure you that any research you choose to undertake will have no bearing on my decision on your complaint.

Yours sincerely

A handwritten signature in cursive script that reads 'Ron Paterson'.

Ron Paterson
Health and Disability Commissioner

Ref: 01/02515/KH

APPENDIX 5

A genealogy of the thesis through presentations

November 2002

PhD School: Department of Public Health, Wellington School of Medicine

A Matter of Fat: Power Relations, Doctors and Weight-Full Women Patients.

Abstract:

This research will be focused on the significance and meaning of weight-fullness for New Zealand Women in the doctor/patient relationship. My questions concern the implications of current negative stereotypes of fatness, evident in the wider New Zealand community, for women within the doctor/weight-full-women-patient relationship?

How do weight-full women experience this relationship? How do doctors experience these relationships? How have weight-full women's bodies been medicalised? I will introduce my methodology and talk about methods for proceeding.

I ask:

Standing as I am, in a Department of Public Health, how do I resist being drawn into the epidemiology of fatness or notions of overweight as defined by BMI or arguments that can be made around how children are getting fatter as are adults and that this is accounted for by changes in physical activity and the calories in/calories out equation?

July 2003

PhD School: Department of Public Health, Wellington School of Medicine

Chewing the Fat around Large Body Size: Do we call fat, fat?

Abstract:

Many of the terms used to refer to overweight appear to have very fixed meanings e.g., to be obese is to have a BMI of over 30. Some terms are, or have taken on, derogatory connotations, or have been used in the past to shame or humiliate a person with issues around weight, or have had that effect. This paper addresses changing constructions of weight over time as evidenced in articles drawn from my survey from one hundred years of publications in "The Listener" and "The New Zealand Medical Journal" (in process). This paper references a history of the terminology of weight and seeks to

provide a New Zealand context for a major project, *A Matter of Fat: Power Relations, Doctors and Weight-Full Women Patients*.

December, 2003

SANZA Conference, Auckland

First paper:

Scales Don't Lie: Reading Weight in the Relationship between Weight-full Women and Doctors

Abstract:

Technologies of weighing developed in response to the need to collect health statistics in the pursuit of increased understanding and control of populations. From the experiments of Santorio to the arrival of the scale in the private home, reading the scales has become a fundamental procedure in the measurement of people. The provision of scales within hospitals and clinics and the appearance of the penny-in-a-slot weighing machine outside the local chemist shop were testimony to the increasing significance placed on weight in the diagnosis of relative health and ill health. In a narrative based on the stories of seventeen women, the dominance of scaled weight as a measure of health in the context of the doctor/patient relationship, is narrated and critiqued. This narrative foregrounds the stories of seventeen women in a consciously reflexive document in which the philosophical underpinnings are made explicit.

Second paper

Hanging Out the Washing: Writing and Interviewing in a Reflexive Style

Abstract:

In the research stories that we construct and put out into the world, our past experiences are implicit in the questions we ask, the responses we make, the dialogues in which we are willing to engage and the analysis we undertake. Inevitably, as a researcher working within narrative, feminist and post-structuralist framings, questions arise as to whether, to what degree or indeed how some of this material could be made explicit. After one year of being engaged in researching the functioning of power in the relationships between weight-full women patients and their doctors, I explore some of these dilemmas and practices within a purposely, self-reflexive paper.

As I thought about this paper, a picture of the clothesline from my childhood took

over. It was anchored at both ends on large posts and stretched from the shed to the front hedge. A large y-shaped prong at the end of a long stilt levered the heavy washing-filled line into the breezes. The clothes received a very public airing and the washing on this line was limited to household linens, pyjamas (in sets of course), and shirts, all very clean and most precisely hung. The “smalls” were placed on a separate line, hidden from public view, between the house and the shed, by a variety of less personal and larger items. I think about the marginalisation of certain items of clothing in our family wash that were not considered suitable for hanging in open view. As a metaphor, it has provided me with an interesting structure for thinking about reflexivity in research and writing. Are some ideas, actions, or reflections “too personal” to be re-produced in public? What is the relative positioning of individualised research and generalised research? How do we understand the micro practices that support power relations if they are continually hidden, behind the statistical text of the population story? What questions do we ask in our research? How do we contextualise the answers of participants, let alone our own questions? How would we answer the questions ourselves? How public do we make our answers?

December 2003

Conference: Talk-in-Interaction on Health, Perth

Scales Don't Lie: Reading Weight in the Relationship between Weight-full Women and Doctors

Abstract:

Scales and other technologies of measurement have been interpolated into the discursive space in which the doctor/patient relationship is embedded. This paper provides a brief overview of the historical context in which such technologies developed and ways in which they have come to define a healthy body today. The text is multi-voiced: women's words emerge in layers of text interwoven with reflective recognition and authorial interpretation and deconstruction.

While a healthy body has increasingly come to be defined in terms of weights and measures, the pursuit of a healthy weight has resulted in some anomalous and possibly unhealthy practices. The effects and ethics of noticing, wondering, commenting on and theorising the culturally significant, silenced practices of weighing, within the doctor/patient relationship, is also addressed.

As a result of my attendance at the Perth symposium, I was asked to present two papers:

First paper:

April 2004: Society of Australasian Psychologists' conference in Auckland

A Work in Progress: Using Reflecting Team Processes in Research

Abstract:

Reflecting teams have been developed within a therapeutic environment to encourage clients to view problem-saturated accounts from a variety of perspectives. If the reflecting team concept can be categorised, essentially it fits within the wider denomination of focus groups. In developing reflecting team processes as a research tool, the aim is to provide a respectful environment for discussion between and within groups of research participants wherein multiple truths and perspectives are voiced, explored, contextualised and potentially opened to change.

This presentation, based on material from an ongoing study into the effect of weight on the doctor/patient relationship, re-configures and re-presents the reflecting team as a valuable resource in qualitative research. (Withdrew through ill health)

Second paper:

July 2004

Massey School of Psychology, Research Seminar Series

Downsizing: An emerging analysis of weight-loss surgery options

Abstract:

Within a gendered, social order, health and beauty for women appear to be synonymous with small body size. Increasingly, weight-full women both experience and enact surveillance and criticism of their large body size. As diets and pharmaceutical interventions fail to produce desired, long-term results, the diet-less solution of surgery for permanent weight loss has been promoted. This paper explores the decision-making processes of women and doctors around weight-loss surgery options.

June 2005

PhD Workshop: Massey University School of Health Sciences

Chewing through the mulberry leaves: Cultivating a bricolage

Abstract:

Traditionally, the emphasis in academic research has been on choosing methods, materials and texts from within particular disciplines: it has been those practitioners who practiced greater degrees of relative conformity to customary practices (which has encouraged young researchers to accept or, at least, tolerate methodological strait

jackets early in their careers) to more easily access traditional academic posts and journals.

In this presentation, I trace my experimentation with ways to allow, within the thesis, a reading that is at least suggestive of the multiplicity of layering and that is sufficiently compelling to demand numerous readings and retellings. While exposure to and practice within a diverse models and paradigms are made available within the academy, it is obvious that ways of working academically have a great deal to do with experiencing and managing these-ourselves within many spheres in lived-lives. I refer to those theories which inform the practices of my personal lives as they do my academic life as I develop a practice of research based on a diversity of possibilities for research practice rather than limited by constrictive notions of uni disciplinary.

November 2006

PhD Workshop: Massey University School of Health Sciences

Connecting on the platform, clashing in the underground: women, weight and medical consultation.

Abstract:

From the storying of lived weight-fullness flow participants' varied interpretations of the statistical storying of weight, appearance and health, stories of resistance, agency and capitulation within lived habitus. In recalling and recasting narratives of weight within these interviews, how we-participants spoke about weight, the actions we took in regards to personal weight and weight within our families, and how we approached weight in consultation, sprang from embedded, encultured beliefs, richly imbued with personally-connoted anecdote and private action. These texts open into the private and public arenas in which norms of body weight and ideal size play out in the personal-cultural and medical contexts within which decisions about weight are constantly being evaluated and resolved¹.

These stories reverberate with the dilemmas and contradictions of living weight-full in our society. The consultation is a platform on which various discourses are selected for performing. What is and can be spoken about weight within a consultation is highly prescribed. Clearly, lip service is applied to certain notions and positions about weight,

¹The use of the term 'resolution' is not to suggest that these processes of decision-making about weight reach a final outcome: resolutions were spoken of in the research as a wish for a final outcome but reverberated more with the constant remaking of New Year's resolutions or short term lenten denials of the flesh.

as in the case of size acceptance. If we were to be the proverbial fly-on-the-wall in a medical consultation about weight, what we would be watching is the performance of a myriad of cultural practices of power played out around a set of encultured beliefs around weight: the clash of positionings around weight remain buried in the underground.

September 2007

Presentation for a Masters' Workshop: Massey University School of Health Sciences (Guest speaker)

Downsizing: an emerging analysis of weight-loss surgery

Abstract:

Within a gendered social order, health and beauty for women are synonymous with thinned body size. Weight-full women, whose bodies do not fit accepted norms in our society, experience and enact surveillance and criticism of their bodies as the (d)-graded “large body,” and are particularly vulnerable to bias when they seek medical attention. As diets and pharmaceutical interventions fail to produce weight loss in the long-term, surgery for permanent weight loss has been promoted. The experiences of weight-full women and their doctors are described, contextualised and analysed with particular attention to the ethics of decision-making processes and outcomes in weight-loss surgery. This qualitative research is based on reports, interviews and case material.

October, 2007

College of Nurses International Symposium: “Obesity: Fa(c)t or fiction? A critical debate.” (Guest speaker)

Abstract:

“One of my (fat) ladies:” Visual Appearance, Health and Rhetoric in Weight-Loss Surgery decisions.

Within a gendered social order, health and beauty for women appear to be synonymous with thinned body size. Increasingly, weight-full women both experience and enact surveillance and criticism of their large body size. As diets and pharmaceutical interventions have failed to produce desired, long-term results, the diet-less solution of surgery for permanent weight loss has been promoted. Women, whose bodies do not fit accepted norms in our society, experience difficulty in many areas of their lives and are particularly vulnerable to bias when they seek medical consultation.

April, 2009

In Sickness and In Health Conference: Victoria, Canada (Presenter)

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

Abstract:

Within the last century, large bodies came to be regarded as unattractive and deviant, and the project of appearance became entangled in projects of health. In the assumed legitimacy of a vital discourse linking overweight with ill health, alternative understandings of large body size and the possibilities for large-body health have been silenced. Within New Zealand's gendered social order, women in particular experience and enact surveillance and criticism of their bodies: those whose bodies do not fit within prescribed norms for health and beauty become (D)-graded large bodies, especially vulnerable to medicalisation, discriminatory practices within consultations and legitimate objects for practice, treatment and experimentation. As diets and pharmaceutical interventions fail to produce 'normal' weight over the long-term, the option of surgery for weight loss has emerged.

Against a statistical backdrop of increasing weight amongst its citizens, New Zealand health authorities have initiated and supported the control of weight-for-health including recent moves to endorse an increased availability for weight-loss surgery options. Unexpected, unpredictable, and often adverse outcomes experienced by some weight-loss surgery patients refocuses attention on decision making for these radical elective surgeries: informing consent for these surgeries is problematised in relation to the conspicuous creep of cultural prescription, morality and trade into the weight-loss surgery arena.

In a consciously reflexive, qualitative research project, reports, case material and interviews with both doctors and patients are analysed with respect to the power/knowledge relations implicit in them. The author suggests that separating promotion, decision-making and follow-up care from the surgical fix itself would allow for greater reflection on lived-body options for well-being, stem the tide of surgery uptake, and improve the provision of post-surgical care. The use of reflecting team processes is briefly elaborated as a context within which caring, connected and ethical communication in consultation might be established.

September, 2009

Article submitted to *Nursing Inquiry* based on *In Sickness and In Health Conference* presentation.

Abstract:

(D)-graded female bodies and the emerging trade in weight-loss surgery technologies

Weight-loss surgery may be of medical value to some patients, but it is also a trade. This paper discusses research findings from a qualitative study in which decision-making for weight-loss surgery was viewed within the context of the increasing techno/medicalisation of weight in the late 20th and early 21st centuries. Currently, the iconic female body is a slim body and the prevailing belief is that overweight not only leads to ill health, it personifies it. From this perspective, large body size is considered unattractive, morally lax, and, “at risk” in relation to health. Losing hope in dieting, some women in this study turned to surgery options for a slimmed body, a body they believed to be both a real possibility and their responsibility to produce. This study references a range of historical, cultural, financial and reputational factors that impact weight consultation. Using brief excerpts from the narratives of research participants, I trace the incursion of such systemic and personal concerns as they began to undermine the possibility of informed consent for weight-loss surgery options.

Keywords: Women’s health; ethics; patient safety; decision-making for health; narrative discourse analysis.

November, 2009

2nd New Zealand Discourse Conference: *Tilts and Shifts – Applying a Discourse Analysis Lens*. Auckland, 18th – 20th November 2009. (Presenter)

The questioning patient in weight-loss surgery (WLS)

Abstract:

Within the context of weight-loss surgery (WLS) as a modern medical trade, I address the relational micro-practices of WLS consultation. In-depth analysis of three particular clinical episodes is a deliberate strategy to focus on the complexities for patients and doctors in enacting consultation protocols when post-surgery problems occur. A narrative episode in which a surgeon expresses his concerns about the impact on doctors when patients complain is juxtaposed within the analysis.

Through this paper, I trace ways in which surgical/professional discourses are invested with symbolic capital in the maintenance of power over consultation. I notice ways in which language is used to maintain and resist power, reflecting Foucauldian notions of resistance as integral within relations of power. Finally, I indicate key points in the communication when addressing WLS patients' concerns might have led to improved outcomes.

September, 2010

Fat Studies: A Critical Dialogue. Macquarie University, Sydney. 9 – 11 September 2010. (Presenter)

Pre(a)ying for fat bodies: Emerging a history of the introduction of weight-loss surgery technologies in New Zealand

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. Alternative understandings of large body size and the possibilities for large-body health have been effectively silenced. This paper traces the development of weight loss surgery during the last ten years within New Zealand. I indicate some unexpected, unpredictable, and adverse outcomes experienced by weight-loss surgery patients particularly when surgeons had minimal experience, training and oversight.

APPENDIX 6

[UNIVERSITY OF OTAGO, WELLINGTON SCHOOL OF MEDICINE HEADER]

Invitation to participate in research¹

This is an invitation to participate in:

Research on Women, Weight-fullness and the Doctor/Patient Relationship

I am interested in the impact of weight on the consultative relationship between patients and their doctors. The research is being carried out to fulfill the requirements for a doctorate at Otago University, Wellington School of Medicine and Health Sciences.

The working title of the research is: **A Matter of Fat: Power Relations, Doctors and Weight-Full Woman Patients.**

I wish to explore this topic by conducting an interview with each participant who will be either a woman with weight issues and/or a doctor, male or female. Interview participants would be invited to participate in the next part of the research which would involve meeting in a small group, of weight-full women or doctors, to discuss the topic. Both the interview and the group discussion would be taped, and it is intended that the taped **group** conversations would be anonymised and made available to the other participant groups for discussion and reflection. This would also be taped and made available to the original group of participants for further discussion or comment.

Ethical approval for this research has been granted by the Wellington, Manawatu, Nelson/Marlborough and Auckland Ethics Committees.

If you would like more information about this proposed research, or if you are interested in participating, please contact me. I look forward to hearing from you and I am happy to answer any questions by phone, mail or e-mail.

¹This invitation to participate was distributed on notepaper headed by the Wellington School of Medicine, Otago University.

Phone: 0800116143 (Leave a short message and I will contact you).

Mail: Margret Westwater

PO Box 31 150

Lower Hutt.

E-mail: mwestwater@wnmeds.ac.nz

APPENDIX 7

[UNIVERSITY OF OTAGO, WELLINGTON SCHOOL OF MEDICINE HEADER]

Information sheet for participants

A Matter of Fat: Power Relations, Doctors and Weight-Full Woman Patients.

Dear

I am really pleased that you are interested in being part of the research as either a weightfull woman and/or as a doctor.

I am a counsellor who has a particular interest in weight-fullness. The research is being carried out in fulfillment of the requirements for a doctoral dissertation through Otago University, Wellington School of Medicine and Health Sciences. My Research Supervisors are Kevin Dew, who may be contacted in the Department of Public Health at the Wellington School of Medicine and Health Sciences on (04) 3855541, and Kath Ryan, School of Pharmacy, University of Otago. I am continuing to work part time as a counsellor in private practice in Lower Hutt.

Ethical approval for this research has been granted by the Wellington Ethics Committee and the Auckland Ethics Committee. The aim of this study is to explore the effect of weight-fullness on the patient/doctor relationship. The working title of the research is: **A Matter of Fat: Power Relations, Doctors and Weight-Full Woman Patients.**

I wish to explore this topic by conducting a semi-structured interview with each participant, who would then be asked if they wished to participate in the next part of the research which would involve meeting as a group to discuss the topic. Both the interview and the group discussion would be taped. Both women and doctors would have an opportunity to reflect on the transcripts of the group discussions.

What it would entail for women participants would be an individual interview of approximately one hour, where we could talk about those things which were important to you in your history with weight issues and how this may or may not have been impacted by your relationship to doctors. I am hopeful that a number of women will be interested in the next part of the research which would involve meeting together, over a period of about two hours, to discuss these experiences. This would be taped and each member would receive a transcript.

The third part of the research involves individual interviews followed by a discussion with a small group of doctors. The focus of the interviews and the group discussion would be on their experiences of working with women who experience issues of weight-fullness. An anonymous transcript of the women's group meeting would be made available for discussion and reflection. The reflecting team process for the doctors would be taped and made available, anonymised, to the women in the reflecting team process. A second reflecting team process would ensue to discuss this transcript.

I am hopeful also to have two groups of women as part of the research: one who express issues around weight-fullness and a further group who has chosen weight surgery. Depending on all the issues around permission giving being cleared by all participants, transcripts from both groups would be made available to the other group for reflection.

This may all sound very involved!! Basically, there would be one individual interview and up to two group reflections. I am hopeful that a woman who chose to be involved in the whole process would be involved for approximately 5-7 hours over a period of about 15 months.

You will be able to select a pseudonym to ensure that your name will not be linked to the data. If a transcriber is used, the transcriber will sign a confidentiality agreement. My research supervisors and possibly my examiners will have access to the tapes and transcripts but will only be aware of the pseudonym and not your real name.

I will write a report of the findings, which will be assessed by examiners who are appointed by the University. The findings may be published in professional journals,

and may be presented at conferences. A summary of the findings will be made available to you. A copy of the completed thesis will be available at Otago University Library.

As a participant, you have the right:

- To decline to participate;
- To refuse to answer any particular questions and to stop the taping;
- To withdraw from the study at any time and to have all data destroyed;
- To ask any questions about the study at any time during participation;
- To provide information on the understanding that your name or other identifying information will not be used unless you give permission to the researcher;
- To be given access to a summary of the findings of the study when it is completed.

If you are interested in being a participant in this study, please contact me by phone, mail

or e-mail and I will send you a consent form. This will be signed prior to or at the commencement of the first interview. I am happy to answer any questions by phone, mail or e-mail.

Phone: 0800116143. Leave a short message and I will contact you.

Mail: Margret Westwater
PO Box 31 150
Lower Hutt.

E-mail: mwestwater@wnmeds.ac.nz

Thanks for considering this invitation to participate.

Yours sincerely,

Margret Westwater

MNZAC, MA(Hons), Dip Ed, Dip Tching, PhD Student at the University of Otago

APPENDIX 8

Details of data collection by participant

Table 1

Women participants, detailing data collection

Participant-pseudo	Participant Group: Woman Patient (WP); Woman Doctor (WD); Male Doctor (MD); Male Surgeon (MS); Woman Specialist (WSp)	Interviews/dates: original interview (OI); reflecting team (Rflt); reinterview (Reint).	Analysis mapping	Stories	Transcript check and comments
Em	WP	OI, (April, '03)	Complete	Yes	Yes
SusieB	WP	OI (April, '03) Reint, (21 Feb, 07)	Complete Complete	Yes	Yes
Margaret	WP	OI (April, '03)	Complete	Yes	Yes
Marjorie	WP	OI, (April, '03) Reint, (June, 2004) Rflt	Complete Complete	Yes	Yes
Michelle	WP	OI, (April, '03) Reint, (May, '04) Rflt emails	Complete Complete Complete	Yes	Yes

Table 1 (continued)

Women participants, detailing data collection

Participant by pseudonym	Participant group	Interviews/dates	Analysis mapping	Stories	Transcript check and comments
Pansy	WP	OI (April, '03)	Complete	Yes	Yes
Phoebe	WP	OI (April, '03)	Complete	Yes	Yes
Sheree	WP	OI (April, '03)	Complete	Yes	Yes
Ms AR	WP Researcher Reflt	Doctor notes Diary HDC Opinion Tape consultation, June 2000			Taped consultation - yes
Rosie	WP	OI, (June, '03) Reint, (July, '04)	Complete Complete		Yes
Scrapper	WP	OI (June '03) Reflt Profile Doctors notes	Complete Complete		Yes
Meryl	WP	OI (July, 04) Book chapter, article	Complete Complete		Yes
Karlie	WP	OI (October, 04) Article: breast cancer?	Complete		Yes

Table 1 (continued)

Women participants, detailing data collection

Participant by pseudonym	Participant group	Interviews/dates	Analysis mapping	Stories	Transcript check and comments
Topsy	WP	OI (July, 03)	Complete		Part of original transcript missing – full recording available
Clover	WP	OI (June, 03) News stories	Complete		Yes
Shona	WP	OI (June, '03) Reint (May 2004) Emails Diary	Complete Complete Complete		Yes
Hine	WP	OI, (April, '03)	Complete		Yes
Pinkie	WP	OI, (April, '03)	Complete		Yes
Pammy	WP	OI, (June, 03)	Complete		Yes
Rongomai-wahine	WP	OI, (November, 03)	Complete		Yes
Janice	WP	OI, (August, '04)	Complete		Yes

Table 2***Doctor participants, detailing data collection***

Participant by pseudonym	Participant group	Interviews/dates:	Analysis mapping	Transcript check and comments
Dr Kim	WP/WD Article in magazine	OI (June '03)	Complete Complete	Yes (Interviewed as Doctor and weightfull woman)
Dr Jennifer	WD	OI (October, '03)	Complete	Yes
Dr Maurie	MD	OI, (October, '03)	Complete	Yes
Dr M1	MS	OI, (February, '04	Complete	Yes
Dr Mary	WSp	OI, (March, '04	Complete	Yes
Dr Nicky	WSp	OI, (March, '04	Complete	Yes
Dr George	MD	OI, (March, '04	Complete	Yes
Dr Gabrielle	WD	OI, (March, '04	Complete	Yes
Dr Moyra	WD	OI, (March, '04	Complete	Failed transcript – notes written up and given to Moyra later that day

Table 2*Doctor participants, detailing data collection*

Participant by pseudonym	Participant group	Interviews/dates:	Analysis mapping	Transcript check and comments
Dr Lesley	WD	OI, (March, '04)	Complete	Yes
Dr Daisy	WD	OI, (May, '04)	Complete	Yes
Dr Craig	MD	OI, (July, '04)	Complete	Yes
Dr Tricia	WD	Or, (May, '04)	Complete	Yes
Dr M2	MS	OI, (March, '04)	Complete	Yes
Dr Henry	MSp	OI, (May, '04)	Complete	Yes
Dr X	MD	Incidental notes (March, 2004)		
Dr Z	MS	Material from clinical letters, media presentations. Not interviewed		

APPENDIX 9

[UNIVERSITY OF OTAGO, WELLINGTON SCHOOL OF MEDICINE HEADER]

Invitation to participate in research: Doctors¹

This is an invitation to participate in

Research on Consulting with Women about Overweight

The research concerns how weight is brought into a consultation and the diverse histories, views and methods which impact on doctors and patients as they grapple with weight issues.

How you can help:

There are two related research projects. You may choose to participate in either or both of the projects.

1. The Individual Interview:

This requires one hour of your time. It consists of a semi-structured interview about your experiences of consulting with women for whom overweight is potentially a health issue.

2. The Group Interview:

This part of the research would require up to 1.5 hours involvement on two occasions. It looks at the use of small group discussion and reflection to improve/enrich medical consultations around weight. On the first occasion the group would share experiences of consulting about weight and reflect on material from a group process with women who consider that they have problems with weight. This material would again be

¹This invitation to participate was distributed on notepaper headed by the Wellington School of Medicine, Otago University.

exchanged with women for further comment and reflection and the research would conclude with some discussion of the experience of participating in the group process.

Compensation for commitment of time:

- The opportunity to participate in a qualitative, action-oriented, research activity;
- For vocationally registered doctors, the opportunity to participate in an activity which could be considered for CME²;
- Access to the research materials
- Access to the research findings

This research is being carried out to fulfill the requirements for a doctorate at Otago University, Wellington School of Medicine and Health Sciences. Ethical approval for this research has been granted by the Wellington, Manawatu, Nelson/Marlborough and Auckland Ethics Committees.

I look forward to hearing from you and I am happy to answer any questions by phone, mail or e-mail.

Researcher: Margret Westwater

Phone: 0800116143 (Leave a short message and I will contact you).

021 643 993

(04) 385 5541 ext: 6048 (mostly on Mondays, Wednesdays, Thursdays

Fridays and even Sundays!!)

Mail: PO Box 31 150

Lower Hutt.

E-mail: mwestwater@wnmeds.ac.nz

²This was investigated but was not achieved. As well, the doctors generally were not interested in the group reflecting team process.

APPENDIX 10

[UNIVERSITY OF OTAGO, WELLINGTON SCHOOL OF MEDICINE HEADER]

Consent Form

Research: Consulting with Women about Overweight

I have read the information sheet about this study. Questions that I have asked, have been answered to my satisfaction by Margret Westwater. As a participant I have the right:

- To decline to participate;
- To refuse to answer any particular questions and to have the tape turned off at your request;
- To withdraw from the study at any time and to have all data destroyed;
- To ask any questions about the study at any time during participation;
- To provide information on the understanding that your name or other identifying information will not be used;
- To be given access to a summary of the findings of the study when it is completed.

I understand that my participation is voluntary and requires one interview of up to an hour in duration, with the possibility to participate in a reflecting team process of approximately 3 hours divided into two sessions. I am aware that my identity will remain confidential and information gathered will be securely stored. I am also aware that the researcher may use the services of a transcriber but that the transcriber will be bound by a confidentiality agreement.

Should issues arise that may cause me to become uneasy or distressed, I am at liberty to contact the researcher, Margret Westwater: 0800116143; her supervisor, Kevin Dew: (04) 3855541 ext.6046; the Ethics committee at Wellington: (04) 3855999 ext. 5185; the Health Advocates Trust, no. 0800 555050, Northland to Franklin.

I agree to participate in this study under the conditions set out in the information sheet.

I agree to have the interview taped: Yes / No

Name of participant: Name of researcher:

Signature of participant Date Signature of researcher Date

APPENDIX 11

Interview Schedule

1. Individual Interviews with Women Participants:

The first series of questions would be designed to elicit information which would lead to a reasonably full history of the issue – the relationships which this woman had and continues to have with doctors, including GPs, specialists and surgeons, while weight has been an issue.

After talking to the woman about the research and answering any further questions that she might have and explaining about issues of informed consent, we would proceed to the material interests of the study.

Suggested questions might be:

- I'm interested to know about your experiences in seeking medical care from doctors or specialists while you believed yourself to be overweight or might have been considered overweight by others?
- Did the reason for the consultation make a difference? For example, if you went to the doctor about a foot injury, or back pain, or a sore throat, did the question of weight get brought into the conversation? How did that happen?
- Was overweight brought up by yourself or by your doctor, or was it ignored by both of you?
- If it was brought up, how was it handled?
- Did you ever just make an appointment with a doctor to talk about your weight issues? How were these conversations the same or different to other conversations that you had had with that doctor or a different doctor on the same theme?
- When weight issues had come up in the conversation, how did you feel it was handled, at the time of the consultation or when you have looked back on that experience?
- Have you had experiences with any long-term positive or negative effects on your attendance at appointments at the hospital, your GP, or specialists?

- Did you, at that time, consider yourself to be overweight? Did other people consider you to be overweight?
- When you look back on that time, do you consider yourself to have been overweight?
- Have you ever put off going to the doctor about any general issue because of your weight?
- Have you experienced concern that issues about your general health have been ignored or potential threats to your health have been exaggerated because of your weight?
- If you have had both good and bad experiences, which seem to have had the greatest effect and why do you think this is the case?
- How would you characterise relationships with doctors that you have consulted?
- What were your best or most helpful experiences?
- What were your least helpful or worst experiences?
- Look for asking about “fit” if it comes up.
- Ask about the relationship of family and social experiences to the doctor/patient relationship.
- What is your idea of how a doctor comes to a decision about overweight?
- What is a good doctor/patient relationship? Do you think that there is an ideal doctor/patient relationship?
- Hypothetical question: If you went to your GP or surgeon, having weighed yourself before you went, and were happy enough with that weight, how would you react to being called mildly obese? (Need to have another go at this one – maybe just wait for it to come up)

There would be supplementary questions depending on the specific answers that each participant gave. In the case of women who have chosen to have weight loss surgery, such supplementary questions would include questions such as:

- How did you come to the decision to have weight loss surgery?
- What support for or pressure to have the operation did you experience from your doctor and or surgeon?
- How would you characterise the relationship with your doctor and /or surgeon before, during and after the operation?

- Does shame or stigma arise in relation to weight issue within the doctor/patient relationship?
- Is weight more or less difficult to manage in the Doctor/Patient relationship?
How is it the same and how is it different?

Reflecting Team Process with women:

I will introduce the reflecting team process as one in which respect for each other's experience is paramount. I am hopeful that as the participants choose to speak some of our experiences into the group process, that other participants will be interested in the diversity and uniqueness of some experiences and sometimes in their sameness. I would mention to the group that, when I have participated in such groups in the past, other people's experiences have touched me in a variety of ways and sparked other memories for me. I would then reiterate that each woman is free to participate as each feels comfortable to do so, and to welcome feedback at any time in the process or later. I would then invite the women to talk about their experiences of weight-fullness and how this has impacted on or been affected by experiences within the Doctor/Patient relationship.

From that point, I would expect that the conversation would flow, asking supplementary questions to gain insight into the experiences and their ongoing effect.

Individual Interviews with Doctors: (approximately 1 hour interview):

- I will ask the doctors about their own experiences with weight and how they have dealt with weight issues.
- I will ask the doctors to talk about their experiences of working with women whom they consider to have issues of overweight.
- How do they proceed? Do they tend to ignore the issues of overweight and deal with the issues at hand?
- Is there a difference in working with women who have problems with weight to working with men who have problem weight?

APPENDIX 12

Table 3

Weight Loss (approximate) by procedure for participants who proceeded to surgery¹

Weight-loss surgery patient	Initial Weight in kilos	1st surgery	Date	Weight loss prior surgery in kilos	Weight loss after Surgery in kilos	Maintained loss on 1 st interview in kilos	Surgeon	2 nd surgery	Date	Surgeon	Weight Loss Following surgery	Current weight
Clover (52) (2003)	140	Open bypass	1997	Not required	54	17 [^]	Dr M1	Open Bypass/ transected with ring	2002	Dr M1	22	85 (2003)
Janice(45) (2003)	100	Open Bypass/ transected- with ring	2003	Not required	46	44 (only 10 months out from surgery)	Dr M1	N/A				
Karlie (55) (2004)	100	Lap Bypass/ transection	2002	Not required	36	36	Dr M2	N/A				
Marjorie(48) (2003)	149	Lapband 5.5ml	1998	7	10.5	0	Dr M2	Lapband removed	2004	Dr Z	0	140+
Meryl (38) (2004)	116	Lap Bypass/ transection	2003	Not required	58	40+ (Still losing weight)	Dr B not inter-viewed	N/A				

¹ Weights and weight loss are aggregated from those mentioned by the participants.

Table 3 (continued)*Weight Loss (approximate) by procedure for participants who proceeded to surgery, 1999-2007²*

Weight-loss surgery patient	Initial Weight in kilos	1st surgery	Date	Weight loss prior surgery in kilos	Weight loss after Surgery in kilos	Total loss on 1 st interview in kilos	Surgeon	2 nd surgery	Date	Surgeon	Weight Loss following surgery	Current weight/ date
Michelle (36) (2003)	149	Lapband 5.5ml	1999	12	38	10	Dr M2	Lap Bypass/ transection	2004	Dr M2	26	105 (2004)
Pammy(56) (2003)	74	Lap Bypass/ transection with ring	2002	Not required	34	28(2003)	Dr M1	N/A				
Pinky(49) (2003)	Size 20 Approx 106 kgs	Lapband 10ml	2001	10	5	10(2003)	Dr A not Inter-viewed	N/A				
Rosie(50) 2003	135	Lapband 5.5ml	1998		33	23(2003) 3(2004) on reinterview	Dr Z not inter-viewed	Lap Bypass/ transection	2004	Dr Z	N/A	95(2004)
Scrapper(37) (2003)	140	Lapband 5.5ml	1998	6	35	35(2003)	Dr Z	N/A				
Sheree(28) ³ (2003)		Lapband 5.5ml				Some loss, slow; pregnant at time of interview	Dr Z	N/A				

² Weights and weight loss are aggregated from those mentioned by the participants.³ Sheree: "I hate talking about my weight. Weight's kind of a sensitive topic,"

Table 3 (continued)

Weight Loss (approximate) by procedure for participants who proceeded to surgery, 1999-2007⁴

Weight-loss surgery patient	Initial Weight in kilos	1st surgery	Date	Weight loss prior surgery in kilos	Weight loss after Surgery in kilos	Maintained loss on 1 st interview in kilos	Surgeon	2 nd surgery	Date	Surgeon	Weight loss following surgery	Current weight
Shona(34) (2003)	125	Lap Bypass/ transection	2003	lost 16 kgs in preceding year	58	60 (2004)	Dr M2	N/A				
SusieB	125	Lapband 1 5.5ml	2000	8 (117)	22	20	Dr Z	Lapband 2 10ml	2006	Dr Z	(7kg)114	107 (2007)
Topsy (59 approx) (2003)	117	Lapband 10ml	1999	10	27	20(2003)	Dr A					
Patient A#	167	Gastric bypass	1986	unknown	unknown	# no interview	unknown	Open Bypass/ transection	1993	Dr M1	unknown	unknown
Ms AR*	149	Lapband 5.5ml	1999	10kgs	0	* no interview	Dr Z	Open Bypass/ transection	2000	Dr M2	60	79(2003)
Jane• 53(2003)	125	Lapband 5.5	2000	10kgs (approx)	35kgs	• no interview	Dr Z	N/A				

^ Clover's procedures predated the first interviews for this research

Patient A taken from the media coverage

* Ms AR taken from material for the HDC enquiry, finalized in 2003

• Jane taken from media story, Jane, the *Next* Magazine cover girl. "Trim and gorgeous" (Colville, 2003, p.149)

⁴ Weights and weight loss are aggregated from those mentioned by the participants.

APPENDIX 13

Table 4

Reported side effects and benefits by surgeries and by participants

Participant	Surgery 1	Reported Side effects	Reported benefits	Surgery 2	Reported Side effects	Reported benefits
Clover [^]	Open bypass	- Vit B deficient - Anaemia - yoyo weight - staple line disruption - weight regain	+ Good weight loss + improved type 2 diabetes	Open bypass, Transected and with silastic ring	- Reduced weight loss - Vitamin B deficiency - Anaemia	+ Improved type 2 diabetes + some weight loss
Janice	Open Bypass/ transected- with ring	- Incision site infections - Regurgitation - vomiting - dumping	+ Good weight loss + improved type 2 diabetes	N/A	N/A	N/A
Karlie	Lap Bypass/ transection	- Regurgitation - Vit B deficient - good food restricted	+good weight loss	N/A	N/A	N/A

[^] Clover's procedures predated the first interviews for this research

Table 4 (continued)

Reported side effects and benefits by surgeries and by participants

Participant	Surgery 1	Reported Side effects	Reported benefits	Surgery 2	Reported Side effects	Reported benefits
Marjorie	Lapband 5.5ml	- good food restricted - Stomach pains - Nausea - poor loss - pain with port positioning - weight regain	nil	Lapband removal	-weight gain?	+ improved food choices + removal of symptoms
Meryl	Lap Bypass/ transection	- dumping - good food restricted - CRE ¹	+ good weight loss	N/A	N/A	N/A

¹ CRE: chronic restricted eating

Table 4 (continued)

Reported side effects and benefits by surgeries and by participants

Participant	Surgery 1	Reported Side effects	Reported benefits	Surgery 2	Reported Side effects	Reported benefits
Michelle	Lapband 5.5ml	- reflux - goal weight not achieved - weight regain - yoyo weight - vomiting - good food restricted	+ some weight loss maintained	Lap bypass, Transected	- slow weight loss - small weight loss - radical intervention	+ weight loss + cured reflux
Pammy	Open bypass/ transection with ring	- good food difficult to eat - vit B deficient - CRE	+ good weight loss + thinness stands out	N/A	N/A	N/A

Table 4 (continued)

Reported side effects and benefits by surgeries and by participants

Participant	Surgery 1	Reported Side effects	Reported benefits	Surgery 2	Reported Side effects	Reported benefits
Pinky	Lapband 10ml	- good food restricted/bad food easy to eat - poor loss - severe anaemia - severe constipation/ shock – admitted to hospital	+ feeling of weight control	N/A	N/A	N/A
Rosie	Lapband 5.5ml	- reflux - good food restricted - bad food easy to eat - weight regain - yoyo weight	+ some weight loss + some feeling of weight control	Lap bypass, transected	- Intensive care for two months, multiple operations, resuscitated on at least two occasions, continuing ill health; loss of job; inability to work	+ weight loss (but it's not worth it!)"

Table 4 (continued)*Reported side effects and benefits by surgeries and by participants*

Participant	Surgery 1	Reported Side effects	Reported benefits	Surgery 2	Reported Side effects	Reported benefits
Scrapper	Lapband 5.5ml	- worried about band erosion - “good”’s food restricted - “bad” food easy to eat	+ good weight loss + some feeling of weight control	N/A	N/A	N/A
Sheree	Lapband 5.5ml	- slow loss - emergency deflation required - food becoming stuck	+ some weight loss maintained + band adjustable for pregnancy	N/A	N/A	N/A
Shona	Lap Bypass/ transection	- some dumping - Vit B deficient - Some regurgitation - CRE	+ good weight loss + liked being thin	N/A	N/A	N/A

Table 4 (continued)

Reported side effects and benefits by surgeries and by participants

Participant	Surgery 1	Reported Side effects	Reported benefits	Surgery 2	Reported Side effects	Reported benefits
SusieB	Lapband 1 5.5ml	- good food restricted - reflux - regurgitation, - increased asthma assoc with reflux, - weight regain - small weight loss overall - inflations very difficult to achieve	+ some weight loss maintained + a feeling of weight control + feeling less noticeable	Lapband 2 10mls	- good food restricted - reflux - regurgitation, - increased asthma assoc with reflux, - weight regain - small weight loss overall	- Inflations possible - A feeling of weight control
Topsy	Lapband 10ml	- poor port placement - good food restricted - very rapid weight loss	-reasonable weight loss maintained over time	N/A	N/A	N/A

Table 4 (continued)

Reported side effects and benefits by surgeries and by participants

Patients not interviewed	Surgery 1	Reported Side effects	Reported benefits	Surgery 2	Reported Side effects	Reported benefits
Patient A#	Gastric bypass	- staple-line failure	+ weight loss	Open bypass/ transected	- hospitalised for 14 months, spleen removed, damage to bowels, severe abdominal pain, unable to work	
Ms AR*	Lapband 5.5ml	- Incision site infections - Induced vomiting, - no weight loss		Open bypass/ transected	- reflux - nesidioblastosis (extreme dumping) -gall bladder removal -post colicystectomy syndrome -obstruction bowel? -vit B deficient- anaemia - copper deficiency?	+ good initial weight loss + hip replacement surgery

Patient A taken from the media coverage

* Ms AR taken from material for HDC enquiry, finalised in 2003

Table 4 (continued)

Reported side effects and benefits by surgeries and by participants

Patients not interviewed	Surgery 1	Reported Side effects	Reported benefits	Surgery 2	Reported Side effects	Reported benefits
Jane•	Lapband 5.5	- regurgitation, - induced vomit - good food restricted - CRE	+ good weight loss	N/A	N/A	N/A

• Taken from media story, Jane, the *Next* Magazine cover girl. “Trim and gorgeous” (Colville, 2003, p.149),